Illinois Department of Human Services

Rod R. Blagojevich, *Governor*

Carol L. Adams, Ph.D., *Secretary*

100 South Grand Avenue, East Springfield, Illinois 62762
401 South Clinton Street Chicago, Illinois 60607

January 9, 2009

Mr. Dan R. Long
Executive Director
Commission on Government Forecasting
and Accountability (CGFA)
703 Stratton Office Building
Springfield, IL 62706

Dear Mr. Long,

Please find enclosed the responses from the Divisions of Developmental Disabilities and Mental Health to your most recent questions regarding the closure of Howe Developmental Center and the transformation of the Tinley Park Mental Center, respectively.

We appreciate your continued concern and recognize the complexity and importance of this decision.

Sincerely,

Carol L. Adams
Secretary

Executive Summary of CGFA Response on Howe Developmental Center

The difficult decision to close Howe Developmental Center is a sound policy decision made by the Department of Human Services and the Division of Developmental Disabilities. While this policy decision was based on a number of factors, the need to improve the quality of care provided to people living at the Center continues to be of utmost importance and the primary reason for the decision.

This detailed information is intended to provide a foundation for understanding the Department's concerns regarding the quality of care and the systemic issues that continue to prevent the Center from regaining certification.

Since the de-certification process began, the State and Federal entities responsible for reviewing and assessing the quality of care provided at Medicaid funded ICFs/MR have been to Howe. In every case, the reviews done by these entities have demonstrated concern with the quality of care and the potential risk of harm to those who live at the Center. These entities include:

- Illinois Department of Human Services, Division of Developmental Disabilities – responsible for oversight of all public and private ICFs/MR, Medicaid waiver, and grant funded services for people with developmental disabilities.
- Illinois Department of Public Health – responsible for ensuring compliance with Centers for Medicare and Medicaid Services' federal ICF/MR rules and regulations.
- The Protection and Advocacy Agency for Illinois (Equip for Equality) – federally funded and mandated to protect and advocate for the rights of people with developmental disabilities.
- U.S. Department of Justice – responsible for ensuring the civil rights of people in institutional settings are not violated under the Civil Rights of Institutionalized Persons Act (CRIPA)

The loss of certification at Howe Developmental Center has already cost the State $40 million in lost federal matching funds, and continues to cost the State $2.2 million dollars each month it remains open and decertified. In addition to Howe's $55 million annual appropriation, the Division has diverted $7 million dollars from other State Operated Developmental Centers and community services to fund certification efforts including additional staff, consultants and technical assistance. As soon as funds from Howe are re-allocated to other, certified SODCs or waiver-funded community services, they immediately become eligible for federal matching funds again.

Finally, several studies and reports continue to document that the Illinois service system for people with developmental disabilities disproportionately relies on large, institutional settings. The Department continues to support efforts to expand access to community-based services. The decision to close Howe Developmental Center is in keeping with current practices and standards for serving people with developmental disabilities, the U.S. Supreme Court's *Olmstead* decision, and the responsibility the State has to the approximately 40,000 other people served by the Division and the 15,000 people currently waiting for community-based services.

RESPONSE TO QUESTIONS ISSUED BY
THE COMMISSION ON GOVERNMENT FORECASTING AND ACCOUNTABILITY
REGARDING THE PROPOSED CLOSURE OF HOWE DEVELOPMENTAL CENTER
DIVISION OF DEVELOPMENTAL DISABILITIES
JANUARY 9, 2009

1. DHS maintains that significant time money and effort were put into Howe to regain certification. The Commission requests that the Department provide information as to precisely what actions have been taken to re-gain certification of the Howe Developmental Center.

The Department of Human Service's efforts to maintain certification began long before the Center officially became decertified in March 2007. In September of 2006, the Illinois Department of Public Health (IDPH - the State's agency responsible for reviewing the federal standards for Intermediate Care Facilities for Persons with Mental Retardation), conducted a survey that resulted in the citation of deficiencies in three Conditions of Participation (COP). COPs are indicators of providers meeting minimum standards. The 82-page report detailed the specifics of the failure to meet Federal Standards in the areas of Governing Body and Management, Client Protections and Health Care Services.

On-site training and technical assistance, in an effort to retain certification and correct identified issues, were initiated at this point. The Department requested that IDPH conduct a Special Full Certification Survey (commonly know as a "Do or Die Survey") to evaluate the effectiveness of the Center's efforts to comply with the cited COPs.

In February of 2007, the Illinois Department of Public Health conducted the Special Full Survey but despite intense efforts to improve conditions at the Center, IDPH's survey findings resulted in two repeat deficient COPs under the standards of Client Protections and Governing Body and Management. These COPs resulted in Howe being decertified from the federal Medicaid program and have prevented the Center from receiving federal funding. Since decertification, the state has lost $40 million to the Illinois General Revenue Fund, and continues to lose $2.2 million each month.

In March of 2007, the Center received official notification of decertification.

<u>Efforts to Maintain, then Regain Certification at Howe Developmental Center</u>

Beginning in October of 2006, when the Center received a continuation of unfavorable reviews from IDPH, the Center launched an aggressive initiative that included:

A. Dispatching Mr. Ira Collins, Center Director of the Shapiro Developmental Center, to provide administrative oversight and to coordinate and direct technical assistance from a core team of professionals with vast experience in their respective fields. Mr. Collins reported that a total of 3,284 hours of

administrative oversight, technical assistance and training to Howe staff was provided to the Center from October of 2006 to March of 2007. The technical assistance included, but was not limited to, policy revision, training, and monitoring. See Attachment A, Shapiro Center's Coordinated Assistance to Howe for hourly breakdown of technical assistance and training.

B. The Department replaced Center Director Jay Canna with Interim Center Director Sharon Parker in April of 2007. Howe benefited from Ms. Parker's leadership and work experience that included serving as one of Howe's Unit Administrators when Howe was first decertified and subsequently recertified, and when the Federal Department of Justice was at Howe in the late 1980's. Prior to serving as a Unit Director, Ms. Parker held the positions of Director of Medical and Adult Skilled Nursing Services, Medical and Special Services Coordinator for Region 2's Office of Developmental Disabilities; and Administrative Director, and Team Leader at Elgin Mental Health Center in the early to mid 70's.

C. In July of 2007, the Department secured the services of nationally recognized experts in the field of developmental disabilities services and the operation of ICF/MR facilities through the Pennhurst Group and H&W Solutions. In addition to providing four senior-level management staff on a fulltime basis, the Center benefited from 3,800 hours of technical assistance and consultation from a variety of nationally recognized experts. Areas of technical assistance and consultation included:
    - Staffing and project management,
    - Management processes,
    - Incident management,
    - Active treatment,
    - The interdisciplinary team process,
    - Medical services,
    - Psychiatric services,
    - Nursing services,
    - Behavior support and data, and
    - Department of Justice expert shadowing.

    Examples of Pennhurst/H&W's efforts in Howe's certification included:

    a. Development of a strategy to recertify Howe's four distinct living units one unit at a time. The plan was to facilitate a concentrated effort to regain certification for Living Unit 3 first, and then provide a systematic approach in certifying the remaining three living units one at a time.

    b. The establishment of a primary care nursing model to improve the delivery of nursing services and clinical functions.

    c. Strengthening the Center's Incident Management Process to improve in the areas of identification of contributing factors, and corrective actions to

prevent the reoccurrence of the injuries and significant events.

d. Establishment of Home Leaders for each residential home on Living Unit 3. Home Leaders were a highly motivated group of Howe staff who committed to provide support to the certification process through mentoring and team building within each residential home.

e. Establishment of Family Style Dining to meet compliance with Federal regulations.

f. Enhancement of Day Training Services, e.g. improved curriculum, increased staff ratios, completed assessments of training activities, etc.

g. Conducting reviews to evaluate the results of the extensive training, monitoring, consultation and system improvements that had been completed to measure the feasibility of requesting a certification survey from IDPH.

D. The Department also relied on Howe's dedicated professional, administrative, clinical and direct care team members to provide hundreds of additional hours of work to correct cited deficiencies and to improve levels of care and to enhance the safety of individuals served.

E. In the hopes that improved staffing ratios would enhance the quality of Howe's services, the Department increased direct care ratios by hiring additional staff above Howe's approved budgeted headcount. Additionally, the Center continued to enhance its census reduction program to improve the overall ratio of individuals served to staff. The chart provided below shows the progression of increased staffing ratios for direct care providers (mental health technicians).

Date	Number of Mental Health Technicians	Census	Technician to Individuals Served Ratio
October 2006	397	398	1 to1
December 2006	409	387	1.06 to 1
April 2007	428	384	1.11 to 1
December 2008	408	300	1.36 to 1

F. Resources were committed to the Howe Center with services being provided by the Division of Developmental Disabilities' Clinical (Medical) Director, who was assisted by a nursing consultant as well as staff from Bureau of Quality Management to review programs and services.

G. In April of 2008, Joe Turner began serving as the Center Director. Mr. Turner spent the four previous years as Center Director of the Fox Developmental Center located in Dwight. Prior to joining the Department in 2004, Mr. Turner

worked for Cook County's Bureau of Health Services at Oak Forest Hospital.

During Mr. Turner's tenure at Howe, the primary focus has been to improve the health and safety of persons served, and to raise the level of accountability among all levels of the Howe team. At the beginning of his tenure, when certification remained a Department goal, Mr. Turner continued to bring attention and commitment to standards required to meet State and Federal scrutiny. This ever-present challenge has limited the sustainable achievements necessary for the consideration of requesting a new certification survey from IDPH.

H. In August of 2008, Vickie Bushey, RN, began serving as the Director of Nursing. Ms. Bushey was previously the Director of Nursing at Fox Center. Vickie Bushey has 31 years of nursing experience in the fields of developmental disabilities, mental health and long term care.

The Department recognizes that the extensive efforts provided on behalf of everyone involved, including dedicated Howe staff, have made improvements in the overall quality of care at Howe. However, achieved improvements continue to prove difficult to sustain and therefore, are not enough to achieve certification.

2. DHS states that the Federal government continues to implement policies that are moving states towards community settings where clients are served in less restrictive environments. Can you elaborate on the federal policies? Can you provide a breakdown of other states percentage of clients that are living in a community setting?

In February 2001, President Bush announced the New Freedom Initiative, a nationwide effort to remove barriers to community living and to support states' efforts to meet the goals of the Olmstead v. L.C. Supreme Court decision issued in July 1999. The Olmstead decision, based on the Americans with Disabilities Act, requires states to administer services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

The Federal government has supported state efforts to rebalance their long-term care systems away from institutional services toward community settings over the past several years. Federal supports include:

- Policy changes that allow states more Medicaid flexibility to design their long-term care systems through newer types of waivers, such as Independence Plus waivers which focus on self-direction, 1115 demonstration waivers and 1915b managed care waivers, as well as through increased flexibility in the older Home and Community-Based Services waivers (1915c).

- Seed money to states for new initiatives through the Money Follows the Person Demonstration and the Real Choice Systems Change Grants (both part of the New

Freedom Initiative). These grants are designed to help states reduce their reliance on institutional care and to support infrastructure changes to improve community support systems.

- Technical assistance to states through contracts with Thomson Medstat and Human Services Research Institute (HSRI).

- Creation of new, more flexible Medicaid coverage options under the Deficit Reduction Act of 2005.

There is a continuing and long term national trend away from large state-run institutions for individuals with developmental disabilities toward smaller, community-based settings. For example, nationally:

- In 47 states, a majority of people with developmental disabilities receiving residential services live in settings of 6 or fewer.

- In 25 states, a majority of people with developmental disabilities receiving residential services live in settings of 3 or fewer.

- The average daily population of large state-run developmental disabilities facilities has:
  - Decreased 55.9% since 1990
  - Decreased 71.7% since 1980

- 65 large state-run facilities have closed since 1996.

- Nationwide in June 2007, there were over 500,000 Medicaid waiver participants with developmental disabilities.

Source: Residential Services for Persons with Developmental Disabilities: Status and Trends through 2007 (August 2008, Research and Training Center on Community Living, Institute on Community Integration/UCEDD, College of Education and Human Development, University of Minnesota)

Attachment B includes charts that provide additional information regarding trends across the Nation.

Numerous studies based on empirical research have found that individuals with developmental disabilities who transitioned from large institutional settings to community settings experienced a higher quality of life and no increased risk (and possibly a decreased risk) of mortality after the move. A sampling of applicable studies is provided below.

Quality of Life

- An 8-year follow-up study of 186 people in Illinois who moved from nursing homes to community-based residential settings found they had higher levels of adaptive behavior and community integration than those who remained in nursing homes. This is due to a more attractive physical environment, smaller setting, greater opportunity to make choices, and increased family involvement. (Heller et al., 2000)

- A 2003 New Jersey study of deinstitutionalization found improved community participation, improved self-determination and autonomy, improved satisfaction of families who often opposed community placement initially, and greater life satisfaction reported by former residents. (Heller et al., 2007)

- A 1995 study compared thirty-five indicators of quality of life for 51 people with developmental disabilities living in small ICFs/MR versus other community-based living arrangements. People were matched on adaptive behavior, challenging behavior, age and gender to control for these factors. Quality outcomes were superior for those in the community-based living settings on 10 of the 35 measures. The ICFs/MR were not superior on any of the indicators. Results suggested that less intensively regulated and more flexible models of residential living may produce superior outcomes at equal or lower cost. (Conroy, 1995)

- One study summarized outcomes of moving people with developmental disabilities from institutions to community-based settings in the United States. The activities and outcomes tracked in this report occurred between 1975 and 1997 and were measured through data from over 33,000 participants during 77,821 visits.

  The results of this study have been extremely powerful, in that improvements have been documented in nearly every measurable outcome dimension. Improvements in quality of life outcomes were found in independence, productivity, integration, and include:

  - access to the places and rhythms of mainstream life, and to services when needed
  - health, health care utilization and satisfaction
  - mental health, mental health care utilization and satisfaction
  - friendships
  - physical comfort
  - privacy
  - individualized treatment

- freedom from excessive restraints (physical, chemical, and authoritarian)
- respect for dignity and human rights by staff and others
- support for choice making and learning to make choices
- personal satisfaction with multiple aspects of life
- satisfaction of the family members and "circles of friends" who care about the person

This study demonstrates the overall success of a significant number of people in community-based settings. (Conroy, 1998)

Mortality Studies

- A 1998 review by Hayden of eleven studies between 1960 and 1997 examining the effect of community placement on mortality of people with developmental disabilities found no evidence of increased mortality for people moving into the community and some evidence for lower mortality rates. (Heller et al., 2007)

- The only studies reviewed by Hayden that found higher mortality rates in the community were conducted by Strauss, Kastner and Shavelle in California in 1996-1998. These studies were widely criticized for combining different types of community services (including nursing facilities, which often have worse outcomes), failing to include quality of life outcomes, and failing to measure quality of health care. Further, it is difficult to determine a cause and effect relationship because they did not measure the same people over time. (Heller et al., 2007)

- A 1998 study by O'Brien and Zaharia attempted to replicate the Strauss et al. findings in California. They found a declining trend of mortality for persons living in community settings when risk factors were taken into consideration. This declining trend was not found in institutions. They had concerns about the accuracy of the Strauss and Kastner data. (Heller et al., 2007)

3. Howe overcame the decertification in the late 1980's and actually was re-certified. Why can't the Department get Howe re-certified now?

The primary reasons the Department has determined that certification is not attainable are due to the process for regaining certification itself, systemic issues that impede sustainability, and the continuing occurrence of significant incidents at the Center.

Despite intensive efforts and the diversion of millions of dollars of limited state funding, there has been little decrease in the frequency and intensity of these significant incidents. These types of incidents led to decertification, and have continued to hamper efforts to regain certification.

The Certification Process

The stringent requirements of a certification survey would result in IDPH entering the Center to evaluate compliance with the approximately 400 Intermediate Care Facilities for Persons with Mental Retardation Standards.

The certification re-entry process would involve two surveys with a Reasonable Assurance Period between the two surveys. The Reasonable Assurance Period would generally last up to 120 days, but may be shorter depending on the circumstances. When determining the length of time, Howe's history of repeatedly not maintaining compliance would more than likely result in a longer, rather than shorter, Reasonable Assurance Period.

During the Reasonable Assurance Period, acting for the Centers for Medicare and Medicaid Services (CMS), would evaluate if the deficiencies that caused the decertification continue to exist. At the end of the Reasonable Assurance Period, IDPH would then complete a second survey to verify the ability of the Center to sustain certification. This survey would be used to again verify that the issues that led to the decertification have been corrected, that there is evidence showing that compliance has been maintained, and that the center is in full compliance with Conditions of Participation.

Should the reoccurrences of deficiencies exist, and if the center were not in compliance with the COPs, the Center would not be eligible for reinstatement in the Medicaid Program.

As part of the Reasonable Assurance Period survey process, IDPH would review incidents that have occurred at the Center. The Department has provided documentation in Attachment C, Howe Significant Incidents, of the numerous incidents that have occurred at the Center since January 1, 2008. These significant incidents may have resulted in Howe being found deficient with a COP.

Certification demonstrates that an ICF/MR meets basic quality standards established by CMS for the Medicaid Program. The inability of Howe to meet this basic standard is a serious indication of the systemic issues with the quality of care provided to the people who live at the Center.

Significant Incidents

As discussed above, there continues to be a high level of significant incidents that hinder certification efforts. These incidents have included, but are not limited to:

- a wheelchair-bound person acquiring a fractured ankle;
- people who are assigned twenty-four hour staff supervision (known as, one to one supervision, where staff are to be within an arm's length of the person at all times) being found unsupervised;

- people with assigned one to one supervision being injured, due to self injurious behavior, falling, having pica (eating/ingesting inedible objects) incidents, or the cause of the injury being documented as unknown;
- errors in medication administration;
- failure to follow physician orders;
- failure to properly initiate emergency response procedures, e.g. CPR;
- failure to appropriately implement individualized support programs which are individually designed to protect clients; and
- lack of thoroughness in clinical documentation.

Again, a specific listing of these incidents can be found in Attachment C, Howe's Significant Incidents.

The determination that the Center is unable to meet certification standards is supported in part by results of reviews that have been conducted by IDPH, Pennhurst/H&W, and staff from the Department's Bureau of Clinical Services. Review results revealed that issues that led to decertification remained. A sampling of the results include:

- Poor record keeping/documentation.
- Inadequate active treatment.
- Inadequate staff monitoring and compliance with people's nutritional needs, i.e. excessive weight gain/loss, not following people's programs, etc.
- Concerns with medication administration.
- Concerns with lack of attention/response to people's behavioral programs to prevent self-injury.
- Violation of peoples' rights, e.g. seclusion, inappropriate restraint, breach of privacy.
- Clinical concerns, e.g. medication administration errors, missed appointments, inadequate monitoring of peoples' health conditions.

Given the certification process itself, the systemic issues that prevent sustainable improvement, and the number of significant incidents that have had the potential to result in the determination that COPs were not being met, the Department was faced with a very difficult decision regarding Howe's future. Even though improvements had been made, the Department determined that Howe is not able to successfully regain certification, and that resources being used at Howe and diverted from other sources are not being used effectively.

4. DHS states that directors from other SODCs have been brought in to shore up efforts and to support the certification effort. The Commission requests that the Department furnish the names and qualifications of all individuals brought into "shore up" efforts?

Ira Collins, Center Director, Shapiro Developmental Center, Kankakee
Mr. Collins has more that 50 years in the field of developmental disabilities with over 30 as Shapiro's director. Mr. Collins holds a Masters and is an Illinois Licensed Nursing Home Administrator (LNHA). Additionally, Mr. Collins served as the Deputy

Director for the then Illinois Department of Mental Health and Developmental Disabilities, providing executive level leadership for all mental health hospitals and SODCs in northern Illinois. When Howe was decertified in 1986, Mr. Collins simultaneously served as Shapiro's and Howe's Center Director and under his leadership, Howe regained certification. Mr. Collins provided onsite assistance at Howe from October of 2006 to March of 2007. His efforts during that time were focused on assisting the Center pass the Special Full Certification Survey (commonly know as a "Do or Die Survey")

Vickie Niederhofer, RN, former Center Director and Residential Services Director, Murray Developmental Center, Centralia. Ms. Niederhofer holds a Bachelors degree and has more than 30 years in the field of developmental disabilities as a registered nurse, a Licensed Nursing Home Administrator and member of the Developmental Disabilities Nursing Association. Ms. Niederhofer provided onsite assistance at Howe from October of 2006 to March of 2007. Ms. Niederhofer is now the Deputy Division Director of Habilitation Services for the State of Missouri's Division of Mental Retardation and Developmental Disabilities.

Sharon Parker, Director of Employee Services, Trinity Services Inc., Joliet
Ms. Parker holds a Masters degree and is a registered nurse, a Licensed Clinical Social Worker, and a Licensed Nursing Home Administrator with 40 years of progressive experience in the field of developmental disabilities. Ms. Parker served as one of Howe's Unit Administrators when the Department of Justice was first at Howe in the late 1980's when the Center successfully regained certification. Prior to serving as a Unit Director, Ms. Parker held the positions of Director of Medical and Adult Skilled Nursing Services, Medical and Special Services Coordinator for Illinois' Regional Developmental Disabilities Office; and Administrative Director, and Team Leader at Elgin Mental Health Center in the early to mid 70's. Ms. Parker served as Howe's Interim Director from April to July in 2007.

Arthur Holmberg, Mr. Holmberg holds a Masters degree and brought 34 years of experience of working in the field of developmental disabilities. Prior to joining Howe, Mr. Holmberg worked at New York State's Office of Mental Retardation and Developmental Disabilities. As a Deputy Director, Mr. Holmberg was New York's top program operations manager for intermediate care facilities with deficiencies and worked to develop corrective plans of action to ensure that centers remained certified. Prior to serving as the Deputy Director, Mr. Holmberg oversaw residential settings and various programs within the State's system of developmental disabilities. Mr. Holmberg served as the Howe's Center Director from July 2007 to April of 2008.

Robert Kifowit joined the Center in July of 2007 serving as Director of Program Implementation through June 2008. Mr. Kifowit brought more than 30 years of experience in the field of developmental disabilities and prior to joining Howe was the Director of State Mental Retardation Facilities for the State of Texas' SODC system. Mr. Kifowit holds a Masters degree and prior to serving as the Director of Texas' Mental Retardation Facilities, Mr. Kifowit served in the capacities of Unit

Director, Director of Quality Assurance, Assistant Superintendent, and Superintendent. Mr. Kifowit remains employed at Howe through a contractual agreement.

Sharon Coutryer, PhD, served as the Center's Director of Quality Assurance from September of 2007 to June of 2008. Dr. Coutryer holds a Doctorate degree and has more than 30 years of experience in developmental disabilities prior to joining Howe. Previously, Ms. Coutryer served as the Assistant Facility Director of Fort Wayne State Developmental Center in Indiana with vast experience in the field prior to serving as the Assistant Facility Director.

Janet Cummins, RN, initially provided quality assurance reviews and then served as the Interim Director of Nursing from March to July, 2008. Ms. Cummins holds a Bachelors degree and is a Certified Developmental Disabilities Nurse. Prior to Ms. Cummins joining Howe, her progressive experience in the field of developmental disabilities included serving as a Director of Medical and Nursing Services for a ICF/MR provider in the State of New York; serving as a program surveyor for the State of New York's Office of Mental Retardation and Developmental Disabilities, Division of Quality Assurance – Bureau of Program Certification.

Joe Turner, current Center Director was appointed in April of 2008. Mr. Turner previously served four years as Director at the Fox Developmental Center in Dwight. During his tenure as Fox's Center Director, the Center maintained full certification from IDPH and was fully accredited by CARF, an international accrediting body. Also, please note that under Mr. Turner's leadership, the Fox Center's 2007 Illinois Department of Public Health survey resulted in no deficiencies. Mr. Turner holds a Masters Degree and is an Illinois Licensed Nursing Home Administrator. Prior to joining DHS, he worked at Oak Forest Hospital of Cook County for 19 years, with 11 years in a senior management position, serving on the hospital's executive leadership committee. He assisted in maintaining the Hospital's multiple certifications and accreditations from surveying agencies such as IDPH, and the international accreditation bodies JCAHO and CARF.

Vickie Bushey, R.N. Director of Nursing, has been on a temporary assignment from Fox Center since mid July. Ms. Bushey, in addition to managing a successful nursing program at Fox Center in Dwight, has 31 years of nursing experience in the fields of developmental disabilities, mental health and long term care. She has held the positions of Director of Nursing and Assistant Director of Nursing. As the Director of Nursing for a long term care center, Ms. Bushey spearheaded a quality improvement initiative that corrected the Center's pattern of unfavorable IDPH surveys.

Rod Curtis, MD, Dr. Curtis is a practicing physician in internal medicine and psychiatry and has practiced in the field of developmental disabilities for over fourteen years. Dr. Curtis is board certified in internal medicine and serves as assistant professor of internal medicine and psychiatry, as well as Chief of the Division of Developmental Disabilities at the Southern Illinois University School of Medicine. In addition to his academic appointment, Dr. Curtis maintains an active case load

dedicated to the clinical care and support of persons with developmental disabilities and serves as the clinical director of the Bureau of Clinical Services for the Illinois Department of Human Services, Division of Developmental Disabilities. Prior to assuming leadership of the Bureau of Clinical Services, he served as the Medical Director at Jacksonville Developmental Center, one of the nine SODCs.

Michael Hurt, Chief, Bureau of Quality Management, Division of Developmental Disabilities. Mr. Hurt has worked in the field of developmental disabilities over 35 years. He holds a Masters degree and is an Illinois Licensed Nursing Home Administrator. He previously served 22 years from 1986 to 2008 as Center Director at Jacksonville Developmental Center in Jacksonville. During his tenure as Jacksonville's Center Director, the Center maintained full certification from IDPH and was fully reaccredited for multiple times by CARF, an international accrediting body. Prior to his duties at the Jacksonville Developmental Center, he was in a senior management position with the Division of Developmental Disabilities. From 1973-84, Mr. Hurt was Executive Director of a progressive, innovative community-based organization providing a variety of services and supports to persons of all ages with developmental disabilities.

In addition to the on-sight management, the efforts to improve Howe were supported by the following:

Pennhurst and H&W Consultants:

Catherine Hayes. Ms. Hayes, the Founder and President of H&W Independent Solutions, is a nationally recognized expert in the field of developmental disabilities. Among her vast experience within the field, Ms. Hayes served as Branch Manager and Program Analyst for the Centers for Medicare and Medicaid Services (Federal CMS). In these respective capacities, Ms. Hayes has had demonstrated extensive regulatory, survey and quality enhancement expertise. Ms. Hayes provided a wide range of consultation to the quality improvement process undertaken at Howe.

Consultant	**Area of Consultation/Support**
George Langdon, MA	Management practices and efficiencies
Mark Wiesel, BSE	Management practices and efficiencies
Julie McRae, RN, CDDN	Nursing services
Diane Cardiff, MA	Investigations and incident management
Chris Adams, MA	Investigations and incident management
Dale Dangremond, BSW, MBA	Investigations and incident management
Kevin Schock, MA	Behavior management
Dawan Allen, BSN, Nurse Practitioner	Record review and clinical services
John Casner, M.Ed	Behavior management

Penny Kneisler, MSW	Active treatment and day programming
Keith Keefer, MD	Clinical services

5. DHS noted during testimony that additional money was brought into Howe for "technical assistance and consulting". Would DHS please provide a list of all contracts entered into to provide the technical assistance, and the amounts of these contracts?

Contractor	**Assistance Provided**	**Fiscal Expenditure FY 07 & FY08**
Pennhurst / H & W Solutions	As identified above	$1.37M
Gareda Nursing Services	Nursing agency to enhance nursing staffing ratios	$596K
Ingalls Home Care	Provide sitter services for persons hospitalized in an attempt to increase direct care staffing ratios within living units	$224K
Annashae Corporation	For physician services	$125.6K
Formak Corporation	Clinical Record Review	$4.5K

It is important to note that Howe's certification efforts required that approximately $7 million from other areas within the Division of Developmental Disabilities be reallocated to Howe to fund additional staff and overtime; the contractual expenditures; and equipment purchases. Reallocation of funding for Howe resulted in loss of federal match and in other SODCs being required to reduce their fiscal expenditures, thus limiting their ability to hire staff, purchase equipment, etc.

6. Why do incidents that would prevent Howe from getting re-certified continue to happen? If the Department is aware of these "incidents" what is it doing to stop them?

The frequency and significant nature of incidents at Howe has been, and continues to be, one of the most challenging and concerning aspects of the Center's ongoing situation.

Overall, the Department believes that the vast majority of the Howe staff maintain the competencies to effectively meet the needs of people with developmental disabilities. The Department also believes that, throughout the years, there have been pervasive cultural and systemic issues that preclude Howe from operating at a consistent level to meet State and Federal requirements. The people living at Howe have a right to quality services and staff deserve the opportunity to work in an environment that is not

continually operating in crisis mode.

The reasons for the lack of consistent commitment to services are varied and have proven difficult to overcome. The Department has identified potential contributing factors that include:

A. being decertified and unable to regain certification;
B. public criticism of Howe and support of closure in the media (see Attachment D for editorial articles);
C. in general, a culture that believes other providers will be unable to serve the people residing at the Center and is not receptive to innovative concepts;
D. failure to build and maintain accountability in the service delivery system; and
E. a paradoxical perception that Howe will never close, yet at the same time, that despite the allocation of additional financial and human resources, the erroneous and pervasive feeling that the Department always intended to close the Center.

It is important to recognize that Howe has a disproportionate share of significant incidents when compared to other SODCs. Steps to identify the source of these incidents are addressed in part through the Center's Incident Management Committee, which meets to review incidents and address corrective actions. Data, in relation to incidents, is also evaluated to identify trends and commonalities that may identify a source, e.g. people presenting with injuries of unknown source, at specific times of the day or in specific locations.

The fact that there have been few, if any, trends that have identified causal factors and that the incidents occur across all residential settings and shifts, support the Department's position of the cited systemic lack of commitment to quality care as a major contributor to the problems at the Center.

When abuse or neglect is identified, the Center does take administrative action within the parameters of personnel rules and respective collective bargaining unit agreements. However, alleged abuse and neglect cases are referred to the appropriate authority, namely the Department's Office of the Inspector General and the Illinois State Police. The Center may be hindered in its ability to take action if there is insufficient evidence to substantiate an allegation.

The Center reviews incidents as opportunities for improvement in policy and procedures and system enhancements, and individualized staff training. Examples of improvements that have occurred as a result of the review of an incident include:

- Heightened attentiveness to monitoring people for possible head injuries when falls or trauma to head occur.

- Development of a policy for diabetic care in response to a person's low blood sugar event that required hospitalization.

- Development of a database to better track scheduled appointments in

response to a multitude of issues with missed off-campus medical consultations.

7. Since July 1st, 2007 the Department states that 33% of deaths at SODCs have occurred at Howe. Why did these patients die? The Commission also requests the number of deaths at each SODC for the last five fiscal years.

Since the CGFA hearing on December 11, 2008, two people have died. This means that since July 1, 2007, 35% of all deaths in SODCs have occurred at Howe Developmental Center.

The following data delineates the absolute numbers, percentages and rates of deaths at each center between July 1, 2004 and December 30, 2008.

Excluding the Fox Developmental Center (see note below), all other SODCs support a similar population with similar needs. When looking at the data, specifically the mortality rate, it is clear that the Howe Developmental Center consistently demonstrates the highest mortality rate across the SODC system. Over the five-year period, among Centers of like size (i.e., serving 300 to 400 people), Howe's figures nearly double that of Murray and Ludeman. In fact, Howe's number of deaths is comparable to that of Shapiro, which serves approximately 200 more people.

Note: Fox Developmental Center is unique from other State Operated Developmental Centers because of the extreme acuity needs of persons served at that particular center. Unlike other Centers, the Fox Developmental Centers supports individuals with advanced, chronic healthcare needs and the mortality rate at Fox is and should be expected to be generally higher then other SODCs.

SODC Deaths and Death Rates since FY 2004

Facility	**FY 04**					**FY05**				
	Ave. FY Census	Deaths	% of Deaths	% of Census	Rate per 100	Ave. FY Census	Deaths	% of Deaths	% of Census	Rate per 100
Choate	205	2	4.76%	7%	1.0	193	3	10.00%	7%	1.6
Fox	167	4	9.52%	6%	2.4	159	5	16.67%	6%	3.1
Howe	433	9	21.43%	15%	2.1	420	7	23.33%	15%	1.7
Jacksonville	261	1	2.38%	9%	0.4	260	1	3.33%	9%	0.4
Kiley	266	1	2.38%	9%	0.4	261	1	3.33%	9%	0.4
Ludeman	435	5	11.90%	15%	1.1	429	4	13.33%	15%	0.9
Mabley	110	1	2.38%	4%	0.9	105	0	0.00%	4%	0.0
Murray	348	6	14.29%	12%	1.7	345	3	10.00%	12%	0.9
Shapiro	659	13	30.95%	23%	2.0	643	6	20.00%	23%	0.9
Total	2884	42	100.00%	100%	1.5	2815	30	100.00%	100%	1.1

	FY 06					FY 07				
	Ave. FY Census	Deaths	% of Deaths	% of Census	Rate per 100	Ave. FY Census	Deaths	% of Deaths	% of Census	Rate per 100
Choate	175	2	4.55%	6%	1.1	177	1	2.56%	6.78%	0.6
Fox	153	5	11.36%	6%	3.3	146	5	12.82%	5.59%	3.4
Howe	402	11	25.00%	15%	2.7	372	6	15.38%	14.25%	1.6
Jacksonville	261	1	2.27%	10%	0.4	243	5	12.82%	9.31%	2.1
Kiley	254	2	4.55%	9%	0.8	240	2	5.13%	9.19%	0.8
Ludeman	416	4	9.09%	15%	1.0	400	3	7.69%	15.32%	0.8
Mabley	99	1	2.27%	4%	1.0	91	3	7.69%	3.49%	3.3
Murray	341	6	13.64%	13%	1.8	336	5	12.82%	12.87%	1.5
Shapiro	619	12	27.27%	23%	1.9	606	9	23.08%	23.21%	1.5
Total	2720	44	100.00%	100%	1.6	2611	39	100.00%	100.00%	1.5

	FY08					FY09 through 12/31/08				
	Ave. FY Census	Deaths	% of Deaths	% of Census	Rate per 100	Ave. FY Census	Deaths	% of Deaths	% of Census	Rate per 100
Choate	173	0	0.00%	7.00%	0.0	171	0	0.00%	7.26%	0.0
Fox	140	3	8.11%	5.66%	2.1	134	1	5.00%	5.69%	0.7
Howe	322	9	24.32%	13.03%	2.8	310	7	35.00%	13.16%	2.3
Jacksonville	228	6	16.22%	9.22%	2.6	214	4	20.00%	9.09%	1.9
Kiley	224	2	5.41%	9.06%	0.9	220	2	10.00%	9.34%	0.9
Ludeman	382	1	2.70%	15.45%	0.3	373	1	5.00%	15.84%	0.3
Mabley	90	0	0.00%	3.64%	0.0	87	0	0.00%	3.69%	0.0
Murray	326	5	13.51%	13.19%	1.5	305	2	10.00%	12.95%	0.7
Shapiro	587	11	29.73%	23.75%	1.9	541	3	15.00%	22.97%	0.6
Total	2472	37	100.00%	100.00%	1.5	2355	20	100.00%	100.00%	0.8

Of the 16 deaths that have occurred at Howe since July 1, 2007, eight autopsies were completed. Guardians of the remaining eight declined a request for an autopsy. A summary of the cause of deaths is as follows:

Five deaths were attributed to cardiac issues
- Arteriosclerosis (1)
- Cardio Pulmonary Arrest (4)

Five deaths were attributed to cerebral issues
- Seizure Disorder (2)
- Cerebral Edema (1)
- Stroke (2)

Three deaths were attributed to infections
- MRSA/Sepsis (1)
- Urosepsis (1)
- Endocarditis (1)

One death was attributed to aspiration
Two deaths were attributed to gastro-intestinal issues
Acute Upper G.I. Bleed (1)
Necrotic Colon (1)

8. Who specifically will serve on the advisory council the Department references that will be created to oversee transitioning patients out of Howe?

The purpose of this group will be to advise the Division on its closure plan and to assist in addressing concerns and issues as they arise. Potential membership includes the following:

A parent representative from the Howe Friends and Family Group
A person currently living at Howe
An employee representative from Howe
Statewide representatives of the following groups:
Illinois League of Advocates for the Developmentally Disabled
AFSCME
Illinois Associate of Rehabilitation Facilities
Equip for Equality
Illinois Council on Development Disabilities
The ARC of Illinois
University of Illinois at Chicago
United Cerebral Palsy of Illinois
The Institute on Public Policy
The Center for Developmental Disabilities Advocacy and Community Supports
Representatives of Department Executive and Senior Division Management Staff

9. In Illinois, is there any differences in mortality rates for persons residing in SODCs and those residing in a community based setting? Please provide data as to the Department's response.

In preparing a response to this question, the Department reviewed data for Illinois' fiscal years 2006, 2007, and 2008. Specific numbers used for mortality rate calculations are fiscal year end census information, deaths as recorded by the SODCs, and deaths in community-based residential Medicaid Waiver settings (e.g., Community Integrated Living Arrangements, Community Living Facilities, etc.) as reported to the DHS Office of the Inspector General. The information is compared below:

State FY	SODC Rate per 100	Community Rate per 100
FY06	1.6	1.0
FY07	1.5	0.9
FY08	1.5	1.1

10. DHS estimates that 75 residents at Howe will move to a community based

setting. Howe did the Department arrive at this number?

At this present time, approximately 80 families/guardians have identified their wish to pursue placement in a community setting. Also, it is anticipated that when the closure process progresses, families/guardians will further evaluate their options for placement and additional parties may express an interest in transition to a community based-setting.

Over the last six fiscal years, Howe has had continuing success in transitioning people to community settings (see table below). In the last few years, the number of annual transitions has progressively increased and it is anticipated that this trend will continue.

Transitions to Community Settings from Howe

FY04	FY05	FY06	FY07	FY08	FY09 YTD
19	19	13	24	37	12

11.) The Department stated that a portion of the funds from the sale of the property will be used to improve and expand services at SODCs? How can DHS assure this is how the funds will be used since any proceeds will be subject to appropriation by the legislature?

All funding for the Department is subject to appropriation by the Legislature. It is the intent of the Department to submit budget requests in future years that will allocate funding from Howe Developmental Center and the Division of Developmental Disabilities' portion of the proceeds of the potential sale of the property to other parts of the service delivery system. Funding requests will be made to support people from Howe who transition to community-based settings, and to enhance and expand community services. Funding requests will also be made to allocate to the remaining SODCs resources necessary to support the people who transition from Howe.

12.) DHS stated that getting a visit from the Department of Justice is "very severe and not customary". Have any other Illinois SODCs been under investigation by the Department of Justice?

Clyde L. Choate Developmental Center in Anna, Illinois is currently under investigation by the U.S. Department of Justice. DOJ's investigations of Howe and Choate, both of which are being conducted pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. 1997, are focused on the conditions of care and treatment at the Centers and ensuring the constitutional rights of the people who live at the Centers are being respected.

However, there are two critical differences between those investigations. First, the on-site investigation at Choate did not conclude with statements by DOJ attorneys or their experts that the people living at Choate were at risk of harm. In contrast, the on-site

investigation at Howe concluded with negative feedback from DOJ in virtually every area of operation and an expression of grave concern regarding the ability of the Center to keep people free from harm was made by every attorney and every expert on the team, many of whom also participated in the Choate review.

Second, and significantly, this is the second time DOJ has investigated Howe. DOJ had never investigated Choate prior to last year. DOJ's first investigation of Howe, which commenced in the 1980s, concluded with the Department entering into a consent decree; by the time DOJ returned to Howe in 2007, they voiced many concerns regarding the services they observed.

The Department's legal counsel has recently been in communication with the DOJ and confirmed that they have drafted and are now awaiting final approval of the findings letters for Howe and Choate.

Following are some of the verbal comments made during the DOJ Exit Conference at the Center regarding major areas reviewed. This summary is based on notes taken by Department staff during the meeting.

Overall, while they did note that some improvement had been made, the Center was described as "dysfunctional." Again, each attorney and expert specifically stated that they were concerned with the Center's ability to keep people living at the Center safe from harm.

Nursing Care Issues

The environmental culture is crisis driven and reactive according to medical charts. It is hard to track health care concerns. Important data is not reflective or integrated. Regarding falls, Physical Therapist will evaluate whether there are balance issues, but there is no tracking of reports beforehand. Changes are not tracked; therefore, data is not used to evaluate effectiveness. Even where policies exist for documenting, it appears they are not being followed and documentation is not being done.

Clinical Care

There appear to be only minimum expectations. Attended three MD meetings, incident management meetings, and had concerns regarding general clinical care. There is no consistent understanding of when physicians are to do more thorough reviews. There is no quality management committee or peer review committee. Consults are not being reviewed in full detail. There is inconsistent reporting of those who have risks (choking, infection, etc).

Interventions are reactionary. Doctors are only dealing with crisis/emergency situations and not looking at the full health of the person. In medical meetings, there are no notes of discussion. Things are not being followed up like they need to be.

There is no loop with nursing/medical follow-up. There is a lack of communication. There are high incidents of infections, cellulites, MRSA, CDP. Concerned about MRSA. Not recording how people manifest pain. There are many illnesses, falls, and infections, Emergency room visits could have been prevented.

Behavioral/Psychology

Individual Service Plans do not reflect a person-centered approach. A new format for ISPs will help, but correction will require more than that. It does not look like there is an interdisciplinary process. The Center is weak on gathering data and program design. Need to fundamentally change the way interdisciplinary teams operate. Fractured records mirror fractured interdisciplinary teams. People are suffering. People are being deprived community placement because of inadequate behavioral support services. Even people in crisis are not addressed from a different perspective.

13.) How many employees currently employed at Howe were there in FY 2002?

Records indicate that as of December 2008, 522 of the Center's 806 employees were employed at Howe in 2002.

14.) The Department states that it wants to move people into a more community based approach. Didn't the Department recommend reductions in funding for community-based settings?

As a result of the budget shortfall, the Division was originally required to take a 3% reserve on all appropriations for community services. This would have resulted in a reduction of $30 million and 2.5% rate cuts for all Medicaid funded programs in the Division (ICFs/MR, CILA, developmental training, and others). Fortunately, as a result of Senate Bills 790 and 1103, the Division did not have to take this action on Medicaid funded programs.

Grant-funded providers recently had a FY09 funding reserve that totaled $4.23 million (5.83%). The amount of grant funding subject to the reserve was $72.63 million.

The Division funds a total of 373 community providers (including grants, fee-for-service and ICF/MR providers). The FY09 appropriations for all these community services total $1.14 billion.

Currently 69 different providers are actively involved in efforts to transition the 80 people who are exploring community-based placements.

15.) DHS states that community providers are waiting a significant time to get paid? How long is the current payment cycle for these providers? How much does the Department currently owe these providers in total?

As of January 2, 2009, there were approximately $30 million in community provider

payments pending at the Illinois Office of the Comptroller. These payments for the most part are for the month of December.

16.) Are the issues at Howe a result of employee incompetence or neglect? If so, why would the Department even consider allowing incompetent employees to transfer to another facility and possibly endanger other patients?

As previously stated, the Department is confident that the vast majority of Howe's staff maintains the competencies to effectively meet the needs of people with developmental disabilities. These competencies will serve as the foundation of a planned special orientation process each receiving center will provide to Howe employees who transfer. Additionally, employees who transfer to other centers will no longer be subject to the systemic issues that have been identified in previous responses and will do well with a change in the environment and the workplace culture. While the Division has heard concerns about this from parents' groups at other centers, we expect that given the opportunity to succeed in a different environment, Howe employees will be recognized as a competent and quality addition to the receiving centers.

17.) The Department cites that there is an issue regarding "documentation" and even the documentation the center had "they (CMS) didn't believe it". Does DHS agree with these findings? What has been done to rectify this problem?

The issue of documentation was raised at the Department of Justice exit conference. The Department recognizes that issues with documentation have been problematic at Howe, specifically, documentation within persons' medical records. Generally, documentation issues are revealed during routine record reviews or special review of a record after a significant event.

Areas of identified concern include:

- Incomplete documentation of clinical assessments
- Missed documentation of physician-ordered vital signs
- Missed recordings/tracking of routine items, i.e, bowel monitoring, people's weights

Efforts to fully rectify this problem continue. Nursing supervisors have been conducting reviews/audits of clinical records and the Center reports that improvements are being noted and sustaining improvements is a goal of the Center.

18.) The Commission requests a copy of the re-structuring plan the Department referenced during testimony regarding SODCs.

The State-Operated Developmental Center's *Restructuring or System Improvement Plan* the Department referenced during testimony will be available for public distribution once it has been finalized. The *plan* is a living, breathing document that will evolve in time to address the ever-changing challenges the SODC system faces to meet and exceed State and Federal standards. The hallmarks of the *plan* are as follows:

- Strategies to address staffing issues in critical positions and to embed contemporary leadership practices in the SODC system to promote incremental improvements in the service delivery system and to minimize the potential for high rates of overtime, staff burnout and low morale.

- Strategies to improve organizational clarity by communicating clearly defined work responsibilities and streamlining chain of command.

- A plan to improve the quality and functionality of the Interdisciplinary Planning process through a needs (training) assessment and by instituting an external monitoring process that assures inter-disciplinary teams (IDTs) are functioning optimally.

- A plan to identify best practices in the field of developmental disabilities and then to standardize these models across the SODC system.

- A plan to ensure SODCs expand community access for people served and that they are consistently afforded opportunities to participate in community events and activities.

- An initiative to identify and implement best practice models in the area of Risk Management in order to standardize the Incident Management System across the SODCs.

- A policy directive that will assure that behavioral intervention plans address all issues related to challenging behaviors, seek to lessen or eliminate the use of medication, and are focused on decreasing behaviors that preclude transition to community-based settings.

- Strategies to significantly improve the overall quality of clinical services in the SODC system, including a plan that will assure each SODC has a full-time medical director charged with the responsibility of implementing policies and procedures to promote national standards of care.

- A policy directive and training plan that will reduce reliance on restraint techniques, thereby decreasing the potential of accidental injuries through restraint application.

- A protocol that commits each SODC to review the use of anti-epileptic drugs (AEDs) assuring that newer, better drugs with reduced side effects are used when indicated.

- A protocol that will assure that every person in a SODC is screened annually for possible mental health disorders, and that all SODCs have access to psychiatrist

who will complete annual evaluations that use state of the art methods of diagnosis and treatment.

- A plan to promote a peer review system for nurses based on evidence-based Developmental Disabilities (DD) Nursing Best Practices, including self-monitoring and correction of identified practice issues.

- A plan to increase the information technology platform across the SODC system in order to gather, analyze, review, and use data to improve service delivery.

- A protocol that will standardize the process used to manage the flow, dissemination, and storage of relevant clinical information across the SODC system.

19.) Is GOMB agreeable to expanding headcount at the other SODCs to accommodate transfers from Howe?

The Governor's Office of Management and Budget supports the Department's plan.

20.) What will the process be for selling the property that currently is Howe/TPMHC? Can the Department provide the Commission with a step by step plan for the sale of this property? Explain how the proceeds from the sale will be re-allocated back into the SODC system?

Sale (disposal) of the property is governed by the State Property Surplus Act. With the realization of the closure, the property will be deemed surplus and Central Management Services will take control and must first offer the property to other state agencies, then to municipalities, then sale on open market at fair market value. There is a provision in the Act requesting legislation that could allow the Department of Human Services the right to sell the property. Unless specified by legislation, all proceeds go to the General Revenue Fund.

Please refer to Question 11 for information regarding allocation of proceeds from any sale of the property.

21.) How much is the property worth? Has the property been appraised? If so, the Commission request copies of the appraisals. If not, when does the Department plan to seek appraisals?

The Department of Central Management Services has the authority to request an appraisal, not the Department of Human Services. The Department of Human Services, therefore, has not arranged for an appraisal of the property.

22.) One of the problems cited at Howe dealt with staffing. Is there currently mandatory overtime at Howe? If so, wouldn't this be indicative of a facility that is understaffed? If the facility is understaffed, what is DHS doing to increase staffing?

Mandatory overtime is required at Howe, as it is at all SODCs and agreed to in each Master collective bargaining agreement with the American Federation of State, County, and Municipal Employees and the Illinois Nurses Associations. Generalizing that mandatory overtime is solely the result of being "understaffed" is not completely accurate. There are many reasons for mandatory overtime, including a necessity to cover a shift when staff have an absence or call-off just prior to their shift, intermittent utilization of the Family Medical Leave Act, and unanticipated leaves of absence.

Howe has benefited from improved staffing ratios when compared to other SODCs. In general, the Department has attempted to maintain a 2.0 overall staffing ratio at all Centers. Howe's FY08 budgeted staff headcount is 734 Full Time Equivalent (FTE) staff. Given that Howe provides food for three facilities, Howe, Ludeman, and the Tinley Park Mental Health Center, the Department's budget attributes 40 of Howe's FTEs to "shared services", giving Howe a realized FTE of approximately 696. Given the fiscal year's average census of approximately 315 people, the staffing ratio would equate to 2.2 FTEs for each person served. [Please note these numbers differ from those used in the response to Question 1, since they represent all staff and not only mental health technicians.]

It should be noted that Howe has been allowed to extend beyond its budgeted head count in attempts to relieve overtime utilization and to improve services. In FY 07, the Center's FTE peaked at 782 (742 FTEs when factoring shared services), and the Center's current FTE remains above the budgeted allotment of approximately 760, (720 FTEs when factoring shared services), giving the Center a current 2.4 ratio of FTE-per-person served.

Please note the SODCs current staffing ratios:
2.38 Howe Developmental Center
2.03 Choate Developmental Center
1.92 Fox Developmental Center
1.95 Jacksonville Developmental Center
1.83 Kiley Developmental Center
1.80 Ludeman Developmental Center
1.84 Mabley Developmental Center
1.85 Murray Developmental Center
2.03 Shapiro Developmental Center

All of the other Centers are currently certified.

As previously identified, the Department allowed other measures at Howe that were intended to improve staffing ratios. These approaches included entering into contracts with Gareda Nursing Agency to enhance nursing staffing ratios and Ingalls Home Care to provide sitter services for hospitalized persons to improve direct care staffing ratios within the living units. Additionally, the Center continues to appropriately transition people to community settings, thus decreasing the census and improving staffing ratios.

23.) How much in overtime did DHS pay out for employees at Howe in FY 2006, 2007 and 2008?

The table below indicates overtime spending. Note that, until this fiscal year, the anticipated increases in staffing ratios failed to net the anticipated overtime expenditure reductions.

Howe Overtime Spending and Comparative Staffing Ratios

	FY 06	**FY 07**	**FY 08**	**FY 09 YTD**
Overtime Spending	$5.3 M	$7.4 M	$8.5 M	*$6 M – projected*
Staffing Ratio	1.9	2.05	2.37	2.53

ATTACHMENT A

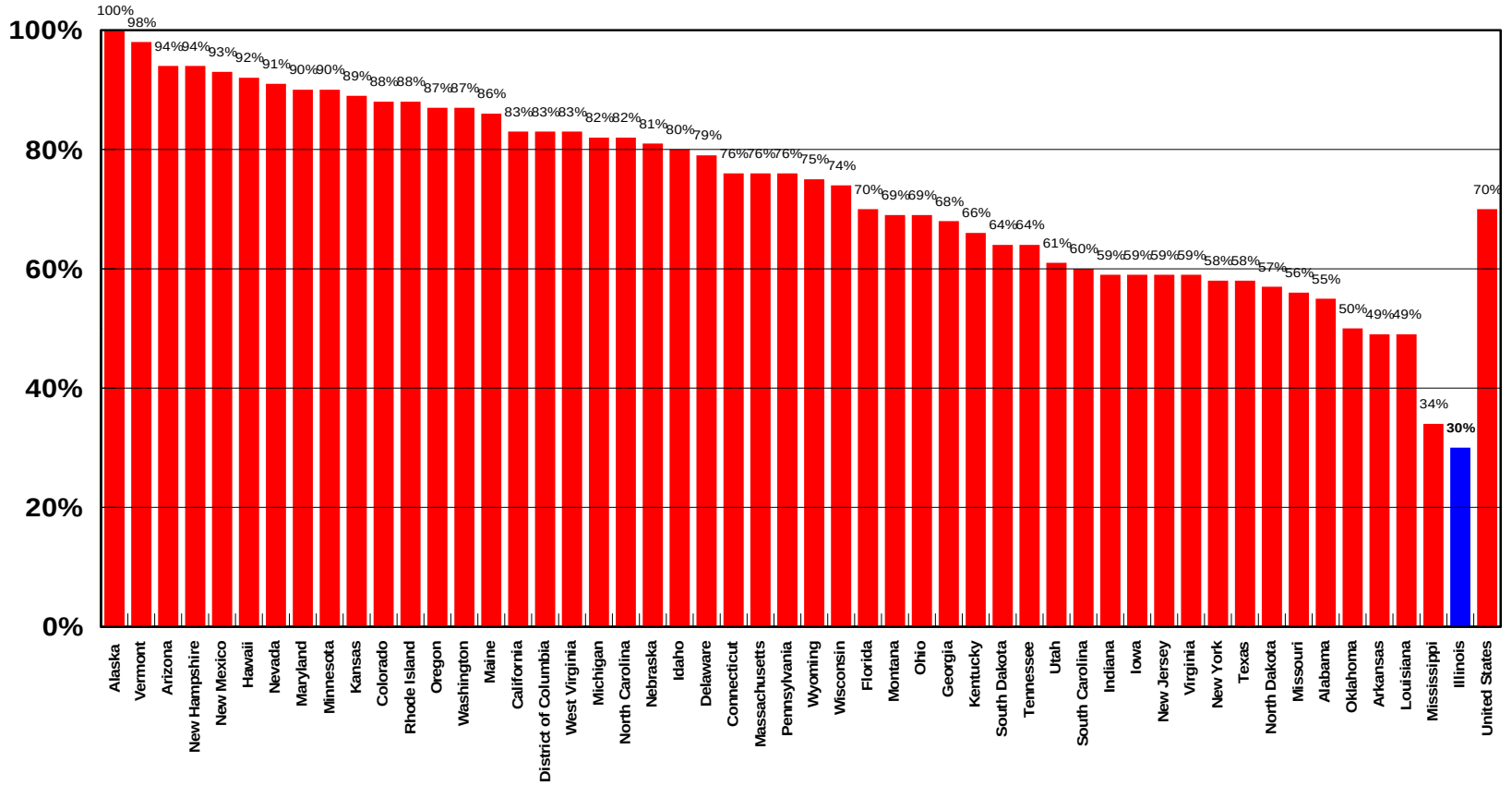
Hours of Technical Assistance Provided by
Shapiro Developmental Center Staff

Shapiro Center	
Howe Center Assistance 10/06 to 3/5/07	
Title	**Hours**
Unit Directors/SPSA (8)	256
SPSA/Director of Behavioral Health	32
PSA/Director of Nursing	64
PSA/Vocational Center Director	40
PSA/Day Program Coordinator	16
PSA/Nursing Supervisor (2)	32
PSA/Staff Development Director	36
Staff Development Specialist (2)	64
MH Admin II (5)	160
MH Tech 4 (5)	160
Physician Specialist (2)	48
Medical Director	24
Quality Assurance - Admin. Asst I (2)	40
Quality Assurance - Residential Service Supervisor	456
QMRP/HPC (2)	32
SPSA - Center Director	608
SPSA - Assistant Center Director	608
SPSA - Assistant Center Director 8N (Murray)	608
Total hours	**3284**

ATTACHMENT B

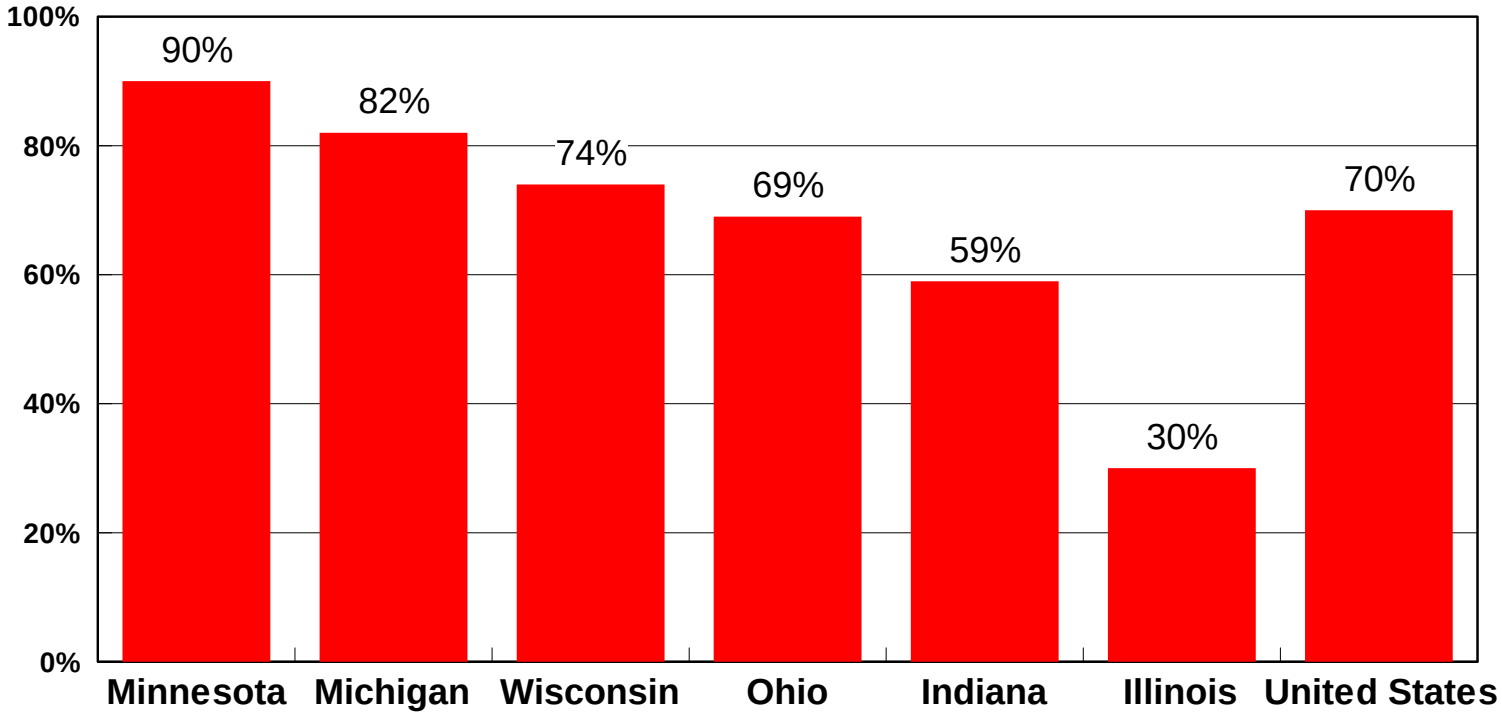
Charts

Percent of Individuals with DD in Settings for 6 or Less: FY 2006



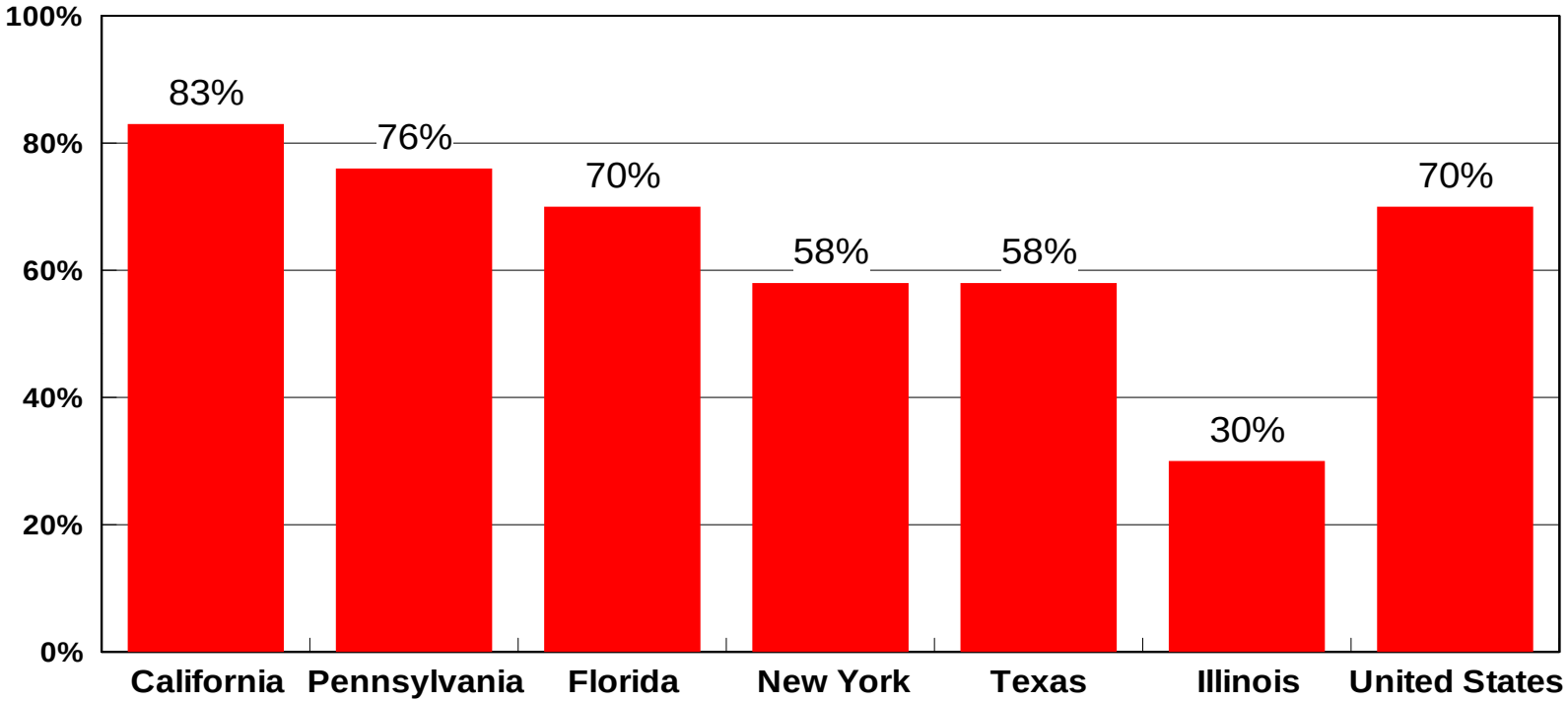
Source: Braddock, D., Hemp, R & Rizzolo, M.C. (2008). *The state of the states in developmental disabilities: 2008* . Washington, DC: American Association on Intellectual and Developmental Disabilities.

Percent of Individuals with DD in Settings for 6 or Less in Midwestern States: FY 2006



Source: Braddock, D., Hemp, R & Rizzolo, M.C. (2008). *The state of the states in developmental disabilities: 2008* . Washington, DC: American Association on Intellectual and Developmental Disabilities.

Percent of Individuals with DD in Settings for 6 or Less in Populous States: FY 2006



Source: Braddock, D., Hemp, R & Rizzolo, M.C. (2008). *The state of the states in developmental disabilities: 2008* . Washington, DC: American Association on Intellectual and Developmental Disabilities.

ATTACHMENT C

Howe’s Significant Incidents

Howe's Significant Incidents

since January 2008

Incidents that limited requesting recertification, and indicators that certification is not sustainable.

The preponderance of the listed incidents would be plausible standard level deficiencies written under:

- **W149 – "The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client"**
- **W150 – "no physical, verbal, sexual, psychological abuse by staff"**
- **W153 – "report allegation immediately"**
- **W154 – "thoroughness of investigations"**
- **W186 – "sufficient staff to manage and serve clients"**
- **W189 – "employee training"**
- **W191 – "staff intervene with client behavioral issues"**
- **W192 – "staff intervene with health issues"**
- **W331 – "nursing services in compliance with individuals' needs"**
- **W460 – "clients have nourishing, well balanced diets"**

The combination and frequency of these incidents would most certainly support a Condition of Participation (COP) not being met:

- **W102 – Governing Body & Management**
- **W122 – Client Protections**
- **W158 – Facility Staffing**
- **W266 – Client Behavior and Facility Practices**
- **W318 – Health Care Services**

Additionally, there are certain sentinel events that could have risen to the level of an Immediate Jeopardy being called.

PLEASE NOTE: The Illinois Office of Inspector General (OIG) statutory requirements and those of the Illinois Department of Public Health/Centers for Medicare and Medicaid Services (IDPH) are completely distinct. A specific finding from one entity has no bearing or impact on findings from the other.

Date	**Significant Incident**	**Finding - Disposition**	**Potential Citation if Certified by Public Health**
1/15/08 Reported to IDPH	A person who was brought back to the Center from their workshop/job was left on the bus and it was later discovered that the person remained on the bus as the bus returned to the workshop for the evening.	It was determined that both the community provider and Howe neglected the supervision/ monitoring of the person.	W189
1/29/08 Reported to OIG	A Center doctor overheard a staff member tell a person "Shut up, shut up!" Shortly thereafter, the doctor reported overhearing the client say "I'll be good. I promise I'll be good so you won't beat me up today." Upon initial investigation the person also stated that the staff member punched him in the chest.	OIG - Unsubstantiated	W149, W150

Date	**Significant Incident**	**Finding - Disposition**	**Potential Citation if Certified by Public Health**
1/31/08 Reported to IDPH OIG and IL State Police	Two employees that worked on the same unit were involved in an altercation, which involved the use of weapons (knives). Both staff sustained serious, life-threatening injuries. The altercation took place on the Howe campus, but not within the peoples' living areas.	Employees were allowed to resign with no reinstatement rights.	
2/27/08 Reported to OIG	A person was found unresponsive in his home and later pronounced dead.	OIG – Unfounded Review of the case identified a delayed response to the medical emergency.	W189, W192 COP-W102 COP-W318
2/29/08 Reported to OIG	A person on one-to-one supervision/ monitoring for consumption of non-food items, was reported to have a finger splint missing and the splint was never located.	OIG -Unsubstantiated Unable to identify time of occurrence even though person was on constant supervision.	W191 COP-W266
3/2/08 Reported to IDPH	A person on one-to-one supervision/monitoring was sent to the hospital emergency room due to swelling and discoloration to her right middle and ring fingers.	Unable to identify time of occurrence even though person was on constant supervision.	W191
3/3/08 Reported to OIG	A person with an identified behavior of eating cigarette butts was found at another building on campus. The person was observed with a mouthful of cigarette butts when he was located.	OIG – Substantiated Employee suspended for 5 days for not properly supervising the person.	W191 COP-W122
3/7/08 Reported to OIG	A person left his home and was found nearly 1/3 of a mile from his home.	OIG – Substantiated Employee suspended for 5 days for not properly supervising the person.	W149 COP-W122
3/12/08 Reported to OIG	A person was injured from a fall as the result of staff not following proper procedures when moving the person.	OIG – Unfounded	W149
4/10/08 Reported to OIG	A person was able to injure himself during bathing when staff failed to properly supervise/monitor.	OIG - Unsubstantiated	W191
4/14/08 Reported to OIG	A person received a serious injury that resulted in him being partially paralyzed.	OIG – Unfounded	W149, W191 COP-W122

Date	**Significant Incident**	**Finding - Disposition**	**Potential Citation if Certified by Public Health**
	The incident resulted from an altercation between housemates.		
5/8/08 Reported to OIG	Inadequate documentation and follow-up continues to be identified, e.g. lack of follow through on low blood sugars, inadequate bowel monitoring, etc.	OIG - Unsubstantiated	W331 COP-W318
5/22/08 Reported to IDPH	A person on one-to -one supervision/monitoring is found on campus, but away from his home unsupervised.	Corrective Actions included retraining and disciplinary action	W149 COP-W122
5/30/08	A home created for people who have dangerous eating habit and/or consume non-food items, is found to have unlocked cabinets and multiple items left in the open e.g. rubber gloves, keys, napkins, etc.	Staff disciplined	W149
6/17/08 Reported to OIG and IL State Police	A senior manager for the Director of Developmental Disabilities, who oversees programs in all SODCs, reported witnessing a staff member slapping the hand of a person served.	OIG referred the case to ISP and the staff member was subsequently arrested and charged. However, due to a preponderance of witnesses not supporting what the senior manager reported witnessing, the charges were dismissed. The case was then referred back to OIG and is presently under review.	W149 COP-W122
7/6/08 Reported to OIG	A person on one-to-one supervision/monitoring was found nearly a 1/3 mile from his home damaging vehicles.	OIG – Substantiated	W149 COP-W122
7/11/08 Reported to OIG and IL State Police	It was alleged that a staff member accused another staff member of stealing street drugs from her purse. The staff accused of stealing the drugs was allegedly coerced to strip of her clothing to prove she did not have the drugs. The incident prompted the need to have police with a drug-sniffing dog search two Howe homes.	Illinois State Police reported no findings.	
7/31 & 8/16	On two occasions, staff calling in for their scheduled shift resulted in individuals leaving their home for the evening to ensure that staffing levels	Center identified that employees should have been mandated to provide coverage.	W186 COP-W122

Date	**Significant Incident**	**Finding - Disposition**	**Potential Citation if Certified by Public Health**
	were met.		
8/1/08	A person is allowed to enter a door not used normally as a client entrance, the person tripped and received a serious cut to his head.	Corrective Action included staff training.	W149
8/4/08 Non Reportable	A staff member left his vehicle unattended, running and with the door open – presenting a potential danger of a person living at Howe accessing the vehicle.	Employee Disciplined	W189
8/24/08	During a visit to several homes, staff are found not providing proper supervision/monitoring clients.	Staffing was sufficient, however, staff were noncompliant with monitoring responsibilities	W186
9/1/08	A person wheelchair-bound/not capable of walking suffered a left ankle fracture.	Case remains open.	W149, W189 COP-W122
9/2/08 Reported to OIG	An anonymous report alleged that on 8/30/08, a staff member kicked the wheelchair of a person so hard that the person's head snapped back.	OIG - Unsubstantiated	W149, W150
9/2/08 Reported to OIG and IL State Police	A staff member (unit manager) witnessed an individual in a cowering position with a staff member attempting to strike him with a broom.	OIG refers the case to ISP. ISP declines the case and refers it back to OIG. The case is presently under OIG review.	W149, W150 COP-W122
10/21/08 Reported to OIG	It was anonymously reported that, on 10/18/08, a staff member shoved a person with a yellow plastic broom from the kitchen to his bedroom, and when the staff member and person entered the room, the person was hit several times to various areas of his body. It was also reported that this occurred in front of another person.	Case remains under OIG review, as a key employee was unavailable due to a leave of absence.	W149, W150 COP-W122
11/10/08 Reported to OIG	A Howe nurse was alleged to have given a person his medications not in accordance with a specially designed diet plan to prevent choking and aspiration.	OIG - Unsubstantiated	W149, W331 COP-W318
12/2/08	A person who is wheelchair-bound and unable to walk was sent to the hospital and was determined to have a fractured patella (knee cap).	No identification of the potential cause of fracture.	W154 COP-W122
12/12/08	20% of scheduled mental health technicians called in for their scheduled shift.		

Date	**Significant Incident**	**Finding - Disposition**	**Potential Citation if Certified by Public Health**
	The call in concurred with their bargaining unit's Christmas party and resulted in 206 hours of staff overtime in a single shift to ensure adequate coverage.		
12/29/08 Reported to OIG and IL State Police	A person is found unresponsive in his bed and is later pronounced dead.	Case is under OIG review. Preliminary findings indicate that there was a delayed response to the medical emergency and that the person potentially was not fed in accordance with a specially designed diet plan to prevent choking and aspiration.	W189, W192 COP-W102 COP-W122 COP-W318

ATTACHMENT D

Editorials

From the Tribune

Howe to close, at last

September 13, 2008

By this time next year, the Howe Developmental Center, a state-run care facility for disabled adults in Tinley Park that houses more than 300 adults, will be closed. State officials announced last week that they will begin relocating residents by winter. Howe will be shuttered no later than July 1.

It's about time. Howe has been plagued by substandard care and health and safety problems. Twenty people died under questionable circumstances at Howe between September 2005 and May 2008, according to Equip for Equality, an advocacy group for the disabled. Conditions were so bad that in March 2007 the federal government stripped Howe of its Medicaid certification—along with $26.5 million in federal operating funds.

Rather than close the facility, Illinois spent more money to make up the loss of federal funds.

Finally, the state is getting the message.

"Although we think we have made progress, we just don't think that we can get it to the point where we can get it recertified. The issues are systemic," said Lilia Teninty, head of developmental disabilities for the Department of Human Services.

Give the Blagojevich administration some credit for finally recognizing that. But if it wants credit for more than a belated decision, it will have to continue to shift this state away from institutional care and toward community-based care.

Illinois has relied much too heavily on expensive, large-scale institutions to care for its developmentally disabled residents. The state has nine such facilities, housing about 2,300 residents. That's 1,100 fewer residents than it had in 1997. Yet Illinois still relies on institutions more than most states. There is a place for such institutions. But most developmentally disabled residents flourish in smaller, community-based settings. Many people are able to integrate into the community and work outside the home.

Institutional care is also far more expensive than community-based care. Illinois citizens pay about $140,000 a year for each person in an institution, compared with $50,000 a year for community care.

Residents of Howe and their families will have the final say on whether they move into community-based settings or other state-run institutions. The state should encourage them to opt for community care where its appropriate. That will likely lead to some initial resistance.

The state has promised to place many of the 755 staff members at Howe in other state facilities. Those staffing decisions have to be made based on the needs of patients and taxpayers, with a clear eye on creating a smaller, more efficient system. The worst thing the state could do would be to transport some of the problems at Howe to other facilities.

Closing Howe and focusing on a more efficient care system should free up money to improve and expand community-based care. A key: Pay more to the people who work in those facilities. They're often forgotten when the state legislature makes budget decisions.

Howe had to close. Now let's build on a sound decision.

From the Southtown Star

Howe closing is long overdue

September 9, 2009

THE ISSUE: The state plans to close the Howe Developmental Center in Tinley Park and relocate residents to small community homes or to larger, less problem-plagued institutions. It also will replace the Tinley Park Mental Health Center with a new 100-bed public-private psychiatric hospital, and sell the land on which both sit.

WE SAY: This has been a long time coming, and we welcome both plans. The track records of these facilities have been mediocre at best, and we think residents will be better served in new settings.

Twenty-six deaths and a loss of more than $27 million in federal money: That's the toll taken by Tinley Park's Howe Developmental Center in terms of human life and the state's bottom line over the last three years.

It's a steep price to pay for a state facility that's been plagued with problems for far longer than the point at which it was decertified last year.

So, while it's been long overdue, we applaud the Illinois Department of Human Services for finally doing the right thing and closing Howe. The 316 or so residents will be moved into small community-based homes or into more traditional institutional facilities for developmentally disabled people. As each goes into a new home, the federal money that accompanies someone living in a certified residence will be restored. We know this closure plan comes as a blow to families whose loved ones have lived at Howe for the bulk of their adult lives and who believe the current arrangement is working well. But we are sincere in our belief that there must be something better than Howe. We do not exaggerate when we say we fear for the lives of those who are there. Because of that, we have to put our faith in human services administrators, who promise work with families in coming up with relocation plans that are palatable to all involved. The goal is to have everyone in new residences by July 2009.

To a certain extent, it's blind faith as the state's track record is not great and because it's never been particularly clear to us why this facility was so plagued with problems in the first place. Despite the replacement of the top administration several times over and the millions poured into Howe over the years, it's been decertified twice. Among other things, state officials blame a constantly changing list of about 400 federal regulations (which other facilities seem able to deal with), but don't really answer why they've been so slow in embracing the small community homes concept that is the norm in many states. Advocates say it's not only more successful, but it's far less expensive.

So here's a chance for state officials to do things right, and prove they can be empathetic, organized, efficient and fair in carrying out

this sensitive plan.

The state also plans to close the Tinley Park Mental Health Center, which shares a location with Howe. Local patients requiring treatment will be sent to new units being built at two existing Chicago-area facilities while a new 100-bed "center of excellence" (state speak for state-of-the-art psychiatric hospital) is built.

Again, this is a welcome announcement as this place, too, lost its certification last year (although it's since been reinstated). And again, we take a leap of faith that officials will follow through on promises, including that the new hospital - an innovative private-public venture that will rely on private, contractual medical care - will be built somewhere in the south suburbs. Given that the hospital also serves all of Will, Grundy and Kankakee counties, and will be built on state-owned land, that's a big "if."

All in all, though, this is an attractive plan. It frees up about 600 acres of prime Tinley Park real estate off Harlem Avenue near Interstate 80 for development. Sale proceeds will fund the new hospital and, depending on who purchases the land, it should go back on local property tax rolls. If stores are built, new sales tax will be generated.

All involved presumably will emerge winners, particularly Howe residents, whom we hope will thrive in smaller, home-like settings. This is our greatest hope. The state's track record may not be great on things like this - OK, it's pretty abysmal - but here's a terrific chance to get things right.