Williams v. Pritzker

Case No. 05-C4673 (N.D. Ill.)

Court Monitor FY2022 Compliance Assessment
Annual Report to the Court

Kathryn du Pree
Court Monitor

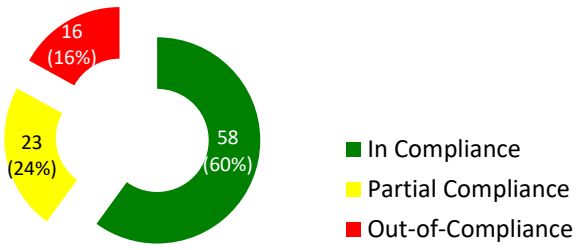
January 4, 2023

Table of Contents

Executive Summary

This report provides Judge Joan Lefkow, Senior United States District Judge, Northern District of Illinois, and the *Williams* Consent Decree Parties with the Court Monitor's detailed assessment of the Defendants' fiscal year 2022 (FY22) compliance under *Williams* v. Pritzker (Case No. 05 C 4673). Within this report, the Court Monitor endeavors to provide the Court and others with a fair and neutral assessment of the Defendants' performance relative to 120 compliance requirements contained in the *Williams* Consent Decree and the FY22 Implementation Plan. This is the first annual report to the Court produced by Ms. Kathryn du Pree, appointed on August 1, 2022.

Figure 1. Defendants' FY22 Compliance with *Williams* Consent Decree and Implementation Plan Requirements
Total Requirements = 97



There were 120 requirements in the *Williams* Consent Decree and *Williams* FY22 Implementation Plan. However, only 97 were applicable for compliance assessment. As displayed in Figure 1, 58 (60%) were found in compliance, 23 (24%) were found in partial compliance, and 16 (16%) were found out-of-compliance.

While this report covers the FY22 compliance period, it provides compliance assessment ratings for FY18-FY21, to allow readers to compare, make judgments, and assess trends relative to the four prior years of compliance data and performance ratings. Figure 2 provides a comparison of compliance assessment ratings – only for those Consent Decree requirements which remained constant throughout FY18-FY22. Figure 3 illustrates the FY22 compliance determinations for each domain (for both Consent Decree and FY22 Implementation Plan requirements), aggregated to the number of requirements falling within each compliance category. This report contains a dedicated section for each of the compliance domains listed below and includes the Court Monitor's rationale for each rating.

Figure 2. Comparison of Compliance Ratings for *Williams* Consent Decree Requirements Only: FY18-FY22

Compliance Rating	*FY18*	*FY19*	*FY20*	*FY21*	*FY22*
In Compliance	22%	26%	36%	40%	55%
Partial Compliance	10%	20%	21%	15%	28%
Out-of-Compliance	58%	54%	43%	40%	15%

Figure 3. Synopsis: FY22 Compliance Ratings for *Williams* Decree & Implementation Plan Requirements

Diversion Requirements (Total=12)	In Compliance	6	Partial Compliance	5	Out-of-Compliance	1
Outreach Requirements (Total=13 with 3 N/A)	In Compliance	5	Partial Compliance	2	Out-of- Compliance	3
Assessment Requirements (Total=10 with 3 N/A)	In Compliance	2	Partial Compliance	2	Out-of- Compliance	3
Service Plan Requirements (Total=16 with 2 N/A)	In Compliance	3	Partial Compliance	8	Out-of- Compliance	3

Transition Requirements (Total=32 with 12 N/A)	In Compliance	12	Partial Compliance	3	Out-of-Compliance	5
Community-Based Services/Housing Requirements (Total=8)	In Compliance	4	Partial Compliance	3	Out-of- Compliance	1
Administrative Requirements (Total=15 with 2 N/A)	In Compliance	13	Partial Compliance	0	Out-of-Compliance	0
Implementation Plan Requirements (Total=14 with 1 N/A)	In Compliance	13	Partial Compliance	0	Out-of-Compliance	0
Total Requirements (120) (N/A=23, applicable=97)	In Compliance	58	Partial Compliance	23	Out-of-Compliance	16
FY22 Performance	In Compliance	60%	Partial Compliance	24%	Out-of-Compliance	16%

At the time of this report's submission, it has been over 12 years since the filing of the *Williams* Consent Decree (filed September 2010). In FY22, the Defendants demonstrated arguably one of its strongest years since the inception of the Decree with strong transition performance (achieving 90% of required transitions), implementation of a redesigned Preadmission Screening and Resident Review (PASRR) and Specialized Mental Health Rehabilitation Facility (SMHRF) pre-admission process, effective hospital-based diversion programming, a greater proportion of in-compliance ratings across Consent Decree and Implementation Plan requirements relative to previous years, among other successes. However, significant challenges persist, and the Court Monitor offers several recommendations centered on three areas (see Section XI):

- Continued implementation and quality assurance of SMHRF pre-admission and hospital-based diversion programming.
- Remediation of issues that delay, or altogether prevent, Class Members from timely progression through pre-transition steps and processes (e.g., assessment, service planning, housing location), with special focus on Class Members who have been stuck in the transition pipeline the longest.
- Increased community-based services and housing capacity, including managed care organizations' direct provision of transition support and community-based services, to transition and serve increased numbers of Class Members in the community.

The Pritzker administration has an important duty to design and administer systems that support Class Members' self-direction, choice, and ability to live in the community. This report provides specific recommendations for the Defendants' consideration to achieve or enhance compliance and advance Class Members' civil rights, while facilitating their full participation in, contribution to, and, in fact, enrichment of community life.

Kathryn du Pree, *Williams* v. Pritzker Court Monitor
December 29, 2022

Section I. Introduction

This report presents the Court Monitor's assessment ratings and relevant discussions of the Defendants' compliance under *Williams* v. Pritzker (Case No. 05 C 4673; United States District Court for the Northern District of Illinois – Eastern Division) based on the assessment period of fiscal year 2022 (FY22) The report's bases for compliance assessment include the original *Williams* Consent Decree requirements and commitments made by the Defendants via the *Williams* FY22 Implementation Plan, which are enforceable as requirements pursuant to the *Williams* Consent Decree. This report is issued in fulfillment of the Consent Decree's requirement for the Court Monitor to, "within 60 days after the end of each year of service…report to the Court and the Parties regarding noncompliance with the Decree." Per the Consent Decree, "such reports shall include the information necessary, in the Monitor's professional judgment, for the Court and the Plaintiffs to evaluate Defendants' compliance or non-compliance with the terms of the Decree." This represents the first *Williams* compliance assessment report to the Court from Ms. Kathryn du Pree, appointed as Court Monitor by Judge Lefkow on August 1, 2022.

Compliance Assessment Period. The period subject to compliance assessment in this report is July 1, 2021, to June 30, 2022, otherwise referred to as fiscal year 2022, or FY22. Other significant developments that occurred prior or after that timeframe are mentioned when deemed relevant to readers' understanding of context, trends, and the like. Additional background/history of the *Williams* Consent Decree is in Appendix A.

FY22 Requirements. The *Williams* Consent Decree and FY22 Implementation Plan contain 120 specific numeric-, process-, and quality-related requirements of the Defendants that focus on designing, developing, and implementing a program that facilitates and operationalizes opportunities for eligible Class Members to re-enter the community from residing in the 23[1] Specialized Mental Health Rehabilitation Facilities (SMHRFs). Out of the 120 total requirements, 97 were assessed for the FY22 reporting period, subtracting duplicated requirements, original Consent Decree requirements which apply to previous reporting periods, and requirements on the Court Monitor and Plaintiffs' Counsel. These requirements span multiple domains of the Defendants' obligations pursuant to the *Williams* Consent Decree, including diversion, outreach, assessment, service planning, transition support, expansion or development of community-based housing and services, implementation planning, and administrative support (see graphic below). Two additional Consent Decree requirements focus on Court Monitor duties and the Parties and Court Monitor's involvement in various planning and reporting aspects.

Of the 97 requirements that apply to FY22, 58 (60%) are in compliance, 22 (24%) are in partial compliance, and 16 (16%) are out-of-compliance.

Structure of Report. Within each domain, the requirements specific to that domain from the

[1] At the beginning of FY22, there were 23 SMHRFs. Due to a SMHRF closure in Spring 2022, there were 22 SMHRFs at the end of FY22.

Consent Decree and FY22 Implementation Plan are identified. As shown in the graphic below, the first five sections of the report align with the chronological sequence of a Class Member's touch points with Consent Decree processes (e.g., diversion, outreach, assessment, service planning, transition), followed by three additional sections: services and housing capacity development, administrative support, and implementation planning. Given that the report's sections are organized in this fashion, the order of the requirements in this report do not reflect the order of the requirements as they appear in source documents (i.e., Consent Decree, Implementation Plan).

Each of the domain-specific sections herein include the following components:

1. A description of the domain and how it relates to overall Consent Decree compliance.
2. A data highlights section that provides a brief synopsis of relevant data and information for the given domain.
3. A table that provides the text of each Consent Decree and Implementation Plan requirement, the Court Monitor's determination of whether the Defendants (or others, when relevant) achieved compliance with each requirement during FY22, and data/information that led the Court Monitor to make that determination. Each compliance criterion correlates to the Consent Decree or Implementation Plan. The grid also includes FY18-FY21 ratings to provide a comparison to prior years.

Compliance Assessment Approach. For this report's purposes, one of three determinations was assigned to each requirement applicable to the FY22 compliance assessment period. Consent Decree language or provisions that do not apply to the reporting period, reflect Court Monitor or Plaintiffs' Class Counsel obligations, or represent repeat language are coded as such. Figure 4 displays the compliance assessment determination categories and their definition of use.

Some requirements under the *Williams* Consent Decree are clearly numeric/quantitative in nature, while others require the Court Monitor's evaluation and compliance determination based on the best available data and the Court Monitor's professional judgment. In both circumstances, data and information are provided, with source citation, to support or justify the Court Monitor's compliance assessment determinations.

Figure 4. Court Monitor Compliance Assessment Rating Categories and Definitions

Compliance Assessment Rating Category	*Definition*	*Legend*
In Compliance	The Defendants' performance was substantially in accordance with the criterion, requirement, or obligation.	Green
Partial Compliance	The Defendants met some aspects, but not other aspects, of the criterion, requirement, or obligation. For numeric requirements, the Court Monitor generally assigned this rating in instances where the Defendants achieved more than 50 percent compliance balanced with whether the Defendants had a system or process in place relative to the specific requirement.	Yellow
Out-of-Compliance	The Defendants either failed to comply with the requirement or failed to demonstrate compliance with the standard. In instances in which the Defendants have been on notice for multiple years of partial compliance and have taken no or too few steps to come into compliance, those ratings may have shifted to out-of-compliance.	Red
Other Categories		
N/A	The Defendants were not required to demonstrate compliance, as the requirement is applicable only before or after the FY22 assessment period.	
Court Monitor Requirement	Requirements reflect the Court Monitor's obligations.	
Duplicate Requirement	Requirements have already been represented and rated (either separately or with other requirements) and double counting would skew the overall compliance determination; in some cases, these requirements represent the overall purpose of a section of the Consent Decree.	

In the FY22 Implementation Plan, the Defendants developed a set of with multiple metrics and "expected improvement[s]/outcome[s]" that fall under each strategy. Given that several strategies had multiple "expected improvements/outcomes," it was difficult to assign a unified rating at the strategy-level. As such, this Court Monitor elected to rate each "expected improvement/outcome" separately. Thus, the total count of requirements for FY22 includes the original Consent Decree requirements and all expected improvements/outcomes from the FY22 Implementation Plan.

Multi-Year Glance. As indicated above, each section provides comparative data ranging back to FY18 to provide a multi-year look at compliance for all Consent Decree requirements, but other multi-year information – including required vs. achieved transitions, year-over-year reduction in Class size, spent vs. lapsed budget appropriations, and diversion programming – provide important context as to the progress of the Decree overall.

Figure 5. *Williams* Transitions: FY2012-FY2022

FY	*Transitions Required*	*Transitions Achieved in FY*	*Performance %*
2012	256	263[2]	103%
2013	384	354	92%
2014	423	321	76%
2015	390	374	96%
2016	400	374	94%
2017	400	377	94%
2018	400	315	79%
2019	400	256	64%
2020	400	170	43%
2021	N/A	180	N/A
2022	400	358	90%
Total	*3,853*	*3,195*	*83%*

Achieved vs. Required Transitions. Figure 5 depicts the number of required vs. achieved Court-required transitions since the Consent Decree's initial implementation. Between FY12 and FY22, 3,195 Class Members were transitioned, with the

[2]147 transitions were removed from this count, as they reflected the double-counting of Class Members who signed more than one lease (DMH data from August 15, 2018).

Defendants exceeding transition requirements in only one out of the 11 years of *Williams* implementation. For this report's compliance period, FY22, the Defendants transitioned 358 Class Members, out of the 400 that were required, achieving the highest percentage of actual transitions compared to the target since 2017.

Williams Class Size. One can also look at the total number of residents in SMHRFs ("SMHRF census") to understand whether Consent Decree efforts of diversion and transition are reducing the number of Class Members residing in SMHRFs overall. The Defendants have historically used this figure to reflect one sub-component of the *Williams* Class,[3] given that most if not all SMHRF residents likely meet the Class definition. Figure 6 provides data on the total number of residents across all SMHRFs between FY12 and FY22, generally calculated on the last day of the prior fiscal year or first day of the new fiscal year. The figure also includes the percentage year-to-year change and the percentage of transitioned Class Members compared to SMHRF census. This data reflects a decrease of 761 residents (18.6%) since FY12. In FY12, there were approximately 170 residents per facility (24 facilities total). In FY22, there was an average of 144 residents per facility (23 facilities total),[4] demonstrating a slight downward trend. For the compliance period, HFS data indicates a SMHRF census total of 3,330 residents (reported as of the first day of FY22). As mentioned above, one sub-component in the *Williams* Class is the SMHRF census. The second subgroup involves the number of Class Members transitioned into the community through the *Williams* program. The Court Monitor and Defendants aggregated a figure for completed transitions since the Consent Decree's inception. As indicated in Figure 6 below, at the FY22 assessment period's conclusion and since FY12 began, the Defendants transitioned 3,195 Class Members.

Figure 6. FY12-FY22 SMHRF Census and Number and Percentage of Class Members Transitioned by Year

FY	*SMHRF Census*	*Year-to-Year % Change (Facility Census Only)*	*# of Transitioned Class Members*	*% of Transitioned Class Members in SMHRF Census*
2012	4091	(baseline)	263	6.4%
2013	4059	-0.8%	354	8.7%
2014	3854	-5.1%	321	8.3%
2015	3835	-0.5%	374	9.8%
2016	3782	-1.4%	374	9.9%
2017	3794	+0.3%	377	9.9%
2018	3815	+0.5%	315	8.3%
2019	3781	-0.9%	256	6.8%
2020	3583	-5.5%	170	4.7%
2021	3484	-2.8%	180	5.2%
2022	3330	-4.4%	358	10.8%

Allocated vs. Spent Budget Appropriations. In FY22, the *Williams* program was allocated a $62.8 million budget to cover staff costs, contractors (e.g., organizations that provide outreach, assessment, and transition services), quality improvement support, and other key program activities. Notably, this budget does not include costs for mainstream resources that — while available to and used by some *Williams* Class Members — are not exclusively developed or designated for them such as some Medicaid spending, housing subsidies, community-based behavioral health services, primary healthcare, and housing services developed or paid for outside of Consent Decree implementation activities.

[3] The Class also includes individuals who have transitioned into the community since the beginning of the Decree.
[4] There were 24 SMHRFs originally, but Monroe Pavilion closed in November 2018. There were 23 SMHRFs at the beginning of FY22. Toward the end of FY22, another SMHRF, Belmont Crossing, closed.

As shown in Figure 7, across the past five fiscal years, the Defendants allowed significant amounts of appropriated funds to lapse. However, in FY22, Defendants' lapsed appropriation was $6.7 million, representing improvement over previous years. It is critical that the Defendants optimize their funds – particularly given under-performance with transition requirements – to support compliance in myriad areas, ranging from investing in the development of additional community-based services and housing, increasing provider staffing and wages, or to improving their data enterprise.

Figure 7. Fiscal Year Budget Allocations, Actual Expenditures, and Lapsed Appropriations (FY18-FY22)[15] and Concurrent Transition Performance

Fiscal Year	Transition Performance %	Budget Allocation	Spent Funds	Lapsed Funds
FY18	79%	$44.7 million	$37.8 million	$6.9 million (15%)
FY19	64%	$44.8 million	$32.9 million	$11.9 million (27%)
FY20	43%	$49 million[16]	$39.7 million	$9.3 million (19%)
FY21	N/A	$60.3 million[17]	$47.5 million	$12.8 million (21%)
FY22	90%	$62.8 million	$56.1 million	$6.7 million (11%)
Total Lapsed Appropriation FY18-FY22				**$47.6 million**

Diversion and Pre-Admission Screening and Resident Review (PASRR). While many Consent Decree initiatives focus on transitioning Class Members from institutions into the community, true systems rebalancing hinges upon stemming the tide of needless admissions into such facilities. Accordingly, the Consent Decree is clear that admissions to SMHRFs should be limited to those who require that level of care or elect to go there. The Consent Decree also requires that Class Members are only admitted when SMHRFs can deliver the services specified in their pre-admission service plans. Preventing needless admissions was to be effectuated through two Consent Decree requirements: one focused on the redesign and enhancement of the PASRR process (due in 2012) and one focused on preventing individuals who could be served in the community from needless admission unless they prefer SMHRF admission (due in 2016). As described in Section II, after nearly a decade of non-compliance, the Defendants have implemented a new SMHRF pre-admission process designed to address the spirit of these requirements.

Further, in acknowledgement that most SMHRF admissions derive from acute care hospital psychiatric units, the Defendants, since 2016, have operated diversion programming in hospitals ("Front Door Diversion Program" or FDDP). In FY22, after a range of COVID-related barriers, FDDP was operational at 46 hospitals. Additional service expansions are planned in FY23. However, it remains unclear whether FDDP, in concert with the redesigned SMHRF pre-admission process, is preventing all individuals appropriate for community-based services who want to live in the community from admission to SMHRFs; however, it is notable that such programming is now in place.

Section II. Diversion

The *Williams* Decree includes requirements that, if implemented, would significantly restrict

the flow of needless admissions to Specialized Mental Health Rehabilitation Facilities (SMHRFs), limiting admissions to those who presently cannot successfully be served outside of a long-term care setting or choose to live in such settings.

The Consent Decree mandated a redesigned Preadmission Screening and Resident Review (PASRR) process, due within one year of the initial Implementation Plan (June 2012). PASRR was to include an enhanced service planning process to assess an individual's appropriateness for community-based services, describe the types and duration of services needed, and – for those ultimately referred to SMHRFs - ensure that the SMHRF can deliver the services specified in the service plan. The Consent Decree then provided the Defendants with four additional years (until June 2016) to ensure sufficient capacity such that no Class Member identified for community-based services at the PASRR stage is needlessly institutionalized unless – after fully informed consent – he or she elects to live in long-term care. In addition to these two original Consent Decree requirements, the FY22 Implementation Plan included 10 more requirements, centered on contracting with a new PASRR vendor, strengthening coordination between new PASRR processes and existing diversion programming, developing new PASRR processes that ensure accuracy and efficiency, and making improvements to the diversion program to overcome barriers to engagement, among others.

While the Consent Decree identifies PASRR as the mechanism to divert appropriate individuals from *Williams* facilities, PASRR generally applies to nursing facility admissions. As of the implementation of the SMHRF Act of 2013, SMHRFs are no longer designated as nursing facilities. As such, the Defendants, in partnership with their PASRR vendor, redesigned the PASRR system for nursing facilities and created an aligned alternative process that encompasses diversion and admission guidelines for SMHRFs. This required them to develop new screening tools, process/policy guidance, workflows, and training.

Diversion Data Highlights. This section summarizes the Defendants' FY22 diversion data provided in their semi-annual reports.

- The Front Door Diversion Program (FDDP) was operational at 46 hospitals, with 854 engagements and 602 assessments. 341 individuals were ultimately diverted.
- The Rapid Reintegration Program, designed to engage recently admitted Class Members to intercept them before they become eligible for outreach, had 252 Class Member engagements and 143 assessments. 17 Class Members were ultimately re-integrated.

Diversion-Related Requirements and Compliance Ratings. Below (in Figure 8), please find the specific requirements in this domain. Across the 12 Consent Decree and FY22 Implementation Plan requirements, **six (6) are in compliance, five (5) are in partial compliance, and one (1) is out of compliance.**

Figure 8. FY18 to FY22 Compliance Assessment Ratings for Diversion-Related *Williams* Consent Decree Requirements and FY22 Implementation Plan Requirements
Diversion-Related Requirements

Req #	Source/ Citation	*Williams* Consent Decree Requirement Language and FY22 Performance	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
1	*Williams* Consent Decree VI(8)(B)	Within one (1) year of finalization of the Implementation Plan [2012][5], no individual with Mental Illness shall be admitted to an IMD without a prescreening having first been conducted through the PASRR Process and an initial Service Plan completed. Defendants will ensure that the PASRR Process: identifies and assesses individuals who may be appropriate for placement in a Community-Based setting; identifies Community-Based Services that would facilitate that placement; and ensures that approved admissions to IMDs are only for those IMDs that can provide treatment consistent with the individual's initial Service Plan and consistent with the goal of transition to a Community-Based Setting. ***Partial Compliance.*** In April 2022, the Defendants implemented a PASRR-aligned SMHRF pre-admission assessment and referral process. Full compliance cannot be assigned because this process was not in place for the full year and because the Defendants did not provide data on the proportion of admitted Class Members that received such pre-screening. However, the Defendants are credited with partial compliance given that the process was established.[6]	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
2	*Williams* Consent Decree VI(8)(B)	After the first five (5) years following the finalization of the Implementation Plan [2016[7]], no individual with Mental Illness whose Service Plan provides for placement in Community-Based settings shall be housed or offered placement in an IMD at public expense unless, after being fully informed, he or she declines the opportunity to receive services in a Community-Based Setting. ***Partial Compliance.*** The Defendants made significant efforts in design and implementation of the PASRR-aligned SMHRF pre-screening process and continued implementation of the Front Door Diversion Program. However, they did not provide data to prove that SMHRF admissions were limited to those whose service plans dictated SMHRF placement or who were offered but declined community-based services.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**

[5] Date added.
[6] In their review of a draft version of this report, the Defendants indicated that, "moving forward, the proportion of admitted Class Members that receive a preadmission assessment is expected to be 100%."
[7] Date added.

FD-1 (1)	FY22 IP	Strategy: Implement redesign of PASRR Plus system including pre-admission screening specifically for SMHRF admissions and referral to Front Door as appropriate. Within 9 months after contract start date, go live with new PASRR and SMHRF prescreening system and processes, including QA mechanism(s). Expected Improvements/Outcomes: ● Compliance with federal PASRR requirements as established by Centers for Medicare and Medicaid Services. ***In Compliance***. Defendants executed a contract with a vendor (Maximus) to implement a redesigned system that is compliant with federal PASRR requirements as established by Centers for Medicare and Medicaid Services.	**N/A**	**N/A**	**In Compliance**
FD-1 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● Coordination between SMHRF pre-screening activities and Front Door Diversion Program (FDDP) referrals. ***In Compliance.*** Defendants launched a redesigned system that improves coordination between SMHRF pre-screening activities and Front Door Diversion Program (FDDP) referrals. This new system went live on 3/14/22.	**N/A**	**N/A**	**In Compliance**
FD-1 (3)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 90% of PASRR Plus screens result in clinically accurate and appropriate determinations. ***Partial Compliance***. The Defendants Indicate that 87.5% of assessment were found to be clinically appropriate, through a rigorous quality assurance process.	**N/A**	**N/A**	**Partial Compliance**
FD-2 (1)	FY22 IP	Strategy: With input and advice from Court Monitor and Plaintiffs' Counsel, design and implement a new SMHRF pre-admission screening process that coordinates with FDDP. Expected Improvements/Outcomes: ● New SMHRF preadmission screening process established within 4 months of PASRR Plus contract start date. ***In Compliance.*** The new SMHRF pre-admission assessment and referral process linking the two programs went live on 4/18/22.	**N/A**	**N/A**	**In Compliance**

FD-2 (2)	FY22 IP	Strategy: Complete FY21 plan by revisiting policy on FDDP eligibility requirements, including reviewing data from FY21 regarding Medicaid eligibility and ineligibility of FDDP participants. Expected Improvements/Outcomes: ● DHS will provide data and convene Parties and Court Monitor for discussion by 12/31/21. ***In Compliance.*** FDDP Medicaid Eligibility Analysis Report was sent to Parties and Monitor on 12/30/21. Meeting was convened on 1/21/22.	**N/A**	**N/A**	**In Compliance**
FD-2 (3)(1)	FY22 IP	Strategy: Implement new Front Door Diversion Program on 7/1/2021; ensure individuals with recommended community options are offered FDD. Expected Improvements/Outcomes: ● 85% of individuals determined to have met SMHRF admission standards who are appropriate for Community-Based Services are provided with a meaningful offer of Community-Based Services/Housing prior to SMHRF admission. ***Out-of-Compliance.*** Following the 4/22 launch of the new pre-screening system, 23% of those meeting SMHRF admissions criteria and appropriate for Community-Based Services were provided a meaningful offer.	**N/A**	**N/A**	**Out-of-Compliance**
FD-2 (3)(2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 85% of those who accept offer of Community-Based Services/Housing receive Community-Based Services/Housing. ***In Compliance.*** In FY22, 95% (358/375) of those who accepted an offer of Community-Based Services/Housing received services/housing (i.e., were diverted) in the reporting period.	**N/A**	**N/A**	**In Compliance**

FD-3 (1)	FY22 IP	Strategy: Implement and monitor effectiveness of new FDDP data management system and quality review, and report to Parties and Court Monitor on an ongoing basis (including through Data Dashboards and Semi-Annual Reports). Expected Improvements/Outcomes: ● 90% of FDDP Community-Based offers include identification of specific services and housing options (as needed) and Consent Decree-related data is tracked. ***In Compliance.*** In FY22, 91% of offers met criteria for a meaningful offer.	**N/A**	**N/A**	**In Compliance**
FD-3 (2)	FY22 IP	Strategy: IDHS will track and report to the Parties and Court Monitor the outcomes of individuals screened and referred to FDDP, but who do not enter into FDDP services. Expected Improvements/Outcomes: ● IDHS will address any identified barriers that may impact entry into FDDP services. ***Partial Compliance.*** In FY22, 57% of eligible FDDP referrals were engaged.[8]	**N/A**	**N/A**	**Partial Compliance**
FD-3 (3)	FY22 IP	Strategy: IDHS will conduct ongoing analysis of reasons why individuals reject the FDDP offer. Expected Improvements/Outcomes: ● IDHS will address any identified barriers that may impact entry into FDDP services. ***Partial Compliance.*** In FY22, 75% of meaningful FDDP offers were accepted.[9]	**N/A**	**N/A**	**Partial Compliance**

[8] While this outcome/objective is general ("address identified barriers"), the metric associated with the expected improvement/outcome in the FY22 Implementation Plan is much more specific: the percentage of eligible FDDP referrals who were engaged in the FDDP program. That is why the data provided to justify the partial compliance rating does not appear to match the language in the expected improvement/outcome.

[9] While this outcome/objective is general ("address identified barriers"), the metric associated with the expected improvement/outcome in the FY22 Implementation Plan is much more specific: the percentage of meaningful offers to participate in the FDDP program that were accepted by individuals. That is why the data provided to justify the partial compliance rating does not appear to match the language in the expected improvement/outcome.

Section III. Outreach

The Consent Decree mandates that all Class Members receive outreach. The objectives of outreach are to effectively and with appropriate frequency help Class Members understand their rights and responsibilities under the Consent Decree, promote the availability of community-based supports and services, navigate any concerns a Class Member has about the process or ultimate transition, and provide opportunities to observe community-based housing and services. Ultimately, the goal of outreach is to link interested Class Members with the opportunity to participate in an assessment to determine appropriateness for transition.

Each Specialized Mental Health Rehabilitation Facility (SMHRF) has an assigned Prime agency that conducts outreach within its facility. Prime agencies primarily utilize each SMHRF's resident census list to inform who should receive outreach, but they also accept referrals directly from SMHRF staff, NAMI ambassadors, and Class Members themselves. Per the Defendants' policy, each Class Member is required to receive an outreach attempt on a quarterly basis. Newly admitted Class Members must receive outreach within a 60–70-day window after admission.

Outreach-Related Requirements. There are four *Williams* Consent Decree requirements related to outreach. They obligate the Defendants to ensure that Class Members residing in SMHRFs receive comprehensive information about their rights to live in the community, as well as to provide detailed information on the types of community-based services and housing available to them. Further, the Defendants must protect Class Members from retaliation or infringement on their rights to explore community-based options. They must also bear the full cost of outreach. In addition to these four requirements, the Defendants are required, pursuant to their FY22 Implementation Plan, to comply with eight additional requirements focused on timely provision of initial outreach and outreach re-attempts, enhanced Peer Ambassador programming to deepen outreach engagement and increased measures to protect Class Members from retaliation, among others.

Outreach Data Highlights. This section summarizes the Defendants' FY22 outreach data, provided in their semi-annual reports.

- 1,976 Class Members were identified for outreach in FY22. These Class Members were either admitted to a SMHRF within the preceding 60-70 days, residing in the SMHRF with no record of previous outreach, due for quarterly outreach, or had requested outreach directly. 1,725 (87%) of Class Members identified for outreach were identified directly through Primes' access to facility census or their presence and direct engagement with Class Members in the facilities.
- Among the 1,976 Class Members identified for outreach, 1,585 (80%) were "able to be completed" outreach because they still residing in the SMHRF at the time of the outreach attempt. The remaining 391 (20%) had been discharged and/or transferred or had died.
- Among these 1,585 Class Members, 697 (44%) were identified as follow-up outreaches, 516 (33%) were initial outreaches to new admissions, and 372 (23%) were

initial outreaches to established admissions.

- Across all three categories of outreach, approximately three-quarters of outreach attempts were completed, resulting in 808 referrals for assessment.
- In terms of outreach timeliness, the Defendants reported that only 18% of initial outreach attempts (194/1092) were timely, although the Defendants assert that this data likely undercounts outreach activity and inflates the number of new admissions who should have received outreach (e.g., some may be readmissions after hospital stays who may have received outreach previously and thus not needed a new initial outreach). For these reasons, the denominator of 1092 does not align internally with other figures provided in their semi-annual reports. To address the lack of internal consistency and other issues, Section XI includes a recommendation to improve outreach data collection and reporting.
- The most common reasons for outreach refusals were "preference to remain in the facility," "lack of interest," and "Class Member refusal," collectively constituting 82% of all refusals.
- The 10 NAMI Ambassadors made 141 community visits and contacted 385 Class Members, engaging 283 of them. This means that on average, each Ambassador conducted 14 community visits and 28 Class Member engagements in the year.

The inadequacy of the Defendants' data renders it difficult to quantitatively assess whether all eligible Class Members are receiving outreach, whether Class Members receive outreach often enough to facilitate rapport and education about their options to live the community, and whether that outreach is of sufficient quality. Examples of potential data reliability issues and/or questions include:

- The Court Monitor questions whether the number of Class Members identified for outreach [1,976] is the accurate denominator representing who *should* receive outreach, given that 3,300 Class Members resided in SMHRFs at the beginning of FY22, and especially given that the 1,976 figure does not yet subtract Class Member discharges, transfers, and deaths.
- The data as currently presented provides no way to assess whether each Class Member received the required quarterly outreach attempts. While 687 Class Member were categorized as having receiving follow-up outreaches, this figure does not contemplate how many follow-up outreaches Class Members received.
- Much of the outreach data is process-oriented (e.g., collecting outreach attempts) instead of outcomes-oriented (e.g., completed outreach).

It is understood that every Class Member contact cannot (and perhaps should not) be captured, given that an effective outreach program should include unstructured and informal engagements that do not lend themselves to onerous data collection requirements. However, as described in Section XI, the Court Monitor believes that it is time to design an approach that is clear and outcomes-oriented, acknowledging the unquantifiable elements of an effective and organic outreach program.

Outreach-Related Requirements and Compliance Ratings. Below (in Figure 9), please find the specific requirements in this domain. Across the 13 Consent Decree and FY22

Implementation Plan requirements, 10 are assessed below (as three are duplicates). **Five (5) are in compliance, two (2) are in partial compliance, and three (3) are out of compliance.**

Figure 9. FY18-FY22 Compliance Assessment Ratings for *Williams* Outreach-Related Consent Decree and FY22 Implementation Plan Requirements

Req#	Source/ Citation	*Williams* Consent Decree Requirement Language and FY22 Performance	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
3	Consent Decree VII(10)	Defendants shall ensure that Class Members have the opportunity to receive complete and accurate information regarding their rights to live in Community-Based Settings and/or receive Community-Based Services, and the available options and opportunities for doing so. ***Out-of-Compliance.*** Class Members are identified for outreach through the following pathways: admitted into SMHRFs within the past 60-70 days, existing residents who have never been engaged in outreach, Class Members due for quarterly outreach, or Class Members who requested outreach proactively. The Defendants report that 42% of Class Members received an outreach attempt but as described in the section above, there is no data to demonstrate that individual Class Members received outreach on a quarterly basis.	**FY2018: N/A** **FY2019: N/A** **FY2020: In Compliance**	**Partial Compliance**	**Out-of-Compliance**
4	Consent Decree VI(6)(C)	Defendants shall ensure, as provided in the Implementation Plan, that all Class Members shall be informed about Community-Based Settings, including Permanent Supportive Housing, and Community-Based Services available to assist individuals in these settings, and the financial support Class Members may receive in these settings. ***Duplicate Requirement.*** The Court Monitor views Requirement 3 as the overarching requirement to assess whether Class Members received outreach. As such, this requirement is treated as a duplicate.	**FY2018: Partial Compliance** **FY2019: Partial Compliance** **FY2020: Partial Compliance**	**Out-of-Compliance**	**N/A, Duplicate Requirement**
5	Consent Decree VI(9)(C)	Class Members shall not be subjected to any form of retaliation in response to any option selected nor shall they be pressured to refrain from exploring appropriate alternatives to IMDs. ***Partial Compliance.*** The Defendants indicated that outreach workers and posters in SMHRFs are designed to educate Class Members on their rights and recourse for retaliation. SMHRF interference with the Consent Decree programming is reported to IDPH for investigation. Posters were displayed in 60% of SMHRFs and all five allegations of retaliation were investigated by IDPH.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
6	Consent Decree	All costs for outreach shall be borne by Defendants.	**FY2018: In Compliance**	**In Compliance**	**In Compliance**

	VII(10)	***In Compliance.*** The Defendants covered all outreach-related costs in FY22, as required by the Decree.	**FY2019: In Compliance** **FY2020: In Compliance**		
O-1	FY22 IP	Strategy: Use new data management system for tracking new and existing CMs to ensure and enforce provider contractual requirements regarding timely access to Outreach for 100% of CMs. Expected Improvements/Outcomes: • 85% of CMs both newly admitted and currently residing in facilities receive Outreach, including information on their rights to live in community, community-based settings, housing, and services, and financial support Class Members may receive in these settings, within 60-70 days of admission ("initial Outreach") and with appropriate frequency ("follow-up Outreach" for those not proceeding in Transition process), defined as one Outreach per quarter for those who are not proceeding to Transition. ***Out-of-Compliance.*** In FY22, the Defendants report that 42% of Class Members received an outreach attempt. In terms of outreach completions, 74% of initial outreach attempts to new admissions, 69% of initial outreach attempts to established admissions, and 82% of follow-up outreach attempts were ultimately completed. The majority of outreach attempts were not timely.	**N/A**	**N/A**	**Out-of-Compliance**
O-2	FY22 IP	Strategy: Continue expansion of Peer Support Ambassador program and In-Home Recovery Support program, increasing implementation of Peer Bridger-like model using NAMI's In-Home Recovery Support program and existing peer staff through Prime Agencies. Expected Improvements/Outcomes: • 85% of CMs hesitant about transitioning to the community (CM who do not accept Outreach or decline to participate in the program) are offered additional Outreach and education by Peer Support. ***Out-of-Compliance.*** In FY22, 385 Class Members were contacted by NAMI Peer Ambassadors. Of those Class Members receiving contact, 74% were engaged. While the Defendants report that 385 Class Members were contacted, there is no data provided on how many Class Members were hesitant about transitioning, so it is not possible to assess compliance. The Defendants started tracking the number of hesitant Class Members in FY23, which will enable them to more effectively assess the impact of re-engagement efforts for Class Members hesitant to transition.	**N/A**	**N/A**	**Out-of-Compliance**

O-3 (1)	FY22 IP	Strategy: Continue to enforce posting of retaliation poster in facilities and IDPH track CM reports of retaliation using Complaints processes as outlined in Rules/Regs. Expected Improvements/Outcomes: • 100% of facilities will have non-retaliation poster prominently displayed by 9/30/21. • All CMs will have access to information regarding their rights to non-retaliation through prominently displayed posters and through continued engagement with provider staff. ***Partial Compliance.*** In FY22, 14/23 (60%) of SMHRFs attested in writing to having posted the required posters relating to non-retaliation.	**N/A**	**N/A**	**Partial Compliance**
O-3 (2)	FY22 IP	Strategy: IDPH will develop a method to track and report data on CM retaliation by SNF or staff and enforce and track/report on recourse imposed by IDPH on facilities. Each month, IDPH will review complaint allegations entered into the central complaint registry and ASPEN system to review whether there are retaliation-related allegations. These allegations, whether they are substantiated or unsubstantiated, will be entered into a monthly report with descriptions and final enforcement outcomes, if finalized by that time. This system will be developed and be operational by 7/31/21. Expected Improvements/Outcomes: • 100% of reports by or on behalf of CMs alleging facility retaliation will have their claims investigated through the regulatory process, provided those claims are reported to IDPH directly or through any other 3rd party or entity. All such investigations and outcomes will be reported in semi-annual compliance reports. ***In Compliance.*** IDPH developed and implemented a method to track complaints of retaliation and barriers to access by Primes during the reporting period. In FY22, 100% (5/5) of Class Members reporting retaliation had their claims investigated.	**N/A**	**N/A**	**In Compliance**
O-4 (1)	FY22 IP	Strategy: During the first or second mandated quarterly site visit in FY22 SMHRFs, Regional Ombudsmen will inquire with Resident Council President to encourage them to allow a presentation on the Long-Term Care Ombudsman Program at a future meeting. If the President agrees, a presentation will be made at the next regularly scheduled meeting. All agreed-upon presentations will occur by 6/30/22. Expected Improvements/Outcomes: • 100% of SMHRFs are provided with an invitation for presentation. ***In Compliance.*** 100% of SMHRFs (23/23) were provided with an invitation for presentation.	**N/A**	**N/A**	**In Compliance**

O-4 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: • Before the end of FY 2022, the Ombudsman will make a facility presentation to all facilities that allow it. ***In Compliance.*** Of the 23 invitations made, 83% (19/23) resulted in presentations during the year. Given that the remaining meetings were unable to be scheduled due to COVID outbreaks (3 facilities) or facility closure (1 facility), the Defendants are found in compliance.	**N/A**	**N/A**	**In Compliance**
O-4 (3)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: • The Ombudsman will provide residents with contact cards and informational materials summarizing residents' rights, the role of Ombudsman, and how to contact their Ombudsman for assistance. ***In Compliance.*** The Defendants report that this is a federal requirement of the Ombudsmen who routinely distribute materials summarizing residents'' rights, the role of the Ombudsman and how to make contact during routine visits and at resident council meetings.	**N/A**	**N/A**	**In Compliance**
O-5 (1)	FY22 IP	Strategy: Develop capacity and programming to introduce and facilitate Class Member observation/visits to community-based settings, for those CM appropriate for such a visit by 10/2/21. Expected Improvements/Outcomes: • 70% of CM hesitant to participate, who are appropriate for a community visit are offered such a visit (including housing options). • 85% of Class Members who accept an offer of a community-visit, visit a community-based setting (including housing options). ***Duplicate Requirement.*** (See Requirement 9).	**N/A**	**N/A**	**N/A, Duplicate Requirement**
O-5 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: • 85% of Class Members who accept an offer of a community-visit, visit a community-based setting (including housing options). ***Duplicate Requirement. (***See Requirement 9).	**N/A**	**N/A**	**N/A, Duplicate Requirement**

Section IV. Assessment

Under the *Williams* Consent Decree, the Defendants are required to design and implement an assessment process to identify a Class Member's medical and psychiatric conditions, along with their ability to perform activities of daily living, to determine what the person would need to transition into the community. Per the Consent Decree, the Defendants must ensure that qualified professionals conduct person-centered assessments of every Class Member who agrees to such, culminating in an indication as to whether the Class Member is or is not recommended for transition.

Assessment-Related Requirements. The *Williams* Consent Decree includes the following requirements for the provision of assessments, including:

- Every Class Member should be offered an assessment (Requirement 8) at the appropriate frequency (Requirement 9) that describes their options to transition into the community (Requirement 7).
- Class Members who decline assessments or who decline to move after being recommended for transition can request and receive an assessment at a later time, which must be offered on a timely basis (Requirements 10 and 14).
- Assessments must be conducted by qualified professionals (Requirement 11).
- Assessments must be conducted annually, providing Class Members who were not recommended for transition or who elected not to move after a transition recommendation are offered future re-assessment opportunities (Requirement 1).
- During the annual assessment process, qualified professionals must explore and address any Class Member opposition to moving out of a Specialized Mental Health Rehabilitation Facility (SMHRF) (Requirement 13).

The *Williams* FY22 Implementation Plan two additional requirements centered on ensuring initial and annual assessments are delivered by trained and qualified staff and are completed on a timely basis.

Assessment Data Highlights. This section summarizes the Defendants' FY22 assessment data, provided in their semi-annual reports.

- In FY22, 808 assessments were due to be initiated after a positive outreach outcome. 296 (37%) were initiated within 14 days. Of the 808 assessments that were due, there were 739 successful attempts, after subtracting 69 Class Members unable to receive assessments due to death or discharges.
- There was a total of 1,087 assessment attempts, presumably inclusive of attempts after positive outreach outcomes and other circumstances such as annual re-assessments and Class Member-requested assessments. A significant majority (996 or 92%) proceeded to a full assessment, with the remaining Class Members deemed "unable to engage" or declining to proceed.
- Among the 185 not recommended for transition, common rationale[10] include: lack of insight/self-management skills, poorly controlled symptoms, current/planned lack of

[10] Individual Class Members can be assigned more than one rationale.

adherence, active psychotic symptoms, and active risk of harm.

- The most common services for those recommended to transition[11] were medication, psychiatry, mental health services, transportation, and "other recommended services."
- Of the 1,126 assessments completed in FY22, 81% were completed by qualified professionals, defined as staff with a master's degree in counseling/social work, psychology, or another related field.
- The Defendants, through UIC-CON, assess the quality of assessments and found that, for the first half of the fiscal year, 85% of recommended assessments were proficient, 91% of not recommended assessment were proficient.
- UIC-CON agreed with assessors' not recommended findings 88% of the time. There was one Class Member appeal against his/her assessment outcome in FY22, but after review, the original Prime agency decision was upheld.

Assessment-Related Requirements and Compliance Ratings. Below (in Figure 10), please find the specific requirements in this domain. Across the 10 Consent Decree and FY22 Implementation Plan requirements, 7 are assessed below (as three are duplicates). **Two (2) are in compliance, two (2) are in partial compliance, and three (3) are out of compliance.**

Figure 10. FY18-FY22 Compliance Assessment Ratings for *Williams* Assessment-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	*Williams* Consent Decree Requirement Language and FY22 Performance	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
7	*Williams* Consent Decree VI(9)(C)	Qualified Professionals shall inform Class Members of their options pursuant to subparagraphs 6(a), 6(d), and 7(b) of this Decree. ***Duplicate Requirement.*** (See Requirement 11).	**Duplicate Requirement, N/A**	**Duplicate Requirement, N/A**	**Duplicate Requirement, N/A**
8	*Williams* Consent Decree VI(6)(A)	Within two (2) years of the finalization of the Implementation Plan described below, every Class Member will receive an independent, professionally appropriate and person-centered Evaluation [Assessment] of his or her preferences, strengths and needs in order to determine the Community-Based Services required for him or her to live in PSH or another appropriate Community-Based Setting. ***Duplicate Requirement.*** (See Requirement 12).	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
9	*Williams* Consent Decree VII(10)	In addition to providing this information, Defendants shall ensure that the Qualified Professionals conducting the Evaluations engage residents who express concerns about leaving the IMD with appropriate frequency.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**

[11]Individual Class Members can be assigned more than one service.

		Out-of-Compliance. The Consent Decree requires that assessment staff frequently engage Class Members who have concerns about transitioning into the community. In FY22, the Defendants utilized Peer Ambassadors to engage those expressing hesitation about transition. NAMI Peer Ambassadors conducted 141 community visits in FY22. No data is available on how many Class Members were hesitant to participate or how many community visits were offered, so it is not possible to assess compliance.	**FY2020: Partial Compliance**		
10	*Williams* Consent Decree VI(6)(A)	Any Class Member has the right to decline to take part in such Evaluation. Any Class Member who has declined to be evaluated has the right to receive an Evaluation any time thereafter on request. ***In Compliance.*** It appears that 49 Class Members requested assessments (through appeals or direct requests), and all received such assessments.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Partial Compliance**	**Out-of-Compliance**	**In Compliance**
11	*Williams* Consent Decree VI(6)(B)	Defendants shall ensure that Evaluations are conducted by Qualified Professionals as defined in this Decree. ***Partial Compliance.*** In FY22, 81% of Assessment attempts (915/1126) were conducted by Qualified Professionals. Eighty percent (80%; 55/69) of Assessors were identified as Qualified Professionals.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**Partial Compliance**	**Partial Compliance**
12	*Williams* Consent Decree VI(6)(D)	After the second year following finalization of the Implementation Plan, the Evaluations described in Subsection 6(a) shall be conducted annually. ***Partial Compliance.*** Of the 658 Class Members due for annual assessments who had previously been recommended to transition, 39 received reassessments, 258 moved, and 226 were closed. The Defendants were not able to provide an update on the reassessment status of the remaining 108 (16%). Of the 107 Class Members due for annual assessments previously not recommended for transition, 46 (43%) had no updates.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance** **FY2020: In Compliance**	**Out-of-Compliance**	**Partial Compliance**
13	*Williams* Consent Decree VI(6)(D)	As part of each Class Member's annual Evaluation, the reasons for any Class Member's opposition to moving out of an IMD to a Community-Based Setting will be fully explored and appropriately addressed as described in Section VII.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**

		Out-of-Compliance. While the Defendants provided training to Assessors on motivational interviewing and created a policy on exploring and documenting reasons for declines, they did not provide data to demonstrate that Class Member concerns were addressed per the policy.	**FY2020: Out-of-Compliance**		
14	*Williams* Consent Decree VI(6)(D)	Any Class Member who has received an Evaluation but has declined to move to a Community-Based Setting may request to be reassessed for transition to a Community-Based Setting any time thereafter. ***In Compliance.*** It appears that 49 Class Members requested assessments (through appeals or direct requests), and all received such assessments.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**In Compliance**
A-1	FY22 IP	Strategy: Enforce Assessment performance metrics with Prime Agencies, in line with policy and procedures, including minimum standards for Qualified Professionals, with an emphasis on positive outcomes, engagement of CM, timeliness of Assessments. Expected Improvements/Outcomes: ● 100% of Assessments are facilitated by Qualified Professionals per Comprehensive Program requirements. **Duplicate Requirement.** (See Requirement 11).	**N/A**	**N/A**	**N/A, Duplicate Require-ment**
A-2	FY22 IP	Strategy: During FY22, require Prime Agencies to conduct enough Assessments to allow for a sufficient flow of Recommended CM to meet Transition requirements. Expected Improvements/Outcomes: ● 85% of Class Members receive Assessment in compliance with Comprehensive Program timeliness requirements (initial assessments initiated within 14 days after positive outreach outcome, annual assessments within one year of prior assessment). **Out-of-Compliance.** Only 296 (37%) of initial assessments were initiated within 14 days. No timeliness data was provided for annual reassessments.	**N/A**	**N/A**	**Out-of-Compliance**

Section V. Service Planning

After Class Members are assessed to determine their transition readiness, they are provided with a service plan. Service plans are required to contain the services and supports that align with a Class Member's needs, vision, and goals. For Class Members recommended to transition, they are to receive service plans soon after their assessment ("initial service plan") and prior to their transition ("transition service plan"). Class Members not recommended to transition are also to receive service plans, designed to help prepare them to qualify for community services and housing at a later time.

Service Plan-Related Requirements. The following Consent Decree requirements apply to service plans:

- Service plans must be completed by qualified professionals and include a legal representative or other person of the Class Member's choosing, if desired (Requirement 15).
- Service plans must be person-centered and reflect an individual's needs at home, work, and in the community to facilitate full participation in community life (Requirement 16).
- All service plans must be completed promptly with sufficient time to support transitions (Requirements 17 and 18).
- Service plans must identify the needed community-based services and a transition timetable (Requirement 19)
- For Class Members not approved for transition, service plans must include treatment objectives to prepare them for future transition to permanent supportive housing or other community-based options; the service plans should be periodically updated to reflect Class Members' changing needs and preferences and include services that support the acquisition of living and illness self-management skills (Requirement 20).
- For Class Members in Specialized Mental Health Rehabilitation Facilities (SMHRFs), service plans should focus on support for building the skills needed to live in the community (Requirement 21).
- For Class Members transitioned into non-permanent supportive housing, the service plan must justify that placement and include community-based services that can support the most integrated setting possible (Requirement 22).
- Service plans cannot be limited to what the service and housing system currently has available; any service that is currently provided under the State Medicaid Plan and Rule 132[31] must be made available but nothing beyond those services is required to be made available (Requirement 23).

The FY22 Implementation Plan also obligated the Defendants to 7 additional service plan-related requirements. These requirements focus on service plan (initial and updates) timeliness, accountability measures for providers regarding service plan quality, and increased linkage to employment services for Class Members.

Service Plan Data Highlights. This section summarizes the Defendants' FY22 service plan data, provided in their semi-annual reports.

- Regarding timeliness of initial service plans (due within 45 days after recommended assessments), among the 720 Class Members eligible for such plans, only 106 (15%) were received on time. Over half were "not received"; it is unclear whether these plans were never completed, not reported to UIC-CON, or a mix of both.
- There were 185 service plans completed for Class Members not recommended to transition and 127 (85%) had the required content, in the form of goals to prepare them for future transition.
- 151 service plans required updates (within 180 of the initial or prior service plan) and 61% were either updated or re-assessments of those Class Members were conducted.
- Of the 352 transition service plans completed, 148 (42%) were on-time (within 14-days pre-transition) with another 31 (9%) complete early. 165 (47%) were completed outside of the required timeframe.
- Of the 613 service plans reviewed, 82% met proficiency standards.
- Service plans provide a window into housing preferences among Class Members recommended to transition; among the 391 plans with housing preferences indicated, permanent supportive housing or private residences were indicated as the preference in 89% of plans, with the remainder divided among congregate housing.
- The most desirable geographic regions indicated in service plans were Cook County North (44%) and Cook County South (24%).
- 682 Class Members were recommended for employment supports in their service plans; 136 were ultimately enrolled in employment services with 70 having obtained employment.
- Of the 1,106 service plans completed in FY22, 762 (69%) were conducted by qualified professionals, while 344 (31%) were not.

Service Plan-Related Requirements and Compliance Ratings. Below (in Figure 11), please find the specific requirements in this domain. Across the 16 Consent Decree and FY22 Implementation Plan requirements, 14 are assessed below (as two are duplicates). **Three (3) are in compliance, eight (8) are in partial compliance, and three (3) are out of compliance.**

Figure 11. FY18-FY22 Compliance Assessment Ratings for *Williams* Service Plan-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	*Williams* Consent Decree Requirement Language and FY22 Performance	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
15	*Williams* Consent Decree VI(7)(C)	The Service Plan shall be developed by a Qualified Professional in conjunction with the Class Member and his or her legal representative. The Qualified Professional also shall consult with other appropriate people of the Class Member's choosing. ***Partial Compliance.*** Sixty-nine (69%) of service plans were conducted by qualified professionals.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
16		Each Service Plan shall focus on the Class Member's personal vision, preferences, strengths and needs in home, community and work environments and shall	**FY2018: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**

	Williams Consent Decree VI(7)(D)	reflect the value of supporting the individual with relationships, productive work, participation in community life, and personal decision-making. ***Partial Compliance.*** Service plans are reviewed by UIC-CON to ensure that they meet all content standards, including those reflected in this requirement. Eighty-two (82) percent of service plans met quality standards.	**FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**		
17	*Williams* Consent Decree VI(7)(A)	Based on the results of the Evaluations described above, Defendants shall promptly develop Service Plans specific to each Class Member who is assessed as appropriate for transition to a Community-Based Setting. ***Out-of-Compliance.*** Only 15 percent of initial service plans completed per Comprehensive Program timeliness standards (within 45 days of assessment).	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**
18	*Williams* Consent Decree VI(7)(F)	The Service Plan shall be completed within sufficient time to provide appropriate and sufficient transitions for Class Members in accordance with the benchmarks set forth in the Decree. ***Partial Compliance.*** Fifty-one (51) percent of transition service plans were completed per Comprehensive Program timeliness standards – 14 days prior to transition or earlier.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
19	*Williams* Consent Decree VI(7)(B)	For each Class Member who does not oppose moving to Community-Based Setting, the Service Plan shall, at a minimum, describe the Community-Based Services the Class Member requires in a Community-Based Setting, and a timetable for completing the transition. ***Partial Compliance***. Service plans are reviewed by UIC-CON to ensure that they meet all content standards, including those reflected in this requirement. Eighty-two (82) percent of service plans met quality standards.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
20	*Williams* Consent Decree VI(9)(A)	Those Class Members not transitioning from IMDs to Permanent Supportive Housing will have ongoing reassessments with treatment objectives to prepare them for subsequent transition to the most integrated setting appropriate, including PSH. ***Out-of-Compliance.*** In FY22, 93 Class Members were documented as having moved to non-PSH settings and 10 were identified as having been offered or moved to PSH following the non-PSH move. However, the Defendants did not supply data on how many – among the 93 who moved into the non-PSH settings -- were engaged to develop objectives to facilitate future moves to PSH.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**

21	*Williams* Consent Decree VI(7)(A)	Each Service Plan shall be periodically updated to reflect any changes in needs and preferences of the Class Member, including his or her desire to move to a Community-Based Setting after declining to do so, and shall incorporate services where appropriate to assist in acquisition of basic instrumental activities of daily living skills and illness self-management. Acquisition of such skills shall not be a prerequisite for transitioning out of the IMD. ***Partial Compliance.*** For the 151 Class Members who required service plan updates, 83 (55%) received updates or reassessments.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
22	*Williams* Consent Decree VI(7)(B)	If there has been a determination that a Class Member is not currently appropriate for PSH, the Service Plan shall specify what services the Class Member needs that could not be provided in PSH and shall describe the Community- Based Services the Class Member needs to live in another Community-Based Setting that is the most integrated setting appropriate. ***Partial Compliance***. Service plans are reviewed by UIC-CON to ensure that they meet all content standards, including those reflected in this requirement. Eighty-two (82) percent of service plans met quality standards.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
23	*Williams* Consent Decree VI(7)(E)	The Service Plan shall not be limited by the current availability of Community-Based Services and Settings; provided, however, that nothing in this subparagraph obligates Defendants to provide any type of Community-Based Service beyond the types of Community-Based Services included in the State Plan and Rule 132. ***In Compliance.*** The Defendants attest that service plan staff do not limit the services identified in a Class Member's service plan based on current availability. While found in compliance for this year, the Court Monitor will work with the Parties to develop a more operational and outcomes-oriented criteria for this requirement, focused on ensuring that there is an adequate array of community-based housing and services for Class Members.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Partial Compliance**	**In Compliance**

SP-1 (1)	FY22 IP	Strategy: Issue and enforce performance improvement plans/corrective action plans, in accordance with established IDHS policy, with Prime agencies whose SP submissions do not meet Comprehensive Program requirements, either in terms of timeliness or quality, as identified by DMH/UIC CON. Expected Improvements/Outcomes: ● 100% of providers who are significantly below timeliness performance requirements for more than one consecutive monthly reporting period, or 3 months in 2 consecutive quarters, are issued PIP/CAP. ***Partial Compliance.*** IDHS issued Performance Improvement Plans to the Prime Agencies in the lowest quartile of service plan proficiency ratings in January 2022. Three (3) Prime Agencies were identified as falling substantially below service plan quality standards and all (100%) were issued PIPs/CAPs. This approach deviated from the original IP strategy, focusing on lowest-performing providers and not explicitly breaking out timeliness as a separate performance review component, but rather including it as an element of the quality assessment.	**N/A**	**N/A**	**Partial Compliance**
SP-1 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 100% of providers who are significantly below the quality standards performance requirements for more than one consecutive monthly reporting period, or 3 months in 2 consecutive quarters, are issued PIP/CAP. ***In Compliance.*** Three (3) Prime Agencies were identified as falling substantially below service plan quality standards and all (100%) were issued PIPs/CAPs.	**N/A**	**N/A**	**In Compliance**
SP-2	FY22 IP	Strategy: By 7/1/21, use new data management system for tracking transitioning CMs to ensure and enforce provider contractual requirements regarding Service Plans for all CMs. Expected Improvements/Outcomes: ● 90% CMs transitioning to the community have a Transition Service Plans completed before the date of Transition. ***Duplicate Requirement.*** See Requirement 18.	**N/A**	**N/A**	**N/A, Duplicate Require-ment**

SP-3 (1)	FY22 IP	Strategy: Enforce Service Plan performance metrics with Prime Agencies, consistent with program policies and procedures, with an emphasis on quality. Expected Improvements/Outcomes: ● 85% of Service Plans are completed per Comprehensive Program timeliness requirements. ***Out-of-Compliance.*** In FY22, 35% had a Service Plan within 100 days of Assessment.	**N/A**	**N/A**	**Out-of-Compliance**
SP-3 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 85% of providers meet Comprehensive Program quality standards in Service Planning to CMs. ***Partial Compliance***. In FY22, 82% of Service Plans reviewed by UIC CON met quality standards.	**N/A**	**N/A**	**Partial Compliance**
SP-3 (3)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 85% of Class Members who complete Outreach will have their Service Plans completed within 59 days of a positive outreach outcome. ***Duplicate Requirement.*** See Requirement 17.	**N/A**	**N/A**	**NA, Duplicate Require-ment**
SP-4	FY22 IP	Strategy: Enforce referrals to Employment Services where included in Service Plan. Expected Improvements/Outcomes: ● 100% of CMs whose Service Plan includes Employment Services are referred to Employment Services. ***In Compliance.*** In FY22, 100% of Class Members with Service Plans recommending Employment Services were referred to Employment Services. Of the 682 Class Members referred, 136 were ultimately enrolled in employment services with 70 having obtained employment.	**N/A**	**N/A**	**In Compliance**

Section VI. Transitions

Along with diversion, a second, central purpose underlying the *Williams* Consent Decree is to transition willing and clinically appropriate Class Members into the community, creating a pathway for them to rejoin and fully participate in community life. Along with Front Door diversion, this requirement is often viewed as one of the most important and visible indicators of compliance. Success or failure to achieve the number of required transitions signals the Defendant's ability to effectively reach and identify appropriate institutionalized Class Members, prepare for and effectuate transitions, and, at the systems-level, move toward rebalancing the mental health services system away from institution-based and restrictive care settings to community-based services, supports, and housing.

From March 2020 to present, the Defendants have utilized a new approach – titled the Comprehensive Class Member Transition Program (Comprehensive Program) – wherein 10 Prime Agencies were responsible for transitions.

Transition-Related Requirements. In addition to reaching the numeric transition requirements, the Defendants are required to:

- Utilize permanent supportive housing (PSH) for all Class Members, except for those who have severe dementia or other severe cognitive impairments preventing effective service in PSH, require skilled nursing care such that they cannot be served safely in PSH, or are a danger to self or others (Requirement 24).
- Hold housing units for Class Members who are temporarily hospitalized by paying their rent (Requirement 25).
- Ensure Class Members amid the transition process receive added support and are not left without options when Specialized Mental Health Rehabilitation Facilities (SMHRFs) close (Requirement 26).
- Utilize buildings for community-based housing where fewer than 25 percent of tenants have a mental illness, unless the building has four or fewer units, at which time 50 percent of tenants with mental illness is permitted (Requirement 27).
- Offer all transition-approved Class Members placement in the community, with moves completed within 120 days (Requirement 28).

The FY22 Implementation Plan includes other requirements, identifying a numeric transition figure, timeliness standards for transition, remediation of pipeline issues, and requirements on prioritizing permanent supportive housing, among others.

Transition Data Highlights. This section summarizes the Defendants' FY22 transition data, provided in their semi-annual reports.

- 358 Class Members were transitioned in FY22 representing 90% of their requirement of 400 transitions, a significant improvement compared to prior years.
- 41% of Class Members were transitioned within 120 of their initial service plans.
- Class Members continued to experience protracted delays once approved for transition. At two time points in around FY22 – 2/1/22 and 7/1/22 – respectively, 41% and 37% Class

Members had been in the transition pipeline for beyond the 120 days.

- 1,808 Class Members were identified with low- or no incomes. 823 were referred to the SOAR[12] program with only 109 clients accepted. Among those individuals, only 13 applications were filed with seven approved. One reconsideration was also filed and approved.
- Most transitioned Class Members (74%) were moved to permanent supporting housing (PSH). Among those moved to non-PSH settings, 28% met exclusionary criteria[13] and 72% elected to move to a non-PSH setting. Among transitioned to PSH, 171 received Bridge subsidies and 20 received Statewide Referral Network or Section 811 units. Class Members buildings and units complied with relevant disability segregation rules.
- In FY22, 79 Class Members had 174 rent payments covered by the State while they were temporarily placed in a hospital or other treatment facility.
- There were 111 involuntary discharges/transfers.

After being assessed as appropriate for community-based services and housing, many Class Members experience protracted delays to transition, with some never making it into the community. The prior Court Monitor and her staff conducted a special study (filed by the current Court Monitor, Kathryn du Pree on August 31, 2022) on timeliness of various Consent Decree processes. The study revealed that that approximately 1,100 *Williams* and *Colbert* Class Members – who were recommended to transition between July 2020 and December 2021 – should have been transitioned but remained stuck in the pipeline.

Transition-Related Requirements and Compliance Ratings. Below (in Figure 12), please find the specific requirements in this domain. Across the 32 Consent Decree and FY22 Implementation Plan requirements, 20 are assessed below (as 12 are duplicates or not applicable to this period). **Twelve (12) are in compliance, three (3) are in partial compliance, and five (5) are out of compliance.**

Figure 12. FY18-FY22 Compliance Assessment Ratings for *Williams* Transition-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	*Williams* Consent Decree Requirement Language and FY22 Performance	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating

[12] SOAR stands for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery, and trains staff to effectively gather documentation and submit complete and thorough SSI/SSDI application packets to expedite access to benefits.

[13] Acceptable reasons for a non-PSH move include severe dementia or other severe cognitive impairments requiring such a high level of staffing to assist with activities of daily living or self-care management that Class Members cannot effectively be served in PSH, medical needs requiring a high level of skilled nursing care that may not safely be provided in PSH, or a Class Members' danger to themselves or others.

24	Consent Decree VI(9)(A)	PSH will be considered the most integrated setting appropriate for Class Members except that, (1) for any Class Members (i) who have severe dementia or other severe cognitive impairments requiring such a high level of staffing to assist with activities of daily living or self-care management that they cannot effectively be served in PSH, (ii) who have medical needs requiring a high level of skilled nursing care that may not safely be provided in PSH, or (iii) who present an danger to themselves or others, the evaluator will determine the most integrated setting appropriate, which may be PSH or another setting, and (2) nothing in this paragraph shall prevent Class Members who can and wish to live with family or friends or in other independent housing that is not connected with a service provider from doing so. ***In Compliance.*** The Defendants indicated that 74% of Class Members moved to permanent supportive housing (PSH). Among the remaining Class Members, 28% met exclusionary criteria and 72% preferred a non-PSH option.	**FY2018: Partial Compliance** **FY2019: Partial Compliance** **FY2020: Partial Compliance**	**Partial Compliance**	**In Compliance**
25	Consent Decree VI(9)(B)	Class Members who move to a Community-Based Setting will have access to all appropriate Community-Based Services, including but not limited to reasonable measures to ensure that their housing remains available in the event that they are temporarily placed in a hospital or other treatment facility. **In Compliance**. Seventy-nine (79) Class Members received assistance to maintain housing during temporary placement during FY22, reflecting a total of 174 rent payments.	**FY2018: Partial Compliance** **FY2019: Partial Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
26	Consent Decree VIII(15)	In the event that any IMD seeks to discharge any Class Member before appropriate housing is available, including but not limited to circumstances in which an IMD decides to close, Defendants will ensure that those individuals are not left without appropriate housing options based on their preferences, strengths, and needs. ***Out-of-Compliance.*** The Defendants were only able to report that 3 (3%) of the 111 Class Members who were involuntarily discharged in FY22 received information about available community resources/services. Tracking of the distribution of information to involuntarily discharged Class Members began in June 2022.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**
27	Consent Decree VI(8)(G)	For purposes of this Decree, PSH includes scattered-site housing as well as apartments clustered in a single building, but no more than 25% of the units in one building with more than 4 units may be used to serve PSH clients known to have mental illness. For buildings with 2 to 4 units, no more than 50% of the	**FY2018: Out-of-Compliance** **FY2019: In Compliance**	**In Compliance**	**In Compliance**

		units may be used to serve PSH clients known to have mental illness. However, during first 5 years after finalization of the IP, up to 75 class members may be placed in buildings where more than 25% of the units serve PSH clients known to have MI if those buildings were used to serve PSH clients prior to March 1, 2010. After first 5 years following the finalization of the IP, all class members served in PSH shall be offered the opportunity to reside in buildings that comply with 25% or 50% units limit set forth above in this subparagraph. ***In Compliance.*** The Defendants reported that all PSH units occupied by transitioned Class Members complied with disability concentration rules set forth in the Consent Decree.	**FY2020: In Compliance**		
28	Consent Decree VI(8)(H)	After the end of the fifth year following finalization of the Implementation Plan, Class Members who are assessed as appropriate for living in a Community-Based Setting, who do not oppose transition to a Community-Based Setting and whose Service Plans provide for placement in Community-Based Settings shall be offered the opportunity to move to those settings and shall receive appropriate services consistent with the Service Plan within one hundred and twenty (120) days of the date of the Service Plan. ***Out-of-Compliance.*** The Defendants produced data that shows that 41 percent of transitioned Class Members transitioned within 120 days of their initial service plans. In addition to analyzing the transition timeliness of those who transitioned in FY22, the prior Court Monitor also sought to understand the transition outcomes (including timeliness) of all Class Members who were recommended to transition between July 2020 and December 2021. She found that approximately 1,100 Class Members recommended to transition during that time period (from both the *Williams* and *Colbert* classes) had yet to transition as of March 29, 2022, pointing to extreme timeliness delays.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**
29	Consent Decree X(21)	Within sixty (60) days of Approval of the Decree, Defendants shall offer each of the Named Plaintiffs the opportunity to receive appropriate services in the most integrated setting appropriate to his or her needs and wishes, including PSH. Provision of services to the Named Plaintiffs pursuant to this paragraph shall not be used to determine any other individual's eligibility for services under the terms of the Decree. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
30		By the end of the first year after the finalization of the	**FY2018: N/A**	**N/A**	**N/A**

	Consent Decree VI(8)€	Implementation Plan, Defendants will have: (1) offered placement in a Community-Based Setting to a minimum of 256 Class Members who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting; and (2) developed 256 PSH units for the benefit of Class Members. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2019: N/A** **FY2020: N/A**		
31	Consent Decree VI(8)(D)	By the end of the second year after the finalization of the Implementation Plan, Defendants will have: (1) offered placement in a Community-Based Setting to a minimum of 640 Class Members (including the 256 referenced in subparagraph 8c above) who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting; and (2) developed 640 PSH units for the benefit of Class Members. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
32	Consent Decree VI(8)(E)	By the end of the third year after the finalization of the Implementation Plan, Defendants will have (1) offered placement to at least forty percent (40%) of all individuals who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Settings; and (2) developed the corresponding number of PSH units or other Community-Based Settings sufficient for these individuals. For purposes of this subparagraph, these individuals include the total of (1) all Class Members as of the end of the second year after the finalization of the Implementation Plan who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting, and (2) all former Class Members who have already transitioned from the IMD to a Community-Based Setting or to another community setting since finalization of the Implementation Plan. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
33	Consent Decree VI(8)(F)	By the end of the fourth year after the finalization of the Implementation Plan, Defendants will have (1) offered placement to at least seventy percent (70%) of all individuals who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting; and (2)	**FY2018: N/A** **FY2019: N/A**	**N/A**	**N/A**

		developed the corresponding number of PSH units or other Community-Based Settings sufficient for these individuals. For purposes of this subparagraph, these individuals include the total of (1) all Class Members as of the end of the third year after the finalization of the Implementation Plan who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting, and (2) all former Class Members who have already transitioned from the IMD to a Community-Based Setting or to another community setting since finalization of the Implementation Plan. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2020: N/A**		
34	Consent Decree VI(8)(A)	Within five (5) years of the finalization of the Implementation Plan, all Class Members who have been assessed as appropriate for living in a Community-Based Setting will be offered the opportunity to move to a Community-Based Setting. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
35	Consent Decree VI(8)(G)	By the end of the fifth year after the finalization of the Implementation Plan, Defendants will have: (1) offered placement to one hundred percent (100%) of all individuals who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting; and (2) developed the corresponding number of PSH units or other Community-Based Settings sufficient for these individuals. For purposes of this subparagraph, these individuals include the total of (1) all Class Members as of the end of the fourth year after the finalization of the Implementation Plan who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting, and (2) all former Class Members who have already transitioned from the IMD to a Community-Based Setting or to another community setting since the finalization of the Implementation Plan. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**

T-1 (1)(a)	FY22 IP	Strategy: Transition required number of Class Members. Expected Improvements/Outcomes: ● At least 150 *Williams* CM transitioned by 12/31/21 ***In Compliance.*** The initial target of 150 transitions was exceeded by 12/31/21.	**N/A**	**N/A**	**In Compliance**
T-1 (1)(b)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● At least 400 total *Williams* CM transitioned by 6/30/22. ***Partial Compliance***. In total in FY22, 358 Transitions occurred, meeting 90% of the total annual target.	**N/A**	**N/A**	**Partial Compliance**
T-1 (2)(a)	FY22 IP	Strategy: Enforce transition performance metrics with providers, in line with Comprehensive Program contractual obligations, with an emphasis on outcomes and quality. Expected Improvements/Outcomes: ● 100% of Prime providers meet their contractual obligation of transitions per quarterly reporting period. ***Partial Compliance.*** Ten Prime agencies were contracted to facilitate transitions. Three Primes met 100% of their target or more, five Primes met 85% or more of their target, and two Primes met between 75-84% of their target.	**N/A**	**N/A**	**Partial Compliance**
T-1 (2)(b)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 65% of transitioned Class Members transitioned within 120 days of their service plan. ***Out-of-Compliance.*** In FY22, 352 community moves occurred for Class Members. Of these, 41% (143) moved within 120 days of their first service plan.	**N/A**	**N/A**	**Out-of-Compliance**

T-2	FY22 IP	Strategy: By 7/1/21, use new data management system to track Assessment/SP recommendations for CMs recommended to Transition to settings other than PSH or not recommended to transition, to determine compliance with exclusionary criteria protocol. Expected Improvements/Outcomes: ● 85% of CM recommended to transition to a non-PSH setting meet exclusionary criteria or are documented as based on CM choice. ***Duplicate Requirement***. (See Requirement 24)	**N/A**	**N/A**	**N/A, Duplicate Require-ment**
T-3(1)	FY22 IP	Strategy: Investigate and remedy pipeline issues through dedicated resource development to meet the timeliness requirement for moving from Initial Service Plan to transition (120 days). Specifically, receive quarterly reports from Prime agency, with analysis by UIC CON on pipeline barriers to inform any necessary systems changes. Expected Improvements/Outcomes: ● Major pipeline issues impacting providers' ability to achieve transition benchmarks are identified on a quarterly basis to allow for timely resolution or identification of alternative approaches. ***In Compliance.*** In FY22, Defendants discussed pipeline issues, including staffing shortages and limited housing meeting CM preferences, during the Parties meetings.	**N/A**	**N/A**	**In Compliance**
T-3(2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● Updates on identified pipeline issues, strategies for resolution and outcomes will be included in parties' meetings on a quarterly basis. ***In Compliance.*** In FY22, the Defendants discussed strategies the State is taking to address pipeline issues during the Parties meetings.	**N/A**	**N/A**	**In Compliance**

T-4	FY22 IP	Strategy: IDoA Homecare Ombudsman Program staff (serving individuals receiving HFS Waiver services such as IDoA CCP- Elderly, IDHS- HSP, HIV/AIDS, TBI, as well as advocacy services to MMAI recipients) will conduct a recorded webinar to all Prime Agencies in collaboration with IDHS w/in 30 days of the start of FY22. The Home Care Ombudsman WebEx will provide an overview of the Home Program including the goal and purpose of the HCO Program, the populations served, the role of the Home Care Ombudsman, services available through the program, and other applicable resources for the waiver population. This training/webinar will be required for Prime Agencies and included in the Comprehensive Program training modules. Expected Improvements/Outcomes: ● Upon transition, Primes will ensure that the IDoA Homecare Ombudsmen brochure is included in the CM's transition packet. ***In Compliance.*** In FY22, Prime Agencies were provided Homecare Ombudsman Program information resources, and a recorded webinar training. Primes were issued a requirement to provide all transitioning Class Members the Homecare Ombudsman brochure effective 8/13/21.	**N/A**	**N/A**	**In Compliance**
T-5 (1)	FY22 IP	Strategy: Continue to promote and support the implementation of HFS's Community Transition Initiative with HealthChoice Illinois health plans. Expected Improvements/Outcomes: ● Increase number of CTI transitions in FY22. ***Out-of-Compliance.*** In FY22, only one (1) *Williams* Class Member was transitioned by CTI. The Defendants requested that the Court Monitor find them in partial compliance given that the outcome (one transition) represented an improvement over FY21. Given how minor an improvement, the Court Monitor maintained an out-of-compliance rating.	**N/A**	**N/A**	**Out-of-Compliance**

T-5 (2)	FY22 IP	Strategy: Amend master HealthChoice Illinois Contracts to specify the required minimum transition elements of the *Williams/Colbert* Decrees and to require monthly reporting on those elements by 12/15/21. Expected Improvements/Outcomes: ● 100% of HealthChoice Illinois contracts amended by 12/15/2021. ***In Compliance.*** HFS issued a policy amendment to all HealthChoice Illinois MCOs on 12/15/21 with required minimum transition elements and monthly reporting requirement.	**N/A**	**N/A**	**In Compliance**
T-5 (3)	FY22 IP	Strategy: Monitor and resolve operational issues using existing management and communications platforms (including CEO meetings, weekly operational calls, quarterly business reviews, etc.). monthly updates to Court Monitor. Expected Improvements/Outcomes: ● Prompt resolution of identified operational issues. ***In Compliance.*** CTI operational issues were monitored and resolved at regular meetings, monthly calls, and through technical assistance.	**N/A**	**N/A**	**In Compliance**
T-5 (4)	FY22 IP	Strategy: Monitor and resolve operational issues using existing management and communications platforms (including CEO meetings, weekly operational calls, quarterly business reviews, etc.). monthly updates to Court Monitor. Expected Improvements/Outcomes: ● Monthly updates to Court Monitor regarding operational issues resolved. ***In Compliance.*** Monthly updates were provided to the Court Monitor.	**N/A**	**N/A**	**In Compliance**

T-5 (5)	FY22 IP	Strategy: Prepare a written report assessing the impact of the CTI by analyzing available CTI data from HealthChoice Illinois health plans. The report will include information about how the plans operationalized CTI efforts, as well as metrics showing transitions achieved under the CTI in FY21 compared to FY22 (with a commitment to increasing the number of transitions year over year), and benchmark comparisons as data comparability and availability permits, such as: between *Williams* and *Colbert* Class Members and non-Class Members; between CTI and Comprehensive Program; between individuals with mental illness, substance use disorder, physical disability, or a combination of these conditions; and geography. Expected Improvements/Outcomes: ● CTI report submitted on time and in accordance with agreed upon outline. ***In Compliance.*** The CTI report outline was submitted to the Court Monitor on 11/15/21, followed by a CTI Report submitted to Court Monitor and Parties on 6/30/22.	**N/A**	**N/A**	**In Compliance**
T-5 (6)	FY22 IP	Strategy: Continue to require online Olmstead training for all Care Coordinators newly hired by HealthChoice Illinois Plans on an ongoing basis, with annual confirmation of HealthPlan attestation. Expected Improvements/Outcomes: ● 85% of newly hired care coordinators trained by 6/30/2022. ***In Compliance.*** In FY22, 99% of newly hired Care Coordinators completed Olmstead Training as reported by Health Plan attestations.	**N/A**	**N/A**	**In Compliance**

T-6	FY22 IP	Strategy: Continue to use IDPH's Involuntary Transfers/Discharges (ITD) process for reviewing and approving involuntary discharges to ensure involuntary discharges are in accordance with the rules. IDPH's Hearings Unit will be provided a list of approved contacts for alternative housing and community-based settings. This approved list will be provided by IDPH to the CM at the ITD hearing so that residents subject to involuntary transfer and discharge has been apprised of their options for community-based assessments and placement opportunities. Hearings Unit staff will discuss the available options with the CM if the CM is willing. Expected Improvements/Outcomes: ● 90% of Class Members subject to involuntary discharge are provided resources for Community-Based services and supports. ***Duplicate Requirement*** (see Requirement 26).	**N/A**	**N/A**	**N/A, Duplicate Require-ment**
T-7	FY22 IP	Strategy: IDoA Regional Ombudsmen to identify and contact CMs who receive involuntary discharge notices. If the CM is interested in Ombudsman assistance, the Ombudsman will coordinate with IDPH and the CM Primes on behalf of the CM/resident. Tracking will be required by the Ombudsman on a quarterly basis, and final reports will be reported bi-annually (semi-annual compliance reporting). Expected Improvements/Outcomes: ● 90% of CMs who receive involuntary discharge notices are offered Ombudsman assistance. ***Partial Compliance.*** In FY22, 54% of Class Members (37/69) for whom the Ombudsman were aware of having received facility-initiated discharge notices were offered assistance. Out of the 32 who were not offered assistance, 23 were unable to be contacted due to circumstances beyond the Defendants' or Ombudsman's control (e.g., incarceration, hospitalization), but data was not available for the remaining 9 Class Members. This means that 87% were either offered assistance or justifiably unable to be reached, resulting in a partial compliance finding.	**N/A**	**N/A**	**Partial Compliance**

T-8	FY22 IP	Strategy: For all Class Members appropriately approved for discharge, continue to use and enforce Prime/MCO offering of supports pre-/upon discharge. Expected Improvements/Outcomes: ● 85% of recommended CMs unexpectedly discharged prior to transition are offered Community-Based Services and Housing within 60 days of discharge. ***Out-of-Compliance.*** In FY22, 77 recommended Class Members were discharged before community move and nine of these were contacted by the assigned Prime (12%).	**N/A**	**N/A**	**Out-of-Compliance**
T-9 (1)	FY22 IP	Strategy: For any CM who transitioned to a non-PSH setting, the Prime Agency will evaluate CM interest and appropriateness to move to PSH. If evaluation reveals the Class Member desires PSH but is not ready or appropriate, a plan with goals to prepare Class Member for PSH will be developed within 30 days. Expected Improvements/Outcomes: ● 85% of CMs in non-PSH settings are offered the option to move to PSH in the future. ● 85% of CMs wanting to move to PSH but not ready, receive plan with goals within 30 days of PSH evaluation. ● 85% of CMs who engage in a secondary transition plan to move to PSH and who are deemed appropriate, receive an offer to move to PSH within 60 days. ***Duplicate Requirement*** (see Requirement 20).	**N/A**	**N/A**	**N/A, Duplicate Require-ment**
T-9 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 85% of CMs wanting to move to PSH but not ready, receive plan with goals within 30 days of PSH evaluation. ***Duplicate Requirement*** (see Requirement 20).	**N/A**	**N/A**	**N/A, Duplicate Require-ment**
T-9 (3)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 85% of CMs who engage in a secondary transition plan to move to PSH and who are deemed appropriate, receive an offer to move to PSH within 60 days. ***Duplicate Requirement*** (see Requirement 20).	**N/A**	**N/A**	**N/A, Duplicate Require-ment**

Section VII. Community-Based Services and Housing Capacity Development

The *Williams* Consent Decree issues a clear imperative that the Defendants must ensure the array and quantity of community-based services and housing needed to successfully transition appropriate Class Members from Specialized Mental Health Rehabilitation Facilities (SMHRFs) to community living. From the onset, the Parties, the Court Monitor, and other stakeholders agreed that the current types and quantities of available services and housing in the community are insufficient to adequately support diversion and transition.

Beyond the development of services and housing that specifically serve Class Members, the *Williams* Consent Decree also provides an opportunity for Illinois to begin rebalancing its mental health and disability services system, moving away from its heavy reliance on institutional care toward community-based, recovery-oriented, and person-centered services and housing. By using Class Member data, other states' best practices, and a multimillion-dollar funding allocation, the Illinois systems' leaders can leverage the Consent Decree for real and lasting systems change that strengthens its community-based mental health and housing systems.

Community-Based Services and Housing Capacity Development-Related Requirements**.** The Consent Decree requires that Defendants create and provide to Class Members an adequate system of housing and services. Further, the FY22 Implementation Plan requires an updated capacity development plan, utilization of bridge subsidies for certain Class Members on financial holds, and procurement activities to bring on new providers to serve Class Members with medical and psychiatric complexities, among others.

Community-Based Services and Housing Capacity Development-Related Data Highlights. While not directly responsive to the specific requirements in this domain, several data findings herein suggest that community-based housing and services capacity is inadequate. As indicated in the previous section, only 41% of completed transitions were done so timely (within 120 days of completed service plan). Further, data from two time points (2/1/22 & 7/1/22) demonstrates that more than 200 *Williams* Class Members were stuck in the pipeline beyond 120 days, and many were stuck in a vaguely defined "planning/pre-housing" phase or housing search phase. Further, the timeliness study found that, as of March 2022, approximately 1,100 *Williams* and *Colbert* Class Members – who were recommended to transition between July 2020 and December 2021 – should have been transitioned but remained stuck in the pipeline.

Community-Based Services and Housing Capacity Development-Related Requirements and Compliance Ratings. Below (in Figure 13), please find the specific requirements in this domain. Across the 8 Consent Decree and FY22 Implementation Plan requirements, **four (4) are in compliance, three (3) are in partial compliance, and one (1) is out of compliance.**

Figure 13. FY18-FY22 Compliance Assessment Ratings for *Williams* Community-Based Services/Housing Capacity Development-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	*Williams* Consent Decree Requirement Language and FY22 Performance	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
36	*Williams* Consent Decree V(5)	Defendants shall ensure the availability of services, supports, and other resources of sufficient quality, scope and variety to meet their obligations under the Decree and the Implementation Plan. ***Partial Compliance.*** While the Defendants did submit an updated capacity development plan, hundreds of Class Members remain in the transition pipeline due to inadequate outreach, assessment, service planning, transition support, and community-based services capacity. Specific data that demonstrates inadequate capacity can be found in Sections VI and VII.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Partial Compliance**	**Partial Compliance**
37	*Williams* Consent Decree V(5)	Defendants shall implement sufficient measures, consistent with the preferences, strengths, and needs of Class Members, to provide Community-Based Settings and Community-Based Services pursuant to the Decree. ***Partial Compliance.*** The Defendants report on the continued funding for bridge subsidies which secures tenant-based vouchers to cover any CM housing needs not otherwise funded. IHDA reports an increase in affordable housing units for which Class Members are prioritized from the SRN/811 waiting lists. However, their continued inability to transition Class Members – and particularly address identified pipeline issues – demonstrates that the availability of supports and services is inadequate to address need.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Partial Compliance**	**Partial Compliance**
CD-1	FY22 IP	Strategy: By 1/1/22, develop Bridge Subsidy to Permanent Housing Choice Voucher strategic plan to transition CMs from Bridge Subsidies to other permanent housing options and includes plan for ongoing maintenance. Expected Improvements/Outcomes: • Strategic plan delivered by 1/1/22, identifying a process for assisting Class Members to transition from Bridge Subsidies to other permanent housing options. ***In Compliance.*** Defendants sent the *Bridge Subsidy to Permanent HCV* strategic plan to the Parties and Court Monitor on 12/30/21.	**N/A**	**N/A**	**In Compliance**
CD-2 (1)	FY22 IP	Strategy: By 1/1/22, complete comprehensive Housing & Services Capacity Development gaps and capacity analysis with continued use of data related to CM geographic locations and housing preferences. Expected Improvements/Outcomes: • Deliver gaps analysis by January 1, 2022. ***In Compliance.*** Defendants sent the *Housing & Services Needs and Gaps* reports to the Parties and Court Monitor on 12/30/21.	**N/A**	**N/A**	**In Compliance**

CD-2 (2)	FY22 IP	Strategy: By 3/1/22, complete a capacity development report based on identified gaps, to inform utilization of current housing and services capacity, and future planning and development. Expected Improvements/Outcomes: ● Deliver capacity development plan by March 1, 2022. ***In Compliance.*** Defendants sent the *Housing* and *Services Capacity Development* reports to the Parties and Court Monitor on 3/1/2022.	**N/A**	**N/A**	**In Compliance**
CD-3	FY22 IP	Strategy: Following the delivery of the plan, provide to Parties and Court Monitor ongoing updates on capacity expansion. Expected Improvements/Outcomes: ● Updates provided in May and June 2022. ***In Compliance.*** Defendants provided updates on both the *Housing* and *Services Capacity Development* reports to the Parties and Court Monitor on 5/31/2022 and 6/30/2022.	**N/A**	**N/A**	**In Compliance**
CD-4	FY22 IP	Strategy: Make bridge subsidies available to Class Members recommended for transition but unable to do so due to lack of income, who agree to participate in SOAR and/or employment supports, or who have other means of potential income identified. The data dashboards will report acceptance and refusal rates, the number of Class Members who cannot proceed due to refusal of SOAR and/or employment supports, and the number of successful transitions due to this effort. Expected Improvements/Outcomes: ● 75% of Class Members on financial holds who agree to participate in SOAR, employment supports or who have a potential income source identified, transition with bridge subsidies. ***Out-of-Compliance.*** In FY 2022, 65 Class Members obtained Bridge Subsidies without income. The Defendants report that data on Class Members without income who have other sources of income is not available, and the SOAR enrollment changes monthly, so the denominator is unable to be determined. Given that the Defendants did not provide the number of Class Members who agreed to participate in SOAR/employment supports, it is not possible to assess compliance. This compliance rating can be revisited if the Defendants are able to furnish additional information that speaks to this requirement.	**N/A**	**N/A**	**Out-of-Compliance**

CD-5	FY22 IP	Strategy: Identify and initiate discussions with additional providers to enter into grant agreements under the Comprehensive Program, focusing on those with a Care Management focus, to better serve Class Members with complex medical and psychiatric needs. Expected Improvements/Outcomes: ● Dependent on outcome of discussions, add providers to serve Class Members with medical/psychiatric complexities under the Comprehensive Program. ***Partial Compliance.*** IDHS-DMH posted the Comprehensive Program NOFO for FY23 program in March 2022 and secured one new provider. However, given Defendants' issues in transitioning Class Members timely, they clearly still lack capacity. Per the FY23 Implementation Plan, IDHS will continue efforts to expand the Comprehensive Program provider pool.	**N/A**	**N/A**	**Partial Compliance**

Section VIII. Administrative Requirements

It is critical that the Defendants support Consent Decree planning and operations with strong management and administrative processes. As such, the *Williams* Consent Decree includes several administrative requirements, including obligations for timely reporting on performance relative to Consent Decree and Implementation Plan requirements, responsiveness to the Court Monitor and Plaintiffs' data and information requests, and unfettered access to Class Members and their records, as well as to various staff and stakeholders related to Consent Decree planning, operations, and implementation.

Administrative Requirement. The Defendants' administrative requirements during this compliance period include:

- Delivering semiannual reports containing the information and data agreed to by the Court Monitor and Parties (Requirement 38).
- Providing the Court Monitor unrestricted access to documents, information, and staff involved with the Consent Decree, without counsel present (Requirement 39).
- Ensuring the Court Monitor's unrestricted access to Class Members and their records (Requirement 40).
- Providing data and information requested by Plaintiffs (Requirement 41).
- Compensating the Court Monitor and her staff consistent with their customary rates (Requirement 42).
- Covering all costs associated with the Decree (Requirement 43).

The FY22 Implementation Plan also requires that the Defendants provide regular budget updates with plans to prevent lapsed appropriations, share monthly dashboards with the Parties, develop a staffing assessment, among other requirements.

Administrative-Related Data Highlights. There are no data highlights for this domain.

Administrative-Related Requirements and Compliance Ratings. Below (in Figure 14), please find the specific requirements in this domain. Across the 17 Consent Decree and FY22 Implementation Plan requirements, 13 are assessed below (as four are not applicable for Court Monitor and/or Plaintiffs' Counsel requirements). **All thirteen (13) are in compliance.**

Figure 14. FY18-FY22 Compliance Assessment Ratings for *Williams* Administrative-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	*Williams* Consent Decree Requirement Language and FY22 Performance	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating

38	Consent Decree IX(16)	The Court will appoint an independent and impartial Monitor who is knowledgeable concerning the management and oversight of programs serving individuals with Mental Illnesses. The Parties will attempt to agree on the selection of a Monitor to propose to the Court. If the Parties are unable to reach agreement, each party will nominate one person to serve as Monitor and the Court will select the Monitor. Within twenty-one (21) days of Approval of the Decree, the Parties shall submit their joint recommendation or separate nominations for a Monitor to the Court. In the event the Monitor resigns or otherwise becomes unavailable, the process described above will be used to select a replacement. ***Not Applicable.*** In March 2022, Ms. Gail Hutchings announced her resignation as Court Monitor to the Parties. In April and May 2022, she facilitated recruitment and interviews of qualified candidates to assume the Court Monitor role. In May 2022, the Parties selected Ms. Kathryn du Pree as Court Monitor, and the Court approved her appointment on August 1, 2022. Ms. du Pee officially commenced her role in August 2022, outside of this reporting period.	**FY2018: In Compliance** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
39	Consent Decree IX(18)	Not less than every six (6) months, Defendants shall provide the Monitor and Plaintiffs with a detailed report containing data and information sufficient to evaluate Defendants' compliance with the Decree and Defendants' progress toward achieving compliance, with the Parties and Monitor agreeing in advance of the first report of the data and information that must be included in such report. ***In Compliance***. The Defendants produced semi-annual reports that contained the data and information necessary to assess compliance and performance on the Consent Decree and Implementation Plan requirements.	**FY2018: Partial Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
40	Consent Decree IX(18)	Defendants will not refuse any request by the Monitor for documents or other information that are reasonably related to the Monitor's review and evaluation of Defendants' compliance with the Decree, and Defendants will, upon reasonable notice, permit confidential interviews of Defendants' staff or consultants, except their attorneys. ***In Compliance***. The Defendants complied with this requirement.	**FY2018: In Compliance** **FY2019: Partial Compliance** **FY2020: Partial Compliance**	**In Compliance**	**In Compliance**
41	Consent Decree IX(18)	The Monitor will have access to all Class Members and their records and files, as well as to those service providers, facilities, building and premises that serve, or are otherwise pertinent to, Class Members, where such access is reasonably related to the Monitor's review and evaluation of Defendants' compliance with the Decree. ***In Compliance***. The Defendants complied with this requirement.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**

42	Consent Decree IX(18)	The Defendants shall comply with Plaintiffs' requests for information that are reasonably related to Defendants' compliance with the Decree, including without limitation requests for records or other relevant documents pertinent to implementation of the Decree or to Class Members. Plaintiffs shall also be permitted to review the information provided to the Monitor. All information provided to the Monitor and/or Plaintiffs pursuant to the Decree shall be subject to the Protective Order. ***In Compliance.*** The Court Monitor queried Class Counsel on 12/13/22 and received a response on 12/21/22. While the Class Counsel questioned the validity of some data, they did not report any instances wherein the Defendants did not supply requested data and information.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: Partial Compliance**	**In Compliance**	**In Compliance**
43	Consent Decree IX(20)	Defendants shall compensate the Monitor and his or her staff and consultants at their usual and customary rate subject to approval by the court. Defendants shall reimburse all reasonable expenses of the Monitor and the Monitor's staff, consistent with guidelines set forth in the "Governor's Travel Control Board Travel Guide for State Employees." Defendants may seek relief from the Court if Defendants believe that any of the Monitor's charges is inappropriate or unreasonable. ***In Compliance***. The Defendants complied with this requirement.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
44	Consent Decree XII(24)	The cost of all notices hereunder or otherwise ordered by the Court shall be borne by the Defendants. ***In Compliance.*** The Defendants complied with this requirement.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
45	Consent Decree XI(22)	In full settlement of all attorneys' fees incurred to date in connection with the litigation, Defendants shall pay, subject to court review and approval, $1,990,000.00 to Class Counsel. In full settlement of all out-of-pocket costs and expenses (not to include attorneys' fees) incurred to date by Class Counsel, Defendants shall pay to Class Counsel such costs and expenses incurred by Class Counsel through and including the Approval of the	**FY2018: N/A** **FY2019: N/A**	**N/A**	**N/A**

		Decree and any appeal thereof. Such amounts shall be distributed to Class Counsel in the manner set forth in written instructions provided by Class Counsel. Furthermore, such amounts hall be set forth in a Judgment Order to be entered by the Court. Defendants shall complete and submit all paperwork necessary for payment of such amounts, plus applicable statutory post-judgment interest, within five (5) business days after expiration of the time to appeal the fee award without the filing of a Notice to Appeal or after the issuance of the mandate by the highest reviewing court, whichever is later. ***Not Applicable**. This requirement is not applicable to this reporting period.*	**FY2020: N/A**		
CM1	Consent Decree IX(17)	The Monitor's duties include evaluating Defendants' compliance with the Decree, identifying actual and potential areas of non-compliance with the Decree, mediating disputes between the Parties, and bringing issues and recommendations for their resolution to the Court. Within 60 days after the end of each year of service, the Monitor will report to the Court and the Parties regarding compliance with the Decree. Such reports shall include the information necessary, in the Monitor's professional judgment, for the Court and Plaintiffs to evaluate the Defendants' compliance or non-compliance with the terms of the Decree. The Monitor may file additional reports as necessary. Reports of the Monitor shall be served on all Parties. ***In Compliance.*** The Court Monitor produced her annual report, and it was filed on January 18, 2022.	**FY2018: In Compliance (Court Monitor Requirement)** **FY2019: In Compliance (Court Monitor Requirement)** **FY2020: In Compliance (Court Monitor Requirement)**	**Court Monitor Require-ment -- In Compliance**	**Court Monitor Require-ment -- In Compliance**
CM2	Consent Decree IX(19)	In the event that the Monitor finds Defendants not in compliance with the Decree, the Monitor shall promptly meet and confer with the Parties in an effort to agree on steps necessary to achieve compliance. In the event that Plaintiffs believe that Defendants are not complying with the terms of the Decree, Plaintiffs shall notify the Monitor and Defendants of Defendants' potential non-compliance. The Monitor then shall review the Plaintiffs' claims of actual or potential non- compliance and, as the Monitor deems appropriate in his or her professional judgment,	**FY2018: In Compliance (Court Monitor Requirement)** **FY2019: In Compliance (Court Monitor Requirement)**	**Court Monitor & Plaintiffs' Require-ment — In Compliance**	**Court Monitor & Plaintiffs' Require-ment — In Compliance**

		meet and confer with Defendants and Plaintiffs in an effort to agree on steps necessary to achieve compliance with the Decree. If the Monitor and Parties agree, such steps shall be memorialized in writing, filed with the Court, and incorporated into, and become enforceable as part of, the Decree. In the event that the Monitor is unable to reach agreement with Defendants and Plaintiffs, the Monitor or either Party may seek appropriate relief from the Court. In the event that Plaintiffs believe that Defendants are not in compliance with the Decree and that the Monitor has not requested appropriate relief from the Court, Plaintiffs may seek relief from the Court. The Monitor will not communicate with the Court without advance notice to the Parties. ***In Compliance***. The Court Monitor convened regular Large Parties, Small Parties, and ad hoc meetings to identify and attempt to resolve issues of disagreement or non-compliance. A meeting dedicated specifically to Defendants' FY21 areas of partial- and non-compliance was led by the Court Monitor April 19, 2022.	**FY2020: In Compliance (Court Monitor Requirement)**		
AD-1(1)	FY22 IP	Strategy: Monitor and report on Consent Decrees' budgeted funds spending on a quarterly basis. Include plans to reallocate potential lapsed appropriations to achieve compliance (as permitted). Expected Improvement/Outcome: ● Regular monitoring and reporting of quarterly spending. ***In Compliance.*** The Defendants provided quarterly budget updates (11/30/21, 2/28/22, 5/31/22, 9/1/22).	**N/A**	**N/A**	**In Compliance**
AD-1(2)	FY22 IP	Strategy: See above. Expected Improvement/Outcome: ● Quarterly plan to address potential lapses delivered. ***In Compliance.*** The Defendants provided quarterly budget updates (11/30/21, 2/28/22, 5/31/22, 9/1/22), including planned uses for potential lapsed funds.	**N/A**	**N/A**	**In Compliance**

AD-2	FY22 IP	Strategy: Monitor and report on FDDP and Comprehensive Program services delivered to individuals/CM, and service outcomes on a monthly basis via Data Dashboards. Monthly reporting generated by CASPIO will include: Issues reported by providers (facility/CM access problems, resource needs, etc. and proposed resolutions with outcomes), Corrective Action Plans issued/penalties imposed for providers who do not meet performance standards, data on rapid Medicaid application process, SMHRF/SNF barriers, employment data, and SOAR activities. Expected Improvement/Outcome: ● Regular monitoring and monthly dashboards delivered. ***In Compliance.*** The Defendants provided monthly Parties' Data Dashboards and reported to the Parties and Monitor on provider management efforts, including issuing of PIPs/CAPs on a quarterly basis.	**N/A**	**N/A**	**In Compliance**
AD-3	FY22 IP	Strategy: In FY22, continue to assess Consent Decree staffing needs across all agencies. Expected Improvement/Outcome: ● By December 30, 2021, Defendants will submit a consolidated report to Parties and the Court Monitor that identifies the positions, staff name(s) who occupy the position(s), or for vacant positions, a date by which the position will be filled. ***In Compliance.*** The Defendants sent Staffing Assessment Summary and Report to the Parties and Court Monitor on 12/30/21.	**N/A**	**N/A**	**In Compliance**
AD-4	FY22 IP	Strategy: As part of UIC CON's role in data gathering/ management of the Comprehensive Program/FDDP, UIC CON will continue to manage Prime and FDDP providers, to closely monitor Class Members moving through the process in Consent Decree to ensure that the process is being implemented in a timely manner and to prevent unnecessary admission into SMHRFs. Expected Improvement/Outcome: ● Adequate level of programmatic oversight and support to implement Consent Decrees' programming and achieve compliance. ***In Compliance.*** IDHS-DMH contracted with UIC CON to provide program oversight and manage the CM pipeline to ensure CM transition requirements are met and manage the FDDP efforts to prevent unnecessary admissions to SMHRFs.	**N/A**	**N/A**	**In Compliance**

AD-5	FY22 IP	Strategy: By July 15, 2021, IDHS to provide core components, benchmark studies and primary analysis of Class size and demographics to Parties and Court Monitor. Expected Improvement/Outcome: ● Identified reports provided by July 15, 2021. ***In Compliance.*** Defendants sent reports to the Parties and Court Monitor on 7/15/21.	**N/A**	**N/A**	**In Compliance**
AD-6	FY22 IP	Strategy: By September 30, 2021, HFS to identify data points from Medicaid data systems to support clinical characteristics analysis. Expected Improvement/Outcome: ● Data points provided by September 30, 2021 ***In Compliance.*** HFS identified data points from the Medicaid data systems to support the Class Member clinical characteristics analysis. HFS emailed the information to Court Monitor on 9/30/21.	**N/A**	**N/A**	**In Compliance**

Section IX. Implementation Planning

The Defendants are required to develop an annual implementation plan in consultation with the Court Monitor and Plaintiffs' Counsel, an integral annual deliverable that identifies desired performance indicators and outcome measures, key tasks and action steps, responsible parties, and timeframes/due dates for the forthcoming fiscal year. The *Williams* Consent Decree contains a requirement that Defendants "shall create and implement an Implementation Plan that outlines how they intend to operationalize concrete strategies to satisfy their Consent Decree obligations." The Implementation Plan is filed with the Court and the commitments contained therein become enforceable under the Decree.

Implementation Plan-Related Requirements. The *Williams* Consent Decree contains several requirements that dictate the required components of the Implementation Plan, obligate its development and timely filing, and sanction its enforceability under the Decree. The Court Monitor has determined that some Consent Decree requirements (Requirements 48, 49, and 51-58) apply to the FY22 Implementation Plan and thus fall under this report. However, other Implementation Plan-related requirements (Requirements 50 and 59) apply to the FY23 Implementation Plan. The requirements in this domain include:

- The FY22 Implementation Plan's described methods by which Class Members can understand their rights to and request Consent Decree-related services and procedures for recording those requests (Requirement 48).
- The FY22 Implementation Plan's inclusion of methods for engaging Class Members and a procedure to provide opportunities to visit community-based services settings (Requirement 49).
- Completion of the FY22 Implementation Plan (Requirement 50), which takes place during the FY2021 compliance period.
- The FY22 Implementation Plan's delineation of specific tasks, timetables, goals, and plans to assure the Defendants' fulfillment of the Decree's obligations (Requirement 51).
- The FY22 Implementation Plan's inclusion of hiring, training, and supervision sufficient to implement Decree obligations and operate the Decree overall (Requirement 52).
- The FY22 Implementation Plan's description of activities required to develop community-based services and housing in sufficient measure (Requirement 53).
- The FY22 Implementation Plan's description of a data-driven process that utilizes Class Member service plan data (Requirement 54) and demographic data (Requirement 55) to inform community-based services and housing development.
- The FY22 Implementation Plan's inclusion of key regulatory changes governing SMHRFs that will facilitate stronger Consent Decree compliance (Requirement 56).
- The FY22 Implementation Plan's inclusion of tasks that will support the critical Consent Decree functions of evaluation (Requirement 57) and outreach (Requirement 58).
- The annual development of an Implementation Plan, in this case for FY23 (Requirement

59).

- The FY22 Implementation Plan's Decree enforceability (Requirement 60).

Implementation Plan-Related Data Highlights. There are no data highlights for this domain.

Implementation Plan-Related Requirements and Compliance Ratings. Below (in Figure 15), please find the specific requirements in this domain. Across the 14 Consent Decree and FY22, Implementation Plan requirements, 13 are assessed below (as one is not applicable to this reporting period). **All thirteen (13) are in compliance.**

Figure 15. FY18-FY22 Compliance Assessment Ratings for *Williams* Implementation Plan-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	*Williams* Consent Decree Requirement Language and FY22 Performance	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
48	Consent Decree VII(10)	The Implementation Plan shall describe methods by which such information will be disseminated, the process by which Class Members may request services, and the manner in which Defendants will maintain current records of these requests. ***In Compliance***. The Defendants complied with this requirement, as this required content was included in the FY22 Implementation Plan.	FY2018: Out-of-Compliance FY2019: Partial Compliance FY2020: In Compliance	In Compliance	In Compliance
49	Consent Decree VII(10)	The Implementation Plan shall describe methods for engaging residents, including where appropriate, providing reasonable opportunities for residents to visit and observe Community-Based Settings. ***In Compliance***. The Implementation Plan is required to include the Defendants' strategies for actively engaging Class Members, as well as the process by which Class Members can observe community-based services and housing options for which they are eligible. The Defendants included such strategies and are found in compliance with this requirement.	FY2018: Out-of-Compliance FY2019: Partial Compliance FY2020: Partial Compliance	Partial Compliance	In Compliance
50	Consent Decree VII(11)	Defendants, with the input of the Monitor and Plaintiffs, shall create and implement an Implementation Plan to accomplish the obligations and objectives set forth in the Decree. ***In Compliance***. This requirement pertains to whether the Defendants developed the FY23 Implementation Plan (due near the end of the FY22 compliance period) to identify commitments for FY23. They did so, as the Implementation Plan was filed on 7/26/22. As such, they are found in compliance with these requirements.	FY2018: Out-of-Compliance FY2019: In Compliance FY2020: In Compliance	In Compliance	In Compliance
51	Consent Decree VII(11)	*The Implementation Plan must, at a minimum*: a) Establish specific tasks, timetables, goals, programs,	FY2018: Out-of-Compliance	In Compliance	In Compliance

		plans, strategies, and protocols to assure that Defendants fulfill the requirements of the Decree. ***In Compliance***. The FY22 Implementation Plan included specific, measurable, and time bound activities to advance fulfillment of the requirements of the Decree.	**FY2019: Partial Compliance** **FY2020: Partial Compliance**		
52	Consent Decree VII(11)	*The Implementation Plan must, at a minimum*: b) Describe the hiring, training and supervision of the personnel necessary to implement the Decree. ***In Compliance***. The FY22 Implementation Plan contained several provisions on personnel and their training requirements.	**FY2018: Out-of-Compliance** **FY2019: Partial Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
53	Consent Decree VII(11)	*The Implementation Plan must, at a minimum*: c) Describe the activities required to develop Community-Based Services and Community-Based Settings, including inter-agency agreements, requests for proposals and other actions necessary to implement the Decree. ***In Compliance***. The FY22 Implementation Plan outlined activities to expand capacity of community-based services and housing.	**FY2018: Out-of-Compliance** **FY2019: Partial Compliance** **FY2020: Partial Compliance**	**In Compliance**	**In Compliance**
54	Consent Decree VII(11)	*The Implementation Plan must, at a minimum*: d) Identify, based on information known at the time the Implementation Plan is finalized and updated on a regular basis, any services or supports anticipated or required in Service Plans formulated pursuant to the Decree that are not currently available in the appropriate quantity, quality or geographic location. ***In Compliance***. The Defendants, in partnership with UIC-CON, conducted an analysis of Class Member service plan data to inform housing and services capacity development.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**In Compliance**
55	Consent Decree VII(11)	*The Implementation Plan must, at a minimum:* e) Identify, based on information known at the time the Implementation Plan is finalized and updated on a regular basis, any services and supports which, based on demographic and other data, are expected to be required within one year to meet the obligations of the Decree. ***In Compliance***. The Defendants, in partnership with UIC-CON, conducted an analysis of Class Member service plan data to inform services and housing capacity expansion efforts.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**In Compliance**
56	Consent Decree VII(11)	*The Implementation Plan must, at a minimum*: f) Identify any necessary changes to regulations that govern IMDs in order to strengthen and clarify requirements for services to persons with Mental Illness and to provide for effective oversight and enforcement of all regulations and	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance**	**In Compliance**	**In Compliance**

		laws. ***In Compliance***. During FY22, the Defendants enforced new processes regarding the investigation of retaliation claims and engagement of involuntarily discharged Class Members. Further, they changed SMHRF administrative rules to require facilities to submit monthly census reports, provide reports on voluntary and involuntary discharges, and furnish admitted Class Members with educational materials on the Consent Decree.	**FY2020: Partial Compliance**		
57	Consent Decree VII(11)	*The Implementation Plan must, at a minimum:* g) Describe the methods by which Defendants shall ensure compliance with their obligations under Paragraph 6 *(Evaluations)* of this Decree. ***In Compliance***. The FY22 Implementation Plan included activities and tasks associated with compliance in the assessment (formerly referred to as evaluation) domain.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
58	Consent Decree VII(11)	*The Implementation Plan must, at a minimum:* h) Describe the mechanisms by which Defendants shall ensure compliance with their obligations under Paragraph 10 *(Outreach)* of this Decree. ***In Compliance***. The FY22 Implementation Plan included activities and tasks associated with compliance in the outreach domain.	**FY2018: Out-of-Compliance** **FY2019: Partial Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
59	Consent Decree VIII(13)	The Implementation Plan shall be updated and amended annually, or at such earlier intervals as Defendants deem necessary or appropriate. The Monitor and Plaintiffs may review and comment upon any such updates or amendments. In the event the Monitor or Plaintiffs disagree with the Defendants' proposed updates or amendments, the matter may be submitted to the Court for resolution. ***In Compliance***. This requirement pertains to whether the Defendants developed the FY23 Implementation Plan (due near the end of the FY22 compliance period) to identify commitments for FY22. They did so, as the Implementation Plan was filed on 7/26/22. As such, they are found in compliance with these requirements.	**FY2018: Out-of-Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
60	Consent Decree VIII(14)	The Implementation Plan, and all amendments or updates thereto, shall be incorporated into, and become enforceable as part of the Decree. ***In Compliance.*** The FY23 Implementation was filed and will be enforced in accordance with the Consent Decree, with agreement from the Defendants.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
61	Consent Decree VIII(12)	Within 135 days of Approval of the Decree, Defendants shall provide the Monitor and Plaintiffs with a draft Implementation Plan. The Monitor and Plaintiffs will participate in developing and finalizing the	**FY2018: N/A** **FY2019: N/A**	**N/A**	**N/A**

		Implementation Plan, which shall be finalized within nine (9) months following Approval of the Decree. In the event the Monitor or Plaintiffs disagree with the Defendants' proposed Implementation Plan, the matter may be submitted to the Court for resolution.	**FY2020: N/A**		

Section X. Quality Assurance

Williams Class Members are adults with diagnoses of serious mental illness, often co-occurring with substance use disorders, medical comorbidities, unstable housing, and poverty. Ensuring that they are provided quality services and supports in safe environments is a fundamental responsibility of the Defendants. Use of quality assurance mechanisms and tools buttressed by a commitment to examining process and outcome data to inform decision-making and program implementation is key to successfully meeting this responsibility.

Several data sources — identified in the Defendants' reports — enable one to examine Class Member quality of life and safety. These include pre- and post-transition quality of life survey data completed by Class Members and analyzed by the University of Illinois in Chicago, College of Nursing (UIC CON) under contract to DHS; Specialized Mental Health Rehabilitation Facility (SMHRF) Reportable Performance Indicators data from the Illinois Department of Public Health (IDPH); post-transition critical incident data provided by DMH; and annual mortality data collected and analyzed by UIC CON.

Incident Data. On a monthly basis, IDPH collects — via the SMHRF Reportable Performance Indicators form — the number of specific types of critical incidents reported by SMHRFs, including resident deaths that occur in SMHRFs and acute care hospital visits by SMHRF residents; incidents of abuse, neglect, or maltreatment; and other critical incident types. Not all information is available: for example, outcomes for individuals who are hospitalized may not be reported unless the individual returns to the SMHRF. The following summarizes reportable Incidents during FY2022 that were substantiated and rose to the level of a complaint investigation. A similar set of critical incident categories are collected by the DMH for the first 18 months following a Class Member's transition to the community.

Comparing SMHRF and post-transition critical incident data would ideally allow sound assessment of Class Members' outcomes and experiences in SMHRFs versus in the community. However, several factors make it difficult to conduct a meaningful comparison between SMHRF and post-transition (community-based) critical incident data, including:

- Post-transition critical incident data is only collected for 18 months after transition date, leaving critical incidents that occur for Class Members transitioned longer than this period unreported and thus unknown.
- The critical incident categories across both cohorts have not been independently verified to ensure that definitions and reporting procedures align between SMHRF and community categories.
- Some incidents — such as assaults —may be counted within multiple categories (e.g., sexual assault, abuse, assault, and criminal conduct), potentially giving a misleading picture regarding the true extent of critical incidents.
- The denominators for the subgroups are different. At the beginning of FY22, the census in SMHRFs was approximately 3,300, while the number of people in the community (within 18 months of transition) was 216.

Figure 16. Comparative Analysis, FY2022 Critical Incidents in SMHRF vs. Post-Transition to Community

Incident Type/Category	Within SMHRFs	Post-Transition to Community
Sexual Assault	108	7
Abuse/Neglect/Maltreatment	403	12
Death	29	10
Assault	74	22
Missing Person	9	9
Criminal Conduct	65	4
Fires	0	3

Notwithstanding these methodological issues, the critical incidents occurring in FY22—provided in Figure 16 — suggests that critical incidents are experienced among the Class Members differently. There is a smaller percentage of abuse/neglect reports for transitioned CMs, 12 of 216 (6%) than for SMHRF residents, 403 of 3,300 (12%); a comparable percentage of 3% for both populations for sexual assault; and a significantly higher percentage of assaults among transitioned CMs, 22 of 216 (10%) than for SMHRF residents, 74 of 3,300 (2%).

In FY2022, the most common categories of reportable incidents in SMHRFs were instances of abuse/neglect/maltreatment, sexual assault, and assault. The most common category of incident experienced by post-transition Class Members in the community is assault.

Mortality Review Data. Ten deaths occurred among Class Members in the community in FY22. Four of these deaths were attributed to substance use, three were attributed to cardiovascular disease/failure, and three were pending at the time of Defendants' report submission. Seven decedents were male and three were female. The average age at time of death was 50. The average number of months living in the community at time of death was 11 months.

Quality of Life Data. Quality of life survey data consistently indicates that Class Members report an enhanced quality of life after transitioning into the community from SMHRFs. In FY22, UIC CON facilitated completion of quality-of-life surveys for *Williams* Class Members. Surveys are attempted at two points, first at transition/community move (baseline) reflecting their LTCF or SMHRF stay, and then at one-year post-transition reflecting their experience with community living. Class Members are asked to self-report their satisfaction across seven key domains: Living Situation; Choice and Control of Living Arrangements; Access to Personal Care; Respect and Dignity from Caregivers; Community Integration and Inclusion; Overall Life Satisfaction; and Health Status (includes mood).

The Defendants shared a two-part report prepared by UIC CON summarizing QOL survey findings for both *Williams* and *Colbert* class members, spanning the periods of FY2021 and FY2022. FY2022 data reflects information gathered from 194 survey responses. The average response rate across all surveys (i.e., both baseline and post-transition surveys) in FY2022 was 42%.

Several survey items showed an increase in happiness or satisfaction indicating an improvement in quality of life of *Williams* Class Members post-transition at statistically significant levels. Class Members reported a statistically significant increase in **liking where they live** post-transition as compared to baseline (Survey Q3: *Do you like where you live?*). Additionally, Class Members were significantly **less likely to have experienced sadness in the**

past week at year one compared to baseline (Survey Q39: *During the past week have you felt sad or blue?).*

In addition, survey results suggest that *Williams* Class Members show other significant improvements post-transition, although the design of the survey limits the conclusions that can be drawn from a statistical perspective. Notably, Class Members also showed a statistically significant increase in **feeling happy with the help they receive and the way they live their life** at year one compared to baseline (Survey Q38: *Taking everything into consideration, during the past week have you been happy or unhappy with the help you get with the way you live your life?*). Class Members also showed a statistically significant in their **ability to access community resources** (Survey Q28, *Can you get to the places you need to go, like work, shopping, or the doctor's office?).* Overall, quality of life survey findings indicate positive changes in Class Member satisfaction, mood and community access post-transition. The UIC CON survey reports do not note any areas of concern for Class Members post-transition.

To summarize, data and analyses shared by Defendants indicate that *Williams* Class Members experience statistically significant improvements in several important quality of life measures post-transition. Data also suggest that Class Members are less likely to experience significant safety issues in the community, including abuse, neglect, maltreatment and assault, than they would if housed in SMHRFs.

Section XI. Recommendations

Based on her review and assessment of Defendants' performance with Consent Decree requirements in FY22, the Court Monitor recommends the following priority actions (Figure 17) for the remainder of FY23 and FY24. These recommendations align with current conversations between the Court Monitor and the Parties focused on establishing a plan for "reasonable pace," and operationalizing the prior Court Monitor's recommendations from the timeliness study filed in August 2022.

Figure 17. Priority Recommendations for FY2023 and FY2024	
1) Continue to implement and improve the SMHRF re-admission process and Front Door Diversion Program (FDDP) to fully comply with Consent Decree diversion requirements	The Court Monitor commends the Defendants with Preadmission Screening and Resident Review (PASRR) redesign, which included a SMHRF pre-screening process. When braided with an effective and far-reaching FDDP program, these programs have the potential to ensure that Class Members who can successfully be served in the community (and elect to live there) will not experience needless SMHRF admission. The Defendants should create simple performance indicators that capture the proportion of SMHRF admissions who – either through the PASRR process or FDDP program – were meaningfully offered community-based services and housing. Further, Defendants must ensure these programs are implemented effectively and that quality assurance mechanisms are in place to ensure that the newly designed PASRR system continues to be implemented as it is constructed.
2) Design a new outreach data reporting approach	The current outreach data renders it difficult to assess outreach penetration, appropriate frequency, and quality. The Court Monitor acknowledges that every Class Member contact cannot (and perhaps should not) be captured. A robust outreach program should include unstructured and informal engagements that do not lend themselves to onerous data collection requirements. However, the Court Monitor believes that it is time to design an approach that acknowledges the unquantifiable elements of an effective and organic outreach program while focused on capturing and providing data that reliably reports completed outreach and the time period in which the outreach occurs to relate to compliance expectations.
3) Address severe delays in all stages of the pre-transition process	When Class Members consent to outreach, assessment, service planning and transition processes, they should be able to move through these phases promptly. However, data provided herein – and in the August 2022 timeliness analysis – demonstrates that only 41% percent of Class Members received prompt initial outreach (within 60-70 days of admission), 41% received prompt initial assessments (within 14 days of positive outreach outcome), 29 percent received prompt initial service plans (within 45 days of assessment), and 41% were transitioned within 120 days of the initial service plan. While the organizing principle for the Comprehensive Program was to reduce handoffs among providers and improve process efficiency, it has now become standard that Class Members wait for months (and even years) to move through the rudimentary process steps, which likely erodes their confidence and trust in the program.
4) Ensure that those who have waited longest to transition receive priority in the transition pipeline	Near the end of FY22, an estimated 1,100 *Williams* and *Colbert* Class Members – who were recommended to transition between July 2020 and December 2021 – remained stuck in the pipeline, some nearly two years after their recommended assessments. While it is positive to conduct outreach and assessments to add more Class Members to the transition pipeline, Class Members who were already recommended but wait in the pipeline should be prioritized for transition.
5) Address critical incidents in SMHRFs and in the community, including reducing avoidable hospitalizations	Critical incident data within SMHRFs remains a cause for alarm. The Defendants should conduct a more robust analysis of this data to determine trends, root causes, and potential strategies to prevent or address identified issues. This analysis should include a review of SMHRF policies and operational procedures that might contribute to critical incidents and a regulatory framework that can address SMHRFs that do not address issues. Further, the Defendants should develop dedicated interventions

	and programmatic strategies to prevent avoidable psychiatric and physical health-related hospitalizations, which constitute over half of all community-based critical incidents. Such strategies could include (but are not limited to): enhancements of mobile crisis infrastructure, implementation and increased linkage to/utilization of peer respite and living room models, and enhanced access to ACT services when Class Members are escalating or experiencing crisis.
6) Increase the role of the State's Medicaid MCOs in transitioning *Williams* Class Members.	The vast majority of *Williams* Class Members, whether residing in SMHRFs or the community, are enrollees under a Medicaid MCO. However, there was only one MCO-facilitated transition in FY22. The Court Monitor advises HFS to dedicate concerted attention to the design of requirements, incentives, accountability, and performance measures so that the Medicaid MCO potential to achieve and support transitions consistent with Olmstead is fully realized in both *Williams* and *Colbert* Consent Decrees. Relatedly, MCOs must be required to timely review and approve (when warranted) the services needed by Class Members enrolled in their plans for transition and community tenure.
7) Develop innovative service delivery partnerships to expand transition support and services capacity	In addition to fully optimizing the MCO role in the Consent Decree processes, the State should continue to engage new organizations to perform transition support and community-based services and housing. Such organizations include (but are not limited to): specialty behavioral health organizations, primary/medical care organizations (including health systems that serve complex populations and federally qualified health centers), aging and disability services organizations, housing first organizations, and others. By deepening understanding of the needs of Consent Decree subpopulations (using four-quadrant and other data sources), the State can design dedicated care pathways for specific subpopulations and identify providers who can address their needs, ensuring that Class Members receive accurate care.

Section XII. Conclusion

This report is submitted to the Court in fulfillment of the Court Monitor's duty to assess compliance with the *Williams* Consent Decree and Implementation Plan requirements at least annually; it represents the effort to conduct a fair and impartial assessment. The compliance assessment period covered is July 1, 2021-June 30, 2022 (FY22). Based on FY22 performance data and outcomes on the 120 requirements in the Consent Decree and FY22 Implementation Plan combined, the Defendants were in compliance with 60% of requirements, in partial compliance with 24%, and out-of-compliance with 16%.

While the Pritzker Administration revised Consent Decree operations and processes intended to transition Class Members who want to and are able avoid or exit SMHRFs for community living, they also inherited a multiyear divestment in community-based mental health services including a dismantled crisis stabilization system, an under-developed and poor performing diversion program, an affordable housing shortage, a subjective long-term care admissions process, and many other systems, policy, and practice issues that span the Defendant agencies. Further, the COVID-19 crisis exacerbated these pre-existing issues and added a host of formidable new issues (e.g., behavioral health provider staffing shortages), further destabilizing the mental health and overall healthcare systems and causing a virtual halt to essential Consent Decree operations including outreach, assessments, and transitions.

In FY22, the Defendants made several key achievements under the *Williams* Consent Decree, including strong transition performance and the implementation of a redesigned SMHRF pre-screening process to prevent needless SMHRF admissions. Building on these successes, FY23 should focus on ensuring that Class Members recommended to transition do not experience extreme pre-transition delays, that new and expanded service delivery and housing partnerships are forged to address need, and that the braided efforts of SMHRF pre-screening and hospital-based diversion programming result in no individual who wants or is able to live in the community, is needlessly admitted into a SMHRF. Along with the other recommendations identified in this report, the Defendants are well-equipped to continue to address many of the long-standing issues with Illinois's behavioral health and disability system of care.

APPENDIX A

Background and History: *Williams v. Pritzker* and the *Williams* Consent Decree

In 2005, Plaintiffs brought suit in the United States District Court, Northern District of Illinois, alleging violations of Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. Plaintiffs alleged that the State of Illinois was segregating and institutionalizing adults with mental illnesses in 24 Institutions for Mental Diseases (IMDs) — now known as Specialized Mental Health Rehabilitation Facilities (SMHRFs) — located across the State, failing to provide opportunities for those individuals to live and receive services in the most integrated setting appropriate to their needs. The lawsuit named five Defendants in Illinois state government, including the Governor, the Secretary of the Illinois Department of Human Services (DHS), the Director of the Division of Mental Health (DMH) of the Illinois Department of Human Services, the Director of the Illinois Department of Healthcare and Family Services (HFS), and any of their successors. The Defendants did not admit to violations and, on September 29, 2010,[14] the State of Illinois entered into the *Williams* Consent Decree. DMH, contained within DHS, led Defendants' Consent Decree implementation efforts from initiation of that process in 2010 through 2019. In FY 2020, the Office of the Secretary of DHS began leading Defendants' implementation efforts, while coordinating as needed with DMH and the other Defendant agencies.

This fiscal year (FY22) marks 12 years since the filing of the *Williams* Consent Decree. The Consent Decree defines *Williams* Class Members as, "All Illinois residents who are eighteen (18) years of age or older and who: (a) have a Mental Illness; (b) are institutionalized in a privately owned Institution for Mental Diseases;[15] and (c) with appropriate supports and services may be able to live in an integrated community setting."[16]

The Consent Decree enumerates specific requirements placed on the Defendants, some time-limited and others ongoing, which include diversion, outreach, assessments, service plans, community-based service and housing development, transitions, implementation planning, and administrative requirements. The Consent Decree also addresses the process of hiring a Court Monitor, specifies the duties, grants specific powers, and obligates Defendants to honor requests that are relevant to the fulfillment of the Court Monitor's duties. Finally, the Consent Decree names specific instances in which the Plaintiffs and the Court Monitor must be involved in various processes and states that the Court will make final determinations on matters that the Parties cannot agree upon.

Various court orders have impacted Consent Decree requirements, including but not limited to:

[14] *Williams v. Blagojevich*, Case No. 05 C 4673, United States District Court for the Northern District of Illinois, Eastern Division. Filed August 15, 2005. Page 7.
[15] The term Institutions of Mental Diseases (IMDs) represents a federal classification (pursuant to Medicaid regulations) assigned to hospitals, nursing facilities, or other institutions that each have more than 16 beds, serve adults, and where more than 50 percent of its residents have diagnoses of serious mental illness.
[16] *Williams v. Quinn*, Case 1:05-cv-04673; Docket #326, Filed 3/15/10; Page 2 of 23.

- *Williams* Consent Decree Order, entered on September 29, 2010.
- Initial Implementation Plan, approved on July 29, 2011.
- Order by the Honorable William T. Hart appointing Dennis Jones, MSW, MBA, as Court Monitor, signed on November 1, 2010.
- Order to substitute Bruce Rauner for Pat Quinn as a named Defendant (Governor), signed on January 29, 2015.
- Case reassignment to the Honorable Joan H. Lefkow for all further proceedings, September 8, 2017.
- Order by the Honorable Joan H. Lefkow appointing Gail Hutchings, MPA, as Court Monitor, signed on September 26, 2017.
- Order to substitute J.B. Pritzker for Bruce Rauner as a named Defendant (Governor), signed on April 10, 2019.
- Order by the Honorable Joan H. Lefkow appointing Kathryn du Pree, as Court Monitor, signed on August 1, 2022.

APPENDIX B

Compliance Assessment Ratings for All *Williams* Consent Decree and FY22 Implementation Plan Requirements

FY18-FY22 Compliance Assessment Ratings for ALL *Williams* Consent Decree and FY22 Implementation Plan Requirements					
Diversion-Related Requirements					
Req #	**Source/ Citation**	***Williams* Consent Decree Requirement Language and FY22 Performance**	**Prior Years' Compliance Ratings**	**FY21 Compliance Rating**	**FY22 Compliance Rating**
1	*Williams* Consent Decree VI(8)(B)	Within one (1) year of finalization of the Implementation Plan [2012][17], no individual with Mental Illness shall be admitted to an IMD without a prescreening having first been conducted through the PASRR Process and an initial Service Plan completed. Defendants will ensure that the PASRR Process: identifies and assesses individuals who may be appropriate for placement in a Community-Based setting; identifies Community-Based Services that would facilitate that placement; and ensures that approved admissions to IMDs are only for those IMDs that can provide treatment consistent with the individual's initial Service Plan and consistent with the goal of transition to a Community-Based Setting. ***Partial Compliance.*** In April 2022, the Defendants implemented a PASRR-aligned SMHRF pre-admission assessment and referral process. Full compliance cannot be assigned because this process was not in place for the full year and because the Defendants did not provide data on the proportion of admitted Class Members that received such pre-screening. However, the Defendants are credited with partial compliance given that the process was established.[18]	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
2	*Williams* Consent Decree VI(8)(B)	After the first five (5) years following the finalization of the Implementation Plan [2016[19]], no individual with Mental Illness whose Service Plan provides for placement in Community-Based settings shall be housed or offered placement in an IMD at public	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**

[17] Date added.
[18] In their review of a draft version of this report, the Defendants indicated that, "moving forward, the proportion of admitted Class Members that receive a preadmission assessment is expected to be 100%."
[19] Date added.

		expense unless, after being fully informed, he or she declines the opportunity to receive services in a Community-Based Setting. ***Partial Compliance.*** The Defendants made significant efforts in design and implementation of the PASRR-aligned SMHRF pre-screening process and continued implementation of the Front Door Diversion Program. However, they did not provide data to prove that SMHRF admissions were limited to those whose service plans dictated SMHRF placement or who were offered but declined community-based services.	**FY2020: Out-of-Compliance**		
FD-1 (1)	FY22 IP	Strategy: Implement redesign of PASRR Plus system including pre-admission screening specifically for SMHRF admissions and referral to Front Door as appropriate. Within 9 months after contract start date, go live with new PASRR and SMHRF prescreening system and processes, including QA mechanism(s). Expected Improvements/Outcomes: ● Compliance with federal PASRR requirements as established by Centers for Medicare and Medicaid Services. ***In Compliance***. Defendants executed a contract with a vendor (Maximus) to implement a redesigned system that is compliant with federal PASRR requirements as established by Centers for Medicare and Medicaid Services.	**N/A**	**N/A**	**In Compliance**
FD-1 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● Coordination between SMHRF pre-screening activities and Front Door Diversion Program (FDDP) referrals. ***In Compliance.*** Defendants launched a redesigned system that improves coordination between SMHRF pre-screening activities and Front Door Diversion Program (FDDP) referrals. This new system went live on 3/14/22.	**N/A**	**N/A**	**In Compliance**
FD-1 (3)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 90% of PASRR Plus screens result in clinically accurate and appropriate determinations. ***Partial Compliance***. The Defendants Indicate that 87.5% of assessment were found to be clinically appropriate, through a rigorous quality assurance process.	**N/A**	**N/A**	**Partial Compliance**

FD-2 (1)	FY22 IP	Strategy: With input and advice from Court Monitor and Plaintiffs' Counsel, design and implement a new SMHRF pre-admission screening process that coordinates with FDDP. Expected Improvements/Outcomes: ● New SMHRF preadmission screening process established within 4 months of PASRR Plus contract start date. ***In Compliance.*** The new SMHRF pre-admission assessment and referral process linking the two programs went live on 4/18/22.	**N/A**	**N/A**	**In Compliance**
FD-2 (2)	FY22 IP	Strategy: Complete FY21 plan by revisiting policy on FDDP eligibility requirements, including reviewing data from FY21 regarding Medicaid eligibility and ineligibility of FDDP participants. Expected Improvements/Outcomes: ● DHS will provide data and convene Parties and Court Monitor for discussion by 12/31/21. ***In Compliance.*** FDDP Medicaid Eligibility Analysis Report was sent to Parties and Monitor on 12/30/21. Meeting was convened on 1/21/22.	**N/A**	**N/A**	**In Compliance**
FD-2 (3)(1)	FY22 IP	Strategy: Implement new Front Door Diversion Program on 7/1/2021; ensure individuals with recommended community options are offered FDD. Expected Improvements/Outcomes: ● 85% of individuals determined to have met SMHRF admission standards who are appropriate for Community-Based Services are provided with a meaningful offer of Community-Based Services/Housing prior to SMHRF admission. ***Out-of-Compliance.*** Following the 4/22 launch of the new pre-screening system, 23% of those meeting SMHRF admissions criteria and appropriate for Community-Based Services were provided a meaningful offer.	**N/A**	**N/A**	**Out-of-Compliance**

FD-2 (3)(2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 85% of those who accept offer of Community-Based Services/Housing receive Community-Based Services/Housing. ***In Compliance.*** In FY22, 95% (358/375) of those who accepted an offer of Community-Based Services/Housing received services/housing (i.e., were diverted) in the reporting period.	**N/A**	**N/A**	**In Compliance**
FD-3 (1)	FY22 IP	Strategy: Implement and monitor effectiveness of new FDDP data management system and quality review, and report to Parties and Court Monitor on an ongoing basis (including through Data Dashboards and Semi-Annual Reports). Expected Improvements/Outcomes: ● 90% of FDDP Community-Based offers include identification of specific services and housing options (as needed) and Consent Decree-related data is tracked. ***In Compliance.*** In FY22, 91% of offers met criteria for a meaningful offer.	**N/A**	**N/A**	**In Compliance**
FD-3 (2)	FY22 IP	Strategy: IDHS will track and report to the Parties and Court Monitor the outcomes of individuals screened and referred to FDDP, but who do not enter into FDDP services. Expected Improvements/Outcomes: ● IDHS will address any identified barriers that may impact entry into FDDP services. ***Partial Compliance.*** In FY22, 57% of eligible FDDP referrals were engaged.[20]	**N/A**	**N/A**	**Partial Compliance**
FD-3 (3)	FY22 IP	Strategy: IDHS will conduct ongoing analysis of reasons why individuals reject the FDDP offer. Expected Improvements/Outcomes: ● IDHS will address any identified barriers that may impact entry into FDDP services. ***Partial Compliance.*** In FY22, 75% of meaningful FDDP offers were accepted.[21]	**N/A**	**N/A**	**Partial Compliance**

[20] While this outcome/objective is general ("address identified barriers"), the metric associated with the expected improvement/outcome in the FY22 Implementation Plan is much more specific: the percentage of eligible FDDP referrals who were engaged in the FDDP program. That is why the data provided to justify the partial compliance rating does not appear to match the language in the expected improvement/outcome.

[21] While this outcome/objective is general ("address identified barriers"), the metric associated with the expected improvement/outcome in the FY22 Implementation Plan is much more specific: the percentage of meaningful offers to

FY18-FY22 Compliance Assessment Ratings for *Williams* Outreach-Related Consent Decree and FY22 Implementation Plan Requirements					
Req#	**Source/ Citation**	***Williams* Consent Decree Requirement Language and FY22 Performance**	**Prior Years' Compliance Ratings**	**FY21 Compliance Rating**	**FY22 Compliance Rating**
3	Consent Decree VII(10)	Defendants shall ensure that Class Members have the opportunity to receive complete and accurate information regarding their rights to live in Community-Based Settings and/or receive Community-Based Services, and the available options and opportunities for doing so. ***Out-of-Compliance.*** Class Members are identified for outreach through the following pathways: admitted into SMHRFs within the past 60-70 days, existing residents who have never been engaged in outreach, Class Members due for quarterly outreach, or Class Members who requested outreach proactively. The Defendants report that 42% of Class Members received an outreach attempt but as described in the section above, there is no data to demonstrate that individual Class Members received outreach on a quarterly basis.	**FY2018: N/A** **FY2019: N/A** **FY2020: In Compliance**	**Partial Compliance**	**Out-of-Compliance**
4	Consent Decree VI(6)(C)	Defendants shall ensure, as provided in the Implementation Plan, that all Class Members shall be informed about Community-Based Settings, including Permanent Supportive Housing, and Community-Based Services available to assist individuals in these settings, and the financial support Class Members may receive in these settings. ***Duplicate Requirement.*** The Court Monitor views Requirement 3 as the overarching requirement to assess whether Class Members received outreach. As such, this requirement is treated as a duplicate.	**FY2018: Partial Compliance** **FY2019: Partial Compliance** **FY2020: Partial Compliance**	**Out-of-Compliance**	**N/A, Duplicate Requirement**
5	Consent Decree VI(9)(C)	Class Members shall not be subjected to any form of retaliation in response to any option selected nor shall they be pressured to refrain from exploring appropriate alternatives to IMDs. ***Partial Compliance.*** The Defendants indicated that outreach workers and posters in SMHRFs are designed to educate Class Members on their rights and recourse for retaliation. SMHRF interference with the Consent Decree programming is reported to IDPH for investigation. Posters were displayed in 60% of SMHRFs and all five allegations of retaliation were investigated by IDPH.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
6	Consent Decree VII(10)	All costs for outreach shall be borne by Defendants. ***In Compliance.*** The Defendants covered all outreach-related costs in FY22, as required by the Decree.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**

participate in the FDDP program that were accepted by individuals. That is why the data provided to justify the partial compliance rating does not appear to match the language in the expected improvement/outcome.

O-1	FY22 IP	Strategy: Use new data management system for tracking new and existing CMs to ensure and enforce provider contractual requirements regarding timely access to Outreach for 100% of CMs. Expected Improvements/Outcomes: • 85% of CMs both newly admitted and currently residing in facilities receive Outreach, including information on their rights to live in community, community-based settings, housing, and services, and financial support Class Members may receive in these settings, within 60-70 days of admission ("initial Outreach") and with appropriate frequency ("follow-up Outreach" for those not proceeding in Transition process), defined as one Outreach per quarter for those who are not proceeding to Transition. ***Out-of-Compliance.*** In FY22, the Defendants report that 42% of Class Members received an outreach attempt. In terms of outreach completions, 74% of initial outreach attempts to new admissions, 69% of initial outreach attempts to established admissions, and 82% of follow-up outreach attempts were ultimately completed. The majority of outreach attempts were not timely.	**N/A**	**N/A**	**Out-of-Compliance**
O-2	FY22 IP	Strategy: Continue expansion of Peer Support Ambassador program and In-Home Recovery Support program, increasing implementation of Peer Bridger-like model using NAMI's In-Home Recovery Support program and existing peer staff through Prime Agencies. Expected Improvements/Outcomes: • 85% of CMs hesitant about transitioning to the community (CM who do not accept Outreach or decline to participate in the program) are offered additional Outreach and education by Peer Support. ***Out-of-Compliance.*** In FY22, 385 Class Members were contacted by NAMI Peer Ambassadors. Of those Class Members receiving contact, 74% were engaged. While the Defendants report that 385 Class Members were contacted, there is no data provided on how many Class Members were hesitant about transitioning, so it is not possible to assess compliance. The Defendants started tracking the number of hesitant Class Members in FY23, which will enable them to assess the impact of re-engagement efforts more effectively for Class Members hesitant to transition.	**N/A**	**N/A**	**Out-of-Compliance**
O-3 (1)	FY22 IP	Strategy: Continue to enforce posting of retaliation poster in facilities and IDPH track CM reports of retaliation using Complaints processes as outlined in Rules/Regs. Expected Improvements/Outcomes: • 100% of facilities will have non-retaliation poster prominently displayed by 9/30/21.	**N/A**	**N/A**	**Partial Compliance**

		• All CMs will have access to information regarding their rights to non-retaliation through prominently displayed posters and through continued engagement with provider staff. ***Partial Compliance.*** In FY22, 14/23 (60%) of SMHRFs attested in writing to having posted the required posters relating to non-retaliation.			
O-3 (2)	FY22 IP	Strategy: IDPH will develop a method to track and report data on CM retaliation by SNF or staff and enforce and track/report on recourse imposed by IDPH on facilities. Each month, IDPH will review complaint allegations entered into the central complaint registry and ASPEN system to review whether there are retaliation-related allegations. These allegations, whether they are substantiated or unsubstantiated, will be entered into a monthly report with descriptions and final enforcement outcomes, if finalized by that time. This system will be developed and be operational by 7/31/21. Expected Improvements/Outcomes: • 100% of reports by or on behalf of CMs alleging facility retaliation will have their claims investigated through the regulatory process, provided those claims are reported to IDPH directly or through any other 3rd party or entity. All such investigations and outcomes will be reported in semi-annual compliance reports. ***In Compliance.*** IDPH developed and implemented a method to track complaints of retaliation and barriers to access by Primes during the reporting period. In FY22, 100% (5/5) of Class Members reporting retaliation had their claims investigated.	**N/A**	**N/A**	**In Compliance**
O-4 (1)	FY22 IP	Strategy: During the first or second mandated quarterly site visit in FY22 SMHRFs, Regional Ombudsmen will inquire with Resident Council President to encourage them to allow a presentation on the Long-Term Care Ombudsman Program at a future meeting. If the President agrees, a presentation will be made at the next regularly scheduled meeting. All agreed-upon presentations will occur by 6/30/22. Expected Improvements/Outcomes: • 100% of SMHRFs are provided with an invitation for presentation. ***In Compliance.*** 100% of SMHRFs (23/23) were provided with an invitation for presentation.	**N/A**	**N/A**	**In Compliance**
O-4 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: • Before the end of FY22, the Ombudsman will make a facility presentation to all facilities that allow it. ***In Compliance.*** Of the 23 invitations made, 83% (19/23) resulted in presentations during the year. Given that the	**N/A**	**N/A**	**In Compliance**

		remaining meetings were unable to be scheduled due to COVID outbreaks (3 facilities) or facility closure (1 facility), the Defendants are found in compliance.			
O-4 (3)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: • The Ombudsman will provide residents with contact cards and informational materials summarizing residents' rights, the role of Ombudsman, and how to contact their Ombudsman for assistance. ***In Compliance.*** The Defendants report that this is a federal requirement of the Ombudsmen who routinely distribute materials summarizing residents' rights, the role of the Ombudsman and how to make contact during routine visits and at resident council meetings.	**N/A**	**N/A**	**In Compliance**
O-5 (1)	FY22 IP	Strategy: Develop capacity and programming to introduce and facilitate Class Member observation/visits to community-based settings, for those CM appropriate for such a visit by 10/2/21. Expected Improvements/Outcomes: • 70% of CM hesitant to participate, who are appropriate for a community visit are offered such a visit (including housing options). • 85% of Class Members who accept an offer of a community-visit, visit a community-based setting (including housing options). ***Duplicate Requirement.*** (See Requirement 9).	**N/A**	**N/A**	**N/A, Duplicate Requirement**
O-5 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: • 85% of Class Members who accept an offer of a community-visit, visit a community-based setting (including housing options). ***Duplicate Requirement. (***See Requirement 9).	**N/A**	**N/A**	**N/A, Duplicate Requirement**

FY18-FY22 Compliance Assessment Ratings for *Williams* Assessment-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	***Williams* Consent Decree Requirement Language and FY22 Performance**	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
7	*Williams* Consent Decree VI(9)(C)	Qualified Professionals shall inform Class Members of their options pursuant to subparagraphs 6(a), 6(d), and 7(b) of this Decree. ***Duplicate Requirement.*** (See Requirement 11).	**Duplicate Require-ment, N/A**	**Duplicate Require-ment, N/A**	**Duplicate Require-ment, N/A**
8	*Williams* Consent Decree VI(6)(A)	Within two (2) years of the finalization of the Implementation Plan described below, every Class Member will receive an independent, professionally appropriate and person-centered Evaluation	**FY2018: N/A** **FY2019: N/A**	**N/A**	**N/A**

		[Assessment] of his or her preferences, strengths and needs in order to determine the Community-Based Services required for him or her to live in PSH or another appropriate Community-Based Setting. ***Duplicate Requirement.*** (See Requirement 12).	**FY2020: N/A**		
9	*Williams* Consent Decree VII(10)	In addition to providing this information, Defendants shall ensure that the Qualified Professionals conducting the Evaluations engage residents who express concerns about leaving the IMD with appropriate frequency. ***Out-of-Compliance.*** The Consent Decree requires that assessment staff should frequently engage Class Members who have concerns about transitioning into the community. In FY22, the Defendants utilized Peer Ambassadors to engage those expressing hesitation about transition. NAMI Peer Ambassadors conducted 141 community visits in FY22. No data is available on how many Class Members were hesitant to participate or how many community visits were offered, so it is not possible to assess compliance.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance** **FY2020: Partial Compliance**	**Out-of-Compliance**	**Out-of-Compliance**
10	*Williams* Consent Decree VI(6)(A)	Any Class Member has the right to decline to take part in such Evaluation. Any Class Member who has declined to be evaluated has the right to receive an Evaluation any time thereafter on request. ***In Compliance.*** It appears that 49 Class Members requested assessments (through appeals or direct requests), and all received such assessments.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Partial Compliance**	**Out-of-Compliance**	**In Compliance**
11	*Williams* Consent Decree VI(6)(B)	Defendants shall ensure that Evaluations are conducted by Qualified Professionals as defined in this Decree. ***Partial Compliance.*** In FY22, 81% of Assessment attempts (915/1126) were conducted by Qualified Professionals. Eighty percent (80%; 55/69) of Assessors were identified as Qualified Professionals.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**Partial Compliance**	**Partial Compliance**
12	*Williams* Consent Decree VI(6)(D)	After the second year following finalization of the Implementation Plan, the Evaluations described in Subsection 6(a) shall be conducted annually. ***Partial Compliance.*** Of the 658 Class Members due for annual assessments who had previously been recommended to transition, 39 received reassessments, 258 moved, and 226 were closed. The Defendants were not able to provide an update on the reassessment status of the remaining 108 (16%). Of the 107 Class Members due for annual assessments who had previously been not recommended for transition, 46 (43%) had no updates.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance** **FY2020: In Compliance**	**Out-of-Compliance**	**Partial Compliance**

13	*Williams* Consent Decree VI(6)(D)	As part of each Class Member's annual Evaluation, the reasons for any Class Member's opposition to moving out of an IMD to a Community-Based Setting will be fully explored and appropriately addressed as described in Section VII. ***Out-of-Compliance.*** While the Defendants provided training to Assessors on motivational interviewing and created a policy on exploring and documenting reasons for declines, they did not provide data to demonstrate that Class Member concerns were addressed per the policy.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**
14	*Williams* Consent Decree VI(6)(D)	Any Class Member who has received an Evaluation but has declined to move to a Community-Based Setting may request to be reassessed for transition to a Community-Based Setting any time thereafter. ***In Compliance.*** It appears that 49 Class Members requested assessments (through appeals or direct requests), and all received such assessments.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**In Compliance**
A-1	FY22 IP	Strategy: Enforce Assessment performance metrics with Prime Agencies, in line with policy and procedures, including minimum standards for Qualified Professionals, with an emphasis on positive outcomes, engagement of CM, timeliness of Assessments. Expected Improvements/Outcomes: ● 100% of Assessments are facilitated by Qualified Professionals per Comprehensive Program requirements. **Duplicate Requirement.** (See Requirement 11).	**N/A**	**N/A**	**N/A, Duplicate Require-ment**
A-2	FY22 IP	Strategy: During FY22, require Prime Agencies to conduct enough Assessments to allow for a sufficient flow of Recommended CM to meet Transition requirements. Expected Improvements/Outcomes: ● 85% of Class Members receive Assessment in compliance with Comprehensive Program timeliness requirements (initial assessments initiated within 14 days after positive outreach outcome, annual assessments within one year of prior assessment). **Out-of-Compliance.** Only 296 (37%) of initial assessments were initiated within 14 days. No timeliness data was provided for annual reassessments.	**N/A**	**N/A**	**Out-of-Compliance**

FY18-FY22 Compliance Assessment Ratings for *Williams* Service Plan-Related Consent Decree and FY22 Implementation Plan Requirements					
Req #	**Source/ Citation**	***Williams* Consent Decree Requirement Language and FY22 Performance**	**Prior Years' Compliance Ratings**	**FY21 Compliance Rating**	**FY22 Compliance Rating**
15	*Williams* Consent Decree VI(7)(C)	The Service Plan shall be developed by a Qualified Professional in conjunction with the Class Member and his or her legal representative. The Qualified Professional also shall consult with other appropriate people of the Class Member's choosing. ***Partial Compliance.*** Sixty-nine (69%) of service plans were conducted by qualified professionals.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
16	*Williams* Consent Decree VI(7)(D)	Each Service Plan shall focus on the Class Member's personal vision, preferences, strengths and needs in home, community and work environments and shall reflect the value of supporting the individual with relationships, productive work, participation in community life, and personal decision-making. ***Partial Compliance.*** Service plans are reviewed by UIC-CON to ensure that they meet all content standards, including those reflected in this requirement. Eighty-two (82) percent of service plans met quality standards.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
17	*Williams* Consent Decree VI(7)(A)	Based on the results of the Evaluations described above, Defendants shall promptly develop Service Plans specific to each Class Member who is assessed as appropriate for transition to a Community-Based Setting. ***Out-of-Compliance.*** Only 15 percent of initial service plans completed per Comprehensive Program timeliness standards (within 45 days of assessment).	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**
18	*Williams* Consent Decree VI(7)(F)	The Service Plan shall be completed within sufficient time to provide appropriate and sufficient transitions for Class Members in accordance with the benchmarks set forth in the Decree. ***Partial Compliance.*** Fifty-one (51) percent of transition service plans were completed per Comprehensive Program timeliness standards – 14 days prior to transition or earlier.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
19	*Williams* Consent Decree VI(7)(B)	For each Class Member who does not oppose moving to Community-Based Setting, the Service Plan shall, at a minimum, describe the Community-Based Services the Class Member requires in a Community-Based Setting, and a timetable for completing the transition.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**

		Partial Compliance. Service plans are reviewed by UIC-CON to ensure that they meet all content standards, including those reflected in this requirement. Eighty-two (82) percent of service plans met quality standards.	**FY2020: Out-of-Compliance**		
20	*Williams* Consent Decree VI(9)(A)	Those Class Members not transitioning from IMDs to Permanent Supportive Housing will have ongoing reassessments with treatment objectives to prepare them for subsequent transition to the most integrated setting appropriate, including PSH. ***Out-of-Compliance.*** In FY22, 93 Class Members were documented as having moved to non-PSH settings and 10 were identified as having been offered or moved to PSH following the non-PSH move. However, the Defendants did not supply data on how many – among the 93 who moved into the non-PSH settings -- were engaged to develop objectives to facilitate future moves to PSH.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**
21	*Williams* Consent Decree VI(7)(A)	Each Service Plan shall be periodically updated to reflect any changes in needs and preferences of the Class Member, including his or her desire to move to a Community-Based Setting after declining to do so, and shall incorporate services where appropriate to assist in acquisition of basic instrumental activities of daily living skills and illness self-management. Acquisition of such skills shall not be a prerequisite for transitioning out of the IMD. ***Partial Compliance.*** For the 151 Class Members who required service plan updates, 83 (55%) received updates or reassessments.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
22	*Williams* Consent Decree VI(7)(B)	If there has been a determination that a Class Member is not currently appropriate for PSH, the Service Plan shall specify what services the Class Member needs that could not be provided in PSH and shall describe the Community- Based Services the Class Member needs to live in another Community-Based Setting that is the most integrated setting appropriate. ***Partial Compliance***. Service plans are reviewed by UIC-CON to ensure that they meet all content standards, including those reflected in this requirement. Eighty-two (82) percent of service plans met quality standards.	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Partial Compliance**
23	*Williams* Consent Decree VI(7)(E)	The Service Plan shall not be limited by the current availability of Community-Based Services and Settings; provided, however, that nothing in this subparagraph obligates Defendants to provide any type of Community-Based Service beyond the types of	**FY2018: Partial Compliance** **FY2019: Out-of-Compliance**	**Partial Compliance**	**In Compliance**

		Community-Based Services included in the State Plan and Rule 132. ***In Compliance.*** The Defendants attest that service plan staff do not limit the services identified in a Class Member's service plan based on current availability. While found in compliance for this year, the Court Monitor will work with the Parties to develop a more operational and outcomes-oriented criteria for this requirement, focused on ensuring that there is an adequate array of community-based housing and services for Class Members.	**FY2020: Out-of-Compliance**		
SP-1 (1)	FY22 IP	Strategy: Issue and enforce performance improvement plans/corrective action plans, in accordance with established IDHS policy, with Prime agencies whose SP submissions do not meet Comprehensive Program requirements, either in terms of timeliness or quality, as identified by DMH/UIC CON. Expected Improvements/Outcomes: ● 100% of providers who are significantly below timeliness performance requirements for more than one consecutive monthly reporting period, or 3 months in 2 consecutive quarters, are issued PIP/CAP. ***Partial Compliance.*** IDHS issued Performance Improvement Plans to the Prime Agencies in the lowest quartile of service plan proficiency ratings in January 2022. Three (3) Prime Agencies were identified as falling substantially below service plan quality standards and all (100%) were issued PIPs/CAPs. This approach deviated from the original IP strategy, focusing on lowest-performing providers and not explicitly breaking out timeliness as a separate performance review component, but rather including it as an element of the quality assessment.	**N/A**	**N/A**	**Partial Compliance**
SP-1 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 100% of providers who are significantly below the quality standards performance requirements for more than one consecutive monthly reporting period, or 3 months in 2 consecutive quarters, are issued PIP/CAP. ***In Compliance.*** Three (3) Prime Agencies were identified as falling substantially below service plan quality standards and all (100%) were issued PIPs/CAPs.	**N/A**	**N/A**	**In Compliance**

SP-2	FY22 IP	Strategy: By 7/1/21, use new data management system for tracking transitioning CMs to ensure and enforce provider contractual requirements regarding Service Plans for all CMs. Expected Improvements/Outcomes: ● 90% CMs transitioning to the community have a Transition Service Plans completed before the date of Transition. ***Duplicate Requirement.*** See Requirement 18.	**N/A**	**N/A**	**N/A, Duplicate Require-ment**
SP-3 (1)	FY22 IP	Strategy: Enforce Service Plan performance metrics with Prime Agencies, consistent with program policies and procedures, with an emphasis on quality. Expected Improvements/Outcomes: ● 85% of Service Plans are completed per Comprehensive Program timeliness requirements. ***Out-of-Compliance.*** In FY 2022, 35% had a Service Plan within 100 days of Assessment.	**N/A**	**N/A**	**Out-of-Compliance**
SP-3 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 85% of providers meet Comprehensive Program quality standards in Service Planning to CMs. ***Partial Compliance***. In FY22, 82% of Service Plans reviewed by UIC CON met quality standards.	**N/A**	**N/A**	**Partial Compliance**
SP-3 (3)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 85% of Class Members who complete Outreach will have their Service Plans completed within 59 days of a positive outreach outcome. ***Duplicate Requirement.*** See Requirement 17.	**N/A**	**N/A**	**NA, Duplicate Require-ment**

SP-4	FY22 IP	Strategy: Enforce referrals to Employment Services where included in Service Plan. Expected Improvements/Outcomes: ● 100% of CMs whose Service Plan includes Employment Services are referred to Employment Services. ***In Compliance.*** In FY22, 100% of Class Members with Service Plans recommending Employment Services were referred to Employment Services. Of the 682 Class Members referred, 136 were ultimately enrolled in employment services with 70 having obtained employment.	**N/A**	**N/A**	**In Compliance**

FY18-FY22 Compliance Assessment Ratings for *Williams* Transition-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	***Williams* Consent Decree Requirement Language and FY22 Performance**	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
24	Consent Decree VI(9)(A)	PSH will be considered the most integrated setting appropriate for Class Members except that, (1) for any Class Members (i) who have severe dementia or other severe cognitive impairments requiring such a high level of staffing to assist with activities of daily living or self-care management that they cannot effectively be served in PSH, (ii) who have medical needs requiring a high level of skilled nursing care that may not safely be provided in PSH, or (iii) who present an danger to themselves or others, the evaluator will determine the most integrated setting appropriate, which may be PSH or another setting, and (2) nothing in this paragraph shall prevent Class Members who can and wish to live with family or friends or in other independent housing that is not connected with a service provider from doing so. ***In Compliance.*** The Defendants indicated that 74% of Class Members moved to permanent supportive housing (PSH). Among the remaining Class Members, 28% met exclusionary criteria and 72% preferred a non-PSH option.	**FY2018: Partial Compliance** **FY2019: Partial Compliance** **FY2020: Partial Compliance**	**Partial Compliance**	**In Compliance**
25	Consent Decree VI(9)(B)	Class Members who move to a Community-Based Setting will have access to all appropriate Community-Based Services, including but not limited to reasonable measures to ensure that their housing remains available in the event that they are temporarily placed in a hospital or other treatment facility. ***In Compliance***. Seventy-nine (79) Class Members received assistance to maintain housing during temporary placement during FY22, reflecting a total of 174 rent payments.	**FY2018: Partial Compliance** **FY2019: Partial Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**

26	Consent Decree VIII(15)	In the event that any IMD seeks to discharge any Class Member before appropriate housing is available, including but not limited to circumstances in which an IMD decides to close, Defendants will ensure that those individuals are not left without appropriate housing options based on their preferences, strengths, and needs. ***Out-of-Compliance.*** The Defendants were only able to report that 3 (3%) of the 111 Class Members who were involuntarily discharged in FY22 received information about available community resources/services. Tracking of the distribution of information to involuntarily discharged Class Members began in June 2022.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**
27	Consent Decree VI(8)(G)	For purposes of this Decree, PSH includes scattered-site housing as well as apartments clustered in a single building, but no more than 25% of the units in one building with more than 4 units may be used to serve PSH clients known to have mental illness. For buildings with 2 to 4 units, no more than 50% of the units may be used to serve PSH clients known to have mental illness. However, during first 5 years after finalization of the IP, up to 75 class members may be placed in buildings where more than 25% of the units serve PSH clients known to have MI if those buildings were used to serve PSH clients prior to March 1, 2010. After first 5 years following the finalization of the IP, all class members served in PSH shall be offered the opportunity to reside in buildings that comply with 25% or 50% units limit set forth above in this subparagraph. ***In Compliance.*** The Defendants reported that all PSH units occupied by transitioned Class Members complied with disability concentration rules set forth in the Consent Decree.	**FY2018: Out-of-Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
28	Consent Decree VI(8)(H)	After the end of the fifth year following finalization of the Implementation Plan, Class Members who are assessed as appropriate for living in a Community-Based Setting, who do not oppose transition to a Community-Based Setting and whose Service Plans provide for placement in Community-Based Settings	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance**	**Out-of-Compliance**	**Out-of-Compliance**

		shall be offered the opportunity to move to those settings and shall receive appropriate services consistent with the Service Plan within one hundred and twenty (120) days of the date of the Service Plan. ***Out-of-Compliance.*** The Defendants produced data that shows that 41 percent of transitioned Class Members transitioned within 120 days of their initial service plans. In addition to analyzing the transition timeliness of those who transitioned in FY22, the prior Court Monitor also sought to understand the transition outcomes (including timeliness) of all Class Members who were recommended to transition between July 2020 and December 2021. She found that approximately 1,100 Class Members recommended to transition during that time period (from both the *Williams* and *Colbert* classes) had yet to transition as of March 29, 2022, pointing to extreme timeliness delays.	**FY2020: Out-of-Compliance**		
29	Consent Decree X(21)	Within sixty (60) days of Approval of the Decree, Defendants shall offer each of the Named Plaintiffs the opportunity to receive appropriate services in the most integrated setting appropriate to his or her needs and wishes, including PSH. Provision of services to the Named Plaintiffs pursuant to this paragraph shall not be used to determine any other individual's eligibility for services under the terms of the Decree. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
30	Consent Decree VI(8)€	By the end of the first year after the finalization of the Implementation Plan, Defendants will have: (1) offered placement in a Community-Based Setting to a minimum of 256 Class Members who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting; and (2) developed 256 PSH units for the benefit of Class Members. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
31	Consent Decree VI(8)(D)	By the end of the second year after the finalization of the Implementation Plan, Defendants will have: (1) offered placement in a Community-Based Setting to a minimum of 640 Class Members (including the 256 referenced in subparagraph 8c above) who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting; and (2) developed 640 PSH units for the benefit of Class Members. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**

32	Consent Decree VI(8)(E)	By the end of the third year after the finalization of the Implementation Plan, Defendants will have (1) offered placement to at least forty percent (40%) of all individuals who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Settings; and (2) developed the corresponding number of PSH units or other Community-Based Settings sufficient for these individuals. For purposes of this subparagraph, these individuals include the total of (1) all Class Members as of the end of the second year after the finalization of the Implementation Plan who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting, and (2) all former Class Members who have already transitioned from the IMD to a Community-Based Setting or to another community setting since finalization of the Implementation Plan. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
33	Consent Decree VI(8)(F)	By the end of the fourth year after the finalization of the Implementation Plan, Defendants will have (1) offered placement to at least seventy percent (70%) of all individuals who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting; and (2) developed the corresponding number of PSH units or other Community-Based Settings sufficient for these individuals. For purposes of this subparagraph, these individuals include the total of (1) all Class Members as of the end of the third year after the finalization of the Implementation Plan who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting, and (2) all former Class Members who have already transitioned from the IMD to a Community-Based Setting or to another community setting since finalization of the Implementation Plan. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
34	Consent Decree VI(8)(A)	Within five (5) years of the finalization of the Implementation Plan, all Class Members who have been assessed as appropriate for living in a Community-Based Setting will be offered the opportunity to move to a Community-Based Setting. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
35	Consent Decree VI(8)(G)	By the end of the fifth year after the finalization of the Implementation Plan, Defendants will have: (1) offered placement to one hundred percent (100%) of all	**FY2018: N/A**	**N/A**	**N/A**

		individuals who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting; and (2) developed the corresponding number of PSH units or other Community-Based Settings sufficient for these individuals. For purposes of this subparagraph, these individuals include the total of (1) all Class Members as of the end of the fourth year after the finalization of the Implementation Plan who are assessed as appropriate for living in a Community-Based Setting and who do not oppose moving to a Community-Based Setting, and (2) all former Class Members who have already transitioned from the IMD to a Community-Based Setting or to another community setting since the finalization of the Implementation Plan. ***Not Applicable.*** This requirement is not applicable to this reporting period.	**FY2019: N/A** **FY2020: N/A**		
T-1 (1)(a)	FY22 IP	Strategy: Transition required number of Class Members. Expected Improvements/Outcomes: ● At least 150 *Williams* CM transitioned by 12/31/21 ***In Compliance.*** The initial target of 150 transitions was exceeded by 12/31/21.	**N/A**	**N/A**	**In Compliance**
T-1 (1)(b)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● At least 400 total *Williams* CM transitioned by 6/30/22. ***Partial Compliance***. In total in FY22, 358 Transitions occurred, meeting 90% of the total annual target.	**N/A**	**N/A**	**Partial Compliance**
T-1 (2)(a)	FY22 IP	Strategy: Enforce transition performance metrics with providers, in line with Comprehensive Program contractual obligations, with an emphasis on outcomes and quality. Expected Improvements/Outcomes: ● 100% of Prime providers meet their contractual obligation of transitions per quarterly reporting period. ***Partial Compliance.*** Ten Prime agencies were contracted to facilitate transitions. Three Primes met 100% of their target or more, five Primes met 85% or more of their target, and two Primes met between 75-84% of their target.	**N/A**	**N/A**	**Partial Compliance**

T-1 (2)(b)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 65% of transitioned Class Members transitioned within 120 days of their service plan. ***Out-of-Compliance.*** In FY22, 352 community moves occurred for Class Members. Of these, 41% (143) moved within 120 days of their first service plan.	**N/A**	**N/A**	**Out-of-Compliance**
T-2	FY22 IP	Strategy: By 7/1/21, use new data management system to track Assessment/SP recommendations for CMs recommended to Transition to settings other than PSH or not recommended to transition, to determine compliance with exclusionary criteria protocol. Expected Improvements/Outcomes: ● 85% of CM recommended to transition to a non-PSH setting meet exclusionary criteria or are documented as based on CM choice. ***Duplicate Requirement***. (See Requirement 24)	**N/A**	**N/A**	**N/A, Duplicate Require-ment**
T-3(1)	FY22 IP	Strategy: Investigate and remedy pipeline issues through dedicated resource development to meet the timeliness requirement for moving from Initial Service Plan to transition (120 days). Specifically, receive quarterly reports from Prime agency, with analysis by UIC CON on pipeline barriers to inform any necessary systems changes. Expected Improvements/Outcomes: ● Major pipeline issues impacting providers' ability to achieve transition benchmarks are identified on a quarterly basis to allow for timely resolution or identification of alternative approaches. ***In Compliance.*** In FY22, Defendants discussed pipeline issues, including staffing shortages and limited housing meeting Class Member preferences, during the Parties meetings.	**N/A**	**N/A**	**In Compliance**
T-3(2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● Updates on identified pipeline issues, strategies for resolution and outcomes will be included in parties' meetings on a quarterly basis. ***In Compliance.*** In FY22, the Defendants discussed strategies the State is taking to address pipeline issues during the Parties meetings.	**N/A**	**N/A**	**In Compliance**

T-4	FY22 IP	Strategy: IDoA Homecare Ombudsman Program staff (serving individuals receiving HFS Waiver services such as IDoA CCP- Elderly, IDHS- HSP, HIV/AIDS, TBI, as well as advocacy services to MMAI recipients) will conduct a recorded webinar to all Prime Agencies in collaboration with IDHS w/in 30 days of the start of FY22. The Home Care Ombudsman WebEx will provide an overview of the Home Program including the goal and purpose of the HCO Program, the populations served, the role of the Home Care Ombudsman, services available through the program, and other applicable resources for the waiver population. This training/webinar will be required for Prime Agencies and included in the Comprehensive Program training modules. Expected Improvements/Outcomes: ● Upon transition, Primes will ensure that the IDoA Homecare Ombudsmen brochure is included in the CM's transition packet. ***In Compliance.*** In FY22, Prime Agencies were provided Homecare Ombudsman Program information resources, and a recorded webinar training. Primes were issued a requirement to provide all transitioning Class Members the Homecare Ombudsman brochure effective 8/13/21.	**N/A**	**N/A**	**In Compliance**
T-5 (1)	FY22 IP	Strategy: Continue to promote and support the implementation of HFS's Community Transition Initiative with HealthChoice Illinois health plans: Expected Improvements/Outcomes: ● Increase number of CTI transitions in FY22. ***Out-of-Compliance.*** In FY22, only one (1) *Williams* Class Member was transitioned by CTI.	**N/A**	**N/A**	**Out-of-Compliance**
T-5 (2)	FY22 IP	Strategy: Amend master HealthChoice Illinois Contracts to specify the required minimum transition elements of the *Williams/Colbert* Decrees and to require monthly reporting on those elements by 12/15/21. Expected Improvements/Outcomes: ● 100% of HealthChoice Illinois contracts amended by 12/15/2021. ***In Compliance.*** HFS issued a policy amendment to all HealthChoice Illinois MCOs on 12/15/21 with required minimum transition elements and monthly reporting requirement.	**N/A**	**N/A**	**In Compliance**

T-5 (3)	FY22 IP	Strategy: Monitor and resolve operational issues using existing management and communications platforms (including CEO meetings, weekly operational calls, quarterly business reviews, etc.). monthly updates to Court Monitor. Expected Improvements/Outcomes: ● Prompt resolution of identified operational issues. ***In Compliance.*** CTI operational issues were monitored and resolved at regular meetings, monthly calls, and through technical assistance.	**N/A**	**N/A**	**In Compliance**
T-5 (4)	FY22 IP	Strategy: Monitor and resolve operational issues using existing management and communications platforms (including CEO meetings, weekly operational calls, quarterly business reviews, etc.). monthly updates to Court Monitor. Expected Improvements/Outcomes: ● Monthly updates to Court Monitor regarding operational issues resolved. ***In Compliance.*** Monthly updates were provided to the Court Monitor.	**N/A**	**N/A**	**In Compliance**
T-5 (5)	FY22 IP	Strategy: Prepare a written report assessing the impact of the CTI by analyzing available CTI data from HealthChoice Illinois health plans. The report will include information about how the plans operationalized CTI efforts, as well as metrics showing transitions achieved under the CTI in FY21 compared to FY22 (with a commitment to increasing the number of transitions year over year), and benchmark comparisons as data comparability and availability permits, such as: between *Williams* and *Colbert* Class Members and non-Class Members; between CTI and Comprehensive Program; between individuals with mental illness, substance use disorder, physical disability, or a combination of these conditions; and geography. Expected Improvements/Outcomes: ● CTI report submitted on time and in accordance with agreed upon outline. ***In Compliance.*** The CTI report outline was submitted to the Court Monitor on 11/15/21, followed by a CTI Report submitted to Court Monitor and Parties on 6/30/22.	**N/A**	**N/A**	**In Compliance**

T-5 (6)	FY22 IP	Strategy: Continue to require online Olmstead training for all Care Coordinators newly hired by HealthChoice Illinois Plans on an ongoing basis, with annual confirmation of HealthPlan attestation. Expected Improvements/Outcomes: ● 85% of newly hired care coordinators trained by 6/30/2022. ***In Compliance.*** In FY22, 99% of newly hired Care Coordinators completed Olmstead Training as reported by Health Plan attestations.	**N/A**	**N/A**	**In Compliance**
T-6	FY22 IP	Strategy: Continue to use IDPH's Involuntary Transfers/Discharges (ITD) process for reviewing and approving involuntary discharges to ensure involuntary discharges are in accordance with the rules. IDPH's Hearings Unit will be provided a list of approved contacts for alternative housing and community-based settings. This approved list will be provided by IDPH to the CM at the ITD hearing so that residents subject to involuntary transfer and discharge has been apprised of their options for community-based assessments and placement opportunities. Hearings Unit staff will discuss the available options with the CM if the CM is willing. Expected Improvements/Outcomes: ● 90% of CMs subject to involuntary discharge are provided resources for Community-Based services and supports. ***Duplicate Requirement*** (see Requirement 26).	**N/A**	**N/A**	**N/A, Duplicate Require-ment**

T-7	FY22 IP	Strategy: IDoA Regional Ombudsmen to identify and contact CMs who receive involuntary discharge notices. If the CM is interested in Ombudsman assistance, the Ombudsman will coordinate with IDPH and the CM Primes on behalf of the CM/resident. Tracking will be required by the Ombudsman on a quarterly basis, and final reports will be reported bi-annually (semi-annual compliance reporting). Expected Improvements/Outcomes: ● 90% of CMs who receive involuntary discharge notices are offered Ombudsman assistance. ***Partial Compliance.*** In FY22, 54% of Class Members (37/69) for whom the Ombudsman were aware of having received facility-initiated discharge notices were offered assistance. Out of the 32 who were not offered assistance, 23 were unable to be contacted due to circumstances beyond the Defendants' or Ombudsman's control (e.g., incarceration, hospitalization), but data was not available for the remaining 9 Class Members. This means that 87% were either offered assistance or justifiably unable to be reached, resulting in a partial compliance finding.	**N/A**	**N/A**	**Partial Compliance**
T-8	FY22 IP	Strategy: For all Class Members appropriately approved for discharge, continue to use and enforce Prime/MCO offering of supports pre-/upon discharge. Expected Improvements/Outcomes: ● 85% of recommended CMs unexpectedly discharged prior to transition are offered Community-Based Services and Housing within 60 days of discharge. ***Out-of-Compliance.*** In FY22, 77 recommended Class Members were discharged before community move and nine of these were contacted by the assigned Prime (12%).	**N/A**	**N/A**	**Out-of-Compliance**

T-9 (1)	FY22 IP	Strategy: For any CM who transitioned to a non-PSH setting, the Prime Agency will evaluate CM interest and appropriateness to move to PSH. If evaluation reveals the Class Member desires PSH but is not ready or appropriate, a plan with goals to prepare Class Member for PSH will be developed within 30 days. Expected Improvements/Outcomes: ● 85% of CMs in non-PSH settings are offered the option to move to PSH in the future. ● 85% of CMs wanting to move to PSH but not ready, receive plan with goals within 30 days of PSH evaluation. ● 85% of CMs who engage in a secondary transition plan to move to PSH and who are deemed appropriate, receive an offer to move to PSH within 60 days. ***Duplicate Requirement*** (see Requirement 20).	**N/A**	**N/A**	**N/A, Duplicate Require-ment**
T-9 (2)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 85% of CMs wanting to move to PSH but not ready, receive plan with goals within 30 days of PSH evaluation. ***Duplicate Requirement*** (see Requirement 20).	**N/A**	**N/A**	**N/A, Duplicate Require-ment**
T-9 (3)	FY22 IP	Strategy: See above. Expected Improvements/Outcomes: ● 85% of CMs who engage in a secondary transition plan to move to PSH and who are deemed appropriate, receive an offer to move to PSH within 60 days. ***Duplicate Requirement*** (see Requirement 20).	**N/A**	**N/A**	**N/A, Duplicate Require-ment**

FY18-FY22 Compliance Assessment Ratings for *Williams* Community-Based Services/Housing Capacity Development-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	*Williams* Consent Decree Requirement Language and FY22 Performance	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
36	*Williams* Consent Decree V(5)	Defendants shall ensure the availability of services, supports, and other resources of sufficient quality, scope and variety to meet their obligations under the Decree and the Implementation Plan.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance**	**Partial Compliance**	**Partial Compliance**

		Partial Compliance. While the Defendants did submit an updated capacity development plan, hundreds of Class Members remain in the transition pipeline due to inadequate outreach, assessment, service planning, transition support, and community-based services capacity. Specific data that demonstrates inadequate capacity can be found in Sections VI and VII.	**FY2020: Out-of-Compliance**		
37	*Williams* Consent Decree V(5)	Defendants shall implement sufficient measures, consistent with the preferences, strengths, and needs of Class Members, to provide Community-Based Settings and Community-Based Services pursuant to the Decree. ***Partial Compliance.*** The Defendants report on the continued funding for bridge subsidies which secures tenant-based vouchers to cover any CM housing needs not otherwise funded. IHDA reports an increase in affordable housing units for which Class Members are prioritized from the SRN/811 waiting lists. However, their continued inability to transition Class Members – and particularly address identified pipeline issues – demonstrates that the availability of supports and services is inadequate to address need.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Partial Compliance**	**Partial Compliance**
CD-1	FY22 IP	Strategy: By 1/1/22, develop Bridge Subsidy to Permanent Housing Choice Voucher strategic plan to transition CMs from Bridge Subsidies to other permanent housing options and includes plan for ongoing maintenance. Expected Improvements/Outcomes: • Strategic plan delivered by 1/1/22, identifying a process for assisting CMs to transition from Bridge Subsidies to other permanent housing options. ***In Compliance.*** Defendants sent the *Bridge Subsidy to Permanent HCV* strategic plan to the Parties and Court Monitor on 12/30/21.	**N/A**	**N/A**	**In Compliance**
CD-2 (1)	FY22 IP	Strategy: By 1/1/22, complete comprehensive Housing & Services Capacity Development gaps and capacity analysis with continued use of data related to CM geographic locations and housing preferences. Expected Improvements/Outcomes: • Deliver gaps analysis by January 1, 2022. ***In Compliance.*** Defendants sent the *Housing & Services Needs and Gaps* reports to the Parties and Court Monitor on 12/30/21.	**N/A**	**N/A**	**In Compliance**

CD-2 (2)	FY22 IP	Strategy: By 3/1/22, complete a capacity development report based on identified gaps, to inform utilization of current housing and services capacity, and future planning and development. Expected Improvements/Outcomes: ● Deliver capacity development plan by March 1, 2022. ***In Compliance.*** Defendants sent the *Housing* and *Services Capacity Development* reports to the Parties and Court Monitor on 3/1/2022.	**N/A**	**N/A**	**In Compliance**
CD-3	FY22 IP	Strategy: Following the delivery of the plan, provide to Parties and Court Monitor ongoing updates on capacity expansion. Expected Improvements/Outcomes: ● Updates provided in May and June 2022. ***In Compliance.*** Defendants provided updates on both the *Housing* and *Services Capacity Development* reports to the Parties and Court Monitor on 5/31/2022 and 6/30/2022.	**N/A**	**N/A**	**In Compliance**
CD-4	FY22 IP	Strategy: Make bridge subsidies available to Class Members recommended for transition but unable to do so due to lack of income, who agree to participate in SOAR and/or employment supports, or who have other means of potential income identified. The data dashboards will report acceptance and refusal rates, the number of Class Members who cannot proceed due to refusal of SOAR and/or employment supports, and the number of successful transitions due to this effort. Expected Improvements/Outcomes: ● 75% of Class Members on financial holds who agree to participate in SOAR, employment supports or who have a potential income source identified, transition with bridge subsidies. ***Out-of-Compliance.*** In FY 2022, 65 Class Members obtained Bridge Subsidies without income. The Defendants report that data on Class Members without income who have other sources of income is not available, and the SOAR enrollment changes monthly, so the denominator is unable to be determined. Given that the Defendants did not provide the number of Class Members who agreed to participate in SOAR/employment supports, it is not possible to assess compliance. This compliance rating can be revisited if the Defendants are able to furnish additional information that speaks to this requirement.	**N/A**	**N/A**	**Out-of-Compliance**

CD-5	FY22 IP	Strategy: Identify and initiate discussions with additional providers to enter into grant agreements under the Comprehensive Program, focusing on those with a Care Management focus, to better serve Class Members with complex medical and psychiatric needs. Expected Improvements/Outcomes: ● Dependent on outcome of discussions, add providers to serve Class Members with medical/psychiatric complexities under the Comprehensive Program. ***Partial Compliance.*** IDHS-DMH posted the Comprehensive Program NOFO for FY23 program in March 2022 and secured one new provider. However, given Defendants' issues in transitioning Class Members timely, they clearly still lack capacity. Per the FY23 Implementation Plan, IDHS will continue efforts to expand the Comprehensive Program provider pool.	**N/A**	**N/A**	**Partial Compliance**

FY18-FY22 Compliance Assessment Ratings for *Williams* Administrative-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	*Williams* Consent Decree Requirement Language and FY22 Performance	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
38	Consent Decree IX(16)	The Court will appoint an independent and impartial Monitor who is knowledgeable concerning the management and oversight of programs serving individuals with Mental Illnesses. The Parties will attempt to agree on the selection of a Monitor to propose to the Court. If the Parties are unable to reach agreement, each party will nominate one person to serve as Monitor and the Court will select the Monitor. Within twenty-one (21) days of Approval of the Decree, the Parties shall submit their joint recommendation or separate nominations for a Monitor to the Court. In the event the Monitor resigns or otherwise becomes unavailable, the process described above will be used to select a replacement. ***Not Applicable.*** In March 2022, Ms. Gail Hutchings announced her resignation as Court Monitor to the Parties. In April and May 2022, she facilitated recruitment and interviews of qualified candidates to assume the Court Monitor role. In May 2022, the Parties selected Ms. Kathryn du Pree as Court Monitor, and the Court approved her appointment on August 1, 2022. Ms. du Pee officially commenced her role in August 2022, outside of this reporting period.	**FY2018: In Compliance** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
39	Consent Decree IX(18)	Not less than every six (6) months, Defendants shall provide the Monitor and Plaintiffs with a detailed report containing data and information sufficient to evaluate Defendants' compliance with the Decree and Defendants' progress toward achieving compliance, with the Parties	**FY2018: Partial Compliance** **FY2019: In Compliance**	**In Compliance**	**In Compliance**

		and Monitor agreeing in advance of the first report of the data and information that must be included in such report. ***In Compliance***. The Defendants produced semi-annual reports that contained the data and information necessary to assess compliance and performance on the Consent Decree and Implementation Plan requirements.	**FY2020: In Compliance**		
40	Consent Decree IX(18)	Defendants will not refuse any request by the Monitor for documents or other information that are reasonably related to the Monitor's review and evaluation of Defendants' compliance with the Decree, and Defendants will, upon reasonable notice, permit confidential interviews of Defendants' staff or consultants, except their attorneys. ***In Compliance***. The Defendants complied with this requirement.	**FY2018: In Compliance** **FY2019: Partial Compliance** **FY2020: Partial Compliance**	**In Compliance**	**In Compliance**
41	Consent Decree IX(18)	The Monitor will have access to all Class Members and their records and files, as well as to those service providers, facilities, building and premises that serve, or are otherwise pertinent to, Class Members, where such access is reasonably related to the Monitor's review and evaluation of Defendants' compliance with the Decree. ***In Compliance***. The Defendants complied with this requirement.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
42	Consent Decree IX(18)	The Defendants shall comply with Plaintiffs' requests for information that are reasonably related to Defendants' compliance with the Decree, including without limitation requests for records or other relevant documents pertinent to implementation of the Decree or to Class Members. Plaintiffs shall also be permitted to review the information provided to the Monitor. All information provided to the Monitor and/or Plaintiffs pursuant to the Decree shall be subject to the Protective Order. ***In Compliance.*** The Court Monitor queried Class Counsel on 12/13/22 and received a response on 12/21/22. While the Class Counsel questioned the validity of some data, they did not report any instances wherein the Defendants did not supply requested data and information.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: Partial Compliance**	**In Compliance**	**In Compliance**
43	Consent Decree IX(20)	Defendants shall compensate the Monitor and his or her staff and consultants at their usual and customary rate subject to approval by the court. Defendants shall reimburse all reasonable expenses of the Monitor and the Monitor's staff, consistent with guidelines set forth in the "Governor's Travel Control Board Travel Guide for State Employees." Defendants may seek relief from the Court if Defendants believe that any of the Monitor's charges is inappropriate or unreasonable. ***In Compliance***. The Defendants complied with this requirement.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**

44	Consent Decree XII(24)	The cost of all notices hereunder or otherwise ordered by the Court shall be borne by the Defendants. ***In Compliance.*** The Defendants complied with this requirement.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
45	Consent Decree XI(22)	In full settlement of all attorneys' fees incurred to date in connection with the litigation, Defendants shall pay, subject to court review and approval, $1,990,000.00 to Class Counsel. In full settlement of all out-of-pocket costs and expenses (not to include attorneys' fees) incurred to date by Class Counsel, Defendants shall pay to Class Counsel such costs and expenses incurred by Class Counsel through and including the Approval of the Decree and any appeal thereof. Such amounts shall be distributed to Class Counsel in the manner set forth in written instructions provided by Class Counsel. Furthermore, such amounts hall be set forth in a Judgment Order to be entered by the Court. Defendants shall complete and submit all paperwork necessary for payment of such amounts, plus applicable statutory post-judgment interest, within five (5) business days after expiration of the time to appeal the fee award without the filing of a Notice to Appeal or after the issuance of the mandate by the highest reviewing court, whichever is later. ***Not Applicable****. This requirement is not applicable to this reporting period.*	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**
CM1	Consent Decree IX(17)	The Monitor's duties include evaluating Defendants' compliance with the Decree, identifying actual and potential areas of non-compliance with the Decree, mediating disputes between the Parties, and bringing issues and recommendations for their resolution to the Court. Within 60 days after the end of each year of service, the Monitor will report to the Court and the Parties regarding compliance with the Decree. Such reports shall include the information necessary, in the Monitor's professional judgment, for the Court and Plaintiffs to evaluate the Defendants' compliance or non-compliance with the terms of the Decree. The Monitor may file additional reports as necessary. Reports of the Monitor shall be served on all Parties. ***In Compliance.*** The Court Monitor produced her annual report and it was filed on January 18, 2022.	**FY2018: In Compliance (Court Monitor Require-ment)** **FY2019: In Compliance (Court Monitor Require-ment)** **FY2020: In Compliance (Court Monitor Require-ment)**	**Court Monitor Require-ment -- In Compliance**	**Court Monitor Require-ment -- In Compliance**
CM2	Consent Decree IX(19)	In the event that the Monitor finds Defendants not in compliance with the Decree, the Monitor shall promptly meet and confer with the Parties in an effort to agree on steps necessary to achieve compliance. In the event that Plaintiffs believe that Defendants are not complying with	**FY2018: In Compliance (Court Monitor Require-ment)**	**Court Monitor & Plaintiffs' Require-ment —**	**Court Monitor & Plaintiffs' Require-ment —**

		the terms of the Decree, Plaintiffs shall notify the Monitor and Defendants of Defendants' potential non-compliance. The Monitor then shall review the Plaintiffs' claims of actual or potential non- compliance and, as the Monitor deems appropriate in his or her professional judgment, meet and confer with Defendants and Plaintiffs in an effort to agree on steps necessary to achieve compliance with the Decree. If the Monitor and Parties agree, such steps shall be memorialized in writing, filed with the Court, and incorporated into, and become enforceable as part of, the Decree. In the event that the Monitor is unable to reach agreement with Defendants and Plaintiffs, the Monitor or either Party may seek appropriate relief from the Court. In the event that Plaintiffs believe that Defendants are not in compliance with the Decree and that the Monitor has not requested appropriate relief from the Court, Plaintiffs may seek relief from the Court. The Monitor will not communicate with the Court without advance notice to the Parties. ***In Compliance***. The Court Monitor convened regular Large Parties, Small Parties, and ad hoc meetings to identify and attempt to resolve issues of disagreement or non-compliance. A meeting dedicated specifically to Defendants' FY21 areas of partial- and non-compliance was led by the Court Monitor April 19, 2022.	**FY2019: In Compliance (Court Monitor Require-ment)** **FY2020: In Compliance (Court Monitor Require-ment)**	**In Compliance**	**In Compliance**
AD-1(1)	FY22 IP	Strategy: Monitor and report on Consent Decrees' budgeted funds spending on a quarterly basis. Include plans to reallocate potential lapsed appropriations to achieve compliance (as permitted). Expected Improvement/Outcome: ● Regular monitoring and reporting of quarterly spending. ***In Compliance.*** Defendants provided quarterly budget updates (11/30/21, 2/28/22, 5/31/22, 9/1/22).	**N/A**	**N/A**	**In Compliance**
AD-1(2)	FY22 IP	Strategy: See above. Expected Improvement/Outcome: ● Quarterly plan to address potential lapses delivered. ***In Compliance.*** Defendants provided quarterly budget updates (11/30/21, 2/28/22, 5/31/22, 9/1/22), including planned uses for potential lapsed funds.	**N/A**	**N/A**	**In Compliance**

AD-2	FY22 IP	Strategy: Monitor and report on FDDP and Comprehensive Program services delivered to individuals/CM, and service outcomes on a monthly basis via Data Dashboards. Monthly reporting generated by CASPIO will include Issues reported by providers (facility/CM access problems, resource needs, etc. and proposed resolutions with outcomes), Corrective Action Plans issued/penalties imposed for providers who do not meet performance standards, data on rapid Medicaid application process, SMHRF/SNF barriers, employment data, and SOAR activities. Expected Improvement/Outcome: ● Regular monitoring and monthly dashboards delivered. ***In Compliance.*** Defendants provided monthly Parties' Data Dashboards and reported to the Parties and Monitor on provider management efforts, including issuing of PIPs/CAPs on a quarterly basis.	**N/A**	**N/A**	**In Compliance**
AD-3	FY22 IP	Strategy: In FY22, continue to assess Consent Decree staffing needs across all agencies. Expected Improvement/Outcome: ● By December 30, 2021, Defendants will submit a consolidated report to Parties and the Court Monitor that identifies the positions, staff name(s) who occupy the position(s), or for vacant positions, a date by which the position will be filled. ***In Compliance.*** Defendants sent Staffing Assessment Summary and Report to the Parties and Court Monitor on 12/30/21.	**N/A**	**N/A**	**In Compliance**
AD-4	FY22 IP	Strategy: As part of UIC CON's role in data gathering/ management of the Comprehensive Program/FDDP, UIC CON will continue to manage Prime and FDDP providers, to closely monitor Class Members moving through the process in Consent Decree to ensure that the process is being implemented in a timely manner and to prevent unnecessary admission into SMHRFs. Expected Improvement/Outcome: ● Adequate level of programmatic oversight and support to implement Consent Decrees' programming and achieve compliance. ***In Compliance.*** IDHS-DMH contracted with UIC CON to provide program oversight and manage the CM pipeline to ensure CM transition requirements are met and manage the FDDP efforts to prevent unnecessary admissions to SMHRFs.	**N/A**	**N/A**	**In Compliance**

AD-5	FY22 IP	Strategy: By July 15, 2021, IDHS to provide core components, benchmark studies and primary analysis of Class size and demographics to Parties and Court Monitor. Expected Improvement/Outcome: ● Identified reports provided by July 15, 2021. ***In Compliance.*** Defendants sent reports to the Parties and Court Monitor on 7/15/21.	**N/A**	**N/A**	**In Compliance**
AD-6	FY22 IP	Strategy: By September 30, 2021, HFS to identify data points from Medicaid data systems to support clinical characteristics analysis. Expected Improvement/Outcome: ● Data points provided by September 30, 2021 ***In Compliance.*** HFS identified data points from the Medicaid data systems to support the Class Member clinical characteristics analysis. HFS emailed the information to Court Monitor on 9/30/21.	**N/A**	**N/A**	**In Compliance**

FY18-FY22 Compliance Assessment Ratings for *Williams* Implementation Plan-Related Consent Decree and FY22 Implementation Plan Requirements

Req #	Source/ Citation	***Williams* Consent Decree Requirement Language and FY22 Performance**	Prior Years' Compliance Ratings	FY21 Compliance Rating	FY22 Compliance Rating
48	Consent Decree VII(10)	The Implementation Plan shall describe methods by which such information will be disseminated, the process by which Class Members may request services, and the manner in which Defendants will maintain current records of these requests. ***In Compliance***. The Defendants complied with this requirement, as this required content was included in the FY22 Implementation Plan.	**FY2018: Out-of-Compliance** **FY2019: Partial Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
49	Consent Decree VII(10)	The Implementation Plan shall describe methods for engaging residents, including where appropriate, providing reasonable opportunities for residents to visit and observe Community-Based Settings. ***In Compliance***. The Implementation Plan is required to include the Defendants' strategies for actively engaging Class Members, as well as the process by which Class Members can observe community-based services and housing options for which they are eligible. The Defendants included such strategies and are found in compliance with this requirement.	**FY2018: Out-of-Compliance** **FY2019: Partial Compliance** **FY2020: Partial Compliance**	**Partial Compliance**	**In Compliance**
50	Consent Decree VII(11)	Defendants, with the input of the Monitor and Plaintiffs, shall create and implement an Implementation Plan to accomplish the obligations and objectives set forth in the Decree.	**FY2018: Out-of-Compliance** **FY2019: In Compliance**	**In Compliance**	**In Compliance**

		In Compliance. This requirement pertains to whether the Defendants developed the FY23 Implementation Plan (due near the end of the FY22 compliance period) to identify commitments for FY23. They did so, as the Implementation Plan was filed on 7/26/22. As such, they are found in compliance with these requirements.	**FY2020: In Compliance**		
51	Consent Decree VII(11)	*The Implementation Plan must, at a minimum*: a) Establish specific tasks, timetables, goals, programs, plans, strategies, and protocols to assure that Defendants fulfill the requirements of the Decree. ***In Compliance***. The FY22 Implementation Plan included specific, measurable, and time bound activities to advance fulfillment of the requirements of the Decree.	**FY2018: Out-of-Compliance** **FY2019: Partial Compliance** **FY2020: Partial Compliance**	**In Compliance**	**In Compliance**
52	Consent Decree VII(11)	*The Implementation Plan must, at a minimum*: b) Describe the hiring, training and supervision of the personnel necessary to implement the Decree. ***In Compliance***. The FY22 Implementation Plan contained several provisions on personnel and their training requirements.	**FY2018: Out-of-Compliance** **FY2019: Partial Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
53	Consent Decree VII(11)	*The Implementation Plan must, at a minimum*: c) Describe the activities required to develop Community-Based Services and Community-Based Settings, including inter-agency agreements, requests for proposals and other actions necessary to implement the Decree. ***In Compliance***. The FY22 Implementation Plan outlined activities to expand capacity of community-based services and housing.	**FY2018: Out-of-Compliance** **FY2019: Partial Compliance** **FY2020: Partial Compliance**	**In Compliance**	**In Compliance**
54	Consent Decree VII(11)	*The Implementation Plan must, at a minimum*: d) Identify, based on information known at the time the Implementation Plan is finalized and updated on a regular basis, any services or supports anticipated or required in Service Plans formulated pursuant to the Decree that are not currently available in the appropriate quantity, quality or geographic location. ***In Compliance***. The Defendants, in partnership with UIC-CON, conducted an analysis of Class Member service plan data to inform housing and services capacity development.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Out-of-Compliance**	**Out-of-Compliance**	**In Compliance**
55	Consent Decree VII(11)	*The Implementation Plan must, at a minimum:* e) Identify, based on information known at the time the Implementation Plan is finalized and updated on a regular basis, any services and supports which, based on demographic and other data, are expected to be required	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance**	**Out-of-Compliance**	**In Compliance**

		within one year to meet the obligations of the Decree. ***In Compliance***. The Defendants, in partnership with UIC-CON, conducted an analysis of Class Member service plan data to inform services and housing capacity expansion efforts.	**FY2020: Out-of-Compliance**		
56	Consent Decree VII(11)	*The Implementation Plan must, at a minimum*: f) Identify any necessary changes to regulations that govern IMDs in order to strengthen and clarify requirements for services to persons with Mental Illness and to provide for effective oversight and enforcement of all regulations and laws. ***In Compliance***. During FY22, the Defendants enforced new processes regarding the investigation of retaliation claims and engagement of involuntarily discharged Class Members. Further, they changed SMHRF administrative rules to require facilities to submit monthly census reports, provide reports on voluntary and involuntary discharges, and furnish admitted Class Members with educational materials on the Consent Decree.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: Partial Compliance**	**In Compliance**	**In Compliance**
57	Consent Decree VII(11)	*The Implementation Plan must, at a minimum:* g) Describe the methods by which Defendants shall ensure compliance with their obligations under Paragraph 6 *(Evaluations)* of this Decree. ***In Compliance***. The FY22 Implementation Plan included activities and tasks associated with compliance in the assessment (formerly referred to as evaluation) domain.	**FY2018: Out-of-Compliance** **FY2019: Out-of-Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
58	Consent Decree VII(11)	*The Implementation Plan must, at a minimum:* h) Describe the mechanisms by which Defendants shall ensure compliance with their obligations under Paragraph 10 *(Outreach)* of this Decree. ***In Compliance***. The FY22 Implementation Plan included activities and tasks associated with compliance in the outreach domain.	**FY2018: Out-of-Compliance** **FY2019: Partial Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
59	Consent Decree VIII(13)	The Implementation Plan shall be updated and amended annually, or at such earlier intervals as Defendants deem necessary or appropriate. The Monitor and Plaintiffs may review and comment upon any such updates or	**FY2018: Out-of-Compliance** **FY2019: In Compliance**	**In Compliance**	**In Compliance**

		amendments. In the event the Monitor or Plaintiffs disagree with the Defendants' proposed updates or amendments, the matter may be submitted to the Court for resolution. ***In Compliance***. This requirement pertains to whether the Defendants developed the FY23 Implementation Plan (due near the end of the FY22 compliance period) to identify commitments for FY22. They did so, as the Implementation Plan was filed on 7/26/22. As such, they are found in compliance with these requirements.	**FY2020: In Compliance**		
60	Consent Decree VIII(14)	The Implementation Plan, and all amendments or updates thereto, shall be incorporated into, and become enforceable as part of the Decree. ***In Compliance.*** The FY23 Implementation was filed and will be enforced in accordance with the Consent Decree, with agreement from the Defendants.	**FY2018: In Compliance** **FY2019: In Compliance** **FY2020: In Compliance**	**In Compliance**	**In Compliance**
61	Consent Decree VIII(12)	Within 135 days of Approval of the Decree, Defendants shall provide the Monitor and Plaintiffs with a draft Implementation Plan. The Monitor and Plaintiffs will participate in developing and finalizing the Implementation Plan, which shall be finalized within nine (9) months following Approval of the Decree. In the event the Monitor or Plaintiffs disagree with the Defendants' proposed Implementation Plan, the matter may be submitted to the Court for resolution.	**FY2018: N/A** **FY2019: N/A** **FY2020: N/A**	**N/A**	**N/A**