WILLIAMS CONSENT DECREE

Draft Implementation Plan

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Illinois Department of Human Services, Division of Mental Health
in Partnership with

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Illinois Department of Public Health
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EXECUTIVE SUMMARY

On September 29, 2010, the State of Illinois entered into a Consent Decree, settling the *Williams v Quinn* class action lawsuit, first filed in 2005. The lawsuit alleged that Illinois was in violation of Title II of the American with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act by "needlessly segregating" Plaintiffs, a class of 4500 Illinois residents with Serious Mental Illness (SMI) living in institutional settings (Institutes of Mental Disease[1]), denying them opportunities to receive services in more integrated settings. Though the State denied liability and any violation of these federal laws, the Parties to the suit were always fundamentally in agreement that when clinically appropriate, all persons with Serious Mental Illness currently residing in Institutes of Mental Disease (IMD) in Illinois have the right to choose to live in community-based settings, and that the State has an obligation to expand the current community-based service system to support the needs of those individuals. In addition, the State firmly asserts that Recovery Principles, a set of fundamental beliefs that persons with mental illness can recover and live purposeful lives, should guide all systems reform efforts and frame the development and expansion of all services. In the Draft Implementation Plan that follows, the State proposes not only to expand the current system of care, but to create a number of Recovery oriented system enhancements in both services and housing, designed to assure that each person choosing to move from an IMD has the best opportunity for a successful transition to community living.

The Decree is specific in its requirement for the State to develop a Draft Implementation Plan for consideration by the Parties and the Court Monitor within 135 days of approval of the Decree. The Plan that follows meets this requirement and is offered as a set of core strategies, approaches and processes to comply with the tenets of the Decree. The State looks forward to the next several months during which broader stakeholder input into development of the Plan should strengthen and enrich the core elements presented herein.

The organization of the Plan mirrors the functional elements of the system that have been designed to effectuate the transitions beginning with outreach to the Class Members, evaluation and service planning, and ultimately transitioning to housing and community-based services. The Plan further details State monitoring approaches to assure quality of service provision as well as essential compliance with the Decree.

[1] The designation of Institute for Mental Disease (IMD) means a nursing facility that has been determined to have more than 50% of the residents requiring nursing facility level of care due to a Serious Mental Illness (SMI) and without other co-occurring health disabilities that would require nursing care. As a result, according to the federal Center for Medicare/Medicaid Services (CMS) such facilities cannot receive federal reimbursement for individuals between the ages of 22 – 64.

The Outreach and Information Dissemination Section describes the initial outreach to the Class Members. Outreach Workers will be assigned to each IMD and charged with educating the Class Members about the new opportunities afforded them as a result of the Consent Decree. Individual meetings shall take place with each resident and information will be shared in written form, through video presentations and during community meetings in the IMDs.

The Mental Health Preadmission Screening and Resident Review (MH PASRR) Section details the State's approach to meeting its obligation to evaluate each Class Member to determine his or her service needs. The person-centered, strengths-based evaluations to be conducted by highly qualified clinicians, are comprehensive in scope and will require information gathering from multiple sources. Evaluation results and Class Member preferences will inform the development of a service plan that will guide ultimate transition to the community. For some, the service plan may indicate a need for further remediation while the Class Member is residing in the IMD. If this is the case, the IMD shall ensure that the Class Member is afforded opportunities for strengthening core skills.

Over the next two years, the State will be making improvements to its MH PASRR process for individuals being evaluated for admission to long-term care. These improvements include extensive interagency planning with technical assistance from the federal government. Concurrently, the State shall partner with the University of Illinois to conduct Resident Review evaluations, enhancing the current process for persons with Serious Mental Illness.

The Transition Coordination Section describes both the structures and processes necessary to complete the transition from the nursing home setting to the community-based living option and services. A Transition Coordination Unit, comprised of highly qualified individuals, will be assigned to each Class Member choosing to transition. Transition Coordinators will be responsible for executing a wide range of tasks using the service plan to develop a detailed transition plan. Assistance with the housing search, developing risk mitigation plans and 24 hour back-up plans, assuring entitlements are in effect, assistance with purchasing furniture and supplies and most importantly, assuring linkages are completed for requisite services including mental health and medical services are among the critical tasks performed by this unit. Once the linkages have occurred with the community mental health provider, the Transition Coordinator will continue to support the work of the receiving agencies, for one year after transition, assuring all necessary linkages are executed and necessary services are provided.

The availability of affordable, accessible housing in communities of choice is critical to the success of the Implementation Plan. A partnership between the Illinois Department of Human Services (DHS) and the Illinois Housing Development Authority (IHDA) is the basis for a successful strategy to expand the housing alternatives to Class Members. Utilizing a

number of different State and federal programs, IHDA will work with developers and landlords to increase housing stock. IHDA is also committed to working DHS to explore the development of new models and strategies to expand the array of housing options and supports such as master leasing programs, and various hybrids of the supportive housing models (e.g., Fairweather Lodge models). State funded rental assistance programs (Bridge Rental Subsidies), another critical component of the Plan, may be necessary to support Class Members until such time that they are either able to find employment or acquire other permanent federal or State rental assistance. The State's approach to administering these programs is detailed in the Plan.

The Community Services Section of the Plan describes the State's intention to ensure the adequacy of the existing service system under the Medicaid Community Mental Health Services Program (Illinois Administrative Code, Title 59, Chapter IV, Part 132), and also offers a plan to expand the existing service array to include access to non Medicaid supports such as Supported Employment, Drop-in Centers and other non medical supports critical to the overall success and well being of transitioning Class Members. The Illinois Department of Human Services, Division of Mental Health (DMH) will consistently evaluate the sufficiency of the service delivery network to provide care, conducting routine gap analyses to help identify any pressure points for service delivery. Additionally, in the second year of the Consent Decree a "Clinical Home" model for the system will be implemented that establishes clear guidelines and requirements for integrated care and/or linkages to all critical service components.

The Consent Decree requires the State to specify staffing and training requirements, as well as specific tasks and timelines (see Appendix A) all of which are included in the Draft Implementation Plan. The Draft Implementation Plan also includes staff and training needs related to specific functional areas and has a separate section describing the Compliance, Quality Assurance and Risk Management Plan with appended detailed work plans for each area.

While this Draft Implementation Plan as submitted represents the culmination of over 90 days of work by a broad range of State staff and officials, planning for the implementation of this Consent Decree will be a dynamic process. The State fully intends to broaden its reach to more contributors and will especially draw upon the daily experiences of Class Members and direct care workers whose invaluable input remains central to the State's approach to systems reform. Upon successful implementation, the DHS anticipates this will be the true standard for assuring high quality of life in the community for persons with mental illnesses leaving institutions and choosing this path.

OUTREACH & INFORMATION DISSEMINATION

"Information is the source of learning. But, unless it is organized, processed and available to the right people in a format for decision-making, it is a burden, not a benefit."[2]

1. Description / Purpose

This section will outline the outreach and communication strategy that will serve to ensure that all of the 4,500 Class Members (their families and guardians, if applicable) are afforded easy access to information, assistance and supports. The availability of this information to Class Members is critical to their ability to understand their rights under the Consent Decree and to their ability to make informed choices concerning their options and opportunities. The State is committed to ensuring that information is both factual and easily accessible to both Class Members and families who may be assisting them with their decisions.

With any systems change that represents a significant departure from common practices and policies, it is imperative to ensure that all relevant parties to those impacted also have as much factual information concerning the reform as possible. This generally results in broader acceptance of the systems change resulting in more positive experiences by those directly affected. In the case of the *Williams* Class Members, clearly their knowledge and understanding of the details of every aspect of this systems change is critical, but broadening the audience for information sharing to include IMD caregivers, community stakeholders and others will facilitate a more seamless transition for many.

Throughout the implementation process, the State will remain committed to providing information that is thorough, accurate, and easily understood regardless of primary language or reading ability. To the degree possible, materials and methods of information sharing will reflect the realities of both the process involved in transitioning to more integrated community settings, the challenges of community living and the potential rewards in terms of quality of life. Further, the State will rely on a variety of communication methods to impart information in multiple venues.

2. Staff

To achieve a thorough and comprehensive Outreach/Information Dissemination process for the 4,500 Class Members, DMH will hire, eleven contractual workers (on two-year contracts) to engage in outreach and disseminate information. Nine of the eleven contract employees will be Recovery Support Specialists. A Recovery Support Specialist (RSS) is an individual with lived experience of Serious Mental Illness and is considered "in Recovery." RSSs are often identified as professional consumers or "prosumers," many are, or have been, competitively employed, have operated Peer Support Centers (or other Peer services), have been through Wellness Recovery Action Plan (WRAP) training and are credentialed as Certified Recovery Support Specialists (CRSS). In addition to the RSSs, DMH will hire two Bachelor's level, Mental Health Professionals (MHP). The MHPs will work with the RSSs

[2] English Clergyman William Pollard (1828-1893)

to ensure that IMD nursing facility residents have all of the required information with respect to the Consent Decree.

RSS and MHP contract workers will work under the supervision of the Associate Deputy Director of Long-Term Care Assessments. This executive level staff will provide supervision, assign workers to facilities and fulfill data reporting requirements. Additionally, this staff person will intervene on behalf of the RSS and MHP staff with other state agencies if they encounter obstacles or difficulties.

DMH will also actively recruit bilingual Outreach Workers; two to communicate in Spanish and one to communicate in Polish. If there is a critical mass of Class Members who speak a third non-English language, DMH will hire a bilingual Outreach Worker proficient in the third language. For other Class Members who have limited English proficiency (LEP), DMH will contract with interpreters, as needed.

3. Method/Procedures

By June 20, 2011, the Illinois Department of Healthcare & Family Services (HFS) will release a Provider Notice to the twenty-five IMD nursing facilities to inform them that Outreach/Information Dissemination Teams will be in the facilities, effective August 1, 2011, for the next two years. This notice will request that the IMD nursing facility identify dedicated office space and equipment for use by the team. Ideally, this office space will be dedicated to the Outreach/Information Dissemination Teams although it is recognized that some facilities have limited office space. At a minimum, facilities will need to identify private office space and a firm schedule of availability for exclusive and private use by the team. The Outreach/Information Dissemination Team will have full access to the facility and residents, with understanding that their presence does not interfere with scheduled program activities, unless otherwise arranged in advance.

The Provider Notice will require each IMD nursing facility to prepare two lists of residents: (a) by name and assigned rooms, and (b) by floor with assigned residents and room. These lists will become the method by which the RSSs and MHPs will maintain contact and access to each resident.

The RSSs and MHPs will have several communication channels to assure contact with the Class Member and to assure that the full array of information on transition options is released to all residents. All written materials will be translated into Spanish and Polish, and possibly a third language, if necessary. The various communication methods are detailed below:

- Introductory Meetings
  The RSS and MHP will schedule an introductory meeting with each IMD nursing facility resident. This will be a private one-on-one meeting, at which time the RSS and MHP will explain the *Williams* Consent Decree and explain the resident's option to consider assessment for transition from the IMD to appropriate community resources. At this meeting the RSS and MHP will ensure that residents have all necessary hand-outs and reading materials, will go over these materials and will play a video, featuring individuals who have transitioned to the community.

- Brochures
  DMH will develop linguistically and culturally appropriate, consumer-friendly informational brochures (with translations) explaining the *Williams* Consent Decree, the rights of Class Members and the array of services and housing options (based on individual need).

- Flyers
  DMH will develop linguistically and culturally appropriate flyers that will be distributed to all residents' rooms and posted throughout the facility. These flyers will contain information about the transition options and alert residents to the presence, location and availability of the Outreach and Information Dissemination Teams in the facility.

- Video Presentation
  DMH will develop a short video presentation for use by the RSS and MHP. Through this video, Class Members will be able to see former nursing facility residents who have transitioned to community-based housing options. The video may show Class Members working in supported employment, engaging in Peer Support groups, attending meetings or social events and receiving mental health services in the community. The video will also feature former residents talking about their transition experience and services and supports utilized to succeed in the community. They may also describe any challenges they face with community living.

- Community Meetings
  RSS and MHPs will convene monthly Community Meetings in each of the IMD nursing facilities. Scheduling will be arranged with the facilities to ensure sufficient time to discuss the transition process and activities, answer questions and review community-based service options. Outreach/Information Dissemination Team members will participate in the Community Meetings during the full two years of their employment.

- Introduction to WRAP (Wellness Recovery Action Plan)
  WRAP has been described as a self-directed plan to be used as a personal guide to daily living. It focuses on self-help, personal responsibility, Recovery, and long-term stability. Each RSS will host a monthly "Introduction to WRAP" discussion in each of the IMD nursing facilities. Notices of the time and date of these sessions will be posted throughout the facilities and distributed to each of the residents in their rooms.

- One-to-one exchange
  Residents and their families will have an opportunity to schedule private time with the RSSs and MHPs, as needed, to talk about concerns or questions regarding transitioning.

- Consumer Handbook
  DMH Office of Recovery Services has developed a Consumer Handbook as a guide for consumers wanting to access the public mental health system. This handbook assists consumers in understanding available mental health services, how to access services, complaint procedures, etc. This handbook will be made available to IMD residents and their family members.

The RSSs and MHPs will initiate their involvement with each resident by providing them with a letter of introduction. This letter will identify the role of the RSS and MHP, provide information on where they are located in the IMD nursing facility and where messages can be left for a return response. The RSS and MHP will ask the resident to co-sign this letter of introduction to verify that initial contact has been established. The resident will be given a copy of the letter for their personal file.

The RSS and MHP will document each individual contact with a resident (family or guardian) and enter this information into a common database. If residents are engaged in a community or group process, residents will be asked to sign a sign-in sheet. This contact will also be logged into the database.

It is important that the RSSs and MHPs maintain open communication with residents in their language of comfort. DMH will make every effort to hire RSSs and MHPs that represent the diversity of the IMD nursing home population. DMH will retain the services of contracted interpreters to assist the RSSs and MHPs and ensure that one-to-one communication in the language of choice is maintained.

The role of the RSS and MHP is not to conduct clinical assessments, make promises about one's ability to transition, or direct Class Members to make a decision. The role of these staff is to ensure that the residents and family members have all the available information on their options with respect to transitioning from the nursing facility, the array of community-based service options, and the next step (a clinical assessment). More detailed discussions about transition options will occur after the clinical assessment is completed.

The RSSs and MHPs will continue to conduct outreach and distribute information to Class Members for the duration of two years post-approval of the Implementation Plan. It is DMH's expectation that processes to secure staff and all necessary resources for Outreach/Information Dissemination will be initiated as expeditiously as possible so that Class Members can have as much factual and advance information as possible concerning options available to them pursuant to this Decree.

MENTAL HEALTH PRE-ADMISSION SCREENING & RESIDENT REVIEW

1. Description/Purpose

Mental Health Pre-Admission Screening and Resident Review (MH PASRR), as an evaluation process, should result in a high quality, clinically informed assessment and collection of information for each individual that will be used to assemble a comprehensive picture of the individual's preferences, strengths, needs, services patterns, and outcomes over time. MH PASRR offers a mechanism to improve services and outcomes in the Long-Term Care (LTC) service system, reducing the use of institutional care and avoiding the pitfalls of past deinstitutionalization efforts.

The *Williams* Consent Decree requires that each Class Member receive an independent, professionally appropriate and person-centered Resident Review to assess his or her clinical and functional readiness for transition from the IMD to appropriate community-based settings. All Class Members are to receive evaluations within the first two years after approval of the Implementation Plan. Individual Class Members can decline to receive this evaluation and can subsequently request an evaluation at any time thereafter. After the initial evaluation is completed, an annual evaluation for transition is required for each individual Class Member residing in an IMD beginning in the third year of the Implementation Plan.

The evaluation process, as stated previously, is designed to identify the Class Member's strengths, preferences, needs, and risks and will guide the collaborative development of service and transition plans with the Class Member. The goal is to devise comprehensive plans that will promote individual engagement in Recovery while in the IMD, through transition, and ultimately support successful community living. Recommendations for specific community-based services, including the degree of housing-related supervision required to support transition to community living, are to be identified through this evaluation. The State and its partners are committed to a long term focus on positive individual outcomes, mitigating risks and assuring successful transitions rather than just movement out of nursing home settings. Careful consideration will be given to recognizing and leveraging individual strengths and addressing individual barriers and personal development opportunities throughout the entire transition process. An expert Clinical Review Team (CRT), administered by DMH and HFS, will review individual evaluation results and refer individuals clinically appropriate for transition to the Transition Coordination Unit (TCU) described in the following section. For those individuals not referred to the TCU, the recommendations will focus on treatment and psychiatric rehabilitation planning within the IMD.

1.1 Additional Context

As described in the Consent Decree, MH PASRR system will be utilized to conduct the required initial and subsequent evaluations of Class Members to determine their readiness for community transition. The evaluations called for in the Decree correspond directly to the intent and approach of the Resident Review component of the MH PASRR system.

Resident Review is a relatively recent addition to MH PASRR activity and the State's experiences, to date, as well as new federal requirements and expectations for MH PASRR suggest that improvements in this system are necessary. During a recent on-site visit to HFS and DMH, MH PASRR technical assistance consultants for the Centers for Medicare and Medicaid Services' (CMS) made clear that, in light of the enhanced federal requirements, Illinois must do a more comprehensive re-design of MH PASRR than had been generally assumed. The State was advised that work on re-design should proceed much further before any vendor selection through State procurement is pursued. As such, the State must undertake both the Resident Review Evaluations for this Decree and a substantial re-design of the larger MH PASRR system concurrently. Ultimately, information generated through an enhanced and improved Resident Review evaluation process can inform and guide the development of a broader array of Recovery oriented and rehabilitative community-based options for individuals evaluated for possible or continued Long-Term Care placement.

While the State is pursuing the comprehensive re-design of MH PASRR, it will institute multiple enhancements to the existing Resident Review process. Based on a review of the current MH PASRR operation combined with experience from the federal Money Follows the Person Demonstration Program, the following improvements are planned and will benefit Class Members during this evaluation process:

- Upgrade of assessor qualifications to licensed clinical personnel;
- Movement to a singularly focused, independent MH PASRR service model that does not comingle provision of other services;
- Utilization of significantly fewer MH PASRR agencies;
- Enhancement of clinical assessment components to add clinical detail needed for judgments on the evaluation parameters (Risk of Harm, Functional Status Medical/ Addictive and Psychiatric Co-Morbidity, Recovery Environment, Treatment and Recovery History; and Engagement and Recovery Status) of a standardized assessment instrument, the Level of Care Utilization System (LOCUS);
- The addition of a strengths assessment and cognitive screen;
- An elaboration of individual preferences assessment;
- A review of HFS and DMH Data Warehouse information;

- The development of more comprehensive recommendations, including pre-transition, transition planning, community services and supports, housing/residential;
- Formal report protocols covering assessment findings, level of care and other determinations, and any specific recommendations for the Transition Coordination Unit, the IMD Facility, the Resident/Family/Guardian, community-based service and housing providers;
- Interim information input, data linkage, and tracking strategy / system.

2. Staff

HFS and DMH have determined that the best, most expeditious approach to undertake redesigning and implementing the MH PASRR process for Class Members is through executing an intergovernmental agreement with the University of Illinois at Chicago (UIC). This partnership will lead to the composition of the Illinois MH PASRR and Long-Term Care System Rebalancing Consortium charged with the responsibility of providing oversight to the MH PASRR redesign and implementation. The Consortium will involve close collaboration between UIC partners, national experts, HFS and DMH.

In the initial phase of Consortium activity, the highest priority will be placed on improvements to the Resident Review process, assessor qualifications, assessment components, data linkage strategies, recommendation and report protocols, and basic information system planning in order to support completion of the approximately 4,500 Class Member evaluations. Building on the existing partnership with the UIC's College of Nursing Center for Health Care Innovation, the initiative would include the Department of Psychiatry, as well as selected national experts. Fortuitously, the National Research and Training Center on Psychiatric Disability within the Department of Psychiatry has recently received funding for a new initiative devoted to addressing health issues among people with SMI that includes a project relationship with the College of Nursing.

The Consortium will develop the enhancements to the Resident Review process and assessment components with national expert input as necessary. Training for MH PASRR assessment staff will be developed in consultation and collaboration with DMH Bureau of Long-Term Care Training and the Consortium. A roster of professional and academic resources will be developed for use when further consultation or specialized assessments are required.

UIC College of Nursing Center for Health Care Innovation will form the Resident Review and Assessment Unit for *Williams* (RRAUW) and recruit full-time licensed psychologists, social workers, and nurses to provide the evaluations under contract over the two year period. Assessor recruitment will emphasize the following:

- Interest, expertise and experience in providing services to individuals with Serious Mental Illness;
- Recovery and rehabilitation orientation;
- Assessment and interviewing skills, including motivational interviewing/stage of change assessment;
- Familiarity with various models of Permanent Supportive Housing[3] and Community-based Residential Programs;
- Knowledge of community-based mental health services and supports;
- Understanding of the hospital and nursing facility admission and discharge practices;
- Knowledge of integrated dual diagnosis treatment and substance abuse treatment approaches and resources;
- Assessment of co-occurring chronic health conditions, physical disabilities, and developmental disabilities;
- Person-centered planning and strengths based assessment.

While the day-to-day activities of the RRAUW will be under the direct supervision of the University of Illinois College of Nursing, management oversight will occur by DMH and HFS. The University will provide regular reports on a number of indicators and measures to the DMH Deputy Director for Long-Term Care Assessments. In addition, DMH and HFS will assist the RRAUW in remediating any immediate barriers to completing the assessments.

3. Method / Procedure

HFS will ensure that each IMD has received a Provider Notice informing them of pre-transition processes and activities that will occur in the facilities. Examples of such activities include: Outreach and Information Dissemination, Resident Review screening and assessments and Transition Coordination activities. This notice will reinforce that adequate space and privacy must be made available for the various staff conducting these activities. Utilizing the HFS data warehouse and information system, HFS will create an information file on each resident. This information will be available to the evaluators for the Resident Review process.

3.1 Access to IMD residents

HFS will instruct the IMD administrators to provide the RRAUW with two identification lists of residents for each respective IMD. These lists will be compiled alphabetically with assigned room numbers and by floor with assigned room. This is to ensure that reviewers can effectively locate and track each resident and determine interest in consenting for a

[3] Permanent Supportive Housing is housing (typically rental apartments) linked with flexible community-based support services that are available, but not mandated as a condition of living in the housing unit.

Resident Review. Once consent is obtained, the Resident Reviewers will assess the individual Class Members and elicit information from the Guardian (if applicable) and family/friends (if consent given). Additionally, reviewers will obtain information from the IMD treatment team members, including the treating psychiatrist, and appropriate community mental health agency staff directly involved with the individual in recent months.

HFS will ensure access to the individual, facility records and treatment team members. DMH will facilitate access to involved community agency staff. In addition to standard clinical components of the Resident Review process, assessors may request, where necessary, more specialized assessments or consultation.

3.2 Reporting of Resident Review Findings and Level of Care Needs

Residents Review outcomes will be reported through a refined information system that will be designed to collect data on the transition status of Class Members. The comprehensive narrative assessment will include information on:

- Social History and demographic background information (pre nursing home admission)
- Psychiatric History and history of psychiatric hospitalizations
- Substance Usage History and a Substance Abuse assessment
- Cognitive Impairment Screen
- Co-morbid medical conditions, treatment and management
- Medication History and compliance
- Strength-based assessment
- Assessment of Maladaptive Behaviors or potential
- LOCUS
- Preliminary recommendations on the Level of Care and appropriate community-based service needs
- An independent Psychiatric Evaluation or Neurological Assessment will be commissioned if determined necessary

The outcome of this comprehensive resident review assessment will be forwarded to the DMH/HFS Clinical Review Team (CRT). This Team (recommended composition includes a psychiatrist, registered nurse with psychiatric training and a licensed clinical social worker) will make the final determination to refer a resident to the Transition Coordination Unit. If the individual is not recommended for transition, the MH PASRR evaluator will develop a Service Plan with recommendations for skills development to assist the resident in moving closer toward transition readiness. These recommendations will be incorporated into the IMD's care plan. The Department of Public Health will monitor the IMD's compliance with implementing these recommendations.

3.3 Annual Reassessment or Significant Change Reviews

Class Members who decline an initial Resident Review or who chose not to transition from the IMD once the Resident Review is completed will be scheduled for an annual re-review. This information will be tracked in a common database and managed by the DMH Deputy Director for Long-Term Care Assessments. The Deputy or designee will forward this information to the RRAUW for follow-up.

Additionally, a Class Member may elect to change his/her mind and decide to participate in a Resident Review assessment. In this case, the assessment will be scheduled and completed within 60 days. No more than four Resident Review assessments of an individual will be conducted within a 12 month period. Class Members will receive information in the Outreach and Information Dissemination packet that will detail how to request a Resident Review and the schedule of reviews. Concurrently, this information will be distributed and posted throughout IMD facilities, in common areas.

4. Orientation and Training

Each MH PASRR evaluator will have an initial orientation and training on MH PASRR and annual retraining on the protocol, processes and requirements necessary to conduct a comprehensive assessment. This orientation and training will include but is not be limited to the following:

- Mental health Recovery and rehabilitation;
- Assessment and interviewing skills, including motivational interviewing/stage of change assessment;
- Familiarity with various models of PSH and community-based residential programs;
- Knowledge of community-based mental health services and supports;
- Knowledge on processes to access ancillary support resources;
- Understanding of the hospital and nursing facility admission and discharge processes;
- Knowledge of integrated dual diagnosis treatment and substance abuse treatment approaches and resources;
- Assessment of co-occurring chronic health conditions, physical disabilities, and developmental disabilities;
- Person-centered planning and strengths based assessment;
- Access, interpretation, and utilization of information from HFS and DMH data warehouses to assist MH PASRR processes;
- Relevant proposed curriculum elements for the Transition Coordination Unit;
- MH PASRR determinations, comprehensive recommendation development, report preparation, records and IT system input;
- MH PASRR Quality Improvement.

TRANSITION COORDINATION

1. Description/Purpose

The transition from institutional care to integrated community settings is a complex and multifaceted process that involves an array of social, systemic and strategic navigations that must occur in an orderly and timely fashion. Key steps in that transition include: (a) thorough and systematic planning; (b) coordination of and linkage to vital resources with guarantees that these resources are in place; (c) synchronized timing ensuring that each part of the transition processes is aligned; and finally (d) actualizing the move. The successful transition and resettlement of *Williams* Class Members to the community is contingent upon achievement of each of the aforementioned steps.

The State, with assistance from its partners, intends to assure that the right systems and supports are in place to effect successful transitions for all Class Members making that choice. It is essential that the transition process is carefully crafted and that staff coordinating the transition on behalf of Class Members are highly qualified, well trained and firmly grounded in the principles of Recovery. The ultimate goal of Transition Coordination is to create a seamless interface between transition efforts and community-based supports that include community mental health services, healthcare services and other resources.

To achieve the desired objectives of assisting Class Members to prepare for and make their successful move from the nursing facility to appropriate community-based options, the State intends to issue a Request for Proposal (RFP) to identify potential qualified vendors for the creation and implementation of a Transition Coordination Unit (TCU). The State's positive experiences with the federal Money Follows the Person (MFP) Demonstration Program confirm the value of a Transition Coordination Unit as an extremely effective component to manage major and minor details of relocation planning and execution. In MFP, the TCU has successfully navigated the complex systems that impact the lives and wellbeing of residents once they are in the community. In addition, the TCU effectively interfaces with those systems that must be coordinated prior to when a move to the community actually occurs.

For *Williams* Class Members, the TCUs, as contracted entities with delegated authority, will have the ability to initiate discussions between necessary partners and to eradicate silos that may potentially become barriers to seamless planning. The TCUs will be the resource that bridge the individual's transitional needs across all dimensions necessary to actualize his/her relocation from the IMD. These dimensions may potentially include such things as identification of appropriate housing or residential settings, necessary skill building needed while in IMD residency, coordination of health care and benefits/entitlements, linkage and

interface with a community mental health vendor or Clinical Home (see Community-Based Services Section) and the development of transition plan recommendations.

Concurrently, the Transition Coordination Units will assume responsibility for post transition monitoring in the community for one year. It is imperative that the move from long-term care to community-based settings is supplemented with ongoing monitoring. Specific elements of the Transition Coordination Unit post-transition monitoring are detailed in the Compliance, Quality Assurance and Risk Management Section of this document.

2. Staff

The successful vendor(s) will be responsible for establishing the Transition Coordination Unit, creating both operational and administrative structures that comply with the specifications of the RFP. The vendor(s) will advertise for, interview and hire staff that have at a minimum, a Bachelor's degree with a concentration in one of the Behavioral Health fields (e.g., Social Work, Psychology, Addiction Specialist, Nursing, etc.). Supervisory level staff must have a Master's degree in one of the Behavioral Health Sciences and hold a valid State of Illinois license in the respective discipline. Staff should have no less than three years of previous work experience in the field of mental health, ideally in some aspect of case management, care management or the equivalent of 'Community Support.' The vendor will be responsible for assuring that all employees have been cleared through a series of background checks, including the Nurses Registry, Criminal Background Clearance through the Illinois State Police and the Sexual Offenders Registry.

The vendor awarded the contract for the TCU will detail how it will manage the work flow to achieve desired deliverables in the transition coordination activities and specify work expectations for staff and supervisors. Further, the selected vendor contract will be monitored by the DMH Deputy Director for Transition Coordination for compliance with contract deliverables including ongoing reporting requirements. Further, the vendor(s) must participate in all relevant Compliance, Quality Assurance and Risk Management activities (see Compliance, Quality Assurance and Risk Management Section) to assure provision of quality services to the Class Members as well as compliance with the Consent Decree.

2.1 Orientation

Each TCU employee will undergo orientation and training that will be developed and conducted by the vendor in collaboration with DMH Bureau of Long-Term Care Training and its partners. Orientation shall include at a minimum:

- An overview of Long-Term Care in Illinois;
- The history of the Supreme Court Olmstead Decision;

- The history of the *Williams* Lawsuit;
- The *Williams* Consent Decree;
- The *Williams* Implementation Plan;
- All Rules, policies and procedures utilized by the Division of Mental Health as part of contractual language (e.g., OIG Rules 50 and 51);
- Steps to achieve specific transition coordination activities (detailed later in this document).

2.2 Training Curriculum

The training curriculum will include, at a minimum:

- The Mental Health Pre-Admission Screening Resident Review (MH PASRR) processes;
- Interface of MH PASRR and Transition Coordination;
- Expectations and desired outcomes of Transition Coordination processes;
- Coordination and engagement activities of the TCU staff with the Class Member (and family and guardian);
- Coordination of TCU staff with nursing facility staff and administration;
- Understanding transition needs for Class Members who have comorbid medical conditions;
- Developing transition plans for individuals with a dual diagnosis (both mental illness and developmental disability and mental illness and substance abuse);
- Developing recommendations for additional skill building to occur in the IMD to prepare the Class Member for transition (e.g., medication management, personal hygiene);
- Linkage, coordination and bridging transition efforts with a community mental health vendor/Clinical Home;
- Best practices to identify appropriate housing and identification of housing entitlements or subsides available to the consumer;
- Familiarity with various models of PSH and Community-based residential settings;
- Best practices to coordinate interface with primary health care;
- Networking strategies to navigate benefit and entitlement administrations (e.g., Social Security Administration, DHS Human Capital Development);
- Recovery-oriented services and planning and consumer strength-based planning;
- Documentation, record keeping and data collection.

3. Method

3.1 MH PASRR & Transition Coordination

Each Class Member will be given the opportunity to be assessed by one of the MH PASRR qualified, licensed mental health professionals to determine his/her level of care and functional needs. The results of this evaluation will inform the recommendations concerning the most appropriate community-based transition options, service needs and required resources to facilitate the Class Member's transition to the community. The specific components of this evaluation and subsequent annual re-evaluations (for those Class Members who chose not to be assessed or transition from long-term care) are detailed in the Implementation Plan Section for MH PASRR.

The development of transition coordination activities is contingent on the recommendations of the MH PASRR evaluation (with the consumer's direct input). This evaluation will serve as the foundation for all subsequent discussions with the resident about transition options, planning transition and meeting service and support needs, and finally, the collaborative efforts (across systems) to assemble these resources to make the move a success. All MH PASRR evaluations will be directed to the Clinical Review Team (CRT) (previously described in the MH PASRR Section). The CRT will make the final determination to refer a Class Member to the TCU. The TCU's clinical administrator will work with the respective staff to make assignments and the TCU supervisors will review the MH PASRR evaluation with staff to ensure a thorough understanding of all recommendations.

3.2 Initiating the Transition Coordination Process

Upon receipt of a referral for transition, the TCU will review MH PASRR recommendations and reach consensus on a strategic approach to initiate contact with the identified Class Member. The initial contact will be face-to-face, at the facility where the resident lives. The TCU will make contact with social service staff of the IMD to schedule a time to meet with the Class Member. At this first meeting, the TCU will present the resident with a Letter of Introduction and review its content with the Class Member. The letter will identify the TCU, its purpose and the goals of this process. Each Class Member will be asked to co-sign the Letter of Introduction with the TCU staff member. A copy of the letter will be given to the Class Member, a copy to the IMD nursing facility for their file and a copy will be retained in the TCU's file. If the Class Member has a guardian, approval of the guardian must be given before any transition discussions or activities occur. The TCU will also reaffirm information distributed by the Outreach Workers on community-based services, options of choice (based on the outcome of the MH PASRR recommendations) and how the TCU will assist the individual in actualizing the move from the IMD nursing facility to the community.

The TCU will establish a series of subsequent meetings with the resident to work on transition steps. Once the resident chooses a geographic area or areas of interests, the TCU staff will begin the development of a service plan based on the MH PASRR evaluation and Level of Care determination along with review of nursing home records and discussions with the Class Member (and guardians and family members) to detail the process for transition to the appropriate community-based living option. If the Level of Care recommendation is for transition to Permanent Supportive Housing, the TCU will initiate a PSH application or assist the resident in searching for available housing through other rental assistance programs. It is recognized that Class Members under this Decree may initially require some form of rental subsidy until such time that they are approved for a more permanent Rental Housing Choice Voucher, approved for housing in a subsidized building or until his/her income level increases due to employment. In any event, the TCU will assist the resident in identifying the most appropriate housing option.

The TCU will be the primary resource to assist the Class Member in initiating the actual housing search. The TCU will use all available local community resources, word of mouth, newspaper listings and technology such as the housing stock locator (ilhousingsearch.org), Craigslist, and others, to identify appropriate options. The TCU will also use results from Illinois Housing Development Authority's (IHDA) network of property owners, developers and property management entities to identify housing possibilities. The TCU will be responsible for maintaining a relationship with IHDA and DHS Lead Referral Agencies in order to refer Class Members, where appropriate, to units created under IHDA's Targeting Program. The TCU will accompany the Class Member on each housing search site visit, so that he/she can make an informed final decision.

Once a housing unit is identified, the TCU will assist with the completion of any paperwork necessary to initiate processes with the designated Subsidy Administration (SA) entity. These entities can be a local Housing Authority (Housing Choice Voucher-Section 8) or a contracted SA through DMH or a Low Income Housing Tax Credit vendor through IHDA's rental programs or a regular housing application. If the resident chooses a unit that falls under the DMH PSH model, the TCU will interface with the SA identified for the geographical area where the unit is located to complete income verification, a housing inspection, utility deposit and Housing Assistance Payment contract. This, in turn, initiates the terms of rental payment between the SA and the landlord/property manager. Likewise, the TCU will navigate all steps to ensure that the resident's housing subsidy is secured before the resident signs a lease with the landlord/property manager. Additional information on the activities of the SA is detailed in the Housing Section of the Implementation Plan.

If the Level of Care recommendation is for transition to either a Supervised or Supported Residential setting, as an interim step before independent housing, and the Class Member's geographic preference is an area that has such a setting, the TCU will ensure that the Class

Member is transported to these settings to see the physical structure and its operation. If the Class Member chooses not to accept this setting, the resident will have the choice to explore other Supervised or Supported settings that are available.

As soon as the resident narrows geographic preferences for housing, the TCU will offer the resident a choice of community mental health vendors/Clinical Homes (see Community-Based Services section) in proximity to the geographic area. The resident will also have a choice of pursing mental health services with any other community mental health vendor. The TCU will ensure linkage with the desired vendor to immediately incorporate the services into the transition processes. This partnership with the community is essential as the transition planning process begins and the subsequent monitoring of the transition plan ensues when the Class Member's move to the community is actualized. Concurrently, if recommendations lead to consideration for one of the other models of housing options, the TCU will work with the resident to make a choice under the same premise as described for Supervised and Supported Residential settings.

3.3 Pre-Transition Functions

Once the housing/residential decisions are secured, the TCU will systematically work with the Class Member (and family members, if applicable) and the Clinical Home to complete several key functions prior to transition. These functions include the completion of the activities detailed below.

3.3.1 Pre-Transition Skill Development

Based on the MH PASRR recommendations, the TCU will also work with the IMD if the Class Member has daily living skill deficits that require enhancement prior to community transition. For example, if the Class Member requires training to administer medications, the TCU will document this recommendation with an estimated time frame for accomplishment and present it to the IMD. On a weekly basis, the TCU will monitor the status of skills training and document progress. This information will be reported in a database that will be accessible to the Department of Public Health (DPH). DPH will be responsible for assuring implementation of skills training to meet the identified needs of a Class Member.

3.3.2 Risk Assessment and Mitigation Plan

The Risk Assessment is used to determine factors that could potentially adversely impact the Class Member's ability to stabilize and function effectively in their community environment. These factors may include maladaptive behaviors, medical conditions or personal care needs that must be monitored or managed. Potential risk factors may appear benign, but if not

managed effectively may become problematic for the Class Member's health, safety, wellness or stabilization in the community.

The Mitigation Plan is a strategy used to address the potential risk factors. For each identified risk, there is a plan for the consumer and his/her care manager which details the tasks, services or actions necessary to address or manage the risk factor. In combination, the Risk Assessment and Mitigation Plan becomes the clinical blueprint and strategic response for managing the safety, welfare and stabilization of the individual in his or her community-based setting and an integrated part of the Class Member's overall service plan. It is important to note that the Risk Assessment and Mitigation Plans are individualized and dynamic. As such, the development and revision of this plan is ongoing and conducted by the TCU in consultation with the Class Member, nursing facility staff, community mental health service providers and guardians and family members (if appropriate).

3.3.3 24 Hour Back-Up Plan

The 24 hour back-up plan is the emergency plan. It is also an integrated part of the Class Member's overall service plan. This planning is particularly important for Class Members who live alone, in a shared apartment with another individual or in a setting where there is not 24 hour staff availability. This Plan becomes a life line for the Class Member, by identifying who to contact in an emergency, where to go if the emergency requires immediate medical attention, and contact numbers to reach support staff during the day and/or after hours.

It will be essential that each Class Member has access to a landline phone or cell phone in the event of an emergency. The TCU will work with residents to understand the importance of open communication and to develop a budget that includes phone accessibility. The TCU will also work with telephone companies to access emergency lines, if more convenient for the resident.

3.3.4 Quality of Life Survey (pre-transition and post-transition)

Using the Quality of Life Survey (QLS) tool developed for the federal Money Follows the Person Demonstration Program, the TCU will administer a QLS one week prior to the Class Member's transition from the nursing facility. To measure the effectiveness of the transition processes and the consumer's satisfaction level with aspects of his/her transition, the TCU will administer a repeated QLS six months after the transition date. The QLS will again be repeated one year post transition.

3.3.5 Transition and Service Plan

The TCU, the Class Member, and community mental health service provider will collaboratively develop a comprehensive transition and service plan. This plan will build on the recommendations developed from the MH PASRR evaluation. This plan will also serve as the foundation on which the receiving community agencies may develop individualized, treatment or care plans. The comprehensive transition plan will outline the coordination of resources services and activities needed to ensure a smooth transition to a community setting. These services and activities may include accessing medical and dental healthcare, transfer of benefits/entitlements, establishing a representative payee, coordinating medical transportation, assuring linkage for psychiatric services and medication monitoring, as well as ongoing engagement with other mental health services. The transition plan will also address strength-based needs, interests and Recovery goals of the Class Member, including supportive employment, educational pursuits or other hobbies. The TCU will explore as many of these interests as possible before the Class Member transitions to his/her new environment. The transition and service plan will become the basis for the TCU's subsequent monitoring of the Class Member's transition to the most appropriate integrated community-based settings.

3.4 Transition

The Transition Coordination Unit will have a check list of tasks that must be completed prior to finalizing the transition. The tasks include: (a) scheduling a psychiatric appointment; (b) ensuring that at least a two-week supply of medication is available; (c) coordinating the transfer of benefits/entitlements; (d) coordinating all health care appointments; (e) ensuring that either community-based housing or appropriate residential setting are secured; (f) establishing a representative payee (if necessary); (g) ensuring that a 24 hour back-up plan is in place; (h) completion of the transition plan, (i) scheduling a staffing with the primary services provider identified on the transition plan; (j) ensuring that the individual has applied for food stamps and has at least a two-week supply of food (if in PSH); (k) processing paperwork for Bridge Subsidy housing assistance for eligible units, (l) activating transition funds, (m) working with the Class Member to identify allowable purchases and (n) assisting Class Member with shopping for necessary items.

The Transition Coordination Unit will work with the Subsidy Administrator to secure a set amount of transition funds for each Class Member. These funds will be based on the setting in which the Class Members will reside. Individuals transitioning into PSH (not subsidized) will receive a onetime allocation of $2,000 to meet transition needs, such as security deposit, utility connection (these dollars will not pay for arrearages or past due bills), basic furnishings, etc. Individuals transitioning into subsidized housing will receive $1,000 for basic household expenses. Individuals transitioning into Supervised or Supported Residential settings will receive $250 for toiletries, outer-clothing or miscellaneous needs. These dollars

cannot be used for the purchase of cigarettes or alcohol. Transition funds will be handled and reconciled only by the Transition Coordination Unit or the community mental health service provider. Class Members, family members or collateral contacts will not have direct access to these funds. The Transition Coordination Unit will assist the Class Member to secure necessary household items.

If transitioning into a PSH unit once the lease is signed, the TCU, the Class Member and the staff from the community mental health service provider should determine a move in date. This date must occur no later than two weeks after the lease is signed and keys are in hand. The check list of tasks described above must be completed before the Class Member physically leaves the nursing facility. If transitioning into a Residential setting, the TCU will coordinate with the receiving residential service provider a move-in date, once a bed is available.

3.5 Post Transition

The Transition Coordination Unit will conduct monitoring visits with each Class Member and the responsible community service providers. These visits are to monitor and ensure success in the transition, linkages, engagement, and recommended services and supports delivery. These visits will also ensure stability in housing or residential placement, skills development, attention to management of healthcare and psychiatric needs, socialization/peer support and adherence of the community providers' services to transition and service plan recommendations. These visits will occur monthly for the first six months, then bimonthly thereafter for the duration of the first year post transition.

The TCU will also monitor all Critical Incident Reports. Following each critical incident, the TCU will convene a staffing with the care manager and clinical supervisor to review the incident, engagement activities prior to the incident, and factors known by the community service provider in an effort to determine how future incidents can be minimized or mitigated. More detailed information concerning monitoring approaches and indicators can be found in the Compliance, Quality Assurance and Risk Management Section of this plan.

HOUSING

1. Description/Purpose

Research clearly confirms that stable housing is central to the successful transitioning of persons with Serious Mental Illness from institutional settings. Consistent with this research, the Division of Mental Health (DMH), in collaboration with the Illinois Housing Development Authority (IHDA), has initiated the necessary planning activities to transform its service delivery system into one that will fully address the housing needs of the *Williams* Class Members. IHDA and DMH share a commitment to develop a full continuum of housing and residential alternatives responsive to individual needs of Class Members and informed by their choices.

Effectively assisting individuals in their transition from institutional care to community- based housing or residential alternatives requires an approach that is flexible, adaptable and individualized. In executing the *Williams* Implementation Plan, DMH's priority will be ensuring the environmental safety and emotional wellbeing of Class Members and will ensure that the essential services and supports are available at appropriate levels. The State will develop an array of housing options (consisting of some that currently exist and some that need to be enhanced or developed) designed to address the full range of individual needs of those Class Members who elect to transition. In order to best respond to the requirements of the *Williams* Consent Decree, a comprehensive array of affordable housing and residential options is necessary to ensure that individuals who are clinically and functionally appropriate can safely transition to community-based options that are consistent with their individual needs and choices.

2. Funding Components

Because the *Williams* Draft Implementation Plan contemplates expansion of housing options, all potential funding resources will be explored. A number of funding resources currently exist and are described below. However, in order to ensure Illinois utilizes the most efficient and economical strategies to expand affordable housing, additional resources may need to be developed.

2.1 Capital/Operating Fund Resources

The following resources, subject to availability, have been identified to assist with financing the acquisition and/or development of the physical housing unit for Class Members included under the *Williams* Settlement Plan.

- The 9 % Low Income Housing Tax Credit – A federal affordable housing financing program administered in IHDA under the auspices of the United States Treasury. This program offers federal tax credits to developers who will develop low income housing and agree to keep certain affordability limits for at least 30 years. Developers must apply to IHDA during a competitive funding round to receive LIHTCs. The criteria by which developers are scored is published in IHDA's Qualified Allocation Plan (QAP). This program serves persons of low income earning at or below 60% of the area median income.

In Illinois, IHDA has developed a "Targeting" program within its LIHTC program; the targeting program encourages developers to set-aside 10% of their units for special needs populations earning at or below 30% of the area median income. The housing units created under this targeting program can meet the needs under the *Williams* Implementation Plan.

- Build Illinois Bond Fund – As part of the Illinois General Revenue Capital Budget Bond program, the State has allocated $130 Million to develop affordable housing for low income persons and families, with designated targeting for persons with disabilities and at-risk veterans. Build Illinois Bond Funds must be used for the capital costs associated with the housing units. Based on availability, IHDA proposes to use a significant portion of the Build Illinois Bond Funds to meet the State's Long-Term Care rebalancing efforts, including housing developments that meet the obligations under the *Williams* Consent Decree.

- Illinois Affordable Housing Trust Fund – A State resource legislatively designated to provide loans and grants for the creation of affordable housing. This State Trust Fund is a flexible resource and can be used to fund the development of PSH units and transitional housing units. IHDA is committed to using a portion of the annual appropriation of Trust Fund dollars to assist in satisfying the *Williams* Consent Decree. Unfortunately, with the down turn in the economy, there has been a sharp decline in revenue for this Fund.

- HOME Investment Partnership – A federal housing resource providing loan and grant funding for the acquisition, rehabilitation, and development of affordable rental housing and homeownership for low income households. Some HOME funds may be allocated to support the development of PSH for persons included under the *Williams* Consent Decree.

Operating expenses are costs associated with the operation of the housing, including property management, property maintenance, utilities, taxes and insurance, and any payments for loans used to build the unit. These operating costs are typically paid by rental payments from tenants. However, many individuals included under the Consent Decree will have limited income (usually based on entitlements such as SSI/SSDI) and may require assistance with rent payments. Rental subsidy is the most common form of rental assistance. The DMH Bridge Subsidy Initiative for individuals transitioning into PSH is an example of a potential operating

expense resource. Other forms of permanent rental assistance include Project Based Section 8 and Housing Choice Vouchers.

2.2 Consumer Assistance

2.2.1 Project Based Section 8

Project Based Section 8 and similar HUD programs such as Project Rental Assistance Contracts associated with Section 202 and Section 811 programs give landlords the ability to rent their apartments to Very Low Income (VLI) and Extremely Low Income (ELI) tenants. If a property has a Project Based Section 8 contract (or similar project based rental/operating assistance), the landlord has agreed to a rent standard (up to Fair Market Rent) with the contract administrator; the property can then rent to VLI and ELI tenants who pay 30% of their income towards the rent utilities; the remainder of the rent is paid by HUD through the contract administrator.

HUD does not currently fund new Project Based Section 8 developments, however, there are still a large number of units in the community that have Project Based subsidy and Public Housing Agencies (PHA) have the option to convert a percentage of their Housing Choice Vouchers (see below) to Project Based funding.

2.2.2 Housing Choice Vouchers

The housing choice voucher program is the federal government's major program for assisting very low-income families, the elderly, and the disables to afford decent, safe and sanitary housing in the private market. Housing choice vouchers are administered locally by PHAs. Eligibility for a housing voucher is determined by the PHA based on the total annual gross income and family size. In general, the family's income may not exceed 50% of the median income for the county or metropolitan area in which the family chooses to live. By law, a PHA must provide 75% of its voucher to applicant whose incomes do not exceed 30% of the area median income.

Voucher holders may rent from any landlord that accepts Housing Choice Vouchers. The voucher holder pays 30% of their income towards rent and utilities and HUD, through the PHA, pays the balance of the rent up to the agreed upon payment standard (usually the local fair market rent).

2.2.3 Bridge Subsidy Initiative

The Bridge Subsidy is designed to bridge the gap between when an individual transitions into his or her own community housing unit and the time that they can secure a more permanent

rental subsidy (e.g. Section 8 Housing Choice Voucher, IHDA's Rental Housing Support Program, any other comparable permanent rental subsidy, or can otherwise achieve an increase in their income). The DMH Bridge Subsidy Initiative provides essential, interim support to individuals transitioning into Permanent Supportive Housing.

As needed, Bridge Subsidies will be attached to Class Members assessed as appropriate to transition into a PSH unit. Once the resident meets eligibility criteria for the Bridge Subsidy Initiative, the Transition Coordination Unit will work with the individual through each step of the application for Permanent Supportive Housing, initiate the housing search, and ultimately secure the unit. There is an existing protocol that governs the operation of the Bridge Subsidy Initiative that will be utilized for individuals transitioning under the *Williams* Consent Decree. An expedited application process is available for eligible Class Members.

Class Members will be fully advised of all the PSH requirements, which include that the Class Member must:

- Have a current household income at or below 30% of Area Median Income (AMI), and
- Agree to apply to a waiting list for Section 8 Housing Choice Vouchers or other comparable permanent rental subsidy, or
- Agree to accept the subsidy when such options become available;
- Be Medicaid eligible or apply for Medicaid eligibility at the point of transition, and
- Have a composite LOCUS score of 22 or less (supported by clinical documentation).

All identified housing units must fall within the Department of Housing and Urban Development's (HUD) Fair Market Rental (FMR) Analysis for the County where the unit is located (e.g. a one-bedroom unit in the Metropolitan Chicago area can cost no more than $840.00). Once the unit has been located, a Housing Quality Standards (HQS) inspection must occur before the Bridge Subsidy can be approved. The resident will be responsible for signing a lease that obligates him or her to pay 30% of their income each month toward rent. The resident will be subject to the same tenant/landlord law as all other lease holding tenants.

Class Members will always be afforded choice in geographic preferences in conducting the housing search. The State will make every effort to locate housing in the desired community.

2.2.4 Bridge Subsidy Administration

The contracted partnership known as Subsidy Administration will allow for the transitioning of *Williams* Class Members to PSH to flow smoothly. The Subsidy Administrator will coordinate activities with the Transition Coordination Unit. The following activities and functions are carried out by the contracted Subsidy Administrator:

- Coordinate efforts with the consumer and their DMH community service provider Care Manager to certify the income of the Class Member and identify barriers to the successful completion of any permanent voucher program applications as applicable;
- Assist the Class Member and/or Care Manager with lease preparation, and execution;
- Complete initial Housing Quality Standards (HQS) inspections on units located by each DMH Care Manager and Class Member using the HUD approved HQS forms. The Subsidy Administrator will inform the landlord and/or property manager, as well as the Class Member/and or Care Manager of any deficiencies and/or needed repairs, and establishes a timeline for the completion of the repairs, correction of the deficiencies and re-inspection. The Subsidy Administrator will perform annual re-inspection of the unit within the outlined timeline;
- Negotiate unit rental price with landlord or property manager, in conjunction with consumer and Care Manager, that meet HUD's 'rent reasonableness' test (Fair Market Rate – FMR), local payment standard limitations, and other local factors, if applicable;
- Disperse Transition Funds (for Class Member move in) per DMH directives; for security deposit, utility deposit, and application fee and/or credit check. These costs will be deducted from the consumer's Transition Funds original amount;
- Conduct initial income certification with the Class Member including completing the following:
    - Rental calculation form and;
    - Release of Information Forms including a standard HIPAA compliant release form as well as a, Household Composition/Fraud Statement and;
    - Income Verification form(s)
- Execute the Bridge Housing Assistance Payments (BHAP) Contract with the landlord/property manager on behalf of the consumer;
- Disburse monthly rental payments in accordance with BHAP Contracts;
- Complete interim income certifications with tenants, as necessary;
- Complete annual tenant income re-certification including completing the following forms:
    - Rental Calculation Form and;
    - Release of Information Forms (a standard HIPAA compliant release will be acceptable), and;
    - Household Composition/Fraud Statement, and;
    - Housing Quality Standard form completed and signed; and
    - Income Verification form(s).
- Notify the consumer's Care Managers, as well as DMH of landlord tenant issues that may threaten the Class Member's tenancy status, as well as any sentinel events that come to the attention of the Subsidy Administrator;
- Process move-out inspections as applicable;

- Process Termination of Subsidy Forms, as applicable;
- Assure that staff members receive HQS and other relevant HUD certified relevant training;
- Maintain complete files on all recipients with denied or closed files retained for the greater of 5 years or the time frame put forth in the Subsidy Administrator agency file destruction policy. If any litigation, claim, or audit is started before the expiration period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

2.2.5 Housing Transition Funds

Housing Transition Funds (up to $2,000) will be available to provide one-time, move-in assistance for costs such as security deposits, utility deposits, and acquisition of basic household items. These funds are managed and reconciled with the DMH Bridge Subsidy partners (community-based Care Manager and Subsidy Administrator). Neither the Class Member, family member, nor the guardian, will have direct access to Housing Transition Funds. A maximum of $4,000 (lifetime) may be available for extenuating circumstances as defined by DMH. Transition Funds are managed by the Clinical Home/community agency Care Manager or the Transition Coordination Unit.

3. Housing Options and Residential Settings

A number of residential or housing options currently exist to meet the needs of the Class Members who may choose to transition from an IMD nursing facility; however they do not exist in sufficient quantity. Thus, the State anticipates the expansion of housing options and residential settings to ultimately address the needs of the approximately 4500 Class Members. Concurrently, however, the State will proceed with the development of new models of alternative housing, not in the current DMH service taxonomy. These new alternative housing/residential models may provide skills training in the areas of illness awareness, interpersonal communication and relationships, pre-vocational, independent living and relapse prevention with the focus of increasing level of functioning, promoting personal growth, and sustaining successful re-integration into the community. The development of these resources is necessary for the State to fully meet the individual housing needs of Class Members.

Housing can be further supplemented by enhanced property management. Enhanced property management involves any number of steps that property management can take to better accommodate persons with disabilities. Enhanced property management can include features such as:

- The training of housing and service staff in proper methods to: 1) recognize when tenants are having problems; 2) mitigate those problems, and; 3) identify whom to contact if problems occur and the staff is unable to handle the specific issue;
- Provision of 24 hour staff support;
- Ability to make creative reasonable accommodations for tenants with special needs;
- Dedication to keep lines of communication open between property management and the tenant, the service providers, and the general community (including: police, neighbors, local businesses, etc);
- A commitment to draw a clear line between property management and service provision so that the tenant's privacy is not violated.

Despite the need for multiple strategies to timely address the housing needs of Class Members, the State's preferred goal of the *Williams* Implementation Plan is to transition Class Members into Permanent Supportive Housing. The PSH model, other models currently in the DMH service taxonomy, and those the State anticipates developing are described below.

3.1 Permanent Supportive Housing (PSH)

Permanent Supportive Housing is housing (typically rental apartments) linked with flexible community-based support services that are available to tenants when needed, but are not mandated as a condition of living in the housing unit. These supports could include mental health or substance abuse services and assistance in arranging medical appointments or reminders to pay the rent. The PSH model is based on a philosophy that is Recovery oriented and supports consumer choice and empowerment, rights and responsibilities of tenancy, and appropriate, flexible, accessible, and available support services that meet each consumer's changing needs. These linked support services should include a combination of case management and community support services such as Assertive Community Treatment (ACT), Community Support Team (CST), Community Support Residential (CSR), Psychosocial Rehabilitation (PSR), etc. along with any additional mental health services based on the Class Member's voluntary choice and medical necessity.

PSH units may be a self-contained studio or one to three bedroom apartments, inclusive of a kitchen or kitchenette and bathroom. PSH units may also be shared apartments with up to 3 bedroom units and three individuals, per mutual agreement of the residents. PSH units are considered permanent residences. As such, Landlord/Tenant Law applies to this housing model. Tenants hold their own leases or rental agreements with respective developments, property management companies or landlords. All eligible units must meet Fair Market Rate (FMR) criteria and pass Housing Quality Standards (HQS) inspection. Access to housing options will be facilitated by using the Statewide Housing Locator Website, as well as through the coordinated exploration efforts by the Transition Coordination Unit staff.

3.1.1 Scattered Site

Pursuant to the Consent Decree, Permanent Support Housing may utilize scattered-site rental apartments/units from an array of safe, decent and affordable fair market, open housing stock (usually rental apartment/units, but not restricted as such). Under the Permanent Supportive Housing model, supportive services are available, appropriate to the needs and preferences of residents, either on-site or in close proximity to the housing.

3.1.2 Site-Based or Project Based

Site-Based or Project-Based PSH offers services on site. These housing developments have typically been dedicated to a single disability or population type, provide community support and services for residents and offer economies of scale for service provision. Site-based PSH projects are generally smaller developments. This model offers the advantage of on-site services to those members of the *Williams* Class who need a higher or more immediate service level. While development dedicated to a single disability type would clearly not meet the requirements of the Consent Decree, the model could easily be modified to allow only 25% of the units to serve members of the *Williams* Class, with the remainder of the units serving the general population including persons with other disabilities. Additionally, it will afford the State the ability to secure a set number of units within a project/building to address immediate and long range planning.

3.1.3 Master Leasing

Similar to Site-Based or Project-Based Permanent Supportive Housing, Master Leasing will afford the State the ability to secure agreements/arrangements with developers, property managers, and landlords to identify blocks of apartment units under their control in a variety of locations. These types of arrangements will allow the State to plan for adequate access to PSH units.

3.2 Residential Treatment Settings

Supervised and Supported Residential Settings refer to time-limited, residential options where residents with limited experience living in community-based settings are provided direct, on-site services, skills training, and supports that will assist them in developing the capabilities necessary for living in a more independent setting. DMH currently has two models in its service taxonomy: (a) Supervised Residential and (b) Supported Residential. Each setting will be detailed more extensively below.

The goal of these settings is to provide Recovery-oriented services directed to maximize each consumer's skill development and his or her choices for independent living. Both of these

settings are designed to be time limited (between 12 and 24 months and based on medical necessity) with residency dependent on medical necessity to meet the individual's assessed needs. All consumers will have measurable skill building objectives and self-established Recovery goals to work towards, with the goal of moving to his or her own PSH unit once the skills are acquired. Individuals will meet identified eligibility criteria for this level of community-based residential settings and will be pre-authorized for admission.

3.2.1 Supervised Residential

This model is a structured, cluster of Recovery-oriented, residential-support services designed to provide 24 hour, seven day-a-week supervision, skills training, and supports within an agency controlled (leased or owned) community residential facility. This cluster of services for consumers with moderate to substantial levels of psychiatric disability is focused on community-integration skills, Recovery peer support and vocational readiness. Counseling and other rehabilitation supports are provided in order to facilitate independent living and eventual movement into a less restrictive setting.

The Supervised Residential model provides a time-limited, community-based treatment setting for individuals who have Serious Mental Illnesses and who are either: (a) transitioning from a long-term care nursing facility and assessed to require direct staff support and supervision in the community; or (b) diverted from admission to a Long-Term Care facility when there is no compromising/complicating medical condition to substantiate a referral to nursing care, but needing direct staff support and supervision.

Supervised Residential settings prepare and assist individuals to reach optimal levels of functioning by:

- Assisting them with the necessary tools to develop and/or enhance basic living skills and self-management techniques and,
- Assisting them in the effective management of behaviors and symptoms and elevating skills necessary for transitioning successfully to a permanent independent living setting.

Individual activities of daily living (ADL) skills training and assistance are provided on-site daily, replicating a daily routine in a natural environment. Consumers have "house management" expectations to assist them towards independence.

Supervised Residential settings are congregate living arrangements with common cooking and living areas that house no more than 16 persons in either single bedrooms or two person shared bedrooms with common cooking and living areas. Class Members who are interested in transitioning to the community and who have been clinically assessed and determined to

require additional supervision, skill development and supports before consideration for transition to PSH may be referred to a Supervised Residential Setting.

Supervised Residential Settings would be most appropriate for individuals with SMI who have composite LOCUS score between 23 and 27 (preferably 26-27), a functional Level of Care assessment that supports the need for this setting, and has been preauthorized for this level of care. Individuals are not appropriate for Supervised Residential services if they:

- Meet clinical criteria for a more restrictive level of care;
- Can have their service needs met while in Permanent Supported Housing or another independent living setting or,
- Are experiencing acute psychiatric symptoms requiring crisis stabilization.

Access to supervised residential services is provided through Transition Coordination activity based upon Level of Care appropriateness determined by the Clinical Review Team, (described in the MH PASRR Section of the Implementation Plan), and informed by consumer choice.

3.2.2 Supported Residential

This program is a structured, cluster of Recovery-oriented, residential support services designed to provide less than 24 hour, seven day-a-week supervision, skills training, and supports within an agency controlled (leased or owned) community residential facility. This cluster of services, for consumers with moderate to substantial levels of psychiatric disability, is focused on community integration skills, Recovery peer support and vocational readiness. Counseling and other rehabilitation supports are provided in order to facilitate movement to independent living.

The Supported Residential model provides a time-limited, community-based treatment setting for individuals who have Serious Mental Illnesses and who are either: (a) transitioning from a long-term care nursing facility and assessed to require direct staff support and supervision in the community or (b) being diverted from admission to a long-term care facility when there is no compromising/complicating medical conditions to substantiate a referral to skilled nursing care but needing some direct staff support and supervision.

These Supported Residential services assist residents in reaching their optimal level of functioning. This accomplished by:

- Assisting them with the necessary tools to develop and/or enhance basic living skills and self-management techniques and,

- Assisting them in the effective management of behaviors and symptoms necessary to transition successfully to a permanent independent living setting.

Like the Supervised Residential model, Supported Residential settings also provide an array of services for the residents. Individual activities of daily living (ADL) skills training and assistance are provided on-site daily, replicating a daily routine in a natural environment. All residents will have "house management" expectations to assist them towards independence. Supported Residential settings can be congregate living arrangements with common cooking and living areas that house no more than 16 persons in either single bedrooms or two- person shared bedrooms. These settings can also be individual apartments with common or shared areas.

Supported Residential Settings would be most appropriate for individuals' who have SMI and a composite LOCUS score of 23 – 25, a functional Level of Care assessment that supports the need for this setting, and has been preauthorized for this level of care. The resident stay is time limited and based on medical necessity (targeting 12-18 months). Access is provided through Transition Coordination activity based upon Level of Care appropriateness determined by the Clinical Review Team (CRT) and informed by the consumer choice.

4. New Housing Models for Illinois

Concurrent with the execution of this Implementation Plan, creative models of PSH and transitional housing will be planned and considered to meet a variety of needs of residents who may not desire to live in totally independent scattered-site environments or site-based PSH, but rather in settings with built-in socialization and those supports commonly associated with an enhanced property management structure (24-hour front desk and onsite support services during work hours). These new models will require the collective efforts of State Government, public and private partners, financing entities, capital development funding and support services resources to make these new housing models a reality. These new models are further described below:

4.1 Fairweather Lodge Model

The "Lodge" model incorporates peer support of roommates, as well as continued psychological support, on-going vocational support and the permanent-style supportive housing to provide a greater opportunity for some individuals for long-term success in the community. The Lodge training program is a two-part model, with the first part being an estimated 3-6 month transitional period in the "Training Lodge". While in this phase, consumers participate in a very structured "in home" environment focused on promoting personal growth and independence in psycho-social rehabilitation, including illness/symptom management skills, community adaptation, (social skills, conflict resolution, coping skills, and

daily living skills), in addition to pre-vocational skills and hands-on training in a paid work environment. When a consumer demonstrates skill development in all areas required for graduation, they then transition to a permanent "Independent Lodge", where they may reside on a permanent basis by renewing an annual lease. All supportive services remain ongoing in this phase of the model. It is important to note that the lodge program promotes family-style living – it is not a group home. It is a model that houses a small group of consumers (customarily 8 persons) who voluntarily share in the management of the household and lodge inter-relationship rules, while experiencing the added benefit of the peer/family support elements that are instrumental in the promotion of the consumer's sense of self-worth, which is an essential component of self-reliance.

For Class Members interested in and choosing this type of housing, access will be provided through Transition Coordination activity based upon Level of Care appropriateness determined by the Clinical Review Team and informed by the consumer.

4.2 Transitional Living Alternative Pathways Housing Model

The Transitional Living Alternative Pathways Housing Model, hereafter known as "Pathways", provides a time-limited, community-based "step-down" option from long-term nursing home placement, as well as a "diversion" alternative from a potential nursing home admission, when there is no substantiating condition to require 24-hour skilled nursing care and the individual does not need a 'Residential Rehabilitative Supports' setting. "Pathways" provides housing with ongoing support services intended to help individuals:

- Maximize their highest level of optimal functioning and achieving their personal Recovery goals;
- Regain self-reliance on his/her innate abilities and capabilities to move toward Recovery and assume responsibility for self-care, care of surroundings and decision-making;
- Prepare for independence and transition to a PSH model or another independent community-based setting.

Core services include the reintroduction and enhancement of independent living skills such as cooking, budgeting, self-travel, hygiene and housekeeping maintenance, as well as decision-making and symptom and wellness management.

"Pathways" is provided in multi-unit apartment buildings that house residents in self contained apartments/units that include all amenities for independent living. The "Pathways" portion of the apartment building has:

- One-or two-bedroom units with residents having a choice of selection/approval of new roommates for shared bedrooms.
- A common cooking area for meal preparation and cooking skills development. As individuals progress through their Recovery, they will have latitude to participate in joint meal preparation or prepare meals in their own units.
- Space for elective services that is separated from the individual living areas and does not compromise residents' rights to privacy.

An individual is considered suitable for transition to a "Pathways" setting if he/she has a LOCUS composite score of 23 or less, the assessment supports that the individual is a good candidate for the "Pathways" Model, and the Class Member is interested in this housing option.

"Pathways" can be a cluster of units in an apartment building, or an apartment building of any size dedicated to low-income affordable housing that has a "front desk model" as the service component, allowing tenants to be able to access any support services by making the connection with the front desk staff. A contracted service provider delivers support services, especially mental health services and works closely with building operators to provide needed support to tenants who require that particular service. Buildings can have mixed populations (low-income, persons with disabilities) and dedicate a specified number of units for various populations in accordance to the Consent Decree (i.e., no more than 25% of these units will be occupied by Class Members). Development of these "Pathways" sites can be done through accessing capital development funding to address rehabilitation/renovation of existing properties, accessing available units in currently operating buildings, or new construction. The operating expenses for these sites will require a rental subsidy to offset the expenses of operating this type of housing option, in order to make it accessible to low-income tenants. The contracted mental health service provider for consumers in this housing model will be expected to obtain reimbursement for their services through billings to Medicaid.

5. Accessing Housing

5.1 Expanding Housing Choice

The State will create the initial 640 PSH units and all other subsequent units required to meet the needs of the Class Members by: 1) accessing existing privately held rental housing stock on the market; 2) working with Public Housing Authorities (PHAs) to access Public Housing units and private units in Project Based Section 8 Developments; 3) working with local housing authorities to provide Housing Choice Vouchers to Class Members; and, 4) providing funding to For-Profit and Not-For-Profit developers, through IHDA, to build, acquire, and rehabilitate units that will accept referral of Class Members.

IHDA has already conditionally funded six pilot developments under the Build Illinois Bond Fund. IHDA will solicit a series of applications for capital resources to obtain development proposals from for-profit and not-for-profit housing owners in order to acquire, rehabilitate, and construct affordable Permanent Supportive Housing.

DMH is also committed to using its Bridge Subsidy Initiative model as these funds are available, to augment rental costs in housing developments, and to identifying ways to 'project-base' the Bridge Subsidy for specified project development in order to provide incentives for developers to create more PSH units. Project-basing the Bridge Subsidy would provide a necessary income stream that developers could use to pay operating costs.

5.2 Choosing Housing Options

Class Members, who give consent, will receive a Resident Review (Resident Review assessment processes are detailed in the MH PASRR Section). This will provide a comprehensive assessment of their individual service, housing and clinical needs, and will inform the process of determining the appropriate Level of Care and housing options. The State will make every effort to accommodate individual choice in the selection of housing in the desired communities.

As described in the previous section, Transition Coordinators will identify units utilizing the ILhousingsearch.org Housing Locator website or through notification and solicitation of private unit owners willing to allocate existing units in order to expand the pool of available units. The IL Housing Locator website provides an innovative and modern method to search for available housing on the open housing market throughout the entire state and is available to all State agencies, as well as DMH mental health service providers, social service agencies and the general public. This state-of-the-art resource includes thousands of searchable properties and tens of thousands of searchable rental units throughout the State. It allows users to search potential resources by rental amounts, accessibility features, location, vacancy, screening criteria, acceptance of vouchers, school districts, pets permitted, deposits, fees, and proximity to transit. This website is supported by a call center with a toll free number to assist users and support property owners or managers with registration, property listing and property availability updates.

This resource has been operational since Fiscal Year 2008 and will be available to Class Members transitioning to community-based housing options. Without such a mechanism to easily access information about housing location, affordability, accessibility and availability, the large scale identification of appropriate housing options (based on an individual's needs and preferences) would otherwise prove difficult. DMH will obtain monthly reports from the Illinois Housing Search Database. This will allow DMH to monitor utilization of various

housing resources to support ongoing resource development and strategic planning for serving Class Members.

Once a unit has been identified, Transition Coordinators will arrange site visits to appropriate housing options allowing Class Members to select a desirable unit. The State will provide a DMH Bridge Subsidy where applicable, while continuing to support the Class Members' efforts to secure more permanent rental subsidies. Concurrently, the State will continue to work with Public Housing Authorities (PHAs) both to access their existing resources for housing vouchers and to assist PHA's in applying for any new funding available to them through HUD Initiatives. Recently, the State assisted eight Illinois PHAs with applying for new Housing Choice Vouchers that are specifically designed for non-elderly persons with disabilities. It is hoped that HUD will continue to issue similar Notices of Funding Availability.

5.3 Securing Selected Housing Options

For PSH (DMH model of scattered-site only), once the selection process is completed and the Class Member has approved the housing choice, the Transition Coordination entity will work with the DMH Subsidy Administrator and community agency care manager to secure the identified housing option. The process to secure the unit requires a successful HQS inspection, lease signing (tenant and landlord), completed Housing Assistance Payment (HAP) Contract (Landlord and Subsidy Administrator) and any necessary, one-time Transition Funds. Once all steps are completed, the Class Member may move into their selected housing unit. Alternative housing options would follow a similar process

5.4 Staff and Housing Development Oversight

The Division of Mental Health will hire a Housing Development Liaison. This position will work collaboratively with IHDA staff to promote identification and expansion of scattered-site PSH units. The Housing Development Liaison will also be the representative to local community meetings and network with housing developer associations, property management entities and local community landlord associations. Establishing and maintaining these partnerships is essential to identifying potential apartment/unit resources. Additionally, the Housing Development Liaison will engage local housing administrations to explore possibilities for collaboration.

Integrating the perspective of the Housing Development Liaison with that of the Transition Coordination Unit is essential. The knowledge base that this position will acquire from developing a catalogue of potential housing resources, the ongoing research obtained from navigating the housing locator website and from networking activities with community

resources will provide tremendous assistance to the TCU in their efforts to conduct the housing search in a timely and efficient manner.

The Housing Development Liaison will work in concert with the DMH's existing Housing Development Specialist. The two positions are instrumental to integrating activities and troubleshooting with the Subsidy Administration Entities. This partnership will address all potential housing stability problem areas such as rental payment, inspection of units, maintenance issues, etc.

IHDA will devote staff resources to assist in the networking efforts with property owners and developers. These staff resources will also be utilized to develop incentives for property owners/developers to become partners and to ensure the fluid stock of housing/unit resources for rental purposes.

Supervision of both positions, the Housing Development Liaison and the Housing Development Specialist, will fall within the administrative management of the Division of Mental Health.

Jointly IHDA and DMH will monitor progress toward identifying housing units and developing new housing and residential alternatives. A Housing Implementation Schedule identifies internal benchmarks against which the State will track its progress. Progress in securing/developing housing will be reported to the *Williams* Implementation Team and to the Compliance Officer to ensure that requirements of the Consent Decree are met (see Appendix B for schedule).

COMMUNITY-BASED SERVICES

1. Description/Purpose

To achieve compliance with the Consent Decree, Illinois must assure that Class Members have ready and timely access to needed services and supports. This requires that, at a minimum, the required services governed by Community Mental Health Medicaid Rule (Title 59, part 132 of the Illinois Administrative Code) and Illinois State Medicaid Plan Services recommended in each Class Member's service plan are available in the Member's geographic area in sufficient quantities to meet the Members' needs, and are delivered at expected levels of quality.

However, to assure success, Illinois further recognizes that an array of available Community Services, including some non-Medicaid services, will be critical in achieving and sustaining the successful community placement of *Williams* Class Members. The existing infrastructure of services in the Illinois Medicaid State Plan is inclusive of mental health rehabilitation services, substance abuse and co-occurring services, services for persons with developmental disabilities and physical healthcare services that will be beneficial for Class Members. However, given the current state of knowledge, it is commonly recognized and accepted within the national public mental health field that the most effective and efficient mental health service systems require a new vision and approach, supplemented by some additional services beyond federally authorized Medicaid services.

A Vision of Recovery: Previous visions were based on assumptions that individuals with mental illness, and especially Serious Mental Illness, would remain ill and even disabled for the rest of their lives. As a result, services--such as Assertive Community Treatment (ACT) and others,--were initially designed with an expectation that the service would need to be provided indefinitely and perhaps throughout the individual's life.

The newer vision of Recovery reverses this expectation. Drawing on more recent research that demonstrated that many individuals, including those with Serious Mental Illness, have been able to recover and no longer require the same level of mental health services, Illinois believes this vision of Recovery is paramount to the successful implementation of community services for Class Members. A Recovery vision is built upon the belief that all persons have the ability to recover. It also recognizes that there may be times in an individuals' Recovery when more intensive supports are necessary, and other times when fewer supports are required. Therefore, the service system must be flexible to allow for ready access to variable levels of support and must be designed to create opportunities and environments that empower Class Members to recover and to succeed in reaching their self-defined goals. Key components of a Recovery oriented system include hope, choice and empowerment, with an emphasis on individual strengths, wellness, self-help and mutual support. Although the

impact of this vision and approach on the quality of life for individuals should not be overlooked, the long-term economic value of this vision and approach should also be noted. Over the past several years Illinois has made significant progress in modifying Medicaid services to align with this vision of Recovery, as well as supplementing non-Medicaid services[4] important for supporting and sustaining Recovery, and directing the State toward more evidence-based and cost effective service delivery.

A Clinical Home: In the last several years, increasing attention has been focused on the economic and clinical advantages of patients with physical health issues having a "medical home" to efficiently and effectively coordinate needed health services. Individuals with mental illness experience even broader and more complex needs for coordination of services, as they often require a much wider range of services to effectively address their multiple needs.

For example, individuals with Serious Mental Illness frequently require the following:

- Coordination of mental health services: Currently, not all state-funded providers offer a comprehensive array of mental health services or are as effective as possible in coordinating these services. Solidifying the concept of coordinated delivery of mental health services for all facets of the Class Member's mental health needs will enhance the effectiveness of these services, while controlling costs.
- Coordination with healthcare resources: With a significant portion of Class Members with co-occurring health issues that compound or otherwise interact with the mental illnesses, primary care integration and coordination is critical to maintaining the individual safely in the community. This would be inclusive of coordination with primary care practitioners, Federally Qualified Health Centers (FQHCs), and physical rehabilitation and support services (e.g., homemaker, personal assistant, skilled nursing services)
- Coordination with substance abuse resources: Twenty-five to 50% of Class Members seeking community placement are likely to have a co-occurring substance use disorder. Thus, coordination with DHS/Division of Alcohol and Substance Abuse Services (DASA) is critical for these individuals. DHS/DASA and DHS/DMH have a foundation in collaborating in the development and implementation of services for individuals with these co-occurring disorders.
- Coordination with vocational resources: A substantial number of Class Members have expressed interest in returning or moving into employment. Research evidence supports that employment is often a critical factor for sustaining community living for individuals with Serious Mental Illness. DHS/Division of Rehabilitative Services (DRS) and DMH

[4] Some of the most important non-Medicaid services include vocational supports and services. Ongoing engagement in a vocation is a primary means of limiting isolation and providing meaning and purpose, and one of the most common goals cited by individuals pursuing recovery from their mental illness.

also has a history of working together on coordinated vocational services and supported employment which, with resources, can be built upon through renewed focus and coordination.

- Coordination with housing resources: Individuals with Serious Mental Illness, like all individuals, need an appropriate place to live. Coordination of housing resources with other services is necessary for maximizing sustained successful community placement. The Housing Section of this plan provides additional details.
- Coordination with social supports: Individuals with Serious Mental Illness transitioning from institutional settings to the community often cite isolation as a major concern. Access to peer support groups, faith-based organizations and other organized social support networks is fundamental to addressing this need.
- Coordination with other public resources: Individuals with Serious Mental Illness often require additional public support, such as income support, nutrition supports, public health, elderly services, protection and advocacy services, etc. In addition, a few individuals may also require developmental disabilities and/or physical rehabilitation services.

Given these needs, DMH recommends the development of a "Clinical Home Model" for *Williams* Class Members as a means of not only enhancing the quality and effectiveness of services, but also minimizing the long-term economic cost to the State.

Although Illinois has continued to make progress in inculcating a vision of Recovery and modifying services to support this vision, Illinois is not prepared to implement a "Clinical Home Model" in time to serve the first discharges and community placements required under the Consent Decree. Thus, Illinois is proposing a two phase approach:

- **PHASE I** (to June 30, 2012) – In Phase I, Illinois will build on existing structures, services and providers to meet the community service needs of the Class Members discharged in Year 1, and augment this with tools, referral processes, coordination contacts and problem-resolution mechanisms designed to maximize the successful community placement of the *Williams* Class Members. In addition, Illinois will lay the groundwork and plan for Phase II activities.

- **PHASE II** (July 2012 forward) – Beginning July 1, 2012, Phase II will begin the implementation of a Clinical Home Model where comprehensive service providers are responsible for efficiently identifying and integrating or coordinating the services necessary for successful community placements. In addition, processes for ongoing improvements in the quality and effectiveness of services, as well as monitoring of outcomes, will be initiated.

2. Phase I

Phase I will include planning for community system development necessary to support the service capacity and delivery structures required to more efficiently meet the needs of larger volumes of Class Members in community placements. Major community service activities in Phase I include: Conducting network sufficiency analyses; retraining and developing regional staff, developing coordination protocols for TCU and community service system, and; developing a "Clinical Home" service model. These activities will occur under the leadership of the DMH Associate Director for Community Services with support from the Deputy Director for Transition Coordination.

2.1 Network Sufficiency Analyses (Phase I)

To more fully appreciate the particular service needs of the *Williams* Class Members, an initial needs assessment survey was completed in May and June, 2010. Results of this analysis revealed a wide variety of service needs within the class. A summary of the range of services currently needed by *Williams* Class Members is provided in Appendix C.

While the existing array of services within Illinois is broad, compliance with the Consent Decree will require that these services are available in a timely manner, in sufficient quantities and delivered with sufficient quality in locations geographically accessible to the Class Member. To achieve this, Illinois must: (a) know what services and supports currently exist, in what geographical locations, and with what available capacity, and (b) have means to develop and implement services or additional capacity in a timely manner to meet the needs of Class Members scheduled for discharge from IMDs.

Although DMH has some information on the location and quality of services, this information not only needs to be updated and related to the known or anticipated service needs of the Class Members, but also enhanced and expanded. In particular, DMH has limited information on available service capacity and has researched some generally recognized access standards. However, due to the size and diversity of the State, as well as the fact that Illinois supports not only services that are widely and frequently used, but also specialized intensive and expensive evidence-based services that require an adequate population base to be cost-effective these access standards do not appear suitable for Illinois. Thus, DMH has begun the process of planning for the execution of a network sufficiency analysis focused on the needs of the Class Members, recognizing that it is somewhat limited by not yet knowing precisely where the Class Members will choose to live and what their specific service needs will be. This process will include a review of practices in other states with similar size, diversity, and service array. Access standards to be established include:

- Team Services—Illinois' current array of services includes two team-based services, Assertive Community Treatment (ACT) and Community Support Team (CST);
- Core Services, including Mental Health Assessment, Treatment Planning, Community Support—Individual, Crisis Services, Medication Services, and Therapy/Counseling;
- Psychiatric Services

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In addition, DMH will determine what enhancements or changes to its current processes are necessary for assessing, monitoring and assuring the quality of services being delivered to Class Members.

The access analysis needing the most development by DMH is available capacity assessments, including; (a) the quantity of services presently available; (b) the quantity of services that could become rapidly available by expansion of services from experienced staff and current providers; and (c) the quantity of services that could become available over a longer period of time with recruitment and training of additional staff at existing and new providers. DMH needs to further develop its ability to complete this type of analyses, including the development of capacity and waiting list surveys to assure timely access to services.

In addition, beyond community mental health services, Illinois needs to coordinate, enhance and integrate access information for all other Medicaid and state-funded services that will be most likely be needed by Class Members. Access information for substance abuse services, especially resources for co-occurring mental illness/substance abuse disorders, will certainly be some of the information needed.

For this reason, for initial community placements, DMH will prioritize the placement of individuals with community service needs that can be most readily met by the existing service and provider network, and gradually move towards the placement of Class Members who are less likely to meet these criteria, thus allowing DMH additional time to not only complete its network sufficiency analyses, but also develop and implement the needed services in the community.

It is anticipated that current monitoring processes will be reviewed and enhanced as appropriate. DMH currently monitors and has information regarding the quality of services delivered. This information on the quality of services is presently obtained through several methods (refer to the Compliance, Quality Assurance and Risk Management Section), including:

- Post-payment reviews of services delivered and paid for by DMH, and the associated corrective action processes;

- Clinical practice and guidance reviews conducted on one-third of the public mental health service provider network each year, and its associated corrective action processes;
- Service fidelity reviews and corrective action processes, comparing the provider's actual service delivery to established service standards;
- Annual consumer satisfaction surveys;
- A consumer and family complaint process.

In addition to enhancing current monitoring of community services, further enhancements may include a refinement of the consumer and family complaint process to focus on the needs and corrective actions required for Class Members.

DMH plans to have a minimal network sufficiency analysis inclusive of capacity assessment completed by August 31, 2011 in order to inform the planning of the initial community placements for Class Members, with these analyses expanded and enhanced over subsequent months. As part of this network sufficiency development, DMH will also enhance its utilization of the results on evaluating the quality of services delivered for informing the quality assurance and improvement activities.

2.2 Service Expansion and Development (Phase I)

Considerable service development and expansion will be required to meet the needs of the *Williams* Class Members seeking community placement throughout implementation of the Consent Decree. However, to meet these service needs in a manner that assures the prudent expenditure of public monies in the most efficient and effective manner, Illinois will pursue the development of needed services following a two prong approach.

First, Illinois has already implemented processes in its public mental health system to assure the appropriate expenditure of taxpayer dollars. Specifically, Illinois has implemented processes, such as utilization management and services monitoring, to ensure that the individuals most in need are receiving only the services that are medically necessary and that these services are delivered at expected levels of standards and quality. Illinois intends to not only maintain these processes, but enhance and possibly expand them to assure appropriate expenditure of public monies on mental health services, including redirection of funding and capacity which is not fully utilized or of acceptable quality.

Secondly, if resources cannot be redirected or are not available, Illinois will support and fund the expansion of needed service capacity with the existing provider network, or the development of additional services and capacity with existing or new providers.
Thus, in summary, services development will be driven by the service needs of Class Members, as reflected on their service plans, and Illinois will seek to address these needs by

first evaluating and directing the availability of existing service capacity or resources, and second, supporting and funding the expansion or development of needed services.

The DMH Associate Deputy Director for Transition Coordination, in collaboration with the DMH Associate Deputy Director for Community Services will be responsible for overseeing this services development process for public mental health services.

2.3 Community Transition Support (Phase I)

Effective coordination and oversight will not only assure that Class Members can initiate and achieve community placement in the location of their choice, but also that services are coordinated and efficiently delivered at expected levels of quality. Oversight will assure that Class Members reach their self-identified goals and sustain long-term Recovery.

In Phase I, Transition Coordinators, employed by an independent Transition Coordination Agency, will be responsible for identifying the community service needs of Class Members being discharged from IMDs, and assuring that an effective referral is completed to link Class Members to appropriate service providers. During Phase I, prior to the first discharge, Illinois will prepare and equip the Transition Coordinators through specific community services related training and tools as follows:

- All Transition Coordinators will be trained on the guiding Principles of Recovery, including the understanding that: Recovery is an individualized and personal process; that Recovery is possible for anyone; that hope is a key ingredient for Recovery to occur; and that Recovery is enhanced by supportive role models in the Recovery process (peer support).

- An online Community Service Directory will be developed. The directory will include information on providers of mental health, substance abuse, Medicaid State Plan healthcare services and other resources to allow Transition Coordinators to locate the identified services and offer Class Members a choice of providers and service locations. The directory will be complete by September 1, 2011, maintained online and support search functions. A team representing the service areas across State government will develop or share their existing information required for the directory, and also be responsible for providing any changes in this information on an ongoing basis. The directory will be updated on at least quarterly basis. The DMH webmaster will be responsible for implementing the directory and subsequent changes online.

- To support access to services across Illinois, the State agency partners in complying with the Consent Decree will assist DMH in developing an online Resource and Referral Guide to direct Transition Coordinators to referral and enrollment processes for services.

The guide will also include contact information for an identified staff person from DMH, DASA, DHS/Division of Developmental Disabilities (DDD), Department on Aging (DoA) and HFS who have been specifically charged with assisting Transition Coordinators with any issues that might arise during community placement planning and service linkage. The first version of the Resource and Referral Guide will be available by September 1, 2011 and will be updated quarterly. During the development of the initial guide, opportunities for streamlining referrals across State agencies will be identified and a corresponding work plan element will be completed to improve the referral process as a quality improvement activity. A team representing the service areas across State government will develop the linkages and responsibility for notification of changes in those linkages. The DMH webmaster will be responsible for changes online.

- As necessary, the identified State agency staff will also be responsible for assisting the Transition Coordinators in accessing the services supported by their agency to assure that Class Members receive the services prescribed in their Service Plan. When service access barriers cannot be overcome by these staff, the problem resolution process described later in this section will be activated.

- All Transition Coordinators will be trained on the use of the Community Service Directory and the Resource and Referral Guide, including how barriers to accessing community services are addressed.

2.4 Clinical Home Model (Phase I)

2.4.1 Description

As described earlier, due to the multiple service and support needs typically required for individuals with Serious Mental Illness, DMH intends to implement a Clinical Home Model to best meet the needs of these individuals in a cost-effective manner. The following proposed definition has been developed by adapting the Patient-Centered Medical Home from the American Academy of Family Physicians, American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association:

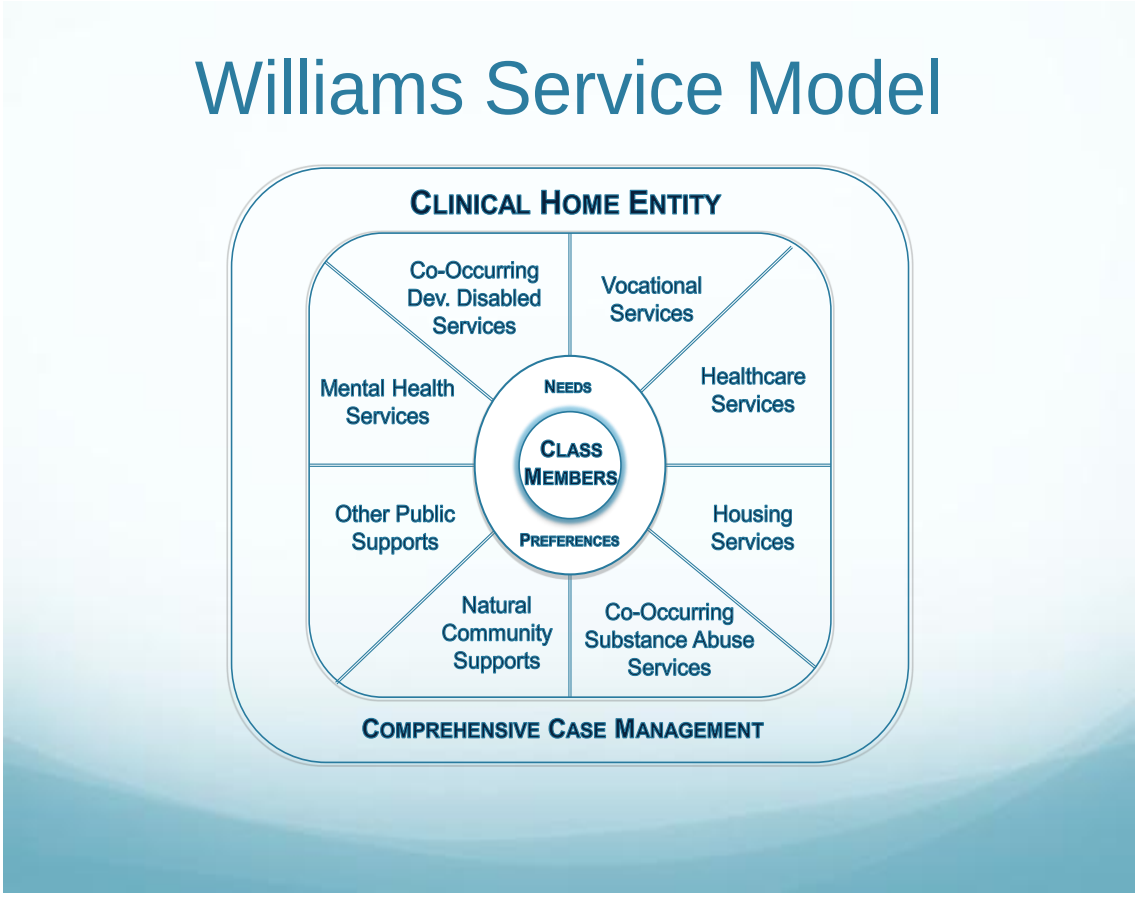
The Clinical Home is for an identified population with significant and complex mental health needs and is an approach to providing comprehensive, highly coordinated and person-centered supports with the goal of facilitating partnerships between persons and their providers, improving access to care, increasing efficiency and satisfaction, and ultimately improving outcomes.

Illinois is familiar with Clinical Home models (and the similar Medical Home models) that have been developed in other States to effectively serve various populations who present with

significant cross-system needs. To support the objectives of the Consent Decree, Illinois believes that the development of a Clinical Home Model will be important for building a service system to support Class Members that efficiently reduces inappropriate or unnecessary institutional placements.

Clinical Home Principles are:

- **Whole person orientation**: The Clinical Home Entity is responsible for providing for all of the individual's mental health and health services needs or taking responsibility for appropriately arranging for care or services with other qualified professionals or organizations.
- **Relationship**: Each individual has an ongoing relationship with a primary case manager in the Clinical Home trained to provide first contact and assure continuous, comprehensive, and coordinated services and supports.
- **Coordination:** Services and supports are integrated and/or coordinated, including medical, mental health, addiction, developmental disability, vocational, housing, and social services, as well as public benefits, natural supports, and other community resources.
- **Quality and accountability: Q**uality and safety are assured by a services planning process that emphasizes the active participation of individuals in decision-making, accessing evidence-based practices and the utilization of helpful information technology, clinical decision-support tools, performance measurement, and quality improvement activities.
- **Enhanced access and direct communication**: Ready and rapid access to services is available using creative options such as open scheduling, expanded hours and new options for communication.
- **Payment is aligned with desired outcomes**: The value-added aspects of the Clinical Home, including recognition of the value of work that falls outside of the face-to-face visit and services, is recognized and rewarded.



2.4.2. Development of the Illinois Clinical Home Model

By July 2011, DMH will initiate the development of a Clinical Home Model by convening key stakeholders for input and advice. The proposed key principles and functions of the Clinical Home will be reviewed and refined with stakeholder input, and options for supporting and implementing the Clinical Home Model in Illinois will be discussed, explored and evaluated by this stakeholder group. Some of the options and issues Illinois anticipates as part of this discussion include:

- Possible modification of the State's Medicaid Targeted Case Management plan and related administrative rules to create a target population and fund Clinical Homes on a monthly rate, with outcome incentives, for case management services for this population;
- Consider prioritizing any non-Medicaid funding to certified Clinical Home providers to further integrate all service needs within one system;
- Solicitation of feedback on alternative or additional means of improving and assuring efficient service coordination and delivery, including:

- Minimizing redundant enrollment and assessment processes between State programs, agencies and funding streams whenever possible;
- Streamline the assessment and determination process for Class Members with indicators to assure timely placement of individuals in compliance with the Consent Decree;
- Consideration of formal Memorandums of Understanding or Intergovernmental Agreements that may be useful in clarifying and documenting mutual responsibilities and obligations for cost-effective service delivery to Class Members by State agencies and divisions;
- Implementation of an ongoing quality improvement activity consisting of interdepartmental review and assessment of options for improving referral processes, the ongoing coordination of services, reduction or elimination of redundant regulatory processes or other administrative burdens, and the minimization of problems and barriers for Class Members' effective access to services (see Compliance, Quality Assurance and Risk Management Section);
- Evaluate funding realignments or enhancements for supporting an improved service delivery system.

The experiences from early outreach, transition and community placement activities will also inform the Clinical Home planning process.

Illinois anticipates that certain providers will emerge as key resources for the transition of Class Members to Community Services, and believes the future plan for implementing a Clinical Home Model will serve as at least a partial incentive for existing providers to appropriately enroll and service Class Members. These providers will likely offer a more comprehensive array of services needed by the Class Members and be responsive to Transition Coordinators in accepting referrals and supporting community placements. These providers may be mental health providers, Federally Qualified Health Centers (FQHCs), or substance abuse providers. As Illinois proceeds with its planned implementation of the Clinical Home Model, it anticipates that the previous service delivery and coordination performance of a provider, including services to Class Members, will be a factor in evaluation of the responses to requests for proposals for the funding of a Clinical Home.

2.5 Problem Resolution (Phases I & II)

In addition to planned service expansion and development, Illinois will prepare for managing and resolving problems that may occur in achieving and sustaining community placements throughout implementation of the Consent Decree. Mechanisms to address problems, including accessing community services, will be designed at multiple levels to provide opportunities to address issues in the most efficient manner with clear responsibilities and timelines.

- DMH regional staff and contract managers will be responsible for leveraging their existing relationships with providers and knowledge of the community systems and other community resources to resolve issues. They will support the Transition Coordination Unit and community mental health providers and Clinical Homes in identifying and establishing necessary linkages and making all appropriate referrals on the behalf of Class Members. The regional staff will also be the front line for identifying alternative community resources when any service gaps are identified, and will work at the individual consumer level to resolve or ameliorate service gaps. Regional staff will be available for both initial placement issues, as well as assisting in the resolution of problems identified from service plan oversight activities or when service changes are indicated. They will also serve as resources for input into network sufficiency analyses and resulting network system development efforts.

- The identification of specific staff at DMH, DASA, DoA and HFS who are responsible for assuring the availability of services for *Williams* Class Members is the next point for problem resolution when Transition Coordinators encounter barriers to linkage or access to community services that cannot be resolved at the DMH Regional level. Referral issues will be submitted to the identified staff members by email and a standard form will be developed to allow tracking of the nature of the problem for purposes of quality improvement and further system development in Phase II. The Transition Coordination Unit will track the request for resolution and raise the problem to the next level if no timely resolution is found at this level. State staff will respond to these requests within 4 business days with either a resolution or assuring that the issue is raised to the next level. Action will be reported to the Transition Coordination Unit at the time it is taken.

- The Associate Deputy Director for Transition Coordination is the next point of responsibility for addressing any barriers to community placement, including the availability of appropriate and timely services. To assure timely access to needed services, the Associate Deputy Director for Transition Coordination will have access to and be accountable for a pool of funding for services needed by Class Members. This funding cannot be used to supplement existing State payment rates for Medicaid services, but rather is to be used to: (a) provide start-up or service expansion funding for a provider's cost in recruiting, employing, training and equipping staff to provide the needed services, and (b) funding needed for non-Medicaid services or supports prescribed by the Class Member's Service Plan.

- The Associate Deputy Director for Transition Coordination will be expected to decide on a course for problem resolution within 4 business days, ensure appropriate and prudent expenditures, and oversee implementation of the resolution which includes

budget development, review, approval, processing of funding and implementation of the resolution. If new or additional services or capacity is needed, the goal will be to have these in place within 120 days.

- If unable to resolve the issue, the Associate Deputy Director for Transition Coordination will assure that the problem is raised to the next level. Actions will be reported to the Transition Coordination Unit at the time it is taken.

- The DMH System Rebalancing Deputy Director has final responsibility for addressing community services barriers and other issues that arise in the community placement of *Williams* Class Members. If necessary, the Deputy Director will work directly with the Director of DMH on resolving the problem. The Deputy Director will respond to these requests within 4 business days with a resolution. Action will be reported to the Transition Coordination Unit at the time it is taken.

The Transition Coordination Unit will collect information regarding identified problems, actions taken, and remaining issues and provide this information at least weekly to the DMH Associate Deputy for Transition Coordination and the DMH Associate Deputy Director for Community Services for integration into the Illinois Consent Decree quality assurance and improvement activities. In addition, the aggregation of the service issues will be incorporated into the annual network sufficiency review and in the planning for long term service and supports development.

2.6 Integrated Care Program (ICP)

Approximately 700 Class Members may be receiving services through a new managed care program in Illinois. In February 2010, the Department of Healthcare and Family Services (HFS) released a Request for Proposal (RFP) for qualified, experienced and financially sound Health Maintenance Organizations (HMOs) to enter into risk-based contracts providing the full spectrum of Medicaid covered services to nearly 40,000 seniors and adults with disabilities whose healthcare is paid for by Medicaid (called AABD in Medicaid). These clients reside in the counties of Lake, Kane, DuPage, Will, Kankakee and suburban Cook County. The Division of Mental Health anticipates that 700-800 of these individuals reside in IMD's and would be Williams class members.

HFS has identified Aetna and Centene-IlliniCare as the two successful bidders of the RFP. Phase I of the Integrated Care Program covers all medical services under the Medicaid state plan, including all professional physician component services. Phase I is expected to begin in April 2011. Phase II will include full at-risk responsibility for all long-term care services, including and specifically the residential component for the identified AABD population. This phase will be designed in consultation with stakeholders during 2011. The contract will

include pay-for-performance measures that incentivize spending on care that produces healthy, quality-of-life outcomes and will be drafted to withhold payments if outcomes are not produced.

DHS/DMH is actively and concurrently involved with HFS on:

- Determination and selection of quality measures and outcomes for vendor contract;
- Attending and supporting stakeholder meetings to solicit input on policy, contractual and implementation strategies;
- Advising HFS and actively soliciting support from mental health advocacy groups for their inclusion in all levels of planning and implementation;
- Working with vendors to identify key providers and support vendor and provider transition efforts;
- Planning the independent project evaluation;
- Educating vendors of all current DMH projects and interpretation of our Rule 132 and current utilization management strategies;
- All phases of project implementation.

DHS/DMH and HFS will continue to work collaboratively in 2011 to assure that any Williams Class Member eligible for the Integrated Care Program will receive all needed services in a coordinated and integrated fashion that supports the individual's transition to residing in a community-based setting.

*Information taken from Integrated Care Program Fact Sheet at http://www.hfs.illinois.gov/newsroom/090910.html.

3. PHASE II

Network Sufficiency Analysis (Phase II)

By July 1, 2012, the start of Phase II, DMH anticipates that it will have established processes for systematically collecting and summarizing the service and support needs of Class Members planned for upcoming community placements, with the information obtained from the Service Plans developed by the Transition Coordinators. The Associate Deputy for Transition Coordination and staff will be responsible for collecting and summarizing this information, which will be compared to the updated network sufficiency analysis.

In Phase II, DMH will complete an enhanced network sufficiency analysis by repeating and expanding the analysis conducted during Phase I. DMH will plan to complete these analyses annually by the end of the first quarter of each fiscal year in order to inform services

development and expansion required to meet the needs of the upcoming placements of Class Members.

The network sufficiency analyses in Phase II are expected to be continuously refined, but include an assessment of geographical proximity of services, available capacity of services, and quality of services. The geographic proximity of services analysis will again apply the specific geographic proximity access standards developed for specific services. Less intensive, frequently and widely used services will have a geographical access standard that is considerably less than more intensive, infrequently required and costly services that cannot be provided in a cost-effective manner without a sufficient population base with the need for the more costly service.

Determining the available capacity of services will continue in Phase II with application of the capacity assessment processes developed in Phase I, including capacity and waiting list surveys of providers. This assessment will again help Illinois know: (a) the quantity of services presently available; (b) the quantity of services that could become rapidly available by expansion of services from experienced staff and current providers; and (c) the quantity of services that could become available over a longer period of time with recruitment and training of additional staff at existing and new providers.

The quality of services will continue to be monitored through several methods, including (see Compliance, Quality Assurance and Risk Management Plan section for additional details):

- Post-payment reviews of services delivered and paid for by DMH, and the associated corrective action processes;
- Clinical practice and guidance reviews conducted on one-third of the public mental health service provider network each year, and its associated corrective action processes;
- Service fidelity reviews and corrective action processes, comparing the provider's actual service delivery to established service standards;
- Annual consumer satisfaction surveys;
- A consumer and family complaint process.
- Residential services monitoring in accordance with the newly developed Residential Rule once adopted.

3.1 Community Transition Support (Phase II)

Two important shifts in responsibilities and focus of activities will occur in Phase II for the Transition Coordinators.

First, the oversight role of the Transition Coordinator is limited to the first year that each Class Member is in community placement. After that first year, this oversight and monitoring responsibility for that Class Member, which is expected to be less intense and demanding, must be transitioned to the DMH Quality Bureau. The Bureau will conduct ongoing clinical reviews and monitor implementation and maintenance of services in accord with each Class Member's service plan. These staff will incorporate this oversight and monitoring of services for Class Members into their overall responsibilities for monitoring and overseeing the publicly-funded community mental health services for all individuals served in their region.

Secondly, with the establishment and evolution of Clinical Homes for Class Members and its responsibility to coordinate services, the coordination responsibilities of the Transition Coordinators should be significantly reduced, permitting these Transition Coordinators to focus more of their monitoring and reporting responsibilities. With this shift, there is an expectation that these staff build upon their individual class monitoring reports to more system level reports in Phase II to inform Illinois of needed systems development or other issues.

3.2 Clinical Home (Phase II)

With the benefit of stakeholder input obtained during Phase I, DMH will finalize the principles, requirements, standards and contractual terms for an Illinois Clinical Home for Class Members. As described earlier, these standards and requirements will focus on the Clinical Home's obligations to efficiently coordinate and streamline the delivery of services for clients.

Illinois will then issue a Request for Proposal (RFP) for providers to serve as a Clinical Home for Class Members, and require that those awarded the Clinical Home contract offer Class Members already placed in the community, as well a future Class Members, an option of enrolling in the Clinical Home. Evaluation criteria for responses to the RFP will include, among other considerations: (a) the bidder's proposal for minimizing service costs by minimizing duplicative services (e.g., intake processes, assessments, etc.) and coordinating services; and (b) the bidder's previous and current performance in serving and meeting the needs of Class Members as well as other clients.

Also during Phase II, DMH and partner State agencies will develop instruments and processes to monitor and evaluate the effectiveness and efficiency of the Clinical Homes.

COMPLIANCE, QUALITY ASSURANCE & RISK MANAGEMENT

1. Description/Purpose

To effectively implement the *Williams* Consent Decree, Illinois must ensure compliance with the terms of the Decree, assure that services and processes meet appropriate standards, resolve problems and minimize risks, whether to the Class Members or the service system itself. Illinois must establish and maintain the structures, processes and monitoring necessary to achieve and sustain compliance with each of the requirements specified in the Consent Decree. In addition, Illinois must ensure that each Class Member transitioning to the community is appropriately placed, has all the necessary services and supports in place and that risk to the individual as well as the service system are avoided or minimized to the greatest extent possible. The Compliance, Quality Assurance & Risk Management Plan was developed to address these and other priorities related to the Implementation Plan. It has, as its foundation, an emphasis on data-driven assessments and decisions, collaboration and consultation with Class Members and other key stakeholders, and a commitment to a process of ongoing corrective adjustments to fulfill the requirements of the Consent Decree.

The Compliance, Quality Assurance and Risk Management Plan has three primary goals:

- Assess, monitor and ensure compliance with each of the specific elements articulated in the Consent Decree;
- Ensure that services, supports, processes and facilities accessed by Class Members meet appropriate standards of quality;
- Identify, manage, mitigate and respond to problems and risks to the Class Members and the service system itself.

1.1 Data Sources

The Compliance Plan, Quality Assurance and Risk Management processes are organized around the flow of the Class Member through the five, key functional areas of the transition process: Outreach, Pre-Admission Screening/Resident Review, Transition Coordination, Housing Development and Community-Based Services. Staff in each of these areas will be required to regularly collect and report on data related to compliance, quality assurance and risk management. The specific data collected and reported will be dependent on the particular functional area, the compliance indicators associated with that area, the specific quality assurance issues and the identified risks, both to the Class Member and the system. For example, during the Outreach phase, Outreach Workers will be recording and reporting on Class Members contacted, date of contact and type of contact, Class Member interest and planned follow-up. They will also be recording and reporting on any barriers or obstacles

encountered and whether these were resolved or need additional follow-up by the *Williams* Implementation Team.

Data and indicators reported from the field will be aggregated by staff or data analysts specific to each functional area, transformed into an indicator measurement if appropriate, and reported to the appropriate oversight body. For example, indicators related to Compliance with the Consent Decree will be reported from the field from each of the functional areas. These data will be aggregated by the data analyst assigned to the Compliance Plan, cross-checked against the established Compliance Tool and reported to the Compliance Officer. The oversight structure and process will be described in further detail in a later section. However, the Compliance Plan, Quality Assurance and Risk Management strategy will all be data driven processes grounded in aggregating data from multiple sources and reporting on those findings to the appropriate oversight body.

2. Compliance Plan

The Compliance Plan is the primary mechanism through which fulfillment of the requirements of the Consent Decree is assured and maintained. The Plan is designed to assess and monitor ongoing compliance with the terms of the Decree, reflecting whether the necessary structures, strategies, services, supports and processes are in place.

The core element of the Plan is the Consent Decree Compliance Tool (see Appendix D) which articulates each of the requirements of the Consent Decree as measurable indicators reflected as either met or not met. For example, the Consent Decree requires that "By the end of the first year after the finalization of the Implementation Plan, Defendants will have (1) offered placement in a Community-Based Setting to a minimum of 256 Class Members who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting…" The Compliance Tool transforms this requirement into the following indicator: "Placement in a Community-Based Setting offered to 256 Class Members, by the end of the first year after finalization of the Implementation Plan (date specified)."

The Compliance Tool covers each of the principle domains of activity involved in implementing the Consent Decree:

- Outreach and Information Dissemination;
- Screening and assessment (including MH PASRR processes);
- Transition coordination and service plan development, including assurance of Class Member choice;
- Housing and residential placement;
- Community mental health and other services and supports.

The Compliance Tool also includes the date of the report, the responsible party and any action taken or necessary to achieve compliance. Compliance Tool indicators will be monitored and reported on an ongoing basis.

The Compliance Plan is to be carried out by two full-time DMH staff, dedicated to assuring and maintaining compliance with the Consent Decree. The Special Assistant to the Director for Long-Term Care is the *Williams* Compliance Officer responsible for aggregating and analyzing data on each of the Compliance Tool indicators and reporting on them to the *Williams* Implementation Team and the *Williams* Steering Committee. Supporting the work of the *Williams* Compliance Officer, is a *Williams* Compliance Data Analyst, who obtains and maintains the data required for each of the compliance indicators by receiving reports from the field and elsewhere. Together with the *Williams* Compliance Officer, this staff member reviews, analyzes and prepares reports on each of the Consent Decree indicators.

3. Quality Assurance

The goal of the Quality Assurance activities is to assure that services, supports, processes and facilities accessed by Class Members meet appropriate standards of quality. That is, for example, a Class Member may receive a named service prescribed in their service plan, but the service may not be delivered as defined or delivered appropriately; the service may not be delivered at the appropriate time, in the appropriate manner, or by the appropriate staff as described in the definition for the service or other established standard.

3.1 Monitoring of Outreach and Information Dissemination

To achieve the terms of the Consent Decree, Illinois is not only interested that outreach and engagement of some Class Members occurs, but that the extensiveness of these efforts and the manner in which they are conducted meet the expectations of the State. To monitor this, the lead supervisor of the individuals contracted to provide outreach and information dissemination services as part of the Implementation Plan will be required to report quantitative and qualitative information to the Deputy Director for Licensing & Quality Management on a regular basis.

Quantitative data will include measures of the amount of information material on the Consent Decree and transition opportunities prepared and distributed (e.g., brochures, posters), the number of group information meetings conducted and the participants, the number of individual informational sessions held, and the number of requests for additional information received and, of those, the number responded to within prescribed time frames.

Qualitative data required will be responses to surveys or focus groups regarding perceptions of how individuals experienced the outreach and information dissemination activities,

including if they felt they were treated with respect, provided information in a clear and timely manner, etc. These data will be gathered on not only the perceptions of Class Members and but also on their families/significant others. A Quality of Life Survey will be given to each transitioning Class Member immediately prior to transition. These results will create a baseline and the same survey will be re-administered six months post-transition and annually from the date of transition.

3.2 Monitoring Screening & Assessment of Class Members

Central to ensuring quality services is utilizing qualified mental health professionals to conduct PASSR screenings and assessments, determine the individual's level of functioning, and develop individualized Service Plans that reflect best practice standards and accurately documents Class Members' choices. Although the actual MH PASRR screenings and assessments of Class Members will be conducted by the University of Illinois at Chicago, the DHS Division of Mental Health will provide direction and oversight to the hiring of the mental health professionals to ensure they have the requisite education, training and experience to provide appropriate screenings and assessments of Class Members. The supervisor of these staff will be expected to report to the Deputy Director for Licensing & Quality Management the number of screenings and assessments conducted by type (e.g., initial, review or re-evaluation), who was screened and the results (e.g., level of functioning determinations).

In addition, the Deputy Director for Licensing & Quality Management will assure that samples of the documentation of the MH PASRR screenings and assessments of Class Members are periodically drawn and reviewed by DMH clinicians to assure that they meet the State's expectations, including consistency with established procedures, completeness, clarity, and timeliness.

3.3 Monitoring Transition Coordination, Service Plan Development, and Class Member Choice

Also integral to quality assurance is ensuring that proper service linkages are available and effected and that services are offered within reasonable proximity to the selected residential setting in order to ensure the appropriate level of support to Class Members transitioning to community-based settings. Ongoing monitoring of residential selections, service providers, service options and geographic location will ensure that proper linkages are available, accessible and consistent with Class Members' choices. The contracted independent Transition Coordination Unit (TCU) staff are the key agents who will work with *Williams* Class Members to plan each Class Member's transition and develop a Service Plan which reflects the Class Member's choices. This plan, based on the screening and assessment information obtained, will recommend the types of services that will assist the individual in transitioning to a community-based setting, the timetable for completing that transition, and

the services and supports needed to live and sustain in a community-based setting. The TCU staff will be expected to interact with Class Members in a manner consistent with a vision of Recovery for each individual, and to develop service plans that support the individual's Recovery goals. During transition and the first year afterwards, the TCU staff will also be responsible for monitoring the implementation of all Service Plans by working closely with the Class Members and community provider(s) to ensure Class Members are receiving the services they need in the community, and, if necessary, adjusting and changing Service Plans. The Director of the TCU will be expected to provide to the Deputy Director for Licensing & Quality Management periodic reports detailing the number of meetings held with each transitioning Class Member, both before and after the actual move into the community, number of service plans completed as well as the number revised, and the number of Quality of Life surveys administered at each prescribed time point. Most importantly, however, the Director of the TCU will also be expected to track and aggregate for reporting exceptions or difficulties in achieving linkages prescribed in service plans, including the identification of any trends, such as by service type, provider, or geographical area.

In addition, periodically the TCU Director will oversee the execution of focus groups or surveys of both Class Members and service providers to assess their perspective of the transition and linkage process, including its effectiveness, clarity, timeliness and the appropriateness of interactions, contacts, and communications. The Deputy Director for Licensing & Quality Management will assure monitoring of the work of the TCU by having samples of Service Plans periodically reviewed by clinicians according to criteria, including whether the Plans reflect client choice, a Recovery orientation, needed services, identified providers and supports and linkage processes. Service Plans not appropriately completed to meet the State's expectations will be identified, and the TCU directed to take corrective action, including additional training or plans of correction if necessary. After the TCU has completed its year of follow up for a Class Member, the Deputy Director for Licensing & Quality Management will oversee staff who will continue to monitor Service Plans and their implementation.

3.4 Monitoring housing and residential placements

Williams Class Members may be appropriate for and choose from an array of housing and service options. These include DMH-funded residential service programs, PSH and new model variations, such as Fairweather Lodges and Transitional Living sites, and other alternative housing options, such as moving in with family, friends or other independent housing options.

3.4.1. Monitoring of Residential Services

DMH is currently developing a Residential Rule that will cover Supported, 24-hour Supervised, and Crisis Residential settings. These settings provide not only housing, but also

some on-site treatment and support services to their clients. This Rule includes specific standards that will be monitored by the DMH Quality Bureau. Findings from reviews of providers of services to *Williams* Class Members will be included in the reports of the DMH Quality Bureau for discussion of any necessary actions.

This Rule also specifies the standards a residential provider and its sites must meet for both initial and re-certification determination. These include standards for life safety requirements, appropriate staffing for the setting, the size and design of units, and maintenance of units. The DMH Quality Bureau will survey these residential programs for initial licensure and certification and recertification. In addition, onsite post payment reviews conducted by the DMH contracted entity will verify documentation of the nights of care individuals received as well as treatment services provided, with the results of these reviews also shared with the DMH Quality Bureau.

It should also be noted that DMH plans to begin requiring that all individuals residing in these residential settings are authorized before entry and annually thereafter. The purpose of this authorization is to ensure that individuals are in the settings most appropriate to their level of need. If a person is found inappropriate for their current level of housing, a process, including discussion with the individual and location of alternative housing and services, will be initiated. When such a change in residential placement is undertaken, the TCU unit or Quality Bureau will monitor the move and identify and document any problems or difficulties that arise during the change in housing.

3.4.2 Permanent Supported Housing Monitoring

Permanent Supported Housing (PSH) units are not owned or controlled by the State and are not necessarily inclusive of on-site treatment and support services. To ensure that these privately-owned units meet a minimum set of standards, DMH will contract with its Subsidy Administrators to inspect these units utilizing the federal Department of Housing and Urban Development's "Housing Quality Standards "(HQS) the same instrument used for HUD's Section 8 housing. HQS establishes the minimum level of acceptable housing quality with respect to the following categories:

- Sanitary facilities
- Food preparation and refuse disposal
- Space and security
- Thermal environment
- Illumination and electricity
- Structure and materials
- Interior air quality
- Water supply
- Lead-based paint

- Access
- Site and neighborhood
- Sanitary condition
- Smoke detectors

HQS standards are not the same as local building codes (for new construction) or local housing codes (for existing housing). HQS standards are established to guarantee a basic level of decent, safe, and sanitary housing, but not so high as to restrict the availability of passable units, or to make large numbers of habitable units unavailable in areas where housing supply is more limited. HQS standards are used in conjunction with local codes to enforce and ensure safe, decent, and sanitary housing.

The Subsidy Administrators will conduct Housing Quality Standard (HQS) Inspections for any prospective unit to be leased under DMH Permanent Supportive Housing. Prior to any unit being leased to any DMH–sponsored and subsidized consumer, that unit must pass an initial and annual HQS inspection to ensure that the consumer is afforded a safe, decent, and sanitary place to reside. Subsidy Administrators will also inspect units annually to ensure they continue to meet standards. Unit owners must respond to any failure to meet standards.
The Subsidy Administrators will be required to file periodic reports of their housing inspections, including the number of inspections completed, for which Class Members, and the results of the inspections, with the Deputy Director for Licensing & Quality Management.
As DMH develops and supports new housing models, such as Fairweather Lodges and Transitional Living sites, the same quality processes will be applied.

3.4.3 Independent Housing

The Implementation Plan recognizes that Class Members may elect to transition to other housing options, such as moving in with families, friends or other independent living units not developed or supported under the Implementation Plan. Although the State will have no direct control or authority over the quality or location of these housing options, Class Members electing independent housing units will be afforded the full range of services and supports offered to all other Class Members. During the first year, the TCU will monitor Class Members living in independent settings and, if requested by the Class Member, will assist them in moving into a housing option developed or supported under the Implementation Plan, if they should elect to do so. This monitoring responsibility will be assumed by the DMH Quality Bureau after the Class Member's first year in the community.

Regardless of their housing arrangement, TCU, DMH and provider staff will encourage Class Members to first attempt to resolve any housing concerns or complaints with the landlord, property manager or property owner. In addition, though, Class Members will also be

provided with information about how to receive advocacy assistance and support through DMH.

Community housing for Class Members is expected to be maintained at the same level of minimum standards throughout their residence there. Property managers, landlords, or owners for housing units to which Class Members have transitioned which fail to be maintained at minimum standards will first be given an opportunity to repair/resolve the problem. If, in the opinion of the TCU staff or Quality Bureau staff and the Class Member, the problem is not satisfactorily resolved in a timely manner, the Class Member will be offered the opportunity to transition to another, similar residence consistent with their PASSR screening and Service Plan.

3.5 Monitoring community mental health and other services and supports

Providers of Rule 132 services (Medicaid Community Mental Health Services Program) receive both Certification reviews and Post Payment Reviews. Medicaid Certification reviews are performed by DHS/BALC or DCFS every three years and more often if there are significant findings needing follow up. These reviews are performed on-site utilizing a standardized tool that assesses a provider's compliance across the Rule 132 requirements. These requirements cover everything from fire safety and staff qualifications to record keeping and documentation standards. At the conclusion of the review, providers are informed if their certification will be approved (for a new provider) or renewed (for an existing provider) and if any plans of correction and follow up reviews will be required.

Post Payment Reviews cover both Medicaid and non-Medicaid funded services that were funded by DMH. The DMH contracted Illinois Mental Health Collaborative performs these on site reviews of providers annually utilizing a standardized tool that assesses a provider's Rule 132 compliance connected specifically to a sample of billed services. At the conclusion of the review, providers are informed of findings. Unsubstantiated claims must be voided and significant findings or trends in findings can require that a plan of correction be prepared by the provider and submitted to DMH for approval and monitoring. Findings from Certification and Post Payment reviews of providers of services to *Williams* Class Members will be included in the Quality reports the DMH Quality Bureau shares with the *Williams* Quality Improvement Committee for discussion of necessary actions.

With respect to monitoring other non-mental health services and supports to Class Members, the TCU and Quality Bureau will be expected to report any concerns with services not meeting standards or the expectations to the *Williams* Implementation Team. Frequent or persistent concerns will lead to involvement and collaboration with any other relevant ongoing monitoring and sanctioning process (e.g., the monitoring processes conducted by DHS Division of Alcohol and Substance Abuse) or the development of any necessary additional monitoring processes.

4. Complaint Resolution and Risk Management

The goal of the Problem Resolution and Risk Management strategy is to effectively resolve problems and proactively identify, mitigate, manage and remediate risk. This applies to problems and risks posed both to the individual Class Members and to the system itself.

4.1 Complaints, Grievances & Appeals

DMH defines a complaint as a formal expression (verbal or written) of dissatisfaction filed by a consumer (including Class Members), a designated representative of the consumer, or a State contracted provider of services. In contrast, DMH defines a grievance as a verbal or written expression of dissatisfaction concerning a violation of written rights, rules, statutes or State contract terms, such as those defined in the Illinois Mental Health and Developmental Disabilities Code, the Mental Health and Developmental Disabilities Confidentiality Act, the Health Insurance Portability and Accountability Act (HIPAA), the State's Administrative Rules and State contracts.

DMH expects *Williams* Class Members to utilize the same complaint and grievance processes made available to all mental health consumers, the toll free phone line published in the DMH "Consumer and Family Handbook", which will be provided to all Class Members transitioning to community settings and reviewed with them during the transition process. This toll free line serves not only to collect complaints and grievances, but also as the means for obtaining assistance formulating and clarifying any complaints or grievances, as well as obtaining answers and resolutions.

Similarly, DMH expects State-funded providers to also utilize existing processes for filing their complaints and grievances, which for DMH providers means first contacting the appropriate DMH Regional Office.

Regional offices and the staff of the toll free line will be asked to report complaints and grievances regarding Consent Decree issues and Class Members separately and on a more frequent basis to the Deputy Director for Licensing & Quality Management. In addition, appeals on these issues and from these Class Members will be handled differently, with appeals heard directly by the Associate Deputy Director for Transition Coordination and, if not satisfactorily resolved, the DMH System Rebalancing Deputy Director. These measures will expedite the resolution of issues and concerns regarding the implementation of the Consent Decree. In addition, with data from these processes provided to the Deputy Director for Licensing & Quality Management, changes in policies, processes or resources can be more quickly planned and executed.

As an example of a possible complaint, as part of the MH PASRR and Transition Coordination process, Class Members will undergo an assessment, by a qualified mental health professional, to identify strengths and level of care needs. The results of this assessment along with information from the Class Member regarding their housing preference will inform the recommendation about the most appropriate residential option to which the Class Member should transition. In the event that the Class Member disagrees with the MH PASRR and TCU recommendation, they may file a complaint using the established toll free complaint line. If not satisfied with the proposed resolution, an appeal can be filed with the Associate Deputy Director for Transition Coordination, and further appealed to the DMH System Rebalancing Deputy Director final administrative determination. In such cases, one likely proposed resolution to be offered will be a re-assessment after 120 days. This reassessment will incorporate progress reports on skill enhancement since the time of the initial MH PASRR determination.

4.1.1 Abuse & Neglect Reporting

Any reports alleging abuse and/or neglect of a Class Member will be referred immediately to the Office of the Inspector General (OIG) for investigation and resolution per DHS Rule 50. The DMH Quality Bureau will receive notice of these types of reported cases and receive resolution reports from the OIG.

4.2 Risk Management

The Draft Implementation Plan seeks to anticipate risks and establish structures and processes which eliminate or mitigate those risks. However, because the Implementation Plan involves many dynamic and highly individualized processes, it is impossible to anticipate every potential risk. Therefore, the Risk Management strategy also sets forth the response to unanticipated risks that arise and the procedures for evaluating and remediating the risk.

There are several types of risk that may impact a Class Member. For example, if a Class Member has inadequate service linkage upon transition to a Community-Based Setting, that presents a risk to the Class Member's successful community transition. Medicaid ineligibility, housing loss and crisis destabilization are additional examples of potential risks posed to individual Class Members.

The risk management strategy also seeks to anticipate, mitigate and remediate risk posed to the system as a whole. For example, Outreach Workers, whose access to Class Members is either delayed or denied, presents a risk to the system that must be addressed.

The risk management strategy will rely on data aggregated from the field and a variety of other indicators to assess individual and system risk and identify the necessary action steps to

effect timely remediation. Appendix E lists anticipated risks and proposed remediation for each of the five functional areas of the Implementation Plan. This is not an exhaustive list, and the Risk Management strategy will compile and analyze other risks that arise during the course of implementation. In addition, trends, patterns and frequency of unanticipated risks will be monitored and used to make any needed adjustments in the overall risk management strategy.

4.3 Sentinel Indicators

Sentinel indicators are those events or circumstances, which pose a significant risk either to the Class Member or the system. There are three types or levels of sentinel indicators which can occur during any of the five functional phases of the Implementation Plan: barriers, disruptions and critical incidents. A barrier is an issue or circumstance that prevents further movement in the transition process. This would include any identified reason a Class Member is not transitioning, ranging from delays in placement in identified housing to change in the willingness of a Class Member to transition. A disruption is any event that interrupts the established community placement process of a Class Member. Examples include a move to another residential setting or a delay in obtaining proper service linkage subsequent to a change in needs. A critical incident is any event that threatens the established community placement of a Class Member such as eviction, hospitalization, injury or arrest. All risks identified will be remediated immediately and referred to the *Williams* Implementation Team (described in detail below) for further analysis or action.

The DMH Quality Bureau will be responsible for collecting, categorizing and analyzing sentinel indicators that develop during the course of implementation, and provide recommendations for DMH and the State in prioritizing its actions and resource deployment to most effectively meet the compliance and quality requirements of the Consent Decree.

4.4 Root Cause Analysis

A root cause analysis is a detailed, retrospective, problem-solving review aimed at identifying and addressing the underlying, core reason for difficulty. This focused, problem-solving approach is based on the idea that problems are best solved by eliminating root causes, rather than surface problem resolution. Critical incidents, that represent a serious risk to the Class Member, may undergo a root cause analysis as deemed appropriate by the DMH Quality Bureau or the *Williams* Implementation Team. Critical incidents in particular may require this level of detailed review to ensure that core issues are addressed and resolved so that they do not present a continuing risk to either Class Members or the system as a whole. Root cause analyses will be conducted by the DMH Quality Bureau and results made available to the *Williams* Implementation Team so that alterations in policies, processes or resources can be considered.

5. Compliance, Quality Assurance and Risk Management Structure

The central organizing body of the Compliance, Quality Assurance and Risk Management Plan is the *Williams* Implementation Team. This is the primary entity responsible for the planning and operations of the Implementation Plan. The *Williams* Implementation Team (WIT) incorporates and responds to data and information from the processes above as well as other Quality Assurance functions (such as those in other State departments and agencies) and reviews and assesses system performance as a whole. Members of the *Williams* Implementation Team are staff of lead State agencies (DHS, DMH, HFS and IDPH) and other key system stakeholders. The WIT provides reports to the Steering Committee (comprised of agency leaders and representatives) on progress of the Implementation Plan as well as all other aspects of system performance. The WIT reviews and analyses risk management and outcome data, in addition to data on key performance indicators as part of their ongoing assessment of system performance.

The Compliance Officer, relying on the Compliance Tool and other performance indicators, reports to the WIT on the status of the Compliance Plan. The WIT is charged with immediately addressing and remediating any issues that compromise compliance with the Consent Decree. The Compliance Officer also reports these data to the Steering Committee which has the responsibility of oversight for the larger system rebalancing effort.

6. Continuous Quality Improvement

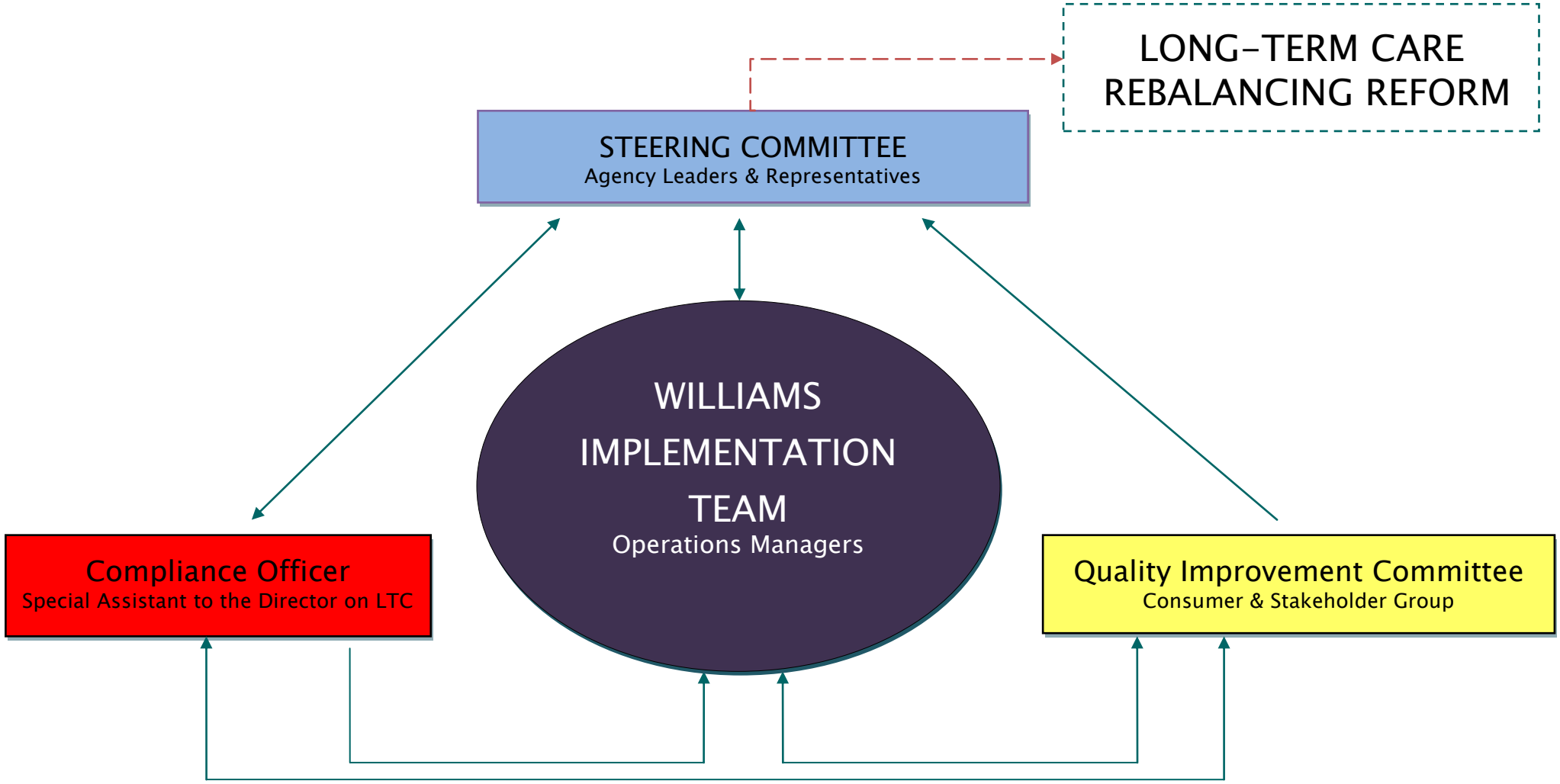
The Implementation Plan will be subject to ongoing review, revision and modification during the term of the Consent Decree. Relying on data from multiple sources, assessment of the execution of the Implementation Plan and overall system performance will be a continuous process. As data on system performance is gathered, it will provide the basis for system adjustments and Implementation Plan revisions. The data-driven adjustments will ensure that the plan and system remain responsive to Class Member needs and choice, and that the State's expectations with respect to quality are assured in the processes, services and housing selections.

The two major continuous quality improvement mechanisms are the Quality Improvement Committee and the DMH Quality Bureau. The Quality Improvement Committee, comprised of consumers and key system stakeholders, reviews data on consumer and provider satisfaction surveys, Class Member appeals, quality reports and outcome data. The Quality Improvement Committee (QIC) communicates consumer-focused performance data to the WIT and the Steering Committee. The WIT, in turn, communicates information on system performance and risk management issues to the QIC for review and input. The QIC also

exchanges information with the Compliance Officer on the status of compliance with the Consent Decree and other relevant performance indicators. The components and processes of the quality assurance activities are depicted on Page 70.

All of the above efforts are supported by the DMH Quality Bureau (lead by the Deputy Director for Licensing & Quality Management), which has primary responsibility for assisting the WIT in identifying and remediating critical system performance and risk management issues. The WIT and the Quality Bureau may refer issues to either to the Compliance Officer or the QIC for follow-up as appropriate.

IMPLEMENTATION PLAN QUALITY ASSURANCE PROCESS



Data Source
- Compliance Indicators
- Performance Indicators

Data Source
- Risk Management Data
- Outcome Data

Data Source
- Consumer Satisfaction Surveys
- Quality Reports
- Outcome Data

INFORMATION SYSTEM SUPPORT

1. Description/Purpose

The State must have the capacity to systematically collect, analyze and interpret data for all *Williams* Class Members across multiple service delivery systems, treatment settings and payers to support assessment, transition planning, residential placement planning, monitoring, outcome evaluation and quality assurance and improvement activities. Data must be collected from a wide range of sources including DMH contracted MH PASRR vendors, Outreach Workers, transition coordination entities, housing subsidy administrators, State psychiatric hospitals, nursing facilities/IMDs and community mental health agencies. For individuals in the *Williams* Class, the collection of information must begin with outreach to nursing home/IMD residents, and follow them across each service delivery system that is touched after discharge. This may include other IMDs, State psychiatric hospitals, community mental health agencies and other service providers. Additionally information with regard to housing options and residential placement must be tracked and monitored.

The State does not expect that there will be one overarching all encompassing information system, however it does envision information systems that have platforms that are interoperable such that information is easily exchanged and shared amongst designated institutions/agencies responsible for providing care and support to *Williams* Class Members, as well as to the Transition Coordination Units responsible for developing and implementing transition plans. Information that is collected will include data specific to each consumer such as physical and psychiatric status, the results of evaluations and assessments that are performed, service and housing preferences, services provided, and the outcomes associated with these services. Historical data must be maintained and easily accessible so that it can inform on-going care and service/treatment planning.

Described below are high level data requirements needed to support DMH in implementing services to address the *Williams* Lawsuit. The current information that is collected resides in the following information systems: Healthcare and Family Services (HFS), the Department of Human Services (MIS/HCD, MIS/PAS-MH), DMH, DHS-Division of Alcoholism and Substance Abuse (DASA), in Nursing Facilities (IMDs), the Illinois Housing Development Authority (IHDA) and within DMH contracted vendor information systems. Gaps in required data, as identified through a systematic requirements analysis, will be addressed using the information technology strategy approach described below.

The implementation timeline calls for *Williams* Class Members to begin receiving services immediately once the Implementation Plan is approved. The State envisions working

diligently to develop interfaces to integrate systems and data that currently exist, and to begin development and system expansion where necessary. It is likely that the full system as envisioned may not be totally automated by the start of services; however an interim solution will capture data to provide support during the implementation.

1.1 Assumptions

All facilities/agencies providing treatment are part of the treatment continuum, thus all are expected to provide information that is needed for care coordination, transition and service planning, treatment planning and continuity of care. This includes State hospitals, nursing facilities/IMDs, housing subsidy administrators, community mental health agencies and other vendors who are contracted to provide services.

- Policies and procedures related to reporting requirements within established timeframes will be implemented across all agencies and for all contracted vendors. The integrity of this data will be assessed regularly.
- State and Federal Confidentiality and HIPAA requirements support the exchange and sharing of information.
- The IT systems through which data is collected to support decision making with regard to transition planning, service delivery and the selection of residential settings for *Williams* Class Members are interoperable, thus allowing for the efficient and effective exchange of information.
- Information requirements for reporting to the Court, State and Federal agencies are met.

1.2 High Level Overview of Requirements

There are five major service components that are the focus of the Draft Implementation Plan: Outreach to *Williams* Class Members, Assessment (MH PASRR), Transition Coordination, Community-Based Services and Housing/Residential Services Development. Data will need to be collected to support decision making and planning associated with each of these components. This data will also provide information for monitoring, evaluation, outcome assessment, and quality assurance and improvement activities. Examples of the type of data required are detailed below; however please note the data elements are representative rather than an exhaustive list.

1.2.1 Outreach and Information Dissemination

The provision of accurate and consistent information is critical to Class Members' understanding of their rights under the *Williams*' Consent Decree so that they may make informed choices and decisions with regard to transitioning from nursing facility level of care to community-based living and service options. Outreach Workers, who work directly with

members of the *Williams* Lawsuit class, will be responsible for providing individuals, as well as family and or guardians, with information with regard to their rights, community-based service and housing options, benefits and entitlements. It is imperative that a database be established to capture consumers/family members' requests for information, individual consumers' interests and preferences with regard to services, housing and geographic living preferences. It is also important to capture information that will permit the State to monitor the outreach process (e.g. type of outreach, number of contacts, information provided etc) as well as the results or outcomes of outreach activities. This information will be tracked for those individuals who choose to transition to community settings, as well as for those individuals who choose to remain in IMDs. It will also provide the basis for follow-up periodically with individuals who fall into the latter group.

1.2.2 MH PASRR

Individuals residing in IMDs will be evaluated by DMH and HFS Mental Health Pre-Admission Screening/Resident Review (MH PASRR) providers (established through an intergovernmental agreement with UIC) to assess consumers' needs and preferences with regard to potential transition from IMDs to community residential living alternatives. The results of the assessment will be used as a basis for making recommendations regarding level of care needed, and services and supports required to support the transition to community living. The MH PASRR provider is responsible for collecting and reporting all required information as established by DMH. Required information includes, but is not limited to, level of care recommendations, Level of Care Utilization Scale (LOCUS) scores, the results of clinical evaluations, consumers' strengths and their preferences with regard to residential setting and community-based services, and service recommendations. It will also be important to have access to historical information regarding prior services. This information, in addition to information gleaned from the outreach process, will be used as a basis for transition and service planning for those individuals who choose to move to a community residential setting.

1.2.3 Transition Coordination

The Transition Coordination Unit whose service plans support transitioning *Williams* Class Members to the most appropriate community-based options will need access to information generated from the MH PASRR assessments, as well as information from IMDs and Outreach Workers. Ultimately however, this entity will need information from all service providers and payers engaged with the consumer to develop transition strategies and plans, to develop service plans, monitor transition outcomes, and to develop risk assessment and mitigation plans. Outcome data associated with the transition process itself will also be collected.

1.2.4 Housing Services

The State is committed to developing an array of housing and residential alternatives, driven by the need and choices of the *Williams* Class Members. Residential alternatives will include Permanent Supportive Housing, as well as supported and supervised residential options. It will be imperative to have readily available information derived from a variety of sources included but not limited to: monitoring pursuant to the new DMH residential rule, annual inspections of residential sites which will occur to assess and assure the quality of these settings, information with regard to housing stock and availability of residential services.

1.2.5 Community-Based Services

The State has made a commitment to assure that *Williams* Class Members have ready and timely access to treatment. As noted above, service plans will be developed with the individual to assure coordinated and integrated delivery of services. A wide array of information must be collected to support monitoring, process and outcome evaluation and to assure quality of services, as well as to provide information to implement quality improvement strategies to support continual system improvement. Information collected will include key elements/components of service and treatment plans, consumer preferences, strengths and needs with regard to home, community and work, the results of evaluations and assessments, the type and amount of services provided, treatment outcomes, information with regard to residential/housing arrangements, as well as demographic and other descriptive information. Consumer perception of care surveys will be administered to gather information directly from *Williams* Class Members regarding their perception of access to services, quality and appropriateness of services, satisfaction, outcomes associated with services, and social connectedness.

1.2.6 Quality Assurance and Improvement

The State has developed a comprehensive quality assurance strategy to assure that data collected from each of the service components described above is systematically used for monitoring and to support decision-making on a day-to-day basis. Data collected will be analyzed, interpreted and used to drive quality improvement processes and efforts.

2. Decision Support/Information Technology Approach

2.1 Overview

As noted above, the State does not envision a single information system to capture the data needed to support implementation of the *Williams* Consent Decree. The vision is to assure that all information systems to which data is submitted are interoperable such that information

can be integrated to support planning, service delivery, monitoring, process and outcome assessment and quality assurance and improvement. Some information is currently collected that addresses the data requirements described above, however additional data collection strategies will need to be developed and built. Currently, data resides in the following information systems: Healthcare and Family Services (HFS) and their partner—the University of Illinois, the Department of Human Services (MIS/PAS-MH), the Illinois Housing Development Authority (IHDA), the DHS Division of Alcoholism and Substance Abuse (DASA), DMH-Value Options, in Nursing Facilities/IMDs, within DMH contracted Vendor information systems and with the Department of Public Health. Every effort will be made to leverage existing systems and to build interfaces that support the implementation and on-going treatment/service delivery and monitoring.

2.2 Approach

The State envisions a five part strategy to put an appropriate IT solution in place: Requirements Gathering and Planning, System Design, Build and Testing of New Components/Interfaces; Deployment of IT Solutions/Components and On-going Maintenance and Improvement as required. This approach requires active involvement of all agencies that are participating partners in the *Williams* Implementation Plan to collect data that is pertinent to the implementation.

2.3 Requirements Gathering and Planning

This phase of the decision support/IT strategy will focus on the following tasks:

- Convening meetings with key Departments/Divisions to determine data requirements
- Documenting business requirements extrapolated from the Decree by meeting with subject matter experts and reviewing the Implementation Plan documentation created
- Determining the System Approach – Where possible, DMH will leverage existing technology investments and will incorporate technological innovations to streamline collection of new data elements. The State may determine that some components can be built internally, again by developing interfaces; some components may be purchased
- Developing a system plan and incorporating it into the overall *Williams* Implementation Plan with specific tasks, objectives and timelines.

A draft requirements analysis will be completed by late March 2011.

2.4 Design Phase/Functional Specifications

Once the data requirements analysis is complete, functional specifications will be developed. The following tasks will be undertaken:

- Design of data interfaces
- Design of security controls
- Development of operational definitions for new data elements
- Design of screen entry to capture new data elements
- Design reports
- Design Batch Processing and other modes of data submission

2.5 Build and Test Phase

Once functional specifications are developed, programming to develop interfaces and new system components as required can begin. This phase encompasses the following tasks:

- Coding/programming based on functional specifications
- Testing of individual system components
- Systems testing
- Testing of integration of interfaces
- Performance Testing
- Documentation/Manual Development
- Development of training material
- Development of monitoring and data integrity strategies

Please note as above, there may be several releases before this phase is completed.

2.6 Deployment

The deployment phase requires the following issues to be addressed:

- Provision of training (internal and external)
- Data integrity checks and monitoring of reporting/data submission
- Generation reports

2.7 On-Going Maintenance

It will be necessary to provide the following on-going maintenance and support

- On-going support and technical assistance
- Application maintenance and improvement

BUDGET NARRATIVE

In FY 2011, the State is investing the amount of $1.393 million dollars as start-up funding to develop the necessary processes, operational procedures and protocols to effectively meet the timeline requirements for full implementation upon final approval of the *Williams* Implementation Plan in June 2011.

Over the next five months, the State will be required to have the following components detailed and operationalized:

- Strategic planning and organizational development
- Development and implementation of training programs
- Data and systems reporting design
- Outreach and Information disseminated
- Readiness for professional assessments and transition determinations and decisions

Funding will be used to execute the aforementioned tasks that are fundamental to assuring the State's ability to fulfill the core elements of the Consent Decree. Consistent with the Draft Implementation Plan, the FY2011 Budget Narrative detail below is organized around each functional element to ensure implementation or implementation readiness.

Element I: Outreach and Information Dissemination - 1 FTE position

This position is directly responsible for developing processes and protocols that will govern the work product of the Outreach Workers and information disseminated on choice to transition. This position will ultimately supervised these contracted staff, as well as manage the contract deliverable with the University of Illinois for the MH PASRR process. Additional funds are allocated for development of materials and supplies.

Element II: MH PASRR – recommended Intergovernmental Agreement (IGA) with U of I

This IGA ensures expediency to retain professional, experienced and credentialed staff to conduct the necessary assessments of Class Members, Healthcare and Family Services has recommended expansion of the Money Follows the Person contract with U of I Department of Nursing to conduct the resident reviews for *Williams*. This will ensure that resident reviews can start as early as September 2011 and that the necessary database will be designed. This amount will be start up funds to hire staff. Included in this amount is $10,000 identified for specialized consultation services (as needed) for any emergency transitions requests prior to an approved Transition Plan.

Element III: Transition Coordination Unit – 2 FTE positions

The individual hired for the staff position, Associate Deputy Director of Transition Coordination, will develop the specifications of the RFP for a Transition Coordination Unit and to subsequently manage the deliverables and productivity of the awarded vendor. The TCU is the cornerstone of the Class Members transition processes and the efficiency and effectiveness of the individualized transition efforts. The second person is for Clerical Support and this is shared with the Associate Director of Assessment.

Element IV: Housing Options – 1 FTE position

The availability of affordable housing options is fundamental to the stability and success of individuals transitioning from IMD. These options will require a considerable amount of networking and resource development to address the multiple needs of Class Members and their respective level of care needs to live in community settings. The incumbent will work with IHDA in property development/partnership efforts to ensure that 640 PSH housing units are identified and other housing options are identified as the needs exist. Without sufficient and diverse housing stock, the intent of the *Williams* Decree cannot be met.

Element V: Community Service – 4 FTE positions

As housing is fundamental to stability, the assurance that community services are available and accessible is paramount to a Class Members Recovery. There are basic mandates in the Consent Decree that must be addressed and that will necessitate manpower to produce the necessary products. There are also community-based mental health services that must be expanded or developed in the existing service network. These positions, which include analysts and clerical support, will be essential to ensure that Class Members have the appropriate treatment resources necessary to support their transition.

Element VI: Quality Management – 1 FTE position

Overarching of all of the work efforts and transition outcomes of Class Members will be and assurance of quality performance. This will be the responsibility of the Deputy Director of Licensing and Quality Management. This position is instrumental in developing protocol to track and monitor performance and service delivery, and quality of care outcomes and satisfaction of Class Members.

Element VII: Information Systems – 3 FTE positions

Information Technology is the systems interface with data, reports and collection information. IT serves as the cornerstone and centralized repository of operation and is the mechanism in

which the State will be able to track consumer and production outcomes. This budget includes 2 Business Analysts/IT Specialists and 1 Administrative Assistant. Additionally, and to ensure expediency, it will also be necessary to contract with the existing Administrative Services Organization, Value Options, to develop interfaces between DMH's existing IT system and other State and community agencies to capture required data relevant to implementation of the Consent Decree.

Administrative Functions

Function 1: Administration and Compliance – 1 contracted position.

The Special Assistant to the Director for Long-Term Care reports directly to the DMH Director and will monitor compliance with the Consent Decree. Functioning as the Compliance Officer for the *Williams* Consent Decree will also serve as the primary public relations contact for all information concerning *Williams* and providing policy direction as appropriate.

Function 2: Training – 3 FTE positions

A comprehensive, detailed training curriculum with an extensive orientation component to the multiple systems involved in the lives and wellness of Class Members and a robust training protocol is absolutely essential requirement before any contracted or hired staff person in either outreach, assessment or transition enters into any engagement activities. Concurrently, there will be retraining requirements for all direct care staff who will assume service responsibility for *Williams* Class Members. DMH plans to immediately bring on the Training Coordinator and two training Assistants to begin to develop the training curriculum and training materials.

Function 3: Fiscal Services – 1 FTE position

This position will be created to manage the fiscal processes required to facilitate all financial activities and supports associated with the Implementation Plan and its related expenses.

APPENDICES