WILLIAMS CONSENT DECREE IMPLEMENTATION PLAN FY21

JULY 15, 2020

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I. Introduction

Pursuant to the requirements in the *Williams* Consent Decree, the following represents the Implementation Plan Amendment for Fiscal Year 2021. This Amendment contains the State's targeted activities and processes intended to achieve compliance with the Decree.

Although not specific to the *Williams* Decree, the State is also embarking on some significant changes to the manner in which both the *Williams* and *Colbert* Decrees, as well as the relevant systems as a whole, are managed as set forth below. In addition, other planned activities, including HFS rate review and adjustments and redesign of the PASRR system, have a large impact on Class Members and reflect larger systems reforms that directly impact Class Members and also reach beyond the Consent Decrees. Further, to the extent PASRR redesign and activities may fall within the Medicaid program, those activities must comport with federal Medicaid regulations. For the purposes of this Implementation Plan, activities in these areas are limited to those that are Consent Decree-specific.

A. COVID-19's Impact on the Implementation Plan for FY21

One caveat for this Implementation Plan is that the unprecedented COVID-19 outbreak currently affecting Illinois has significantly impacted the ability of the Defendants to plan and anticipate needs for FY21, and the ability to address and implement planned changes to the overall system. The response to COVID has increased demands on staff across all agencies resulting in delays to aspects of the FY20 Implementation Plan.

Consent Decree programming, including the Front Door Diversion Program (FDDP) and the new Comprehensive Program, was designed to involve extensive in-person contact with Class Members. Due to in-person contact restrictions in Specialized Mental Health Rehabilitation Facilities ("SMHRFs"), Nursing Facilities ("NFs"), and hospitals (per State and federal guidance) implementation of this programming was severely compromised. While providers are still ramping up in terms of hiring, staffing, and planning, the Comprehensive Program[1] is not fully operational, and thus this Implementation Plan cannot benefit from performance data to identify further modifications and strategies. Defendants will continue to provide the Court Monitor and the Class Plaintiffs with monthly data on Consent Decree activities consistent with past practices.

Further, due to COVID-19, we cannot assign exact deadlines for many IP commitments and instead have provided timeframes based on when the parties enter into what is termed here as the "post-COVID" period (e.g. "three months post-COVID"). For the purposes of this

[11] Under the Comprehensive Program, "Prime" agencies are responsible for contractual obligations they perform directly or through subcontractors, while Defendants retain ultimate responsibility for achieving outcomes required under the Decree.

Implementation Plan, post-COVID refers to restrictions being lifted or other practice modifications being implemented to a sufficient extent to allow providers reasonable access to Class Members and FDDP participants. "Post-COVID" does not mean that COVID-19 no longer exists. Rather, it refers to an environment where Consent Decree operations can be accomplished with clinical quality and safety of Class Members *either* through in-person contacts *or* through other contact means (including telehealth or other telephone or virtual means) with sufficient availability and frequency to allow providers to perform Diversion, Outreach, Assessment, Service Planning, care coordination, and Transition support services required under the Decrees. Post-COVID performance standards will apply once post-COVID access has been sustained for 90 days. To the extent restrictions are reinstituted and those restrictions negatively impact provider access to Class Members and FDDP participants, the "post-COVID" status will be adjusted accordingly.

1. COVID Adaptations

a. Reinvent Workgroup

To address when in-person contact is not feasible under the current circumstances, Defendants are working with FDDP and Comprehensive Program agencies to identify and develop alternate means to conduct essential activities, including Outreach, Assessments, development of Service Plans and even supporting preparation for and Transitioning of Class Members into Community-Based Services and housing. In order to facilitate these modifications and strategies, a work group has been created which includes both State and provider representatives to address Front Door and Comprehensive Program activities (the Restore and Reinvent Williams and Colbert Workgroup).

This workgroup will meet regularly to discuss potential alternatives and/or adjustments to in-person activities and will implement various protocols and strategies continue as much of the Front Door/Comprehensive Program's work as possible. Specifics regarding the plans of this work group are not included in this Implementation Plan, but summaries of the activities, proposals, strategies and outcomes will be provided to the Parties and Monitor on a monthly basis. The expected outcome of this workgroup is to identify best practices for continuing to serve Class Members and FDDP participants in the COVID-19 environment.

The workgroup is scheduled to complete its work by July 17, 2020, with a report outlining the best practices delivered to Parties and the Court Monitor by July 31, 2020. The best practices will include identification of strategies, necessary equipment (including PPE-which providers are utilizing grant funding to purchase), and guidelines for providers to continue transition work. Providers will be required to prioritize those Class Members who have completed all pre-Transition Assessments and activity, and are in the "housing search" phase to expedite those Transitions whenever possible.

b. Telehealth Services and Other Adaptations

In response to the COVID-19 crisis, HFS implemented emergency rules to allow reimbursement for certain previously unapproved virtual Medicaid services. These rules permit using the patient's home or other settings, expand the provider types authorized to provide telehealth, and provide coverage in new and previously unexpected ways. In addition, HFS has maintained face-to-face rates for many services now provided virtually.

During the period of restrictions mandated under COVID-19, efforts are being made to utilize telehealth services to allow activities to continue under the Comprehensive Program. A sixty-day pilot program began on April 27, 2020, and will continue through June 30, 2020, to determine the feasibility of remote work within the SMHRFs and NFs. In addition, alternative telehealth services utilized in other states will be examined. At the conclusion of the pilot, the Defendants will provide a brief written report by July 31, 2020 to the Court Monitor and the Parties about lessons learned, and new policy and practice requirements regarding telehealth services that will be implemented. This will include new telehealth guidance and performance standards for Primes. This report, along with the Reinvent workgroup report, will be discussed in detail during the August 2020 Parties Meeting.

Beginning August 1, 2020, Defendants will work with Prime agencies to assist in the purchasing and configuration of needed technological equipment and software to facilitate the initial statewide rollout of telehealth services to Class Members. Statewide implementation of telehealth services will start on September 1, 2020 on a rolling basis. All Prime agencies are expected to have all of the necessary equipment prior to September 1, and access on the SMHRF side will be achieved by October 31, 2020.

Defendants will have lead responsibility for ensuring that all Class Members in all SMHRFs have meaningful access to the full range of Transition-related services delivered via telehealth. Agencies will be required to identify which, if any, Transition-related services cannot be resumed until in-person access is restored, and these will be considered on a case-by-case basis. Beginning on September, 1, 2020, the date of the telehealth rollout, Prime agencies will be required to maintain records of Class Members with whom neither in-person nor remote access has been possible, so that those Class Members will be prioritized once in-person activities resume. Further, per the Consent Decree, SMHRFs are required to grant access to Class Members, which will be reinforced in a letter sent to SMHRF administrators by September 1, 2020 by IDPH and IDHS, jointly. Follow-up with SMHRFs will be conducted as needed.

As of September 30, 2020, providers will be required to identify any SMHRFs to which they are assigned who are currently unable to facilitate video or telephonic access with Class Members, and the reasons for the lack of access. DMH and IDPH will work with those facilities to resolve the issues. Barriers are expected to be resolved either through the Prime agency or through

assistance from IDHS/DMH and IDPH no later than October 31, 2020. Defendants will continue to work with Prime agencies to continue to refine and improve on the delivery of telehealth services in furtherance of the Decree's objectives.

By December 1, 2020, all Primes must provide Defendants with a report outlining the techniques and strategies they are using to achieve and maintain access to Class Members to adequately perform Diversion, Outreach, Assessment, Service Planning, care coordination and Transition support services required under the Decrees. Defendants shall review these materials and work with the Primes to ensure that the strategic guidance for telehealth can be refined and improved based on the Primes' collective experience in the months following the telehealth rollout to ensure the Primes are using effective practices.

Defendants remain committed to achieving compliance with the requirements of the Decree and implementation of the Comprehensive Program, including transition of Class Members as soon as possible, while ensuring the safety of Class Members and provider staff. To the extent necessary, appropriate benchmarks and timelines will be applied or modified by agreement of the Parties and Court Monitor.

B. Court Monitor Recommended Key Priorities for FY2020 and FY2021

In the status report to the Court on January 22, 2020, the Court Monitor recommended ten key priorities for the Defendants' focus for the remainder of FY20 and FY21. These are as follows, and are addressed as indicated:

1. Complete satisfactory implementation of Defendants' FY20 priority commitments.
    a. This includes expansion of the FDDP to offer Community-Based services prior to SMHRF admission, completion of the Multi-Year Growth Plan, Medicaid rate review, and PASRR reform.
        i. The Medicaid rate review will be completed by HFS by September 30, 2020, to be preceded by a conversation with the Court Monitor regarding HFS' approach and methods.. HFS will provide a written report to the Court Monitor and the Parties by October 15, 2020 on the results, implications, and any next steps regarding Medicaid rate changes to benefit Class Members.
        ii. Efforts to achieve expansion of the FDDP and PASRR reform will continue through FY21 and are discussed in subsequent sections of this Implementation Plan.
2. Apply rigorous project management to the new Comprehensive Program.
    a. This includes prompt start-up, systems development, appropriate spending levels, provider accountability, quality monitoring, and troubleshooting.
        i. As will be identified in subsequent sections, there are specific and identifiable quality assurance, reporting, and project management

requirements built into the Comprehensive Program that will be reported on regularly throughout FY21. Due to the COVID-19 pandemic, the Comprehensive Program was unable to launch as planned FY20, but virtual adaptations are underway as discussed in this Implementation Plan (see Section I.A.).

3. Correct known Outreach issues.
    a. This includes engaging Class Members unable to communicate, increasing frequency of outreach, removing inappropriate subjectivity through shared decision-making tools and re-training.
        i. Improvements to Outreach in accordance with identified concerns are part of the Comprehensive Program and are more fully detailed in the Outreach section of this Implementation Plan.
4. Streamline the FY21 Implementation Plan.
    a. Center on a smaller number of specific, measurable, attainable, realistic and time-limited objectives.
        i. This Implementation Plan reflects the more streamlined approach and contains targeted and specific objectives. Development of time-limits and specific targets/benchmarks are currently impaired by the COVID-19 pandemic and related service delivery restrictions, but anticipated measures are included in this Plan.
5. Continue recent progress to develop a data enterprise system.
    a. This includes data for both quality monitoring and for programmatic and policy planning and decision making.
        i. A significant portion of Consent Decree-related data is contained in the new Comprehensive Program data system. Those data elements and reporting requirements for the Comprehensive Program were established during FY20. Due to restrictions pertaining to in-person delivery of services, initial data will be limited. However, additional elements and measures may be added as system adaptations are developed in response to COVID. As a result of an IDHS and UIC-CON planning effort, revised, accurate and complete Data Dashboards will become available on August 1, 2020 and will be updated and shared on a monthly basis with the Court Monitor and Parties.
6. Create a suite of evidence-based decision support tools and instruments.
    a. These tools and instruments are to reduce subjectivity across processes (i.e. Outreach, Assessment) and supply providers with training for utilization.
        i. Revisions to certain tools were developed through the Comprehensive Program as described in later sections, with the intent to reduce subjectivity. The same tools and quality assurance measures will be applied to the Front Door Diversion Program by University of Illinois

Chicago College of Nursing (UIC-CON). In addition, UIC Jane Adams School of Social Work will be reviewing additional tools utilized under the Comprehensive Program to further address subjectivity concerns and exclusionary criteria. While these tools are under review, UIC-CON will be reviewing outcomes to monitor for subjectivity and/or improper exclusion of Class Members. Defendants will inform the Court Monitor of which decision-making tools are under consideration for redesign, those that are being redesigned, and where progress is being made with eliminating subjectivity and otherwise improving the tools, including where evidence-based practices are added or enhanced. As the review process continues through FY21, additional tools slated for examination after the original list is submitted will be included in subsequent updates to the Court Monitor.

7. Align Medicaid Managed Care Organization (MCO) contracts, processes reimbursement mechanisms and policy with Consent Decree objectives.
    a. To leverage MCOs for long-term care system rebalancing, care coordination and Community-Based services.

        HFS will continue to work closely with MCOs to advance the objectives of the Consent Decree. Specifically, HFS will operationalize the transition incentive program, examine the master managed care contract, offer education and technical assistance activities to MCOs, and explore additional strategies for advancing Consent Decree objectives.
8. Identify necessary regulatory and policy changes (IDPH).
    a. To increase compliance with Consent Decree requirements.
        i. IDPH has filed proposed amendments to its rules under 77 Admin. Code Section 380 that cover SMHRFs. The changes were filed in March, 2020 and as of the date of this Implementation Plan are in the comment period. The amendments: (1) require all facilities display for consumer/resident benefit the right to explore or decline community transition; (2) contain provisions on the consumer/resident's right to be free from retaliation and to report any such issues to IDPH; and (3) require SMHRFs to "provide transitional living assistance to prepare those with SMI issues to reintegrate successfully into community living." As of the date of this Implementation Plan, no comments or opposition statements have been submitted in response to the proposed rule/amendment. As the rules enter the second notice period, the Joint Commission on Administrative Rules (JCAR) has a 45-day review period and this may be extended an additional 45 days should there be issues that JCAR would like addressed. Given that there are no comments or objections received about these rule

changes, IDPH does not anticipate the process taking up to 90 days for finalization. Review will continue into FY21 as feasible.

ii. IDPH will convene a meeting with the Court Monitor and Parties to discuss potential needed rules and regulations to advance Consent Decree objectives and improve compliance. This meeting will take place by October 31, 2020.

iii. IDPH will provide updates on SMHRF accreditation status via the semi-annual reports.

iv. IDPH will provide SMHRF reportable incident data in the Defendants' semi-annual reports.

9. Pursue Defendants' plan to transition Class Members currently on financial holds.
    a. Provide financial support, benefits planning (including SSI/SSDI) and employment opportunities.
        i. SOAR services and expansion of employment opportunities are included in the Comprehensive Program. IDHS/DMH and DRS, have developed a set of strategies to transition Class Members on financial holds which are described in more detail below.
10. Organize and enhance Consent Decree staffing.
    a. Examine current staff roles and responsibilities, adjusting and adding staff as necessary. Recommended for all Defendant agencies as well as IHDA.
        i. IDHS and other agency staffing and restructuring continues to be reviewed and will continue through FY21. To the extent positions are added or responsibilities specific to Consent Decrees are modified, these changes will be reported to the Court Monitor and Parties. IDPH added a dedicated legal staff person to address issues arising under the Consent Decrees and is developing additional staff within the Office of Health Care Regulation to provide assistance as needed on Decree matters. In addition, contractors are being brought in to provide analysis and recommendations in a number of areas, including Front Door and Comprehensive Program. Additional utilization of outside sources will continue to be assessed and will be reported on to the Parties and Court Monitor.
        ii. HFS will establish a new leadership position to advance Consent Decree objectives and compliance. A job description has been created. Upon approval from Central Management Services and then the Governor's Office, HFS will proceed to post/recruit, interview, and seek to hire this leader by November 1, 2020 (subject to hiring processes and the identification/availability of a qualified candidate). HFS will update the Court Monitor on a monthly basis until the position is filled.

C. Targeted Action to Analyze Class Member Characteristics and Evaluation of Comprehensive Program Strategies

In order to better understand the characteristics and potential barriers to transition of *Colbert* and *Williams* Class Members, IDHS will be entering into an Intergovernmental Agreement with UIC-Jane Adams School of Social Work to conduct analysis of *Williams* & *Colbert* Class Members still residing in the facilities and evaluate the progress and outcomes of the Comprehensive Class Program pilot. This analysis will not only assist in development of strategies and services to address the current SMHRF/NF Class Member population, but will also evaluate the Comprehensive Program pilot to assess progress made, conduct a gaps analysis, and provide recommendations for a future NOFO. This analysis is not specific to any one domain, but will inform and guide future strategies designed to increase Class Member participation in Outreach, Assessments, and Transitions, and provide additional data on challenges certain sub-sets of Class Members face in transitioning to Community-Based services and settings.

The proposed scope of services includes the following:

a. Identify demographics and needs of current SMHRF/NF Class Members;
b. Identify any Class Members that fit Consent Decrees exclusionary criteria (definition to be proposed by the Defendants in consultation with medical professionals and agreed upon with the Court Monitor and Plaintiffs);
c. Identify those Class Members who repeatedly decline to participate in an Assessment; and
d. Evaluate the Comprehensive Class Member Transition Program pilot.

This analysis will be completed by June 30, 2021. However, updates and data will be provided to the Parties and Court Monitor throughout the process.

II. Front Door Diversion Program - Offers of Community-Based Services

Pursuant to the *Williams* Decree, any individual "whose Service Plan provides for placement in Community-Based Settings shall not be housed or offered placement in an IMD at public expense, unless, after being fully informed, he or she declines the opportunity to receive services in a Community-Based Setting."

HFS is proceeding with its redesign of the Pre-Admission Screening and Resident Review process. Unlike their predecessor Nursing Facility IMDs, SMHRFs are not nursing facilities and are technically not subject to the Federal PASRR screening requirement.[2] However, the *Williams* Consent Decree expressly imposes a Decree-defined PASRR process. The current process

[2] Subsequent to the entry of the Williams Consent Decree, in 2013 the Specialized Mental Health Rehabilitation Act established a new category of health facilities under Illinois law, separate and apart from the Nursing Home Care Act, licensed by IDPH.

appears to be ineffective at: diverting individuals to Community-Based services, ensuring that individuals meet SMHRF eligibility requirements, and meeting initial Service Planning requirements.

HFS intends to include in the PASRR procurement *a process that will ensure SMHRF admissions are appropriate.* HFS will address PASRR alternative application to SMHRFs as part of its procurement, and will discuss HFS intentions in advance with the Court Monitor and the Parties. This redesigned process will comport with the Consent Decree requirement (Section 8b) that "no individual with Mental Illness whose Service Plan provides for placement in Community-Based Settings shall be housed or offered placement in an IMD at public expense unless, after being fully informed, he or she declines the opportunity to receive services in ~~a~~ Community-Based Setting." Thus, the redesigned process will only offer SMHRF placement at the State's expense if an individual with Mental Illness whose Service Plan provides for placement in Community-Based Settings, declines the opportunity to receive services in a Community-Based Setting.

HFS will use the following milestones and anticipated dates of completion to monitor progress toward implementation of a redesigned PASRR system:

- Consultation with sister agencies, Court Monitor, and Plaintiffs on redesign, especially strategies to ensure a robust PASRR pre-screening process – complete by 8/20/20;
- Finalize Request for Proposal (RFP) requirements – by 8/20/20;
- Post RFP – by 10/1/20;
- Responses to RFP received – by 11/30/20;
- Evaluation proposals, select vendor, and negotiate contract - by 2/26/21;
- Award contract – by 3/1/21;
- Train help desk staff – by 8/31/21;
- System development and configuration – by 9/30/21;
- Draft and publish new HFS policies and protocols regarding redesigned PASRR system – by 9/30/21;
- Execute data use sharing agreements as needed – by 9/30/21;
- Train end users – by 9/30/21;
- Go live with redesigned system – by 10/4/21.

To address the concerns regarding compliance with this Decree requirement, the following actions will take place in FY21:

1. PASRR agents will be provided additional documentation and instruction on the FDDP program (including modification of the IDHS-DMH PASRR manual, informational bulletins and training), and their obligation to first offer FDDP consultation and services

to every individual whose Level 2 screen indicates they would be eligible for a SMHRF level of care, but could instead be served in a Community-Based Setting;

2. FDDP agencies will continue to work to co-locate staff in at least thirteen (13) high-volume hospitals where such staff are permitted, and will work to address barriers to access within those hospitals. For the remaining low-volume hospitals, IDHS/DMH will develop, in consultation with the Court Monitor and Parties, improved diversion strategies by September 30, 2020;
3. FDDP agencies will be required to complete the same trainings as Comprehensive Program to ensure appropriate techniques (such as motivational interviewing) are utilized;
4. UIC-CON will conduct a conflict-free review of a sample of FDDP assessments to ensure the assessment outcomes are objectively supported; and
5. Post COVID-19, explore and report on feasiblity of rapid reintegration program/pilot to allow individuals working with FDDP staff to continue to do so for up to 60 days post-SMHRF admission; and
6. IDHS and HFS will attempt to identify and report on, using available data sources, a method to analyze housing status and type by utilization of FDDP participants pre-hospitalization and upon discharge from hospital settings. A report on the availability of data and a timeframe for analysis, will be provided by August 31, 2020. If such data exists, IDHS will report to the Court Monitor and the Parties on housing status by utilization type for FDDP participants by September 30, 2020.

No.	**Decree Requirement/ Compliance Finding**	**Description**	**Action/Strategy**	**Performance Standard***	**Performance Metrics**
FD1	1 (out of compliance)	All individuals will receive an appropriate screening and have a service plan developed prior to SMHRF admission.	Redesign of PASRR system to meet Federal requirements and evidence-based practice standards, with targeted implementation date of 10/4/21.	Implementation of redesign.	Completion of redesign based on consultant recommendations.
FD2	2 (out of compliance)	No individual shall be admitted to a SMHRF who is appropriate for Community-Based Services without first	Modification of IDHS-DMH PASRR instructions by September 1, 2020, to mandate offering FDDP referrals and	(Performance Goal**) 85% of all individuals offered opportunity to explore Community-Based Services	# of Individuals admitted to SMHRF who were offered FDDP referral *divided by* # of individuals admitted to SMHRF.

		being offered such services.	services for all individuals clinically eligible for SMHRF who could be served in a Community-Based Setting.	prior to SMHRF admission.	
FD3	2 (out of compliance)	No individual shall be admitted to a SMHRF who is appropriate for Community-Based Services without first being offered such services.	Complete co-location of FDDP staff in a minimum of thirteen (13) high-volume hospitals as access barriers are resolved and consistent with safety requirements.	Co-located FDDP staff in 13 high-volume hospitals within 3 months post COVID.*	# of high-volume hospitals with embedded FDDP staff *divided by* 13 high volume hospitals.
FD4	2 (out of compliance)	No individual shall be admitted to a SMHRF who is appropriate for Community-Based Services without first being offered such services.	Post-COVID, explore and report on the feasibility of implementing program/pilot allowing FDDP staff to continue to work with individuals up to 60 days post-SMHRF admission. Report to be completed by August 1, 2020.	Report to be completed within 3 months post-COVID.*.* Post-implementation: (Performance Goal) 85% of individuals who continue to work with FDDP post-SMHRF admission are offered Community-Based services and housing within 60 days[3] of admission.	# FDDP participants offered housing/ Community-Based services within 60 days post-admission to SMHRF *divided by* # of individuals admitted to SMHRF who continue to work with FDDP.

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

** The Parties and Court Monitor agree that requirements with less than the Consent Decree performance standard, as applicable, of 100% are indicated with a performance improvement

[3] For purposes of this Implementation Plan, days will be measured as follows: Fourteen days (14) or less will be measured as business days, and any timeframes over fourteen days will be measured as calendar days.

goal for FY21. This footnote applies to all subsequent tables in this document where a "Performance Goal" is noted.

III. Outreach

Outreach activities will continue to change significantly under the Comprehensive Program, into FY21. While the general nature of Outreach is consistent with that of the prior system, numerous changes have been made to increase accountability, frequency of contacts, availability of full and accurate information on services available in a Community-Based Setting and to reduce delays in proceeding thorough the transition process.

A. Contact Intervals/Tracking/Information

The Comprehensive Program includes clearly set intervals for Outreach for both new and existing Class Members, and stringent reporting and tracking requirements to ensure Class Members are approached at an appropriate frequency.

1. Initial Outreach (Post-Admission)

- All admitted to a SMHRF will receive an initial Outreach attempt within between 60 and 70 days, post-admission
- All existing Class Members (residents post-60 days) who have not previously agreed to participate in transition activities (either by refusing Outreach, refusing an Assessment, or declining to Transition after a recommended Assessment) will receive an initial Outreach attempt from the Comprehensive Program provider within 30 days of the assignment of the Prime Agency.[4]

2. Continued Outreach

During FY21, Defendants will engage the Parties and Monitor on proposed modifications to the Decree to more effectively reach Class Members who have an interest in transitioning, and to reduce the number of attempts made for Class Members who have repeatedly refused all Outreach or Assessment attempts for an extended period of time.

B. Additional Outreach Strategies and Activities

In addition to required Outreach attempts, efforts to engage Class Members have been enhanced under the Comprehensive Program, which will continue into FY21. These include providers

[4] For existing Class Members who did not receive Outreach from the Prime Agency under the Comprehensive Program prior to the restrictions enacted due to COVID-19, the deadline will restart and be counted when "post-COVID" status is reached as defined in Part I.A. To the extent Class Members receive Outreach during the COVID-19 restrictions via remote means (including but not limited to telephone, video conferencing or other means), any such Outreach will be counted as a valid Outreach attempt (either initial or ongoing).

building rapport with SMHRF staff, Class Members and family/guardians through increased presence in the SMHRF, question and answer sessions, community meetings and provision of a "menu" of available services and supports. Additionally, where appropriate, enhanced efforts include taking Class Members into the community to observe different Community-Based settings, including Drop-In Centers and potential housing options.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard	Performance Metrics
O1	4 (partial compliance)	Inform Class Members about Community-Based Settings, including Permanent supportive Housing, and services and financial supports available.	Initial Outreach between 60-70 days of admission.	100% of new CM receive Outreach attempt within 70 days of admission. Measured 3 months post-COVID.	# of CM receiving Outreach within 70 days of admission *divided by* # of CM admitted to SMHRF within 60-70 days.
O2			Re-attempt Outreach every three months/quarterly.	(Performance Goal) 90% of CM receive quarterly outreach attempt. Measured 3 months post-COVID.	# quarterly Outreach attempts *divided by* # CM due for quarterly Outreach.
O3			Create, by July 30, 2020, and have available a "menu" of services, supports, and housing options for Class Members.	100% of CM receive full information/ Menu of services. Measured 3 months post-COVID.*	# of CM provided menu of services *divided by* #/of CM provided Outreach.

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

C. Training/Education to Ensure Consistency in Outreach Activities

To ensure consistency in the delivery of Outreach services and the information provided to Class Members, contracts have been executed which are uniform across all Prime Agencies. Providers are required to complete Web-based training in a number of areas, including Outreach. These trainings began in FY20 will continue during FY21, and are recorded and available online. Included in the training module on Outreach are a number of specific strategies to encourage Class Member engagement, including motivational interviewing techniques.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard	Performance Metrics
O4	4 (partial compliance)	Inform Class Members about Community-Based Settings, including Permanent supportive Housing, and services and financial supports available.	Creation of comprehensive training module for Outreach activities, including service array and motivational interviewing techniques.	100% of Outreach staff completes training within 60 days of start date.	# Outreach staff who have completed enhanced training within 60 days of start date *divided by* # of Outreach staff hired.

D. Ambassadors/Peer Provided Outreach

Comprehensive Program Prime Agencies provide primary Outreach services, but the Ambassador program utilized under the prior system will continue under contract with NAMI. NAMI Ambassadors (Class Members who have already transitioned to the community and provide Outreach services and support), will operate under revised Comprehensive Program requirements during FY21. This includes, but is not limited to holding at least one face-to-face meeting with each Class Member, quarterly re-engagement, and inclusion of family/guardians and attendance at group/community meetings to share lived experiences.

Prime Agencies operating in the Comprehensive Program are also encouraged to utilize Peers to provide Outreach services, separate from the NAMI Ambassadors. Peers may be those who have transitioned from a SMHRF to a Community-Based Setting, or who have lived recovery experiences, including those in recovery from substance use disorders.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard	Performance Metrics
O5	4 (partial compliance)	Inform Class Members about Community-Based Settings, including Permanent supportive Housing, and services and financial supports available.	Increased use of Peer Outreach (Ambassadors and/or peers through Prime Agencies).	(Performance Goal) 10% increase (over FY20's estimated 438 CM) in number of Class Members who receive Peer-Based Outreach, prorated monthly. Measured 3 months post-COVID.*	# of Class Members who receive Peer-based Outreach in individual or group settings *divided by* # of CM receiving Outreach in individual or group settings.

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

E. SMHRF Interference/Non-Retaliation

Effective Outreach requires access to SMHRF residents, and the ability for Prime agencies and NAMI Ambassadors to have unimpeded, private communications with Class Members. Further, Prime agencies need SMHRF administrations to keep them up to date on new admissions. In addition, pending proposed IDPH rules, SMHRFs must display non-retaliation posters in common areas and provide information on how a Class Member can report retaliation when exploring (or declining) community transition. A complaint will result in IDPH survey staff conducting a review of the complaint and investigation, in which the SMHRF must participate. If the complaint/investigation warrants, the SMHRF will be required to submit a plan of correction to IDPH to address the issue.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard*	Performance Metrics
O6	5 (Out of Compliance)	Class Members will not be subject to retaliation in response to any option selected nor shall they be pressured to refrain from exploring appropriate alternatives to SMHRFs.	Send joint letter by September 1, 2020 to SMHRF administrators advising of their obligation to provide unimpeded access to Comprehensive Program agencies to Class Members and relevant information, including admission/census information. Follow up will be conducted as necessary.	100% of SMHRFs provide full and unimpeded access to CM and their records, including census information.	# of SMHRFs who provide monthly census information *divided by* # of SMHRFs. # of CM unable to be contacted due to SMHRF interference/barrier *divided by* # of unduplicated CMs who should have had an attempted contact. # of CM records unable to be obtained due to SMHRF interference/barrier *divided by* # of CM records requested.
O7			Enhanced non-retaliation language in Informed Consent form.	100% of CM who sign (or verbally agree to) Informed Consent receive enhanced non-retaliation information and ways to report.	# of CM who sign Informed Consent with enhanced non-retaliation information and ways to report *divided by* # of CM who agree to sign Informed Consent.
O8			Poster for display in SMHRFs.	100% of SMHRFs display poster in common area.	# of SMHRFs that display non-retaliation poster *divided by* # of SMHRFs sent poster.

O9			Display of poster included as compliance measure.^	Upon establishment of compliance measure, 100% of SMHRFs display poster in compliance with requirement.	# of SMHRFs with non-compliance findings based on failure to display *divided by* *# of SMHRFs.*

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

^ May require amendment to the Illinois Administrative Code

F. Tracking and Reporting

Prime Agencies are responsible for timely reporting of various Outreach activities and outcomes to ensure that Class Members receive Outreach and information at an appropriate frequency. All Outreach attempts and outcomes are required to be submitted to UIC-CON within 48 hours of the attempt. In addition, summary reports are submitted to UIC-CON on a quarterly basis. All data on Outreach is separated for New Class Members (those admitted within the last 60 days) and Existing Class Members (Class Members post-60 days admission and who have had at least one initial Outreach attempt).

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard	Performance Metrics
O10	4 (partial compliance)	Inform Class Members about Community-Based Settings, including Permanent supportive Housing, and services and financial supports available.	Overall Outreach data will be reported quarterly, identifying all Outreach attempts and outcomes; activity is also updated routinely as forms are submitted so that activity can be monitored monthly through the Data Dashboard. Data will be reported separately	100% of Outreach attempts and outcomes reported monthly and quarterly.	# of Outreach attempts and outcomes included in monthly/quarterly reports *divided by* # of Outreach attempts and outcomes.

			for New Class Members and Existing Class Members.		

G. Financial Responsibility for Outreach

All costs associated with Outreach will continue to be borne by the Department of Human Services.

IV. Assessment

A. Staffing Requirements and Training

All providers under the Comprehensive Program must have Assessors with appropriate qualifications: a Master's Degree in Counseling, Social Work or other highly-related field, who are supervised by a Licensed Practitioner of the Healing Arts (LPHA), Registered Nurse (RN) or Occupational Therapist (OT).

In addition, training has been created to ensure proper clinical skills, Consent Decree adherence, and continuity in Assessments, and to educate and inform Assessment staff on best practices to engage Class Members both initially, and at appropriate frequencies to address concerns about transitioning to the Community. Assessment staff will also be trained on available services in the community. Assessment staff are required to complete the training and all training modules are recorded and available online.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard*	Performance Metrics
A1	11 (in compliance)	Assessments must be conducted by Qualified Professionals.	All Assessments must be conducted by staff that meet the qualifications mandated by the Comprehensive Program requirements.	100% of CM Assessments conducted by staff that meet program qualifications.	# of Assessments completed by staff who meet Program requirements *divided by* # of Assessments completed.
A2	10, 13 (Out of Compliance)	Class Members with concerns will be engaged at an appropriate frequency, and	Training and education on engagement, information on Class Member	100% of Assessment staff completed training within	# of Assessment Staff who have completed all training within 60 days of start date *divided by*

		concerns will be fully explored and addressed.	concerns and how to address will be provided.	60 days of start date. 100% of CM Assessments conducted by trained staff.	# of Assessment staff hired. # of Assessments completed by trained staff *divided by* # of Assessments completed.

B. Timing/Frequency and Completion

The timing and frequency of Assessments are mandated for all providers:

- Initial Assessments (the first Assessment for a Class Member, typically after a positive Outreach outcome) must be attempted within 14 days of referral by Outreach staff;
- Assessments must be updated at least annually;
- Any Class Member may request an assessment at any time, up to four times per year (quarterly). For all such requests, the Assessment must be attempted within 14 days of the request.

All Assessments must include the following:

- A review of the Class Member's medical record;
- Face-to-face interviews with the Class Member, and face-to-face or telephonic interviews with other contacts (family, friends, guardian) and key facility staff to gain insight into the strengths and needs of the Class Member, with documentation of involvement;
- A full clinical write-up with transition recommendations, including clear and specific goals for Class Members not recommended for transition; and
- Notice to the Class Member of appeal rights should they disagree with the Assessment outcome.

No.	**Decree Requirement/ Compliance Finding**	**Description**	**Action/Strategy**	**Performance Standard***	**Performance Metrics**
A3	9, 10, 12, 13, 14 (in compliance/ out of compliance)	Class Members shall be approached with appropriate frequency; Assessments shall be	Conduct initial Assessments within 14 days of referral from Outreach.	(Performance Goal) 95% of initial Assessments timely attempted/	# of initial Assessments attempted within 14 days of referral from Outreach *divided by* # of Assessments referred from Outreach.

		conducted annually; Class Members who have been assessed but declined to transition or who have declined an Assessment may request a re-Assessment at any time thereafter.		completed with CM consent. Measured 3 months post-COVID.*	# of initial Assessments attempted after referral from Outreach *divided by* # of referrals from Outreach # of initial Assessments completed within 14 days of referral from Outreach *divided by* #referred from Outreach. # of initial Assessments completed after referral from Outreach *divided by* # of referrals from Outreach.
A4			Timely annual Assessments.	(Performance Goal) 95% of annual Assessments timely attempted/ completed with CM consent. Measured 3 months post-COVID.*	# of annual Assessments attempted by due date *divided by* # of annual Assessments due. # of annual Assessments attempted *divided by* # of annual Assessments due. # of annual Assessments completed by due date *divided by* # of Class Members who consent to annual Assessment. # of annual Assessments completed *divided by*

					# of Class Members who consent to annual Assessment.
A5			Quarterly assessments as requested within 14 days of request.	(Performance Goal) 95% of requested quarterly Assessments timely attempted/ completed with CM consent. Measured 3 months post-COVID.*	# of requested quarterly Assessments completed within 14 days of request *divided by* # of quarterly Assessments requested. # of requested quarterly Assessments completed *divided by* # of requested quarterly Assessments.

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

C. Reporting and Tracking of Data and Outcomes

Comprehensive Program Agencies are required to track all Assessment data and outcomes for all Class Members. This includes information that is separated by the type of Assessment - initial, annual, or Class Member request. Assessment data must be reported within 7 days of either the attempt (if unsuccessful) or completion of the Assessment. Quarterly summary data reports are also required.

Prime Agencies are not mandated to conduct a specific number of Assessments, other than those required quarterly/annually. Rather, as all transition services from Outreach through Transition are conducted by a single Prime Agency, the agencies are expected to self-manage their caseloads to ensure transition targets are achieved.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard*	Performance Metrics
A6	12,13,14 (out of compliance)	Assessments shall be conducted annually; Class Members who either decline an Assessment or	Submission of all Assessment outcomes and full Assessments to UIC-CON/DMH within 7 days.	100% of Assessment data reported; 100% of completed Assessments submitted to	# of Assessments submitted to UIC-CON/DMH within 7 days *divided by* # attempted/

		who decline transition post-Assessment may request a reassessment at any time (quarterly).		UIC-CON within 7 days.	completed Assessments. # of completed Assessments submitted to UIC-CON *divided by* # attempted/completed Assessments.

D. Quality Assurance

To ensure Assessments meet the stringent Comprehensive Program requirements, UIC-CON will be reviewing a minimum of one Assessment completed by each Assessor each month. Assessments are scored, and any Assessment that scores lower than 80% will be returned to the agency for revision and resubmission. Any Assessors that repeatedly fail to meet criteria will be referred for additional training and support. All data on Assessments will be tracked to reflect proficiency.

In addition, UIC-CON will conduct a conflict-free review of all Assessments in which the Class Member is not recommended for transition. In the event UIC-CON determines the Assessment does not support a not-recommended finding, it will be returned to the agency for a re-Assessment. If the re-Assessment continues to not recommend transition, UIC-CON and DMH may review, and if transition would be appropriate, reverse the Assessment outcome to "recommended for transition" and instruct the agency to proceed with transition activities.

No.	**Decree Requirement/ Compliance Finding**	**Description**	**Action/Strategy**	**Performance Standard**	**Performance Metrics**
A7	11 (in compliance)	Assessments shall be conducted by Qualified Professionals as defined under the Comprehensive Program.^	UIC-CON will review one recommended and one not recommended Assessment from each Assessor monthly and require revisions for those that do not meet Comprehensive Program standards.	(Performance Goal) 85% of Assessments reviewed meet Comprehensive Program standards. 100% of revised Assessments meet Comprehensive Program standards.	# of Assessments that meet compliance standard *divided by* # of Assessments reviewed by UIC-CON. # of Assessors with sub-85% compliance who submit revisions that meet 85% compliance *divided by*

					# of Assessors with sub-85% compliance required to submit revisions.
A8	11 (in compliance)	Assessments shall be conducted by Qualified Professionals as defined under the Comprehensive Program.	UIC-CON to review all not-recommended Assessments; may be re-submitted or overturned.	100% of not recommended Assessments submitted to UIC-CON for review. 100% of overturned Assessments proceed to transition.	# of not recommended Assessments submitted to UIC-CON *divided by* # of not recommended Assessments. # of not recommended Assessments resubmitted/ overturned *divided by* # of not recommended Assessments reviewed by UIC-CON/DMH.

V. Service Planning

Significant changes to both creation of Service Plans and Quality Assurance protocols are included under the Comprehensive Program, which will continue for FY21.

A. Service Plan Requirements

Under the Comprehensive Program, agencies are required to complete Service Plans that meet the following requirements:

- All Class Members who complete an Assessment must have a Service Plan completed within 45 days of the Assessment, and updated every 180 days at a minimum, or as needed based on changes to Class Member's skills, needs/preferences or circumstances;
- Service Plans must be person-centered and include documented input (including signatures were possible) from the Class Member, facility staff, family and/or guardians, as well as others as requested by the Class Member;
- Service Plans must include specific service, support, education, housing and employment strengths, needs, and desires of the Class Member, including in the following areas: functional status, psychosocial status, risk assessments and mitigation strategies, medication status, healthcare utilization and community engagement. The Service Plan must contain goals and timelines for transition, and services and supports must not be limited by current capacity/availability;
- For Class Members not recommended to transition, the Service Plan must include goals and objectives in furtherance of transition; and

- For Class Members recommended to transition but not recommended for PSH, services necessary for transition that are not available in PSH must be identified and should further include goals and objectives in furtherance of eventual transition to PSH where appropriate; and
- Provider agencies are required to provide SOAR assistance to Class Members without a sufficient income source and will be required to report on status and outcomes of all such Class Member SSI/SSDI applications and appeals.

No.	**Decree Requirement/ Compliance Finding**	**Description**	**Action/Strategy**	**Performance Standard***	**Performance Metrics**
SP1	15, 16, 17, 20, 21, 22, 23	Service Plans must be person centered, include Class Members and others, be promptly developed and contain services, supports, objectives and goals.	Service Plans must be completed within 45 days of the completion of the Assessment.	100% of Service Plans for consenting CM completed within 45 days of Assessment. Measured 3 months post-COVID.*	Service Plans completed within 45 days of Assessment *divided by* # of Service Plans due (45 days post-Assessment). Service Plans completed more than 45 days of Assessment *divided by* # of Service Plans due (45 days post-Assessment)
SP2			Service Plans must be updated every 180 days at a minimum.	100% of Service Plans for consenting CM updated every 180 days. Measured 3 months post-COVID.*	# of Service Plans updated within 180 days *divided by* # of Service Plans due for update (180 days old). Service Plans completed more than 180 days of Assessment *divided by* # of Service Plans due (180 days post-Assessment)

SP3			Transition Service Plans must be completed 14 days prior to Transition.	100% of Transition Service Plans for consenting CM completed within 14 days prior to transition. Measured 3 months post-COVID.*	# of Transition Service Plans completed 14 days prior to transition *divided by* # of CM transitions. # of Transition Service Plans completed less than 14 days prior to transition *divided by* # of CM transitions.
SP4			Service Plans must be person-centered, include input from others, include services, supports and goals.	(Performance Goal) 95% of completed Service Plans for consenting CM meet Program requirements. Measured 3 months post-COVID.*	#/% Service Plans reviewed by UIC-CON that meet Comprehensive Program requirements *divided by* # of Service Plans reviewed by UIC-CON.
SP5			SOAR services must be provided to assist Class Members with no income.	100% of CM who are in SMHRFs and on financial holds are offered SOAR services.	# of CM who are offered SOAR services *divided by* # of Class Members in SMHRFs on financial holds.
SP6			SOAR services must be provided to assist Class Members with no income.	(Performance Goal) 85% of Class members who consent to SOAR services have SOAR applications submitted within three months of consent.	# of CM who consent to SOAR services and have applications submitted within three months *divided by* # of Class Members who consent to SOAR services.
SP7			SOAR services result in CM approval for SSI/SSDI.	60% of CM who complete the SOAR process for initial application and 40% of appeals result in	# of CM who receive funding after initial SOAR application *Divided by* # of CM who submit initial application through SOAR.

				approval for SSI/SSDI.	# of CM who receive funding after SOAR appeal *Divided by* # of CM who submitted appeal through SOAR.

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

B. Class Member Employment

In order to encourage Class Member interest and participation in employment activities, a number of strategies will be implemented in FY21, subject to procurement requirements (for more detailed information, see Employment section of the Capacity Growth Plan, incorporated by reference into this Implementation Plan):

- Monitor employment service teams to determine current capacity and need; work to increase teams (dependent on funding) if increased need is identified;
- Prime agencies receive an average of $1000/transitioned Class Member to meet unanticipated expenses related to community living. In conjunction with Supported Housing, LI-HEAP, SNAP, and SafeLink, Class Members will be referred to DRS Vocational Rehabilitation Services for individualized assistance with securing community integrated employment. With an open DRS VR case, Class Members will be eligible for additional funding for interview clothes, footwear, outerwear, uniforms, corrective lenses or hearing devices, employment-related transportation costs, and other expenses related to obtaining or maintaining employment;
- Training and technical assistance will be provided to Prime agencies on Class Member employment abilities, opportunities, and the benefits of employment; and
- Provide additional on-line and provider-based resources for Class Members to educate them on the benefits of employment and dispel the myths regarding adverse effects of employment on SSI/SSDI benefits.

No.	**Decree Requirement/ Compliance Finding**	**Description**	**Action/Strategy**	**Performance Standard***	**Performance Metrics**
SP6	15, 16, 17, 20, 21, 22, 23	Service Plans must be person centered, include Class Members and others, be promptly developed and contain services,	Encourage Class Members to explore employment opportunities; enhance employment supports.	(Performance Goal) 10% increase compared to FY20 (estimated 137) of CM recommended to Transition who	# of CM who engage in supported employment or vocational rehabilitation programs *divided by* # of CM recommended for Transition.

		supports, objectives and goals.		engage in supported employment/ vocational rehabilitation programs. To be measured 3 months post-COVID.*	

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

C. Services for Class Members with Co-Occurring Substance Use Disorders

Under the Comprehensive Program, providers are required to provide all necessary covered services to Class Members, based on the Class Member's individual needs. This includes provision of services related to Substance Use Disorders. In order to better prepare providers to serve this challenging population, IDHS/SUPR is working with Illinois Co-occurring Center for Excellence (ICOCE) to assess Comprehensive Program providers via the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index. The results of this analysis will encompass 35 separate benchmarks on provider level policies, clinical practices, and workforce capabilities. Based on these outcomes, ICOCE will be able to create a program-level assessment and provide targeted training to enhance the provider's ability to effectively deliver services to Class Members with co-occurring Substance Use Disorders.

In addition, DMH is sponsoring a virtual Evidence Based Practice Conference. The conference will include discussion of best practices in provision of services to individuals with co-occurring disorders. This virtual conference will be made available to all Comprehensive Program providers and added to the training institute schedule.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard*	Performance Metrics
SP7	15, 16, 17, 20, 21, 22, 23	Service Plans must be person centered, include Class Members and others, be promptly developed and contain services, supports, objectives and goals.	DDCAT analysis of provider services for co-occurring Substance Use Disorders and provision of targeted training.	100% of Comprehensive Program providers received DDCAT assessment and training in response to findings.	# of Comprehensive Program providers receiving DDCAT analysis and training *divided by* # of Comprehensive Program providers.
SP8			Hold Evidence Based Practice Conference to include best practices in services for individuals with co-occurring Substance Use Disorders by November 1, 2020.	100% of Comprehensive Program providers attend Evidence Based Practice Conference.	# of Comprehensive Program providers receiving DDCAT analysis and training *divided by* # of Comprehensive Program providers.

D. Training for Service Plan Development

All Prime agencies and their subrecipients are required to complete training under the Comprehensive Program. The training focuses on the requirements for each individual Service Plan and sub-type (initial, updates, transition) and is available online for continued education. In addition, at the conclusion of the training, there is a certification test, to identify competency and areas in need of further training.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard*	Performance Metrics
SP9	15, 16, 17, 20, 21, 22, 23	Service Plans must be person centered, include Class Members and others, be promptly developed and contain services,	Creation of comprehensive training module for Service Planning standards	(Performance Goal) 95% of Staff fully trained to complete Service Plans 60 days after start	# of Service Planning staff who completed training *divided by* # of Service Planning staff.

		supports, objectives and goals.		date for new staff. (Performance Goal) 90% of trained staff achieve certification.	# of Service Planning staff to achieve certification *divided by* # of Service Planning staff who completed training.

E. Quality Assurance

Providers are not required to complete or submit a specific number of Service Plans under the Comprehensive Program. However, all Prime Agencies have mandated transition targets included in their agreements. Agencies are required to ensure that Class Members who have been approved for transition have timely Service Plans created and submitted with clear timelines for transition such that they can meet their transition goals.

All Service Plans and updates must be submitted to UIC-CON for quality review (within 7 days of completion). A random sample of Service Plans will be reviewed each month: one per type (initial, update or transition) from each Service Planning staff. Service Plans are scored based on their adherence to Comprehensive Program standards. Any Service Plan reviewed that has a score lower than 85% will be returned to the agency for revision and resubmission. Any agency that fails to meet standards on an ongoing basis will be required to complete additional training. After review, any Service Plans that do not meet the requirements of the Comprehensive Program will be returned to the provider to correct any identified deficiencies. A revised Service Plan must then be submitted to UIC-CON within 14 days for further review. UIC-CON will track Service Plans received, those in need of corrections and whether deficiencies were properly addressed.

No.	**Decree Requirement/ Compliance Finding**	**Description**	**Action/Strategy**	**Performance Standard***	**Performance Metrics**
SP10	15, 16, 17, 20, 21, 22, 23	Service Plans must be person centered, include Class Members and others, be promptly developed and contain services, supports,	Require agencies to submit all Service Plans to UIC-CON for review.	(Performance Goal) 75% of completed Service Plans submitted to UIC-CON for review within 7 days.	# Service Plans submitted to UIC-CON within 7 days *divided by* # of Service Plans expected (based on completed Assessments).

		objectives and goals.			# Service Plans submitted to UIC-CON after more than 7 days *divided by* # of Service Plans expected (based on completed Assessments).
SP11	15, 16, 17, 20, 21, 22, 23	Service Plans must be person centered, include Class Members and others, be promptly developed and contain services, supports, objectives and goals.	Review sample of all types of Service Plans (initial, update, transition) to ensure they meet Comprehensive Program standards and requirements.	Reduction in Service Plans requiring corrections by 20%.*	# of Service Plans reviewed that score below 85% compliance with Comprehensive Program standards *divided by* # of Service Plans reviewed.

* Benchmark will need to be established during the first 3 months post-COVID, as Service Plan data is not available for prior years. The 20% reduction in needed corrections will apply for the remainder of FY21 after the benchmark is established.

VI. Transition

A. Transition Benchmarks

Providers under the Comprehensive Program have set transition benchmarks based on their grant proposals and resulting contracts. In addition, there are specific requirements for transitions and reporting to ensure providers are analyzing their own Class Members' status in the transition continuum to meet those benchmarks. However, as previously noted, due to COVID-19 restrictions, much, if not all Transition activity has been delayed. For FY21, the transition target for *Williams* Class Members will remain at 400 Class Member transitions, but this total is unlikely to be achieved, and will depend on how much transition work providers can perform while COVID in-person contact restrictions are in place.

Once "post-COVID" access (as defined in Section I.A.) resumes, providers will be given 30 days to re-establish their operations in SMHRFs (Outreach, Assessments, etc.) and resume in-person work with Class Members who have been approved for and are ready to transition. After the 30 days, providers will be expected to resume all activities (including Outreach, Assessment, etc.), reach 75% of their monthly transition target (33 transitions per month) within the next month (two months post lifting of restrictions), and 100% within three (3) months.

In addition, providers will be encouraged to transition Class Members as quickly as possible while maintaining clinical standards and focusing on Class Member safety and success. Providers will be required to monitor and report on their Class Member status and transition pipeline to UIC-CON. Providers will report on transition dates, for all Class Members recommended to transition, from the date of the initial Service Plan.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard*	Performance Metrics
T1	28 (out of compliance)	Class Members shall be offered the opportunity for placement in Community-Based Services within 120 days of the date of their Service Plan.	Transition Class Members based on monthly target of 33 Class Members per month post-COVID.	75% of monthly transition target met in second month post-COVID; 100% of monthly transition target met for remainder of FY21.*	#/% CM transitioned each month *divided by* # 33 targeted transitions per month.
T2	28 (out of compliance)	Class Members shall be offered the opportunity for placement in Community-Based Services within 120 days of the date of their Service Plan.	Providers shall transition Class Members within 120 days of initial service plan, while maintaining clinical and safety standards.	75% of CM recommended to transition, transition within 120 days of initial Service Plan. To be measured 3 months post-COVID.*	# of CM transitioned within 120 days of initial Service Plan *divided by* # of CM recommended to transition whose Service Plans are older than 120 days.
T3			Providers will regularly report (quarterly at a minimum) on transition pipeline issues and address bottlenecks or delays; UIC-CON will analyze and engage provider to remedy.	100% of Class Members' status and provider pipeline data timely reported; bottlenecks identified.	# of Class Members whose pipeline status is reported *divided by* # of Class Members recommended for transition who remain in the SMHRF.

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

B. Class Member Transition Housing

Permanent Supportive Housing continues to be the most integrated setting for Class Members who do not meet the three identified exceptions (high medical needs, dementia or risk of harm to self or others). Prime agencies will be required to follow these PSH requirements as well as the Class Member concentrations in buildings into which Class Members transition. Providers will be expected to continue to work with Class Members who transition into Bridge-subsidy units to refer them for Section 811/SRN units. A protocol for those referrals is being developed by IDHS and IHDA for completion by September 1, 2020. In addition, Community-Based Housing for transitioned Class Members who are in need of inpatient treatment (in a hospital, nursing facility or rehabilitation facility) will continue to be retained for up to 90 days.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard*	Performance Metrics
T4	24 (out of compliance)	Class Members shall be transitioned into PSH unless they meet one of the three exclusionary criteria.	Prime Agencies are required to utilize PSH for Class Member transitions unless one or more of the exclusionary conditions are met, and to document and justify transitions using alternative housing (Supportive or Supervised Residential).	(Performance Goal) 90% of CM transitions will be to PSH or other approved housing (family, etc.).[5] (Performance Goal) 95% of transitions to alternate settings will contain adequate documentation and justification (excluding transitions under COVID discharge protocol).	# of CM transitioned to PSH *divided by* # CM transitioned. # of CM transitioned to non-PSH settings with documented justification including either an exclusionary condition or Class Member choice to live in non-PSH settings *divided by* # CM transitioned to non-PSH settings.

[5] The Consent Decree specifically identifies types of permissible housing.

T5	27 (in compliance)	Class Member concentration in buildings shall not exceed 25% (for over 4 units) or 50% (for 4 units or less).	Housing subsidy administrators will track and report on Class Member concentrations, and document where concentration not met based on Class Member request (waiver).	(Performance Goal) 95% of transitions meet PSH concentration limits. 100% of waivers based on CM request are documented.	# of CM transitions to PSH in compliance with concentration limits *divided by* # of CM transitioned to PSH. # of CM transitions to PSH in excess of concentration limits with documented waivers *divided by* # of CM transitioned to PSH in excess of concentration limits.

C. Class Member Discharges Prior to Transition

As Prime Agencies will have a significant presence in their assigned SMHRFs and will be building relationships with staff and the SMHRF administrators, it is expected that agencies will closely monitor Class Members who are engaged in the transition process, including any issues which may lead to an involuntary discharge. Prime agencies should seek advance notification from SMHRF administration on any potential discharge for a Class Member who has been approved for transition to address the Class Member's needs, including temporary housing.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard	Performance Metrics
T6	26	In the event a SMHRF seeks to discharge a Class Member prior to housing being obtained, the Class Member will not be left without appropriate housing options.	Defendants and Prime agencies will work with SMHRF administration to ensure they are notified of any upcoming discharges so that housing can be identified.	(Performance Goal) 85% of CM recommended to Transition who are involuntarily discharged from SMHRF are offered housing/ continued transition services.	# of CM recommended for transition discharged from SMHRF for whom housing was identified and offered *divided by* #/of CM recommended for transition discharged

				To be measured 3 months post-COVID.*	

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

D. Medicaid Eligibility Issues

As in FY20, IDHS will continue to utilize dedicated staff to address any Medicaid eligibility issues Class Members may encounter. This includes issues related to send-downs and re-determinations. Prime agencies have been provided contact information for staff to address any such issues. Defendants will continue to report in the monthly data dashboards the frequency of these events and outcomes.

VII. Medicaid Managed Care

HFS will continue to work closely with the MCOs to advance the objectives of the Consent Decree. A transition incentive program combined with contract review, education, and technical assistance activities will strengthen alignment between the Medicaid delivery system and the objectives of the Consent Decree.

Contract language authorizing incentive payments to MCOs for successful transition of Class Members has been in effect since January 1, 2020. Features of the incentive program include:

- A comprehensive transition plan for each Class Member prior to transitioning that includes evidence of housing in the manner required under the Decree. This plan must be prior approved by HFS. Transitions initiated and supported through the Comprehensive Program are not eligible for incentive payments;
- Documentation of successful community transition defined as continuous residence in the community for at least six months, and direct activities performed to show responsibility for community transition; and
- HFS will set minimum performance targets for successful community transitions-if MCO does not meet minimum target, no incentive payment will be made.

HFS will operationalize this incentive program by September 30, 2020. This will include training of MCO staff and establishment of tracking systems to trigger incentive payments when appropriate.

HFS will examine the HealthChoice Illinois model contract to ensure there are no explicit or implicit barriers to implementation of the Consent Decree. HFS will provide a brief, written report of its findings to the Parties and Monitor by October 31, 2020.

In FY21, HFS will also explore two additional strategies for improving MCOs' performance relative to systems rebalancing. First, the HFS will consider whether and how to engage MCOs in a collaborative Performance Improvement Plan with its Quality Improvement Organization. Second, HFS will consider adding a formal performance measure, such as the Discharge to Community Measure, which determines the percentage of all new admissions from a hospital who are discharged back to the community and remain out of any skilled nursing center for the next 30 days. HFS will develop a plan about whether and how to proceed with these options and will provide the plan to the Court Monitor and Parties by March 31, 2021.

No.	**Description**	**Action/Strategy**	**Performance Standard**	**Performance Metrics**
MC1	HFS will operationalize incentive program	Develop guidance, documentation standards, tracking system, and training for MCOs.	Increase percentage of CM transitioned by MCOs.	# of CMs transitioned by MCOs *divided by* # of Class Members enrolled managed care, reported semi-annually (FY 21 to provide baseline data).
MC2	HFS will undertake Consent Decree-focused examination of HealthChoice Illinois contract	Review existing contract language to identify any barriers to Consent Decree Implementation.	Brief report of findings by October 31, 2020.	Report distributed to Court Monitor and Parties.

MC3	HFS will provide Consent Decree-specific education and consultation to MCOs though existing, recurring meetings. Once session with CEOs per quarter and one session per quarter with operations staff will be devoted to Consent Decree issues.	Devote quarterly sessions with CEOs and operations teams to Consent Decree topics.	CEOs from each MCO in attendance at quarterly meeting focused on Consent Decrees; Operations staff from each MCO in attendance at quarterly meeting focused on Consent Decrees. Each meeting includes Consent Decree-related topics.	# of CEOs in attendance at each quarterly meeting *divided by* # of Medicaid MCOs; # of MCOs represented in operations staff quarterly meetings *divided by* # of Medicaid MCOs. # of agendas with Consent Decree-focused agenda items *divided by* # of meetings.
MC4	In conjunction with IDHS, HFS will develop an educational tool on Decree requirements and operations for care management staff employed by MCOs	Adapt/develop content about Consent Decree operations to be used for training new MCO care management staff by March 31, 2021.	All new care managers hired after April 1, 2021 receive Consent Decree training.	Annual attestation from MCOs that all newly hired care management staff have completed Consent Decree training.
MC5	HFS will explore Performance Improvement Plan and formal performance measure.	Assess each option, considering potential impact, required resources, etc.	Written plan indicating whether and how to proceed with each strategy.	Plan shared with Court Monitor and Parties.

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A has been reached.

VIII. Capacity and Housing Development

A. Prime Agency Service and Housing Requirements

Under the Comprehensive Program, Prime agencies are required to develop and maintain sufficient Community-Based services for the Class Members they serve. The provision of services must be consistent with the preferences, strengths and needs of the Class Members, and cannot be limited by availability of any such covered service, including services related to co-occurring substance use disorders. Prime agencies must expand their staffing and service array, including ACT and CST teams and services, to meet the needs of their Class Members. Finally, Prime agencies are also responsible for locating and securing appropriate housing for transitioning Class Members. This includes, but is not limited to, enrolling Class Members on the Statewide Referral Network for Section 811/SRN units, building relationships with landlords in preferred areas for private rental units funded by Bridge Subsidies and assisting Class Members in the housing search and application process. As in prior years, Bridge Subsidies are awarded based on need and are not limited to a certain number. Any Class Member who is unable to secure a Section 811/SRN unit and who identifies and is approved for a qualifying private unit will receive a Bridge Subsidy.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard	Performance Metrics
C1	36 (out of compliance); 37 (out of compliance)	Ensure availability of services and supports of sufficient quantity and quality to meet Decree requirements. Provide sufficient measures, consistent with the preferences, strengths and needs of Class Members to provide Community-	Using FY2021 IP as the basis, Defendants will brief the Court Monitor and Parties on FY2021 resource commitments, expected compliance outcomes, and FY2022 budget implications by October 31, 2020.	Defendants identified specific resource commitments and expected impact on adequate service availability.	Resources are used to close identified gaps between needed vs. available services.

		Based Services and Settings.			
C2	36 (out of compliance); 37 (out of compliance)	Ensure availability of services and supports of sufficient quantity and quality to meet Decree requirements. Provide sufficient measures, consistent with the preferences, strengths and needs of Class Members to provide Community-Based Services and Settings.	Update capacity development plan by January 31, 2021 or earlier in order to inform Defendants' budget requests for the Governor's proposed FY2022 budget.	Capacity Development Plan updated to support development of FY22 Implementation Plan.	Capacity Development Plan updated as appropriate; reviewed quarterly at a minimum.
C3	36 (out of compliance)	Ensure availability of services and supports of sufficient quantity and quality to meet Decree requirements.	Require Prime Agencies to maintain and develop sufficient services and supports to meet the needs of the Class Members served by their agency.	100% of CM recommended to transition are able to secure required services and supports for transition. To be measured beginning 3 months post-COVID.	# of CM who received specific services and supports *divided by* # of CM who require specific services and supports.
C4	37 (out of compliance)	Provide sufficient measures, consistent with the preferences, strengths and needs of Class Members to provide Community-	Require Prime Agencies to develop, maintain and locate housing and services sufficient to meet the preferences and needs of their assigned Class Members.^	100% of CM recommended to transition receive all necessary services and supports, and are able to secure housing.	# of CM approved to transition but unable to locate appropriate services, supports or housing *divided by* # of CM recommended to transition.

		Based Services and Settings.		To be measured 3 months post-COVID. As an improvement goal, 95% of CM able to locate and secure housing that meets their identified needs and preferences. To be measured 3 months post-COVID.	

^ Housing preferences will be honored to the maximum extent possible, and Class Members will be offered a minimum of three (3) housing options in their preferred geographic area(s). No more than three such housing options are guaranteed.
* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

B. Housing Development-IHDA

1. PSH

The Illinois Housing Development Authority (IHDA) makes housing available to Class Members and FDDP participants in two major ways: (i) investing in buildings and (ii) providing rental assistance.

The annual Low-Income Housing Tax Credit program requires developers to set aside a minimum 10% of the building's units for individuals/families referred to the Statewide Referral Network (SRN) waitlist. It typically takes two years from funding approval to develop the property and have individuals move in.

IHDA also holds special funding rounds for Permanent Supportive Housing, each round typically creates 125 units a year. Due to the concentration rules under the Decree, a typical funding round will generate approximately 31 units for Class Member/FDDP preference. IHDA intends to have another round of funding in FY2021.

2. Rental Assistance

IHDA continues to increase the SRN and 811-unit inventory that will benefit Class Members/FDDP participants. SRN units are added to all new Low-Income Housing Tax Credit

(LIHTC) funded developments. These units may have a rental subsidy, and are rent restricted for households at or below 30% of the area median income. Section 811 units will be fully allocated by the end of the fiscal year, and IHDA has applied for another round of funding to increase Section 811 units in FY21.

Finally, IHDA will continue to offer guidance on training and assistance for providers on how to enroll Class Members on the wait list and service providers' responsibility when notified of an available unit.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard	Performance Metrics
C5	37 (out of compliance)	Provide sufficient measures, consistent with the preferences, strengths and needs of Class Members to provide Community-Based Services and Settings.	Development of Statewide Referral Network Units for Class Member utilization (250 per year, depending on awarded LIHTC projects; 31 of which are available for Class Members).	98% of all SRN units with a CM identified on the unit specific waitlist will send at least one Notice of Availability to at least one CM on the waiting list. To be measured beginning 3 months post-COVID.	# of CM who move into an SRN unit *divided by* # of CM referred to an SRN unit.
C6	37 (out of compliance)	Provide sufficient measures, consistent with the preferences, strengths and needs of Class Members to provide Community-Based Services and Settings.	Development of Section 811 Units for Class Member utilization.^	98% of all 811 units with a CM on the unit specific waitlist will send at least one Notice of Availability to at least one CM on the waiting list. To be measured beginning 3 months post-COVID.	# of CM who move into a Section 811 unit *divided by* # of CM referred to a Section 811 unit.

* Performance Standard timelines will begin once the parties agree that "post-COVID" access as defined in Section I.A. has been reached.

^ All units are first offered to Class Members (*Colbert*, *Williams* or *Ligas*) as well as individuals under the FDDP. However, if the timing does not work after 90 days for new units or 30 days for turnover units, the unit may be rented to another extremely low-income household.

C. Quality Assurance and Reporting

Under the requirements of the Comprehensive Program, Prime agencies are required to report all transition and service delivery information within 14 days, as well as provide summary quarterly reports. As part of this reporting, agencies are required to report on the current needs of their assigned Class Members, as well as the staffing and service capacity needed to meet those needs. This includes, but is not limited to the number of Class Members requiring ACT/CST services, the service capacity for such services and the staff necessary to provide those services. Prime agencies are required to hire additional staff as needed to meet the needs of their Class Members. UIC-CON and DMH will continuously review staffing and service capacity needs and available resources to ensure needed services are available in sufficient quantity and quality to meet Class Member needs.

In addition to service needs, housing preferences for Class Members must be identified at the time of Service Plan development, and data reported on both stated preferences and transition locations. This data will assist in future housing development.

No.	Decree Requirement/ Compliance Finding	Description	Action/Strategy	Performance Standard*	Performance Metrics
C7	36 (out of compliance)	Ensure availability of services and supports of sufficient quantity and quality to meet Decree requirements.	Require Prime agencies to routinely report on Class Member service needs and available staffing and capacity.	100% of Prime agencies track and report on CM service needs, staffing and capacity, including ACT and CST. 95% of CM who transition are able to secure all necessary services and supports, including ACT and CST.	# of CM who are able to secure necessary supports and services *divided by* # of CM who require specific services and supports.

				To be measured beginning 3 months post-COVID.	
C8	37 (out of compliance)	Provide sufficient measures, consistent with the preferences, strengths and needs of Class Members to provide Community-Based Services and Settings.	Require Prime agencies to track and report on Class Member geographic housing preferences and transition locations.	100% of Prime agencies track and report on CM housing preferences and transition locations. 95% of CM who transition are able to locate and secure housing that meets their preferences and needs. To be measured beginning 3 months post-COVID.	# of CM who transition to a preferred geographic area (based on most recent Service Plan) *divided by* # of CM who transition.

* Performance Standard timelines will begin once the parties agree that COVID restrictions have been lifted to a sufficient extent for operations to fully and/or meaningfully resume.

IX. Administration

As in prior years, the administrative activities associated with implementation of the Williams Decree will continue. This includes the following:

- Preparation and submission of semi-annual compliance reports, which will include updates on SMHRF accreditation status and critical incident reporting;
- Holding regular meetings with the Parties and Monitor (including small-Parties meetings on targeted issues);
- Providing information and/or documentation based on reasonable requests of the Plaintiffs or Court Monitor;
- Supplying budget briefings, including updates on expenditure of funds and potential lapses (will be provided quarterly, or as modified by agreement);
- Convening internal IDHS and State-only meetings to discuss issues, strategies and policies related to implementation and compliance;
- Participating in regular communications between the Olmstead Compliance Officer (and/or her staff or designee) and Plaintiffs and Court Monitor; and

- Ensuring continued review of Defendants' staffing needs and modifications. These will be identified via reassignment or new staff hiring. Updates to the Parties and Monitor will be provided on staffing determinations, vacancies and hiring efforts as part of the Large Parties meeting agendas.
    - Coordinated by IDHS, each named Defendant agency will provide to the Court Monitor and the Parties by July 31, 2020 a list of vacant positions and anticipated new positions which are/will be assigned to Consent Decree implementation. The list will include position titles and roles specific to Consent Decree implementation, how long the position has been vacant, and committed posting dates. Filling of positions will be dependent on the hiring process and the identification and availability of qualified candidates. The list will include, at a minimum, the following:
        - IDPH's Office of Health Care Regulation (OHCR) hired new legal staff who will address current and future compliance and implementation issues prior to FY21;
        - HFS's new senior position who will coordinate Consent Decree compliance and implementation by November 1, 2020, or as soon thereafter given state hiring regulations;
        - IDHS hiring individual for vacant DMH Quality Monitor positions by August 1, 2020.

In addition, during FY21, a renewed focus on system revision and accountability will continue under the Comprehensive Program. As identified in prior sections, the Comprehensive Program is expected to drastically modify the service delivery system for *Williams* Class Members and providers by removing unnecessary or duplicative hand-offs and requiring a single lead provider agency (Prime agency) approach from Outreach through Transition. In addition, the Comprehensive Program mandates a significant increase in data reporting, which will be reviewed and analyzed by IDHS/DMH in conjunction with UIC-CON to monitor performance and ensure deliverables are met. Corrective action plans for underperforming providers will be implemented where necessary in a timely manner by IDHS, and failure to remediate deficiencies may lead to reassignment of Class Members and/or termination of the Prime's contract. However, performance expectations may be modified due to the COVID pandemic and related restrictions.

X. Implementation Planning

Defendants will develop an Implementation Plan (IP) for FY22 to be filed with the Court by June 30, 2021. The IP development process will include preparation of an initial draft for review and comment by the Parties and Court Monitor, revised draft(s) for comments, and filing the final IP with the Court.