COLBERT, ET AL. V. RAUNER, ET AL., NO. 07 C 4737

Colbert Consent Decree

Implementation Plan Phase 3

Illinois Department on Aging

March 22, 2017

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COLBERT CONSENT DECREE

A. Background

In August of 2007, a number of disabled individuals filed a lawsuit, *Colbert v. Quinn*, 07 C 4737, seeking declaratory and injunctive relief to remedy alleged violations of Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. 12131-32, Section 504 of the Rehabilitation Act, 29 U.S.C. 794(a) and the Social Security Act, 42, U.S.C. 1396-1396v (SSA). Those Plaintiffs alleged that they and members of their Class were being unnecessarily segregated and institutionalized in Nursing Facilities in Cook County in violation of the ADA and the Rehabilitation Act. Plaintiffs further alleged that the Defendants, specifically, the Governor of the State of Illinois and the directors of four (4) state agencies (the Illinois Department of Human Services [DHS], the Illinois Department of Public Health [IDPH], the Illinois Department on Aging [IDoA], and the Illinois Department of Healthcare and Family Services [HFS]), denied them the opportunity to live in appropriate community integrated settings where they could lead more independent and productive lives.

Four (4) years after the Colbert lawsuit was filed, a Consent Decree, negotiated and agreed to by the Parties, was approved on December 21, 2011 by United States District Court Judge Joan Lefkow. Since that date, the State has changed lead agencies moving compliance responsibility for the Consent Decree from HFS in November 2012, to the IDoA in January 2014. Reports are periodically issued by the State and by the Court Monitor regarding overall compliance and recommendations. See IDoA Colbert webpage.

Colbert Class Members are “Medicaid-eligible adults with disabilities who are being, or may in the future be, unnecessarily confined to Nursing Facilities in Cook County, Illinois, and who with appropriate supports and services may be able to live in a Community-Based Setting.” The Class includes individuals with a primary diagnosis of mental illness, but does not include individuals with intellectual disabilities.

The Consent Decree required the State Defendants support the transition of 1,100 Class Members in 30 months from Nursing Facilities to Community-Based Settings, which involves multiple steps, including development of community capacity, outreach services to Class Members to advise them of the opportunities offered under the Decree and Evaluations and Service Plan development for Class Members. The Consent Decree also required the

development of a Cost Neutral Plan which was ultimately adopted by the Court on November 16, 2016.

B. Introduction

In the four (4) years since the initial Implementation Plan began, the State has been building infrastructure to facilitate significant transition activity for Colbert Class Members expressing an interest in transitioning to a Community-Based Setting. As of October 31, 2016:

- Two (2) social service agencies provide dedicated outreach for Colbert Class Members;
- Two (2) Managed Care Organizations provide Evaluation and Care Coordination services for Colbert Class Members;
- Three (3) Social Service agencies provide Housing Locator services;
- Nine (9) Community Mental Health Centers provide transition services for Class Members diagnosed with a serious mental illness;
- Four (4) Community Mental Health Centers provide comprehensive transition services for Colbert Class Members diagnosed with a serious mental illness;
- Two (2) Community Mental Health Centers conduct Evaluations for Class Members diagnosed with a serious mental illness;
- Three (3) Care Coordination Units provide comprehensive transition services for selected Colbert Class Members age 60 and over;
- 9,700 Class Members have been contacted through outreach services;
- 5,441 Class Members have been evaluated;
- 2,727 (50% of those evaluated) Class Members have been recommended for transition;
- 1,424 Colbert Class Members have transitioned from Nursing Facilities to Community-Based Settings;
- A web-based data system has been created into which providers enter data regarding Colbert Class Member transition activities and generates critical management reports;
- A universal Evaluation tool was developed and training provided to enhance the effectiveness of decision making regarding transition;
- Quality systems developed with the University of Illinois College of Nursing monitor the quality of Service Plans and Evaluations, and conduct incident and mortality reviews;
- Assistive Technology and Home Modification assessments for transitioning Colbert Class Members are conducted by the University of Illinois at Chicago Assistive Technology Unit;
- Peer Mentors are recruited and trained to provide outreach and education to Colbert Class Members;
- A Peer Advisory Council was created to elicit the Colbert Class Member perspective regarding Colbert transition activities.

Through these efforts, the State has transitioned 1,114 Colbert Class Members to Community-Based Settings by January 8, 2016. While the State continues to work to identify and resolve barriers to increase transitions, the average number of transitions per month during calendar year 2016 was approximately 32, in contrast with the average 43 transitions per month in

calendar year 2015. Currently, the State has identified the following approaches to making the transition process more efficient and to increase the number of transitions in calendar year 2017 as required by the Cost Neutral Plan:

- Increase outreach attempts at Nursing Facilities as required by the Consent Decree and thereby the number of referrals for Evaluations;
- Increase Housing Locator resources for transitioning Class Members to Community-Based Settings;
- Work with Housing Locators to increase the number of Class Members transitioned to Community-Based Settings;
- Work with Department of Human Services/Division of Mental Health to explore ways to incentivize Community Mental Health Centers to enhance services provided and to provide resources to increase the number of Class Members transitioned to Community-Based Settings;
- Improve Housing Quality Standard Inspection and Transition Fund acquisition efficiencies;
- Provide more training opportunities for all of the disciplines involved in transition activities.

Finally, it should be noted that this Implementation Plan Phase III (IP Phase III) is an updated version of the Implementation Plan Phase II (IP Phase II) filed with the Court on August 20, 2014. IP Phase II language has been updated when indicated to document the implementation and progress of strategies that were planned for Phase II. There are new approaches and strategies documented in IP Phase III, in some cases, designed to meet the requirements of the Consent Decree and the Cost Neutral Plan. In other cases, changes and additions to approaches and strategies in IP Phase III reflect the needs of Colbert Class Members not foreseeable when IP Phase II was written. The Post-Transition and University of Illinois at Chicago Assistive Technology Unit sections are examples of this.

Details regarding the updated approaches and strategies to meet the requirements of the Cost Neutral Plan are in the body of this document.

C. Colbert Consent Decree Requirements

The Colbert Consent Decree and the Cost Neutral Plan set forth terms and a timetable for the State of Illinois to develop and implement necessary and sufficient measures and Community-Based Services and supports so that Class Members desiring to relocate to the Community may do so. The terms of the Decree specify that the State must develop and implement supports and other resources, to locate affordable housing, to arrange for transition into Community-Based Settings, to develop Service Plans of Care for Class Members transitioning to the Community that includes accessing Community-Based Services consistent with their needs.

Requirements of the Consent Decree (as amended) and the Cost Neutral Plan include:

- Filing of an initial Implementation Plan, with updates and amendments to be filed at least annually, all of which are incorporated into and become enforceable as part of the Decree;
- Documentation of the process and outcome of targeted communication and recruitment strategies of eligible Class Members;
- Evaluation by Qualified Professionals of 500 Class Members residing in Nursing Facilities by May 2013 and a total of 2,000 Evaluations by Qualified Professionals of Class Members residing in Nursing Homes by May, 2014;
- Specific benchmarks for transition of Class Members residing in Nursing Homes (original Decree):
    - By November, 8, 2013, movement of 300 Class Members who desire to live in Community-Based Settings and who have received an Evaluation and a Service Plan;
    - By November 8, 2014, movement of 800 Class Members who desire to live in Community-Based Settings and who have received an Evaluation and a Service Plan;
    - By May 8, 2015, movement of 1,100 Class Members who desire to live in Community-Based Settings and who have received an Evaluation and a Service Plan;
- Transition of 1,100 Class Members who desire to live in a Community-Based Setting and who have received an Evaluation and a Service Plan;
- If the cost data analysis demonstrated cost neutrality or savings, completion and submission to the Court of an agreed Cost Neutral Plan by June 8, 2015, which addresses transition of all interested and appropriate Class Members into Community-Based Settings at a reasonable pace. If the Parties and Court Monitor cannot agree on a Cost Neutral Plan, each party shall each file a proposed Plan.

After considerable negotiation, the Parties determined that they were unable to agree on all of the elements of the Cost Neutral Plan, and, after a hearing, on September 29, 2016, the Court ruled on the matters on which the Parties differed. The final Cost Neutral Plan incorporating those rulings was approved by the Court on November 16, 2016.

The Cost Neutral Plan contains various provisions regarding updates to the Implementation Plan, outreach activities, Evaluations and Transitions of Class Members. Among these provisions, the Plan requires the following:

- By November 10, 2016, the State will create a list of all Class Members living in Nursing Facilities in Cook County as of September 30, 2016, and will update the list at least annually for the life of the Decree;
- The State will create and perform outreach activities required to comply with the requirements of the updated Implementation Plan and the Consent Decree;
- The State will complete at least 1,000 Evaluations by June 30, 2017;

- The State will ensure that Service Plans are provided within three (3) months of the Evaluations for those Class Members who are approved for transition to a Community-Based Setting;
- An amended Implementation Plan will be filed with the Court by December 30, 2016;
- By December 30, 2016, the State shall create a Transition Activity Schedule that will include at least 150 Class Members who are not opposed to moving to a Community-Based Setting (excluding those not currently approved for transition and waiting in the housing queue), and will update the Schedule with an additional 1,000 Class Members by June 30, 2017;
- The State will transition 250 Class Members to Community-Based Settings by June 30, 2017, and an additional 300 Class Members by December 31, 2017;
- The Court Monitor, at the State's expense and with the input of the State and the Class Counsel, will retain an appropriate independent consultant (who will report solely to the Monitor) to advise the Court Monitor on how the State can develop community capacity sufficient to transition the required number of Class Members in calendar year 2018 and subsequent calendar years under the Consent Decree and Cost Neutral Plan. The Parties will work with the consultant and the Court Monitor so that the final consultant report is expected by April 2017. The consultant's report will be reviewed and analyzed by the Court Monitor, who will make recommendations on additional modifications to the Implementation Plan;
- During the second quarter of calendar year 2017, the Court Monitor shall submit a proposal to address barriers to developing community capacity and recommendations for addressing those barriers to expand substantially community capacity. The transition benchmarks will be determined for 2018 and 2019 after the submission of this proposal by agreement of the Parties in conjunction with the Monitor, or the Court, if necessary;
- Prior to December 31, 2018, the Parties and the Court Monitor shall agree upon a reasonable pace for moving to Community-Based Settings all Class Members who desire to live in Community-Based Settings and who have been determined appropriate for transition;
- The State continues to be responsible to develop and increase community capacity as necessary and appropriate to comply with the Consent Decree, the Cost Neutral Plan, and this amended Implementation Plan;
- The Parties, either jointly or separately, may request termination of the monitoring process at any time after December 31, 2019, if the Court Monitor agrees that the State has substantially complied with the terms of the Consent Decree, the amended Implementation Plan and the Cost Neutral Plan.

D. Court Monitor

The Court Monitor has filed annual reports with the Court documenting the status of the State's compliance or noncompliance with the requirements of the Consent Decree, most recently in January 2016.

Strategies for Achieving CY 2017 *Colbert* Consent Decree Cost Neutral Transition Requirements

A. Outreach and Education

In accordance with the Cost Neutral Plan and the Consent Decree, the State will provide outreach and education to every *Colbert* Class Member regarding the *Colbert* Consent Decree and their rights to be evaluated for transition from the Nursing Facility to a Community-Based Setting. Outreach and education will be conducted in individual and small group engagement and information sessions by the Outreach Entities listed in the chart below to educate *Colbert* Class Members, guardians, family members, Nursing Facility staff, and other program stakeholders on Class Members' rights to live in the community and/or receive Community-Based Services. This includes education and information on transition costs, home accessibility adaptation costs and the various options and opportunities for housing assistance. Once identified, consenting Class Members will be referred within 10 business days for Evaluation for transition through the Illinois Pathways to Community Living/Money Follows the Person (MFP) Web Application or its successor.

The State will use twelve (12) entities (Outreach Entities) with combined expertise in the multiple disability groups within the Class to provide outreach services sufficient to meet or exceed the Evaluation and Transition numbers required by the Cost Neutral Plan. These outreach efforts will use (1) lists provided quarterly by the Illinois Department of Healthcare and Family Services (HFS) that have the names and identifying information of Class Members who reside in non-IMD Nursing Facilities in Cook County, (2) lists of names and identifying information of individuals who respond affirmatively to transition on the Nursing Facility Minimum Data Set Section Q (MDS-Q), (3) referrals submitted through the MFP Web Application, and (4) other referrals generated by Outreach and Evaluation Entities. The State will monitor the activity at least quarterly to see if any changes are necessary to achieve the Evaluation and Transition numbers required by the Cost Neutral Plan.

IDoA initiated an outreach pilot program with Aetna, Age Options, IlliniCare, and Marillac St. Vincent during the period November 1, 2016 – February 3, 2017. Data was tracked on spreadsheets regarding the following outcomes: (1) agreed to evaluation, (2) declined evaluation, (3) refused engagement, (4) unable to engage, (5) unable to locate, and (6) deceased. Aggregated outcome data will be available for reporting purposes on at least a quarterly basis after June 30, 2017.

As of February 7, 2017, all of the Outreach Entities are tracking outcomes and data as described in the above paragraph and will be entered in the *Colbert* Tracking System in March 2017.

Staff in IDoA's Office of Transition and Community Relations will set outreach targets on a monthly basis for each Outreach Entity. The Outreach Entities will be directed to contact at least the targeted number of Class Members at the assigned facilities to fulfill their outreach service responsibilities. IDoA staff will closely monitor results and outcomes to ensure a

sufficient number of Class Members agree to be evaluated to meet transition requirements, and make adjustments as appropriate.

Outreach Entity Name	**Target Population**	**Source of Referrals**
AgeOptions	General	Outreach List
Marillac St. Vincent	General	Outreach List
Thresholds	SMI	Outreach List
Trilogy	SMI	Outreach List
Sertoma	SMI	Outreach List
LSSI	SMI	Outreach List
Metropolitan Family Services	SMI	Outreach List
Aetna	General	MFP referrals, MDS-Q, Outreach List
IlliniCare	General	MFP referrals, MDS-Q, Outreach List
Catholic Charities Older Adults	Age 60 and over	Outreach List
Catholic Charities South Suburban	Age 60 and over	Outreach List
Aging Care Connections	Age 60 and over	Outreach List

A.1. Peer Mentors

The use of Peer Mentors in outreach efforts will be expanded to assist staff at Community Mental Health Centers (CMHCs) with Outreach, as they have proven to be effective communicators who are able to motivate their peers to overcome their fears and concerns to seriously consider transitioning from the Nursing Facility to a Community-Based Setting.

A.2. Mass Mailing

The effectiveness of mailing written material to *Colbert* Class Members regarding the *Colbert* Consent Decree will be tested in selected Nursing Facilities in CY 2017.

A.3 Ombudsmen

Efforts will be made to expand the collaboration with Long-Term Care Ombudsmen in Cook County so that all *Colbert* Class Members are informed of their rights under the *Colbert* Consent Decree in accordance with the Cost Neutral Plan.

A.4. Choices for Care

CCU staff responsible for conducting both Choices for Care prescreens and post-screens of individuals who are admitted to Cook County Nursing Facilities are required to collaborate with *Colbert* staff to develop a system to ensure timely follow up with individuals on short-term rehabilitation stays. CCU Care Coordinators will provide Outreach Entities with the names of

individuals for follow up who are identified through the Choices for Care screen process within a designated timeframe after completion of the screen. Designated Outreach Entities will follow up with potential Colbert Class Members within a designated timeframe after receiving the referral from the CCU.

A.5. Referrals

The Money Follows the Person Web Referral Portal may not be accessible for referrals of *Colbert* Class Members after June 30, 2017. IDoA is currently working to ensure that a web referral system will continue to be available. A replacement system is projected to be in the testing phase by May 2017, and implemented by June 30, 2017.

B. Transitions

For calendar year 2017, the State will utilize CMHCs to provide transition services for *Colbert* Class Members diagnosed with a serious mental illness (SMI) and Housing Locators to locate housing for *Colbert* Class Members with physical disabilities in order to meet the Cost Neutral requirements. CMHCs and Housing Locators are funded differently and provide distinctly different service packages. Transition targets for both groups have been designed to exceed in total the overall transition requirements of 250 transitions by June 30, 2017, and an additional 300 transitions by December 31, 2017.

B.1. Colbert Class Members with SMI

Nine (9) CMHCs in Cook County that provide services in distinct geographic areas in Cook County have been funded in Fiscal Year (FY) 2017 to provide transition services to *Colbert* Class Members diagnosed with SMI through an Intergovernmental Agreement between IDoA and the Department of Human Services Division of Mental Health (IDHS/DMH) (IDoA/DHS IGA) (see page 9 of IPIII). The contractual funding amounts are directly associated with a projected number of transitions, agreed upon by IDoA and the respective CMHC, to be accomplished during the contracted fiscal year. Funding is also provided through this IGA for service capacity when indicated to expedite transitions and to meet the needs of the transitioned Class Members in the community.

As of December 31, 2016, these CMHCs have achieved 23.5% of their contracted transitions for FY 2017.

Agency Name	# transitions contracted FY17	# transitions 12/31/16	# remaining potential transitions	# referrals as of 01-12-17
Association House	20	2	18	5
C4	25	5	20	25
Grand Prairie Services	35	10	25	24
Kenneth Young Center	25	1	24	15

LSSI	30	4	26	34
Pilsen	30	1	29	8
Sertoma Centre	40	7	33	22
Thresholds	70	23	47	104
Trilogy	84	31	53	102
Total	**359**	**84 (23.5%)**	**275 (76.5%)**	**339**

IDoA staff will employ the following steps and strategies to improve CMHC transition performance:

- By February 1, 2017, meet with each CMHC executive staff members to review FY17 transition commitment and performance to date, with follow up monthly meetings beginning in March 2017 to review performance to date on the following:
    - Review and confirm agency's active referrals for transition;
    - Review Class Members identified by agency to transition by June 30, 2017, and by December 31, 2017;
    - Confirm that agency has sufficient capacity to meet Class Member needs;
    - Review any agency barriers to meeting transition goals and develop possible steps and plans to breakdown those barriers;
    - Revise FY 17 transition goals as appropriate;
- Beginning February 2017, provide agencies with monthly reports of previous month's transition activity and progress towards transition goals;
- Beginning March 2017, conduct monthly meetings with all CMHC executive staff members to review CMHC transition data in the aggregate and to address any barriers to agencies meeting their transition goals and develop possible steps and plans to breakdown those barriers;
- Continue to meet with CMHC staff to review progress of Class Members projected to transition in the current month, by June 30, 2017, and by December 31, 2017;
- Work with Outreach Entities and Evaluation Entities to target Nursing Facilities in communities that are expected to generate referrals for Class Members who wish to live in the areas in which CMHCs that lack referrals provide services;
- Work with CMHCs in FY18 contract cycle to expand capacity and allow for a 10% or more increase in *Colbert* Class Members contracted to transition; and
- Work with DMH to explore ways to provide resources to enhance services and to increase the number of Class Members transitioned to Community-Based Settings.

B.2. <u>Colbert Class Members with Physical Disabilities</u>

Housing Locators, Access Living and Featherfist, are contracted with IDoA in FY17 to provide housing location services for *Colbert* Class Members with physical disabilities referred by Aetna or Illinicare. As of December 31, 2016, these Housing Locators have achieved 35% of their transition targets for FY17.

Agency Name	# targeted transitions FY17	# transitions 12/31/16	# remaining potential transitions	# referrals as of 01-12-17
Access Living	120	41	79	46
Featherfist	120	43	77	38
Totals	**240**	**84 (35%)**	**156 (65%)**	**84**

IDoA staff will employ the following strategies to improve Housing Locator transition performance and to meet the cost neutral transition targets for June 30, 2017, and December 31, 2017:

- By February 15, 2017, meet with each Housing Locator executive staff members to review FY17 transition commitment and performance to date with follow up monthly meetings after June 30, 2017 to review performance to date on the following:
    - Review and confirm agency's active referrals for transition;
    - Review Class Members identified by agency to transition by June 30, 2017, and by December 31, 2017;
    - Confirm that agency has sufficient capacity to meet Class Member needs;
    - Review any agency barriers to meeting transition goals, and develop possible steps and plans to breakdown those barriers;
    - Revise FY 17 transition goals as appropriate;
- Beginning February 2017, provide Housing Locator executive staff members with reports of previous month's transition activity and progress towards transition goals;
- Beginning March 2017, conduct monthly meetings with Housing Locator executive staff members to review transition data in the aggregate and to address any barriers to agencies meeting their transition goals and develop possible steps and plans to breakdown those barriers;
- Continue to meet with Housing Locator staff weekly to review progress of Class Members projected to transition in the current month and by June 30, 2017;
- Assign Outreach Entities and Evaluation Entities to Nursing Facilities that are targeted to generate referrals for Class Members with physical disabilities;
- By July 1, 2017, identify and contract with another Housing Locator that has the capacity and ability to move a minimum of 10 *Colbert* Class Members per month;
- Work with Housing Locators to explore ways to provide resources to enhance services and to increase the number of Class Members transitioned to Community-Based Settings;
- Work with Housing Locators in FY18 contract cycle to expand capacity and allow for a 20% increase or more in *Colbert* Class Members moved to Community-Based Settings.

C. Housing

Housing Quality Standard Inspection and Transition Fund disbursement processes are critical to the timely transition of Colbert Class Members from Nursing Facilities to Community-Based Settings. Each housing unit secured for Colbert Class Members must meet quality standards as

set forth by the federal Department of Housing and Urban Development. Inspections are conducted by a third party subcontracted by HACC. Transition funds are used by the housing locators to pay security deposits and to purchase household items necessary for the Class Members to transition from the Nursing Facility to the Community-Based Setting. IDoA will improve its processes for more efficient and timely inspections and disbursement of these funds to Housing Locators.

D. Nursing Facility Cooperation

IDoA will convene an inter-agency workgroup to address the requirement that Nursing Facilities respond in a timely, efficient manner to requests for documents and information necessary to complete evaluations and other pre-transition activities for *Colbert* Class Members and develop possible steps and plan to breakdown any problems.

E. Consultant Recommendations

In accordance with the *Colbert* Cost Neutral Plan Amendment, the Court Monitor has engaged an independent consultant to advise the Court Monitor on how the State can develop community capacity to transition Class Members according to the requirements of the Consent Decree and Cost Neutral Plan. Due to timing of the consultant's recommendations, the State's achievement of the requirement to move 250 *Colbert* Class Members by June 30, 2017 will not be impacted by the consultant's recommendations, but the State expects such recommendations to positively impact the State's efforts to move 300 *Colbert* Class Members by December 31, 2017. Maximum impact is expected from consultant recommendations on the State's transition efforts in CY 2018 and beyond. The Parties will work with the consultant and the Court Monitor so that the final consultant report is expected by April 2017. The consultant's report will be reviewed and analyzed by the Court Monitor, who will make recommendations on additional modifications to the Implementation Plan.

OFFICE OF TRANSITIONS AND COMMUNITY RELATIONS

In January 2014, the Defendants determined that the Illinois Department on Aging (IDoA) would assume the role of lead agency for the implementation of the Colbert Consent Decree and established the Office of Transitions and Community Relations to expedite the implementation of the Colbert Consent Decree. The Office develops strategies and approaches to ensure that the State is compliant with the requirements of the Consent Decree.

The implementation strategy of the Office of Transitions and Community Relations features collaborative and community-based approaches to transition Colbert Class Members living in Nursing Facilities to the most integrated setting appropriate. Colbert Class Members are then provided with services and supports that are necessary to live independently in the Community.

The Office of Transitions and Community Relations has been monitoring and evaluating the development and implementation of this innovative service delivery system which combines

the services of health, housing, and other social services as needed, including employment services. As the number of Class Members living independently increases, the Office ensures that there are adequate and appropriate post-transition services to support the needs of the Class Member. Effective March 2017, the Nursing Home Interagency Workgroup will meet regularly to consider if any changes can be identified in the regulations that govern Nursing Facility residents to make certain that transitions from Nursing Facilities can occur as required by the Consent Decree.

A. Staffing

The Office of Transitions and Community Relations is currently staffed with six (6) full time staff: the Colbert Project Director, two (2) Quality and Compliance Liaisons, a Housing and Transition Liaison, and two (2) Project Assistants.

The Housing and Transition Liaison and Data Analyst Coordinator positions are vacant at the present time and work is underway to move forward with replacements.

B. Inter-Governmental Agreements

B.1. Illinois Department of Human Services/Division of Mental Health (DHS/DMH)

In order to ensure efficient community integration efforts, IDoA and DHS/DMH entered into an Inter-Governmental Agreement (IGA) to collaborate on serving certain Class Members who require community mental health services. Currently, Colbert Class Members who require community mental health services are referred to one of nine (9) Community Mental Health Centers (CMHCs) contracted by DHS/DMH to provide Outreach, Evaluation, and/or community integration and placement services, but with funding and oversight by IDoA.

In addition to Medicaid Rehabilitation Option Services, Colbert Class Members are able to access non-Medicaid services created for persons who require community mental health services transitioning from Nursing Facilities to Community-Based Settings. These services include Outreach, Resident Reviews, oversight by a Quality Administrator, Transition Coordination, Supported Employment, Supported Education, Integrated Health Care and Recovery Drop-In Centers.

These processes were adopted in order to increase the number of transitions from Nursing Facilities to Community-Based Settings for the approximately 50% of Class Members who have been diagnosed with a serious mental illness (SMI). These processes are based on models developed by DHS/DMH for implementation of the Williams Consent Decree.

B.2. University of Illinois at Chicago Assistive Technology Unit

Effective February 2015, IDoA engaged in an IGA with the University of Illinois at Chicago Assistive Technology Unit (UIC-ATU) to provide Assistive Technology and Accessibility Modifications needed by Colbert Class Members to enable them to maximize their independence as they move into the community. Additionally, training and research components by UIC-ATU will serve to promote increased effectiveness among service providers

involved in the implementation of the Consent Decree and to properly document processes and outcomes for reporting and analysis.

B.3. University of Illinois College of Nursing
An IGA was executed between IDoA and the University of Illinois at Chicago College of Nursing (UIC-CON) in September 2015 for quality assurance services to include incident report management, mortality reviews, evaluation review and clinical review of Class Members not recommended for transition. Training activities designed in response to quality assurance findings were added to the IGA in fiscal year 2017.

B.4. Housing Authority of Cook County (HACC)
An IGA was executed for HACC to administer the Colbert Bridge Subsidy, and to distribute transition funds for Colbert Class Members. See Section G.2.a. for details.

TRANSITION ACTIVITIES

A number of transition activities are necessary for most Class Members to successfully transition from Nursing Facilities to Community-Based Settings and to comply with the Consent Decree. IDoA has thoughtfully developed processes for these activities so that Class Members receive services with promptness and professionalism. They include Outreach, Referral for Evaluation, Evaluation, Service Plan of Care development, Transition Coordination, Housing Location Assistance and Support, Post-Transition Care Coordination and/or Case Management, Assistive Technology/Home Modification and Quality Assurance.

In the original Implementation Plan, Evaluation, Service Plan of Care development, Transition Coordination and Post-transition Care Coordination were provided exclusively through Aetna Better Health, Inc. (Aetna) and IlliniCare Healthplan Inc. (IlliniCare). These two (2) organizations also collaborated with a Housing Locator to search for suitable housing based upon Class Member choice and need. In the IP Phase II, Aetna and IlliniCare refer Class Members diagnosed with SMI to CMHCs for housing location services and to provide community mental health services both before and after transition.

More recently, three (3) approaches for transition-related services have been implemented and have been monitored closely for effectiveness and refined as necessary. These approaches include:

- Metropolitan Family Services employs Qualified Professionals as Resident Reviewers who conduct Evaluations of Class Members diagnosed with SMI. Class members who are recommended for transition are subsequently referred by IDoA to the appropriate CMHC agency for Service Plan of Care development, Transition Coordination, Housing Location and Post-Transition community mental health services and case management.

- Trilogy, Inc., Thresholds, Lutheran Social Services of Illinois, and Sertoma Centre, employ Qualified Professionals as Resident Reviewers and members of Transition Care Teams to provide a continuum of care to Class Members diagnosed with SMI, including Outreach, Evaluation, Care Coordination, Housing Location, community mental health services and case management pre- and post-transition. If Class Members are recommended for transition, but express a preference for working with another CMHC, IDoA refers the Class Member to the preferred CMHC as long as that CMHC can provide the appropriate level of care.
- Care Coordination Units (CCUs): Aging Care Connections, Catholic Charities-South Suburban and Catholic Charities-Older Adults provide Colbert services for Class Members over 60 years old. With the assistance of HFS, IDoA provides names of Class Members who reside in assigned Nursing Facilities for outreach by the CCUs. The CCUs conduct Evaluations, develop Service Plans of Care, Risk Mitigation plans, Social Histories, 24-hour Back-up Plans and provide post-transition monitoring for 12 months in accordance with the Colbert Consent Decree and IDoA requirements.

Pursuant to the Cost Neutral Plan, key transition events relative to all strategies will be tracked on a Transition Activity Schedule that will document the dates these activities occur for Class Members who have expressed interest in transitioning from Nursing Facilities to Community-Based Settings. See Appendix A for the Transition Activity Schedule template.

A work plan and a flow chart detailing these implementation processes are attached as Appendix B and Appendix C, respectively.

A. Outreach and Education

In accordance with this updated Implementation Plan, the Cost Neutral Plan and the Consent Decree, the State will provide outreach and education to every Colbert Class Member regarding the Colbert Consent Decree and their rights to be evaluated for transition from the Nursing Facility to a Community-Based Setting. Outreach and education will be conducted in individual and small group engagement and information sessions to educate Colbert Class Members, guardians, family members, Nursing Facility staff, and other program stakeholders on Class Members' rights to live in the community and/or receive Community-Based Services. This includes education and information on transition costs, home accessibility adaptation costs and the various options and opportunities for housing assistance. Once identified, consenting Class Members will be referred for evaluation for transition through the Illinois Pathways to Community Living/Money Follows the Person (MFP) Web Application (or its successor).

A.1. Referrals for Outreach

The State will use twelve (12) entities (Outreach Entities) with combined expertise in the multiple disability groups that reside in Cook County Nursing Facilities to provide outreach services to consenting Class Members in accordance with the Evaluation and Transition requirements of the Cost Neutral Plan. These outreach efforts will be informed by (1) lists provided quarterly by the Illinois Department of Healthcare and Family Services (HFS) that include the names and identifying information of the individuals that reside in non-IMD

Nursing Facilities in Cook County enrolled in the Medicaid program, (2) lists provided regularly of the names and identifying information of individuals that responded affirmatively to transition on the Nursing Facility Minimum Data Set Section Q (MDS-Q), (3) referrals submitted through the MFP Web Application (or its successor), and (4) other referrals generated by Outreach and Evaluation Entities.

The results of these outreach efforts will be uniformly documented in the Colbert Tracking System (as further described in Section J) for reporting and analysis. Data to be reported includes information about the Class Member's willingness to speak with the outreach worker, the Class Member's willingness to be evaluated and the outreach worker's ability to locate the Class Member.

Monthly outreach targets, assigned to each Outreach Entity, are designed to generate the required number of Evaluations and, ultimately, transitions. These assignments will be reviewed and adjusted as necessary.

Outreach Entity Name	**Target Population**	**Source of Referrals**
AgeOptions	General	Outreach List
Marillac St. Vincent	General	Outreach List
Thresholds	SMI	Outreach List
Trilogy	SMI	Outreach List
Sertoma	SMI	Outreach List
LSSI	SMI	Outreach List
Metropolitan Family Services	SMI	Outreach List
Aetna	General	MFP referrals, MDS-Q, Outreach List
IlliniCare	General	MFP referrals, MDS-Q, Outreach List
Catholic Charities Older Adults	Age 60 and over	Outreach List
Catholic Charities South Suburban	Age 60 and over	Outreach List
Aging Care Connections	Age 60 and over	Outreach List

A.1.a. Master Class Member Outreach List

Beginning November 10, 2016, HFS provided IDoA a complete listing of all residents of non-IMD Nursing Facilities in Cook County who are enrolled in the Medicaid program. This list will be updated quarterly by HFS, and will be used to ensure that there is an attempt made to provide outreach and education to all Colbert Class Members. Outreach Entities will be assigned to designated Nursing Facilities in accordance with their expertise and provide outcome data as

described above. IDoA will compile outcome data and report quarterly regarding outreach efforts.

A.1.b. MFP Referrals

The web referral form found on the MFP Web Application is the primary vehicle by which interested Colbert Class Members are referred to Aetna or IlliniCare for outreach, education and potentially Evaluation. (See Section J for further information.) The users of the referral form may include the Class Members themselves, family members, friends, Nursing Facility staff and others. The on-line referral form, designed to be used by the general public to refer residents of Nursing Facilities in Illinois for an Evaluation to transition to Community-Based Settings, is user-friendly and widely distributed. Additionally, Colbert Class Members may use the Senior HelpLine (1-800-252-8966) or Colbert Information Email (AGING.ColbertDecree@illinois.gov) for assistance with making referrals through the MFP Web Application.

A.1.c. MDS-Q Referrals

The MDS-Q Referral and Money Follows the Person Pilot Project is designed to provide a timely response to those individuals living in Nursing Facilities who answer positively to discharge-planning questions found in the federal Centers for Medicare and Medicaid Services (CMS) Nursing Facility MDS-Q assessment. Nursing Facility residents are required to be routinely and comprehensively assessed throughout their stay in the Nursing Facility, and regularly queried, as clinically appropriate, about their interest in talking to someone regarding moving into a Community-Based residence.

Effective June 14, 2016, lists of Colbert Class Members who have indicated their interest in moving to a Community-Based Setting are sent to approved pilot site agencies, Aetna and IlliniCare, on a regular basis for follow-up. Such follow-up involves Aetna and IlliniCare staff providing outreach and education regarding the Colbert Consent Decree and its opportunities for Colbert Class Members followed by Evaluation and care coordination services.

HFS provided 1,557 names for the MDS-Q reporting periods March through June 2016. 354 (23%) of these Class Members were filtered out of the lists sent to the pilot site agencies for various reasons including:

- Class Member already transitioned to a Community-Based Setting
- Class Member name duplicated from previous list
- Class Member is active in the Colbert Housing Queue
- CTS reflects recent Colbert activity

The charts below identify results for the remaining 1,203 Class Member names sent to Aetna and IlliniCare for outreach and education.

Total Agreed to Evaluation = 275	
Recommended for transition	**Not Recommended for transition**
159	116

Discharged	Declined	Expired	Other
408	354	22	144

Aetna and IlliniCare continue to work with the lists of Colbert Class Members who responded affirmatively to the MDS-Q question and report results as part of the effort to outreach to every Colbert Class Member.

A.2. Alternative Outreach Strategies

A.2.a. Peer Mentors

The outreach work of AgeOptions and Marillac St. Vincent will be accomplished with the assistance of Peer Mentors recruited and trained specifically to inform Class Members, family members, Nursing Facility staff and the general public about the Colbert Consent Decree and the rights of Class Members. The use of Peer Mentors will be expanded to some or all of the Outreach Entities as Peer Mentors have proven to be effective communicators who are able to motivate their peers to overcome their fears and concerns and to seriously consider transitioning from the Nursing Facility to a Community-Based Setting.

A.2.b. Ombudsmen

Mandated by the Federal Older Americans Act and the Illinois Act on Aging, Long-Term Care Ombudsmen are assigned to Nursing Facilities in Cook County, to protect and advocate for residents. Ombudsmen assist in the identification of Colbert Class Members desiring to transition to the community by providing information and making referrals for evaluation for Colbert Class Members who are interested in transitioning to Community-Based Settings. Ombudsmen also assist Class Members who wish to file a complaint, grievance or appeal during any stage of the transition continuum.

A.2.c. Choices for Care

In 2017, IDoA will be working with the CCU Care Coordinator/Choices for Care screeners on developing strategies to increase outreach to individuals who are admitted to Nursing Facilities for less than 90 days rehabilitation stays to ensure they do not unnecessarily become long-term residents. CCU staff will notify Colbert staff and designated Care Coordinators of hospital to Nursing Facility transfers for these short-term rehabilitation stays. Care Coordinators will provide outreach to these individuals within 60 days to follow-up on their progress and possible return to the Community with the necessary supports.

A.3. Outreach Materials

A.3.a. Outreach Documents
In accordance with the Consent Decree, IDoA will continue to review and revise Outreach materials as necessary. These materials have been distributed to all Colbert providers and are available in English and Spanish. Outreach materials are used to inform Colbert Class Members, Colbert Class Member families, Nursing Facility staff and other interested parties about the opportunities afforded as a result of the Colbert Consent Decree. Outreach materials include the Colbert Fact Sheet, Colbert Frequently Asked Questions, Colbert Things You Should Know, and Colbert Right to Appeal, and a poster for display in each Nursing Facility. IDoA will make posters available for display in Nursing Facilities.

A.3.b. Class Member Notification Documents
To ensure that Colbert Class Members and their families and guardians have access to accurate information about the Colbert Consent Decree process, and provider contact information, IDoA created seven (7) Informational Notices for Class Members to advise them of what to expect, time-frames, and who to contact from the point of outreach and initial engagement, to being notified of a recommendation for or against transition, and through the delivery of pre- and post-transition services, when applicable. Colbert providers leave these notices with Class Members, as they move through the Colbert transition continuum.

A.3.c. Informational Videos
Colbert and MFP informational videos are used by Outreach Entities to inform Colbert Class Members, Colbert Class Member families, Nursing Facility staff and other interested parties about the opportunities afforded to Class Members as a result of the Colbert Consent Decree. The informational video is featured on the IDoA Colbert webpage and will be updated in fiscal year 2018 with input from the Court Monitor and Class Counsel.

A.3.d. Colbert Webpage
*(*https://www.illinois.gov/aging/CommunityServices/colbert%20v.%20quinn/Pages/Colbert%20v.%20Quinn.aspx*)*
The IDoA website has been updated to include the Colbert webpage for use by the general public. The webpage includes Colbert Consent Decree related documents such as the Consent Decree, the Implementation Plan, Outreach Material, Semi-Annual Reports, Court Monitor Reports, and any relevant Court Orders. In addition, this webpage offers links to the Colbert Information Email address, the Colbert Video as well as the MFP Web Application.

A.4. Outreach & Education Resources

A.4.a. Colbert Information Email
A Colbert information email account (AGING.ColbertDecree@Illinois.gov) was created to provide Colbert Class Members, Colbert Class Member families, Nursing Facility staff and other interested parties the opportunity to submit questions and comments via email. The Colbert Information Email address is displayed on the Colbert webpage and has been included in

written outreach materials and is included on the posters on display in Nursing Facilities. Colbert staff will respond within three (3) business days to questions raised regarding the Colbert Consent Decree process including specific questions regarding a Colbert Class Member's status on the Colbert transition continuum. Class Members can also file any appeals, grievances or complaints via this email.

A.4.b. IDoA Senior HelpLine
Effective September 1, 2014, Colbert Class Members have access to the IDoA Senior HelpLine (HelpLine) Monday through Friday, 8:30 a.m. through 5:00 p.m. The HelpLine telephone number is included in written outreach materials and on the Colbert webpage. Colbert Class Members, Class Member families, Nursing Facility staff, and other interested parties can ask questions, and initiate referrals using the HelpLine. Class Members can also file any appeals, grievances or complaints via the HelpLine.

Agents staffing the informational telephone line are trained to answer general questions regarding the Colbert Consent Decree and its implementation. Those calling with specific questions regarding Colbert Class Members who have been evaluated, assessed, or otherwise engaged in Colbert implementation activities are referred to Colbert staff for follow-up.

B. Referrals for Evaluation
Outreach Entities will refer Class Members who express interest in moving to Community-Based Settings for Evaluation by an Evaluation Entity. It is also expected that referrals for Colbert Class Member Evaluations will come through self-referral, family members or friends, Nursing Facility staff, Ombudsmen, Class Counsel and others. Individuals referred for Evaluation for transition to a Community-Based Setting will receive an initial outreach by an Evaluation Entity within ten (10) business days.

Colbert Class Members and others can use the IDoA Senior HelpLine or Colbert Information Email for referrals, but the web referral form found on the MFP website is currently the primary vehicle by which Colbert Class Members are referred to an Evaluation Entity for outreach, education, and, potentially, Evaluation.

C. Evaluations
IDoA has engaged multiple Evaluation Entities to conduct Evaluations for Colbert Class Members who are interested in transitioning from Nursing Facilities to Community-Based Settings. All Evaluation Entities will receive referrals generated by outreach efforts to Colbert Class Members as described in the outreach section of this document. Aetna and IlliniCare will also continue to receive referrals for evaluations submitted by the general public.

Evaluations are conducted utilizing the following:

- Aetna and IlliniCare utilize inter-disciplinary teams comprised of Qualified Professionals, including a Health Care Professional, a Behavioral Health Specialist and a Care Coordinator;

- Metropolitan Family Services, Trilogy, Inc., Thresholds, Sertoma Centre and Lutheran Social Services of Illinois employ Qualified Professionals as Resident Reviewers for Class Members diagnosed with SMI;
- CCUs, Aging Care Connections, Catholic Charities-South Suburban and Catholic Charities-Older Adults employ Qualified Professionals for Class Members over 60 years old.

To ensure compliance with the Cost Neutral Plan's requirements, each Evaluation Entity has a targeted number of Evaluations for completion.

C.1. Evaluation Composition

Colbert Class Members interested in transitioning to a Community-Based Setting are required to receive a high quality, clinically informed Evaluation that assembles information for a full picture of the individual's preferences, strengths, needs, abilities, service patterns and outcomes over time. In accordance with the Colbert Consent Decree, Evaluations are required to be conducted by Qualified Professionals who are knowledgeable of populations with special and often complex needs.

Effective January 2016, Qualified Professionals were required to use a uniform Colbert Consent Decree Evaluation tool developed by UIC-CON in consultation with IDoA. The design and data elements of the tool are grounded in best practices from the field and incorporated some of the more useful features of previously used tools. The 40-page Evaluation tool is comprehensive in scope and provides detailed information about the Class Member:

- Background and demographics;
- Interests, skills, strengths, and goals;
- Previous living experiences and preferences;
- Social histories;
- Medical and behavioral health histories and diagnoses;
- Medication use, knowledge and adherence;
- Cognitive and functional abilities;
- Service utilizations; and
- Health and safety risks.

Information garnered from the Colbert Evaluation tool, the Nursing Facility medical record, interviews with the Class Member, his or her family members/support system, and the Nursing Facility staff inform the Evaluator about the Community-Based Supports and Services necessary for the Class Member to transition to a Community-Based Setting safely and successfully.

C.1.a. Determination of Need (DON)

When assessing the needs of persons with disabilities and/or functional limitations, and determining eligibility for Community-Based Services, the Evaluation Entity requests a DON assessment. The DON is composed of a Mini-Mental Status Exam, an assessment of the Class Member's level of functioning in six (6) activities of daily living (ADLs) and nine (9) instrumental

activities of daily living (IADLs), as well as the Class Member's ability to perform certain health tasks and to recognize and respond to danger when left alone. The DON is conducted by DHS/DRS for individuals under age 60, and IDoA for individuals over age 60.

C.1.b. UIC-ATU

When a Class Member has functional limitations or a physical disability requiring assistive devices and home accessibility modifications in a Community-Based Setting, the Care Coordinator completes a referral and consults with UIC-ATU. UIC-ATU's assessment specifies the assistive technology and accessibility modifications required to maximize the Class Member's independence when he or she moves into the Community and works with the Care Coordinator to make those resources available. As required by the Consent Decree, IDoA provides a one-time payment of up to $5,000.00 for allowable expenses necessary to make a Community-Based Setting accessible for a Class Member. Additional funds up to $25,000.00 may be available for accessibility modifications for Class Members under the age of 60 years old through DHS/DRS. Eligible Class Members will be informed of the availability of these additional funds and guided through the process to obtain these funds by the Care Coordinator. The State is exploring how and where to obtain any necessary added funds for Class Members over the age of 60. See Section G.3. Assistive Technology/Home Modifications.

C.2. Evaluation Dispositions and Reporting

When a Class Member is recommended for transition into a Community-Based Setting, the results of the Evaluation are used to determine the recommended type of housing and the services and supports that are needed to allow the Class Member to transition safely and successfully.

Evaluation Entities report the dispositions of the Evaluations according to categories defined by IDoA in the Colbert Tracking System (CTS) as the Evaluations are completed. IDoA staff use this data to track Evaluation activity, monitor the flow of referrals to CMHCs and Housing Locators, as applicable, and to perform a monthly analysis of Colbert Consent Decree data for compliance and other reports. Completed Colbert Evaluations are also submitted to UIC-CON and IDoA for use in a variety of quality improvement activities, as described in upcoming sections of this document.

C.3. Service Plans and Care Coordination

In accordance with the Cost Neutral Plan and the Consent Decree, the Care Coordinator will develop a Service Plan of Care for each consenting Class Member within 90 days of his or her Evaluation. Depending on how the Class Member enters the Colbert Consent Decree service system, the Care Coordinator could either be a Qualified Professional from a Colbert MCO, the CCU or a CMHC. When the Colbert MCO Care Coordinator refers to a CMHC for transition coordination, the Colbert MCO Care Coordinator and the CMHC work collaboratively to complete the Service Plan of Care.

Consistent with federal home and Community-Based Service requirements, Service Plans of Care are developed incorporating a person-centered planning process that addresses health,

disabilities and long-term services and support needs in a manner reflecting individual preferences and goals. That is, the service planning process is directed by the Class Member and may include other individuals the Class Member chooses to be included. This process is designed to result in a person-centered plan that reflects goals and preferences identified by the Class Member.

For Class Members transitioning from Nursing Facilities to Community-Based Settings, the purpose of the resulting person-centered Service Plan is threefold: (1) to assist the Class Member in achieving personally defined outcomes post-transition; (2) to ensure delivery of services in a manner that reflects personal preferences and choices; and (3) to contribute to assuring the health and welfare of the Class Member. As required by the Consent Decree, the Service Plan of Care shall focus on the Class Member's personal vision, preferences, strengths and needs in the home, Community and work environments. Additionally, the Service Plan of Care takes into consideration the involvement of key collateral contacts as applicable, including family members, Nursing Facility staff, other service providers, the Plan MCO care coordinator, and the Colbert Housing Locator or CMHC provider.

For Class Members who are recommended for transition, the Service Plan of Care must be updated by the Care Coordinator and Class Member at least every 180 days to reflect any changes in the needs and preferences of the Class Member, both pre- and post-transition. The Plan shall incorporate, where appropriate, services to assist in acquisition of basic activities of daily living skills and health and disability self-management. Colbert Class Members who meet the eligibility criteria for certain federal Medicaid home and Community-Based waiver programs may also have access to a wide range of additional services to support them while living in a Community-Based Setting. Additionally, if the Class Member is not referred to Permanent Supportive Housing or a Private Residence, the Service Plan of Care will specify what services the Class Member needs that cannot be supplied in Permanent Supportive Housing or a Private Residence, and the services to be provided at an alternate Community-Based setting. As provided by the Consent Decree, these options may include, as appropriate to a Class Member, a Supportive Living Facility (SLF) or other appropriate supported or supervised residential setting.

If the Class Member is not recommended for transition to a Community-Based Setting due to impairments in physical health, mental health, and/or functional abilities to an extent that the needs of the Class Member cannot be met with available Community-Based services and supports, the Evaluation summary provides a brief Service Plan. The brief Service Plan recommends continued placement in a 24-hour skilled Nursing Facility and describes the services in the Community required to meet the Class Member's needs but which are not currently available, as well as any functional, medical and/or behavioral health improvements that are necessary before the Class Member would be considered appropriate for transition to a Community-Based Setting at some future point. The brief Service Plan is required to be re-assessed every 180 days to determine if the services in the Community are adequate to meet the current needs of the Class Member and successfully transition him or her into the Community.

If a Class Member declines to be evaluated for transition, this is noted as the Service Plan of Care on the Evaluation and shared with IDoA. The Service Plan of Care is required to be updated annually in the case of a Class Member who declined Evaluation.

If a Class Member is determined by a physician who is not affiliated with the Nursing Facility to have a condition requiring a high level of medical care or staffing to assist with ADLs and self-care that cannot be provided in a Community-Based Setting, such as severe dementia, other severe cognitive impairments or an irreversible medical condition, it is noted in the Evaluation that the Class Member cannot be served effectively in the Community. In those instances, the Service Plan of Care does not need to be regularly updated.

C.4. Transition Coordination for Class Members with Physical Disabilities

Once a Class Member with physical disabilities is recommended for transition and the Service Plan of Care is complete, the Care Coordinator assists the Class Member with obtaining: (1) necessary personal documents (at a minimum a State Identification Card and income verification), (2) any benefits such as Supplemental Security Income (SSI), if necessary, and (3) any follow-up assessments, i.e., the DON and/or the UIC-ATU assessment. The Care Coordinator then makes the referral to the Housing Locator.

If a Class Member is recommended for transition to a SLF and the Service Plan of Care is complete, the Care Coordinator assists the Class Member with: (1) obtaining necessary personal documents and any benefits such as SSI, (2) identifying an appropriate SLF in the Class Member's desired geographic area, (3) providing required clinical information to the SLF, and (4) making the referral to the Housing Locator with all pertinent information regarding the SLF move.

For Class Members with physical disabilities, and those moving to SLFs, IDoA has contracted with three (3) agencies for housing location services: Featherfist, Access Living, and Catholic Charities, Inc. See Section E.1 for further details.

C.5. Transition Coordination for Class Members Diagnosed with SMI

To meet transition coordination and housing location needs for Class Members diagnosed with SMI that require community mental health treatment, Colbert MCO Care Coordinators have access to nine (9) DHS/DMH contracted CMHCs through Inter-Governmental Agreement (see page 9). The CMHCs currently include Association House, Community Counseling Center of Chicago, Lutheran Social Services of Illinois, Trilogy, Inc., Thresholds, Pilsen Wellness Center, Kenneth Young Center, Sertoma Centre, and Grand Prairie Services.

Once a Class Member diagnosed with SMI is recommended for transition, the Colbert MCO Care Coordinator will ensure any necessary follow-up assessments are requested, i.e., the DON and/or the UIC-ATU assessment. The referral is then made to a CMHC able to provide the level of community mental health services required in the geographic location of choice for transition coordination and housing location services. The CMHC will assist the Class Member in obtaining personal documents and either the Colbert MCO Care Coordinator or the CMHC may

help the Class Member obtain other necessary benefits such as Social Security to transition to a Community-Based Setting. In addition, CMHCs offer Class Members who are diagnosed with SMI further specialized mental health assessments, an individualized treatment plan, prescribed community mental health treatment, case management and, social, employment or health care services, as needed. See Section E.1 for further details.

C.5.a. Resident Review Agency
If the Class Member Evaluation was completed by a Resident Review agency not providing transition care and the Class Member has a diagnosis of SMI, IDoA manages the referral to the appropriate CMHC, who will serve as the Transition Coordinator and the Care Coordinator.

C.5.b. Community Mental Health Centers
For the CMHCs that provide Evaluations for Class Members with SMI followed by a continuum of care, the CMHC makes the referral to the agency transition team when the Class Member agrees. IDoA handles referrals to another CMHC when the Class Member prefers working with a CMHC other than the one completing the Evaluation or requires a different level of service than the evaluating CMHC can provide. In this case, the CMHC serves as the transition coordinator and the Care Coordinator.

C.6. Discharge Service Planning Conferences
Care Coordinators, CMHC staff, Nursing Facility staff, family members, service providers and Plan MCO staff as applicable collaborate to address the Class Member's needs. Teleconferences and case reviews are facilitated by UIC-CON during the course of the Class Member's transition to discuss his or her needs and the approaches to meet those needs. Care Coordinators also regularly discuss the status of transitions during weekly teleconference meetings with IDoA staff and the Housing Locator and CMHCs.

Finally, at least two (2) in-person care conferences are conducted prior to the Class Member's transition to a Community-Based Setting. The first is a Pre-Discharge meeting that is held with the Class Member, Care Coordinator, CMHC (when applicable), Nursing Facility staff, and Plan MCO staff (if applicable) at the Nursing Facility to review and coordinate plans and steps taken towards the move into the community. Within approximately two (2) weeks prior to the actual move into the community, a Discharge meeting is held with the Class Member, Care Coordinator, CMHC (when applicable), Nursing Facility staff, and Plan MCO staff, (if applicable) at the Nursing Facility. The purpose of the Discharge meeting is to confirm the necessary services and supports are or will be in place by the date of the projected move.

C.7. MFP Transition Requirements
In recognition of MFP requirements and best practice, certain other documents are completed by the Care Coordinators prior to transitioning an individual from a Nursing Facility to a Community-Based Setting. They include:

- 24 Hour Back-up Plan
  The 24 Hour Back-up Plan is a written document provided to the Class Member that lists resources and supports for use in the event of an emergency or as a remedy for loneliness. Class Members will be coached regarding the resources listed on the 24 Hour Back-up Plan to ensure that the Class Member has access to a telephone for use in emergency situations.

- Quality of Life Survey
  The baseline Quality of Life survey is to be completed by the Care Coordinator two (2) to four (4) weeks prior to the Class Member being discharged from the Nursing Facility (See the Quality section for more details).

D. Post-Transition

Effective care coordination and post-transition monitoring is critical to the success of Colbert Class Members' tenure in Community-Based Settings. The Care Coordinators and/or the CMHC staff offer comprehensive services to ensure that the needs of Class Members are identified and addressed through referrals for all available services for which the Class Member is eligible for 12 months post-transition. Care Coordinators and CMHC staff also: (1) provide assistance with arranging transportation; (2) verify and assist with adherence to medication therapy; (3) verify and assist with attendance at medical and psychiatric appointments; (4) respond to and follow up on critical incidents experienced by Class Members, including ER visits and hospitalizations; (5) conduct home visits to monitor for health, safety and housing maintenance; (6) monitor and evaluate the effectiveness of the care plan and adjust as needed; (7) coordinate care with providers and the Class Member's social support network of family, friends, and others; (8) educate and coach the Class Member on self-management skills; and (9) assist Class Members to secure permanent housing subsidies. Care Coordinators and CMHC staff, when applicable, are expected to document all contacts with the Class Member, other providers, and the legal guardian, family, friends, significant others, as applicable. The contacts are recorded in the Class Member's agency record and in CTS. Although the frequency of contacts will vary with the current needs of the Class Members, the minimal number of contacts should occur in accordance with the guidelines of the Colbert Consent Decree and the MFP Operational Protocols, when applicable. The guidelines are as follows:

- Month 1: Weekly face-to-face visits with the Class Member;
- Month 2: Face-to-face contact once monthly; face-to-face contact twice monthly for Class Members defined as high risk;
- Months 3-8: Face-to-face contact at least once monthly; face-to-face contact bi-weekly during month 3 for Class Members who are under age 60 and physically disabled;
- Months 9-12: Face-to-face or phone contact at least once monthly.

Additional contact procedures shall include:

- Increased frequency of face-to-face visits as needed following reportable incidents, ER visits, hospitalizations, significant changes in the Class Member's health and/or functioning.
- Contacts with the person identified in the Service Plan of Care as a contact for Class Member (*e.g.*, legal guardian, family, friend, significant other) or service providers as needed, by telephone once a week, or more often as needed.
- Face-to-face contact shall occur at least once with the Medicaid Managed Care Plan, when applicable, prior to termination of post-transition monitoring by Care Coordinators.

If the Class Member is enrolled in a Medicaid Managed Care Plan, the Class Member's care coordination will be transferred to the Class Members' Plan MCO Care Coordinator after the 12th month post-transition. The Class Member will be informed of this transfer and will be guided through this process by the Care Coordinator, who will inform the Plan MCO Care Coordinator of the transition approximately 60 days prior to the 365th day post-transition. Plan MCO Care Coordinators continue to implement Service Plans of Care unless the Class Member and his or her guardian, if applicable, agree to a modification.

Class Members who are receiving community mental health services will continue receiving those services beyond the 12th month as long as the Class Member remains eligible for and in need of those services, as determined by the CMHC.

D.1. Post-Transition -- Housing

Ongoing support to transitioned Colbert Class Members is essential to their continued success in the Community. Class Members benefit from guidance regarding their responsibilities as a tenant and a Colbert Bridge Subsidy recipient.

All Colbert Class Members sign the IDoA Colbert Bridge Subsidy Participation Agreement, which includes Class Member goals to "be a good tenant, pay my portion of rent on time, keep my apartment clean and orderly, and be a good neighbor." Some Class Members have had difficulty meeting these responsibilities in the past, or have not had to manage these responsibilities for a significant period of time. It is important that Class Members fully understand their responsibilities, and strengthen their skills in fiscal management and apartment maintenance, as well as communication/relationship building with landlords and neighbors.

IDoA works closely with Class Members and involved parties (Housing Authority of Cook County, Care Coordinators, and landlords) to provide continued support and guidance in these areas, and to address any concerns that may have an impact on the Class Member's tenancy or continued eligibility for the Colbert Bridge Subsidy. These concerns include, but are not limited to:

- Class Member request to move at middle or lease end because of Landlord nonresponse to repair requests;

- Landlord complaint regarding Class Member behavior, including: non-payment of rent, excessive noise, destruction of property;
- Eviction prevention efforts in response to Landlord legal notices.

IDoA follows the Chicago Residential Landlord Tenant Ordinance to ensure that the rights and needs of Colbert Class Members are respected. IDoA focuses on eviction prevention measures through ongoing dialogue with all parties, in order to collaboratively identify and resolve issues. IDoA also relies on HACC expertise to work with landlords/property managers to address concerns.

IDoA routinely holds a teleconference with individual Class Members, and CMHC or Care Coordinators, to address any issues that may be affecting his or her tenancy. Circumstances are fully discussed, including Class Member/landlord rights and responsibilities. Next steps are identified, with follow-up assistance from CMHC and/or Care Coordinator. IDoA continues to work with the Class Member and involved parties until resolution is reached. Teleconferences are required for any requests to move by either the Class Member or landlord.

IDoA continues to work with Class Members, as described above, regarding tenancy/subsidy issues during the period for which they receive the Colbert Bridge Subsidy. In particular, IDoA, along with HACC, is a main contact for individuals who do not have an ongoing relationship with a CMHC after the 12-month monitoring period is completed. For these post-12-month transitioned Class Members, IDoA works instructively and collaboratively with other non-Colbert entities who may be working with the Class Member, relying on their support of the Class Member if needed for events such as a request to move. IDoA strives to refer these Class Members to resources if the Class Member identifies other needs beyond housing status.

IDoA works with HACC to maintain accurate and up-to-date information regarding events that will affect continued subsidy payments, such as: mortalities, out-of-state moves, return to the Nursing Facility, move to a SLF, abandonment of property, permanent voucher acquisition, or other event which disqualifies the Class Member for a continued Colbert Bridge subsidy. IDoA also works with HACC and Class Members regarding subsidy recertification requirements.

D.2. Colbert Class Member Skill-Building

The State recognizes that individuals leaving Nursing Facilities after long stays may lack certain life skills necessary to function well and thrive in a community. Part of the Evaluation process conducted by the Care Coordinators is to determine what skills the Class Member may need to live successful in a community-based setting. Those skills may include financial management, accessing and using transportation, shopping, and medication management.

The Service Plans of Care and Mental Health Treatment Plans, completed by the Care Coordinators, CMHC staff and Class Members, use a person-centered approach and include services that reinforce independent skill development. In addition, Class Members will have access to a continuum of programs and services as well as a treatment approach that supports

the challenges of managing a disability and independent living and includes Supported Education and Employment, as appropriate.

D.2.a. DHS/DRS & Access Living

DHS/DRS is also working to support skill development by contracting with Access Living to provide the following services to eligible Colbert Class Members:

- Money Smart (a FDIC approved financial management curriculum) to support financial management;
- Training to manage personal assistants;
- Training to access Emergency Back-up CNA referrals and services; and
- Stepping Stones for Individuals and Groups - a comprehensive peer support curriculum for persons with disabilities to learn vital independent living skills (i.e., positive disability identity and self-advocacy, technology, harm protection, rights and legal protection, maintaining healthy relationships, budgeting).

D.2.b. AgeOptions Community Reintegration Program

AgeOptions has developed a Community Reintegration Program for eligible Colbert Class Members which provides skill building for Class Members recommended for transition. The Community Reintegration Program is eight (8) weeks in duration, and provides Class Members the ability to develop independent living skills and confidence, access community resources and socialize with others. The curriculum is flexible, designed to meet the needs of the individual Class Member and is presented in small groups in the Nursing Facility.

The classes include the following topics:

- Loneliness
- Home & Personal Safety
- Medication Compliance
- Healthy Eating
- Managing Chronic Illnesses
- Accessing Community Resources
- Money Management

D.3. <u>Individual Placement and Supported Employment (IPS)</u>

DHS/DMH and IDoA have developed the Illinois Individual Placement and Supported Action Plan to enhance the availability of IPS Employment for Williams and Colbert Class Members diagnosed with SMI. The Colbert/Williams action plan was developed to help engage Class Members diagnosed with SMI around employment as part of community integration. IPS is an evidence-based, fast track, no denial employment program for people recovering from mental illness and will help support people with community integration. The goal of IPS is competitive employment in the community, using a team approach. The team is composed of a clinical therapist, employment specialist, and a benefits specialist, who meet with each participant on a regular basis, to create problem-solving strategies as well as to provide assistance with career

planning and advancement. A Colbert/Williams IPS Trainer began working on October 20, 2015 to develop an action plan that includes materials and strategies to engage Colbert Class Members in IPS and to collect and analyze data for reporting and planning. As of September 15, 2016, a total of 24 Class Members have participated in IPS. Class Members are initially informed about IPS during the evaluation process. Information about IPS is provided to Colbert Class Members in the transition process and post-transition in an on-going manner by Care Coordinators and in the Drop-In Centers.

D.4. Vocational Rehabilitation Services

DHS/DRS offers Colbert Class Members with physical disabilities Vocational Rehabilitation Services with the support of the Care Coordinator. DHS/DRS's Vocational Rehabilitation program offers training, job placement, and physical/mental restorative services that can assist a Colbert Class Member in achieving a positive employment outcome. IDoA staff continues to work with DHS/DRS to make this process as efficient as possible and to track Colbert Class Member outcomes. Class Members are initially informed about Vocational Rehabilitation Services during the evaluation process. Information about Vocational Rehabilitation is provided to Colbert Class Members in the transition process and post-transition in an on-going manner by Care Coordinators.

E. Housing

Stable housing is essential to successful community integration. IDoA works with Colbert providers to ensure that Class Members are provided the opportunity to live in the most appropriate integrated setting where they can lead independent and productive lives in the Community. This requires an approach that is flexible, adaptable and individualized. IDoA's priorities are to maximize housing options that address the environmental safety and emotional well-being of Class Members and to provide essential services and supports. Working closely with the Statewide Housing Coordinator, IDoA identifies and develops an array of housing options designed to address the full range of individual needs of those Class Members who elect to transition.

Housing options available for Class Members may include:

- Permanent Supportive Housing (PSH): Units with very low rents and/or rental assistance with available, but not mandatory, supports:
  - Scattered Site PSH: Apartments available through open housing stock in an array of areas, which allow greater choice in location, choice of living with another individual and which services and supports to utilize.
  - Small Site PSH: Units in which supports and services are offered on site, and are typically dedicated to a single disability or population (although some are becoming disability neutral), and are often utilized by Class Members with more intensive service needs.
- Project-Based Rental Assistance Units (PBRA): Utilized for Class Members with barriers to traditional leasing options, such as criminal backgrounds or credit issues. Units are either scattered-site or a number of units in a building. These units have long-term (2-3 year) contracts between HACC and the landlords and

due to the guaranteed payment and long-term nature are at a discounted rate. There are currently PBRA agreements in place with five (5) property management companies.

- Clustered Models: Clustered models are used for Class Members who require staff support on site, and allows a set number of units in a building or small area that are secured with a contract between HACC and the property management company. Referrals to Clustered Model housing are made by the Care Coordinator.

DHS employs a Statewide Housing Coordinator, whose responsibility is to identify means of enhancing housing opportunities for special needs populations, including Class Members, across applicable State Agencies. The Coordinator's responsibilities include expanding housing resources through the development and expansion of networking opportunities, partnerships and relationships with landlords, housing developers and public housing agencies; facilitating the expansion of housing resources including Permanent Supportive Housing (PSH); providing housing opportunities for Class Members of the Consent Decrees; and management of the referral flow to Illinois Housing Development Authority (IHDA) Low Income Housing Tax Credit Statewide Referral Network Units and Section 811 Project Based Rental Assistance Units. A portion of IHDA's Low Income Housing Tax Credit Units (IHDA's major multi-family funding resource) are targeted for persons with disabilities and referred through a Statewide Referral Network (SRN) that includes, but is not limited to, Class Members of the *Olmstead* Consent Decrees.

IDoA staff also work closely with the Housing Locators and the fiscal agent subsidy administrator to identify housing options for individual Class Members and resolve obstacles to finalizing placements.

E.1. Housing Locators

The Housing Locators (including those working within a CMHC) collaborate with Care Coordinators, IDoA and the Class Member to identify appropriate housing. In accordance with this updated Implementation Plan, the Cost Neutral Plan and the Consent Decree, Care Coordinators work with each Class Member to determine geographic and housing preferences and options, including living with family, guardians, friends and significant others. Care Coordinators also offer assistance with obtaining any necessary documentation to secure housing, including a State Identification Card, Birth Certificate or a Social Security Card and income verification. The Housing Locator then works with each Class Member to identify housing using existing relationships with landlords, web/internet advertisements and housing identified through the ILHousingSearch.com website by placing the Class Member on the online housing waiting lists for SRN and Section 811 Units and other means.

Additionally, the Housing Locators work with landlords and Class Members to complete and submit applications, secure leases, obtain inspections of the units, access transition funds, purchase necessary household items, arrange utility connections, and actually move Class Members and his or her belongings into the unit.

F. Housing Search Tools

Housing Locators are able to use any of the resources listed below as appropriate to expedite Colbert Class Members' transition to Community-Based Settings:

- Illinois Web Based Housing Search: The primary on-line search inventory tool funded by the State at www.ILHousingSearch.org. The website is accessible to the general public as well as Housing Locators, but has a case worker portal that allows Housing Locators (with a username and password) to access the Prescreening, Assessment, Intake and Referral (PAIR) Module and place Class Members on waiting lists for housing options targeted to Class Members of various Consent Decrees, including *Colbert*, including State Wide Referral Network and Section 811 Project Based Units;
- Collaboration with Public Housing Authorities (PHAs) and Section 811 Match: The Statewide Housing Coordinator works with local Public Housing Authorities to increase Class Member access to various rental assistance programs and units, including Section 8 housing units, Housing Choice vouchers and use of Section 811 Match resources.

G. Funding Resources

IDoA continues to work with private developers to create more supportive housing options for Colbert Class Members. A number of initiatives are underway to provide funding and support to developers' requests to participate in or who have expressed an interest in affordable housing initiatives. The State will also look into potential new supportive service funding opportunities as they may arise. The following are current resources that help fund new unit development, rental assistance for both new and existing units, and accessible housing.

- Unit Development is achieved through the following:
  - Low Income Housing Tax Credits (LIHTC) to encourage affordable housing production. There are two rounds of LIHTC every year. In round one (1) for 2015, IHDA approved $8.19M to create 503 affordable units. This included 56 SRN units. In the 2015 round two (2), IHDA approved $12.38M in tax credits to create 860 affordable units. This included 88 SRN units. In round one (1) for 2016, IHDA approved $12.2M to create 955 units and in round two (2), IHDA approved $12.7M for 955 units. It is estimated 123 SRN units will come from round one (1) 2016 LIHTCs and 102 SRN units will come from round two (2);
  - Use of the Statewide Referral Network (SRN) (a partnership between IDoA and DHS) for development of affordable housing units targeted for use by vulnerable populations who require access to supportive services in order to maintain housing. SRN units utilize LIHTC as noted above and are a sub-category of the affordable housing resulting from these tax credits;
  - Section 811 Interagency Panel's Communities of Preference: This Interagency Panel works to improve access to SRN/Section 811 housing units for all *Olmstead* Consent Decree Class Members, including *Colbert* in geographic areas preferred by Class Members. For 2016-2017, these

areas include: (within the City of Chicago) Uptown, Rogers Park, Near West Side, West Town, Edgewater, Lincoln Park, South Shore, Austin, Hyde Park, South Lawndale, Lake View, and Clearing; (cities) Peoria, Kankakee, Bourbonnais, Champaign, Urbana, and Decatur; (counties) Cook, DuPage, Kane, Kendall, Lake, Madison, McHenry, McLean, Sangamon, St. Clair, Will and Winnebago;

- Build Illinois Bond Program (BIBP): 225 SRN units were created with funds allocated to IDoA from the BIBP program;
- Home First Illinois Initiative: HFI develops integrated, physically accessible, and affordable units, providing permanent, community based housing to people with disabilities. Vacancies in these units are available to Class Members through the Housing Locators. HFI has made 70 units available to Class Members and is in the process of developing an additional 54 units that will give preference to various Consent Decree Class Members, including Colbert.

G.1. Rental Assistance

G.1.a. Colbert Bridge Subsidy

Many Colbert Class Members have income limited to entitlements such as SSI/SSDI, and require assistance with rental payments. The Colbert 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). The Colbert Bridge Subsidy provides essential, interim support to individuals transitioning into Permanent Supportive Housing and can also be project-based for specific units. Key components of the Colbert Bridge Subsidy are:

- Designed to look like the Section 8 Housing Choice Voucher, the tenant is obligated to pay 30% of their income each month toward rent and the subsidy rental assistance pays the remainder of the rent each month directly to the landlord.
- All identified housing units must fall within the Fair Market Rental (FMR) or Local Payment Standard. Exceptions may be made in appropriate cases as defined by IDoA – for example, where exceeding the FMR is necessary to obtain certain accessibility features needed by a tenant with a disability.
- All housing units must pass Housing Quality Standard (HQS) inspections.
- The Class Member signs a lease with the landlord and is subject to the same tenant/landlord law as all other lease holding tenants.

IDoA has contracted with HACC to administer the Colbert Bridge Subsidy. HACC is responsible for the following activities related to the Bridge Subsidies:

- Certification of Class Member income (initial and annual);

- Ensuring landlords/property managers provide necessary documentation for execution of the Subsidy;
- Negotiation of unit rental price with landlords/property managers in accordance with FMR standards, Local Payment Standard limitations, and other local factors, if applicable;
- Ensuring initial and biennial Housing Quality Standards (HQS) inspections are completed on each unit;
- Disbursal of Transition Funds (for Class Member move in) per IDoA directives.
- Execution of the Housing Assistance Payments (HAP) Contract with the landlord/property manager on behalf of the Class Member.
- Disbursal of monthly rental payments in accordance with HAP Contracts.

As of October 31, 2016, approximately 65% of the 1,428 Colbert Class Members who transitioned to a Community-Based Setting were supported by a Colbert Bridge Subsidy.

G.1.b. Transition Funds

Housing Transition Funds, not to exceed $4,000.00 per Class Member, will be available to provide one-time, move-in assistance for costs such as security deposits/move-in fees, utility deposits, and the acquisition of basic household items. The Housing Locator will coordinate with the Class Member to determine the needs of a transitioning Class Member and make the necessary arrangements to secure these items. Neither the Class Member, family member, nor the guardian, will have direct access to Housing Transition Funds. These funds are managed and reconciled with IDoA and HACC.

G.1.c. Permanent Housing Subsidies

Colbert Class Members transitioning under the Colbert Consent Decree, assisted by the Care Coordinator, are required to apply for open Section 8 Housing Choice Vouchers or other comparable permanent rental subsidy, and agree to accept the subsidy if and when it becomes available. The State will continue to work with Public Housing Authorities (PHAs) and other entities that administer and distribute housing rental subsidies in an effort to transition Class Members from the Colbert Bridge Rental Subsidy to permanent housing subsidies. IDoA will continue to work closely with Care Coordinators and Housing Locators to identify Class Members' needs and eligibility for the various permanent funding resources below, and connect them to the relevant subsidy administrator.

There are various types of Permanent Housing Subsidies available to Class Members. Among the options are the following:

- Section 8 Housing Choice Vouchers
- Section 811 Project Based Rental Assistance Program: Provides affordable housing linked with voluntary services and supports. These units are accessed by Housing Locators through the 811 Waiting List within the State's web-based housing locator. Funds were awarded to IDoA by HUD in 2013 ($11.9M) to provide 370 project-based

vouchers to disabled individuals moving from institutional to community-based living. An additional 6.42M was awarded in March 2015, which will permit an additional 200 vouchers to be awarded. Housing projects are being brought to IHDA's Board for approval, and as of September 2016, 104 units have been approved and will be available through the 811 Waiting List.

G.2. Accessible Housing

Colbert Class Members with disabilities require accommodations with accessible features that address their needs. Accessible housing refers to the physical design as well as accessibility features such as modified furniture, shelves and cupboards, or even electronic devices in the home that enable independent living for persons with disabilities. IDoA works with Public Housing Authorities in the City of Chicago and Cook County, private property owners and developers to identify existing accessible units as well as adaptable units that can be easily modified. The Home First Illinois initiative has provided accessible units dedicated to Colbert Class Members and IDoA has entered into contract with UIC-ATU to assist with modification requests. Colbert Class Members are also able to access accessible units within the Statewide Referral Network and/or the Section 811 Program by indicating their need for accessible features within the online waiting list or PAIR module.

G.3. Assistive Technology/Home Modification

In order to enable Class Members to maximize their independence and safety in a Community-Based Setting, IDoA has an agreement with UIC-ATU to provide assistive technology and home modifications to Class Members. These services may be provided at any time during the transition timeline from Nursing Facility to Community-Based Setting depending on the needs of the Class Member.

UIC-ATU is a multi-disciplinary, community-based clinic within the UIC Department of Disability and Human Development. UIC-ATU Colbert team is staffed with Assistive Technology Specialists from five (5) disciplines: occupational therapists, physical therapists, speech-language pathologists, rehabilitation engineers, and architects. Additionally, UIC-ATU Colbert team support staff includes a fabrication specialist, office manager, case management staff, and a graduate student from the UIC School of Architecture.

UIC-ATU services are available in the Assistive Technology areas of activities of daily living (ADLs), adaptive equipment, augmentative communication, computer access, electronic aids to assist in daily living, environmental control, home modification, seating/wheeled mobility, and worksite modification. UIC-ATU's services thus far for Colbert Class Members have been in the areas of ADLs, adaptive equipment, augmentative communication, home modification, and seating/wheeled mobility.

UIC-ATU staff address various adaptive technology matters, ranging from durable medical equipment as recommended by the Evaluation Entities (for example, a wheelchair), to specific home modifications and equipment that will assist the Class Member in their daily living activities. These can include a range of equipment and modifications, such as grab bars in

bathrooms, cantilevered sinks for ease of use, adaptive cutlery and household equipment and other equipment to assist the Class Member in their ADLs.

UIC-ATU involvement in the Colbert initiative began on February 2015, and 494 referrals for assistive technology assessments have been made, to date. During fiscal year 2017, an increased referral rate has been experienced, and is on a pace now for 393 referrals for the fiscal year. UIC-ATU produces and submits reports about assistive technology and home modification activities semi-annually.

H. Continuous Quality Improvement, Data Collection, Tracking and Reporting

The State is committed to establishing quality as on ongoing process and goal through a system of data collection, tracking, reporting and implementing improvements. The focus is on evaluating system effectiveness in delivering positive outcomes for Colbert Class Members and measures focus on process as well as clinical outcomes. Based largely on the DDRI (Design, Discovery, Remediation and Improvement) model endorsed by the Centers for Medicare and Medicaid, the State has implemented a set of performance management activities that assess quality and identify priorities for intervention. Data sources may include but are not limited to a variety of reports, case records, Evaluations, claims data and other information captured by the Care Coordinators, CMHC staff, Housing Locators, and other providers (Design). Using the performance measures, data is reviewed and analyzed (Discovery). Findings are shared with Colbert provider directors and program staff for corrective action (Remediation), and Quality Improvement (Improvement).

In addition to reviewing the results of data analyses with Colbert provider staff, IDoA has established a Quality Assurance (QA) Committee. This committee, comprised of state staff, representatives from each of the Colbert provider agencies, UIC-CON and UIC-ATU staff, meets quarterly in-person. The members discuss and resolve common challenges impacting their work and review data and reports from a wide range of sources, including QA reports from UIC-CON and IDoA. The information helps the members propose systemic changes to improve service delivery, client outcomes and satisfaction. Items for improvement that require special attention become the subject of QA workgroups that meet in-between the QA Committee meetings. The workgroups pinpoint the specific issues related to the subject matter and propose solutions for change back for the larger committee and IDoA to consider. Four (4) workgroups currently exist to:

- Enhance procedures and collaborative planning to ensure that the housing accessibility needs of Class Members are fully addressed at the time of transition into the community.
- Strengthen mitigation strategies that reduce or eliminate the impact of substance misuse and abuse on a Class Member's safety and success in the community.
- Improve partnerships with Nursing Facility for greater access to Class Members, Nursing Facility staff and Nursing Facility records for the purposes of evaluation and transition planning.

- Explore ways to better aid Class Members who are recommended for transition to obtain the income that is needed to sustain them in the community.

Additional areas that the Quality Assurance Committee may delegate to work groups during Phase III may address the complaints, grievances and appeals process, and preparing Class Members for success after the first year in the community.

As quality of services is of the utmost importance, IDoA and UIC-CON continue to monitor ongoing quality improvement activities. Those activities include: reviewing Evaluations for quality, validating the appropriateness of evaluations concluding Class Members are not recommended for transition, convening pre- and post-transition case reviews, and using a universal Evaluation tool to determine what supports and services a Class Member needs to transition into the community safely and successfully. Areas in need of improvement are identified through monthly and semi-annual analyses of these processes, which are prepared by UIC-CON, as well as ongoing communications between IDoA and UIC-CON as issues arise. Collaboratively, UIC-CON and IDoA develop and disseminate written guidelines, offer technical assistance and provide in-person, teleconference or web-based trainings to address the areas needing improvement.

H.1. Incident Management

Colbert Consent Decree Care Coordinators are accountable for reporting critical and reportable incidents involving a Class Member, using a standardized form. The Incident Reporting Form requires the first responder to the incident to classify it into one of three distinct categories: Level I - Urgent/Critical/Reportable; Level II – Serious/Reportable; or Level III-Significant/Reportable. Reports are accompanied by the Class Member's initial Evaluation, current medication and diagnosis lists, relevant medical records and laboratory results, current care plan and 24-hour back up plan, and Medicaid claims data to provide additional information that may be relevant to the incident's occurrence or resolution.

Incident Reviews are conducted for Levels I and II incidents by UIC-CON and IDoA staff to determine the strengths and areas in need of improvement in the documentation and response of Colbert providers to incidents involving Colbert Class Members, post-transition. Reviews of incident reports typically occur by phone three (3) days a week, within ten (10) business days of receipt of the report. The outcomes of these reviews are summarized in writing by UIC-CON and include action steps for immediate follow-up and to prevent the re-occurrence of incidents. A 30-day follow-up written report is completed by the appropriate Colbert provider to confirm that the action steps were successfully implemented and to share updates on the Class Member's condition and current housing.

Incident report reviews are conducted by telephone and involve Care Coordinators and staff from UIC-CON and IDoA. The reviews are facilitated by UIC-CON staff, including a nurse and social worker. IDoA staff includes the Quality Assurance and Compliance Liaison. Provider agencies are also encouraged to invite the Care Manager of the Class Member's Plan MCO to participate as an additional resource.

UIC-CON provides an incident data report on frequency and types of incidents to IDoA on a monthly basis. Additionally, the aggregate of incident reports is reviewed semi-annually for trends and patterns as a means to identify opportunities and implement strategies for systemic improvement in reportable incident management.

H.2. Mortality Review

Class Member deaths from all causes are reported on the Incident Reporting Form and followed up with Mortality Reviews by UIC-CON. The purpose of a Mortality Review is to identify patterns, themes, or behaviors surrounding an individual's death that could be beneficial to Care Coordinators and/or other community providers in the management of future individuals who transition to the community. The mortality review includes face-to-face interviews with the care management team, other providers who worked with the Class Member, family members and the guardian, when applicable, and a formal review of clinical documentation including:

- Service Plans of Care Informed Consents
- Initial and Subsequent Evaluations
- Care Coordinator Case/Visit Note(s) – Pre- and Post-Transition
- All Incident Reports
- List of Service Providers (i.e., medical, mental health, social services, etc.)
- List of Medications
- Hospital Records (< 3 months prior to death)
- Death Certificate
- Contact information for contact person who saw the Class Member in the community
- Any types of email communication and/or phone communication about the Class Member

UIC-CON produces a preliminary root cause analysis report within 60 calendar days of the notice of mortality. The findings from the analysis are discussed by teleconference with UIC-CON and IDoA staff, the relevant Colbert provider directors, supervisors and the Class Member's care management team. The calls are facilitated by UIC-CON staff. IDoA staff may include the Colbert Project Director and/or the Quality Assurance and Compliance Liaison.

Within five (5) business days of the teleconference, UIC-CON submits a final Mortality Review Report to IDoA, who in turn, shares it with the respective Colbert providers. The report includes a summary of the review and recommendations to mitigate future risk. The Colbert provider is responsible for submitting an action plan in response to the recommendations within 30 days of receiving the report. The action plan is intended to describe policy changes, training needs and supervisory measures, as appropriate.

UIC-CON produces and submits to IDoA a semi-annual report that documents the frequency and nature of mortalities and provides an analysis of trends and patterns and recommendations. UIC-CON works collaboratively with IDoA to develop and implement strategies for quality improvement including staff development training and/or policy and procedural changes.

H.3. Case Reviews

Case Reviews review the continuum of care provided to transitioning Class Members. The reviews focus on the quality and comprehensiveness of Evaluations and how that information is used in the development of service plans of care, risk mitigation plans and 24-hour back-up plans. Case reviews help to determine the degree to which the Class Member's needs are being met. Recommendations for improvements are offered to enhance and support the Class Member's successful transition into the community.

UIC-CON staff conducts two (2) types of case reviews involving transitioning Class Members. The first type focuses on high risk Class Members (see Appendix F) receiving care coordination from a Colbert MCO that is engaged with a Housing Locator or CMHC for housing searches and mental health services. The Review helps to engage both parties in collaborative planning and decision making. The second type focuses on cases where a CMHC or CCU is the sole transition Care Coordinator. Reviews assist the CMHC's and CCU's in developing Service Plans of Care, particularly when issues are present that are outside of the traditional scope of these providers.

Case reviews are conducted by teleconference and facilitated by UIC-CON staff, including an Advance Practice Nurse and clinical Social Worker. IDoA staff includes the Quality Assurance and Compliance Liaison. Colbert provider participants include the Care Coordinator, nurse and other staff as relevant to the particular Class Member. Provider agencies are also encouraged to invite the Care Manager of the Class Member's Plan MCO to participate as an additional resource on case review calls. Case reviews are enhanced by the inclusion of several documents referencing the Class Member's care including the Evaluation, Service Plan of Care, Medicaid claims, Nursing Facility records, and current medication lists.

Case review teleconferences are scheduled within 30-60 days of a tentative transition (move-in) date to discuss the progress being made to transition the Class Member into the community. The discussion and resulting recommendations are recorded in writing and shared with the respective Colbert providers. At approximately 30 days post-transition, a second teleconference is held to review the outcome of each recommendation made during the initial review, the status of the Class Member's Service Plan of Care and to make adjustments in the plan as needed. Patterns and trends in recommendations provided by UIC-CON are identified and used to implement quality improvements via training and/or changes in policy and procedures.

H.4. Quality of Evaluations

Quality of Evaluations Reviews offer clinical support to Colbert providers in the implementation of person-centered planning. The reviews assess the comprehensiveness of the Evaluation process and the validity of the outcome regarding a Class Member's appropriateness for

transition into the community. The Evaluation reviews further help determine if the Class Member's strengths, needs, abilities and preferences have all been considered in the development of the Service Plan of Care.

UIC-CON has established criteria to evaluate the quality of Evaluations completed by Colbert Evaluation Entities. A random sampling methodology is used to review the appropriate number and category of Evaluations completed monthly by the Care Coordinators and CMHC Resident Reviewers.

UIC-CON shares its recommendations for each Evaluation reviewed as well as an aggregate of Evaluations in a monthly report to IDoA. Findings are used to work collaboratively with IDoA to implement quality improvement activities, including the refinement of the universal Colbert Evaluation tool, instructions and guidance on the Evaluation process, staff training, and policy/procedural changes.

H.5. Reviews of Evaluations Resulting in Not Recommended Dispositions

UIC-CON staff reviews the Evaluations of interested Class Members who are not recommended for transition to a Community-Based Setting. Each review determines if the decision not to recommend the Class Member was appropriate and if the Evaluation meets a set of established quality standards.

UIC-CON receives all not recommended Evaluations and has a process and criteria for the review of a random sample of those Evaluations. A monthly report documents their findings on the quality of each "not recommended" Evaluation that was reviewed. If UIC-CON believes that the Evaluation data and summary does not sufficiently justify a not recommended disposition, the report is overturned. For each overturned report, IDoA requires the respective agency to conduct another Evaluation, using another Evaluator or Evaluation team. The re-Evaluation is to be completed with the Class Member within ten (10) business days.

UIC-CON prepares and submits to IDoA a semi-annual report that summarizes the findings from the clinical reviews of Class Members who were not recommended for transition. This information is used to identify the determinants involved in the decision-making of Evaluators, to propose alternate indicators for transition recommendations, and to improve policy, procedures and practices.

H.6. Annual Quality Reports

UIC-CON produces annual quality reports that examine the effectiveness of the Colbert Evaluations, service planning and care coordination. Using the recommendations that result from their analyses of data from incidents, mortalities, assessments and case reviews, they are able to identify trends and patterns of recommendations that are common across all areas. They are further able to isolate those recommendations that are most prevalent among particular Colbert provider agencies. UIC-CON and IDoA share that information with the entire direct service staff and the administrators of the provider agencies. In turn, the providers will be required to develop and implement action plans of remediation.

H.7. Consumer Input and Engagement

Key to the success of any service delivery system is the ability to demonstrate positive outcomes for those individuals receiving care in the system. Methods for investigating consumer "perception" of care become central strategies to a quality improvement methodology. In the Colbert Consent Decree implementation, the State conducts Quality of Life Surveys and created a Peer Advisory Council for ongoing input on ways to strengthen the system for others choosing to move to the community.

Quality of Life surveys are conducted in accordance with MFP guidelines for all Colbert Class Members pre-discharge, and at 11 months and 24 months post-discharge to discern the Class Members' perceptions relating to quality of life while still living in the Nursing Facility and then in the Community-Based Setting. Class Members' perceptions of quality of life are queried in seven domains: living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction and health status.

The Colbert Peer Advisory Council was created in accordance with the belief that Colbert Class Members are valuable consultants regarding the process and can offer significant input into quality improvement efforts. The Council provides ongoing consultation and advice to the IDoA staff, Court Monitor, and Plaintiffs regarding implementation of Colbert activities from the perspective of Class Members and their families. They will also select two (2) members to represent them on the Colbert Quality Assurance Committee not later than March 2017.

Summaries of Council meetings and any written recommendations will be included in semi-annual reports.

H.8. Complaints and Grievances

IDoA defines a complaint as a formal expression (verbal or written) of dissatisfaction by a Class Member, a designated representative of the Class Member, or a State contracted provider of services. A grievance is defined as a verbal or written expression of dissatisfaction concerning a violation of written rights, rules, statutes or State contract terms, such as those defined in the Health Insurance Portability and Accountability Act (HIPAA), the State's Administrative Rules, State contracts, the Illinois Mental Health and Developmental Disabilities Code and the Mental Health and Developmental Disabilities Confidentiality Act. Colbert Class Members will be informed of their right to file a complaint or grievance and the process involved in Colbert outreach materials distributed by Colbert providers. See IDoA's Colbert webpage.

Allegations of abuse and neglect are considered serious and must be reported to the appropriate authority. For persons living in Nursing Facilities, complaints must be directed to the Department of Public Health; for individuals living in the community, complaints must be directed to the 24-hour Adult Protective Services Hotline at IDoA at 1-866-800-1409. Providers and consumers will receive ongoing training on all reporting requirements and procedures in cases of suspected abuse or neglect.

H.9. Appeals

Colbert Class Members will be informed of their right to appeal decisions made during the implementation process initially through an informal review process administered by IDoA staff. A Class Member's right to grieve is included as part of the outreach materials and a fact sheet on the Colbert webpage. If the Class Member disputes the decision made through the informal review process, he or she will be given notice of appeals through existing HFS fair hearing processes. Timeframes for requesting hearings through this process will only begin after the conclusion of the informal review process.

H.10. Training Institute

Providing long-term community based care for persons with disabilities, mental illness and/or medical conditions that have previously required care in a 24-hour medically supervised facility is a major undertaking. It requires a work force that is prepared with the knowledge and skills to effectively conduct assessments, engage in person-centered planning and coordinate care such that the appropriate services and supports are in place to help persons transition safely and successfully into Community-Based Settings.

IDoA is expanding its partnership with DHS/DMH to help Colbert and Williams Consent Decree providers develop their knowledge and skills in a number of areas. The Training Institute provides a series of interactive educational sessions that are designed and facilitated by UIC-CON, in consultation with DMH and IDoA staff. Appendix E includes the schedule for the first phase of the Training Institute that began in November 2016.

The sessions that are intended to promote adherence to process and procedures and improve outcomes will cover a wide range of subjects that are grounded in best practices for community reintegration, build upon lessons learned in the implementation of both Consent Decrees and address common areas for quality improvement based upon findings of service delivery data analyses. Such topics include conducting Quality Initial and Ongoing Evaluations, Care Planning, Care Coordination, Collaboration with Providers and Supports, and Staff Burnout.

Clinical training sessions will focus on subjects that respond to challenges jointly encountered by Colbert and Williams providers when engaging Class Members in the Evaluation, care planning, transition and post-transition care coordination processes. These topics will include Trauma-Informed Care, Risk Identification, Disease Management, Motivational Interviewing, Substance Abuse Disorders, and Medication Management.

The Training Institute offers IDoA and DMH an opportunity to standardize and promote consistent language, definitions and protocols among Colbert and Williams providers. It also encourages networking, collaboration and information sharing among all disciplines and provider agency types within both systems, including CMHC staff, Housing Locators, Care Coordinators, UIC-ATU staff, and Outreach Entities. Training will be provided every other month either in-person or by teleconference and/or webinars. Clear training objectives and the qualifications of the presenters will enable the participants to receive Continuing Education Units (CEUs).

To supplement the training provided by the Training Institute, IDoA will continue to provide Colbert-specific training, technical assistance and resources. This training and technical assistance will be provided by IDoA staff, with assistance from subject matter experts as needed, to assist providers in the application of Consent Decree operational procedures and to improve the overall quality of Colbert services. Topic areas are determined in response to provider requests or as a result of data from CTS and UIC-CON's reviews of reportable incidents, mortalities and assessments. Additionally, Colbert providers are expected to have annual training plans and procedures for supervising their staff. Summaries of provider protocols for training can be found in Appendix E.

I. Contract Performance Monitoring

I.1. Outreach Contract Performance Monitoring
IDoA staff review activity reports and outreach outcome data submitted by AgeOptions and Marillac St. Vincent to monitor compliance with contract deliverables. Reports include (1) the names of the Nursing Facilities that were visited, (2) the types of engagement activities conducted, (3) the number of Colbert Class Members who were engaged, and (4) the number of peer mentors that participated. IDoA staff meets with agency staff by telephone at least monthly. Outreach Entity records will be routinely audited for quality and consistency with monthly reports and contract deliverables.

I.2. Evaluation/Care Coordinator Contract Performance Monitoring
Evaluation and Care Coordination functions as stipulated in contract deliverables are monitored through Quality Assurance activities conducted by UIC-CON and IDoA staff. These Quality Assurance activities are described in detail in Section H of this document.

I.3. Housing Locator & CMHC Contract Performance Monitoring
IDoA and DMH jointly monitor the performance of the CMHCs and IDoA monitors the performance of the non-CMHC Housing Locators to identify inconsistencies and areas for improvement. IDoA staff participates in weekly transition management calls to monitor the pace of transitions as well as adherence to Colbert transition processes. Site visits are conducted routinely to audit files and review the implementation of Colbert housing policies and procedures. IDoA staff accompanies selected housing location and CMHC staff to monitor unit viewings with Class Members, pre-inspections, lease negotiations, and move-ins.

J. Colbert Tracking System (CTS)
CTS is a web-based application, developed by IDoA in October 2014 that tracks Colbert Class Member transition activities. CTS is currently populated by referral data that is uploaded from the HFS Customer Relationship Management (CRM) database on a weekly basis. Colbert providers then enter data regarding Colbert Class Member transition activities.
CTS performs the following functions: (1) effectively tracks Colbert Class Members through the Colbert transition continuum; (2) provides a technology platform to facilitate communication and collaboration, (3) collects and processes data for monitoring and analysis and (4) implements data-based strategic decision making. CTS enables IDoA and Colbert providers to

better pinpoint where obstructions to transitions may occur and address them during weekly update telephone meetings. CTS continues to be the vehicle through which IDoA is able to track outcomes and provide reporting to the Plaintiffs on transition activities. CTS continues to be updated and modified with changes that allow IDoA to report the most accurate information.

All identified users are trained for proper usage of the system and required to submit a signed copy of the Colbert Tracking System and Network User Training Certification and Non-Disclosure Agreement. IDoA continues to be responsible for on-going support and technical assistance for users. Planning and development continues to expand the functionality and improve CTS.

IDoA is currently working on a new IT system for referrals that will be operational in July 2017.

J.1. Reports in CTS

Critical management reports are generated by CTS regarding Class Member transition activities. Reports most frequently used by IDoA staff are:

- Monthly Statistical Report – reports the number of initial contacts, number of evaluations completed, and the number of people who have transitioned by disability group per month.
- Provider Performance Report – reports the number of referrals, transition, and Class Members who will not transition for each Colbert provider.
- Housing Locator Report – reports Class Members actively in the Housing Queue.
- Transition Timeline Report – reports the number of people and average length of time for each housing event.
- Demographic Reports – demographic reporting about Class Members including all Class Members, transitioned Class Members, and evaluated Class Members

All reports in CTS are monitored on an on-going basis to ensure data integrity and relevancy. IDoA will work with the Class Counsel and Court Monitor to revise the Monthly Statistical Report in 2017.

K. Budget

For fiscal year 2017 a total of $31,765,200 in appropriation authority was established which sufficiently funded the community transition efforts under Colbert. IDoA will seek full funding for fiscal year 2018.

L. Reports

All reports referred to or described in the Implementation Plan will be provided to Counsel for the Class Plaintiffs on an agreed upon monthly schedule for any reports received in the prior month.

Appendix A – Transition Activity Schedule

Last Name	First Name	Birth Date	RIN	Care Coordination Entity	Nursing Facility	Agreed to Evaluation Date	Evaluation date	Evaluation Disposition

Appendix B – Work Plan

Colbert Consent Decree Implementation Plan Work Plan

This work plan is an internal management tool for use by IDoA and the State in Colbert Implementation. The work plan is an evolving document that the State may modify to address developments and issues with the goal of improving performance and increasing efficiency.

Appendix B – Care Coordinator Work Plan

Care Coordinator Tasks	Party Responsible	Monitored By	Monitoring
Qualified Professionals shall be retained to provide care coordination in accordance with contractual requirements	MCO, CMHC, CCU	Quality Compliance Liaison	Annually
Sufficient Care Coordinators shall be retained to limit the caseload of each Care Coordinator to a maximum of 15 Class Members in the transition process and 50 Class Members in the community.	MCO, CMHC, CCU	Quality Compliance Liaison	Annually
Protocols are to be in place for retaining, training, and supervising members of the Qualified Professionals providing services to Class Members.	MCO, CMHC, CCU	Quality Compliance Liaison	Annually
Sufficient staff shall be retained and operations will be conducted in a way that is calculated to meet the transition targets in the Consent Decree.	MCO, CMHC, CCU	Quality Compliance Liaison	Annually

Appendix B – Evaluation Work Plan

Evaluation Tasks	Party Responsible	Monitored By	Monitoring
Upon referral, evaluations shall be conducted that include a chart review, a face to face interview with the Class Members and interviews with family members, friends, and Nursing Facility staff as needed. Evaluations are to be conducted within 10 business days after receipt of referral.	MCO, CMHC, CCU Evaluation Staff	Quality Compliance Liaison	Sample/Quality Assurance
Within 7 business days after the evaluation, the team of Qualified Professionals shall meet to identify those Class Members who are candidates for transition.	MCO, CMHC, CCU Evaluation Staff	Quality Compliance Liaison	Sample/Quality Assurance
The Qualified Professionals shall meet to identify those Class Members who do not appear to be immediate candidates for transition and what services or supports not currently available would allow them to transition. The discussion shall include what the Class Member can do to prepare for transition and whether the needed services and supports will become available.	MCO, CMHC, CCU Evaluation Staff	Quality Compliance Liaison	Sample/Quality Assurance
If transition is recommended, the Qualified Professionals shall make arrangements for a UIC-ATU evaluation and/or a DON assessment if warranted.	MCO, CMHC, CCU Evaluation Staff	Quality Compliance Liaison	Sample/Quality Assurance

Appendix B – Evaluation Work Plan

Evaluation Tasks	Party Responsible	Monitored By	Monitoring
If transition is recommended by a MCO or a CMHC, the Care Coordinator shall prepare within 7 business days after recommendation, the Service Plan of Care and Social History. The MCO or CMHC Care Coordinator will refer the Class Member who is diagnosed with a serious mental illness and who requires community mental health services to a Community Mental Health Center that provides the appropriate mental health services in the Class Member's preferred location for transition. CMHC Care Coordinators do this internally or in collaboration with IDoA.	MCO, CMHC Evaluation Staff	Quality Compliance Liaison	Sample/Quality Assurance
If transition is recommended by a CCU, the Care Coordinator shall prepare within 7 business days after recommendation, the Service Plan of Care and Social History. CCU Care Coordinators, within 30 business days after a recommendation for transition, will refer Class Members to Catholic Charities for housing location and transition services.	CCU Evaluation Staff	Quality Compliance Liaison	Sample/Quality Assurance
If transition is recommended by a MCO for a Class Member who does not require mental health services, the Care Coordinator shall prepare within 7 business days after recommendation, the Service Plan of Care and Social History. MCO Care Coordinators, within 30 business days after a recommendation for transition will refer these Class Members to Featherfist or Access Living for housing location and transition services depending on the preferred geographic area.	MCO Evaluation Staff	Quality Compliance Liaison	Sample/Quality Assurance

Appendix B – Evaluation Work Plan

Evaluation Tasks	Party Responsible	Monitored By	Monitoring
If transition is recommended to a Supportive Living Facility (SLF) by a MCO or CCU Care Coordinator and the Service Plan of Care is complete, the Care Coordinator shall identify an appropriate SLF in the Class Member's desired geographic preference, provide any required clinical information to the SLF, and then make the referral to the Housing Locator.	MCO, CCU	Quality Compliance Liaison	Sample/Quality Assurance
If transition is recommended and the Class Member refuses to consent to the preparation of Social History and Service Plan of Care, the Care Coordinator shall attempt to obtain and document an explanation for the Class Member's refusal.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Quality Assurance
If transition is not recommended, the Care Coordinator, within 7 business days after the determination, shall have a face to face conversation with the Class Member and others that the Class Member would like to be present to explain the concerns raised by the team of Qualified Professionals and to further determine if the Class Member's needs can be addressed in the community.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Quality Assurance
If transition is still not recommended the team of Qualified Professionals shall document, within 7 business days after the determination, the basis for the recommendation and document any plans for follow-up.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Quality Assurance

Appendix B – Evaluation Work Plan

Evaluation Tasks	Party Responsible	Monitored By	Monitoring
If transition is not recommended, the Care Coordinator within 7 business days after the determination must explain the Class Member's rights to re-open the evaluation, either by requesting a re-assessment at some future point or through appeal of the decision to not recommend.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Quality Assurance
The Class Member and any legal guardian shall be given written information that summarizes the Class Member's appeal rights.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Quality Assurance
Enter and maintain current Class Member information in the Colbert Tracking System.	MCO, CMHC, CCU	Colbert Project Assistant	Weekly

Appendix B – Service Plan of Care Work Plan

Service Plan of Care Tasks	Party Responsible	Monitored By	Monitoring
The Service Plan of Care completed by the Care Coordinator shall be developed within 7 business days of the recommendation to transition.	MCO, CMHC, CCU, Class Member	Quality Compliance Liaison	Sample/Case Review
The Service Plan of Care is completed by the Care Coordinator and other Qualified Professionals as appropriate, and shall include a risk mitigation plan.	MCO, CMHC, CCU, Class Member	Quality Compliance Liaison	Sample/Case Review
The Service Plan of Care shall reflect timely identification and assignment to a community-based setting; such as a SLF, PSH, or Supervised Residential Group Home.	MCO, CMHC, CCU, Class Member	Quality Compliance Liaison	Sample/Case Review
The Service Plan of Care shall reflect as applicable identification and timely access to appropriate services and supports; such as DASA, DMH Medicaid Rehabilitation Option Services, and/or Home and Community-Based Services.	MCO, CMHC, CCU, Class Member	Quality Compliance Liaison	Sample/Case Review
The Service Plan of Care shall address strengths and deficits in independent living skills, fiscal management, health care management, and tenancy skills.	MCO, CMHC, CCU, Class Member	Quality Compliance Liaison	Sample/Case Review
The Service Plan of Care shall include verification that Durable Medical Equipment (DME) will be present at the time of transition.	MCO, CMHC, CCU, Housing Locator	Quality Compliance Liaison	Sample/Case Review
The Service Plan of Care shall assure that there are no gaps in service and/or supports.	MCO, CMHC, CCU, Class Member	Quality Compliance Liaison	Sample/Case Review

Appendix B – Care Coordinator Work Plan

Care Coordinator Tasks	Party Responsible	Monitored By	Monitoring
A Clinical Case Review shall be completed at least 30-60 days before a Class Member transitions.	MCO, CMHC, CCU, UIC-CON	Quality Compliance Liaison	Ongoing
The Pre-Discharge meeting shall occur as soon as possible after the Service Plan of Care has been developed to review and identify any additional needs that need to be addressed for the Class Member's successful transition.	MCO, CMHC, CCU, Nursing Facility Staff, Class Member	Quality Compliance Liaison	Sample/Case Review
The Care Coordinator shall administer the initial MFP Quality of Life Survey at least 2-4 weeks before discharge from the Nursing Facility.	MCO, CMHC, CCU, Class Member	Quality Compliance Liaison UIC-CON	Ongoing
A final Discharge meeting shall occur no more than 2 weeks before a Class Member is scheduled to transition at a mutually agreeable date and time. The Discharge meeting shall occur to confirm that all services and supports are available on the day of discharge and to clarify each provider's transition day responsibilities.	MCO, CMHC, CCU, Nursing Facility Staff, and Class Member	Quality Compliance Liaison Housing & Transition Liaison	Sample/Case Review
The Care Coordinator will communicate with the Housing Locator Entity to confirm all household items, groceries, furnishings, and other needed items such as non-Medicaid covered OTC medication and/or medical supplies are being purchased with transition funds.	MCO, CMHC, CCU, Housing Locator	Housing & Transition Liaison Housing Project Assistant	Weekly
A 24-hour 7-day-a-week back-up plan shall be confirmed at the Discharge meeting.	MCO, CMHC, CCU, Class Member	Quality Compliance Liaison	Sample/Case Review

Appendix B – Care Coordinator Work Plan

Care Coordinator Tasks	Party Responsible	Monitored By	Monitoring
The Care Coordinator shall assist with moving the Class Member from the Nursing Facility to the community-based setting.	MCO, CMHC, CCU, Housing Locator	Housing & Transition Liaison Housing Project Assistant	Weekly
After transition to the community-based setting, the Care Coordinator shall ensure that the Service Plan of Care is being implemented, reassessed and updated as needed or at least every 180 days to meet the needs of the Class Member.	MCO, CMHC, CCU, Class Member	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews
For the first month post-transition, the Care Coordinator will make contact with the Class Member face-to-face once a week, or more often as needed.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews
In the first month post-transition, the Care Coordinator will contact the person identified in the Service Plan of Care as a contact for the Class Member or as needed, services providers, by telephone twice a week, or more often as needed.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews
For the second month post-transition, the Care Coordinator will make contact with the Class Member face-to-face once monthly.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews
For the second month, post-transition, the Care Coordinator will make contact with the Class Member, who is defined as high risk, face-to-face contact twice monthly.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews

Appendix B – Care Coordinator Work Plan

Care Coordinator Tasks	Party Responsible	Monitored By	Monitoring
In the second month post-transition, the Care Coordinator will contact the person identified in the Service Plan of Care as a contact for the Class Member or, as needed, service providers, by telephone once a week, or more often as needed.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews
In the third through eighth month post-transition, the Care Coordinator will make contact with the Class Member face-to-face at least once monthly.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews
For the third month post-transition, the Care Coordinator will make face-to-face contact with the Class Member who is under the age of 60 and is disabled twice monthly.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews
In the ninth through twelfth month post-transition, the Care Coordinator will make contact with the Class Member face-to-face or by phone at least once monthly.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews
In the third through twelfth month post-transition, the Care Coordinator will contact the person identified in the Service Plan of Care as a contact for the Class Member, or as needed, service providers, by telephone as needed.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews
Face-to-face contact shall occur at least once with the Managed Care Health Plan Entity, when applicable, prior to transfer and discharge by an MCO or CMHC Care Coordinator.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews

Appendix B – Care Coordinator Work Plan

Care Coordinator Tasks	Party Responsible	Monitored By	Monitoring
Increased frequency of face-to-face visits as needed following reportable incidents, ED visits, hospitalizations, significant changes in the Class Member's health and/or functioning.	MCO, CMHC, CCU	Quality Compliance Liaison	Sample/Incident Reviews/Mortality Reviews
The Care Coordinator shall keep IDoA and other providers as appropriate, informed about any concern that may impact the Class Member's Health and safety, tenancy or continued eligibility for the Colbert Bridge Subsidy.	MCO, CMHC, CCU	Housing & Transition Liaison	Ongoing
The Care Coordinator or the first responder to a reportable incident shall prepare and submit written reports of incidents as required and in the format provided by IDoA.	MCO, CMHC, CCU	Quality Compliance Liaison UIC-CON	Sample/Incident Reviews/ Mortality Reviews
The Care Coordinator shall participate in post-transition case reviews, reportable incident reviews, and mortality reviews, and provide any required or requested follow-up documentation.	MCO, CMHC, CCU	Quality Compliance Liaison UIC-CON	Sample/Incident Reviews/Mortality Reviews
Enter and maintain current Class Member information in the Colbert Tracking System.	MCO, CMHC, CCU	Colbert Project Assistant	Weekly

Appendix B – Quality Work Plan

Quality Tasks	Party Responsible	Monitored By	Monitoring
Establish a set of quality and performance measurement activities for assessing Colbert Consent Decree implementation.	Quality Compliance Liaison, UIC-CON	Colbert Project Director	Annually
Review, assess, and summarize data using quality measures.	Quality Compliance Liaison, UIC-CON	Colbert Project Director	Monthly
Use findings to require corrective action on the provider level, to design training activities and to implement long-term systemic solutions.	Quality Assurance Committee, Quality Compliance Liaison, UIC-CON	Colbert Project Director	Ongoing
Submit plans of correction based off of recommendations from case reviews, quality reviews of assessments, reportable incident reviews and mortality reviews	MCO, CMHC, CCU	Quality Compliance Liaison	Ongoing
Convene teleconferences to review cases pre-transition and post-transition to provide consultation and recommendations for the Service Plan of Care.	UIC-CON, MCO, CMHC, CCU	Quality Compliance Liaison	Ongoing
Complete quality review of assessments that are not recommended for transition.	UIC-CON	Quality Compliance Liaison	Monthly
When an assessment is over-turned, complete a re-assessment with the Class Members within 10 business days.	MCO, CMHC, CCU	Quality Compliance Liaison	Ongoing

Appendix B – Quality Work Plan

Quality Tasks	Party Responsible	Monitored By	Monitoring
Conduct MFP Quality of Life Surveys at 2 to 4 weeks before discharge from the nursing facility.	MCO, CMHC, CCU	Quality Compliance Liaison UIC-CON	Ongoing
UIC-CON shall conduct MFP Quality of Life Surveys at 1 year post-transition and at 2 year post-transition.	UIC-CON	UIC-CON	Ongoing
UIC-CON shall analyze results of the MFP Quality of Life surveys at 1 year post-transition and 2 years post-transition.	UIC-CON, IDoA	UIC-CON	Annually
Investigate and respond to all complaints, grievances, and appeals of Colbert Class Members, including arranging for re-assessments when appropriate.	Quality Compliance Liaison	Colbert Project Director	Ongoing
Document complaints, grievances, and appeals on the Colbert Referral Log.	Colbert Project Assistant	Quality Compliance Liaison	Semi-Annually
Review and analyze complaints, grievances, and appeals.	Quality Compliance Liaison	Colbert Project Director	Semi-Annually
Clarify and update complaint, grievance and appeal process.	Quality Compliance Liaison	Colbert Project Director	One-time
Facilitate and support Peer Advisory Council activities and quarterly meetings.	Quality Compliance Liaison	Colbert Project Director	Quarterly

Appendix B – Housing Locator Work Plan

Housing Locator Tasks	Party Responsible	Monitored By	Monitoring
Develop and maintain relationships with landlords and Property Managers and current list of housing options identifying rental properties.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Participate in weekly transition update meetings with Care Coordinators, UIC-ATU and IDoA staff.	MCO, CMHC, CCU, Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Receive and review Class Member referral for housing location from Evaluation Entity.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Conduct intake with Class Members to establish housing needs and barriers within 7 business days of referral.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Accompany Class Members on site visits to properties in the geographic areas of the Class Member's choice within 30 days of intake.	Housing Locators	Housing Project Assistant	Weekly
Accompany Class Members who are assigned to a CMHC on site visits to properties in the geographic areas of the Class Member's choice within 60 days of intake.	Housing Locators	Housing & Transition Liaison	Weekly
Provide or arrange transportation to site visits for the Class Member.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Utilize UIC-ATU evaluation recommendations to locate appropriate housing and communicate with UIC-ATU staff when indicated.	Housing Locators, UIC-ATU	Housing Project Assistant Housing & Transition Liaison	Weekly
Assist the Class Member with the application process.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Request and manage Class Member's transition funds to purchase necessary household items, furnishings and groceries per Class Member's choice.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly

Appendix B – Housing Locator Work Plan

Housing Locator Tasks	Party Responsible	Monitored By	Monitoring
Submit request to HACC for inspection and rent reasonableness within 24 hours of application approval.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Facilitate the execution of the lease within 2 business days of approved rental amount.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Assist as necessary with the submission of Landlord documents to HACC.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Ensure set-up of furnishings and household items.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Ensure utilities are established in Class Member's name.	Housing Locators	Housing Project Assistant Housing & Transition Liaison	Weekly
Assist the Class Member with the application process.	Housing Locators,	Housing Project Assistant Housing & Transition Liaison	Weekly
Work to move Class Member into unit within 90 days of date of referral.	Housing Locators	Housing Project Assistant	Weekly
Work to move Class Members who are assigned to a CMHC into unit within 120 days of date of referral.	Housing Locators	Housing & Transition Liaison	Weekly
Enter and maintain current Class Member information in the Colbert Tracking System.	Housing Locators	Colbert Project Assistant	Weekly
Within 30 days of Class Member move-in, Forward debit card and receipts for all items purchased with transitions funds to HACC for reconciliation.	Housing Locators	HACC Housing Project Assistant	Monthly

Appendix B – Outreach Tasks Work Plan

Outreach Tasks	Party Responsible	Monitored By	Monitoring
HFS will provide lists of all residents of Nursing Facilities in Cook County.	HFS	Colbert Project Director	Quarterly
IDoA shall assign Nursing Facilities to Outreach Entities and provide Outreach Entities list of Class Members.	Colbert Staff	Colbert Project Director	Quarterly
Outreach Entities shall attempt to contact assigned Class Members from assigned Nursing Facilities.	Outreach Entities	Colbert Staff	Ongoing
Outreach Entities shall make referrals in the MFP Web Application for Class Members interested in transitioning to a community-based setting.	Outreach Entities	Colbert Staff	Ongoing
IDoA will provide lists of Class Members who have responded affirmatively on the Nursing Facility Minimum Data Set Section Q (MDS-Q) and the MCO Outreach Entities shall attempt to make contact with these Class Members.	Colbert Staff	Colbert Project Director	Ongoing
MCO Outreach Entities shall utilize MDS-Q lists for Outreach attempts.	MCO Outreach Entities	Colbert Staff	Ongoing
MCO Outreach Entities shall refer interested Class Members through the MFP Web Application.	MCO Outreach Entities	Colbert Staff	Ongoing
MCO Outreach Entities shall respond to referrals submitted through the MFP Web Application.	MCO Outreach Entities	Colbert Staff	Ongoing
Outreach Entities continue to recruit and utilize Peer Mentors.	Outreach Entities	Colbert Staff	Monthly
Enter and maintain current Class Member information in the Colbert Tracking System.	Outreach Entities	Colbert Project Assistant	Ongoing
Peer Mentors are to be trained to assist Outreach Entities as they conduct small group and individual engagement and information sessions.	Outreach Entities	Colbert Staff	Monthly
Peer Mentors should assist Outreach Entities as they conduct small group and individual engagement and information sessions.	Outreach Entities	Colbert Staff	Monthly

Appendix B – Outreach Work Plan

Outreach Tasks	Party Responsible	Monitored By	Monitoring
Update written informational materials to educate Class Members regarding their rights and the Colbert transition process.	Quality Compliance Liaison	Colbert Project Director	One-time and as needed
Respond to Class Member queries within 3 business days. Queries may include request for evaluations, complaints, grievances or appeals; or Colbert Bridge Subsidy issues. Follow-up assistance will be provided as needed to resolve Class Member concerns.	Colbert Staff	Quality Compliance Liaison	Semi-Annually
Respond to queries from the Ombudsmen, Transition Engagement Specialists, Nursing Facility Staff, Care Coordinators, or others within 3 business days. Follow-up assistance will be provided as needed to resolve Class Member concerns.	Colbert Staff	Quality Compliance Liaison	Semi-Annually
Monitor and document queries on the Colbert Referral Log.	Colbert Project Assistant	Quality Compliance Liaison	Ongoing
Continue to provide updated information to the Senior HelpLine staff.	Colbert Staff	Quality Compliance Liaison	Ongoing
Receive and document queries made on the Senior HelpLine.	Senior HelpLine Staff	Quality Complaint Liaison	Semi-Annually

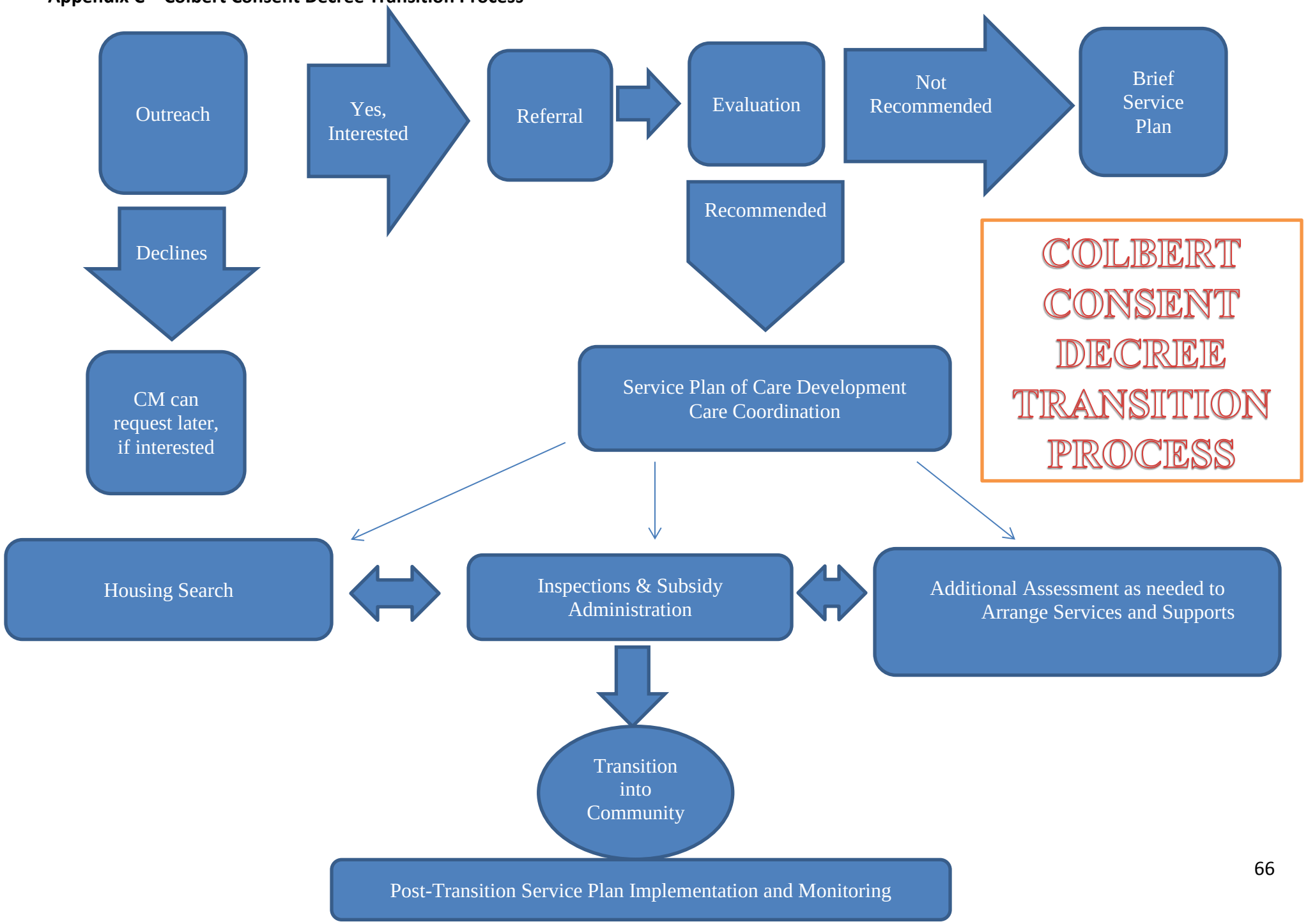
Appendix B – Subsidy Administrator Work Plan

Subsidy Administrator Tasks	Party Responsible	Monitored By	Monitoring
Develop and maintain a current list of all Class Members referred for transition that pertains to inspections, transition funds, and subsidy information.	HACC	Colbert Project Director	Weekly
Process Class Member's transition funds to purchase necessary household items with 24 hours of fund approval.	HACC	Housing Project Assistant Housing & Transition Liaison	Weekly
Confirm that all identified housing units fall within the Fair Market Rent (FMR) or Local Payment Standards. Exceptions may be made in appropriate cases as defined by IDoA.	HACC	Colbert Project Director	Ongoing
Submit inspection requests to inspection sub-contractor for units that will receive a Colbert Bridge Subsidy within 3 business days of request.	HACC	Housing Project Assistant Housing & Transition Liaison	Weekly
Calculate unit rent offer with utility allowances and work with landlords/Property Managers to obtain completed documents.	HACC	Colbert Project Director	Ongoing
Generate the contract for Housing Assistance Payment (HAP) after obtaining completed landlord/Property Manager documents.	HACC	Colbert Project Director	Ongoing
Calculate Class Member rent portion once the Class Member's income has been restored and ensure that the Class Member's portion does not exceed 30% of their income.	HACC	Colbert Project Director	Ongoing
Receive and process reconciliation of debit card expenditures submitted by Housing Locators and CMHC Housing Locators within 30 days of Class Member transition.	HACC	Housing Project Assistant	Monthly
Administer the Colbert Bridge Subsidy for Colbert Class Members and for Project-Based rental units.	HACC	Colbert Project Director	Ongoing

Appendix B -- Subsidy Administrator Work Plan

Subsidy Administrator Tasks	Party Responsible	Monitored By	Monitoring
Communicate and assist IDoA with any situations that could affect payment of the Colbert Bridge Subsidy including lease/housing termination and short-term nursing facilities stays.	HACC	Housing & Transition Liaison	Ongoing
When possible, HACC shall affirm and assist Class Members applying for and being placed on waiting lists for housing subsidy programs to obtain more permanent subsides such as Section 8 Vouchers.	HACC	Colbert Project Director	Ongoing
HACC shall process inspections every 2 years and interim re-certifications to set tenants' portions of rent.	HACC	Colbert Project Director	Ongoing
Produce detailed reports of all transition and subsidy expenditures.	HACC	Colbert Project Director	Quarterly

Appendix C – Colbert Consent Decree Transition Process



Appendix D – Illinois Home and Community-Based Services Waivers for Colbert Class Members

WAIVER	ABBREVIATION	OPERATING AGENCY	TARGET POPULATION
Persons with Brain Injury	Brain Injury	DHS, Division of Rehabilitation Services	Persons with brain injury, all ages
Persons Diagnosed with HIV/AIDS	HIV/AIDS	DHS, Division of Rehabilitation Services	Persons with HIV/AIDS, all ages
Persons with Disabilities	Disability	DHS, Division of Rehabilitation Services	Persons with disabilities, ages 0-59 (will cover disabled persons over 60 if they entered program prior to 60th birthday)
Elderly	Elderly	IDoA	Persons over 60
Supportive Living Program	SLF	HFS, Division of Medical Programs	Frail elderly age 65 and older, or those age 22 to 64 with disabilities, living in a 24-hour assisted living facility

Appendix D – Illinois Home and Community-Based Services Waivers for Colbert Class Members

BASE SERVICE	BRAIN INJURY	HIV/AIDS	DISABILITY	ELDERLY	SLF
24 hour response/security staff					X
Adult day care	X	X	X	X	
Ancillary (transportation to group/community activities, shopping, arranging outside services)					X
Behavioral/ cognitive services	X				
Day habilitation	X				
Environmental modifications	X	X	X		
Health promotion and exercise programming					X
Home delivered meals	X	X	X		
Home health aide	X	X	X		
Homemaker	X	X	X	X	
Housekeeping maintenance					X
Laundry					X
Medication oversight and assistance with self-administration					X
Nursing	X	X	X		X

BASE SERVICE	BRAIN INJURY	HIV/AIDS	DISABILITY	ELDERLY	SLF
Occupational therapy	X	X	X		
Personal care	X	X	X		X
Personal emergency response system	X	X	X	X	X
Physical therapy	X	X	X		
Prevocational services	X				
Respite care	X	X	X		
Social/recreational programming					X
Specialized medical equipment and supplies	X	X	X		
Speech therapy	X				
Supported employment	X				

Appendix E - Training

A. Outreach Entity Training

It is expected that the Outreach Entity will have procedures in place to train and supervise their staff. These procedures are to include a plan for on-going training of Peer Mentors and are to be submitted to IDoA for review annually for the duration of the contractual arrangement. Minimally, topics to be included are:

- Background of the Colbert Consent Decree
- MONEY FOLLOWS THE PERSON
- Social Work Methods of Person-Centered Practice, Strengths Perspective, Person in Environment
- Long Term Services and Supports and Waiver Options
- Older American Act Programs
- Medicaid Rehabilitation Option Mental Health Services
- Motivational Interviewing
- Multicultural Competence
- Engagement of a Class Member Regarding Community Transition
- Building Positive Relations with Nursing Facilities

B. Housing Locators, CMHC Housing Locators Training

It is expected that Housing Locators and CMHC Housing Locators will have procedures in place to train and supervise their staff. These procedures are to include a plan for on-going training of Housing Locators. At a minimum, topics to be included are:

- Background of the Colbert Consent Decree
- Motivational Interviewing
- Multicultural Competence
- Engagement of a Class Member Regarding Community Transition
- Building Positive Relations with Nursing Facilities
- The Housing Search; Landlord Engagement
- Colbert Bridge Subsidy
- HQS Inspection Requirements
- Eviction Prevention
- Fair Housing
- Supportive Housing

C. Care Coordinator Staff Training

It is expected that Care Coordinators will have procedures in place to train and supervise their respective staffs. These procedures are to include a plan for on-going training of its staff that is

to be submitted to IDoA for review at least annually for the duration of the contractual agreement.

Annual training topics will include at a minimum the following:

- Background of the Colbert Consent Decree
- The Holistic Approach to Care Coordination using a Multi-Disciplinary Integrative Approach
- Building Positive Relations with Nursing Facilities
- Engagement of a Class Member Regarding Community Transition
- Multicultural Competence
- Philosophical Approaches to Meeting the Needs of People with Disabilities
- Social Work Methods of Person Centered Practice, Strengths Perspective, Person in Environment
- Health and Disease Management
- Physical and Behavioral Health Management and Treatment Options
- Motivational Interviewing
- Substance Abuse Management and Treatment Options
- Nutrition
- Caregiver Supports
- Expectations of Evaluation
- MFP Forms
- Financial Assistance and Insurance Programs
- Medical Assistance Benefits
- Long Term Services and Supports; Waiver Options
- Medicaid Rehabilitation Option Mental Health Services
- Older American Act Programs
- Legal Issues: Power of Attorney and Guardianship
- Natural Supports
- Housing Resources
- Professional Ethics
- Person-centered Care Planning

D. Training and Educating Housing Developers

IHDA, the Division of Mental Health (DMH), and the Corporation for Supportive Housing continue to provide supportive housing training for IHDA-funded developers. The goal of the trainings is to encourage housing developers to consider inclusion of PSH units in affordable housing developments.

E. Colbert and Williams Consent Decree Training

Beginning November 2016, IDoA and DHS/DMH launched a training initiative with UIC-CON for the direct service and management staff of all Colbert & Williams providers. The Colbert-

Williams Consent Decree Training Institute provides in-person trainings and webinars every other month. Below is the schedule for fiscal year 2017:

Process & Procedure **In Person Trainings** 160 North LaSalle, C500 MABB Auditorium Chicago, Illinois 60601 **Day 1 8:30-5** **Day 2** **8:30-1**	Training Day 1 November 3 & 4, 2016 (Thursday/Friday)	• Improving quality of assessments and documentation (include collateral, clarifying, history and role structure plays, clear documentation, ongoing process, context) • Home visits/ongoing assessment • Risk identification • Documentation
	Training Day 2 December 8 & 9, 2016 (Thursday/Friday)	• Collaborating with providers and supports • Care planning/action steps (include DME) • Medication management and high risk medication
	Training Day 3 February 9 & 10, 2017 (Thursday/Friday)	• Motivational interviewing/stages of change • Trauma informed care • Assertive engagement • Substance use disorders • Harm Reduction
	Training Day 4 April 6 & 7, 2017 (Thursday/Friday)	• Patient advocacy and development of self-management • Transitioning care • Burn out/ staff turn over
Clinical **Webinars**	Thursday, November 10, 2016 9:30-11:30 am	• Diabetes • Flu
	Thursday, January 5, 2017 9:30-11:30am	• Pulmonary • Smoking
	Thursday, March 2, 2017 9:30-11:30 am	• Cardiac conditions • Stroke • Blood clots
	Thursday, May 4, 2017 9:30-11:30 am	• Seizures • Kidney disease • Wounds

Appendix F -- Definitions

Care Coordinator – Staff of Colbert MCOs, IDoA-contracted Care Coordination Units, DMH-contracted Community Mental Health Centers that provide Service Plan of Care development and Care Coordination Services to Colbert Class Members pre- and post-transition to a Community-Based Setting.

Care Coordination Entities – Colbert MCOs, IDoA-contracted Care Coordination Units, DMH-contracted Community Mental Health Centers that employ staff to provide Service Plan of Care development and Care Coordination services to Colbert Class Members pre- and post-transition to a Community-Based Setting.

Colbert Managed Care Organization (MCO) – The two (2) MCOs (Aetna Better Health and IlliniCare Healthplan) contracted with IDoA to employ Qualified Professionals to exclusively provide outreach and education, Evaluation, Service Plan of Care development and Care Coordination services to Colbert Class Members pre- and post-transition to a Community-Based Setting.

Evaluation Entity – Entities contracted to complete Evaluations for Colbert Class Members who are interested in transitioning from the Nursing Facility to a Community-Based Setting. Entities include Colbert MCOs, IDoA-contracted Care Coordination Units and DMH-contracted Community Mental Health Centers.

High Risk – A Class Member who has experienced at least one hospitalization in the past 12 months, plus a diagnosis of at least one serious and/or chronic health condition.

Plan Managed Care Organization (MCO) – MCOs contracted with HFS to manage benefits and coordinate health care for individuals enrolled in the Medicaid program.