

WILLIAMS CONSENT DECREE

Implementation Plan

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Prepared by:

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

Office of the Governor

Illinois Department of Public Health

Illinois Housing Development Authority

Illinois Department of Healthcare & Family Services

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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 4,500 Illinois residents with Serious Mental Illness (SMI) living in institutional settings (Institutes of Mental Disease¹), and 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, consistent with the parameters now set forth in the *Williams* Consent Decree, 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. This is in keeping with an aim of providing services to an individual in the least restrictive and most integrated setting possible. 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. An effective recovery-oriented mental health service system is also individualized and person-centered, involving the individual (and, if appropriate, their families or significant others) in the planning of their services, including soliciting and respecting the individual’s choices and focusing on the individual’s strengths as well as their needs. In the 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 Draft Plan was completed as scheduled and submitted to the Parties. Comments on the Draft Plan were received from the Plaintiffs, the Court Monitor and several other stakeholders. What follows is the revision of that Draft Plan based on the input and comments received and agreements reached by the Parties, and constitutes the finalized Implementation Plan called for in paragraph 12 of the Consent Decree. As called for in the Consent Decree, this finalized

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.

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Implementation Plan is subject to revision on at least an annual basis. The Implementation Plan details a set of core strategies, approaches and processes to comply with the tenets of the Decree.

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

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 consequence 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 both in and outside of 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 individualized evaluations, to be conducted by 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 an individualized service plan that will guide ultimate transition to the community for Class Members choosing this option and detail the services and supports that are to be provided to assure sustained tenure in the community.

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 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 availability of housing for Class Members. Utilizing a number of different State and federal programs, IHDA, in partnership with DHS, will work with developers and landlords to increase housing stock. State funded rental assistance programs (Bridge Rental Subsidies), another critical component of the Plan, may be necessary to support

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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 plan for transitioning interested Class Members to a community placement. The processes necessary to complete the transition from the nursing home setting to the community-based living option and services are described, including the State's expectation that the chosen community service provider will assure the provision of a number of transition coordination services. Among these will be assistance with the housing search, developing comprehensive individualized service plans for each Class Member that include a risk mitigation plan and a 24 hour emergency back-up plan, assuring entitlements are in effect, assistance with purchasing furniture and supplies and, most importantly, assuring linkages are completed for requisite services, including all needed mental health services as well as medical and other necessary services and supports.

The Community Services Section also 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 plans 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 (DHS/DMH) will periodically evaluate the sufficiency of the service delivery network to provide care, conducting gap analyses to help identify pressure points for service delivery. Additionally, an "Integrated Behavioral and Medical" model for the system will be developed and piloted as a model for integrated care with 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 Implementation Plan. The timelines are designed to keep activities on track as the State fulfills its commitments pursuant to the Consent Decree. The Implementation Plan also includes a separate section describing the Compliance, Quality Assurance and Risk Management Plan, with appended detailed work plans for each functional area.

While this Implementation Plan represents the culmination of work by a broad range of State staff and officials as well as the Plaintiffs, the Court Monitor and other stakeholders, the Consent Decree recognizes that planning for the implementation will be a dynamic process. The State will continue to solicit input on the implementation process, relying heavily on the experiences of Class Members and direct care workers from community mental health providers, whose input remains central to the State's approach to systems reform. The State anticipates that successful

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implementation of the Consent Decree will assure a higher level of satisfaction and quality of life in the community for persons choosing this transition.

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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/guardians that 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 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 DMH proposes to contract with a consumer advocacy organization capable of managing the effort and

² English Clergyman William Pollard (1828-1893)

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meeting the specific contract deliverables. The selected vendor will hire full-time staff who will initiate the initial contact and engagement activities with the 4,500 Class Members. These staff will reflect the diversity of the Class Members and be highly qualified Recovery Support Specialist (RSS) and Outreach Counselors. 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, the selected vendor will hire Outreach Counselors who will minimally possess a Bachelor’s in counseling and guidance, rehabilitation counseling, social work, education, vocational counseling, psychology, pastoral counseling, family therapy, or related human service field. The Outreach Counselors and RSSs will work in tandem to assure that IMD nursing facility residents and family/guardians (as appropriate) have all of the required information with respect to the Consent Decree.

DMH will also assure through its contract specifications with the selected vendor that they 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, the selected vendor will hire a bilingual Outreach Worker proficient in the third language. For other Class Members who have limited English proficiency (LEP), the selected vendor will contract with interpreters, as needed.

The contract with the selected vendor will be managed by the Associate Deputy Director of Long Term Care Assessments. This position will assure that all terms and specifications of the contract are met.

3. Method/Procedures

By July 2011, the Illinois Department of Healthcare & Family Services (HFS) will release a Provider Notice to the twenty-four IMD nursing facilities to inform them that Outreach/Information Dissemination Teams will be in the facilities, effective August 1, 2011, for the next five 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,

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with understanding that their presence does not interfere with scheduled program activities, unless otherwise arranged in advance.

Additionally, the state shall ensure that IMDs permit frequent and full access to residents by community mental health providers engaging in transition coordination services to assist residents in exploring opportunities to move out of the IMDs (see Transition Coordination and Community Services, 2.1-2.3). Such access is necessary to facilitate successful transitions.

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 Outreach Workers will maintain contact and access to each resident. These lists must be shared as well with the providers of transition coordination services.

3.1 Communication Methods/Initial Contact

The Outreach Workers 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 Outreach Workers will schedule an introductory meeting with each IMD nursing facility resident. This will be a private one-on-one meeting, at which time the Outreach Workers 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 Outreach Workers 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.

Residents will always have the option to meet with an Outreach Worker outside of the NF/IMD facility if they so choose to have discussions in a more neutral/natural setting. IMD "level" or "privilege" systems shall not be used to deny residents the ability to meet with outreach workers or community service providers. Off-site meetings will be conducted in a public venue, one that is conducive to the resident's choice and in reasonable proximity to the IMD/nursing facility. Such meeting sites may include a local library, internet café, coffee shop, day time socialization setting, etc. The resident may also request a meeting at a local church or place of worship if

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this is determined to be a more comfortable location, and with approval of the responsible authority for the setting.

If a resident is interested in visiting an integrated community-based service/or setting the opportunity will be arranged with a visit to one of the local mental health centers in proximity to the NF/IMD. These visits will be scheduled at a time when agency support staff can provide a tour and information. Arrangements for such visit will either be coordinated with availability of the IMD/NF or community providers to provide transportation.

- 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 Outreach Workers. Through this video, Class Members will be able to see former nursing facility residents who have transitioned to community-based housing options. 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

As part of their facility engagement, Outreach Workers 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.

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- 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. Outreach Workers 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 Outreach Workers, 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 Outreach Workers will initiate their involvement with each resident by providing them with a letter of introduction. This letter will identify the role of the Outreach Worker, provide information on where they are located in the IMD nursing facility and where messages can be left for a return response. The Outreach Workers 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. If requesting Class Members’ signatures is deterring them from talking to Outreach Workers, DMH will propose alternative means of demonstrating that the initial contact has been established.

3.2 Continued Involvement of the Outreach Worker

The role of the Outreach Worker 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). To this end, the Outreach Worker may have multiple contacts with the Class Members. Each individual contact with a resident will be documented and entered in to a database. The purpose of outreach is not to conduct clinical assessments or make promises about one’s ability to transition, but

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Outreach Workers may certainly assist Class Members in thinking through their options and helping them to reach informed decisions. More detailed discussions about transition options will occur after the clinical assessment is completed.

The Outreach Workers will remain a resource to Class Members throughout the transition process as well as during their adjustment to community life for the tenure of the Consent Decree. As the work of the Outreach sunsets, the RSS will be re-engaged to support the activities of the Quality Assurance (QA) Monitors. They will work in tandem with clinical staff to “monitor” all aspects of the transition activities, the consistency of coordinated care and ancillary support resources and the effectiveness of community integration and clinical stabilization efforts. As such, these workers will be able to follow the transitional changes of consumers from NF/IMD residents to community participants. They will also serve as a resource for consumers who may request guidance from a peer in recommending best techniques/tips for successfully navigating new communities, coping with a new level of independence and personal responsibility and assuring housing stability. Additionally, the former Outreach Workers, now QA Monitors will be instrumental in conducting in-home consumer satisfaction surveys and consumer perception surveys. The Outreach Workers/QA Monitors may also be assistive in working through problem resolutions with Critical Incident reviews.

Each individual contact with a resident (family or guardian) will be documented and this information entered 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.

3.3 Full Disclosure of Transition Opportunities

Engagement of residents will be done by all parties involved in the processes to facilitate transition to more integrated settings, including Outreach Workers, Resident Review Staff, and Community Mental Health Agencies. At all points of engagement, residents will have full explanation of their rights as Class Members under the Consent Decree, the purposes of assessments and the processes to obtain Permanent Supportive Housing or other community based alternatives.

Residents will be afforded full explanation of the support resources and services available in Permanent Supportive Housing and other community-based settings, including the benefits and financial aspects of PSH and other community alternatives.

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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 needs, and as clinically appropriate, determine the necessary services (within DMH Rule 132 service taxonomy) and ancillary supports to assure a successful transition from the IMD to appropriate community-based settings. All Class Members are to receive initial individualized 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 reevaluation 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 potential risk factors that must be addressed to ensure successful community living. Additionally, the evaluation will guide the collaborative development of service and transition plans with the Class Member. Recommendations for specific community-based services (including housing resources and supports to retain housing) that are necessary to complete successful transitions 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.

It is recognized that for residents who have court appointed or court ordered guardians that these individuals may assume very instrumental and influential roles in the lives, and decision making of the Class Member. The State understands that in some situations guardians may be extremely

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concerned about the capability of the ward to transition into community settings from a safety and security perspective. In other situations, the guardian may lack sufficient information about Recovery and the ability of persons who have serious mental illnesses to reach optimal levels of recovery outside of an institutional setting. In these situations, the State is prepared to work with and educate guardians around issues of Recovery, wellness and individualized pursuits for the most integrated and appropriate community based care. Guardians will also be assured that under the Consent Decree individuals will not be transitioned into community settings that are unsafe -- for example, if moving to PSH would compromise the individual's ability to receive ongoing medical care that could not be effectively provided in PSH; or if the individual's cognitive impairments and severe functional limitations necessitate 24 hour skilled nursing support.

1.1 Additional Context

As described in the Consent Decree, the MH PASRR system will be utilized to conduct the required initial and subsequent evaluations of Class Members, including the identification of service needs and ancillary supports to assure a successful transition from the IMD to appropriate community-based settings. The individualized 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. As such, the State will 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 will inform and guide the development of a broader array of Recovery oriented and rehabilitative community-based service options for individuals. The determination processes of MH PASRR will have a stronger emphasis on community placement options, housing/residential options and service availability and focus consideration of Nursing Facility/Long Term Care placement only when medically necessary (that is, when an individual could not successfully live in a more integrated setting).

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 will be initiated and will benefit Class Members during this re-design process:

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- Upgrade of assessor qualifications to licensed clinical personnel;
- Movement to an independent MH PASRR entity 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) needed for decision-making and judgments on the parameters 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;
- A review of available HFS and DMH Data Warehouse information on the individual;
- The development of more comprehensive recommendations, including pre-transition, transition planning, community services and supports, and housing/residential options;
- Formal report protocols covering assessment findings, level of care and other determinations, and any specific recommendations for transition services;;
- Interim information input, data linkage, and tracking strategy / system.
- While an individual's LOCUS score may in some cases provide useful information in determining what types of services the person may need, it does not determine the most integrated setting appropriate for that person.

In addition, the MH PASRR agents, who conduct screening in hospital settings for individuals seeking admission to Long Term Care, will receive training and annual retraining on Rule 132 community mental health services, the array of other services and supports and service referral processes. The goal is to assure that MH PASRR is exploring integrated community placements with mental health services and support for individuals seeking nursing facility admission. The objective is for MH PASRR to first consider community alternatives to NF placement. As such, MH PASRR will have the same knowledge base as the Resident Review and Assessment Unit for *Williams* (RRAUW) and will have at their disposal all Outreach/Information Dissemination materials to share with consumers and family members, as well as inpatient treating psychiatrist/physician and social service staff.

By the end of FY 2012, all individuals with a mental illness seeking admission to an IMD will be pre-screened via the PASRR process, which will clearly identify and assess individuals who may be appropriate for placement in a community-based setting. An initial service plan will be completed for all such individuals, which will include the community-based services necessary to facilitate a placement in the community.

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The State will ensure that any approved admissions to IMDs are only to IMDs that can provide care and treatment consistent with the initial service plan and consistent with the goal of transition to a community-based setting. The State's data system will include the number of new individuals with mental illness who seek admission to an IMD and the number subsequently admitted or diverted to community-based services. The State will use the data collected in FY'12 to plan for the necessary community capacity to ensure that persons needing and desiring community placement are placed directly into community services.

As provided by the Consent Decree, after the first five years following the finalization of the Implementation Plan, no individual with a serious mental illness referred for PASMH evaluation and for whom a recommendation for placement in a community-based setting has been made will be housed or offered placement in an IMD at public expense unless he or she is appropriate for nursing home level of care and, after being fully informed, declines the opportunity to receive services in a community-based setting. The State will take necessary steps to meet this requirement.

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, a high 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. Training for RRAUW assessment staff will be developed in consultation and collaboration with DMH Bureau of Long-Term Care Training and

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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 Housing³ 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.

All assessors will be trained on the requirements of the *Williams* Consent Decree, and the parameters it establishes for determining the most integrated setting appropriate for Class Members. (See 4. Orientation and Training).

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.

DMH will periodically review a sample of the assessments to ensure that they are being done correctly and consistently with the *Williams* Consent Decree. DMH will also share the samples with Plaintiffs' Counsel and Court Monitor.

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.

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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/community mental health service 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 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 any community mental health agency staff directly involved with the individual in recent months. Listings will be updated weekly.

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

Resident Review outcomes will be reported through an 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 Use History and a Substance Abuse assessment
- Cognitive Impairment Screen

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- Co-morbid medical conditions, treatment and management
- Medication History and compliance
- Strength-based assessment
- Assessment of Risk Indicators 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

In large part, this information is relevant to determining what types of services an individual may need in order to live in a community setting. For *Williams* Class Members, the Resident Review evaluations must follow these principles, directly referenced in the Consent Decree, in determining what is the most integrated setting appropriate for Class Members:

“PSH will be considered the most integrated setting appropriate for Class Members except that, (1) for any Class Members (i) who have severe dementia or other severe cognitive impairments requiring such a high level of staffing to assist with activities of daily living or self-care management that they cannot effectively be served in PSH, (ii) who have medical needs requiring a high level of skilled nursing care that may not safely be provided in PSH, or (iii) who present an imminent danger to themselves or others, the evaluator will determine the most integrated setting appropriate, which may be PSH or another setting.....”

The foundation of the evaluation process conducted by the RRAUW is to determine the Class Member’s resource needs and supports to successfully integrate into the community. In the event that an RRAUW assessor determines that neither PSH nor any other community setting is the most integrated setting appropriate for a Class Member, the outcome of this comprehensive resident review assessment will be forwarded, by the RRAUW, to the professional experts that comprise the Clinical Review Team (CRT). This Team (recommended composition includes a psychiatrist, registered nurse with psychiatric training and a licensed clinical social worker) will determine what is the most integrated setting for the individual and if there are viable options constituting community supports to meet the individual’s needs not previously considered. If so, the RRAUW and the CRT will reverse the initial determination that the individual could not live outside of a nursing home. If the CRT supports the recommendation not to transition, the clinical reasons for this decision will be documented as an addendum to the RRAUW evaluation. Additionally, the RRAUW evaluation will contain a plan detailing the service needs and recovery goals for the resident. These recommendations will be incorporated into the IMD’s care plan.

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The evaluation process must be completed in a timely manner and must not delay placements beyond the timeframes set forth in the *Williams Consent Decree*.

It is important to emphasize that residents who are on insulin injections and who choose to self-administer this medication must be fully comfortable and competent with this process. It is a matter of life safety for the nursing facility to implement a training program for those moving into the community on self-injectable medications and to document the effectiveness of the residents' administration of these medications. The Department of Public Health will monitor the IMD's compliance with implementing these recommendations. Whether or not an IMD has adequately trained a Class Member to self-administer medication while residing in the IMD, such training can and will occur through the community-based service provider. If at any time the Class Member's inability to properly self-administer medications jeopardizes his or her safety, and the Class Member cannot safely accept administration of medication from a trained professional when appropriate, clinical measures will be taken to assure his/her safety including hospitalization if necessary.

Once the Resident Review DMH evaluation has been completed, the results will be electronically sent to the Deputy Director of LTC Assessment (DDA). The DDA will maintain an active database to track all assessments (time frame of assignment, completion, appeal processes and decisions, etc.), as well as the identified geographical preference. On a weekly basis the DDA will meet with the Deputy Director of Transition Coordination (DDTC) to link the resident with a DMH contracted community mental health center (vendor) of choice or (if vendor selection is not an issue) a CMHC in the geographic service area where the resident has expressed interest/desire to relocate. A letter will be sent to the CMHC that officially refers and links the resident to the agency. This letter will contain the resident's name, the name of the NF/IMD and will be accompanied by the preliminary Service Plan. Upon receipt of this referral, the CMHC will have seven (7) business days to initiate contact with the resident to begin activities of transition coordination planning. The DDTC will be responsible for tracking and assuring that a firm connection between the resident to the respective CHMC has been made, that the CMHC has frequent and full access to the resident, and that the agency is assuming all necessary tasks to actualize seamless transition planning activities.

Each Resident will be informed verbally and in writing of the outcome of his/her Resident Review evaluation (with CRT input, if necessary) and the recommended Service Plan. If the resident (family/guardian) disagrees with the recommendation(s), it is their right to appeal any decision/recommendation made by the RRAUW evaluators or the Clinical Review Team. The appeal processes are included as an attachment to this Plan.

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3.3 Annual Reassessment or Significant Change Reviews

Class Members who decline an initial Resident Review or who choose 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 database and managed by the DMH Deputy Director for Long-Term Care Assessments. Residents who were assessed and determined not to be a transition candidate will be scheduled for an annual reassessment. The Deputy or designee will forward this information to the RRAUW for follow-up.

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 from formal notification. No more than four Resident Review assessments 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.

When a Class Member is hesitant about moving or does not wish to move (or to be assessed) continued efforts will be made to explore the person's concerns and to afford the person opportunity to interact and build relationships with a peer support program and/or community mental health provider agency. These efforts will be made by all parties involved in the processes to facilitate transition to more integrated settings, including Outreach Workers, Resident Review staff and community-based mental health agency staff.

4. Orientation and Training

Each RRAUW evaluator will have an initial orientation and training on RRAUW and annual retraining on the protocol, processes and requirements necessary to conduct a comprehensive assessment. *Williams* Class counsel will be invited to participate in this training, as appropriate. 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;
- Models of PSH and community-based residential programs;
- Community-based mental health services and supports;
- Processes to access ancillary support resources;
- Hospital and nursing facility admission and discharge processes;
- Integrated dual diagnosis treatment and substance abuse treatment approaches and resources;

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- 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 RRAUW processes;
- RRAUW determinations, comprehensive recommendation development, report preparation, records and IT system input;
- RRAUW Quality Improvement.
- Consent Decree principles in determining the most integrated setting appropriate for Class Members noting the limited specific exceptions to the presumption that PSH is the most integrated setting appropriate, as described in paragraph 9 of the decree.

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HOUSING

1. Housing Objectives

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 address the housing needs of the *Williams* Class Members. IHDA and DMH share a commitment to develop Permanent Supportive Housing alternatives.

Effectively assisting individuals in their transition from institutional care to community-based housing requires an approach that is flexible, adaptable and individualized. In executing the *Williams* Implementation Plan, DMH's priorities are to maximize opportunities for independence and building life skills, to address the environmental safety and emotional wellbeing of Class Members and to assure essential services and supports at appropriate levels. The State will identify and develop an array of housing options 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, affordable housing options (focusing primarily on PSH) are 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. To meet the goals established above, DMH has identified the following objectives:

Objective A)

Williams Class Members transitioning to community-based housing will be referred for housing using various resources including: 1) existing and newly developed PSH, 2) public housing stock, and 3) homes of family and friends.

Objective B)

DMH will work with State agencies, community service providers, and developers to identify and develop housing models that provide the levels of support necessary for *Williams* Class Members to live independently in the community.

Objective C)

Class Members will be afforded choice of geographic preferences in conducting the housing search. The State will make every effort to work with Class Members to locate housing in desired communities.

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Objective D)

Class Members will be assisted to meet all tenant selection, occupancy, and payment requirements associated with the selected community-based housing. Class Members will be fully advised of all the occupancy requirements.

2. Housing Options

The State currently finances the development of a range of housing models appropriate for the *Williams* Class Members. Class Members, in cooperation with the community service providers, will have access to available housing in the pipeline for current and new development. During the initial years of the implementation plan, the State will expand the development of qualified PSH housing appropriate for the *Williams* Class Members by working with developers to provide traditional and creative housing solutions for persons with disabilities and persons being relocated from institutional care.

2.1 Permanent Supportive Housing (PSH)

Permanent Supportive Housing is 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), and Psychosocial Rehabilitation (PSR), along with any additional mental health services based on the Class Member's voluntary choice and medical necessity.

PSH units range from self-contained studios to 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. In accordance with the DMH model of PSH with a Bridge Subsidy, all eligible units must meet Fair Market Rate (FMR) criteria (unless an exception is warranted, as defined by DMH) and pass Housing Quality Standards (HQS) inspection. Access to housing options will be facilitated by using the Statewide Housing Locator Website (as

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discussed in section 5.2), among other resources, as well as through the coordinated exploration efforts of the community care manager.

2.1.1 Scattered Site

Pursuant to the Consent Decree, Permanent Supportive 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). Participation in the open housing market, with provider assistance, affords *Williams* Class Members the most choice as to where they will live, with whom they will live (if they choose not to live alone), and which services and supports to use. Under the scattered site 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, and more likely to be delivered confidentially. A full array of flexible mental health and other services, including ACT, case management, crisis intervention, medication monitoring, assistance with daily living skills, and other services are available to individuals in scattered site PSH. Preference will be given to the development of scattered site PSH.

2.1.2 Site-based

Site-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 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 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.

2.1.3 Enhanced Property Management

In addition to on-site services, many site-based permanent supportive housing communities have enhanced property management. Enhanced property management includes:

- The training of staff in proper methods to: 1) recognize when tenants are having problems; 2) how to mitigate those problems, and; 3) who to contact if problems occur and the staff is unable to handle the specific issue.
- Provision of 24 hour staff support (such as a front desk model).
- Ability to make creative reasonable accommodations for tenants with special needs.

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- Dedication to keep lines of communication open between property management and the tenant, the service provider, and the general community including, police, neighbors, local businesses.
- A commitment to draw a clear line between property management and service provision so that the tenant's privacy is not violated.

DMH will contract with housing experts who will provide training to landlords, property managers and community service providers on enhanced property management.

2.1.4 Master Leasing

The goal of master leasing is to identify specific permanent supportive housing options (scattered sites, or a set number of units in a building) that can more immediately be accessed through this pre-determined lease arrangement.

Master leasing is designed as a flexible resource to create a variety of housing options in terms of housing type, density, and location. Through the master leasing approach, which is primarily focused on existing rental housing, the following occurs: 1) execution of long-term master lease agreements (3 to 5 years) with property owners of quality rental housing; 2) securing units at a discounted rate because of long term arrangements; and 3) guaranteed payment for open units resulting in securing a specific targeted number of rental units. The primary purpose of the master leasing approach is to “jump start” the availability of actual rental units for Class Members who may be less likely to secure an individual lease.

3. Housing Models for Illinois

Concurrent with the execution of this Implementation Plan, other models of 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 those supports commonly associated with an enhanced property management structure (24-hour front desk and onsite support services during work hours). These models will require the collective efforts of State Government, public and private partners, financing entities, capital development funding and support services resources to make other housing models a reality.

The Division of Mental Health will convene experts in subsidized and market housing development to advise the State as it works to meet the needs of *Williams* Class Members. This Focus Group will be comprised of housing developers, private financiers, property managers and community service providers, as well as representatives of government. The Focus Group will be asked to provide input on the housing development plan to meet the needs of *Williams* Class Members. The Focus Group will also help DMH create relationships with organizations and

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agencies that can provide the resources needed to achieve the stated housing goals. The conclusions of the Focus Group will not change Defendants' obligations to meet the requirements of the Consent Decree.

4. 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 that Illinois utilizes the most efficient and economical strategies to expand affordable housing, additional resources will need to be developed.

4.1 Capital 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 covered by the *Williams* Settlement Plan.

- The Low Income Housing Tax Credit (LIHTC) – 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.

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. IHDA will review and allocate

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funding to qualified and financially feasible development proposals. It is estimated \$130 Million in grants from this program could create over 800 total units of housing.

- 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 helping the State meet its long term care reform goals.
- Community Development Block Grant -- At least \$5 million in Community Development Block Grant (CDBG) funding may be targeted for developments that will provide permanent supportive housing for special needs population, including at risk veterans, persons and households facing homelessness, and those persons transitioning as part of the State’s Long Term Care Rebalancing efforts. Williams Class Members will be eligible for referral to units created under this funding round.
- HOME Investment Partnership-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.

4.2 Consumer Rental Assistance/Bridge Subsidy Initiative

Many individuals included under the Consent Decree will have limited income (usually based on entitlements such as SSI/SSDI) and may require assistance with rental payments. 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. DMH may have the ability to “project base” the Bridge Subsidy for specific units.

As needed, Bridge Subsidies will be available for Class Members who meet eligibility requirements and who have been assessed as appropriate to transition into a PSH unit. Once this determination is made, the community care manager 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 apply to the individuals transitioning under the *Williams* Consent Decree. An expedited application process is available for eligible Class Members.

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Class Members will be fully advised of all the DHS Bridge Subsidy requirements, such as:

- 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 if and when such options become available, and if the person meets the eligibility requirements for that subsidy;
- Be Medicaid eligible or apply for Medicaid eligibility at the point of transition, and
- Have a clinical assessment by a Resident Review Assessment Unit Worker (RRAUW) who will develop a preliminary service plan that will serve as a guideline in transitioning from Long Term Care (LTC) to PSH.

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 \$904.00). Exceptions to the FMR may be made in appropriate cases as defined by DMH – for example, where exceeding the FMR is necessary to obtain certain accessibility features needed by a tenant with a disability. 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 be afforded choice in geographic preferences in conducting the housing search. The State will make every effort to locate housing in the desired community.

4.2.1 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 community care manager. 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

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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.

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4.2.2 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 community provider agency and the Subsidy Administrator.

4.3 Other Consumer Rental Assistance/HUD and Public Housing Authorities

The State of Illinois will work with Public Housing Authorities (PHA) and other entities that administer and distribute housing rental subsidies (such as Section 8 Housing Choice Vouchers, and Project Based Section 8 contracts) in an effort to transition Class Members from the DMH Bridge Rental Subsidy to permanent housing subsidies.

4.3.1 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 eligible Public Housing Agencies (PHA) have the option to convert a percentage of their Housing Choice Vouchers (see below) to Project Based funding.

4.3.2 Housing Choice Vouchers

The housing choice voucher program is the federal government's major program for assisting very low-income families, the elderly, and persons with disabilities 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

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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 vouchers 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. HUD, through the PHA, pays the balance of the rent up to the agreed upon payment standard (usually the local fair market rent).

4.3.3 Rental Housing Support Program (RHSP)

The Illinois Rental Housing Support Program (RHSP) is a State funded rental assistance program. The RHSP program provides rent subsidies for an estimated 4,000 "rent burdened" households to make ends meet on extremely low incomes. IHDA is the state administrator of the RHS Program.

The program is designed to utilize Local Administering Agencies (LAAs) who manage and coordinate the program locally in their area. LAAs approved for funding, contract directly with landlords to provide units for the RHSP. The LAAs work with the landlords to provide outreach to potential tenants. The RHSP is unit based, so the subsidy stays with the unit, not the tenant. Community care managers will assist Class Members in identifying available RHSP units. *Williams* Class Members seeking rental of RHSP units will need to apply and meet eligibility, tenant selection, and wait list criteria.

4.3.4 Long Term Operating Support (LTOS)

The Long Term Operating Support Program ("LTOS") is part of the Rental Housing Support Program for affordable housing developments. The goal of the LTOS program is to increase the supply of affordable housing to households earning at or less than 30% of Median Income by providing a long term, unit based, rent subsidy. LTOS grants are awarded in response to a competitive program application. Funding under the LTOS Program is generally targeted for supportive housing and special needs populations. Community care managers will assist Class Members in identifying available LTOS units. *Williams* Class Members seeking rental of LTOS units will need to apply and meet eligibility, tenant selection, and wait list criteria.

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5. Choosing Housing Options

Class Members, who give consent, will receive a clinical assessment by a Resident Review Assessment Unit Worker (RRAUW) that will develop a preliminary service plan which will serve as a guide in transitioning from Long Term Care (LTC) to PSH or other housing options. The State will make every effort to accommodate individual choice in the selection of housing in the desired communities.

Affordability and choice are principles of the State of Illinois' Annual Comprehensive Housing Plan. The Illinois Housing Locator (www.ILHousingSearch.org) promotes affordability and choice by providing equal access to locate housing. 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. It is not, of course, the exclusive resource to be used in identifying housing units. 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. As of 5/22/2011 nearly 60,000 units were listed on the site, with just over 4,800 of those being currently vacant and available.

Once a unit has been identified, community care managers 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

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that are specifically designed for non-elderly persons with disabilities. It is hoped that HUD will continue to issue similar Notices of Funding Availability.

5.1 Securing Selected Housing Options

Under the DMH Bridge Subsidy Program once the selection process is completed and the Class Member has approved the housing choice, the community care manager will work with the DMH Subsidy Administrator to secure the identified housing option; the selected units may be subject to waiting lists or occupancy requirements that the community care manager will have to assist the Class Member in negotiating. 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. Accessing other potential housing models would follow a similar process. The process shall be completed promptly to avoid delays in Class Members' ability to access housing.

6. 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 referrals of Class Members.

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 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.

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7. Enhanced Strategies and Benchmarks for Housing Development Year 1

In Years 1 and 2 DMH will work with appropriate partners to secure a total of 640 PSH units from the open market of housing units available for rental opportunities. In accordance with the Consent Decree, in Year 1, DMH will secure a minimum of 256 PSH units and in the second year, DMH will secure an additional 384 units through this methodology.

Year 1 (July, 2011 through June 2012):

DMH will utilize the following strategies to achieve the transition goal of moving 256 Class Members in year one:

1. Will continue to secure approximately 70% of required PSH units from the open housing market for available rental opportunities via scattered sites.
2. Will identify service providers, property managers/landlords that have access to PSH resources that can be subsidized on a site-based basis to provide for approximately 10% additional units.
3. Will target a Master Leasing Implementation Plan for approximately 15% of the required transitions to PSH.
4. IHDA and DMH will collaborate to identify funding initiatives through the Low Income Housing Tax Credit Program, the Build Illinois Bond Program, and other capital resources to increase the supply of PSH in Illinois.
5. IHDA and DMH will collaborate to identify targeted local Housing Authorities to identify a number of set aside units or subsidies that would allow for *Williams* Class Members to utilize directly or to transition from Bridge Subsidies through a pilot project proposal.

In subsequent years, the State will identify targets for Years 2 through 5 and will update this plan to reflect those targets.

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TRANSITION COORDINATION AND COMMUNITY SERVICES

This section will describe transition coordination, community treatment services, provider qualifications, training needs, coordination with DHFS Integrated Care Program, an Integrated Behavioral-Medical Health Model, and Network Sufficiency Analysis.

1. A Vision of Recovery

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.

Previous visions were based on assumptions that individuals with mental illnesses, and especially serious mental illnesses, would remain ill and even disabled for the rest of their lives. As a result, services--such as Assertive Community Treatment (ACT), residential services, and, in Illinois, Community Integrated Living Arrangement (CILA) programs, 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 illnesses, 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

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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 individuals 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 services⁴ important for supporting and sustaining recovery, and directing the State toward more evidence-based and cost effective service delivery.

2. Transition Coordination

2.1 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.

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.

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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 fund community mental health service agencies to provide a specific service of transition coordination for Class Members electing to relocate to a community setting. Staff providing this service will be at least at the Mental Health Professional (MHP) level per the State's Rule 132, and supervised on a ratio not greater than 1:10 by individuals at least at the Qualified Mental Health Professional (QMHP) level per the same State Rule 132. These individuals will ensure that Class Members can successfully navigate the complex systems that impact their lives and well being once they are in the community. In addition, these staff must effectively interface with those systems that must be coordinated prior to when a move to the community actually occurs.

For *Williams* Class Members, provider staff charged with delivering transition coordination services will be expected to initiate discussions between necessary partners and to eradicate silos that may potentially become barriers to seamless planning and service delivery. These staff will serve as the resource that bridges the individual's transitional needs across all dimensions necessary to actualize relocation from an IMD. These dimensions may potentially include such things as identification of appropriate housing or residential services, coordination of health care, securing and/or transferring appropriate benefits or entitlements, linkage and interface with needed community mental health and other services, and the development of specific transition plan recommendations.

2.2 Individualized evaluations from RRAUW as the foundation for transition coordination planning

Each Class Member will be given the opportunity to be assessed by one of the RRAUW 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 successful 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 Mental Health Pre-Admission and Resident Review section of this document.

The development of transition coordination activities is contingent on the results of the individualized RRAUW evaluation, which will include the consumer's direct input, including any preferences for community placement, such as geographical location of the placement, housing and any roommate preferences, and community mental health service provider preferences, if any. This evaluation will serve as the foundation for subsequent discussions with

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the individual 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.

2.3 Initiating the Transition Coordination Process

Upon receipt of the individualized evaluation and description of individual preferences from the RRAUW evaluation, provider staff responsible for transition coordination will develop a strategic approach to initiate contact with the identified Class Member and begin the engagement process with the individual. The initial contact will be face-to-face, at the facility where the resident lives. The staff providing transition coordination service 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 staff will present the resident with a Letter of Introduction and review its content with the Class Member. The letter will identify the staff member and contact information, and the purpose, sequence and the goals of the transition process. Each Class Member will be asked to co-sign the Letter of Introduction with the 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 transition coordination service provider's file. The staff providing transition coordination services will also reaffirm information distributed by the Outreach Workers on community-based services, options of choice (based on the outcome of the RRAUW individualized evaluation) and how the staff providing transition coordination services will assist the individual in actualizing the move from the IMD nursing facility to the community. If requesting Class Members' signatures is deterring them from pursuing opportunities to move to more integrated settings, DMH will propose alternative means of demonstrating that transition coordination staff talked with Class Members about the transition process.

If the Class Member has a guardian, involvement of the guardian along with the Class Member in the transition planning process is to occur and their approvals obtained before any transition discussions or activities occur, with any disagreements or disputes arising between the guardian and the Class Member to be handled pursuant to applicable State and Federal law.

The staff providing transition coordination services will establish a series of subsequent meetings with the Class Member to work on planning and transition steps. After reconfirming the individual's choice of a geographic area or areas of interests, the staff will begin the development of a service plan based on the RRAUW evaluation 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.

The state will ensure that the transition coordination staff has frequent and full access to IMD residents.

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2.4 Comprehensive Service Plan (CSP) Development

The staff providing transition coordination services, the Class Member, and, as appropriate, family, guardians and other service providers, will collaboratively develop a Comprehensive Service Plan that includes the plans for transition from the IMD to a community placement. This Plan will build on the recommendations developed from the RRAUW individualized evaluation. The Comprehensive Service Plan will outline the coordination of resources, services and activities needed to ensure a smooth transition to a community setting, as well as reference any needed specific treatment plans, such as for mental health or substance abuse services. These services and activities may include accessing medical and dental healthcare, transfer or establishment of benefits or entitlements, establishing a representative payee, coordinating medical and other transportation, assuring linkage for psychiatric services and medication monitoring, as well as ongoing engagement with mental health or other services and supports. The service plan will also address strength-based needs, interests and recovery goals of the Class Member, such as employment, educational pursuits or other hobbies. The staff providing transition coordination services will explore as many of these interests as possible before the Class Member transitions to his/her new environment. The Comprehensive Service Plan will become the basis for monitoring of the Class Member's transition to the most appropriate integrated community-based settings.

For some Class Members, some adjustments and skill development prior to implementing the transition to a community placement may enhance the likelihood of a successful and sustained placement. For example, if the Class Member requires training to administer injectable medications, the staff member responsible for transition coordination will be expected to recommend actions and services to be carried out by the staff of the IMD and of the community provider that will serve the person when he or she leaves the IMD, to work and assist them in this process and document this as part of the overall Comprehensive Service Plan. However, as the Consent Decree provides, acquisition of daily living skills and illness self-management skills shall not be a prerequisite for transitioning out of an IMD. Whether or not an IMD has adequately trained a Class Member to self-administer medication while residing in the IMD, such training can and will occur through the community-based service provider. If at any time the Class Member's inability to properly self-administer medications jeopardizes his or her safety, and the Class Member cannot safely accept administration of medication from a trained professional when appropriate, clinical measures will be taken to assure his/her safety including hospitalization if necessary.

2.5 Risk Mitigation Plan

Included in the Comprehensive Service Plan shall be a detailed plan describing any assessed level of risk for the individual, that is, factors that could potentially adversely impact the Class

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Member's ability to stabilize and function effectively in their community environment, as well as planned steps and actions for mitigating these risks. Risk 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 staff providing transition coordination services will work with Class Members to understand the importance of open communication. To facilitate this, it is important that planning or budgeting occur to ensure access to a landline phone or cell phone in the event of an emergency (or arrangements with telephone companies to access emergency lines, if more convenient) for the Class Member in their community placement setting.

For each identified risk, the Comprehensive Service Plan is to detail the tasks, services or actions necessary to address or manage the risk factor. This part of the Service Plan, the risk mitigation plan, becomes the clinical blueprint for a strategic response for managing the safety, welfare and stabilization of the individual in his or her community-based setting.

Part of this section of the Comprehensive Service Plan, especially for individuals living alone or in a setting with limited access to immediate staff support, shall include an emergency plan that can be executed at anytime. The plan would include specifics on the individuals the Class Member can contact for immediate assistance and how they can be contacted if needed, as well as where to go for immediate attention, such as medical needs, is required.

As with the entire service plan, the specification of potential risks and planned responses are to be individualized and dynamic, with the plan changed, adjusted and revised as called for by changes with the individual, his environment, services or supports.

2.6 Securing Housing and Related Supports

2.6.1 Transition to Permanent Supportive Housing

When transition to Permanent Supportive Housing (PSH) is planned, the staff providing transition coordination services 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 staff providing transition coordination will assist the resident in identifying the most appropriate housing option.

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The staff providing transition coordination will be the primary resource to assist the Class Member in initiating the actual housing search. This staff member will assist the Class Member in using all available local community resources, word of mouth, newspaper listings and technology such as the housing stock locator (see www.ilhousingsearch.org), Craigslist, and others, to identify appropriate options. They 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 staff providing transition coordination 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. Finally, this staff member will accompany the Class Member on each housing search site visit, so that he/she can make an informed final decision. *Williams* Class Members interested in PSH will be afforded a reasonable choice of housing units.

Once a housing unit is identified, the staff providing transition coordination 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 Subsidy Administration through DHS/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 DHS/DMH PSH model, the staff providing transition coordination will interface with the Subsidy Administration 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 staff providing transition coordination 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 Subsidy Administration is detailed in the Housing Section of the Implementation Plan.

2.6.2 Transition to Other Residential Supports

If the community agency finds a Class Member that is interested in moving from the IMD but rejects a transition to independent housing, either a Supervised or Supported Residential setting may be considered as an interim option or permanent setting if deemed clinically appropriate and medically necessary. The Class Member's geographic preference of areas that have such programs is to be obtained, and the staff providing transition coordination will ensure that the Class Member is transported to these programs to see the physical structure and program and services operations. If the Class Member chooses not to accept this setting, other available Supervised or Supported programs are to be explored.

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Supervised and Supported Residential Settings refer to 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, offering 24 hour onsite supervision and (b) Supported Residential, offering up to 12 hours onsite supervision.

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. 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.

The Supervised Residential 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 community-based treatment setting for individuals who have Serious Mental Illnesses and who meet medical necessity 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.

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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.

The Supported Residential 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 community-based treatment setting for individuals who have Serious Mental Illnesses and meet medical necessity 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.

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For services and supports not offered by the mental health service provider agency preferred by the Class Member, the staff providing transition coordination will offer the individual a choice of providers, and will begin the process to ensure linkage with the desired provider(s) and services/supports.

2.7 Transition to Community Placement Checklist

Staff responsible for transition coordination services 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 or securing of benefits or entitlements; (d) coordinating all health care appointments; (e) ensuring that community-based housing is secured; (f) establishing a representative payee (if necessary); (g) ensuring that a Comprehensive Service Plan is completed that includes the plans for transition to a community setting and plans for handling risks and emergencies; (i) ensuring that the person is linked to all necessary services and scheduling appointments with the primary and other services providers identified on the Comprehensive Service 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.

Staff providing transition coordination services 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 one-time 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 \$2,000 for basic household expenses. Individuals may be eligible for a lifetime maximum up to \$4,000 based on extenuating circumstances as defined by DMH. These dollars cannot be used for the purchase of cigarettes or alcohol. Transition funds will be handled and reconciled by the staff providing transition coordination services. Class Members, family members or collateral contacts will not have direct access to these funds. The staff providing transition coordination services will assist the Class Member to secure necessary household items.

If transitioning into a PSH unit, once the lease is signed the staff providing transition coordination services and the Class Member 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

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tasks described above must be completed before the Class Member physically leaves the IMD facility.

2.8 Priority System for Allocating PSH (and Other Community Housing)

DMH will create a plan that describes the method and order of transitioning Class Members. This plan will make the process for transitioning to housing transparent, and will enable Class Members to understand how to obtain these units and the priorities that will be applied in selecting tenants.

During Year One of the Consent Decree, priority for transitioning to PSH units developed for Class Members will be given to:

- (1) Class Members whose service needs are less complex
- (2) Class Members who were transferred to congregate settings, including other IMDs, upon the closure of Somerset and Wincrest, but who could be served in PSH
- (3) Class Members residing in other IMDs that may close in Year One
- (4) Based on provider capacity, some number of units may be allocated to Class Members with significant needs who are more challenging to serve.

In Year 1 the state will attempt to transition Class Members in each of these priority groups.

DMH's plan will describe priorities for each year of the implementation period, and will ensure that all Class Members have opportunities to move to the most integrated setting appropriate during the course of the implementation period. DMH will periodically reevaluate the priorities for allocating PSH (and other community housing) to ensure that the needs and preferences of all Class Members are addressed.

3. Community Mental Health Services Expansion and Development

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 service monitoring, to ensure that the individuals most in

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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.

During the initial phases of the Implementation Plan, some immediate expansion of services will need to occur with only limited information about the needs, preferences and choices of the Class Members to be in the first transitioning cohorts. Thus, DHS/DMH will need to work with providers assessed to be most likely to serve the initial cohorts of Class Members and assess or estimate available as well as additional services and service capacity that will be needed, including Medicaid and non-Medicaid services funded by DHS/DMH as well as other services funded by other State entities, such as DHS/DASA and DHS/DRS.

Once the Implementation Plan is underway, DHS/DMH will begin to accumulate more precise information from the individualized evaluations completed as part of the RRAUW process on the specific geographical and other choices by Class Members, as well as their service and support needs and preferences. This will allow more accurate planning and execution of service expansion activities by DHS/DMH, other state entities, and community service and support 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 Community Services, in collaboration with the DMH Associate Deputy Director for Transition Coordination will be responsible for overseeing this service development process for public mental health services.

3.1 Community Mental Health Medicaid Services

Rule 132 defines the array of community mental health services in Illinois. Specifically, the service list includes the following:

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Mental Health Assessment to provide a formal gathering of information on an individual's strengths and mental health challenges in order to identify necessary services.

Psychological Evaluation consistent with nationally standardized psychological assessment instruments.

Treatment Plan Development, Review and Modification to provide individualized care planning for a person's specific mental health treatment needs.

Assertive Community Treatment to provide comprehensive team based services to adults with serious persistent mental illnesses consistent with the evidence based practice model. This service provides the individual with access to a highly qualified, multi-disciplinary team of practitioners who provide most services in the community as opposed to office-based settings. Individuals served by these teams often require outreach to remain engaged in services. Team members are available 24 hours per day, 7 days per week.

Case Management to provide supports such as planning, coordination, advocacy, professional consultation with other providers of service, and assistance with transition of living arrangements. Included is establishing linkages to other needed services and supports and assuring the provision of these services and supports to the individual.

Community Support is provided primarily in community settings to assist an individual in putting skills into practice in order to live, work, learn and participate fully in the community. This includes supporting the individual's development and practice of a WRAP plan. This service is provided to both individuals and groups in a variety of settings (community, office, residential).

Community Support Teams make community support services available 24 hours per day, 7 days per week from a team of staff who are all familiar with each of the consumers' needs.

Crisis Intervention is available to individuals experiencing a psychiatric crisis and includes assessment and brief interventions for the purpose of reducing symptoms, stabilizing the crisis and restoring previous level of functioning.

Community Support Residential services and support for adults to assist him or her to achieve and maintain rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions that facilitate illness, self management, skill building, identification and use of natural supports, and use of community resources.

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Mental Health Intensive Outpatient services are intended for individuals at risk or with a history of psychiatric hospitalization, and are focused on symptoms which in the past have resulted in hospitalization. This intensive level of office-based service is available at least 4 hours per day, 5 days per week, and is provided by Master's level clinicians.

Psychosocial Rehabilitation provides intensive skill-building in a classroom setting, and is focused on facilitating independent living, adaptation, problem solving and coping skills. Among the skills that may be taught are WRAP and DBT skills groups.

Psychotropic Medication services include the administration of medications by licensed medical staff, monitoring of progress and potential side effects, and training of the individual and/or family members to self-administer psychotropic medications.

Therapy/counseling may be provided in individual, group and or family sessions and involves the delivery of formal sessions provided by staff trained within specific theoretical frameworks and/or to address specific issues. This includes evidence based therapeutic approaches such as DBT, Cognitive Behavior Therapy and Motivational Enhancement Therapy.

This comprehensive service array allows for the provision of several evidence based practices, including Dialectical Behavior Therapy (DBT) and Wellness Recovery Action Planning (WRAP) wherein discreet treatment modalities are billed individually using one of the above services.

3.2 Community Mental Health Non-Medicaid Enhanced Services

These services are important for assuring successful transition and stabilization in a community setting, but are not considered "medically necessary" by Medicaid authorities. DHS/DMH plans to support the following non-Medicaid services:

Supported employment and vocational services are designed to secure and maintain employment for an individual, with supported employment being an evidence-based service with prescribed requirements and features, such as ongoing program staff support to the individual in navigating and managing their work life experiences.

Supported education is similar to supported employment, but with a focus on the individual achieving specific goals in advancing their educational level.

Peer support and mentoring/social network development is a service aimed at providing support to an individual with mental illness by qualified peers who have also had personal direct experience with handling their own mental illness, and training and experience in assisting an individual in establishing and maintaining an effective and satisfying social network.

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Recovery resource centers (e.g. drop-in) are facilities or locations accessible to individuals with mental illnesses where informal support, socialization and information can be obtained to assist and support the individual as they progress along their individualized path to recovery. These centers will be staffed by trained consumer peers.

Peer directed volunteer programs will be a component of the recovery resource centers and serve to obtain volunteer opportunities of interest to individuals and residents of Nursing Facilities, including IMD's as part of their recovery process.

Family education and support is a service that will be offered to the families and significant others of individuals with mental illnesses and focus on how these individuals can assist and support the individual's goals, choices and efforts to advance in their recovery.

Integrated Dual Disorder Treatment for individuals with mental illness and substance abuse disorders is an evidence-based treatment with prescribed requirements and features for assisting individual with these dual disorders.

Medications and physical health monitoring services at the mental health service provider is planned by DHS/DMH in the form of support for an Advance Practical Nurse as a staff member who will assist with medications, including obtaining any necessary prior approvals for psychiatric or other medications, and monitor the physical as well as the psychiatric health of Class Members. Working closely with staff psychiatrists and physicians, this additional staff resource will extend and enhance psychiatric and physical medical health services.

Crisis/diversion residential beds are aimed at providing an alternative to admission or extended stays in more restrictive and expensive institutional settings, such as hospitals or nursing facilities, in order to provide an opportunity for the individual to manage and mitigate a crisis situation, such as an exacerbation of symptoms due to stressful events, sudden loss of housing, escalation of conflicts with roommates or landlords, etc.

Non-medical transportation is a service for assuring an individual's access to important services and supports that are deemed as not medically necessary and, thus, transportation costs not covered by the Medicaid program, but is important to the individual's successful tenure in the community.

Highly specialized, infrequently needed services may sometimes be required for exceptional service needs by some Class Members, and not available by current providers. For such situations, DHS/DMH will establish a process for requesting funding for and obtaining assistance in securing needed exceptional services to support a Class Member in the community.

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Some of these services, particularly the Recovery resource centers and the Peer directed volunteer programs will be made available to Class Members residing in IMDs and awaiting transition to the community. Outreach Workers will share information about the availability of these services in the community and encourage Class Member involvement in preparation for moving into the community.

3.3 Residential treatment services

As stated previously, Supervised and Supported Residential Settings refer to residential options where residents with limited experience living in community-based settings are provided direct, on-site services, skills training, and supports. 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.

Because these services have evolved over time and according to the needs of the particular community as identified by the specific provider of the residential service, there is currently broad variance in practices within the state. DHS/DMH is working on a Residential Rule, which will refine and standardize residential services within the state. While this is still a work in progress, the goals of the rule are to define standards for safety, service expectations, and admission and continuing stay criteria for consistency in practice across the state.

3.4 Services provided by entities other than a community mental health agency

Staff providing transition coordination services will not only have to ensure linkages and service provision by providers funded by DHS/DMH, but also with providers of other services and supports needed by Class Members and essential for assuring their successful tenure in community placements.

- **Housing**

The first and primary responsibility of staff will be to assure the arrangement of appropriate community housing for individual Class Members based on their choice and preferences. As detailed in the "Housing" section of the Implementation Plan, contact and linkages may need to be established with DHS/DMH and its housing and Subsidy Administrator contractors to access Permanent Supportive Housing (PSH), or with the Illinois Housing Development Authority (IHDA), or other housing entities to secure a housing arrangement that matches the choices and preferences of the Class Member.

- **Primary/physical medical services**

Although some Class Members may have more essential needs for linkages with primary/physical health care providers, staff providing transition coordination services will be expected to assure a linkage with a primary health care provider for all Class

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Members to assure appropriate monitoring of each individual's physical health. Primary health care providers that are accepting Medicaid clients and that can meet any unique needs of a Class Member will need to be identified and the Class Member accepted as a patient of that provider.

- Substance abuse services

DHS/DMH plans to enhance access to the evidence-based service of Integrated Dual Disorder Treatment (IDDT) for individuals with both a mental illness and substance abuse disorder. However, it is anticipated that not all Class Members may elect or require this level of service, and some may require other substance abuse treatment and support services funded by DHS/DASA. Staff providing transition coordination services will need to assure appropriate access to such services when needed by Class Members.

- Vocational services

Similarly, DHS/DMH plans to enhance access to the evidence-based service of Supported Employment for individuals interested in this service, but some Class Members may prefer other services offered by DHS/DRS. Staff providing transition coordination services will need to assure appropriate access to such services when needed by Class Members.

- Educational services

Some Class Members may have a personal goal of advancing their educational status. Staff providing transition coordination services will need to assist Class Members with this interest in accessing appropriate educational opportunities and supports.

- Support groups

Other support groups may be recommended to a Class Member or a Class Member may independently express an interest in such groups, such as mental health peer support groups, depression and bipolar support groups, Alcoholics or Narcotic Anonymous, etc. Staff providing transition coordination services will need to assist Class Members with accessing and arranging the means for attending such groups if the Class Member is interested.

- Other community social, support and spiritual groups

In addition to support groups for individuals with disorders, there are other community groups, such as church, spiritual, social, exercise, or volunteer oriented groups, that a Class Member may elect to become involved in as part of their community integration and may need the assistance of the staff providing transition coordination services.

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4. Provider Qualifications for Transition Coordination & Community Services

4.1 Individual choice and the quality of services funded by the State

Although a key component of a recovery approach to services is assuring individual choice, including choice of service provider, the State as the payer of services also has responsibility for assuring that the services being purchased with taxpayer dollars are appropriate, of adequate quality and delivered by qualified staff. And in order to maximize the likelihood of successful and sustained transition to community settings for Class Members, the qualifications and commitment of providers interested in developing services to meet the needs of Class Members will be evaluated and monitored.

4.2 Meetings with providers

DHS/DMH conducted a Provider Forum on May 6, 2011. Approximately 30 community mental health and substance abuse providers were invited. These providers were selected for their geographic proximity to the IMDs. The forum was well-attended with more than 12 providers represented. The revised conceptual framework of the *Williams* Implementation Plan was presented to them along with a list of non-Medicaid Enhanced Services the Division will purchase for Class Members in FY12. Providers were asked to identify any other needed services that would benefit the Class Members and associated costs and needed resources for their implementation. Areas that were identified included (but not limited to) staff training, increased rates for current services, minimizing administrative burdens and assurance that funding would cover 100% of costs. DHS/DMH will develop a format for providers to use when submitting their narrative plan and budget for serving Class Members during FY12.

In addition to the above meeting, a series of site visits to a sample of providers is in the process of being conducted by DHS/DMH staff and expert consultants in order to obtain a more detailed understanding of the current status of providers with respect to their capability for the provision of services to Class Members, including such factors as the financial status of the providers, the degree of correspondence between state rates for services and provider costs for the provision of the services, current service capacity, ability to expand services and service capacity, resources needed to support the expansion of services and service capacity, etc. Additional meetings with providers will be scheduled as needed, most likely following the issuance of a “Request for Information” (RFI) to providers.

4.3 RFI to providers

Although discussions with providers are useful, DHS/DMH will benefit greatly in its planning if it is able to obtain detailed documentation of what the capabilities are of each provider to serve Class Members, as well as what additional resources and supports they would specifically need in order to expand the array of services they currently offer and the capacity of their services.

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For this reason, DHS/DMH plans to issue a “Request for Information” (RFI) to providers to obtain individualized documentation on these capabilities and needs. On the basis of provider response to the RFI, DHS/DMH can plan its next steps for the necessary expansion of services for Class Members, including identification of needed resources as well as follow-up meetings with providers. The gathering of this information shall not delay the state’s compliance with its obligations under the Consent Decree.

4.4 Required and preferred provider qualifications

Throughout DHS/DMH’s efforts to expand services and service capacity for Class Members, focus will be on establishing collaborative working relationships with existing or new providers that demonstrate certain characteristics capabilities or experience that DHS/DMH believes will be important in maximizing the likelihood of successful and sustained community placement of Class Members. Depending upon the number of qualified providers, some of these characteristic may be required, while others only preferred.

- Commitment to recovery and person-centered service delivery. With the increasing abundance of evidence that mental health treatment works and that recovery from serious mental illness is possible, providers who exhibit a parallel positive attitude and approach to service delivery will benefit Class Members. Furthermore, a deep respect as well as an understanding of the role and importance of individual choice throughout the service process, and the role of choice in the recovery process, is important. Providers who can demonstrate an understanding and capability for these characteristics will receive priority consideration.
- Experience serving individuals with similar backgrounds and needs to those of the Class Members. Clearly, providers who have previously serviced individuals from IMDs or other nursing facilities will have knowledge and experience regarding at least some of the assets as well as needs of individuals with similar institutional placements and experiences which will serve the provider well in planning and implementing services and supports for these individuals, including Class Members.
- Ability to deliver most of the full range of Medicaid and other mental health services needed by Class Members, including evidence-based services. DHS/DMH values evidence-based and evidence-informed services as being cost-effective expenditures of State resources. Moreover, the broader the range of services a provider can deliver the more likely it will be that services will be coordinated and integrated and the less likely there will be gaps in services or supports due to additional complexities required for referral and linkages to other service provider entities.
- Ability to execute and secure linkages to services and supports provided by other service providers and entities. It is recognized, however, that few mental health service providers will ever be able to provide the full range of services and supports

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needed by Class Members. Thus, a provider's ability to successfully and effectively link an individual to other needed services and supports, as well as their ability to assure coordination of services and supports across providers, will be an important provider characteristic DHS/DMH will look for in providers that will serve Class Members.

- Ability to exercise high degrees of flexibility in response to any changing needs or choices of Class Members. Since movement from an IMD will be a new experience for most Class Members, and, even with extraordinary efforts at information dissemination, many decisions and choices that must be made by Class Members will be based on necessarily limited information and experiences, it should be anticipated that Class Members may wish to reconsider their original choices and decisions once they gain experience living outside of an IMD. A provider that can demonstrate agility in responding to changing decisions, choices and service needs of a Class Member will be more effective in the delivery of services and supports to that individual.
- Ability to effectively develop additional services and capacity on a timely basis to meet the needs of Class Members. Additional services and service capacity will be required to effectively serve the increasing numbers of Class Members transitioning to community placement over the upcoming years of the Implementation Plan. Providers who demonstrate a capability to develop, implement, and sustain additional services and capacity on a timely basis matched as closely as possible to when the services are needed will not only enhance effective service delivery to Class Members, but also minimize costs to the State in funding unneeded or unused services or capacity.
- Demonstration of sufficient financial stability and solvency to assure the likelihood of ongoing service provision without disruption due to organizational difficulties. The possibility of organizational difficulties or even agency closure that could impact the reliability of ongoing service delivery and support to Class Members is a risk DHS/DMH will strive to minimize. Providers that are capable of effectively managing their organization and services during times of financial hardship and stress will be most likely to avoid disruptions on an ongoing basis.
- Ability to develop and maintain an effective quality assurance and quality improvement program relative to services for Class Members. DHS/DMH is interested in assuring that the services purchased by the State are of the highest quality possible. Thus, providers who demonstrate a willingness to seek and obtain outside review and evaluation of their operation and services, such as through application for and maintenance of accreditation from national organizations and comparison to national standards, provides the State with some level of additional assurance of the overall quality of the provider organization and its services. Similarly, providers who maintain an active and ongoing program of quality assurance and improvement for

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their operations and services, perhaps as an accreditation requirement, likewise demonstrate a commitment to quality.

- Ability to report individual and aggregate recovery outcomes for Class Members. Providers with a focus on recovery outcomes, both at the individual and more aggregate levels, will ensure that the State's investment in services for Class Members produce clearly documented returns, as well as improved quality of life for the Class Members.

4.5 Contractual terms for provider performance in service provision

As is the current situation with all DMH-funded mental health service providers, the State has the option to terminate any contract with a provider, including termination for unacceptable or insufficient performance in the provision of services to any individual or group of individuals, including Class Members. However, DHS/DMH is also interested in exploring means for emphasizing incentives for providers based on the successful transition of Class Members with positive outcomes; DHS/DMH plans to continue to explore what inducements may be possible, and how such measures could be implemented within state regulations and guidelines.

5. Training of Providers

In order to assure that providers that will be serving Class Members are adequately prepared and consistent with DHS/DMH expectations, a number of information, development and training activities are planned.

5.1 Additional support materials

An online Community Service Directory will be developed for providers to readily identify the name, address and phone numbers of other providers of services that Class Members may need. The directory will include information on providers of mental health, substance abuse, Medicaid State Plan healthcare services and other resources to allow staff providing transition coordination services to locate the identified services and offer Class Members a choice of providers and service locations. The directory will be 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.

Similarly, to support access to services across Illinois, the State agency partners complying with the Consent Decree will assist DHS/DMH in developing an online Resource and Referral Guide to direct staff providing transition coordination services to referral and enrollment processes for services. The guide will contain details on the processes and forms required for enrolling or

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engaging a Class Member in the services of a provider, state or local agency, including the specific contact information and eligibility criteria for services as well as intake procedures. The guide will also include contact information for an identified staff person from DHS/DMH, DHS/DASA, DHS/Division of Developmental Disabilities (DDD), Department on Aging (DoA) and HFS who have been specifically charged with assisting staff providing transition coordination services with any issues that might arise during community placement planning and service linkage. In addition, in meetings with State agency partners involved in implementing the Consent Decree, opportunities for streamlining referrals across State agencies will be discussed and, as appropriate, a corresponding work plan element developed to improve the referral process as a quality improvement activity. A team representing the service areas across State government involved with the Consent Decree will discuss known and emerging issues regarding the linkages to services and responsibility for notification of changes in those linkages.

State agency staff will be identified who are responsible for assisting staff providing transition coordination services 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. Staff providing transition coordination services will be trained on how barriers to accessing community services are to be addressed.

5.2 Workforce development

Through ongoing meetings with providers, the information garnered through the RFI process and ongoing clarification and specification of the service needs of Class Members, DHS/DMH will work with providers of services to Class Members in planning what activities and supports will be useful in enhancing the development of the workforce necessary for this Implementation Plan.

All providers funded by DHS/DMH are expected to ensure a minimum level of orientation, training and staff development for their staff, and the same expectation will be applied for some training topics for provider staff that will be serving Class Members. For example, providers will be expected to ensure that their staff are knowledgeable regarding key federal and state statutes, such as confidentiality of consumer and clinical information, abuse and neglect reporting, etc., as well as key requirements from administrative rules and the contract between the provider and the State, such as the specific definitions and requirements of treatment services funded by the State, documentation requirements, etc.

For staff assigned to treat Class Members, some additional training is appropriate and expected, including some background on the Olmstead Decision, the *Williams* lawsuit and Consent Decree, the *Williams* Implementation Plan and its components (such as the outreach and information dissemination activities, the RRAUW, the wide variety of services and supports that are available to individuals in PSH, alternatives and processes for securing housing and housing

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supports, services and supports available for Class Members). Through meetings with providers and as the Implementation Plan is rolled out, DHS/DMH will collaborate in assuring sufficient support for this more focused training for provider staff serving Class Members.

5.2.1 Individualized person-centered planning and recovery-oriented service provision

Provider staff who will be providing or coordinating services to Class Members will be required to participate in training 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). In addition, training on a person-centered approach to service planning and delivery, including the importance of individual choice in the process will be offered, along with training on clinical methods, such as motivational interviewing, which support this approach.

5.2.2 Comprehensive Service plan development

As staff providing transition coordination services will be required to develop, document, maintain and revise as necessary a Comprehensive Service Plan for each Class Member, training on these activities will be offered and required by DHS/DMH, including the required components of each Service Plan as well as how the specific treatment plans or service plans from various providers are to be reflected in the overall Comprehensive Service Plan.

5.2.3 Transition Coordination

Staff providing transition coordination services will be required to attend DHS/DMH training on the details of the service “transition coordination”, which will include service definition, examples, underlying values and expectations, how the service will be funded by DHS/DMH, tools and checklists to assist in the provision of transition coordination and documentation requirements.

5.2.4 Linkages to other providers, services and supports

Staff providing transition coordination services will also be required to attend DHS/DMH training on the details of establishing and assuring the linkages to other providers, services and supports that a Class Member might need, and how these linkage activities are a component of the service “transition coordination”. Included will be instruction on how to utilize referral and application processes necessary for accessing other services and supports, as well as the follow-up and documentation requirements for all referral and linkage activities.

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6. Coordination with HFS Integrated Care Program

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) and who are not also eligible for Medicare. 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 and enrolled starting with Phase I.

HFS has identified Aetna and Centene-IlliniCare as the two successful bidders of the RFP. During Phase I of the Integrated Care Program the HMO's will cover all Medicaid covered services except for long-term care services in institutions or the community, including all professional physician components and acute behavioral health services. First enrollments for Phase I were effective May 1, 2011 and the initial enrollment roll-out will be completed October 1, 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 except individuals with developmental disabilities. This phase will be designed in consultation with stakeholders during 2011 and implementation is targeted for July 2012. The contract includes 30 specific quality and outcome measures that will be tracked, including 14 pay-for-performance measures that incentivize spending on care that produces healthy, quality-of-life outcomes and withhold payments if outcomes are not produced. In addition, the Department of Public Health and the University of Illinois at Chicago are collaborating on an independent evaluation of the program.

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

- Determination and selection of further quality measures and outcomes for vendor contract;
- Attending and supporting stakeholder meetings to solicit input on policy, contractual and implementation strategies from providers, consumers and advocates;
- 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;

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- All phases of project implementation.

Managed care vendors (Aetna and Illinicare) will be responsible for insuring access for all ICP enrollees, including those *Williams* Class Members, to State Plan services including Rule 132 and 2060, 2090 services and other inpatient and ambulatory (e.g. if covered, Partial Hospitalization Intensive Outpatient programs) behavioral health services. The vendors are to provide for these services through their network of contracted providers. The vendors will be responsible for providing the right service to the right consumer at the right time and will assess, monitor, and readjust services delivery based on coordinated treatment plans with the consumer (enrollee), contracted providers and the vendors' care coordination teams. The vendors are obligated to integrate and coordinate behavioral health services with physical health services and have plans to co-locate these services when possible. The vendors, through their case coordination teams, will be responsible for insuring and coordinating access to all services, even those separately funded, as prescribed under current waivers and court orders, including the *Williams* Consent Decree. Vendors are obligated to submit to HFS complete encounter data detailing every service received by an enrollee. This enables HFS to monitor the access to care of enrollees as well as improvements in health resulting in fewer hospitalizations and institutionalization.

Williams Class Members who are enrollees in the Integrated Care Project (ICP) will be afforded the same access to care and undergo the same level of managed care oversight for State Plan Services as other enrollees, including utilization management controls distinct to each vendor, IlliniCare or Aetna Better Health. Similarly, Class Members who are ICP enrollees will have the same access to grievance and appeal processes of each separate vendor as afforded to all managed care clientele under Federal Regulations (Balanced Budget Act of 1997) and Illinois statutes and associated rules (Managed Reform and Patient's Rights Act, 215ILCS 123 4/1 et seq).

The consumer (Class Member), Community Mental Health Agency, advocate or family member on behalf of the consumer may file an appeal or grievance to the ICP managed care entity using the vendors' process; if the consumer is not satisfied with an outcome of the appeal then the consumer or those on behalf of the consumer may ask for an independent outside reassessment of the appeal. The process has a final step which can move the appeal to a HFS departmental fair hearing.

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. DHS/DMH Quality Bureau will assure that each Class Member

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enrolled in the Integrated Care Program has a service plan that includes any necessary services and supports for community tenure. DHS/DMH will work with HFS to ensure that DHS/DMH is able to effectively monitor the services being received by the Class Member relative to their service plan, including the appropriateness and quality of the services. This will include the reporting of the necessary data to DHS/DMH by the managed care vendors, including any risk management sentinel indicators, as required in their contract with HFS. Information on the Integrated Care Program can be found at: <http://www.hfs.illinois.gov/newsroom/090910.html>.

The State will periodically update the Court Monitor and Plaintiffs' counsel on the implementation and operation of the Integrated Care Program, including planning for Phase II.

7. Integrated Behavioral-Medical Model

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 illnesses 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 Illnesses 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 integrated/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 integration/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 and will enhance these services when needed.

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- 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 also has a history of working together on coordinated vocational services and supported employment which, with resources, will be built upon through renewed focus and coordination.
- Coordination with housing resources: Individuals with Serious Mental Illnesses, 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 Illnesses 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 Illnesses 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 an “Integrated Behavioral-Medical Health 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. There is currently much work being done on integrating behavioral and medical health care for individuals on the federal, state and local levels. Terms such as Medical Home, Person Centered Healthcare Home, Integrated Health Home, Health Care Homes, Community Health Center, Four Quadrant Model and Bidirectional Integration are becoming common terms in the movement to better serve individuals in a coordinated manner. DMH would be moving toward a model that is focused on serving individuals with Severe and Persistent Mental Illnesses using the following principles:

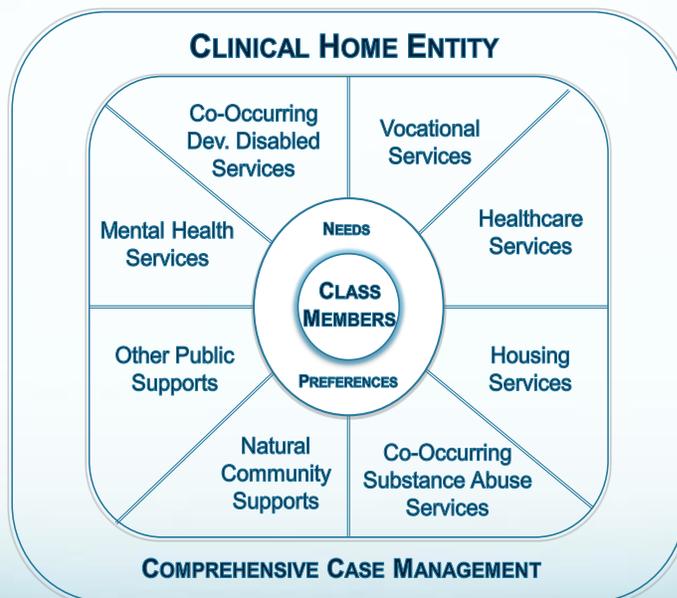
- **Whole person orientation:** One provider is responsible for providing for all of the individual’s mental health and health services needs or taking responsibility for appropriately arranging for care or services with other qualified professionals or organizations.
- **Relationship:** Each individual has an ongoing relationship with a primary case manager trained to provide first contact and assure continuous, comprehensive, and coordinated services and supports.

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- **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:** Quality and safety are assured by a service 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.

7.1 Development of the Integrated Behavioral-Medical Health Model

Williams Service Model



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In Fiscal Year 12, DMH will initiate the development of an Integrated Behavioral-Medical Health Model by convening key stakeholders for input and advice. The proposed key principles and functions of the Integrated Behavioral-Medical Health Model will be reviewed and refined with stakeholder input, and options for supporting and implementing this 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:

- Capture of federal dollars for pilot of model, possible modification of the State's Medicaid Plan and related administrative rules and/or utilization of federal waivers to create streamlined funding approaches wherever possible;
- Consider prioritizing any non-Medicaid funding to certified Integrated Behavioral-Medical Health providers in order to purchase support services;
- 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;
 - 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 the ongoing integration/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);
 - Evaluating 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 Integrated Behavioral-Medical Health Model planning process.

DMH anticipates issuing a Request for Information from providers interested in serving as an Integrated Behavioral-Medical Health Home for Class Members, and require that those awarded the contract offer Class Members already placed in the community, as well as future Class Members, an option of enrolling in the Integrated Health Home. Levels of integration could be based on the needs and resources of a given community, meaning that the State would not require that all services be integrated or co-located, although this would be permissible, but leave room for innovation around how partnership occurs and where specific services are located.

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Evaluation criteria for responses will include, among other considerations: (a) the bidder's proposal for integrating behavioral and medical care; (b) qualification of proposed staff; (c) appropriateness and feasibility of approach and cost; and (d) the bidder's previous and current performance in serving and meeting the needs of Class Members as well as other clients.

8. Analyses of Service Capacity and Upcoming Needs

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 DHS/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, DHS/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, DHS/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;

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- Psychiatric Services

In addition, DHS/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 DHS/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. DHS/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 most likely be needed by Class Members. Access information for substance abuse services, especially resources for co-occurring mental illness/substance abuse disorders, will be some of the information needed.

DHS/DMH plans to have a minimal network sufficiency analysis inclusive of capacity assessment completed by December, 2011, 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.

By July 1, 2012, DHS/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 individualized evaluations as well as the Comprehensive Service Plans developed by the staff providing transition coordination services. 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. DHS/DMH will plan to complete similar 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.

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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.

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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 RRAUW processes);
- Transition coordination and service plan development, including assurance of Class Member choice;
- Housing and residential placement;

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- 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.

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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.

Contact with IMD staff will begin with outreach and information dissemination and continue until transition to a community setting is completed. If IMD staff fail to comply with requests for information, access to Class Members, or other needed actions to ensure smooth transition or if IMD staff retaliate against Class Members, the Outreach or Community Agency staff working with the Class Member will notify DMH immediately so that DMH, the Department of Public Health, and Healthcare and Family Services can address the issue with the IMD immediately.

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 RRAUW 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 RRAUW 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

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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. DMH contracted community providers 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. Provider 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. Provider staff will work closely with the Class Members to ensure Class Members are receiving the services they need in the community, and, if necessary, adjusting and changing Service Plans.

The DMH Quality Bureau will oversee monitoring of the transition process through a combination of reports from community providers and on-site surveys of provider documentation. To monitor successful transition planning and key tasks, DMH Quality staff will review provider documentation of the Service Plan, which will include the presence and quality of the 24 Hour Backup Plan, the Risk Assessment and Mitigation Plan, and the Transition Plan and will determine whether the Plans reflect client choice, a Recovery orientation, needed services, and identified providers and supports and linkage processes. In addition, DMH Quality staff will review provider documentation for evidence that key transition tasks occurred successfully, including: 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 or securing of benefits or entitlements;
- d. Coordinating all health care appointments;
- e. Ensuring that community-based housing is secured;
- f. Establishing a representative payee (if necessary);
- g. Ensuring that a Comprehensive Service Plan is completed that includes the plans for transition to a community setting and plans for handling risks and emergencies;
- h. Scheduling appointments with the primary and other services providers identified on the Comprehensive Service Plan;

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- i. Ensuring that the individual has applied for food stamps and has at least a two-week supply of food (if in PSH);
- j. Processing paperwork for Bridge Subsidy housing assistance for eligible units, (l) activating transition funds;
- k. Working with the Class Member to identify allowable purchases; and,
- l. Assisting Class Member with shopping for necessary items. DMH Quality staff will also monitor the proper use of transition funds by the community provider.

Post transition, DMH Quality staff will review provider reports and documentation to ensure the provider is monitoring the Class Member's stability in the housing or residential placement, skills development, management of healthcare and psychiatric needs, socialization/ peer support, and adherence to the Service Plan recommendations (unless documented reasons for a change). Providers will be monitored to ensure that services and approaches change when an individual's needs change, such as after a hospitalization. DMH Quality staff will also closely monitor all critical incident reports and staff Root Cause Analysis meetings with community provider staff. Documentation or processes that do not meet the State's expectations will be identified and the community provider directed to take corrective action, including additional training or plans of correction if necessary.

Periodically the DMH Quality Bureau will oversee the execution of focus groups or surveys of Class Members to assess their perspective of the transition and linkage process, including its effectiveness, clarity, timeliness and the appropriateness of interactions, contacts, and communications.

DMH's monitoring and review activities will not delay Class Members' transitions to integrated settings, nor delay the state's compliance with its other obligations under the Consent Decree.

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 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

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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 community provider 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

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- 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 HQS inspections shall be timely completed and shall not delay Class Members' transitions to integrated settings.

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.

To ensure that housing units continue to meet quality standards throughout the year, community provider staff will monitor the state of the housing unit during in-home visits. In-home visits are a common feature of current community-based services and will be particularly important for community-based services to Class Members. Monitoring the status of the housing unit during these visits will serve as unannounced inspections as the community provider does not notify landlords or officials in advance. If the community provider staff finds issues, they will alert the Subsidy Administrator staff so they may pursue immediate corrections with the landlord.

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

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independent housing units will be afforded the full range of services and supports offered to all other Class Members. Community providers and the DMH Quality Bureau 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.

Regardless of their housing arrangement, 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 of 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 Community Provider staff or DMH 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 RRAUW 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

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Quality reports the DMH Quality Bureau shares with the *Williams* Quality Improvement Committee for discussion of necessary actions.

DHS/DMH currently collects data at the provider level to monitor their performance. The performance of providers of services to *Williams* Class Members will also be closely monitored. The DHS Community Services Agreement, which is the contract DHS holds with community providers, includes language that providers who fail to comply with contract conditions may receive sanctions including contract termination.

With respect to monitoring other non-mental health services and supports to Class Members, the community providers and DMH Quality Bureau staff 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. Quality of Life Survey

Using the Quality of Life Survey (QLS) tool developed for the federal Money Follows the Person Demonstration Program, the Recovery Support Specialists (RSS) who performed outreach functions 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 Class Member's satisfaction level with aspects of his/her transition, the RSS will administer a repeated QLS six months after the transition date. The QLS will again be repeated one year post transition. The RSS will thereby provide some consistency across the transition process as well as become a part of the monitoring team that evaluates the Class Member's outcomes and satisfaction.

5. 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.

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5.1 Remedy for Retaliation Against Class Members

Healthcare and Family Services (HFS) has inserted into its revised Rule (Subpart S) language which explicitly indicates that it is a violation for any IMD/NF owner, administration or other employees to impede or interfere with a resident's interest, desire or pursuit to move from that facility to the community or to anyway sabotage or attempt to influence that resident's transition options. Currently, HFS has issued a series of Provider Notices reaffirming that there must be cooperation through the mechanisms developed to assist residents in transition efforts, such as Resident Review and Transition Coordination activities.

The Department of Public Health (DPH) will implement a process for citing Nursing Facility/IMDs with a violation and apply a fine for any acts of retaliation against residents who express an interest or desire to transition/move from the setting. DPH will determine through rulemaking whether retaliation is going to have a high-risk designation, and if so, then the fines would be doubled. A finding of retaliation will result in a violation without the department having to prove harm to the resident. Such a finding will result in a type A violation. This language will be included in an amendment of the NHCA as well as SB769 which covers the five pilot IMDs.

If any violation of these directives should occur, residents will have access to a Department of Public Health (DPH) 1-800 hot line number. In addition to residents, third parties such as RSSs, community service providers, or RRAUW staff may file a complaint alleging retaliation or other harm that they observed directed at a resident. HFS and DPH will assure that each facility has posted notices, in all places of common gathering (dining areas, community rooms, front desk, lounge areas, etc.) with clearly detailed instructions that explain the complaint processes – how to file a complaint, when to file, how to track complaints, etc. All complaints will be investigated by DPH within designated timelines and tracked by DPH. No Class Member will be terminated or discharged as an act of retaliation from an IMD/NF without an appeal process and due process hearing. In accordance with existing Rules, no adverse actions including verbal, physical or punitive measures will be taken against any Class Members who elect to file a complaint against the IMD/NF.

DPH shall exercise the full measure of its enforcement authority to protect residents from retaliation.

5.2 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

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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.

As an example of a possible complaint, as part of the RRAUW 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 RRAUW findings and Community Provider recommendation, they may file a complaint using the established toll free complaint line. A third party, such as an advocate, may file a complaint on behalf of a Class Member.

In addition to a complaint or grievance, a Class Member may file a formal appeal with DMH. This appeal process is guided by the principles that it should be easy for a Class Member to negotiate, have clearly identified steps that all involved parties understand, and that third parties (those not involved in the initial determination) should review the appeal.

A Class Member could appeal the determination of appropriate level of care by the PAS Screener or could appeal the identified housing option or residential setting. A process is currently in place and will continue to ensure an additional level of review by a Clinical Review Team if the PAS process determines an individual is most appropriate for a nursing home level

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of care. The PAS determination is not finalized until this clinical review takes place. Once the Class Member is notified of the result of their PAS determination, they have three weeks to notify DMH in writing of their request to appeal. The appeal will be reviewed by a committee consisting of the Associate Deputy Director for Transition Coordination and DMH Quality Bureau staff. The Class Member will be notified in writing of the results of this appeal review within three weeks of their request. If the Class Member wishes, they then have three weeks to notify DMH in writing of their request to file a second level appeal. This second level of appeal will be reviewed by the DMH System Rebalancing Deputy Director. The Class Member will be notified in writing of the results of this second level appeal review within three weeks of their request. If the Class Member wishes, they then have three weeks to notify DMH in writing of their request to file a third level appeal. This third level of appeal will be reviewed by the Office of the Secretary of DHS. The process is repeated for Class Member appeals of the housing option or residential setting that Community Provider staff identified for their transition, beginning with the community provider notifying the Class Member of the identified setting. These appeal procedures will be clearly documented and shared with Class Members.

5.2.1 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.

5.3 Risk Management

The 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.

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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. Problem resolution will occur at the source of the issue and these issues will be reported to and analyzed by DMH Quality staff for trends to inform system improvements.

5.4 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.

5.5 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

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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.

6. Plan for Rapid Downsizing

The Department of Healthcare and Family Services (HFS) and the Division of Mental Health (DMH) with input from the Department of Public Health (DPH) will collaborate to develop a NF/IMD closure protocol. This protocol will serve as step-by-step guidance to be enacted in the event of a subsequent Federal decertification or owner decision to relinquish certification. Plaintiffs' Counsel and the Monitor will be given an opportunity to comment on the protocol before it is finalized.

The State will have available a completed and signed protocol (by the Directors of DMH, HFS and DPH) to address downsizing of NF/IMDs by the June 2011 due date for submission of the Implementation Plan. At that time the finalized protocol will be presented to the Court Monitor.

7. 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), the Court Monitor, and other key system stakeholders (such as the Court Monitor). 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.

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8. 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.

In addition to more formal data, DMH will continue to solicit input directly from stakeholders through focus group forums held twice yearly. Resulting information will be integrated into the other continuous quality improvement mechanisms and will assist in appropriate design of processes, including understanding Class Member preferences for housing and residential options.

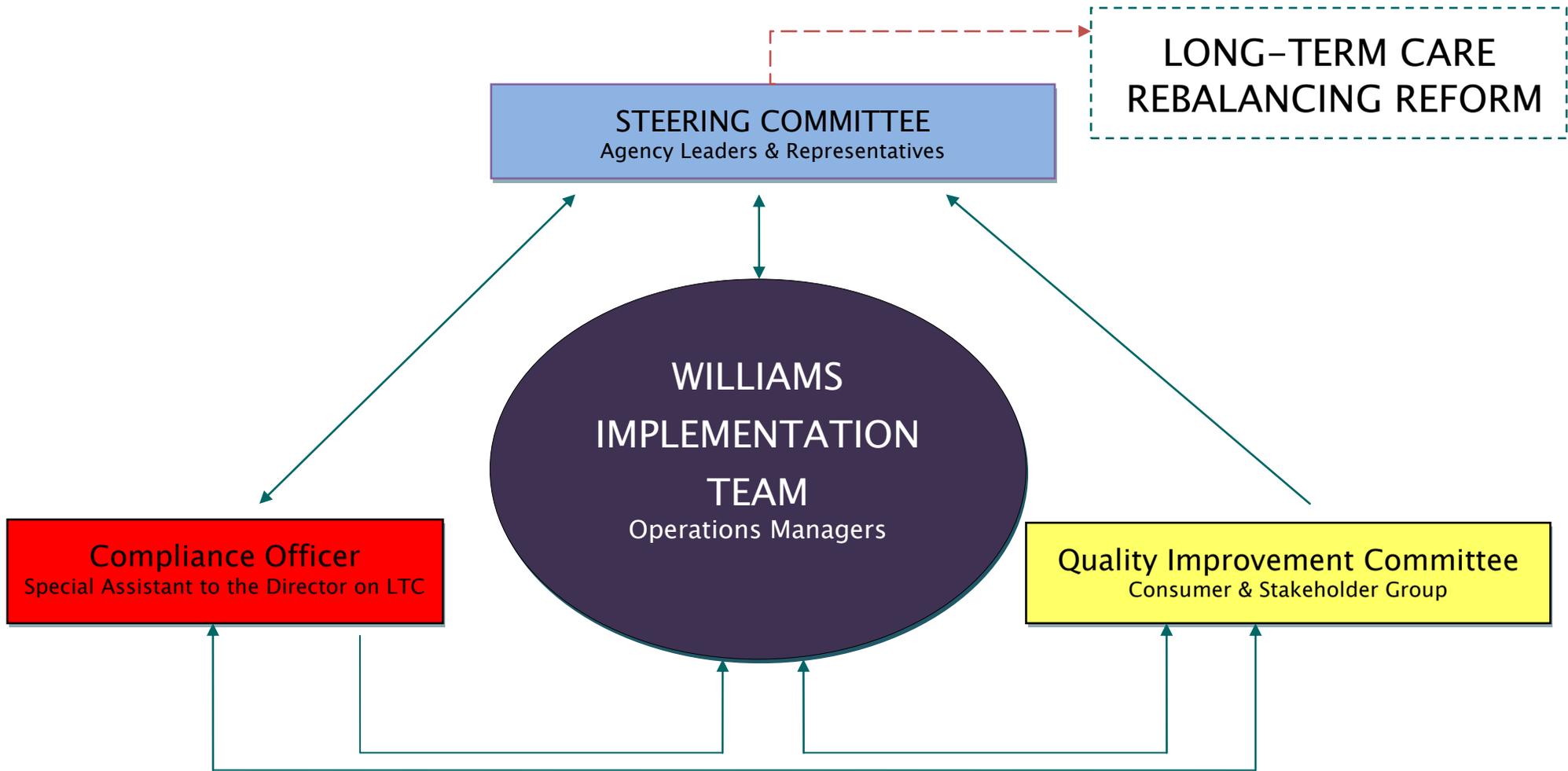
One of the principal functions of quality improvement is to ensure that processes meet the needs of customers. One of the best ways to measure this success is by measuring outcomes. DMH currently has a robust outcomes measurement system. DMH will utilize stakeholder feedback through the mechanisms referenced above to ensure outcome measures reflect the true needs of Class Members. DMH proposes key outcome measure areas to include: satisfaction with housing, satisfaction with services, participation in treatment planning, social connectedness, family connectedness, work / school functioning and clinical outcomes, such as reduced psychiatric hospitalizations

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. In addition, DHS/DMH will contract with an external research entity

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to evaluate the approaches used in the *Williams* Implementation Plan and provide an independent analysis.

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

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INFORMATION SYSTEM AND DECISION 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.

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.

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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.

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. 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

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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. 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.

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1.2.6 Decision Support for Planning and 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 as well as continued planning.

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. 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

2.1.1 Decision Support/Information Technology Implementation

The implementation of the IT strategy is a major undertaking because of the scope of the overall implementation plan. As such, the Decision Support/Information Technology implementation will occur in three phases that correspond to the development, programming and release of software to support the implementation. The Phase I software/data collection implementation is scheduled for October 2011, Phase II for December 2011 and Phase III for March 2012. During Phase I, the focus will be on: (1) developing and implementing a database to capture information for the Outreach Component of the Implementation Plan. Because Outreach is the earliest phase of the implementation, this database will become operational as of July, 2011; (2) Finalizing the business and functional requirements necessary for the assessment, transition coordination, community services and housing components of the plan; (3) Developing software and system interfaces to capture information for the Williams Implementation Plan; (4) Testing software and interfaces and

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(5) implementation. The general approach that will be undertaken is to implement as much as possible of the IT strategy during Phase I; additional requirements will be implemented during Phases II and III. The detailed tasks, responsible parties and timelines are displayed in the Decision Support/Information Technology Timeline.

2.3 Phase I: Requirements Gathering and Planning

This phase of the decision support/IT strategy has focused on the following tasks:

- Establishing and 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.

During the first quarter of the calendar year (January – March 2011), the state focused on the first two tasks listed above. To accomplish these tasks, DMH convened multiple meetings weekly with state partner agencies and Williams’ subject matter experts for all of the components of the consent decree. These meetings accomplished three goals:

- (1) All participants gained a better understanding of the processes and workflows that must be documented to provide necessary information for decision support;
- (2) An initial set of business requirements containing essential data elements, data sources and system modifications for each implementation phase was developed and
- (3) Workflows in the form of flowcharts were developed for each element of the implementation plan.

The second quarter of the calendar year has focused on business requirements and specifications for assessment, transition coordination, community services and housing. These requirements have now been drafted and are currently in the process of being refined. It is envisioned that this process will be completed for most components of the Williams Implementation Plan by early July 2011.

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Determining the System Approach and Developing a System Plan

The *Williams* IT Implementation Workgroup has begun a discussion of the approach to building new IT components and establishing interfaces. These discussions will be finalized by early July 2011. As noted above, specific tasks and timelines have been developed for each phase of the Decision Support/Information Technology component of the Implementation Plan.

2.4 Phase 2: Design /Functional Specifications

Once the data requirements analyses are 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 Phase 3: Build and Test IT Components

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 Phase 4: Deployment

The deployment phase requires the following issues to be addressed:

- Provision of training (internal and external)

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- Data integrity checks and monitoring of reporting/data submission
- Generation reports

2.7 Phase 5: 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

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BUDGET NARRATIVE

In FY2012, the state is investing \$18.5M to continue to build the infrastructure for transitioning *Williams* Class Members and to support the development of 256 permanent supportive housing units and service supports necessary for successful transitions. The budget builds upon the FY2011 budget that seeded the development of infrastructure supports in the form of required personnel and administrative supports to begin the process of transitioning individuals to the community.

The parties acknowledge that the State of Illinois' funding relating to human services, including but not limited to community mental health and Permanent Supportive Housing programs currently is subject to enormous pressure. However, the defendants intend to identify and obligate appropriated funds in a timely way such that defendants are able to meet the timelines in Appendix A for Year One of the Implementation Plan. The defendants have agreed to keep the Monitor and the Plaintiffs advised on a regular basis of any significant developments affecting the appropriated or available funding involving community-based services and supports for people with mental illness and the impact of such developments.

Consistent with the Implementation Plan, the FY2012 Budget Narrative below is organized around each functional plan element that has been designed to assure proper implementation of all aspects of the Consent Decree. Additional administrative supports are also included in the budget. Please note that figures presented are close estimates but not absolute.

Element 1: Outreach and Information Dissemination - \$1,048.4M
One time start-up costs: \$48.2k

DMH intends to contract with an advocacy organization to provide Outreach and Information dissemination to Class Members. It is the expectation that the selected vendor will hire individuals (approximately 10) in Recovery, holding certificates in Recovery Support Specialists, as well as Outreach counselors who will operate in teams with assignments to specific facilities. Expenses for interpreter and translation services, print and video production and all administrative costs are included in the total Outreach budget. The budget does support a senior level staff in DMH overseeing/monitoring Outreach and Information Dissemination as well as Assessment activities by both vendors.

Element 2: MH PASRR – Intergovernmental Agreement (IGA) with the University of Illinois - \$2,675.3M

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This IGA with the University of Illinois, Department of Nursing will ensure expediency in retaining professional, experienced and credentialed staff to conduct the necessary assessments of Class Members. The Nursing Department has been successfully conducting the assessments for the Money Follows the Person Demonstration Project under the auspice of Healthcare Family Services and needs only to expand its current operations to serve this population. The budget does support staffing a professional Clinical Review Team, Significant change reviews and annual reassessments. It also supports interpreter services and specialty consultants (e.g., neuropsychology, gerontology consultants, etc.) to be used on an as needed basis.

Element 3: Housing - \$2,311.4M

One time start-up costs: \$6.6k

The availability of affordable housing options is fundamental to the successful transitioning and ongoing stability of individuals moving to the community from institutional settings. It is also central to the State's ability to demonstrate compliance with the Consent Decree. The budget supports 3 key housing staff who will be key in developing and managing this resource. In addition the budget includes support for rental assistance for 256 Class Members, transition funds for 256 Class Members and emergency funds (rental assistance and transition funds) for 25 Class Members who may need to transition as a result of an unanticipated course of events. Transition funds were calculated at \$2,000 per person; rental assistance was calculated at \$9,200 per person.

Element 4: Community Services (and Transition Coordination) - \$8,988.8M

One time start-up costs: \$11.9k

Transition coordination is a defined service that will be provided by staff in community-based provider organizations. Its goal is to assure that all activities and supports necessary for a smooth transition to the community are in place in a timely manner. The state anticipates that community-based provider organizations will treat this as a discrete function and assumes approximately 30 vendor employees across all agencies under contract.

As is the case with affordable housing, the assurance that community services are available and accessible is paramount to a Class Member's recovery and successful community adjustment. In addition, based on the state's immediate experience with Money Follows the Person, the State anticipates that most individuals leaving institutional care are in need of the most intensive services available, Assertive Community Treatment (ACT) for some period of time following transition. Many can later be "stepped down" to less intensive treatment options, such as Community Support services, as indicated clinically. In addition, a myriad of critical non-Medicaid supports are included in budget. These services include Supported Employment, Peer support services and Drop-In Centers. Finally, the budget supports a

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Manager for overseeing and tracking Transition Coordination services specifically as well as two clinical/policy staff and a data analyst to conduct the required network service gap analysis and service model development.

Element 5: Quality Management - \$1,294.6M

One time start-up costs: \$46.5k

As the State is committed to consistent and steady system improvements, evaluating the efficacy of the service system developed to implement the Consent Decree as well as consistently assessing Consumer Satisfaction and Class Member outcomes are key to informing policy and management decisions going forward. The budget for Quality Management includes resources to support a contractual arrangement with a University for review and analysis of process and outcome data on all transition activities. In addition, the budget supports managers and staff to serve as quality monitors for on-site monitoring and licensing/certification of community-based care in both residential settings as well as Permanent Supportive Housing. The monitoring will be informed by elements to be included in the newly proposed Residential rules.

Element 6: Information Systems - \$1,516.4M

One time start-up costs \$1,215.9M

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 by which the State will be able to track consumer and production outcomes. The budget supports contracting with a vendor to design a “data capture interface” to operate between DMH’s existing IT system and other State and community agencies to capture required data relevant to the Consent Decree.

Element 7: Administrative Functions to include Fiscal, Training, Administration - \$698.9k

One time start-up costs: \$26.3k

The FY2012 budget includes resources to sustain the staff hired in fiscal, training and administration that were initially funded in the FY2011 budget. These positions include a fiscal analyst for *Williams*, two training staff, a Director of Long-term Care Rebalancing, a Special Assistant to the Director/Compliance Officer and clerical support.