

# WILLIAMS SEMI-ANNUAL REPORT #5

---

## EXECUTIVE SUMMARY

This report, required by the Williams Consent Decree on a semi-annual basis, describes Williams Consent Decree implementation activities June 1, 2013 through November 30, 2013.

The State achieved two important benchmarks mandated by the Williams Consent Decree during this time period.

- 643 Williams Class Members were transitioned to community-based settings or had leases signed with transition imminent by June 30, 2013 exceeding the requirement to transition 640 Class Members and to develop 640 Permanent Supportive Housing units by the end of Year II, and
- All Williams Class Members had the opportunity to be assessed for transition to a community-based setting by September 30, 2013 in accordance with the modified Consent Decree (see below).

The Agreed Motion to Modify Consent Decree and For Other Relief, filed by the Parties June 3, 2013, was granted June 13, 2013. This motion requested modification of the Williams Consent Decree, by revising the schedule for completing evaluations of Class Members and adjusting the way the benchmark for the third year of implementation is measured. That is, 1) the deadline for completing Resident Reviews on all Williams Class Members was extended to September 30, 2013 and, 2) the formula to calculate the Year III transition benchmark was altered to consider all Williams Class Members who are assessed as appropriate for transition, rather than the original requirement that the Class Members to be considered would be those that are, both, assessed as appropriate for transition and that do not oppose moving to the community. The result of this change in formula is that **832** Williams Class Members must transition to the community or have leases signed with transition imminent by June 30, 2014.

In addition, the motion required that the Williams Consent Decree Implementation Plan be amended by July 1, 2013 with strategies developed to 1) improve information provided in the Outreach process, 2) modify the evaluation process and instrument so that it more effectively describes what, if any, services and supports are not available in the necessary quantity, quality, or geographic area to allow a Class Member to transition to the community successfully, and 3) develop appropriate enhancements to community-based services and supports, consistent with Paragraphs 5 and 7(e) of the Consent Decree, to permit more Class Members to successfully transition to the community. The Parties are in agreement that these strategies should improve both the Resident Review assessment acceptance rate and the Williams Class Member transition referral rate. While the workplan developed to meet these objectives is briefly described in the body of this document, it should be noted that elements of this comprehensive workplan can be found in all of the implementation components that organize this report. This plan defines much of the work accomplished during this time period.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

### OUTREACH AND INFORMATION DISSEMINATION

#### Outreach Workers

Outreach activities continue during this time period. The National Alliance on Mental Illness of Greater Chicago's (NAMI-GC) Outreach Workers continue to 1) provide information and materials about the Williams Consent Decree to newly admitted Class Members, 2) provide updated information to interested Williams Class Members, IMD staff, guardians and family members regarding the Williams Consent Decree, Recovery and other related topics, 3) attempt to re-engage formerly disinterested Class Members to determine if they're interest in being informed about the Williams Consent Decree has changed, 4) perform pre-transition Quality of Life surveys (see results in the Quality section of this report), and 5) assist with special projects as assigned by DHS/DMH. As of November 11, 2013, 6976 Class Members have been approached for Outreach; 4298 Class Members have agreed to private interviews and 2173 Class Members have refused any interaction with Outreach Workers.

In July, 2013 Outreach Workers were asked to approach Class Members who had previously refused assessment to encourage them to participate in the Resident Review process and to gather information regarding why they chose not to participate. See outcomes regarding this project in the Resident Review section of this report.

#### Williams Video

Department of Human Services (DHS)/Division of Mental Health (DMH) has contracted with a creative consultant to develop a video series that will be used to educate Class Members about their opportunities under the William Consent Decree. Two focus forums were conducted to glean information regarding Class Member perceptions about transition to the community as well as to identify potential subjects for the informational video. The filming of eight Class Members, showcasing their homes, and discussing their personal transition experiences, occurred in October and November 2013. It is anticipated that the video series will be completed in December 2013.

#### Williams Community Fairs

An objective of the FY14 Strategies for Improving Community Transition was to pursue creative attempts to inform and educate Class Members about *Moving On*. The idea of Williams provider agencies hosting an event, one that would provide socialization activities and informational content about the Williams Consent Decree and transition options, culminated in the concept of a Williams Community Fair.

Nine Williams agencies executed their own design for a Community Fair. Agencies were instructed to coordinate efforts between Williams providers so that there would not be duplicate invitations to Class Members in one IMD. This was a means to maximize exposure assuring that all IMD residents would have invitation to a Fair and that agencies located in the same geographic areas would not unknowingly target the same IMDs. Agencies were also advised to be extremely innovative; to use resources to create interest about transition options and life in the communities; to have presentations from Class Members with live experiences on their personal transition and what this pursuit meant in their recovery journey.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

DHS/DMH afforded Williams provider agencies with reimbursement up to \$3,500.00 to make these Fairs memorable events. Agencies also provided transportation for Class Members and IMD staff escorts to and from the Fairs. Most of the Fairs were held during the month of August 2013, with the most recent Fair hosted in November 2013 for Class Members of the two IMDs located in Kankakee County.

More than 350 Williams Class Members and family members participated in the combined Community Fairs. Feedback obtained from the Williams Outreach Workers, as well as DHS/DMH staff representatives who were present at the majority of the Fairs, indicated that these events were extremely successful. In addition to agencies sharing information on community based services, and supports, agencies had available an array of outside vendors and community affiliates including local libraries, faith-based organizations, Salvation Army representatives, Walgreens representatives, bank representatives, local hospitals, etc., which provided literatures and information on available resources.

### **Williams Newsletter**

The first edition of the Williams Newsletter was released in October 2013. This will be a quarterly publication showcasing accomplishments and innovations of the Williams community agencies, as well as the recovery highlights of Williams Class Members.

This edition includes descriptions of several Williams Community Fairs and articles written by Class Members. The Class Member articles provide tips and insight as well as reflections on their experiences in the transition processes and independent living. Each Class Member's road to recovery is a personal journey and it is the intent of the Newsletter to expound on a wide range of experiences. The reader will be enlightened regarding the multi-faceted lives of individuals who have been diagnosed with serious mental illnesses and their personal quests to reach their optimal level of recovery.

### **Williams Informational Line**

The Williams Informational Phone Line, operated by the DHS/DMH is a live response telephone line, operated five days a week for eight hours daily. The Williams Informational Line has received 51 calls during this reporting period with questions regarding Williams Consent Decree issues. 47 (92%) calls were from Williams Class Members and 4 (8%) calls were from family/friends of Williams Class Members.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

### RESIDENT REVIEW

Lutheran Social Services of Illinois (LSSI) and Metropolitan Family Services (MFS) continue to offer and complete Resident Review assessments, for all consenting Class Members, in accordance with the tenets of the Williams Consent Decree. In accordance with the modifications made to the Consent Decree on June 13, 2013, all consenting Williams Class Members had a Resident Review assessment completed and submitted to DHS/DMH by September 30, 2013.

As of November 26, 2013, the DHS/DMH internal management database reflects 6234 Resident Reviews initiated, of which 3057 (49%) were accomplished. Of the 3,057 Resident Reviews completed, 2616 Class Members received 1 review, 388 Class Members received 2 reviews, 48 Class Members received 3 reviews, 4 Class Members received 4 reviews and 1 Class Member received 5 reviews.

As a result of the 3057 Resident Reviews completed, 1795 (58.7%) Class Members were referred to community mental health agencies for transition to the community (this number includes Clinical Review Team overturns and Appeal overturns).

#### **Resident Review Acceptance Rate**

Efforts continue to improve the Williams Class Member Resident Review acceptance rate. The following initiatives were implemented during the time period covered by this report to inform DHS/DMH staff regarding reasons why Class Members refuse Resident Reviews and to improve the Resident Review acceptance rate:

- Resident Reviews were sampled for reasons why Class Members refuse to be assessed.
- A focus group was conducted of Class Members who have successfully transitioned to query reasons why some Class Members may decline transition.
- A focus group was conducted with Resident Reviewers for their perceptions regarding why Class Members refuse assessments.
- The popular Moving On theme is being promoted across all components of the implementation process with the goal being consistent usage by Outreach Workers, Resident Review staff and community mental health agency staff.
- Funds were granted to Williams community mental health agency staff to conduct informational community fairs for Williams Class Member participation (see the Outreach section).
- Funds were allotted for the production of an educational video series created to inspire Williams Class Members (see the Outreach section).
- The National Alliance on Mental Illness of Greater Chicago (NAMI-GC) Outreach Workers and Resident Reviewers were requested to attempt to reengage Class Members who previously refused assessment using a “soft approach”. Class Members are to be gently encouraged to

## WILLIAMS SEMI-ANNUAL REPORT #5

---

consider participating in the Resident Review process and to provide specific information regarding why they decline assessment.

The below Refusal Report table reflects data provided by NAMI Outreach, as of November 11, 2013:

Total Number of Class Members soft approached to date: **501** **619**<sup>1</sup>

Reason	Number of Responses	Percent of Respondents
Refusing Transition	309	61.7%
Guardian is Refusing	41	8.2%
Go Away	23	4.6%
I am Happy Here	94	18.8%
Family Objects to Moving	8	1.6%
I am afraid because others have failed	3	0.6%
Other things in my life	15	3.0%
Maybe later	42	8.4%
I am thinking about it	12	2.4%
I want to but have not had an assessment <sup>2</sup>	72	14.4%

### Transition Referral Rate

In the first quarter of FY14, the Parties requested a sample of Resident Reviews completed for those Class Members who were not recommended for transition and whose case files went before a Clinical Review process. Seventy-two (72) files of Class Members whose Resident Review recommendations were not to transition, at this time, were sent to the Plaintiffs' attorneys. The predominate concern raised by Plaintiffs was that the large number of Class Members not recommended for transition was in direct violation of the language of the Consent Decree. A letter dated September 19, 2013 from the ACLU provided feedback from their analysis of these Resident Review documents. The State considered these findings and proposed to use this feedback as an opportunity for improvement. The State is in

---

<sup>1</sup> 501 is the Number of individual CMs approached; 619 is a duplicate number with some CMs identifying multiple reasons

<sup>2</sup> Further drill down required to determine if these CMs were assessed, but not recommended for transition.



## WILLIAMS SEMI-ANNUAL REPORT #5

---

agreement that the primary goal is to assure that the Resident Review recommendation ultimately assures overall quality of life, quality of care and safety (physical health and mental health) for the Class Member, while identifying the services and supports that would be needed to make transition to the community a reality.

The State's objectives are:

- to refine how the reviewers approach the assessment process, how they incorporate Class Members' desires and individualized interests, needs or challenges into the recommendation's summary.
- and
- to assure that the content of the assessments are appropriate for the reader to understand and clearly represents a comprehensive, descriptive portrait of each Class Member that will assist the community agency in facilitating seamless and hopefully successful transition and stabilization.

During a training session of the two Resident Review teams in late October, the following principles were emphasized:

- Expressed interest of a Class Member to move from the IMD as the first determining factor to transition readiness - the assessment builds on this interest.
- Assessments will be written in clear, defensible, descriptive language. Categorical silos will no longer be used (for example Activity of Daily Living (ADL), Instrumental Activity of Daily Living (IADL), poor coping skills, lack of insight, etc.) as reasons for not referring Class Members for transition to the community.
- Lack of documented or demonstrated skill proficiency will not be incorporated as a predictor of transition readiness or ability, unless there is an inherent safety risk (to self or others). Skill deficits will not preclude a recommendation to transition.
- Insight into one's mental illness will not be considered as a prerequisite for transition readiness, unless there are historical, documented safety risk factors (examples: medication discontinuation results in aggression towards others and/or property).
- Community-based Supervised Residential settings may be used as a transition recommendation options with clear, detailed documentation of the rationale supporting this level of care.

The same training will be provided to the community mental health agency staff for their utilization in Clinical Review Team proceedings.

### **Resident Review Instrument**

Information regarding revisions to the Resident Review instrument as required by the Williams Consent Decree Implementation Amendments filed July 1, 2013 was submitted to HealthCare and Family Services (HFS) for development. Requested changes have been made but DHS/DMH is experiencing some difficulty with accessing this information. DHS/DMH and HFS are working to resolve this issue so that the revised instrument can be implemented.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

### **Clinical Review**

Resident Reviews of those Class Members that are not recommended for transition to the community are sent to Williams contracted community mental health agencies located in the geographic areas selected by the Class Member for a 2<sup>nd</sup> level paper review. As of November 26, 2013, 1429 Resident Reviews were referred to Clinical Review, with 203 (14%) recommendations overturned and referred to community mental health agencies for transition to the community.

# WILLIAMS SEMI-ANNUAL REPORT #5

## TRANSITION COORDINATION/COMMUNITY SERVICES

### Transition Coordination/Community Services

The Williams community mental health service provider network now includes 10 agencies that have contracted with DHS/DMH to provide the full range of Williams services and supports: Thresholds (Chicago), Trilogy (Chicago), Community Counseling Center of Chicago (Chicago), Human Service Center (Peoria), Lake County (Waukegan), Human Resource Development Institute (Chicago), Association House (Chicago), Grand Prairie Behavioral Health Services (Tinley Park), Heartland Health Outreach (Chicago) and Heritage Behavioral Services (Decatur). Heritage Behavioral Services only provided limited services in FY13, but contracted with DHS/DMH, and was trained to provide the full array of Williams services and supports in FY14. The seven other agencies, recruited in response to Class Member preferences, that offer limited services are Cornerstone Services (Joliet), Ecker Center (Elgin), Iroquois County Mental Health (Watseka), New Foundations Center (Northfield), Kenneth Young Center (Elk Grove Village), Alexian Brothers Center (Arlington Heights) and Dupage County Health Department (Wheaton).

As of November 26, 2013, 1795 Class Members (this number includes Clinical Review overturns and Appeal overturns) have been referred to Williams community mental health agencies, based on Class Member choice, when applicable. 774 Williams Class Members have transitioned to the community or have leases signed with transition imminent.

Of these 1795 Class Members, 1) 406 Class Members declined the agency's offer to provide housing in the community with services and supports and 2) 151 Class Member assignments were returned to DHS/DMH because their assigned community mental health agencies determined that the services required by them do not exist in the current Illinois service taxonomy. These Williams Class Members have been loosely categorized in an attempt to describe the reasons that the community mental health agencies deemed them unable to serve in the table below:

Service Needs of Class Members identified as Unable to Serve	# Williams Class Members
Financial	9
Medical	28
Medical/Diabetes	19
Medication Management	29
Psychiatric/Behaviors	66
Total	151

## WILLIAMS SEMI-ANNUAL REPORT #5

---

It is the intention of the State to meet the needs of as many Class Members as possible. Some of these Class Members' needs will be met with the expanded services described at the end of this section. Additionally, DHS/DMH staff is working with the community mental health agencies to determine what other services and supports can be developed to meet the needs of some of these Class Members. A workplan is being developed to expedite the following strategies:

- Expand Supervised Residential services;
- Develop the "Project-based/Clustered Housing Model ( see Housing section);
- Explore the ability to allow billing for ACT services in residential care;
- Initiate discussions with the Medicaid authority regarding 1) flexibility in rates for nursing services and 2) the ability for community mental health agencies to bill for more than one staff during a single client visit.
- Initiate discussions at the national level regarding Social Security eligibility issues.

### **Characteristics of Williams Class Members Registered as of October 31, 2013**

#### A Descriptive Analysis

Division of Mental Health (DMH) contracted providers serving in the role of transition coordinators are contractually required to register/enroll Williams Class Members (WCMs) in the DMH Community Information System within seven days of their initial contact with Class Members which occurs within the IMD in which the individual resides. They are also required to re-register these individuals to update key fields at six month intervals. As of October 31, 2013, eight hundred and thirty-six (836) Williams Class Members were enrolled in the DMH Community Information System as a result of being assigned to an agency for transition coordination. This analysis provides a summary of demographic and basic clinical characteristics of this cohort of individuals.

#### Age, Gender, Ethnicity and Hispanic Origin

Those Class Members who are registered range in age from 19 to 80 years old, with an average age of 46. Of the 836 class members, 551 (66%) are male and 285 (34%) are female. Overall, 5.5% of Class Members were reported as being of Hispanic Origin. With regard to primary ethnicity, 54.9% of Class members are Black/African-American and 41% are Caucasian. A very small percentage are Asian (.2%) or Native Hawaiian/Pacific Islander (.2%); ethnicity was reported as unknown for 1.7%.

#### Marital Status

The majority (75%) of Class Members have never been married; 11% percent are divorced and another 5% are separated. Only 2.3% are married and 1.7% are widowed.

#### Highest Level of Education Completed

Thirty percent of Class Members have earned a high school diploma and an additional 8.5% were reported as having earned a General Equivalency Degree (GED). Twenty-three percent of Class Members completed some high school (e.g., one, two or three years) with no diploma earned. Eighteen percent have completed some college, and 5% hold a Bachelor's Degree. A small percentage (1.5%) of Class Members has completed post-secondary training and 1.1% has completed post graduate training. The highest level of education completed by approximately 3% of class members was 8<sup>th</sup> grade. Education level was not reported for approximately 9% of registered Class Members.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

### Residential Living Arrangement

As of October 31st, 40% of Class Members were reported to reside in Permanent Supportive Housing, while 48% were reported as residing in IMDs.

### Military Status

Five percent of Class Members reported being a veteran having formerly served in the military.

### Primary Language

The primary language spoken by nearly 99% of Class Members included in this analysis was English.

### Justice System Involvement

The majority (91%) of Class Members were reported as not having any involvement with the justice system (courts, jails etc). However, .7% had been arrested, and a very small percentage reportedly had been charged with a crime (1%), or incarcerated in a jail or prison (.2% or 2 individuals). An additional 3 Class Members (.3%) had a status at some point of being on parole or probation. The status of 6.5% was reported as unknown at the time that the individual was registered/re-registered.

### History of Mental Health Treatment

During the registration process, information is gathered regarding an individual's history of mental health treatment. Fifty-two percent have a history of continuous treatment for mental health related problems, 83% have a history of continuous residential treatment. Eighty one percent of Class Members have a history of receiving outpatient mental health services for their illnesses.

### Level of Care Utilization Scale Scores Based on Assessor Recommendations

A little less than half (43%) of the Class Members included in this sample were recommended by the assessor to receive high intensity community based services (level 3) based on the results of the LOCUS assessment. An additional 40% percent were recommended for Medically Monitored Non-Residential Services. A little more than 5% of Class Members were recommended for Medically Monitored Residential Services, while 1.6% were recommend for a Medically Managed level of Residential Services. Four percent were recommended for Low Intensity Community-Based Services, while .7% were recommended for Recovery Maintenance and Health Management. LOCUS scores were missing for approximately 6% of the cohort.

### Diagnosis

Seventy-five percent of Class Members had a primary diagnosis of schizophrenia and other psychotic disorders; 23% were diagnosed with bipolar and mood disorders. Sixteen percent had a co-morbid substance use disorder.

### Functional Impairment

The Global Assessment of Functioning (GAF) Scale (also known as Axis 5 of the DSM-IV) is used to determine functional impairment of an individual in the psychological, social and occupational spheres of their lives. The scale ranges from 1 to 100 with 1 representing lowest level of functioning or the highest level of impairment. Class members GAF scores ranged from 15 to 70 with an average of 44

## WILLIAMS SEMI-ANNUAL REPORT #5

---

which represents..." Serious symptoms or any serious impairment in social, occupational, or school functioning".

### Other Areas of Functional Impairment

DHS/DMH providers are asked to rate an individual's serious functional impairment in 7 areas as part of the registration/enrollment process: Social/Group Functioning, Employment, Community Living, Financial, Supportive/Social, Daily Living Activities and Inappropriate Dangerous Behavior. Ninety percent of class members were identified as having a serious functional impairment in the employment area, 84% in the financial area, 83% in Social/Group functioning and 76% in Community Living area. Fifty-two percent had a serious functional impairment in the supportive/social area, 55% in activities of daily living and 34% had a serious impairment in relation to inappropriate or dangerous behavior.

### Comparison to Previous Analysis for March 29<sup>th</sup> Cohort

The prior analysis of descriptive demographic and clinical data for Williams Class Members registered in the DMH Community Information System was performed in May 2013 for Class Members registered as of March 29, 2013. Although the number of Class Members included in the current analysis is nearly twice the number of Class Members whose information was included in the prior analysis, there is very little variability in the descriptive information reported for the two cohorts.

### **Utilization of Community Services**

The table below summarizes service utilization for Williams Class Members between July 1, 2013 and October 31, 2013. The data are based on claims submitted by Williams contracted providers, thus the utilization information reflects only claims submitted as of October 31, 2013. Based on this data, 151 individuals were assessed for community service needs, and 206 had individualized treatment plans developed. Note that assessments occurred prior to July 1, 2013 for some of the 206 individuals who had treatment plans developed during this period. This assessment and planning begins in the IMD prior to transition to the community, to identify the services needed to address the individual's mental illness needs.

Transition Coordination services (billed as case management and community support individual) were provided to 574 individuals (duplicated count across services). As described in the implementation plan, the purpose of Transition Coordination is to assure that the right systems and supports are in place to effect successful transitions for all Class Members making the choice to resettle into the community. The ultimate goal of Transition Coordination is to create a seamless interface between transition efforts and community-based supports that includes community mental health services, healthcare services and other resources.

To further assist individuals in developing specific skills, the services of Psychosocial Rehabilitation (PSR) and Community Support Group (CSG) have been offered to Class Members. PSR, a facility-based/classroom model of treatment was provided to 95 individuals during this time period. CSG, a community-based service that assists in generalizing the service to the individual's natural environment, was provided to 76 Class Members.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

Once an individual transitions from the IMD, team services of Assertive Community Treatment (ACT) or Community Support Team (CST) are available according to the individual's assessed medical necessity. Both services provide access to a multidisciplinary team, with ACT being an all-inclusive service developed for the needs of individuals who would otherwise not engage in treatment. CST is a service developed for individuals who will benefit from the team approach and are willing to engage in treatment. A total of 453 individuals received services from teams during the period.

Therapy/Counseling services, which provide interventions based in psychotherapy theory and techniques to promote specific emotional, cognitive, behavioral or psychological changes, has been provided to 16 individuals. Crisis Intervention Services, which provide interventions aimed at stabilizing a psychiatric crisis, were required by 50 individuals during this period, while 8 individuals received some skill training and support within a residential setting of a community provider.

Type of Service	Allowed Amount	Allowed Units
Assertive Community Treatment	\$994,594.08	35,280
Case Management	\$313,180.58	16,325
Case Management - LOCUS	\$8,925.48	213
Community Support	\$454,550.49	25,065
Crisis Intervention	\$14,194.58	414
Psychological Evaluation & Mental Health Assessment	\$22,508.60	1,170
Psychosocial Rehabilitation	\$30,703.56	4,763
Psychotropic Medication Administration	\$520.28	50
Psychotropic Medication Monitoring	\$13,370.38	667
Psychotropic Medication Training	\$12,019.21	665
Residential Services	\$0.00	206
Therapy/Counseling	\$4,312.57	260
Treatment Plan Development, Review, Modification	\$18,542.33	1,000
<b>TOTAL</b>	<b>\$1,887,422.14</b>	<b>86,078</b>



## WILLIAMS SEMI-ANNUAL REPORT #5

---

### Community Tenure

An important indicator of the success in Class Members transition from the institutional setting of an IMD to the community setting of their own home is the extent to which Class Members continue to reside in these homes post IMD discharge. Table 1 displays a frequency distribution showing the length of time Class Members resided in permanent supported housing for 663 Class Members as of October 15, 2013. While this table does not provide a conclusive picture of the extent to which Class Members will remain in the community following community transition because new Class Members are continually transitioning from IMDs, it does provide descriptive point in time information regarding the number of days that Class Members are living in community residential settings post IMD discharge. For example, the data displayed in table 1 shows that approximately 20% of the 663 Class Members for whom data was obtained had lived in their own homes for 90 days or less. An additional 26% had remained in their own homes from 91 to 180 days, while the remaining 54% remained in the own homes post IMD discharge for 181 days or 6 months or more.

To get a better idea of the success associated with transitioning to community living in terms of community tenure, data were obtained with regard to the number of Class Members reported as continuing to reside in permanent supportive housing as of October 15, 2013 versus those Class Members who had left or relocated. Ninety-two percent (92%) of the 663 were still living in their residences in the community, while 52 (8%) of the 663 Class Members had relocated to other settings as of this date. This relocation was due primarily to the following reasons: hospitalization (42%, n=22) or return to an IMD (42%, n=22). The disposition for the remaining 8 (16%) Class Members was: admitted to a nursing facility (n=3), moved in with family/relatives (n=2); incarcerated (n=2), moved to alternative residential setting (n=1). A significant portion (39%, n=20) of the 8% of Class Members leaving permanent supported housing left within 30 days post IMD discharge, while 13.3% (n=7) of the 52 relocated after remaining in their own homes for more than 6 months. When the community tenure for the seven Class Members remaining in the community for 6 or more months before relocating to other settings is compared to the length of stay in community residences for the full cohort of Class Members continuing to reside in their community residences for 6 or more months (n=361), the percentage of individuals leaving permanent supportive housing drops to less than 2%. Thus it would appear that the longer Class Members reside in the community, the less likely they are to leave their homes to reside in other settings.

### Community Tenure Post IMD – Class Members Discharged as of October 15, 2013\*

Community Tenure – Number of Days in Community in PSH	Number of Class Members	Percentage
1 to 30 Days	50	7.5%
31 – 60 Days	39	5.9%
61 -90 Days	40	6.0%

## WILLIAMS SEMI-ANNUAL REPORT #5

---

91 – 120 Days	49	7.4%
121 – 150 Days	73	11.0%
151 – 180 Days	51	7.7%
181 – 210 Days	49	7.4%
211 – 240 Days	40	6.0%
241 – 270 Days	41	6.2%
271 – 300 Days	29	4.4%
301 – 330 Days	83	12.5%
331 – 360 Days	42	6.3%
361 – 390 Days	21	3.2%
391 – 420 Days	15	2.3%
421 – 450 Days	28	4.2%
>450 Days	13	2.0%
<b>TOTAL</b>	<b>663</b>	<b>100.0%</b>

\*Excludes the 5 Class Member who were deceased as of October 15, 2013

### **Proposed Service Expansion Update**

Although not required by the Consent Decree, the State has identified the additional services needed by some Class Members for successful transition consistent with the terms of the Consent Decree. Four new service areas were defined by an interdepartmental workgroup, and work is currently being done within HFS to determine funding mechanisms and develop necessary policies and procedures for implementation. The services to be added are:

#### Recovery Supports

This service will address the need for activities that are not currently being provided as a part of Community Support. These include activities that assist in engagement in community, and involvement with individuals, such as accompanying them to activities, such as community support groups. In addition, the provision of a supportive presence during the early phases of transition will be available to the individual. It is noted that agencies are providing linkages to supports, but what is lacking is someone being with the person, supporting their attempts to engage in the community. This service

## WILLIAMS SEMI-ANNUAL REPORT #5

---

will be provided by individuals with a Certified Recovery Support Specialist (CRSS) credential, who will be considered a part of the individual's treatment team.

### Dual Diagnosis Residential Treatment

This specialized service of residential rehabilitation will assist in assuring success for some individuals with dual diagnoses of mental illnesses and substance abuse disorders, for whom the current substance abuse residential services are not a good fit. Included in the service array will be:

- Dual diagnosis - enhanced Inpatient Substance abuse treatment services
- Relapse prevention Services
- WRAP plan development
- Direct linkage between the residential provider and community mental health services
- Personal support services network development
- Psychiatric services
- Medication assisted treatment

These treatment sites of 16 beds or fewer will be licensed through Department of Human Services/Division of Alcohol and Substance Abuse (DHS/DASA), and enrolled as DHS/DMH providers, allowing for fully integrated services defined by both agencies. There will be access to self help groups both on site and in the community to further support the development of natural supports and full community integration. In order to provide these services, the agency will have to score as "Dual Diagnosis Enhanced" on the Dual Diagnoses Capability in Addiction Treatment (DDCAT) index, employ clinical staff trained in services to clients with Dual Diagnosis including provision of crisis services for both, and maintain 24 hour access to Psychiatric Services.

### Assertive Community Treatment (ACT) and Community Support Team (CST) - Enhanced Skills Training and Assistance

This enhancement to team services will assist individuals who cannot manage ADLs and IADLs necessary for safe community living. Currently, the service system is not equipped to address these skill development needs, despite skill development being included in current Rule 132. This is due to a number of factors, including:

- Most mental health professionals are not educated by colleges and universities to do the following:
  - Assess, teach, and facilitate the development of ADLs, IADLs, and health rest and sleep routines.
  - Analyze how the neurophysiology of mental illnesses and medication side effects impact the ability to perform daily life tasks, and regulate states of arousal and attentiveness.
  - Analyze how co-morbid medical conditions impact ADL and IADL performance.
  - analyze the interactions among task demands, environments, contexts, and personal factors, all of which influence performance
- Community Mental Health staff usually learn how to facilitate skill performance on the job, while the assessment of the reasons underlying performance deficits lacks sophistication. Typically, there is no assessment done of the factors contributing to ineffective and unsafe

## WILLIAMS SEMI-ANNUAL REPORT #5

---

performance. The repertoire of strategies to facilitate ADL and IADL performance is very limited, and may be misdirected.

- The current services system is focused on engagement, support, and maintenance, rather than rehabilitation and habilitation to improve performance of essential life tasks and roles. While the State will increase the skill set of team services staff in these areas, some Class Members require skill development beyond the current scope of ACT and CST practice.

To address this issue, the State is developing an enhanced level of ACT and CST services. The two elements of the service enhancement are: (1) an increased frequency and intensity of contact (beyond the usual front-loading) that projected for the year after transition; and (2) the direct involvement of Occupational Therapy practitioners, who are uniquely qualified to address skill development issues. These clinicians will provide evaluation and interventions to improve performance of critical ADLs, IADLs, and health rest and sleep routines, which are particularly relevant to living safely in the community. In order to increase the potential pool of Occupational Therapy (OT) providers willing and prepared to work with ACT and CST teams, the State recently hosted a seminar for OT students and practitioners focused on careers within the mental health field. In addition, the State is in the process of developing internship programs for students to gain experience working with community mental health providers. The State will also develop an orientation to ACT and CST services and training on the enhanced skill development model for both OT practitioners and team services providers.

### Bi-Directional Healthcare and Enhanced ACT/CST Self-Management and Adherence Support

While not technically a specific service, this integration of the behavioral health and health service systems needs to be further developed within the State. It includes close coordination of behavioral and primary health care provision and illness management/self-management strategies to ensure that the needs of individuals with Serious Mental Illness (SMI) or Serious Mental Illness/Substance Abuse (SMI/SA) who have complex medical issues are met. By integrating the service delivery, successful management of the complex needs and increased self-management capacity in individuals diagnosed with both serious mental illnesses and significant physical health issues can be achieved for most consumers. This will include close bi-directional coordination and collaboration between the mental health provider, primary care physician and disease managers.

In addition, the State will develop an enhancement to ACT and CST team services. The two elements of the service enhancement are: (1) an increased frequency and intensity of contact (beyond the usual front-loading) that projected for the year after transition; and (2) direct involvement of Advance Practice Nurses (APNs) and OTs in assessment, individualized intervention plan, hands-on in-home teaching, and close monitoring to address critical self-management and adherence issues.

Individuals in need of this service are those who meet the “Quadrant IV” designation under Four Quadrant Clinical Integration Model, i.e., those with high physical and mental health service needs. Their services will be provided by highly trained staff with competency in both behavioral and physical health care, including Advance Practice Nurses, with access to specialty medicine when needed, and OT assessments and services.

The two forms of enhanced ACT and CST services will be provided through a demonstration project involving consumers served under the Williams, Colbert, and Money Follows the Person (MFP) projects.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

Funds for the Williams population are included in the plan for the federal Balancing Incentive Program (BIP). The demonstration will support the refinement of models, finalization of criteria, methods for identification of individuals with enhanced service need, and exploration of the best mechanism for incorporation in the Illinois Medicaid Program.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

### HOUSING

DHS/DMH, the Governor's Office (GO), the Illinois Housing and Development Authority (IHDA) and the Corporation for Supportive Housing (CSH) continue to collaborate to identify Permanent Supportive Housing (PSH) units for Williams Class Members and to support the efforts of Williams providers as they transition Williams Class Members into Permanent Supportive Housing in the communities of their choice. It should be noted that there was limited involvement with CSH June 30, 2013 thru September 15, 2013 due to delays in this organization's contract renewal.

DHS/DMH in collaboration with the Governor's Office (GO), IHDA and CSH has utilized an array of strategies during this reporting period to outreach with numerous landlords, and property management firms including:

- Participation in the Chicago Housing Authority Owner's Symposium October 12, 2013 which provided an opportunity for CSH, the DHS/DMH Housing Coordinator and Williams Housing Locators to speak directly with hundreds of property owners about the Williams Consent Decree.
- Support of special project development coordinated by non-profit community development financial institutions such as the Illinois Facilities Fund (IFF) and Diamond Development. These nonprofit organizations facilitate the full spectrum of supported housing development in multiple communities and commit access to Williams Class Members upon completion of such projects. DHS/DMH anticipates that several of these projects will be completed by spring 2014.
- A training program was developed and presented by CSH in June 2013 for housing developers that have or are looking to develop integrated housing projects. Topics included: *Supportive and Integrated Housing and State of Illinois Priorities, Developing Effective Partnerships in Integrated Housing, Financing Integrated and Supportive Housing and Property Management Strategies and Best Practices*
- Open house events hosted by Williams community mental health agency Housing Locators to educate landlords about the Williams program.
- Increased usage of the Illinois housing search website by Williams transition coordinators and Housing Locators
- Statewide target area programs administered through the Governor's office and DHS/DMH regional contract managers.
- A presentation delivered to the Chicago Metropolitan Agency for Planning Housing Committee September 17, 2013 to encourage support for new developments of supportive housing for people with serious mental illness in the communities under their purview.

Additional Permanent Supportive Housing activities occurred during the time period covered by this report are:

- Negotiations began in November 2013 with U.S. Department of Housing and Urban Development (HUD) regarding the HUD Section 811 Contract Agreement and the State expects to begin awarding assistance over a three year period beginning spring 2014. IHDA is

## WILLIAMS SEMI-ANNUAL REPORT #5

---

responsible for program development and implementation under the direction of the Governor's Office's coordination to meet long term care needs. An interagency panel has been established that advises IHDA on policies for how best to deploy Section 811 housing resources. This panel met on November 20, 2013 to discuss the Section 811 Special Demonstration Project and to clarify the roles and responsibilities of each State agency, the Statewide Housing Coordinator and the Office of the Governor.

- In summer 2013 the Statewide Referral Network Units (formerly known as IHDA Targeted Units) were added to the caseworker portal on the Illinois housing search website to help speed the referral process, allowing for more visibility of the unit pipeline. Using the "saved search" feature, agency staff can receive email notification as soon as a unit becomes available.
- The State secured funding through a grant from the Chicago Community Trust to work with a consultant to assist with the State's implementation of its Olmstead Coordinated Remedial Plan. That is, the State will provide guidance to Public Housing Authorities regarding the HUD approved streamlined processes by which Public Housing Authorities can grant preferences to Olmstead Class Members, Money Follows the Person (MFP) enrollees, and persons transitioning from State Operated Developmental Centers (SODC)
- On November 14, 2013, IHDA presented sessions on the State's Olmstead Coordinated Remedial Plan and Fair Housing in Illinois at the Illinois National Association of Housing and Redevelopment Officials Conference. CSH presented as well on it's PSH toolkit for supportive housing development.
- IHDA has 12 new PSH developments under review from the recent funding round. The total request for funding from all applications is approximately \$40 million, and would create approximately 336 new PSH units.
- 5 units were acquired as a result of a new landlord relationship making the total of Williams project-based units 77. DHS/DMH anticipates acquiring 25 -50 more project-based units in the next months.
- The Williams-Colbert Focus Forum, conducted November 19<sup>th</sup>, 2013 discussed the progress of Williams and Colbert implementation to date, review the Comprehensive Housing Plan and the outlook for increased PSH development in Illinois to meet the goals of the consent decrees. Attendees will include: the Governor's Office, IHDA, IDHS, HFS, service providers, and supportive housing advocates.
- It was announced that effective December 1, 2013, DHS/DMH increased the Fair Market Rent (FMR) in Chicago to be comparable to the Chicago Housing Authority'there will be a significant increase in the fair market rent (FMR) payment standard in Chicago. This increase in allowable rent will allow transition coordinators to seek better apartments in more desirable communities for Williams Class Members.

### **Alternative Housing Models**

DHS/DMH continues to explore alternative housing models to meet the needs of those Class Members who may need additional support in order to successfully transition to the community.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

### Clustered Model

CSH will convene a work group to include DMH staff, provider organizations and other stakeholders to continue the study of “clustered housing models”, with specific focus on financing and scale.

### Residential

DHS/DMH proposed in its FY14 Work Plan/Strategies for Improving Community Transition, to utilize existing community Supervised Residential beds for 7 to 10% of Williams Class Members who (1) either request this level of support as a transition option or (2) who are assessed through the Resident Review process to require more support or skills development before transitioning to PSH. DHS/DMH requested that its Williams provider agencies conduct an internal assessment of existing occupants in their 24 hour Supervised Residential settings to ascertain if any of these residents are ready for transition to the community. DHS/DMH will afford any such existing residents (who meet income eligibility) a Bridge Subsidy with Transition Assistance Funds so that they may secure a Permanent Supportive Housing unit. As these Supervised Residential beds are made available, Williams Class Members will transition into these beds (which are to be time limited, based on need). When they are ready to exit the Supervised Residential setting for community living they will also be afforded a PSH Bridge Subsidy and Transition Assistance funds. To date, ten (10) Class Members have moved from IMDs to Supervised Residential settings.

### PSH Rule 150

The draft Rule has gone through several edits, by the Office overseeing administrative rule making to assure that there are context reference sources for various sections, including Individual Care Grant, DCFS Aging out Wards, HUD Housing Quality Standards, etc., as well as any needed language clarification. It is hopeful that all information needed has now been satisfied to move this Rule forward for internal governmental review and then to the Joint Committee on Administrative Rules (JCAR) for final approval.

### Residential Rule 140

Rule 140 continues to be discussed with stakeholders. It is close to being filed with JCAR, but there are some issues that remain unresolved. Meetings with stakeholders were recently held with specific concerns identified. As these are addressed the rule will move forward.

### **Williams Class Member Housing Stability Maintenance**

DHS/DMH continues to monitor any housing related issues that could jeopardize 1) a Class Members' health and welfare, 2) a Class Member's ability to maintain his lease or secure housing in the future and/or 3) threaten the State's relationship with a landlord who has the ability to provide Permanent Supportive Housing for other Williams Class Members. DHS/DMH Housing Coordinators routinely conduct teleconferences with Williams Quality Administrators, the DHS/DMH Associate Deputy Director of Transition Coordination, Bridge Subsidy administrators, Regional Supportive Housing Facilitators and other pertinent parties, such as, clinical staff and family members to devise strategies to avoid further escalation of such issues.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

As of November 8, 2013, DHS/DMH Housing Coordinators conducted approximately 132 Housing teleconference staffings to resolve housing related incidents or concerns. Ninety-one Class Members had only one staffing call. Sixteen CMs had 2 staffing calls and 3 CMs had 3 staffing calls.

Of the 110 unduplicated Class Members, 31 (28%) bridge subsidies were terminated. Of those, 27 (87%) Class Members returned to the IMD, 2 (6%) moved in with family, one (3%) Class Member was hospitalized and one (3%) Class Member moved to a supervised residential setting. Seventy-nine (72%) Class Members have been maintained in PSH after requiring a staffing call to mitigate some type of housing related issue or incident.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

### QUALITY

#### **Deputy Director of Licensing and Quality Management**

The Deputy Director of Licensing and Quality Management position is presently vacant. The Unit's interim supervisor is the Division of Mental Health's Special Assistant for Quality Administrative Services.

#### **Quality Improvement Committee**

The Quality Improvement Committee (QIC) meets quarterly and serves as a vehicle for stakeholders review and recommendations on specific system performance and risk management issues. The Quality Improvement Committee was designed to include consumers, family members of consumers, Class Members, Williams community mental health agency staff, NAMI-GC staff and representatives from DHS/DMH, HFS, IHDA, IDPH, and the IMD industry. It should be noted that the September 2013 Quality Improvement Committee meeting was cancelled. The next meeting will be held in December 2013.

#### June 2013

Outreach, Resident Review, Transition and Incident data were presented at the June 2013 QIC meeting. Representatives from NAMI-GC, Trilogy, Inc. and Community Counseling Center of Chicago provided field perspectives regarding Outreach and Transition activities. Discussion topics were: 1) Social Security change of payee, 2) frequent lack of community staff involvement in Class Member hospitalizations, and 3) improved Class Member participation in the Quality Improvement process. The Division has developed strategies that incorporate the recommendations of the committee.

#### **Quality Monitoring**

There are currently ten Williams Quality Monitors, eight of which are assigned to Williams community mental health agencies in the Chicago area, with the remaining two Quality Monitors assigned to community mental health agencies located in Peoria and Decatur. Two of the Quality Monitors are psychologists, four are licensed social workers and four are registered nurses.

Williams Quality Monitors have conducted a total of 818 home visits to Class Members as of November 8, 2013. As stated in previous reports, these monitoring visits are used to ascertain that the essential needs of Williams Class Members are being met. It is the Quality Monitor's task to determine that 1) the Comprehensive Service Plan accurately depicts Class Member needs and goals, 2) the approaches stated on the Comprehensive Service plans are actually being implemented, 3) Class Member homes are safe and well maintained and 4) the Class Member is adapting to the new environment. Concerns that are identified during these visits are communicated directly to the assigned community mental health agency. Effective November 1, 2013, Quality Monitor

## WILLIAMS SEMI-ANNUAL REPORT #5

---

responsibilities expanded to include documentation of follow-up actions taken by agency staff in response to reported concerns.

When appropriate, second, third and fourth level Quality of Life surveys are conducted during these visits. An analysis of the Quality of Life Survey frequencies can be found below.

### **Quality of Life Survey Analysis**

#### Williams Class Members Evaluation of Quality of Life and Treatment

The assessment and evaluation of the quality of care received by Williams Class Members is multi-tiered and multi-faceted. Of utmost importance in this assessment process is the voice of Class Members to provide direct feedback regarding their quality of life and their evaluation of treatment/care received pre and post transition to community living and treatment. Two instruments are utilized to capture this information: the Mental Health Statistics Improvement Program (MHSIP) Adult Evaluation of Care Survey and the Lehman Quality of Life Survey (brief version). Both instruments are nationally known and well regarded. Both have excellent psychometric properties and are widely used in the mental health field.

The MHSIP Evaluation of Care survey is comprised of 36 items covering 6 domains: General Satisfaction with Services, Access to Care, Quality/Appropriateness of Care, Participation in Treatment Planning, Outcome associated with treatment, Social Connectedness and Functioning.

The Lehman Quality of Life Survey is comprised of the following domains: General Life Satisfaction, Daily Activities and Functioning, Family Relations, Social Relations, Work, Legal and Safety Issues, Health and a small set of selected items from the Survey used in the Money Follows the Person (MFP) initiative.

The instruments are administered pre-IMD discharge (within 30 days of discharge) and post IMD discharge at 6 month, 12 month and 18 month intervals. NAMI Outreach workers, with whom the DMH contracts, administer the instruments pre-IMD discharge. DMH Quality Monitors are responsible for administering the instruments during regularly scheduled home visits with Class Members post IMD discharge. The instruments are administered within a 30 day window of the administration due date.

#### Preliminary Analysis

Pre-IMD discharge surveys completed within the specified timeframes have been obtained for 248 Class Members; Surveys completed within the specified timeframes post IMD discharge at 6 months have been collected for 120 Class Members. The results discussed below are based on a very preliminary analysis and comparison of Class Members ratings on these surveys pre and post-IMD transition and is intended only to show trends in the data observed thus far. As more surveys are completed, appropriate analytic/statistical techniques will be applied to the data to determine if the changes that are observed pre and post IMD discharge are statistically significant.

#### Preliminary Results of Evaluation of Care

Class members' ratings on five of the six MHSIP adult survey evaluation of care domains were slightly more positive at 6 months post-IMD discharge than pre-IMD discharge. Thus Class Members reported

## WILLIAMS SEMI-ANNUAL REPORT #5

---

that they were more satisfied with regard to the following aspects of mental health treatment: access to care, the quality of mental health treatment received, outcomes as a result of treatment, and social connectedness after transitioning to their own homes in the community. Pre and post transition ratings on the functioning domain were the same.

### Preliminary Results – Quality of Life Survey

The summary below presents results for a subset of domains and items comprising the survey, comparing responses pre-IMD and post-IMD discharge. The results thus far, are somewhat mixed.

#### *General Life Satisfaction*

In response to the item, “*How do you feel about your life in general?*”, Class Members rated their general satisfaction more positively post IMD discharge: Seventy-three percent (73%) reported that they were mostly satisfied, pleased or delighted pre-IMD discharge, while 83% reported positively for this item post-IMD discharge.

#### *Functioning in Home, Social, School and Work Settings*

In response to the item, “*Overall, how would you rate your functioning in home, social, school and work settings at the present time?*”, 75.4% rated their functioning at good or excellent pre-IMD discharge while 78.7% rate their functioning as good or excellent post discharge.

When asked about specific ways in they spend their time, or about opportunities for enjoyment, 47% of Class Members reported that they were pleased or delighted about the way they spend their time pre-IMD discharge, while 40% reported feeling pleased or delighted post-IMD discharge. Similarly more Class Members reported more positively about having the chance to enjoy pleasant things pre-discharge (53%) vs. post discharge (47%), while the amount of fun they have was rated the similarly pre and post IMD discharge (43% vs. 41%).

#### *Social Relations*

Quality of life survey items related to social relations revolve around how often class members have the opportunity to visit/telephone someone with whom they do not live, as well as the opportunity to spend time with another person doing pre-planned activities or spend time with a significant other. The ratings for each of these items were more positive post-IMD discharge versus pre-IMD discharge. Spending time with a significant other such as a boyfriend, girlfriend or spouse showed the least amount of change pre-IMD vs. post-IMD discharge however.

#### *Safety*

Safety items revolve around how Class Members rate their safety in their neighborhood, where they live and whether they feel they have protection against being robbed or attacked. Class Members rated neighborhood safety more positively pre-IMD discharge, while rating perception of safety where they live and protection against being robbed/attacked more slightly more positively post-IMD discharge.

#### *Health*

Class Members rated their overall state of health higher pre-IMD discharge versus post-IMD discharge

## WILLIAMS SEMI-ANNUAL REPORT #5

---

(72% vs. 66%). When asked about their health in general, their physical condition and emotional well-being—ratings were slightly more positive pre-IMD discharge.

### *Satisfaction with Living Arrangements and Crisis Response*

When asked if they like where they live, Class Members ratings were more positive post-IMD discharge (86% vs. 71%). Class Members were also more likely to reply that they know what to do in a crisis post-IMD discharge versus pre-IMD discharge (94% vs. 86%).

### *Summary*

In summary, clearly there is much to learn from Class Members direct evaluation of their quality of life and evaluation of mental health treatment. As more data is gathered, this information will be used in conjunction with other data to inform planning and continued implementation of the Consent Decree.

### **Incidents**

DHS/DMH contracted agencies providing transition coordination and services to Class Members are responsible for reporting incidents that occur to individuals to whom they are assigned by DHS/DMH. Incidents reported occurred after individuals transitioned to community living. Thus far, 731 incidents have been reported by 12 agencies for 329 individuals.

Type of Incident	Number	Percent of Total
Psychiatric	263	36.5%
Medical	217	29%
Criminal Activity	99	14%
Housing	70	9.5%
Substance Abuse	30	4%
Accident	22	3%
Missing	12	1.6%
Other	7	1%
Deceased	6	.8%
Fire	5	.6%
Total	731	100%

## WILLIAMS SEMI-ANNUAL REPORT #5

---

The type of incident most frequently reported was related to psychiatric issues. All individuals with these types of incidents were seen at a hospital for an assessment for psychiatric-related symptoms, although not all individuals were admitted. Individuals for whom medical incidents were reported were also seen at a hospital for an evaluation, but, again, not all individuals were admitted for these symptoms or problems. Criminal activity accounted for the next largest percentage. This category includes events in which Class Members were the victims of criminal activity and when they participated in criminal activity. Six individuals died after they transitioned to the community. These deaths were the subject of root cause analyses and natural causes were determined to be the cause in all cases.

The number of incidents for Class Members ranged from 1 to 13 as displayed in the table below. Almost half (49.54%) of Class Members who experienced incidents only experienced one incident.

# of Incidents	Unduplicated Class Member Count	Percent of Total
1	163	49.54%
2	68	20.67%
3	34	10.33%
4	35	10.64%
5	10	3.04%
6	6	1.82%
7	8	2.43%
8	2	0.61%
9	1	0.30%
10	1	0.30%
13	1	0.30%
<b>Total</b>	<b>329</b>	<b>100%</b>



## WILLIAMS SEMI-ANNUAL REPORT #5

---

### **Appeals, Complaints, Grievances**

#### Appeals

Williams Class Members have the right to file an appeal to dispute decisions made on their behalf in the Williams implementation process. The Williams appeal process allows three levels of appeal that can be filed by telephone, email or U.S. postal mail.

Williams Class Members filed 23 first level appeals. Fifteen first level appeals were regarding Resident Review findings of which 1 was overturned on behalf of the Class Member. Seven first level appeals were regarding the transition agency assigned of which 0 were overturned and 1 first level appeal was regarding the transition worker assigned and it was not overturned.

Williams Class Members filed 3 second level appeals, all of which were regarding Resident Review findings. Two of the second level appeals were overturned on behalf of the Class Member

#### Complaints

Complaints are to be filed with the Illinois Mental Health Collaborative for Access and Choice. Complaints can be filed by telephone, email or U.S. Postal mail.

There were no complaints filed by Williams Class Members during this reporting period.

#### Grievances

Williams Class Members have the right to grieve a violation of written rights, rules, statutes or State contract terms such as those defined in the Illinois Mental Health and Developmental Disabilities Code, the Mental Health and Disabilities Confidentiality Act, the Health Insurance Portability Act (HIPAA), and the States' administrative rules and State contracts.

There were no grievances filed by Williams Class Members during this reporting period.

### **Court Monitor Supplemental Report**

On September 12, 2013, a Joint Motion, filed by the Defendants and the Plaintiffs, was granted by the Court. This motion called for the Court Monitor to submit a supplemental report, within 60 days, that discusses the processes for evaluating the services and supports provided to Williams Class Members who have moved from Institutions for Mental Disease/Nursing Facilities to community-based settings. This motion was filed in response to questions asked by the Court regarding Class Members who have elected to move into the community. This report, submitted to the Court October 31, 2013, sought to answer four basic questions:

- What are the elements of the current state system for monitoring the quality and adequacy of community services and supports?
- Is this overall system adequate in its design and scope?
- How is the system of monitoring working in practice?
- How can it be improved?

## WILLIAMS SEMI-ANNUAL REPORT #5

---

The Court Monitor found that “the overall quality assurance and quality improvement system for Williams is well-designed and is working in practice”. Nevertheless, the following recommendations were made to “reinforce the quality efforts”:

- Increase the oversight and retraining of the existing Resident Review providers. Provide consistent feedback as to performance and outcomes.
- Ensure that the new Specialized Mental Health Rehabilitation Act Facilities (SMHRF) rules contain critical incident criteria that match those required of community providers. Develop the Information Technology (IT) and analytic capacity to measure critical incidents (and rates) across both settings.
- Reinstatement of the State’s capacity to perform post-payment audits on community providers (including all Williams providers).
- Develop a consistent policy and protocol for performing analyses of sentinel events? Review national standards as a benchmark for this effort.
- Create increase awareness and opportunity for Class Members to participate in community programs prior to leaving the IMD. Drop-in centers are a recommended option.
- Continue and intensify efforts to increase the capacity and scope of community services for Class Members with multiple service and support needs. Identify specific target populations; this should include the current list of 136 Class Members recommended for community placement, but on hold due to providers current inability to serve. Partner with providers on recommended service strategies.

DHS/DMH staff is reviewing the above recommendations and developing strategies for implementation.

# WILLIAMS SEMI-ANNUAL REPORT #5

---

## DECISION SUPPORT/INFORMATION TECHNOLOGY

### Accomplishments and Updates

#### Williams Class Member Data Collection

DHS/DMH contracted agencies working with Williams Class Members, as noted in previous reports, are required to submit registration/enrollment information, transition coordination and transition coordination tracking, comprehensive service planning, permanent supportive housing and permanent supportive housing outcome data to the DHS/DMH/Collaborative community information system. Ongoing technical assistance continues to be provided as needed to these agencies.

#### Data Integrity Checks

The data integrity processes that were instituted previously to assure the validity and reliability of data being submitted for Class Members has resulted in improved data collection and improvement in the timeliness of submission of data for Class Members. Similarly, the database created to monitor the administration of Quality of Life and Evaluation of Care surveys has also led to improvement in the timeliness of the administration of the surveys. DHS/DMH staff are continuing to monitor these processes closely.

#### Resident Review Database

As reported previously HFS has assumed responsibility for the Resident Review database that captures the full Resident Review, including narrative, for Resident Reviews performed for Williams Class Members. The database is now housed on the HFS server, and HFS staff are now responsible for maintenance and modifications to the database. The two DHS/DMH contracted community agencies charged with performing Resident Reviews now have direct access to enter Resident Review data. DHS/DMH staff have also been assisting with entering Resident Reviews that were not entered previously by the University of Illinois of Chicago (UIC) Resident Review contract staff. Progress is being made on this latter task, however due to the amount of data to be entered, DMH plans to contract with a temporary staffing agency to complete this task to assure that the data is available for analytic purposes. The DMH continues to work with HFS to obtain access to Resident Review raw data which is stored in the database. Still to be discussed is the role that this database will continue to play in the capture of Resident Review data.

#### Implementation Support Databases

DMH decision support staff continue to maintain internal databases created to assist Williams' staff with day-to-day monitoring of activities associated with the Consent Decree as well as to assure compliance with the Implementation Plan. Decision Support staff recently assisted the Williams Compliance Officer with the development of a Dashboard to monitor key indicators associated with the Consent Decree and to provide feedback to Williams contracted agency staff and DHS/DMH staff.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

### BUDGET

Final spending for FY13 included \$14.3 million in grant funded services as well as \$2.7 million for Medicaid services to Class Members. In addition, administrative and operational expenditures totaled \$3 million.

In FY14 the Illinois General Assembly appropriated \$35.9 million in General Revenue funds and \$20 million in Special State funds dedicated to expanding home and community-based services, and other transitional assistance costs associated with the consent decree implementation. Expenditures thru October, 2013 include \$0.8 million for administrative and operational expenses as well as \$8.9 million in grant funded services. In addition, \$1.9 million has been expended for Medicaid services to class members. By the end of FY14 it is estimated that spending will total approximately \$35.9 million.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

### OTHER PERTINENT ACTIVITIES

#### Medicaid Spenddown

DHS/DMH continues to work with HFS on the Spend-down Advance Payment. During this reporting period an additional 42 Class Members were approved for spenddown Advance Payment, totaling \$114,000.00 annually. Additional spenddown requests are processed quarterly.

It should be noted that, in January 2014, the Medicaid eligibility thresholds will increase to \$1,322.00 for those under 65 years of age and not in Long Term Care. This will significantly impact the number of Williams Class Members with spenddown amounts.

#### The Workplan

The Workplan developed by DHS/DMH and its State and community partners to execute Williams Implementation Plan Amendments, and improve community transition for Williams Class Members, is a compilation of strategies that cover 8 key objectives:

- Improve data information collection
- Improve treatment engagement to promote medication adherence
- Improve community capacity to address co morbid and complex medical conditions
- Enhance provider network management and analysis
- Create incentives for Class Members to consent to a Resident Review assessment
- Improve efficiencies in ACT service delivery
- Enhance responses to training needs
- Implement utilization coordination to oversee and manage access to Supervised Residential settings for a limited cohort of Class Members.

Strategies around each of these objectives continue to evolve as innovative attempts are made to increase service efficiencies and positive outcomes for Class Members. These efforts and activities are centered in changes to make the systems' performances better for Class Members and are articulated throughout respective sections of this Semi-Annual Report.

The Division has used this Plan as a blue print to also promote Work Force Development, specifically in the area of OT and their contribution to the skills development, recovery processes and community stability of Class Members. Forging partnerships and networking between Williams provider agencies and academic institutions for training of OT and Occupational Therapy Assistant (OTA) professionals will open significantly more doors for Williams Class Members who have not been recommended for transition. Incorporating OTs into the daily staffing mix of IMDs, now SMHRFs may potentially assist in increasing the number of Williams Class Members who have, heretofore, refused to be assessed, by providing them with the skills sets and supports to comfortably consider independent living

In addition to Work Force Development, this Plan readdressed for the community agencies their flexibility in providing services to Williams Class Members, specifically by adjusting staff ratios for Assertive Community Treatment. DHS/DMH validated that agencies must use staff differently and smartly by provide the greatest intensity of services to those with the greatest need. This has been a tremendous benefit for Class Members who have been the most difficult to serve.

## WILLIAMS SEMI-ANNUAL REPORT #5

---

This plan will continue to evolve as the State better understand gaps and weaknesses in the system as well as the greater needs of Class Members to transition from Long Term Care.

### **Olmstead Technical Assistance**

As stated in Semi-Annual Report #4, Illinois was one of five States invited to participate in a 2011 Olmstead Policy Academy. Through this participation, the State was able to receive technical assistance through a SAMHSA contracted vendor, Advocates for Human Potential (AHP). DMH has used this opportunity to provide needed training to Williams provider agencies addressing potential vulnerabilities to the wellness and safety of Class Members. In working with the lead consultant from AHP, three critical areas of training were identified:

- 1) Best practices in serving individuals with co-morbid/complex medical conditions
- 2) Strategies for serving individuals who present high risk criminogenic factors
- 3) Approaches for teaching practioners skill training and building for individuals with skill deficits

In July 2013, Carol VanderZwaag, M.D., clinical professor of psychiatry at the University of North Carolina, School of Medicine, conducted two days training on serving individuals with co-morbid/complex medical conditions. Dr. VanderZwaag brings direct experiences in this process as she also serves as an ACT team psychiatrist. To maximize the synergy from this training, DMH has established for Williams provider agencies a monthly Learning Collaborative. This is a didactic process using case examples to problem solve and talk through treatment options and strategies.

In September 2013, Ann Marie Louison from the Center for Alternative Sentencing and Employment Services (CASES) in New York, New York, conducted two-days of training on strategies for serving individuals who present high risk criminogenic factors. The next step to evolve from this presentation is to bring the criminal justice system (Parole Agents, Specialty Court, State's Attorneys and Public Defenders) to the table in a cross training effort. The rationale is that both the service system and the criminal justice systems must work in tandem to understand how each impact the life of a person who has mental illness and who becomes justice involved. More information on the outcome of this next step will be presented in a subsequent report.

The final training on Skills Development/Skills Building will be held post submission of this report. This training will be conducted by AHP's consultant Patricia Tucker. Ms. Tucker is a nationally recognized leader in the area of supportive housing, supported employment, and community reintegration for person with disabilities, including behavioral health conditions. A focus forum was held with Williams provider agencies to develop the foundation for this training's curriculum, which will occur in early December.

### **Intergovernmental Agreement (IGA) with the University of Illinois Jane Adams School of Social Work**

As discussed in previous reports, the DHS/DMH has made a commitment to evaluate the implementation of the Consent Decree, using the results of it's continuous quality monitoring and improvement program. This work has two spheres of focus: an internal and an external evaluation. The internal evaluation is focusing on utilizing data collected by DHS/DMH Decision Support staff through the course of the implementation such as descriptive, demographic, claims, quality of life and

## WILLIAMS SEMI-ANNUAL REPORT #5

---

evaluation of care information. The external evaluation will focus on predictive studies that will address issues that will inform the continued implementation of the Consent Decree as well as to address topical issues that impact the implementation. DHS/DMH staff have garnered ideas for topics of focus from the Williams plaintiffs, the Williams Court Monitor and DHS/DMH staff. The Division of Mental Health has finalized and executed an intergovernmental agreement with the University of Illinois at Chicago (UIC) Jane Adams School of Social Work to perform the external evaluation. The IGA, which covers a period of four years, will be a collaborative evaluation effort between DHS/DMH and UIC. DHS/DMH leadership staff and a representative from the Office of the Governor have had an initial meeting with the UIC School of Social Work Dean and staff to lay the foundation for this work. A follow-up meeting is expected to occur within the next two weeks.