

**COLBERT CONSENT DECREE
DRAFT IMPLEMENTATION PLAN**

July 13, 2012



Prepared by:
Illinois Department of Healthcare and Family Services
in Partnership with

Office of the Governor
Illinois Department of Aging
Illinois Department of Human Services
Illinois Department of Public Health

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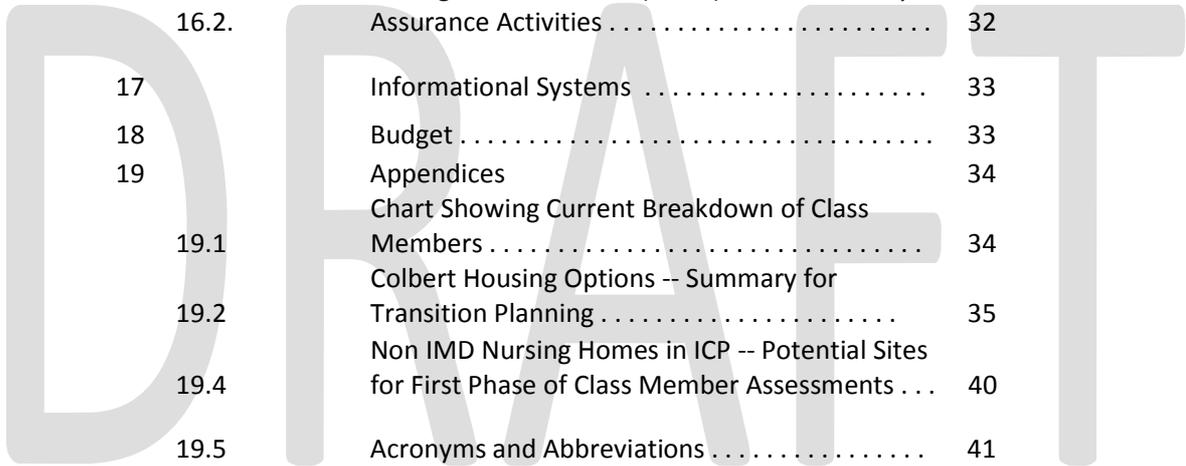
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Executive Summary

1.1. Background

On behalf of a class of Illinois residents with disabilities living in nursing facilities in Cook County, Illinois, a lawsuit, *Colbert versus Quinn* was filed on August 22, 2007. The suit was settled on December 20, 2012, at which time the Consent Decree was issued and set-forth a series of benchmarks. This Implementation Plan is the first requirement and defines the strategies to implement the Decree and meet the court ordered benchmarks and timeframes.

The Colbert lawsuit sought 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, US.C 794(a) and the Social Security Act, 42, U.S.C. 1396-1396v (SSA). Plaintiffs alleged that they are inappropriately segregated and institutionalized in Nursing Facilities and forced to live with numerous other people with disabilities in violation of the ADA and the Rehabilitation Act.

Plaintiffs further alleged that Defendants which include the office of the Governor of the State of Illinois, the Illinois Department of Human Services, the Illinois Department of Public Health, the Illinois Department on Aging and the Illinois Department of Healthcare and Family Services (HFS) denied them the opportunity to live in appropriate integrated settings where they could lead more independent and more productive lives in their own communities. Plaintiffs sought injunctive relief requiring that Defendants (1) inform Plaintiffs as to their eligibility for community-based services and their choice of such services; (2) provide comprehensive evaluations to determine the eligibility of Plaintiffs for community-based services, both prior to and after admission to nursing facilities; and (3) provide, as appropriate, Plaintiffs with services and supports in the community-based setting and refrain from providing services only in institutional settings.

This Consent Decree is intended to assist the Defendants in providing Class Members with the opportunity to receive the array of supports and services that they need in the most integrated settings appropriate to their needs, including community-based settings, and to promote the development of integrated settings that attempt to maximize individuals' independence, choice, opportunities to develop and use independent living skills, and that attempt to afford them the opportunity to live their lives similar to individuals without disabilities.

1.2. Overriding Philosophy

The State of Illinois, including all Defendants support the principles of the U.S. Supreme Court's decision in *Olmstead v. L.C.* that persons should reside in the most integrated and least restrictive environments and be provided with the services and supports to thrive in the community. The implementation of the Colbert Consent Decree is viewed as one component of a multi-strategic approach to balancing the long-term care system in Illinois. The Colbert Decree and parallel

consent decrees in the *Williams vs. Quinn* suite targeting persons who reside in Institutions for Persons with Mental Disease (IMDs), and the *Ligas vs. Hamos* suit targeting persons who reside in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD), advance the efforts of balancing the long-term care system in the State of Illinois. These are in addition to the Office of the Governor’s leadership related to the closure of state operated facilities where residents will also be offered opportunities to explore alternatives to institutional care and be encouraged to live-in the most integrated setting appropriate to their needs.

1.2.1 Principles

In addition to the Olmstead principles, value is placed on the individual’s right to self-determination, informed choice and respect of that choice; person centered planning, and the provision of the necessary services and supports in a coordinated manner to enable individuals to succeed in the community.

- Self-Determination as defined by the UIC (University of Illinois at Chicago) National Research Training Center on Psychiatric is “the right of individuals to have full power over their own lives, regardless of presence of illness or disability. It encompasses concepts such as free will, civil and human rights, freedom of choice, independence, personal agency, self-direction and individual responsibility.”
- Informed Choice is defined using a composite of definitions including language taken from a 1982 report by Lidz and Meisel. Informed Choice requires the individual “to understand, or at least be able to understand, the information divulged . . . and demonstrate a capacity for rational manipulation of information. They may, for example, be required to show that they not only understand the risks and benefits but also have weighed them in relation to their personal situation.” The process involves counseling a Class Member, listening his/her expressed needs and desires, eliciting his/her concerns and offering information pertinent to the conversation. The professional providing the counseling should validate by questioning the understanding of the Class Member of the available options and the expectations and consequences of a selection.
- Person-Centered Planning as defined in the Consent Decree is a “process designed to empower Class members to make plans for their future according to their needs and desires, with the support of their legal guardians, family, friends or service providers as appropriate. For Class Members with Mental Illness, Person Centered means a process based on a model of recovery.”
- Care Coordination is the support that will be offered to each Class Member through a single Care Coordinator (to the extent possible) throughout all stages – assessment, transition services and ongoing community supports and services – to enable the Class Member to build the necessary trusting relationship that facilitates transition to the community. Care coordination is needed for all persons who are Seniors and Persons with Disabilities in the current fragmented healthcare environment in order to be able to attend

to the complex health and behavioral health needs of Class Members in a holistic manner, and thereby produce better health outcomes.

All staff will be trained and expected to involve the Class Member, his/her significant others and guardian, if applicable, in all aspects of evaluation, care planning and transition. It is important that Class Members be kept up-to-date in order that they make informed choice. The Consent Decree defines a person-centered approach as a “planning process designed to empower Class Members to make plans for their future according to their needs and desires, with the support of their legal guardians, family, friends, or service providers as appropriate.”

Increasingly, federal Centers for Medicare and Medicaid guidelines for Home and Community-Based Medicaid Waiver programs are mandating enhanced quality assurance measures. These standards focus on participant-centered desired outcomes and address the development of performance measures, risk assessment and mitigation plans, 24-hour back-up capacity, and monitoring of health and welfare when and if critical incidents occur. Illinois’ Medicaid waiver funded programs and services must comply with these federal expectations. These quality assurance standards are viewed as supportive of a person’s independence and ability to live in least restrictive environments.

With the above philosophical approach in practice, Defendants also understand that Class Members will need assistance in making informed choice. It is expected that options be explored that provide adequate resources for alternatives to nursing home residency. An individual’s medical and behavioral health status will determine the Plan of Care and the environment required to support his/her state of health and well-being.

Defendants also anticipate that a percentage of Class Members may choose to remain in a nursing home even with proactive engagement and discussion of options. An individual’s choice, regardless of what choice is made is to be viewed as respectful of being person-centered. Processes for re-visits of Class Members are to be established by the entities involved in the evaluations to determine if needs and/or desires have changed.

1.3. Class Members

The Court Decree defines Class Members as all Medicaid-eligible adults with disabilities who are being, or may in the future be, unnecessarily confined to nursing facilities located in Cook County, Illinois, and who with appropriate supports and services may be able to live in a community-based setting. It should be noted that Class Members include persons who have a primary diagnosis of mental illness and do not include persons with an intellectual disability as they are not expected to be residents of traditional nursing homes. It is estimated that at the adoption of this Implementation Plan that there are between 16,000 and 17,000 residents of nursing homes in Cook County, Illinois currently residing in 185 long-term care facilities.

2. Implementation Plan Development

The Illinois Department of Healthcare and Family Services (HFS), as one of the Defendants in the Colbert Decree has the lead responsibility for the creation of an Implementation Plan. The process has included working collaboratively with fellow Defendants, the Office of the Governor, the Illinois Department on Aging (IDoA), the Illinois Department of Public Health and the Illinois Department of Human Services (DHS) and its Divisions of Mental Health (DMH) and Rehabilitation Services (DRS). In addition, the process has included listening sessions with the Plaintiffs. This plan reflects the outcome of these individual, small and large group meetings.

3. Cost Neutrality

The Colbert Consent Decree defines a requirement of the development of a Cost Neutral Plan. As stated on page 4 of the Consent Decree, “the Cost Neutral Plan must include agreed upon time periods during which Defendants will transition Class Members to Community-Based Settings such that, based on the criteria described herein (pages 4, 5 and 6 of the Consent Decree) and set forth in more detail in the plan, the transitions of Class members cost the same or less to the State in the aggregate as if those Class Members instead had remained in the Nursing Facilities.” The cohort of Class Members to be used to develop the Cost Neutral Plan is to be the first 1100 individuals that transition to community residency.

At the time of the drafting of this Implementation Plan the framework that includes what data will be used and how it will be obtained, while somewhat defined in the Consent Decree is in process of development. A workgroup comprised of HFS and Plaintiff representation has been formed and is expected to have some recommendations that will be added to this Implementation Plan during the summer of 2012.

4. Dissemination, Community Education

A critical element to the success of the Implementation Plan is informing and educating Class Members and their families and guardians of the Colbert Consent Decree. Class Members may not have considered transition to the community as a possible life goal. For some, the original placement in the long-term care facility followed an acute care hospital stay where it may have been required or perceived that moving to the nursing home was the most appropriate option. Frequently, the health and welfare of the nursing home resident has improved or stabilized to a point that consideration of transitioning to community residency is appropriate and/or desirable. In other situations, the Class Member presented with significant health issues, but was admitted to the nursing home because he/she lacked an alternative community residence and linkage to community-based resources. Whatever may have been the Class Member’s life narrative, an understanding that there are home and community-based options may not have been presented or appreciated at the time of nursing home admission. A proactive integrated approach by trained professionals, including discussion of alternative home and community-based programs and

mental health services that meet the needs of the nursing home resident, could lead to success in a community setting.

4.1. Ombudsmen

The Illinois Long-term Care Ombudsmen Program (LTCOP) performs activities in nursing homes according to 20 ILCS 105/4.04 of the Illinois Act on Aging and in accordance with specific provisions of the federal Older Americans Act (OAA). These OAA provisions state an Ombudsman, among other responsibilities is to investigate and resolve complaints made by or on behalf of residents of nursing homes; address major issues which affect residents; work to educate residents, nursing home personnel and the public about residents rights and other matters affecting residents; and perform other functions to protect the health, safety, welfare and rights of residents.

Due to Ombudsmen having direct connection with nursing home residents, they have a unique opportunity to speak with Class Members. Education on behalf of the Colbert Consent Decree would be performed in individual and small group meetings. These meetings represent the same activities that the Ombudsmen routinely perform. It is anticipated through the City of Chicago Department of Family and Support Services and the Legal Assistance Foundation serving suburban Cook County, a sufficient staff of ombudsmen will discuss community options, the Colbert Consent Decree and how a Class Member may engage in the processes defined in this Implementation Plan.

4.2. Centers for Independent Living (CILs)

Staffs of the CILs and their constituents have distinctive skills and experiences in the area of advocacy for the rights of persons with physical disabilities. If they wish to participate, the CILs will be encouraged to assist the Ombudsmen in large group educational forums in the dissemination and education of the Colbert Consent Decree.

4.3. Tracking Outcomes of Outreach and Education Activities

Entities performing outreach and education will be asked to maintain attendance records that will be sent to HFS on a monthly basis. Names of Class Members will be entered into a database. The names from this database will be matched with names of Class Members that complete a self-referral via the on-line MFP referral form, Section Q of the MDS system of referrals, and names of persons that are entered in the Colbert IT system by the Care Coordinators performing the assessment and care planning activities. This methodology will provide a means to track each Class Member through the process beginning with outreach and education continuing through assessment. Tracking these activities will provide data regarding the effectiveness of the outreach and education forums and conversations. Attendance alone or a satisfaction survey completed at the end of a forum is not an indicator of effectiveness.

5. Informational Materials and Methods for Class Member Self-identification

All Class Members are entitled to request an evaluation conducted by qualified professionals. Class Members already enrolled in a Managed Care entity will be encouraged by managed care staff to discuss community transition as part of their overall wellness plan. In addition, the previous section defines the potential roles of the Ombudsmen in dissemination and community education which may result in the self-identification of a Class Member.

5.1. Illinois Pathways to Community Transition/Money Follows the Person (MFP) and On-Line Referral Form

Pathways to Community Transition/MFP established in March 2012, an on-line referral form at <http://www.mfp.illinois.gov>. This on-line referral form allows individuals and their families and/or guardians to self-identify as a potential candidate for transition and link to HFS who in turn disseminates the referral to the appropriate entity for follow-up. IDoA has a process in-place, well-known to the Ombudsmen to refer individuals to the Pathways to Community Living/MFP program. Clarification will be provided prior to implementation to the Ombudsmen on whether one or both methods of making referrals will be utilized. These referral processes allow Class Members to self-identify and offers persons assisting Class Members a simple process to link a resident with the appropriate evaluation entities. HFS will track the self-referrals in order to ensure that a follow-up interaction has occurred with each of the Colbert Class Members.

5.2. Section Q Minimum Data Set (MDS)

The MDS 3.0 is a clinical assessment instrument mandated by the federal Centers for Medicare and Medicaid Services for use in assessing all Medicare/Medicaid residents in nursing homes. The tool assesses the nursing home resident across multiple health domains, assists in the determination of health issues and drives the development of the care plan of a nursing home resident.

Beginning in 2010, CMS made important revisions to Section Q of the MDS instrument in order to achieve a more person centered planning approach. The changes to the overall tool and especially Section Q, relating to discharge planning refocused the questions to require active participation of the nursing home resident in a person-centered and person-driven assessment and goal setting. Residents that indicate an interest in returning to the community are to be referred to a Local Contact Agency (LCA). Under the Colbert Consent Decree, the LCA will be those identified entities responsible for the evaluation processes.

5.3. Brochure

The Colbert Consent Decree will utilize a brochure developed to specifically describe the key processes defined in this Implementation Plan, options available on how a Class Member

resident can self-identify, what to expect in the evaluation, development of the Service Care Plan and transition to community residency.

5.4. Signage

Defendants will make every effort to produce signage that indicates the charges set-forth in the Colbert Consent Decree. This signage would be similar to those already posted in nursing homes indicating how and where a resident, family/significant and guardian, if applicable may contact the local Ombudsmen to report suspected abuse.

5.5. Letters to the Guardians

Many Colbert Consent Decree Class Members may have been assigned a guardian by a court of law. Guardians may be assigned by the Office of the State or County Guardian, or may be a private guardian. Individuals who have been assigned a guardian, while not in a position to independently make the choice to pursue community residency shall have the same rights as any other Class Member. Consequently, a letter from the Director of HFS or designee will be issued to the Office of the State and County Guardian and to all private guardians informing them of the responsibilities set-forth in the Colbert Consent Decree and the processes defined in the Implementation Plan to reach Class Members.

In an effort to inform all guardians, over the summer of 2012 HFS will be requesting from nursing homes subject to the Colbert Consent Decree, a list of all current nursing home Class Member/residents that includes name, address and contact information of any person appointed by a court of law as guardian of that individual. Guardians will subsequently be sent a letter, as stated previously and the names will be given to the entities performing the assessments to contact. Once contact has been made, conversations will take place to discuss community re-integration of the Class Member.

5.6. Video

HFS will develop a short video that can be shown at educational sessions and initial face-to-face pre-assessment engagement meetings. The video will make every effort to include testimonials from former nursing home residents who have successfully transitioned to community residency and articulate what to expect during the pre-assessment, assessment, care planning and transition phases.

6. Focused Approach to Class Member Identification Using Integrated Care Coordination

As an essential principle of fulfilling the goals and mandates of the Colbert Consent Decree, care coordination will be provided to Class Members through managed care entities (MCEs). The Consent Decree does not prohibit the State from using managed care entities to create integrated delivery systems, and Defendants believe that this is the most effective structure to be able to access all required services in a coordinated, efficient manner.

Class Members will be identified utilizing two parallel approaches. The first and primary approach is through participation in an MCE. The secondary approach is through self-identification by Class Members. These approaches are defined in this section.

6.1. Class Members in Managed Care Entities (MCE)

State law requires at least 50% of Medicaid recipients to be enrolled in some form of care coordination by January 1, 2015. Care coordination for all Seniors and Persons with Disabilities in Cook County, including Colbert Class Members, will be offered through a number of different managed care entities (MCEs). In this Implementation Plan, an MCE includes (1) either of the two managed care organizations on contract through the Integrated Care Program (ICP), currently operating in the Cook County suburban area and collar counties; (2) a new Care Coordination Entity (CCE) being developed through the HFS Care Coordination Innovations Project and covering the City of Chicago, (3) a new or existing Managed Care Community Network (MCCN) covering the City of Chicago, or (4) an entity on contract through the federal Medicare and Medicaid Alignment Initiative, covering dual eligible Medicare-Medicaid clients the City of Chicago and Cook County suburbs; MCEs selected for this Initiative will also be available to serve Medicaid only Seniors and Persons with Disabilities in Cook County. Additional definitions are found in Section 19.5.

All of these MCEs offering services to Seniors and Persons with Disabilities who desire long-term care services, including Class Members, will be required to coordinate a service package of healthcare services and a second service package of Long-term Services and Supports (LTSS); all Medicaid clients who are Seniors and Persons with Disabilities who desire long-term care services, including Class Members, will be required to enroll in an MCE for LTSS.

ICP is already providing a package of healthcare services, but through Phase II will expand to offer a service package of LTSS for its 40,000 members by fall, 2012 – including Colbert Class Members who reside in nursing facilities in Cook County suburbs. The new CCEs and MCCNs currently applying through the HFS Care Coordination Innovations Project are expected to be on contract by January or early spring, 2013. The Medicare and Medicaid Alignment Initiative will be ready for enrollment by spring 2013, based upon approval from the federal Centers for Medicare and Medicaid (CMS). [NOTE: For dually eligible persons who desire long-term care services, HFS plans to require enrollment in a service package of Medicaid LTSS, even if federal policy prohibits mandatory enrollment in Medicare managed care.]

All of the Class Members will have a choice of at least two managed care entities throughout Cook County on a phased-in basis, as various managed care entities come on line. Initial contact will begin with currently enrolled ICP Colbert Class members; there appears to be sufficient numbers of suburban Class Members to begin the assessment processes in September 2012. Additional Class Members in the City of Chicago will begin the process of enrollment through the Illinois Client Enrollment Broker (see Section 8), beginning in January 2013, who will

explain the choice of two or more MCEs in operation in the City of Chicago and will make a referral to the appropriate MCE selected.

In addition, throughout this process, a Class Member who is not currently or otherwise enrolled in a MCE will be able to self-identify. Class Members who self identify will be referred to the Illinois Client Enrollment Broker (see Section 8) to make a selection among the MCEs serving the Class Member's community and most appropriate to meet their needs based on network coverage. Mechanisms are in-place for self-identification, including the Pathways/MFP on-line referral process and Section Q of the MDS instrument.

6.2. Focused Methodological Approach to Identification of Initial Class Members

With as many as 185 nursing homes and 17,466 residents who are Class Members, it is clear that not everyone can be evaluated immediately. Accordingly, in addition to the strategies and approaches discussed above, the Defendants also will employ a focused methodological approach to prioritize the identification of initial Class Members; however, this is intended only to create an orderly, systematic process, and in no way affects the eligibility of Class Members to receive the services to which they are entitled under the Colbert Consent Decree. This process will enable a mix of characteristics among the Class Members that is essential for the development of the cost neutrality plan in the Consent Decree. It also bolsters the philosophy that all Class Members are candidates for transition to community residency in accordance with this overriding philosophical approach.

6.2.1. MDS 3.0 and RUG Groupings

The use of MDS 3.0 and Resource Utilization Groups (RUG) data clusters is one strategy to help identify Class Members in a systematic way. This objective outreach is based upon the work of Dr. Brant Fries of the University of Michigan. Under the methodology of Dr. Fries, MDS and RUGS data and in particular those lower RUG score groupings will be matched with data from the data warehouse at HFS for further analysis. Group profiles from this analysis will be used to identify similar profiles amongst individuals currently residing in Cook County nursing facilities.

The rationale for an initial lower RUG score groupings is that this classification system uses information from the MDS assessment to classify nursing home residents into a group that represents relative care resource requirements. RUGS groups form a hierarchy from the greatest to the least resources used. The low RUGS groups include Reduced Physical Function, Behavioral Symptoms and Cognitive Performance. The Reduced Physical Function category includes residents whose needs are primarily for support with general supervision and also activities of daily living (ADLs) such as eating, bed mobility, transferring and toileting. The Behavioral Symptoms and Cognitive Performance category includes residents who receive assistance with the same ADLs and also have behavioral or cognitive performance symptoms.

However, even with this methodology, based on what the Defendants have learned from the MFP Initiative, most nursing home residents present with complex health histories and co-morbidities, that are identified using the methodology of Dr. Fries and have lower RUG scores. Participants possess multiple health and social conditions.

6.2.2. Analysis of Pathways to Community Living/Money Follows the Person Initiative

At the time of drafting this Implementation Plan, over 500 MFP participants have transitioned from nursing homes to community living. At the end of 2011, 80% of the participants were still living in the community. HFS proposes to further examine the pre and post transition characteristics of these individuals to determine if a specific Illinois profile can be developed to help identify those potential candidates for transition, and used the information learned to further develop a focused selection and approach of those enrolled in a MCE.

6.3. Process and Goals to Achieve Benchmarks

At the writing of this Implementation Plan there are 17,466 Class Members residing in 185 nursing homes in Cook County. Of the 17,466, 1,713 are currently enrolled in an ICP. Based upon calculations of outcomes of initial face-to-face meetings from the Illinois experience to-date in the MFP initiative, there is a .076% success rate of persons who transition to community residency. Estimating an improved success rate of 10% under the Colbert Consent Decree, approximately 171 out of the 1,713 enrolled in an ICP are projected to transition from the nursing home to community residency. Consequently, the Defendants project needing to conduct an estimated 3,000 face-to-face contacts with nursing home residents to reach the first year benchmark of 300 transitions. Furthermore it is estimated to achieve the benchmark of moving 800 Class Members by September 2014, the Defendants will need to reach 8,000 Class Members and to reach the benchmark of 1,100 Class Members by February 2015, and the Defendants will need to reach 11,000 Class Members.

There is a chart in the Appendix Section that shows the breakdown of the current 17,466 Class Members by age and whether or not there is a diagnosis of Serious Mental Illness (SMI). Data is based on the MDS. The chart also shows the number of Class Members that are Medicare and Medicaid dual eligible enrollees. Ultimately, all Class Members will be provided an opportunity for an evaluation. Defendants are keenly aware that a mix of Class Member characteristics is critical for cost neutral plan data analysis. It is expected that this mix of characteristics will be accomplished through a conscious review by State of Illinois staff of Class Members as they are evaluated, and as Class Members are encouraged to self-identify. It has been the experiences of the Defendants that people who have transitioned under Pathways to Community Living/MFP often demonstrate multiple diagnoses and complex health conditions.

As stated above, while Class Members are identified, a systematic tracking of their characteristics will be completed to ensure they reflect a mix of complexity. This tracking and sensitivity to a mix is essential. Class Members who comprise the first 1100 individuals and analyzed for the cost neutrality requirement of the Consent Decree should reflect a diverse population of need.

7. Colbert Consent Decree in Relationship to Pathways to Community Living/Money Follows the Person (MFP)

A MFP participant may be a Colbert Class Member within the class definition in Section III of the Colbert Consent Decree. It is the intention of the Defendants that all Colbert Class Members who are eligible for MFP be counted as MFP participants. To be eligible for MFP, a person must be a nursing home resident for a period of 90 days or more and that none of these days be for the sole purpose of short-term rehabilitation and paid for by other government sources such as Medicare; and that the resident be on Medicaid for at least one day prior to transition to community residency. In addition, a participant of MFP is to choose one of the following community settings in which to move: 1) a home owned or leased by the individual or a family member of the individual; 2) an apartment with an individual lease, secure access and living, sleeping, bathing and cooking areas over which the individual or his/her family has control; 3) a community-based residential setting with no more than four unrelated individuals. In Illinois, a Supportive Living Facility qualifies according to the description in #2 above. If a Class Member chooses a setting other than one the three defined MFP options, he/she could not be counted as a MFP transition. Participation in MFP is also voluntary.

A participant in MFP should qualify to be counted as a Colbert Class Member per the definition of a Colbert Class Member in Section 1.3. The federal Centers for Medicare and Medicaid Services (CMS) has validated the inclusion of the Colbert Class Members in the MFP Program in a conversation on June 1, 2012.

The Defendants recognize that the Colbert Consent Decree offers benefits to Class Members that are not part of the current MFP program. For example, a Class Member who has lived in a nursing home for six months or more may be eligible for housing assistance under the Colbert Consent Decree. Under MFP, a housing bridge subsidy is provided only to qualifying participants being transitioned by the Illinois Division of Mental Health and MFP requires only a 90 day nursing home stay to qualify for this benefit.

Similarly, most MFP participants who reside in a nursing home in Cook County meet the definition of a Colbert Class Member. The difference is primarily related to the housing benefit, and the Defendants will seek to modify the MFP Operational Protocol to reflect the enhanced Colbert Consent Decree benefits to residents of Cook County nursing homes.

Consequently, the Defendants intend to count Colbert Class Members enrolled in MFP and fulfill the projected benchmark numbers of transitions under the Colbert Consent Decree and likewise

count Colbert Class Members who are enrolled in MFP in the projected benchmark numbers of transitions under the MFP program. The inclusion of the Colbert Class Members in the MFP Program enables the benefits of MFP – including the provision of HCBS Waiver services and State Plan Mental Health services; coverage of transition costs; and demonstration services that are not covered under the Waivers.

Additionally, the MFP Program provides enhanced quality oversight for all individuals transitioning from nursing homes to the community. The quality oversight and requirements defined in the MFP Operational Protocol that are in practice and approved by the federal Centers for Medicare and Medicaid should be appreciated by all parties as being beneficial to the Class Member. The MFP Risk Inventory, Risk Mitigation Plan and 24-hour Back-up Plan are documents and the activities performed to complete these documents support and provide tools to better ensure a successful transition. They consider how the needs of the Class Member will be safely met through pre and post transition planning by addressing and asking the participant and Care Coordinator to identify the Class Member's health, activities of daily living and social requirements. The 24-Hour Back-up Plan is given to the Class Member to help them identify alternative community resources in the event the primary supports break down or an unforeseen health crisis emerges.

All transitions that are counted under MFP enable the state of Illinois to receive an enhanced federal match on its Medicaid Waiver and State Plan services provided to individuals for the one year period post transition. These additional dollars, under the MFP initiative, are placed in a rebalancing fund that is used for an expansion of home and community-based services. Expansion of services will ultimately benefit all residents of nursing homes, including Colbert Class Members transitioning to community-based settings.

Over the summer of 2012, specific strategies will be identified to bring the steps identified in this Implementation Plan in-line and as stated above with the current strategies employed under MFP, specifically as they relate to nursing home residents in Cook County. When the above inclusion of Colbert Class Members in MFP was discussed with a representative of federal CMS on June 1, 2012, she welcomed the opportunity for Illinois to amend its MFP Operational Protocol.

8. Illinois Client Enrollment Broker (ICEB)

Each Class Member who is not yet enrolled in an MCE (e.g. in the Integrated Care Program, or ICP) will be visited by an Illinois Client Enrollment Broker (ICEB). The ICEB will be under contract with HFS for the purposes of discussing options available to the Class Member in order that he/she makes an informed choice regarding the managed care entity options. Whatever option is chosen, the Class Member will be linked with a Primary Care Physician (PCP) and other allied health and mental health providers, as well as home and community-based services

in their network. Networks are to include current Medicaid waiver programs, State Plan services and other governmental and non-governmental resources.

9. Evaluation by the Managed Care Entity

Once the Class Member has chosen a MCE through contact with an ICEB and the processes of evaluation begin. As previously stated, every Class Member is a potential candidate for community transition. The role of the professionals charged with evaluation, pre and post transition to community residency planning, including the development of the Plan of Care is responsible for using a person-centered approach. The Consent Decree defines a person-centered approach as a “planning process designed to empower Class Members to make plans for their future according to their needs and desires, with the support of their legal guardians, family, friends, or service providers as appropriate.”

Defendants support a person-centered approach, as Service Plans of Care need to be inclusive of the Class Members’ needs and require active participation of the Class Members’ family and significant others or guardian. A Service Plan of Care must reflect the concept that a person should not be isolated in an institution or in the community. Specifically, Class Members may suffer from a dementia where community residency places themselves or others at risk for harm. As stated in the Consent Decree, there is recognition that Class Members who have been determined by a medical doctor to have a diagnosed condition and are unlikely to improve may not be deemed as a successful candidate for transition. However, all Class Members are to have a planned re-evaluation.

Similarly persons with a Severe Mental Illness may lack the capacity to perform tasks associated with community living such as shopping, cooking and medication management. While it would appear that these skills could be learned, Class Members must have the capacity and motivation to learn even under a framework of a person-centered approach. These are persons that may not achieve recovery. Evaluators are to work with these Class Member candidates to identify all possible resources in an effort to transition to less restrictive environments.

9.1. Quality Components – Evaluation, Risk Assessment and Mitigation

As part of the evaluation, all possibilities and conditions, as well as the individual’s strengths will be explored and addressed. Assessment instruments are only tools to further define and clarify. It is the status of a Class Member’s physical and mental health, including cognitive abilities that ultimately determine the candidacy for transition. With that in mind, decisions regarding appropriateness for transition depend on changes to the individual’s physical and mental health. Where physical and/or mental health status may appear to place the individual at too much of a health and safety risk at the time of initial evaluation, improvement may occur allowing the individual to be a potential candidate for the future.

9.2. Successful Transition

The goal of the Defendants is to provide individuals with the resources they need in order to succeed and thrive in the community after they transition. A transition will not be viewed as successful if the individual is soon readmitted to a nursing home or some other institutional setting in a short period of time.

Class Members transitioned to community residency are to maintain a relationship with their managed care professionals providing the evaluation and supportive transition planning and the care coordination once in the community. Excellent care coordination, at all phases of the processes is critical.

9.3. Responsible Entity for Conducting the Evaluation and Development of the Service Care Plan of Class Members

In an effort to reduce redundancy and eliminate role confusion, all aspects from initial contact and engagement, evaluation, Service Care Planning and implementation of the Service Plan of Care will be the responsibility of a professional Care Coordinator employed by one of the managed care entities. The specific entity that is involved depends upon the choice of the Class Member. The professionals employed by these entities will be well-trained in available community resources and possess a skill set representing cross-disciplines. This approach will enable the Class Members to see one professional or team of professionals having the skill set to assess for physical and behavioral health needs. The lead person assigned to and developing the long-term relationship with the Class Member, representing the cross-disciplinary team and the managed care entity, is called the Care Coordinator.

As required by Medicaid policies and procedures an eligibility determination for a Medicaid waiver or state plan mental health service may be involved. These frequently require the involvement of an organization such as a Care Coordination Unit (CCU) visiting a Class Member or conducting a review to determine eligibility. When these outside assessors are needed based upon those evaluations and projected plans of care, it will still be the Care Coordinator representing the managed care entity chosen by the Class member that will be responsible for the total coordination of care and will be responsible for interfacing with these providers.

9.4. Initial Contact and Engagement

The act of engaging an individual requires skill and proper training. In addition to the ability to work effectively with Class Members, family members, significant others, guardians, nursing home staff (including nurses, doctors, discharge planners, advocates, guardians and all others), the Care Coordinators from the various managed care entities must be good listeners. Class members will be encouraged to share life goals as one of the means to begin to identify interest in community transition and begin the informal process of assessing the strengths and risks of the

Class Member that will need to be mitigated as part of a successful transition to community residency.

9.5. Cross Disciplinary Teams

The initial activities from the MCEs will be conducting the outreach and evaluation in multi-disciplinary teams. Teams will be charged with visiting nursing home residents and initiating engagement of the Class Members. These processes will be cross category, meaning that they will be making contact with each Class Member regardless of age or status of disability. The team will possess the knowledge to recognize the risks that may be associated with persons with physical disabilities and persons with a serious mental illness.

9.6. Review of Nursing Home Medical Records

Each on-site pre-assessment will include a review of the nursing home medical record of the Class Member. At the initial nursing home visit and prior to a face-to-face conversation with a Class Member, the Care Coordinator and team will review the nursing home medical record and begin to evaluate the Class Member's strengths and needs relative to planning for community transition. Objective criteria will be established to determine whether a face-to-face meeting with the Class Member is to take place at this time or determined to take place at a later date. An example of reasons for delay in conducting a face-to-face pre-assessment would be documentation of an advanced dementia or current palliative care for the end-stage of an illness.

If a Class Member's medical record indicates a significant mental illness, his/her last Resident Review and scores on the LOCUS (Level of Care Utilization System) will be reviewed. If a Resident Review has not occurred recently, either a member of the team or another professional that is skilled at administering the LOCUS will administer the tool.

A timeframe will be established for reviewing Class Members who are determined to meet the criteria identified for a follow-up assessment.

9.7. Face-to-Face Contact in the Initial Evaluation by a Care Coordinator

Class Members who have resided in an institutional setting for an extended period of time may not have thoughts of returning to community residency. Others may have lived-in institutions for all of their lives and thoughts of establishing community residency are new. The Care Coordinator will meet the Class Member to engage him/her in a conversation, and begin to develop the relationship that is deemed so necessary to a successful transition to the community.

It is expected that the interaction will involve asking the Class Member to identify his/her life goals and what brought them to the nursing home. This conversation will have several objectives:

- To learn where the Class Member hopes to be in the short-term and long-term;
- To have the Class Member present issues related to nursing home admission as often they relate to why the Class Member is a nursing home resident;
- To understand what strengths and needs the Class Member may possess;
- To result in the Class Member beginning a conversation regarding transition to community residency.

It is hoped that rapport is established with the Class Member so if an affirmation is not made at that point-in-time to consider transition to community residency, that it will occur at a future visit.

Class Members may need to talk with significant others or guardians in the community regarding the decision to transition to community residency. In addition, the conversation may lead the Care Coordinator to determine that transition to the community residency is premature. An example of this outcome is someone who states that they are in the nursing home in preparation for a future surgery. If these types of situations emerge, the Care Coordinator would document this outcome and plan for a future follow-up visit.

10. Assessment/Evaluation

Assessment involves speaking with the Class Member and those that he/she may identify as persons who should be involved in transition planning and in the development of a Service Plan of Care. The process of conducting an assessment not only involves the administration of assessment instruments; it also requires obtaining clarifications on current treatment protocols. While nursing home medical records and discussions with nursing home personnel can be invaluable in helping to create a comprehensive picture of the Class Member, frequently information requires further medical evaluations and consultations. It is critical that an array of evaluation strategies and assessment domains is explored.

10.1 Assessment Tools

No single tool has been identified to assess a Class Member. A statewide effort is currently underway by the Defendants with a national consulting firm to identify such a resource that would assess cross-disability. In the meantime, a number of tools will be utilized including the Illinois Determination of Need (DON), the Comprehensive Assessment Instrument of the Illinois Department on Aging, the LOCUS and tools that the managed care entities may select. Additional tools will include those designed to assess for mental health and substance abuse. It should be noted that an assessment tool assists a professional to cover a pre-set array of domains such as physical health, medication, behavioral health, social supports, housing requirements and

nutritional status, among others that documents the assessment. No one tool gives a professional with a definitive picture of the Class Member. Putting the assessments together from an array of instruments, one-on-one conversations with the Class Member and his/her support system and consultations with other professionals should provide enough information to give to the Class Member the ability to make decisions for a successful plan of care.

10.2. Access to Medicaid Home and Community-based Service Options and Rule 132 – Medicaid Community Mental Health Services Program

All home and community-based services (HCBS) and medical services will be accessed and delivered through the integrated delivery systems of an MCE. It is anticipated that the majority of Class Members will qualify and benefit from the array of HCBS options available to Medicaid recipients based upon his/her eligibility. For example, persons who have physical disabilities between the ages of 18 to 59 years of age may qualify for the Persons with Disabilities and/or State Plan services. Persons over the age of 60 may qualify for the Community Care Program under the Illinois Department on Aging and State Plan services. Persons 22 years of age and over may qualify for the Supportive Living Facility Waiver. Persons with a Serious Mental Health illness may qualify for various state plan services. There are a number of other waiver options depending upon meeting established criteria such as diagnosis of a brain injury or HIV/AIDS.

As stated in Section 10.1, the Defendants are beginning work with a national consulting firm to potentially redesign a cross-disability assessment tool as well as the process for conducting eligibility determinations and delivery of services through nine separate waivers. Stakeholders will be invited into this process. It is possible that the process for the provision of waiver and state plan services described in this Implementation Plan will be restructured in future years.

In Year 1, Class Members will continue to benefit from the array of services that are currently defined in the separate waiver programs and state plans. However, the service providers will be required to participate in one or more networks organized by the MCEs. It is expected that providers will be working in collaborative, cross-disciplinary teams, with the Care Coordinator assigned to the Class Member, creating a more cohesive, person-centered environment than the current fragmented system.

10.3. Eligibility for Home and Community-based Services and State Plan Mental Health Services

In order to determine if a Class Member is eligible for one of these waivers, the Department on Aging and the Department of Human Services Division of Rehabilitation Services has established processes for eligibility determination. It is a role of the Care Coordinator to assure that Class Members who are deemed to qualify for waiver services are evaluated using the current eligibility standards for these programs and services. While the linkage with the actual providers of services is the responsibility of the Care Coordinator, the eligibility determination is

conducted according to the policies, procedures and rules of State agencies as defined by approved protocols between the State of Illinois and the federal Centers for Medicare and Medicaid.

Currently, IDoA has contracted independent agencies known as Care Coordination Units who perform this activity for persons over the age of 60. Similarly, representatives of the Illinois Department of Human Services, Division of Rehabilitation Services perform these assessments for the non-elderly disabled population. These state agencies and their representatives will visit the nursing home prior to a Class Member's transition to the community to affirm eligibility.

The current tool used in Illinois for persons with physical disabilities beginning at age 18 is the Determination of Need (DON). The DON "score is derived from the Mini-Mental State Examination (MMSE), six activities of daily living (ADLs), nine instrumental activities of daily living (IADLs) including the ability to perform routine health and special health tasks and the ability to recognize and respond to danger when left alone. Each ADL, IADL and special factor is rated by level of impairment (0-3) and unmet need (0-3). Scores for each area are totaled and weighted toward people with moderate or severe dementia. The process is designed to target services to people with high levels of impairment who may have informal supports, and to people with lower levels of impairment without informal supports" (Mollica and Reinhard (2005), p. 2-3.)

The Care Coordinator will collaborate with the community mental health provider to determine eligibility for the Rule 132 – Medicaid Community Mental Health Services Program. The Division of Mental Health utilizes the Level of Care Utilization System (LOCUS) tool. The LOCUS determines the level of care needs across six domains. It is the responsibility of the Care Coordinator to identify and collaborate with mental health service providers in their networks to determine and further establish a comprehensive Service Plan of Care. The strength of the cross-discipline integrated approach is the ability of the professionals to coordinate the Service Plan of Care and develop an integrated Service Plan of Care.

It is expected that those entities responsible for eligibility determination for the waiver services will determine eligibility in a timely manner. It is also expected that the Care Coordinator working with the Class Member will assure that a timely eligibility determination is made.

10.4. Social History

All conversations with Class Members are opportunities to learn something relevant to the development of the Service Plan of Care. It is critical that in addition to the various assessment tools that are used, a social history will create a cohesive narrative of each Class Member. Not only will the writing of a social history explore the Class Member's past and future goals and aspirations, but the Class Member and others appreciate a holistic view that will be useful for linkages to home and community-based resources, including mental health services necessary for success in the community.

10.5. Individualized Budget Plan

The Care Coordinator is required to develop an individualized Budget Plan in full collaboration with each Class Member engaged in planning for transition. This Budget Plan will indicate the Class Member's income and all expenses that are being paid for by a Medicaid service (including costs associated with a housing subsidy). In addition, part of the Budget Plan is a comparison of current costs associated with nursing home residency as contrasted with projected costs associated with community residency. The Budget Plan reinforces the concept that all Class Members should have a consumer-directed plan for spending based upon his/her individual needs. It is also an integral collection of data to project cost neutrality in the overall Consent Decree expectations.

10.6. Pathways to Community Living/Money Follows the Person (MFP) Requirements Including an Inventory of Risks and Risk Mitigation Plan

The goal is to utilize the resources, policies and procedures identified in the Money Follows the Person Operational Protocol for Class Members under the Colbert Consent Decree. Specifically, Money Follows the Person has developed an Inventory of Risk document. The Inventory of Risks and the Risk Mitigation Plan serve a critical purpose of further defining elements for successful transition. They are additional tools in the development of a holistic evaluation of the Class Member.

In order to successfully identify potential risks or harms inherent in all settings, what is learned in an assessment is re-framed to be defined into risks. For example, a Class Member that has difficulty preparing meals or may have a history of non-compliance to prescribed diet could have a notable a nutritional risk. Risks will emerge from the review of all face-to-face meetings and assessment tools. The risks will be documented in the MFP Risk Inventory and the computer software program links the risks with mitigation strategies. These strategies define actions that both the Care Coordinator and Class Member working in conjunction should address in a Service Plan of Care.

10.7. 24-Hour Back-up Planning

Pathways to Community Living/Money Follows the Person requires the completion of a 24-hour back-up plan. The preparation and development of this 24-Hour Back-up Plan that is also prepared in conjunction with the Care Coordinator, Class Member, his/her identified significant others and guardian, if applicable is expected to be an effective resource once the Class Member resides in the community. This document is one of the critical pieces and tools for the Class Member and the Care Coordinator in sustaining a successful transition.

The best intended plans often experience unanticipated challenges. Persons who said they would provide assistance to Class Members may fail to live-up to expectations. In addition, the Class Members likely have physical and/or mental health issues that may require emergency or

alternative assistance. A 24-hour back-up plan is synonymous with calling 911. While reaching-out to emergency services may be required, it is the use of alternative resources that should be put into action if plans fail to meet expectations. It is always better to plan for critical events versus inappropriately taking hasty actions, no action or using emergency services.

10.8. Care Coordination Care Conferences

Care Coordinators and service providers within their networks are to work collaboratively to assure all of the Class Members needs are addressed. It is expected that a minimum of one and more care conferences using this integrated care approach will take place prior to transition to community residency. The care conference will include the Class Member and his/her significant others he/she chooses to participate, the Care Coordinator, the guardian, if applicable and other professionals affiliated with the managed care entity, home and community based service and mental health providers. HFS staff will participate from time-to-time in these care transition conferences to ensure all processes and identifiable needs are being adequately addressed. The other participants in this initial care conference may include nursing home staff that are intimate and knowledgeable about the care and care giving that is presently being provided in the nursing home.

10.9. Quality Assurance Resources Available through Pathways to Community Living/Money Follows the Person

The Pathways to Community Living/Money Follows the Person Initiative has as part of its Operational Protocol a quality assurance team led by a nurse who reviews the Service Plan of Care. This quality assurance (QA) activity takes place via a conference call. This is viewed as an additional assurance that all medical needs are sufficiently addressed. This conference prior to discharge will further assure quality to plan development by the managed care entity and fulfill the expectations set-forth in the Operational Protocols stated to the federal Centers for Medicare and Medicaid (CMS) in Illinois' Pathways to Community Living/Money Follows the Person Initiative for all participants in this program.

11. Class Member Finances

A comprehensive assessment of each Class Member will include a domain relating to the individual's finances. A Class Member may require income to successfully transition into a community-based setting, such as a private residence or permanent supportive housing. Class Members may receive income from many sources and will be required to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled including, but not limited to Veterans' compensation and pensions, Social Security Administration retirement benefits (SSA), income from Social Security Disability Insurance benefits (SSDI), railroad retirement benefits, unemployment compensation, and/or income from Supplemental Security Income benefits (SSI). The Care Coordinator will link the Class Member to resources and/or legal advocates for the aged or disabled population to assist with the

applications for any sources of income and for any appeals of eligibility denials for such income. Each Class Member’s financial picture should be reviewed as early as possible in order to avoid delays in transitioning to the community due to a lack of necessary income.

12. Housing

The Consent Decree states that Class Members should transition to community-based settings that promote “independence in daily living and ability to interact with persons without disabilities to the fullest extent possible.” These settings include “a private residence, a Supportive Living Facility, Permanent Supportive Housing, or other appropriate supported or supervised residential settings that are specifically chosen by the Class Member.” The selection of a particular type of residential setting may be a qualifying determinant of MFP participation. However, Class Member preferences, what is available and type of setting will be factors for the Class Member to consider when making his/her choice.

The terms of the Consent Decree define an initial group of Class Members who may be eligible for financial assistance to subsidize the costs of housing in the community. It also requires the Class Member, assisted by the Care Coordinator in the housing search, to make every effort and these efforts be documented to identify long term rental subsidy supports. The various rental subsidy support programs may be found in the Appendix section of this Implementation Plan.

The total housing subsidy provided for in the community where the Class Member wishes to live is based on unit availability of housing in the marketplace. It shall be calculated as follows: the subsidy provider will pay the difference between 30% of the class members’ household adjusted gross income, as defined by HUD, and the lesser of actual market rent that is reasonable for the community in which the housing is located or the HUD published Fair Market Rent (FMR) applicable in the year of transition. The amount of housing assistance shall be capped in the first 30 months following implementation of the Consent Decree with the aggregate housing assistance maximums determined thereafter as part of the Cost Neutral Plan.

12.1 Identification of Housing

12.1.1. State Housing Coordinators

On March 1, 2012 the Governor’s Office hired two Housing Coordinators to identify means of enhancing housing opportunities for Class Members and to coordinate communication and actions between state agencies and the Illinois Housing Development Authority (IHDA).

One Housing Coordinator is focused on housing opportunities in Cook County and the other Housing Coordinator has Statewide Housing responsibilities. The Housing Coordinators are to expand networking opportunities, partnerships and relationships by facilitating the expansion of housing resources including Permanent Supportive Housing (PSH), access for Pathways to Community Living/MFP, housing opportunities for Class Members of the Consent Decrees and

manage the referral flow to IHDA's Low Income Housing Tax Credit Units. Low Income Housing Tax Credit units are targeted to persons with disabilities that include, but not limited to Class Members of the Consent Decrees.

During the drafting of this Implementation Plan, the Housing Coordinators, in partnership with IHDA, have developed strategies to work in collaboration with the Chicago Housing Authority (CHA) and the Housing Authority of Cook County (HACC), as well as HUD and other local Public Housing Authorities. This collaboration is developing methodologies within the context of existing HUD policy guidance to increase the availability of access by Class Members to rental assistance. This collaboration is true for both tenant based and project based units. In addition, IHDA in partnership with the various housing entities is obtaining access for Class Members to vacant public housing units that exist within certain public housing authorities in the State.

The Housing Coordinators are also working in partnership with IDHA to assure that the CHA provides Project Based Rental Assistance to persons with physical disabilities who will occupy apartments in IHDA funded Home First Illinois units. Home First Illinois is an affiliate of the Illinois Facilities Fund and is acquiring units for persons with physical disabilities with the proceeds of \$5 million in Build Illinois Bonds. These proceeds were made available to IHDA through the Governor's office with the goal to promote the development of PSH.

IHDA has also worked closely with local housing authorities to develop methodologies, within the context of existing HUD guidance, to enhance the availability of Housing Choice Vouchers for persons with disabilities, including the elderly. They have secured access to technical assistance, through private foundation support of the Technical Assistance Collaborative, to aid the State in completion of a highly competitive application for the U.S. Department of Housing and Urban Development (HUD) Section 811 program. The expansion of the Section 811 program will for the first time allow State Housing Finance Agencies, such as IHDA, to apply for Project Rental Assistance separate from capital financing to help meet the intent of the Supreme Court's Olmstead Decision. In addition, the Housing Coordinators have fostered relationships with many property management entities and housing developers across Cook County who are now potential resources of PSH.

12.1.2. Care Coordinator Responsibilities for the Identification of Housing

The actual identification of housing options for each Class Member is the responsibility of the Care Coordinator. However, it is expected that the Care Coordinator will work in conjunction with the Housing Coordinators as it is deemed that both entities have a dual role in the identification of housing. The Care Coordinator will work with each Class Member to determine what are his/her best options and the Housing Coordinators will help in identifying the properties that meet these needs and expectations.

While acknowledging the effort the Care Coordinator and the Housing Coordinators to identify housing, it is ultimately the Class Member's responsibility to find housing. Care Coordinators will work with each Class Member to explore all options including family, friends, significant others, newspaper advertisements and options identified through an on-line state funded housing search inventory (described below). One key resource to assist in the housing search process and identification of available housing units is the Illinois Housing Search web based search engine that lists thousands of units that landlords are listing for rent in the private market place. This website contains a caseworker portal that allows Care Coordinators to search a subset of housing options wherein landlords have expressed a specific willingness to rent apartments to persons with disabilities.

12.1.3. State-funded Internet On-Line Housing Locator

The primary on-line state funded housing search inventory is the Illinois Housing Locator, www.ILHousingSearch.org, which promotes choice by providing equal access to housing options. It allows Class Members and Care Coordinators easy access to housing by location, features, vacancy, among other screening criteria.

Once a unit or housing option is located, the Care Coordinators will assist in making arrangements for Class Members to visit a property. Part of the arrangement involves housing choice. In addition, a factor in the decision relates to assuring the property is accessible or can be made accessible for persons that may have physical challenges.

Care Coordinators will have a secure access to a web portal that enables them to search for housing options that may be targeted to populations represented by the various Olmstead Consent Decrees and the Pathways to Community Living/Money Follows the Person Initiative. This option further advances the ability to access additional and more detailed housing information relevant to the populations that they serve.

12.2. Assessment for Home Modification

Depending upon the housing, those units that appear to require home modification to meet the environmental needs of the Class Member will be referred to an assistive technology program. The assistive technology program will conduct an on-site inspection of the unit and make recommendations for retro-fitting and environmental modifications needed to make the unit accessible. Per the terms of the Consent Decree, a Class Member may be eligible for up to \$4,000 to cover the cost of the home assessment and home accessibility costs that may be required as a result of that assessment.

12.3. Housing Assistance

The Consent Decree states that following a review of the finances of a Class Member, financial assistance for housing may be required. The Consent Decree also establishes specific limitations to access the financial assistance. The specific criteria can be found on page 7-9 of the Colbert

Consent Decree. The housing assistance is calculated by the difference of the actual or Fair Market Rent less any government-funded housing subsidy and 30% of the Class Member's income and this subsidy. Class Members are to seek alternative arrangements or financing that may include accessing Section 8 HUD Vouchers or other public or privately supported housing programs.

At the point of transition and the development of the Service Plan of Care, the Care Coordinator utilizes a two-stage process. The first stage is a home inspection by an identified home inspection agent. This agent has responsibilities separate from those previously described as relating to accessibility and home modification. All identified properties where the future Class Member tenant requires financial assistance to help pay rent must be inspected in order that it meet the United States Housing and Urban Development (HUD) approved Housing Quality Standards. Based upon the inspection, properties will likely require corrective actions for needed repairs. These repairs will be subject to the establishment of a timeline for the completion. The correction of deficiencies will require re-inspection before a property can be occupied and its future tenant is eligible for the state-funded housing subsidy.

The second stage is the actual monthly disbursement of housing subsidy funds. The establishment of the exact subsidy amount is formula based. It is part of each Class Member's Budget Plan (described in 10.5). The Budget Plan will be administered by a Fiscal Agent.

12.4. Guidelines for Costs Associated with Moving and the Establishment of Household

Financial resources are available to Care Coordinators to provide a Class Member with the necessary items and services to ensure a successful transition to community residency. One-time transition costs fall under five broad categories as defined on page 12 of the Consent Decree. On page 13 of the Consent Decree there are defined costs that may not be counted as expenses associated with moving and the establishment of a household. It is the responsibility for the Care Coordinator to coordinate the identification of each transitioning Class Member's needs and make the necessary arrangements to secure these items. These costs may not exceed \$4,000 as allowed under the terms of the Consent Decree.

12.5. Guidelines for Costs Associated with Home Adaptation

Guidelines for the provision of environmental modifications to occur under the Colbert Consent Decree are an adaptation of those currently used DRS Home Services Program. Environmental modifications may be provided to a Class Member if:

- The modification will enable the Class Member to independently perform his/her Activities of Daily Living (ADLs), will result in a decrease need for assistance from another individual in the completion of his/her ADLS, will prevent an anticipated

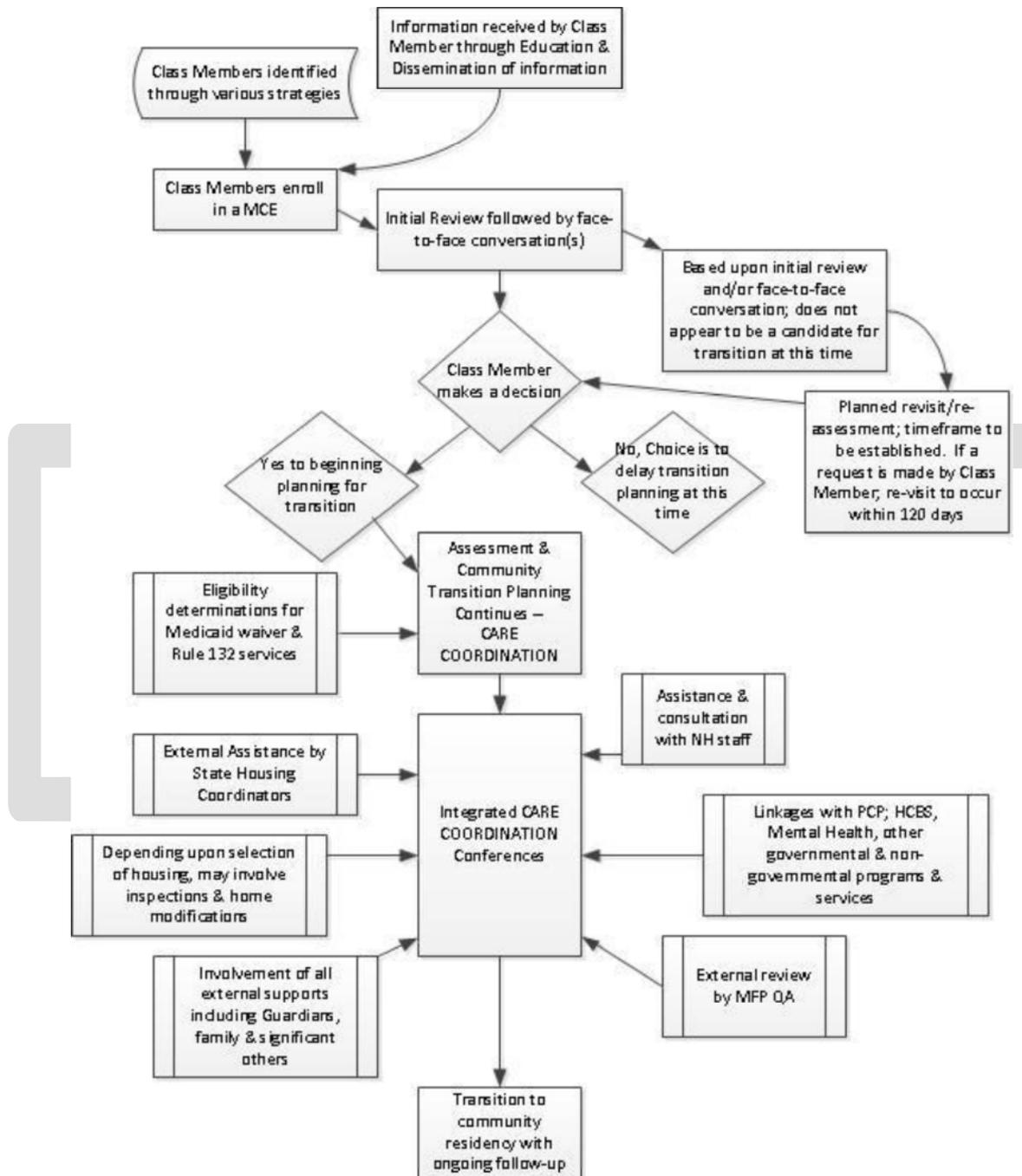
increase in service costs, or will improve the safety of the customer during the completion of his/her ADLs;

- There are no other resources, public or private, that will provide the modification and
- The cost for purchase of all environmental modifications and assistive equipment purchases, rentals and repairs does not exceed \$5,000 as allowed under the terms of the Consent Decree.

12.6. Fiscal Agent

A separate component of each Class Member's Service Plan of Care is a Budget Plan. The purpose, development and components of a Budget Plan have been previously described. The Fiscal Agent will be a single independent entity partner with all of the managed care entities. Responsibilities of the fiscal agent will be to administer the payment of all funds that are authorized in the Budget Plan. Specifically, funds to be paid include any housing rental subsidies including payment of a Class Member's rent for any temporary stay in a hospital or long-term care facility. It also includes approved costs associated with the establishment of a household as defined in the Consent Decree as transition costs that may not exceed \$4,000 for the lifetime of the Class Member. Guidelines for the appropriate uses of these funds may be found in the Appendix.

13. Visual Presentation of Process Flow



14. Relationship of Colbert Implementation Plan with Various State Agencies

Defendants of the Colbert Consent Decree include the Governor of the State of Illinois, Secretary of the Illinois Department of Human Services, Director of the Illinois Department of Public Health, Director of the Illinois Department on Aging and the Director of the Illinois Department of Healthcare and Family Services (HFS). All of these entities and the programs and services to which these directors represent are partners in the development and implementation of this Plan. As stated previously in this Implementation Plan, HFS has the lead responsibility due to Class Members being defined as Medicaid recipients, all under the jurisdiction of HFS.

Many of the programs and services that Class Members will receive once transitioned to community residency have historically been part of the various Medicaid waivers and State Plan services. As Illinois moves and advances the inclusion these programs and services to a managed care environment, the Defendants are engaged in an on-going process of redefining the relationships of the service providers to current and future managed care entities. Many of these same services providers will be members of the networks organized by the managed care entities, with some having the same, modified or new roles. Class Members of the Colbert Consent Decree, as well as other Medicaid recipients, will be part of this transformation to care coordination and managed care. Through established monthly meetings addressing long-term care reform and other on-going discussions amongst all of the Defendants, processes are in-place for ongoing collaboration in relationship to the Implementation Plan.

15. Expectations of Professionals Responsible for All Aspects of Processes Defined in Implementation Plan – Hiring, Training and Supervision

Managed care entities contracted by HFS for the Colbert Consent Decree will be required to have procedures in place for hiring, training and supervising their respective staffs. Evidence of such protocols will be required under the terms of their contracts. HFS has required and will continue to require all of the managed care entities to have quality assurance procedures in place to show that they are able to demonstrate adherence to various federal rule and law in relationship to managed care.

With recognition of a changing environment for service provision, delivery and a new model of care coordination bringing medical and non-medical resources together using an integrated care approach, all network partners will benefit from education. Managed care entities will be required to provide a plan for on-going training of its staffs and encourage their staffs to attend state and local conferences and workshops. Also, it is expected that the Defendants will periodically provide training specific to the managed care entities to insure a well-informed staff working with each Class Member.

16. Quality Assurance Activities and Actions to Comply with Obligations Under the Decree

The goal of the all Quality Assurance activities is to assure that services, supports, processes and successful maintenance once transitioned to community residency meets appropriate standards of quality.

16.1. Monitoring of Dissemination and Community Education

It is expected that the Defendants will monitor the activities of providers engaged in dissemination of information and community education in relationship to the Colbert Consent Decree. In addition, there shall reporting streams to document and affirm the value of these dissemination and community education activities.

While it is expected that those provider entities will provide dissemination and education in a professional and quality manner, state agencies will be interested in documenting their effectiveness. Effectiveness is to be measured by counting the number of transitions that can be attributed to the dissemination and community education activities. Currently, there are processes in place that records the number of referrals generated by Ombudsmen. The on-line self-referral system for Pathways to Community Living/MFP will record all self-referrals. Class Members and the providers will be instructed to use these current systems in order that effectiveness is measured.

16.2. Managed Care Entities (MCEs) Internal Quality Assurance Activities

Under contracts with all MCEs, internal processes for monitoring the quality of all activities will be required. The managed care entities are to incorporate accepted practice guidelines that are based on valid and reliable clinical evidence and consider the needs of their enrollees. As the contractors develop the work of assessment, pre-and post transition planning and care coordination, they will be expected to provide a written description of a Quality Assurance Plan (QAP) that include medical and non-medical related services, care coordination, care management, disease management and behavioral health services. This QAP must include: goals and objectives, scope, methodology, activities, provider review, a focus on outcomes, processes of quality assessment and improvement and consumer input. A more detailed description of these requirements is to be found in the contracts of these entities.

HFS is vested in assuring that these QAP measures are practiced well. A uniform method of reporting outcomes will be developed with each entity holding a contract. HFS staff will also be making on-site visits to the nursing homes as assessment activities are performed, and randomly participate in pre-transition and post care coordination conferences.

A benefit of participation in MFP is an additional level of quality assurance performed currently by representatives of the University of Illinois College Of Nursing. This quality assurance

process which is led by a nurse reviews the Service Plan of Care. This activity takes place by means of a conference call. It has a particular focus of examining the medical needs and recommending actions to be taken to assure that needs currently being addressed in the institutional setting are addressed once in the community.

17. Information Systems

During the drafting of this Implementation Plan, HFS has begun an exploration of what options are available to build upon existing IT systems currently in operation. There is no plan to develop another IT specifically for the Colbert Consent Decree. HFS is cognizant of the fact that a system must be in-place from the commencement of the Implementation Plan.

While the IT system is being identified, it is expected to have an array of screens representing all the processes of care coordination. These include: 1) File Review/Screening; 2) Initial Face-to-Face; 3) Assessment(s) 4) Social History; 5) Service Plan of Care including housing; 6) Budget Plan and 7) Referrals to Community Resources. The referral document may be separate or part of the Service Plan of Care. There will be a section for all case notes. In addition, regardless of whether a person is enrolled in MFP, the Care Coordinator will be expected to complete the MFP Risk Inventory; Risk Mitigation Plan and 24-Hour Back-up Plan. As stated in Section 7, the inclusion of not just these additional documents, but the activities associated with the development of these documents will further support a successful transition as they require the Class Member and the Care Coordinator to consider the needs of a Class Member when planning for community transition.

The IT system will be linked with an enhanced version of the on-line MFP system so Care Coordinators will not have to re-enter data into two systems, furthermore it will separate persons who are Colbert Class Members and may not be MFP enrollees even though the same or similar forms will be utilized. This IT system will be able to track all Class Members as they progress from a medical record file review and screening to transition to community residency. The utilization of this type of IT system will afford the Defendants to accurately report the status of Class Members and provide data on the progression in reaching the Colbert Consent Decree benchmarks.

18. Budget

(To be inserted)

19. Appendices

19.1 Chart Showing Current Breakdown of Class Members

Chart shows the classification of current Class Members by age and whether or not there is a diagnosis of a Serious Mental Illness (SMI). Data also shows how many of the Class Members enrolled in Medicaid are also enrolled in Medicare as indicated by the term “Dual.”

< 60	< 60	60 - 64	60 - 64	65 +	65 +	Total	
SMI	No SMI	SMI	No SMI	SMI	No SMI	Medicaid	Dual
3225	1691	928	836	2803	7983	17466	14094

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Appendix 19.2 -- Colbert Housing Options - Summary for Transition Planning

HOUSING PROGRAM OPTIONS (IN FORMATION)	Program Description	Funding Source	Number of Units	Notes
<p>1. IHDA Tax Credit Targeting Program ("LIH TC Targeting Program")</p>	<p>Developers Seeking Tax Credits Obtain Preference for setting aside 10%-20% of units for PSH at rents that do not exceed payment of 30% of adjusted household for households with extremely low incomes at or below 30% of HUD Area Median Income. Supportive services providers refer consumers to the State Lead Referral Agent for referral and processing of rental applications by the property manager.</p>	<p>IHDA Low Income Housing Tax Credit Program: Developers receive scoring preference for participation in LIHTC Targeting Program</p>	<p>350 units developed since 2008. Approximately 175 units added annually. Units in program are available for 30 years on turnover basis after being made initially available at project opening for a 90 day marketing period</p>	<p>1. Because rents are relatively low at 30% of AMI (Average \$400 in Chicago for 1 BR) cost of rental subsidy is "low" relative to subsidy levels at HUD Fair Market Rent of \$853 for 1BR. Successful placement of class members in targeted units with Bridge Subsidy will increase the number of units that can be provided with the available resources.</p> <p>2. IHDA site and marketing review for all projects has strong emphasis on supporting developments in opportunity communities that do not have a high concentration of assisted or tax credit housing based upon market studies provided in tax credit application.</p>
<p>2. Housing Choice Vouchers</p>	<p>Tenants pay 30% of income; PHA Pays difference in rent up to HUD Fair Market Rent or an "exception rent" if justified by market conditions</p>	<p>Public Housing Authorities</p>	<p>TBD</p>	<p>1. CHA willing to match names of class members with waiting list to determine who is eligible for a voucher preference under CHA Administrative Plan; CHA has executed Protective Orders and the State is preparing class lists in format to protect privacy of class members and will submit to CHA shortly for list comparisons.</p> <p>2. State in ongoing discussions with CHA regarding additional Voucher commitments consistent with HUD notices, and commitment of Project Based Rental Assistance ("PRA") under State preference in CHA Administrative Plan.</p>

	<p>3. CHA providing PRA in support of Home First Illinois acquisition of accessible units with proceeds from Build Illinois Bond Program; for Thresholds scattered site initiative and for the Diplomat Hotel under IHDA PSH Demonstration Program.</p> <p>4. State in ongoing discussions with Housing Authority of Cook County to negotiate a Demonstration Program for an allocation of Housing Choice Vouchers and public housing units for Money Follows the Person and Consent Decree Class Members.</p> <p>5. State has received list from HUD of hard unit vacancies in public housing authorities in State if Illinois and is following up with each PHA with vacancies to determine if units that are vacant may be viable opportunities for MFP Participants and Consent Decree Class members.</p> <p>6. IHDA has received a commitment of 50 Housing Choice Vouchers and 30 Public Housing Units from Rockford Housing Authority for Consent Decree members and MFP enrollees;</p>		
	<p>1. Original RHSP Authorizing Statute precludes preference for persons with disabilities</p> <p>2. At Governor’s and IHDA’s request the Illinois Legislature adopted HR 5450 in 2012 Legislative Session which authorizes IHDA to grant a preference for persons with disabilities under the RHSP program. The Governor has expressed his commitment to sign this bill. Once legislation is signed IHDA is planning a new round of RHSP.</p>	<p>IHDA Receives \$10 per recorded document to fund RHSP</p>	<p>3. Rental Housing Support Program (RHSP)</p>
	<p>TBD Based on Next Funding Round and \$\$ available per funding source</p>	<p>City receives \$10 per recorded document in City of Chicago</p>	<p>4. City of Chicago Low Income Housing Trust Fund</p>
	<p>TBD Based on Next Funding Round and \$\$ available per funding source</p>	<p>City receives \$10 per recorded document in City of Chicago</p>	<p>1. Need for Discussion with City on Availability of funding for PSH; meeting scheduled with City of Chicago Department of Housing and Economic Development in August, 2012.</p>

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<p>5. Bridge Subsidy Program (“BSP”)</p>	<p>Provides rental subsidy to allow extremely low income tenants to pay 30% of income in rent</p>	<p>Division of Mental Health receives funding from Hospital Lockbox and GRF per Governor’s FY 13 Budget</p>	<p>700 units currently subsidized under BSP; program is expanding to provide housing subsidy for Williams and Colbert class members</p>	<ol style="list-style-type: none"> 1. Current BSP administered for the State by Catholic Charities for persons with Mental Illness 2. Program model can be replicated for Colbert Class 3. Program has reputation for efficiency and excellent administration/payment cycles and inspection protocol 4. Out of 700 Bridge Subsidies to date only five evictions 5. Transition Coordinators experienced in use of BSP to house persons with disabilities; State Housing Coordinators and Divisions are working to expand the supply of landlords accepting BSP 6. Caseworker Portal on Illinois Housing Search housing search engine provides supportive service providers with access to database of landlords who have expressed a specific preference to house persons with disabilities
<p>6. Public Housing Authority Waiting List Preferences for Housing Choice Voucher Program for MFP enrollees</p>	<p>Provides rental subsidy to allow tenants to pay 30% of income in rent</p>	<p>HUD PIH Notice 12-31 issued June 29, 2012 encompasses a wide variety of HUD policy to encourage PHA’s to prioritize rental resources for Olmstead class members, including specific guidance that PHA’s may establish “Olmstead” waiting lists separate and distinct from their existing waiting lists</p>	<p>TBD</p>	<ol style="list-style-type: none"> 1. PHA’s have authority to grant preference on waiting lists to MFP Enrollees and Olmstead class members; 2. See paragraph 2 above for further detail on State actions in this area; 3. State invited to present on Consent Decrees and housing needs to Illinois Association of Public Housing Authorities in September, 2012; 4. HUD has offered to reach out to PHA’s to encourage their participation in Olmstead compliance initiatives

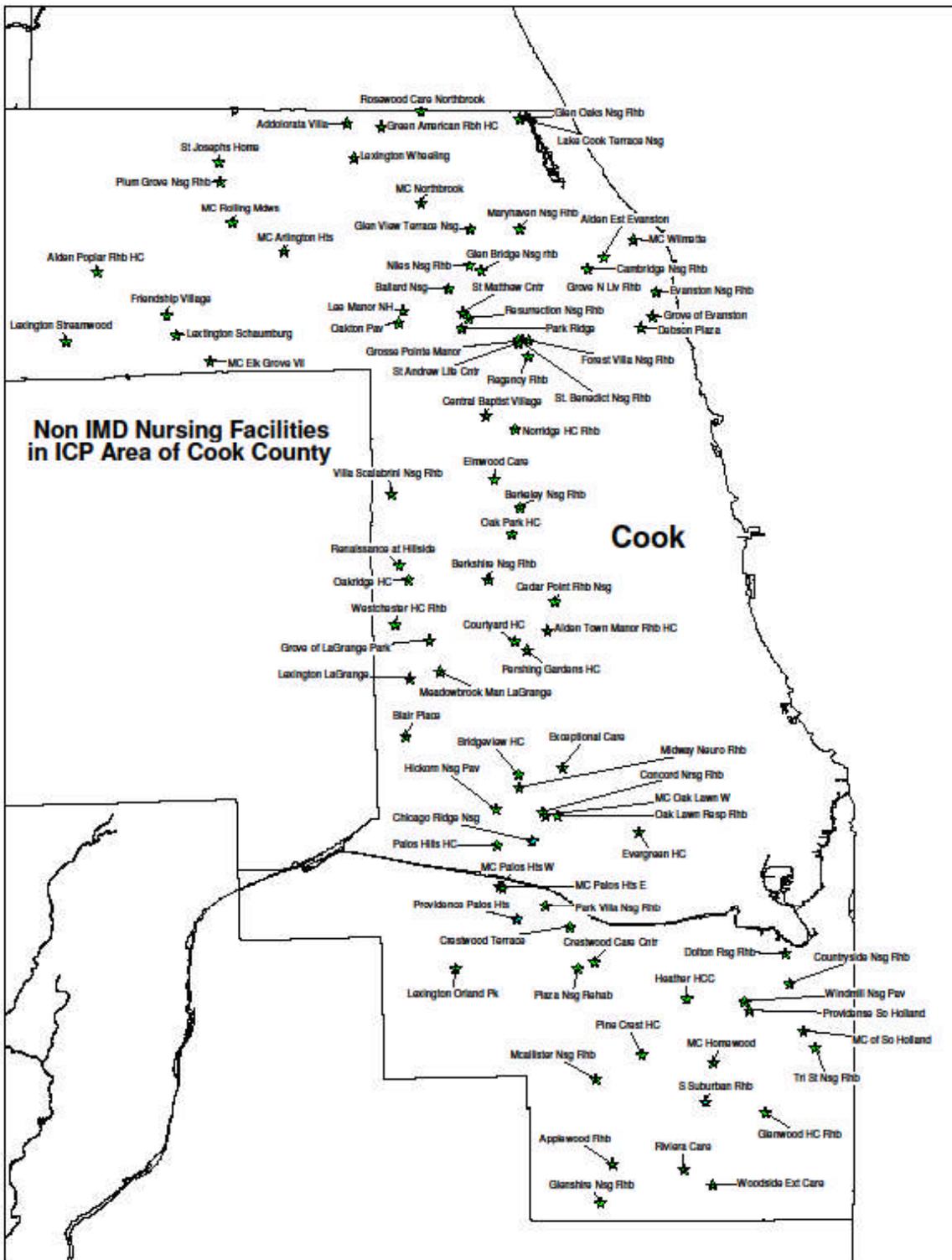
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<p>7. Non Elderly Disabled Housing Choice Vouchers</p>	<p>Provides Rental Subsidy to allow tenants to pay 30% of Income in Rent and PHA pays difference up to Fair Market Rent</p>	<p>HUD award to PHA's</p>	<p>Under NED 1 Illinois has 445 NED 1 Vouchers allocated to 6 PHA's that are in place and can be utilized for non elderly disabled households on voucher turnover; Under NED 2 Illinois received 25 NED 2 Vouchers; 15 to the Oak Park PHA and 10 to the Springfield PHA that are currently in lease up</p>	<p>Must lobby HUD/Congress for continued annual allocation of NED Vouchers</p>
<p>8. Project Based Rental Assistance Program(PRA)</p>	<p>Provides 15 year Rental Subsidy contract for up to 25% of units for PSH in a market project or 100% PSH for developments that serve a 100% PSH tenant population</p>	<p>PHA Award to Developers on rolling application basis</p>	<p>CHA has 2500-3000 PRA units for both PSH and non PSH developments; Housing Authority of Cook County has approximately 260 PRA units</p>	<p>State in dialogue with PHA's regarding set aside of percentage of PRA units for MFP enrollees or Consent Decree Class members</p>
<p>9. HUD Section 811 Project Rental Assistance Program</p>	<p>Allows State agencies to apply for rental assistance for a 20 year term to allocate non elderly disabled households with preferences for members of Olmstead classes; Authorized by Frank Melville Act to reform Section 811 as a community integrated program</p>	<p>HUD, Administration by IHDA</p>	<p>Maximum of \$12 million per state; maximum for Illinois approximately 400 units</p>	<p>1. NOFA released May 15, 2012 with response date July 31, 2012 2. \$85 million to be divided between 9-16 successful applicants 3. NOFA grants scoring preferences to States that have entered Consent Decrees to address the Olmstead case 4. NOFA Grants scoring preference to States that obtain commitments from PHA's for Housing Choice Vouchers or public housing units as leverage to increase the supply of assisted housing for persons with disabilities</p>

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<p>5. Must be under 62 to initially qualify for assistance but participants may age in place under the program beyond the age of 62 and so applications demonstrating strong programs for independent elderly households will be highly competitive;</p>			
<p>1. \$27 million allocated to finance 180 units under Demonstration Program in 2011 including HomeFirst Illinois/Access Living Initiative; funding for Thresholds scattered site initiative and other PSH initiatives; With 2012 funding round PSH is receiving 54% of \$130 million in total commitment of Build Illinois Bonds for Affordable Housing under the State Capital Authorization; 2. IHDA is planning an additional PSH funding round opening before the fall of 2012.</p>	<p>\$30million in bonds in disabled/Veteran set aside have been allocated as first funds from capital bonds for housing in history of Illinois; \$40 million in additional bond proceeds to be provided as part of a PSH Request for Applications by Fall, 2012</p>	<p>Governor's Office Allocation to IHDA</p>	<p>10. Build Illinois Bond Program Provides Capital Grants for construction/rehab of PSH</p>

19.4. Non IMD Nursing Homes in ICP – Potential Sites for First Phase of Class Member Assessments



19.5. Acronyms and Abbreviations

Coordinated Care Entity (CCE): A CCE is a collaboration of providers and community agencies, government by a lead entity that receives a care coordination payment in order to provide care coordination services for its enrollees.

Integrated Care Program (ICP): The program under which HFS contracted with HMOs to provide the full spectrum of Medicaid covered services through a risk-based integrated care delivery system to seniors and adults with disabilities who are eligible for Medicaid but are not eligible for Medicare.

Illinois Client Enrollment Broker (ICEB): The entity contracted by HFS to conduct enrollment activities for potential enrollees, including providing impartial education on health care delivery choices, ICPs, CCEs, MCCNs and all other managed care entities that may become available, providing enrollment materials assisting with the selection of a PCP and CCE or MCCN, and processing request to change CCEs or MCCNs.

Managed Care Entity (MCE): MCE is the term referring to any number of options that is currently or planned to be offered to a Medicaid beneficiary in Illinois. MCEs include Integrated Care Program (ICPs), Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs), and the Medicare and Medicaid Alignment Initiative, including the care coordination provided by these organizations. All Colbert Class Members will either currently be in a MCE or be enrolled in a MCE.

Managed Care Community Network (MCCN): A MCCN is an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with HFS exclusively to persons participating in programs administered by HFS.

20. References

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