Illinois Department of Human Services

# Division of Mental Health
# Williams Semi-Annual Report
# #10

## Contents

## EXECUTIVE SUMMARY

The State of Illinois Department of Human Services/Division of Mental Health (IDHS/DMH) and its partners submit this 10th Semi-Annual Report. This report reflects implementation activities from the period of January 1, 2016 - June 30, 2016. In accordance with the language of the Consent Decree, the last six months of fiscal year 2016 should have been the sunset period of operational implementation. It has been acknowledged by Plaintiffs' attorneys, the Court Monitor and State government that the implementation of the *Williams vs. Rauner Consent Decree* will continue for another fiscal year, as there are alleged critical elements of service design, delivery and sustainability that still remain in question. However, an overlying question is whether or not the alleged missing 'elements' constitute a fundamental alteration. This question, pondered at the onset of implementation, continues to substantiate the need for serious discussion as the State attempts to align its transformation agenda with the realities of the Olmstead decision and determine what can be accomplished pragmatically.

The focus on the first six months of 2016 was to solidify the deliverables outlined in the Implementation Plan Amendment. The infusion of Ambassadors into the Outreach working agenda has taken off tremendously. Ambassadors are actively working in the facilities (with oversight by NAMI) to engaged Class Members who have not transitioned and/or who are still reluctant to consider or explore the possibilities of transitioning – by sharing their personal journey toward recovery, with messages of hope and pursuits for optimal self-sufficiency, self-determination and survival. Retaining Ambassadors, on the other hand, has been a challenge. NAMI is continuously attempting to identify interested Class Members to fill this role.

Specialized assessments continue to be provided by the University of Illinois Departments of Psychiatry and Occupational Therapy for Class Members from both the 'Unable to Serve' list as well as those who were not recommended for transition via the Resident Review process. More detailed information on the outcomes of these specialized assessments is discussed in the respective sections of this document. Activities surrounding orchestration of several pilot projects have taken considerable energies during this period. These include the work products contracted with independent consultants to conduct interviews and provide recommendations on a sample of Class Members from the 'Unable to Serve' list, and to convene the structure of a Permanency Board's sample paper review with recommendations from a separate cohort sample of Class Members from the 'Unable to Serve' list; negotiation and execution of a short-term Transition Coordination pilot with two hospitals that have high utilization of referrals to Long Term Care; and implementation of two comparison pilots exploring the most optimal and/or effective model to transition, with possibilities of replication to garner better outcomes (safety and stability) for Class Members pursing community reintegration.

Finally, these last six months have witnessed sufficient movement in Individual Placement and Support with the infusion of Supported Employment awareness, language and interface into the fabric of the daily operations of the Drop-In Centers. Concurrently, the State has dedicated considerable attention and resources at its executive level to seriously understand and dissect the full ramifications and

systems' impact needs for managing the "Front Door" - not just from the perspective of the 24 IMDs but to achieve the full transformation and rebalancing of Long Term Care utilization. This work will definitely continue throughout this reporting period and into the future.

## OUTREACH AND INFORMATION DISSEMINATION

**Outreach Workers**

NAMI Chicago Outreach Workers continue to provide Class Members with resources that can assist them as they prepare to move out of the Institutes for Mental Disease (IMD). Outreach Workers provide Class Members with information on their rights under the Williams Consent Decree, help answer questions and concerns about the processes, show *Moving On* videos to all Class Members interested and provide information on the supports and services available to Class Members under *Moving On.* NAMI Chicago continues to work in tandem with *Moving On* Outreach Ambassadors, Class Members who have successfully transitioned from the IMDs to the community.

Outreach Workers continue to conduct baseline Quality of Life Surveys (QLS) with Class Members who are nearing transition from the IMDs. They also report to DMH on incidents of concern that are revealed while conducting the QLS. During this reporting period 80 baseline surveys were completed.

In this reporting period 368 Class Members signed Introductory Letters and engaged with the Outreach Workers to learn about their rights under the Williams Consent Decree and *Moving On*. Outreach Workers conducted 358 private interviews with Class Members. Outreach Workers were approached 3,027 times with questions or concerns about the process. Approximately 115 new Class Members refused to engage with Outreach Workers when approached. Lastly, the Outreach Workers made contact with 39 guardians via telephone or in person. Reasons for refusal and data on IMD residents seen are outlined in the following charts.

**Refusal Report Totals as of May 4, 2016**

Total Number of unduplicated Class Members – 2569 (some gave more than one answer)

| Reason | Number of Responses | Percent of Respondents |
|---|---|---|
| Refusing Transition | 1639 | 63.8% |
| Guardian is Refusing | 87 | 3.4% |
| Go Away | 93 | 3.6% |
| I am Happy Here | 359 | 14.0% |
| Family Objects to Moving | 34 | 1.3% |
| I Am Afraid Because Others Have Failed | 10 | 0.4% |
| Other Things in My Life | 61 | 2.4% |
| Maybe Later | 166 | 6.5% |
| I am Thinking About It | 41 | 1.6% |
| I want to but have not had an Assessment | 833 | 32.4% |
| Total Number of Responses | 3323 | |

**Number of Residents seen as May 4, 2016 by IMD:**

| Facility | Number of Beds | Number Seen |
|---|---|---|
| Abbott House | 104 | 196 |
| Albany Care Inc | 385 | 622 |
| Bayside Terrace | 148 | 320 |
| Belmont Crossing of Lakeview | 54 | 115 |
| Bourbonnais Terrace | 197 | 356 |
| Bryn Mawr Care | 170 | 396 |
| Central Plaza | 260 | 431 |
| Clayton Residential Home | 228 | 492 |
| Columbus Manor Res Care | 99 | 302 |
| Grasmere Residential Home | 206 | 491 |
| Greenwood Care Center | 140 | 328 |
| Kankakee Terrace | 146 | 412 |
| Lake Park Center | 205 | 322 |
| Lydia Healthcare Center | 412 | 899 |
| Margaret Manor Central | 125 | 280 |
| Margaret Manor North | 94 | 290 |
| Monroe Pavilion Health Center | 136 | 316 |
| Pershing Estates | 134 | 325 |
| Rainbow Beach Nursing Center | 211 | 537 |
| Sacred Heart Home | 172 | 405 |
| Sharon Health Care Woods | 152 | 281 |
| Skokie Meadows Nursing Center | 111 | 155 |
| Thornton Heights Terrace Ltd | 220 | 416 |
| Wilson Care Inc. | 186 | 522 |
| Total | 4295 | 9209 |

**Outreach Ambassadors**

The Outreach Ambassadors are Class Members who have successfully transitioned from the IMDs and have agreed to perform in the role of a Williams Ambassador of Good Will. They are an extension of NAMI Chicago Outreach Workers. The Ambassadors speak at quarterly community meetings held in the IMDs and at various events sponsored by the Outreach Workers and the community mental health agencies. The Ambassadors speak from a voice of commonality about their experiences while living in the IMDs. Simultaneously, they share their individual journey on the road to community transition, wellness and recovery. They explain to fellow Class Members, firsthand how the process worked for them. They are able to answer questions about the process and speak about the services and supports available in the community.

Each Ambassador has gone through extensive training on their role and responsibility. They have been trained on etiquette protocol on how they are to conduct themselves in the facility. The Ambassadors wear purple *Moving On* shirts at all times while serving in this capacity. "*Moving On"* is printed on the front of the shirt and "*Ambassador"* on the back so that they are easily identified.

The Ambassador program has operated smoothly, however there have been challenges. Some of the IMDs have required that when visiting, the Ambassadors are to remain in a conference room or they are not permitted to proceed beyond the lobby. These situations have restricted the Ambassadors' access to the Class Members they would like to meet with. Having access to the cafeteria, activity rooms, group rooms, smoking areas, etc. would allow Class Members to know when the Ambassadors are in the facility.

Another challenge is that some Ambassadors have not been able to fulfill their time commitments. Ambassadors were asked to work 8 hours per month in a given IMD (some cover 2 IMDs). NAMI Chicago communicates with DMH and others in their efforts to recruit new Ambassadors that have the necessary time to meet with Class Members.

**Ongoing Efforts**

The Outreach Workers provide Class Members with resources that they can take advantage of prior to moving out of the IMDs. Some Class Members have not experienced life outside of these settings for some time. Outreach Workers also take drop-in center brochures, which include their programs, locations and telephone numbers, to each IMD visit. Class Members are encouraged to visit the drop-in centers where they can communicate with others who have successfully moved into the community.

Outreach Workers and Class Members participate in a monthly 'Recovery and Empowerment Statewide Call'. These educational forums enable the Class Members to feel empowered by placing an emphasis on sharing successful tools and strategies for wellness. The calls are also opportunities for Class Members to receive information directly from DMH and to ask questions. Here they are able to express their thoughts and concerns, and make comments and suggestions directly to DMH.

## RESIDENT REVIEW

In FY16, as a tool to monitor the completion of Class Members' Resident Review assessments and to assure that all admissions within this reporting time frame were completed, DMH incorporated use of the January 2016 Healthcare and Family Services (HFS) IMD census data and plans to overlay it with the June 2016 IMD census data. Using this protocol, Lutheran Social Services of Illinois (LSSI) and Metropolitan Family Services (MFS) approach new admissions, Class Members who are eligible for annual re-assessments, those referred by NAMI or the Engagement Team, those referred by Managed Care Organizations, and Class Members and/or guardians who requested assessments.

As part of our ongoing goal to improve the Resident Review process, DMH moved from the use of the University of Illinois (U of I) Online System to a "Fillable Word Document" version of the Resident Review. The launch of the fillable document in April, 2016 was preceded by a DMH Training Webinar with both reviewing agencies and their full team of reviewers. Feedback from both review teams indicates that use of this fillable document has led to a more efficient use of staff time by 1) eliminating the need for multiple attempts to enter data into the system which was previously being lost due to online glitches and by 2) streamlining the data entry process with use of pre-programmed drop box selections that previously required manual entry.

The weekly teleconferences and random sampling of Resident Reviews completed by LSSI and MFS allow the agencies to stay abreast of issues identified with the review process. They provide an opportunity to share observations and give continuous feedback to the Resident Review Teams to help ensure that Resident Review Assessments are as detailed and clinically informative as possible.

DMH continues to capture, review and analyze outcome areas through Quarterly Performance Measure data submitted by LSSI and MFS. The following table reflects total numbers for the current reporting quarter.

**Performance Measures Outcome**[1]

| | # 1 Approached | # 2 Approached Refused | # 3 Signed Participation Agreement | # 4 Full Assessment Completed | #5 Aborted Asst'mt | #6 Recom'd for Transition | #7 Not Recom'd | #8 Staff productivity Approved | #9 Complex medical need | #10 criminal histories | #11 Staff Productivity Denied |
|---|---|---|---|---|---|---|---|---|---|---|---|
| LSSI | 1153 | 750 | 954 | 396 | 7 | 326 | 70 | 326 | 158 | 103 | 70 |
| | | | | | | | | | | | |
| MFS | 373 | 188 | 335 | 182 | 3 | 112 | 70 | 112 | 101 | 61 | 70 |
| | | | | | | | | | | | |
| TOTAL | 1526 | 938 | 1289 | 578 | 10 | 438 | 140 | 438 | 259 | 164 | 140 |

[1] Time frame from January 1, 2016– April 30, 2016

Data analysis shows that there are disparities within the percentages of positive recommendations that exist between LSSI and MFS, with LSSI having approval rates almost three times greater than MFS. This may be indicative of the fact that LSSI approached four times as many Class Members for review as compared to MFS and similarly had four times as many refusals. Data also shows that despite this disparity both agencies' rates of denial were exactly the same in the current recording period. This seems to suggest that even with a higher number of approaches by LSSI the rates of denials remain relatively low. Resident review team size, number of reviews completed per reviewer, IMD size, and diagnostic indicators are felt to be potential contributing factors in the noted disparities.

**Specialized Assessments**

With the two contracted specialized assessments, NAMI Outreach Workers were charged with obtaining consent from Class Members to be assessed by the respective UIC departments. For those Class Members who refused, DMH requested that Outreach Workers reach out to these Class Members a second time. It was our interest to ensure that Class Members were clearly informed about the nature of these assessments and to give them an opportunity to change their mind, accordingly. DMH only required NAMI Outreach to make two attempts to obtain consent.

The University of Illinois, Department of Psychiatry/Office of Dr. Neil Pliskin continues to provide contracted neuropsychological assessments for Class Members referred if there is a suspicion of severe cognitive impairments, including dementia or the onset of Alzheimer's disease. This report reflects assessment activities since January 1, 2016. The total number of *referrals* for a neuropsychological assessment (since inception) is fifty-nine (59) which includes twenty-four (24) referrals for this reporting period. The *actual* number of neuropsychological assessments completed for this reporting period is thirteen (13).

Of the 24 new referrals, one Class Member refused to give consent and ten (10) Class Members were recommended to remain in a nursing level of care setting – that transition to the community would be counter-productive based on their need for 24 hour skilled nursing support to maintain wellness and safety. Of the thirteen completed assessments, three (3) Class Members were recommended for possible transition to a group home setting/living environment where there is staffed support. No Class Member was recommended for transition to independent living in Permanent Supportive Housing.

<u>Neuropsychological Assessments:</u>

| | |
|---|---|
| Number of Class Members (CM) identified for assessment (new) | 24 |
| Number of CM recommended to remain in a nursing level of care setting | 10 |
| Number of CM recommended for group home setting | 3 |
| Number of CM who refused to give consent | 1 |
| Number of CM discharged from IMD before NAMI attempt | 8 |
| Number pending (to date) | 2 |

The University of Illinois, Department of Occupational Therapy & Disability and Human Development (OT assessments) continues to complete assessments for individuals with suspected skills deficits as

barriers to community transition. The total number of *referrals* for OT assessments during this reporting period is 20 Class Members. Of the 20 Class Members referred, thirteen (13) refused to give consent. One Class Member who initially consented subsequently retracted consent. Of the six Class Members who consented, one was referred for a neuropsychological assessment. The remaining 2 Class Members had full OT assessments during this time period. Of this number one (1) was recommended for transition to the community to PSH. The other Class Member was recommended for a Supervised Residential setting. The overall recommendation for community transitions for the cohort of Class Members referred for an OT assessment included the provision of required services and safety net resources in order to assure wellness and safety. In addition to ACT services, medication monitoring and administration, and skills training, the accompanying resources were identified as:

- Environmental safety assessments
- Pre-programmed phones
- Emergency alert systems (life alert)
- Detailed Support Plan
- Peer Monitoring

Since inception of specialized assessments, a cumulative total of 88 Class Members have been referred for an OT assessment. During this reporting period 29 of these Class Members were recommended for community transition and have been or will be assigned to a respective community agency based on geographical preference. As of this writing, assigned cases are going through the intake process, but none have transitioned to the community.

<u>Occupational Therapeutic Assessments:</u>

| | |
|---|---|
| Number of Class Members (CM) identified for assessment (new) | 20 |
| Number of CM who refused to give consent | 13 |
| Number of CM who consented, then refused assessment | 1 |
| Number of CM discharged from IMD before NAMI attempt | 0 |
| Number of CM who consented to be assessed by OT specialist | 6 |
| Number of CM who consented but moved before assessment | 0 |
| Number of CM who were discharged | 1 |
| Number referred for neuropsych assessment | 1 |
| Number of assessments completed | 2 |
| Number pending (to date) | 1 |
| Number of CM on medical hold | 0 |
| Number of CM hospitalized | 1 |

**Clinical Review**

During this reporting period, 138 Resident Reviews were received for Clinical Review and referred to one of the respective Williams provider agencies for a second level, paper review. Of the 138 Clinical Reviews conducted, 85 were supported, i.e., in concurrence with the recommendations of the Resident Reviewers. Ten (10) Clinical Reviews were overturned by the clinical review team, thereby recommending community transition for those Class Members. Forty-three (43) reviews are pending completion by the CRT agencies.

Three appeals of the findings of the Resident Review were submitted to DMH during this reporting period. The three appeal recommendations were supported by DMH and found to be in agreement with the findings of the Resident Reviewer.

The Clinical Review Coordinator convened weekly teleconference calls with all of the Williams agencies. The participants discussed policies and procedures in an effort to improve the overall quality of the clinical review process. The calls also served as a platform to discuss complicated issues facing a clinical review team which require feedback.

## TRANSITION COORDINATION/COMMUNITY SERVICES

The ten (10) community mental health centers contracted to provide the full array of Williams services and the nine (9) agencies contracted to provide 'transition only' and existing Rule 132 services continue to pursue efforts to expeditiously and effectively transition Class Members to the community. As of April 30, 2016 a *cumulative* total of 3446 Class Members were *referred* to the Williams agencies to engage and initiate transition activities, based on choice of geographic preference or provider agency. There were 491 Class Members who declined to transition. As of April 30, 2016, 1587 Class Members have transitioned, have signed leases to transition or signed leases and subsequently decided not to proceed with transition.

In May 2016, New Foundation Center and Thresholds merged with the intent to preserve and expand critical community mental health services. Their goal is to serve more clients in suburban Cook and Lake County. By integrating with Thresholds, New Foundations Center's north suburban and Lake County programs will readily assist Williams Class Members currently residing in IMDs in farther reaches of the metro area who wish to reside in Threshold's region. Additionally, the merger adds significant depth and breadth to its quality assurance tracking, reporting and service quality monitoring. By combining their target transitions the two agencies expect to conduct 160 Williams transitions in FY2016.

**Unable to Serve – Pilot Projects**

DMH has contracted for two distinct pilot projects focused on the 'Unable to Serve' population. These are comparison projects conducted by Thresholds, Inc. and Trilogy. Thresholds' pilot is to identify 10 Class Members and immediately move them into an apartment within 45 days of contract execution. There is an overlay of ACT plus, with the addition of a nurse and peer support staff. Trilogy's pilot is to work with 5 Class Members who are residents of Albany Care, while still in residency at Albany Care. Negotiations and planning were done between Albany administration and Trilogy to work on the interface and operations. Trilogy's charge is to provide the necessary training, skills development or supports needed to prepare the identified Class Members for transition with seamless community integration. The objective is to assure that the basic skills needed to successfully live in the community are mastered by the Class Member while in residency. By the end of June, 2016 these 5 Class Members are to be transitioned to the community.

As of this writing, Trilogy is aggressively working with five Class Member residents of Albany Care. Most of these Class Members are being seen on a daily basis by Trilogy's Transitional Coordinator, OT staff, peer staff, nursing and medical staff. There are two Class Members who are planned to transition by the end of June. Trilogy has identified varying degrees of improvement in all five Class Members. However, three Class Members continue to present serious concerns to transition appropriateness at this time.

Thresholds, Inc. has identified 7 Class Members for transition to the community and is working with each of them on their individual pathways for transition. Two Class Members are ready to move to the

community and Thresholds is waiting on the arrival of their debit cards. The other Class Members are in the apartment search phase.

To date, no Class Member has transitioned under either pilot.

**Unable to Serve – Consultant Work Product**

As referenced in the Executive Summary, during the past months the State has exerted considerable effort to better understand issues and/or barriers identified by Williams community provider agencies based on their challenges in transitioning the population of Class Members identified as 'Unable to Serve', and to ascertain whether or not these challenges can be rectified with difference service models or modified approaches. At the request of Plaintiffs, the State agreed to pursue several ideas that could possibly give guidance to better understand alternative methods to effectively serve the more difficult presentations that some Class Members face as the agencies attempt to manage successful transition to the community.

Suggestions were offered to DMH from several sources on possible expert consultants in the field, to explore their willingness to work on a short-term contract (under $10,000), focused on the 'Unable to Serve' population. This contract had two distinct parts under its deliverables: (1) to interview a sample cohort of Class Members from the 'Unable to Serve' list and to interview the assigned community agencies to ascertain the agency's rationale why the respective Class Member is defined as 'Unable to Serve' and then make appropriate recommendations on the most optimal level of care, services and supports to meet the Class Members' needs; and (2) to convene a Permanency Board (comprised of a multidisciplinary team) who were to complete a paper review of information on a sample of the "Unable to Serve' population and make recommendations on transition supports and resources, as appropriate.

The consultant team who was recommended, interviewed and subsequently agreed to do this work was Stacy DiStefano and William Maroon. Both came highly recommended by the Bazelon Center for their work in numerous states with similar populations. Over the course of four months, from contract execution in mid-November 2015 through the end of March 2016, the consultants interviewed a total of 35 Class Members representing a cross segment of 16 IMDs both in metro Chicago (including the two collar Counties) and the two central Illinois facilities. The consultants also convened the Permanency Board process, which reviewed information on a separate sample of 31 Class Members. The consultant team submitted a final report to DMH on March 28, 2016.

After the final report had been submitted it was learned that the consultants had not interviewed community agencies for their rationale or understanding of why these Class Members were categorized as 'Unable to Serve' or the presenting challenges identified as barriers to transition. As this was a critical omission in information gathering for completion of the final product (based on the contracted deliverables), DHS/DMH and the Court Monitor requested that the consultants complete interviews with community agency staff on Class Members selected from the sample (ten names were provided by DMH). An addendum to the final report was completed and submitted on May 20, 2016.

**Unable to Serve – Supervised Residential Settings**

DMH converted four of its former Transition Living Centers (Comparable Community Services) into Supervised Residential settings for Class Members designated as 'Unable to Serve'. These settings are located in Decatur (7 beds), Kankakee (10 beds), Chicago (south side – 8 beds) and Chicago (north side – 10 beds). As of this writing, 29 of these beds are occupied. Decatur is projected to have its remaining 8 beds filled by the end of June.

Concurrently, Habilitative Systems, Inc. (HSI) has a former DD/CILA (HUD financed) building that will be converted into an eight beds Williams Supervised Residential setting for Class Members designated as 'Unable to Serve'. This building is under renovation by HUD due to extensive repairs required from damages incurred when the property was unoccupied. DMH has negotiated with HSI on the parameters of this contract and HSI's role in providing residential services only, with the provision of nursing and peer support. The time frame for occupancy of this setting is dependent on the completion of renovations and repairs and the hiring and training of support staff.

**University of Illinois Study – Return to IMDs**

The UIC College of Social Work was contracted to complete two distinct studies during FY2016. This discussion explores the outcome of the study to better understand why Class Members return to the IMD post-community discharge. The study had two levels of interviews. The first level interviews were with Class Members to ascertain their experiences living independently in the community and their perception on the reason(s) why they returned to the IMD. The second level interviews were with direct care staff assigned to provide services and supports to the respective Class Members, and to elicit the perspective of the community worker on the issues/challenges that were a catalyst to community stabilization. A total of 112 Class Members who returned to the IMD (or Long Term Care) were identified and 44 responded to recruitment efforts and agreed to participate in interviews about their experiences with the *Moving On* program.

Excerpt from the study suggest that . . . "among the factors discussed by both the Class Members and the CMHA staff, each individual's narrative described what appears to be a cascade of events, each one compounding on the others, that led to the decision to return to the IMD. For some Class Members the cascade was triggered prior to leaving the IMD; for others it did not occur until more than a year after transition. Common responses among the cascade of events included loneliness/isolation, barriers related to physical disabilities/medical conditions, substance abuse relapse, and problem with maintaining medication regimen. More than 75% of respondents experienced one or more critical incidents during their community tenure (including, but not limited to, psychiatric or medical emergency; hospitalization; police-related incidents; or evictions)."

"A smaller group of Class Member respondent (n=15, 34%) described a negative experience of transition preparation. CMHA staff frequently discussed their opinion that inappropriate Class Members were approved to transition . . . and that symptoms were not well managed from the start and then quickly worsened as the Member transitioned."

"18 Class Members indicated that it was not their decision to return to the IMD. CMHA staff reported that Class Members who did not want to return to the IMD were subsequently returned due to concerns regarding safety, frequent psychiatric hospitalizations, their inability (skill deficits) to manage psychiatric and medical issues in the community . . . ".

"From Class Members' perspective they believe more support from the CMHA would have enabled them to succeed. Some Class Members suggested that the CMHA did not take their problems seriously. From the CMHA worker's perspective, the Class Members who transitioned and remained in the community appeared to have more strengths, coping skills and resilience from the start compared to those who returned to the IMD."

Subsequent to the submission of this study, DMH convened several groups to discuss the report and to provide recommendations. The first group consisted of all Williams Quality Monitors. The second group consisted of Williams agencies' staff (Quality Administrators, Executive Directors, ACT/CST supervisors and team leaders and direct care staff and CRSS). The third group consisted of DMH Williams staff, Region Executive Directors and Certified Recovery Support Specialist (CRSS). The outcome of these processes resulted in the following themes, observations and recommendations:

1. Need for intensive staff training/retraining*.
2. Exploration of incorporating specific "teams" of peers to provide more dedicated time during the initial months of transition – this may be effective in minimizing the initial trauma experienced by some by living alone.
3. Agencies feeling 'pressured' to move people who are not ready to move, then not having enough time to adequately support their needs.
4. Many of the direct care staff are new graduates with limited experience in community mental health and may be overwhelmed by associated service demands of individuals with more chronic/behavioral issues.
5. Limited ability and time to develop relationships and trust on the front end, which compounds the effectiveness of sustaining a therapeutic healthy relationship, post transition.
6. Not immediately identifying 'red flags' that could be indicators to more symptomatic behaviors.
7. High community staff turnover rates, resulting in basic orientation without substantial field experience.
8. Lack of investment demonstrated by some IMDs in concerted efforts to work with Class Members on transition readiness and basic skills development which could definitely promote better and successful independence.
9. Compounding barriers in community stability due to issues and influences of the co-occurring (alcohol and drug abuse) subculture.
10. Staff issues with burn-out; feelings of being overwhelmed; letting go of control.

*Recommended Training Topics (curriculum development)

A. Managing complex medical conditions and co-occurring serious mental illness
B. Relationship building
C. Motivational Interviewing
D. Cultural Awareness; cultural sensitivity; multi-cultural interactions/approaches
E. How to effectively use and understand the application of evidenced based practices
F. Trauma-informed behavioral health care
G. Identifying and managing co-occurring personality disorders
H. Establishing and recognizing boundaries to foster respect; avoiding a tug-of-war
I. Developing therapeutic relationships and working through resistance
J. Developing strategies to better identify risk factors and risk mitigation planning

As a result, the Division of Mental Health proposes to execute its sub-contractual agreement with the University of Illinois through the partnership with the Department on Aging. DMH's contract with UIC for the Center was approved and signed in February 2016. Specifically, DMH wants to maximize opportunities to obtain optimal adult learning which includes an array of teaching modalities:

- Training in classroom settings
- Distance-learning, using webinars, Ted talks and you-tube videos
- E-learning, on-line courses and/or computer based modules that afford learning at individual paces
- Train-the-trainer models

In addition, it is anticipated that UIC will leverage existing curricula and training partnerships, with incentives of continuing education credits for staff participants.

DMH proposed to use this contract to develop the curricula and train Williams' community provider staff on those topic areas needed to assure excellence in service delivery, as identified in the discussions.

**University of Illinois Study – Declines**
This study is being finalized by the School of Social Work and will be ready for submission in June 2016.

**Provider Spreadsheet Clean Up**
In an effort to assure accuracy on the UTS lists, the Williams provider agencies were directed to review and update their respective UTS list. The agencies were instructed to determine that there were no Class Members identified as Unable to Serve who should not have this designation, and to reclassify or place them in the pipeline for transition, accordingly. At the same time, meetings were held with the agencies for them to better explain why the agency is not able to serve these Class Members with the focus on the agency's capabilities rather than on the Class Member's needs.

As of April 30, 2016 there were 287 Class Members who fell within the UTS category. The chart below aggregates the categories of Class Members who have been identified as 'Unable to Serve':

| Reasons for Unable To Serve | Count |
|---|---|
| Financial | 60 |
| Medical | 29 |
| Medical/Diabetes | 7 |
| Medication Management | 5 |
| Mental Health | 155 |
| Housing | 31 |
| Total | **287** |

**Community Tenure**

A measure of the success of a Class Member's transition from the IMD to the community is the length of time that the Class Member resides in their home post discharge. The table below displays a frequency distribution showing the length of time or community tenure of Class Members residing in permanent supported housing post IMD discharge. (Note that the data excludes individuals returning to IMDs who did not return to the community, and those Class Members who are deceased.)

Class Members continually transition from IMDs. While this table does not provide a conclusive picture of the extent to which Class Members will remain in the community following transition, it provides descriptive point in time information regarding the number of days that Class Members are living in the community post IMD discharge. The data displayed in the following table shows that over 51% of Class Members have lived in their own homes for more than 691 days, after transitioning from IMDs. Another 21% have resided in the community between 361 and 690 days.

**Class Members[1]**
**Number of Days Residing in the Community as of April 30, 2016**

| Days of Community Tenure | N | Percentage |
|---|---|---|
| 0 - 30 | 23 | 2.02 |
| 31-60 | 29 | 2.55 |
| 61-90 | 30 | 2.64 |
| 91-120 | 32 | 2.81 |
| 121-150 | 22 | 1.93 |
| 151-180 | 37 | 3.25 |
| 181-210 | 27 | 2.37 |
| 211-240 | 16 | 1.41 |
| 241-270 | 17 | 1.50 |
| 271-300 | 21 | 1.85 |
| 301-330 | 24 | 2.11 |
| 331-360 | 38 | 3.34 |
| 361-390 | 26 | 2.29 |
| 391-420 | 33 | 2.90 |
| 421-450 | 19 | 1.67 |
| 451-480 | 19 | 1.67 |
| 481-510 | 19 | 1.67 |
| 511-540 | 26 | 2.29 |
| 541-570 | 19 | 1.67 |
| 571-600 | 23 | 2.02 |
| 601-630 | 16 | 1.41 |
| 631-660 | 16 | 1.41 |
| 661-690 | 20 | 1.76 |
| >690 | 585 | 51.45 |
| Total | 1137 | |

[1] Excludes Class Members returning to IMDs who did not return to community based housing and Class Members who are deceased.

**Characteristics of Class Members**
**Registered as of April 30, 2016**

This analysis provides an update to previous analyses performed looking at the characteristics of Williams Class Members enrolled in the DMH Community Information System. As stated in previous reports, DMH contracted providers serving in the role of transition coordinators are contractually required to register/enroll Class Members in the DMH Community Information System within 7 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 April 30, 2016 three thousand seventy-two (3072) Class Members were enrolled in the DMH Community Information System as a result of being assigned to an agency for transition coordination. The results of the analyses summarized below indicate that there were very few changes in the profile of enrolled Class Members as of April 2016 in comparison to October 2015. The clinical and descriptive characteristics appear to be fairly stable for this population.

| Age Group | Count | % |
|---|---|---|
| 18 - 20 | 2 | 0.1% |
| 21 - 24 | 90 | 2.9% |
| 25 - 44 | 1073 | 34.2% |
| 45 - 64 | 1713 | 54.6% |
| 65 and over | 194 | 6.2% |

| Gender | Count | % |
|---|---|---|
| Female | 1083 | 34.5% |
| Male | 1989 | 63.4% |

| Ethnicity | Count | % |
|---|---|---|
| American Indian/Alaskan Native | 9 | 0.3% |
| Asian | 48 | 1.5% |
| Black/African American | 1490 | 47.5% |
| More Than One Race Reported | 10 | 0.3% |
| Native Hawaiian or Other Pacific Islander | 5 | 0.2% |
| Race/Ethnicity Not Available | 82 | 2.6% |
| White | 1428 | 45.6% |

| Hispanic Origin | Count | % |
|---|---|---|
| Central American | 11 | 0.4% |
| Cuban | 3 | 0.1% |
| Mexican/Mexican American | 82 | 2.6% |
| Not of Hispanic Origin | 2718 | 86.7% |
| Other Hispanic | 61 | 1.9% |
| Puerto Rican | 44 | 1.4% |
| Unknown, not Classified | 153 | 4.9% |

| Marital Status | Count | % |
|---|---|---|
| Never Married | 2271 | 72.4% |
| Married | 78 | 2.5% |
| Widowed | 67 | 2.1% |
| Divorced | 366 | 11.7% |
| Separated | 82 | 2.6% |
| Unknown, declines to specify | 1 | 0.0% |
| Civil Union | 207 | 6.6% |

***Highest Level of Education Completed.*** A little over twenty-eight percent (27.4%) of Class Members have earned a high school diploma and an additional 6.6% were reported as having earning a General Equivalency Degree (GED). Twenty-four percent (23.5%) of Class Members completed some high school (e.g., one, two or three years) with no diploma earned. Nineteen percent (17.2%) have completed some college, and 4.9% hold a Bachelor's Degree. A small percentage (1.1%) of Class Members has completed post-secondary training and 1.1% has completed post graduate training. Education level was not reported for approximately 15.6% of registered Class Members.

***Residential Living Arrangement.*** A large number of individuals (27.2%) were reported as residing in private unsupervised settings (permanent supportive housing), another 1.1% were reported as living in other unsupervised settings; 13.5% were reported as living in supervised settings; and 45.2% were reported as residing in institutional settings. Data was not reported for 162 individuals (5.2%), and a small percentage of individuals were reported as residing in settings other than the ones reported above.

***Military Status***. There were 4.3% of Class Members reported as being a veteran having formerly served in the military. There were another 7.8% of Class Members that were listed as unknown.

***Primary Language.*** The primary language spoken by 96.2% of Class Members English, while .5% were reported as Spanish and another .6% reported as unknown.

***Justice System Involvement.*** The majority (84.1%) of Class Members were reported as not having any involvement with the justice system (courts, jails, etc.). However, 1.2% had been arrested, .7% had been charged with a crime, .7% had been incarcerated or detained. An additional .9% of Class Members had a status at some point of being on parole or probation. 9.2% was reported as unknown; 1.0% were reported as having a status of "Other" 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. Over forty-nine percent (49.5%) have a history of continuous treatment for mental health related problems, 69.6% have a history of continuous residential treatment. 61.9% have a history of living in multiple residential settings. 78.3% of Class Members have a history of receiving outpatient mental health services for their illnesses. 82.3% of Class Members reported having received previous mental health treatment.

***Level of Care Utilization Scale Scores Based on Assessor Recommendation***. More than twenty-eight percent (28%) of the Class Members included in this analysis were recommended by the assessor to receive high intensity community based services (level 3) based on the results of the LOCUS assessment. An additional forty-five (45%) percent were recommended for Medically Monitored Services: 36.2% were recommended for Non-Residential while 8.8% were recommended for Residential. 2.8% were recommended for a Medically Managed level of Residential Services. 4.7% percent were recommended for Low Intensity Community-Based Services, while .9% was recommended for Recovery Maintenance and Health Management. LOCUS scores were missing for approximately 17.1% of the cohort.

***Diagnosis.*** There was a substantial change implemented effective October 1, 2015. Diagnosis reporting was required to change from ICD-9 to ICD-10 values as of that date. The results of ICD-9 values were reported for the period of July 1, 2015 to September 30, 2015. From October 1, 2015 through the date of this report (April 30, 2015), all new diagnosis values were required to be ICD-10. The most frequent counts are broken out in the tables below.

- *ICD-9 Frequencies:*
    - 71.2% of Class Members had a primary diagnosis of schizophrenia and other psychotic disorders
    - 20.1% were diagnosed with bipolar and mood disorders.
        - The remainder of diagnosis values fell under the following categories: Adjustment Disorders, Anxiety and Stress Disorders and Other Mental Disorders.
- *ICD-10 Frequencies:*
    - 70.5% of Class Members had a primary diagnosis of schizophrenia and other psychotic disorders
    - 27.6% were diagnosed with bipolar and mood disorders.

- The remainder of diagnosis values fell under the following categories: Anxiety and Stress Disorders, Disorders usually diagnosed in infancy, childhood or adolescence and Other Mental Disorders.

***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 10 to 99 with an average of 43 which represents…"Serious symptoms or any serious impairment in social, occupational, or school functioning".

***Other Areas of Functional Impairment.*** 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. Eighty-two percent (75.7%) of Class Members were identified as having a serious functional impairment in the employment area, 72% in the financial area, and 74.4% in Social/Group functioning and 69.6% in Community Living area. Sixty-three percent (62.5%) had a serious functional impairment in the supportive/social area, 56.1% in activities of daily living and 41.6% had a serious impairment in relation to inappropriate or dangerous behavior. It was also reported that 75.7% of the Class Members had a previous functional impairment.

***Comparison to Previous Analysis for October 2015 Cohort***

The prior analysis of descriptive demographic and clinical data for Class Members registered in the DMH Community Information System was performed in October 2015. A comparison of the data for this period to the previous period reveals that there is little variability in the descriptive information reported for the two cohorts. The majority of values show little change while some have had a variance in the five to eight percent range.

**Individual Placement and Support (IPS)**

The evidence-based practice of IPS (supported employment) has been on the forefront as a service/resource to assure full and productive recovery for individuals diagnosed with serious mental illness. There have been 308 Class Members enrolled in IPS since July 1, 2012. Currently there are 117 Williams enrollees in IPS. Eighty-six (86) Class Members or 28% of the Class Members who received IPS Supportive Employment have worked. Of those who are still on the active IPS caseload, 36 are currently working.

The table below reflects the number of months of job tenure for the 42 Class Members who worked in mainstream competitive work experiences in Fiscal Year 2016 (2 Class Members held 2 jobs).

| | Job Tenure | | | | | |
|---|---|---|---|---|---|---|
| | 1 month | 2 months | 3 months | 4 months | 5 months | Over 6 months |
| # of Class Members | 4 | 3 | 1 | 1 | 2 | 33 |

It is a normal part of the IPS - Supported Employment model - for individuals to lose jobs in the process. One core principle is that job loss is a learning event and not a reason to discontinue program engagement. When there is job loss, the individual and the employment specialist work together to determine what worked well and what did not. This collaboration is incorporated into lessons learned and in developing a correction plan. Individuals who have experienced job loss are immediately supported in finding other employment.

In FY15, DMH developed an action plan to increase the engagement of Williams and Colbert Class Members around work. This plan included a list of strategies including hiring a project manager, developing an employment campaign, providing IPS training and technical assistance and building ACT Team capacity to provide IPS and evidence-informed employment practices. In this reporting period process and outcome monitoring systems are underway to evaluate the effectiveness of the plan.

The employment trainer has been very active in implementing the action plan strategies. These activities include:

- Met twice with the Drop-In Center Coordinators and their staff at all 18 Drop-In Centers.
- Hosted monthly Williams Employment Learning Collaborative Conference calls with the Drop-In Center Coordinators and the Williams/Colbert quality administrators.
- Initiated individual meetings and conference calls with the Community Mental Health Centers around having their ACT Vocational Worker implement more of the Evidence Based IPS Principles of Supported Employment.
- Held discussions with the Community Mental Health Centers on how they can improve clinical integration around employment with their ACT, CST, and CSI Teams.
- Developed marketing materials to encourage engagement around employment with the Class Members.

In this reporting period, data collection began in the month of March with 136 employment engagement activities taking place resulting in an average of 31 employment engagement activities per week and occurring across the Drop-In Centers.

## HOUSING

**Rule 145**

Rule 59 IAC 145 – Permanent Supportive Housing was adopted effective 5/20/16. It will be published in the 6/3/16 Illinois Register.

**Section 811**

The Illinois Housing Development Authority (IHDA) and the Statewide Housing Coordinator continue to provide group and individual trainings on using the online housing locator and waiting list tool to people who are connected to eligible households. Meetings with Williams and Colbert transition coordinators, housing locators and case managers are planned to stress the importance of using federally funded Section 811 PRA resources to increase the number of Class Members who can move to the community by accessing affordable housing resources. A Waiting List Manager started on January 4, 2016 which has enhanced and improved the Section 811 and SRN matching process substantially.

The Incenting Supportive Housing (ISH) group, created by the Section 811 Interagency Panel, met in January 2016 to review existing data from Williams, Ligas, Colbert and Money Follows the Person Consent Decrees and to discuss other potential data that could help improve Communities of Preference designation. Proposed developments with Statewide Referral Network (SRN) unit buildings in Communities of Preference are awarded additional points in IHDA's Qualified Allocation Plan to encourage affordable housing development in those areas where persons have moved and/or wish to move and who are involved with the Williams, Ligas, Colbert and Money Follows the Person program. The group will be meeting in May 2016 to look at mapped data points and determine what other data might be missing from the map. If this project is completed in FY2016, there may be an updated QAP Communities of Preference list for FY2017.

IHDA is working with SocialServe to update and enhance the current SRN monthly periodic poll email in order to capture Section 811 unit availability information as Section 811 units are added to the portfolio. The Statewide Housing Coordinator is working with SocialServe on issues that arise within the Pre-Screening, Assessment, Intake and Referral (PAIR) online waiting list module to improve performance and matching. An updated contract is up for review at IHDA's May 2016 board meeting which addresses these additions to the contract.

IHDA continues to sign Rental Assistance Contracts (RACs) with new projects that are beginning to come online. When a project is 65% construction complete, IHDA begins looking for referrals for the property and begins the RAC process if the units are in Communities of Preference. IHDA also signs Agreements for Rental Assistance Contracts (ARACs) for currently operating properties that will have open units in the near future. At the time of this report, one 811 property, Milwaukee Avenue Apartments in the

Avondale community area, has leased its 811 units. The Bloomington-Normal scattered sites are still filling their 811 units. The RAC for Belle Shore (clustered model) is up for approval at the next IHDA board meeting in May 2016.

**Public Housing Authorities**

As of April 19, 2016 127 Williams and Colbert Class Members have converted their Bridge Subsidy to a CHA Housing Choice Voucher and 14 are actively searching for units. There are currently 119 of 200 Project Based Voucher units that are identified, being filled or have been filled by eligible Class Members. DMH has begun to work with their Williams Care Coordinators in order for them to assist Class Members who "lost" their CHA Housing Choice Voucher to reapply. Fifty applications have been re-submitted to date and have a first interview scheduled.

The Housing Authority of the County of Cook has converted 32 Williams and Colbert Class Members from Bridge Subsidy to HACC Housing Choice Vouchers. Fourteen additional Class Members have turned in all required documents and are in the process of receiving HCVs. Thirty-one additional Class Members are being assisted by DMH and DoA in submitting paperwork or documents that are missing from their files.

The Lake County Housing Authority has received approval from HUD to offer an Olmstead preference. They have developed a Pre-Application for Lake County Bridge Subsidy Class Members to complete in order to begin the process of them accessing the Section 811 Housing Choice Voucher Match. On March 1, 2016 CSH and SHC trained Lake County Williams' service providers on the process to obtain a Lake County Housing Authority Housing Choice Voucher and transition from a Bridge subsidy to the HCV. The providers have begun to assist Class Member residing in Lake County to complete the LCHA pre-application and submit it to the SHC. The providers will also assist the Class Members in attending necessary appointments and submitting required documents. There are a total of 100 Housing Choice Vouchers pledged as match to the Section 811 grant from the Lake County Housing Authority.

The Decatur Housing Authority has submitted all of the required documents to HUD and are awaiting final approval. The Rockford Housing Authority is completing submitting additional documents to HUD PIH.

**Coordinated Remedial Plan**

The Statewide Housing Coordinator, in partnership with IHDA, and others continue to outreach to Public Housing Authorities (PHAs) across the state encouraging them to opt-in to the Remedial Plan which was approved by HUD that will allow a preference to be given to Olmstead populations. The immediate focus has been PHAs with pledged Section 811 matching resources. We plan to expand outreach to PHAs in those counties identified by the Section 811 Interagency Panel Allocations Committee as "Communities of Preference." Further outreach to additional Public Housing Authorities in key areas of the state has begun and will continue as we seek to increase the number of affordable housing options for persons with disabilities in Illinois.

**Supportive Housing Working Group**

The Supportive Housing Working Group was re-convened by Illinois Housing Task Force in January 2016 to update the 2008 report to better reflect all populations in the State that need permanent supportive housing. The updated report will better reflect current inventory, unmet need, and estimated production of PSH units for all three consent decree populations (Williams, Colbert and Ligas), as well as those who are at risk of homelessness. The Working Group is meeting in subcommittees and as a whole on a regular basis and plans to submit its report by end of FY2016.

**Medicaid Innovation Accelerator Program Technical Assistance**

A team of Illinois Departments, led by HFS, has been awarded intensive in-person and virtual technical assistance under the Medicaid Innovation Accelerator Program (IAP) to explore funding housing related services and supports within Medicaid. The team is comprised of HFS, DHS and IHDA personnel and will meet often during the six months of TA (beginning in May 2016) in order to determine what is the best way to add housing related services and supports to Medicaid waivers and/or the State Plan. Illinois was one of eight states selected by CMS to receive this TA from a pool of 30+ states. Three webinars and a series of calls have already taken place to prepare for the in-person meetings. A core group of Illinois team members along with other awarded states met in Washington, DC the first week of May 2016 for the first round of intensive, in-person technical assistance.

**Supervised Residential Expansion**

As DMH continues to transition Class Members from IMDs there is clear evidence that some Class Members require a level of care and support that cannot be satisfied through direct transition to open market permanent supportive housing rental units without the possible of risk factors to wellness and safety. DMH is aware that there must be a variety of 'housing' options to address the diverse clinical and therapeutic needs of Class Members. To adequately address the treatment resources needed and to adequately provide a treatment level of care for Class Members who require more support, DMH has explored opportunities to create additional Supervised Residential Program capacity.

One such opportunity involves the conversion of bridge subsidies to allow individuals who live in supervised residential settings to move into the community. For this reporting period, there two (2) Williams Class Members who transferred directly into Supervised Residential level of care. There has been a cumulative total of sixty-nine (69) Class Members who stepped down through the Supervised Residential setting. Thirty-four (34) individuals who were residents of supervised residential housing that received Bridge Program Subsidies, moved into the community which opened a bed for a Williams Class Member. Those 34 individuals were not Williams Class Members however their move opened up slots at residential programs for Williams Class Members who needed that level of care. The 34 individuals received subsidies funded by the Williams program.

**Corporation for Supportive Housing**

Corporation for Supportive Housing (CSH) is under contract with DMH to assist in developing housing access to integrate Class Members into community-based housing options. CSH facilitates and brokers policy discussions between DMH and housing developers, advocates, other governmental entities, and

investors with the goal of developing and leveraging quality supportive housing. This involves impacting the housing operations and client access to units, the planning and delivery of effective services, and the coordination between housing and services to get and keep the target populations in housing in the long-term.

Housing Policy & Cross-Systems Partnerships

- Chicago and Cook County Supportive Housing, Healthcare, and Systems Integration
  In 2016, CSH continued to implement a multi-pronged action plan for Chicago and Cook County to integrate housing creation and healthcare policy to increase supportive housing with sustainable services delivered through Medicaid and health-system partnerships. This initiative, called the Chicago and Cook County Housing and Health Action Plan will help the most vulnerable, experiencing chronic homelessness, and most at-risk for repeated hospitalizations or admittance into nursing homes for lack of affordable housing. This initiative and its partners such as Cook County Health and Hospital Systems, alongside Williams providers like Thresholds and Heartland Health Outreach, will be critical in contributing to long-term systems goals of the Consent Decrees, particularly as the majority of people with mental health needs and Class Members are in the Chicago/Cook area.

- Statewide Collaborative Planning for Supportive Housing
  CSH continues to participate with the Interagency Council on Homelessness meeting at IDHS-DMH/DASA, where the focus is to end chronic homelessness through supportive housing with specific focus on service needs in behavioral health and substance use. CSH consulted with DASA on the application to Substance Abuse and Mental Health Services Administration for new efforts to integrate substance use and mental health services for families with children and young adults experiencing chronic homelessness. CSH connected DASA to Chicago-based efforts to prioritize similar populations for supportive housing.

  CSH also is represented on the Illinois Housing Development Authority Supportive Housing Working Group that will release an updated statewide assessment of the need for supportive housing for a range of populations and the investments in supportive housing production over the coming years. CSH participates on the full committee, the Strategy Subcommittee, and facilitates the Production Subcommittee. This updating of the 2008 Supportive Housing Needs Report is the opportunity to link the need for supportive housing to groups that are likely to interact with unnecessary institutional care such as IMD's.

  At the request of the Division of Mental Health Director, CSH participates in the Certified Community Behavioral Health Center (CCBHC) Information Advisory Council Meeting working group that is led by DMH. This federal initiative is intended to help Illinois strengthen its behavioral health services for Medicaid beneficiaries who are more likely to use a community mental health center as their primary medical health services home. Enhanced Medicaid rates

for certain comprehensive mental health centers may allow the state to successfully medically and psychiatrically stabilize some of the state's highest users of Medicaid services.

- Public Housing Authority Outreach
  CSH continues to assist with the transition of Class Members from Bridge to Housing Choice Vouchers including maintaining logs for the provider agencies, DMH, and Catholic Charities regarding relevant status and processing information. CSH also acts as a liaison between the provider agencies and CHA on circumstantial situations as they arise and serving as advocate for direct service staff. CSH provides weekly updates and facilitates weekly calls with all Williams' providers and DMH staff to provide relevant updates and report and changes to policies and processes. CSH also provides similar status updates to Williams Transition Agencies regarding HCV's coming from the Housing Authority of Cook County.

- Center for Medicare-Medicaid Services Innovation Accelerator Program (IAP) for Medicaid Housing-Related Services and Partnerships
  CSH joined the Illinois State Team for the CMS IAP for Medicaid Housing-Related Services and Partnerships program.

<u>Trainings & Presentations</u>

- CSH conducted a series of webinar trainings and presentations targeted to Williams Transition Agencies but also are open to agencies and staff working on Colbert Consent Decree, Ligas Consent Decree, and community-based providers of supportive housing. These topics aim to engage providers in timely issues that impact long-term success of supportive housing for people moving into their own home after many years.
  - January 6th, 2016: From Bridge to the Rental Housing Support Program.
  - February 1st, 2016: How to Build Relationships with Landlords for NAMI
  - March 10th, 2016: Accessing HUD 811 Units for Williams and Colbert Class Members
  - April 1st, 2016: Converting Lake County WCM to Section 811 Lake County Housing Authority HCV
  - May 9th, 2016: Converting Lake County WCM to Section 811 Lake County Housing Authority HCV
  - May-June 2016: Trainings are being planned that relate to DMH Agencies working with consumers receiving CHA HCV subsidies

- CSH Delivered its Supportive Housing Academy May 2-5, 2016 at the IDHS Building at 401 S. Clinton. This training was attended by 22 people including developers, attorneys, advocates, managed care, and mental health providers. Training curriculum covered the following topics:
  - Housing First and Harm Reduction
  - Supportive Housing –Integrated Models
  - Supportive Services and Property Management Coordination
  - Involving Tenants in Project Planning

- Engagement Strategies
- Eviction Prevention
- Supportive Housing Budgets

The Academy culminated with a day of site visits to Milwaukee Avenue Apartments (Full Circle Communities), Wicker Park Apartments (Renaissance Social Services), Buffet Place (Thresholds), and The Schiff (Mercy Housing Lakefront)

- Landlord Trainings on Supportive Housing and Williams Consent Decree
  CSH works closely with the Statewide Housing Coordinator to deliver training presentations on the Williams Consent Decree and Bridge Subsidy directly to landlord groups. CSH delivered the following trainings to landlords:
  - January 14th, 2016: West Suburban Landlord Association
  - January 25th, 2916: South Side Community Investors Association
  - March 14th, 2016: Community Investment Corporation Landlord Training
  - Mercy Housing regarding developments in Kane and DuPage Counties
  - Chicago Low-Income Housing Trust Fund Landlord Training

<u>Increasing Housing Availability</u>

- Housing Locator Conference Calls
  CSH participates in regular housing locator conference calls. The calls cover landlord outreach strategies and actively problem solve in real-time. In March, CSH provided additional information on building the Class Members "portfolio" to assist in competing for available units, such as: Letter of recommendation from the agency; Letter of explanation about the program, about supportive housing; Letter of support from a landlord you currently have a relationship with about the relationship with the service provider and/or being a landlord for a supportive housing tenant. CSH also offered support to housing locator staff on addressing Class Member discrimination practices.

<u>Consumer Satisfaction with Housing and Improving Housing Assessment Process</u>

- Consumer Satisfaction Survey FY16
  CSH conducted the third Consumer Satisfaction Survey for the participants of the Bridge Subsidy Program. Approximately 713 surveys were returned for analysis. The results will be published in a report that will be released by June 30, 2016.

## REPORTABLE INCIDENTS

DMH continues to make a concerted effort to accurately capture all reportable incidents and pay particular attention to those incidents that could impact the safety and wellness of Class Members. Reportable incidents are any situations in which the Class Member experiences a perceived or actual threat to his/her health and welfare or to his/her ability to remain in the community. It is mandatory that these incidents are reported to DMH in a timely manner.

The incident reporting process is categorized into three distinct levels:

**Level I – Urgent; Critical Incidents**: Situations or outcomes that result in adverse occurrences impacting life, wellness and safety.

**Level II - Serious Reportable Incidents**: Situations or outcomes that could have implications affecting physical, emotional or environmental health, wellbeing and community stability.

**Level III – Significant Reportable Incidents**: Situations or occurrences that could possibly disrupt community tenure.

For the period January 1, 2016 thru April 30, 2016 the total number of reportable incidents (310) was categorized as follows.

| | | |
|---|---|---|
| **Level I:** | 31 | 10.0% |
| **Level II**: | 261 | 84.2% |
| **Level III:** | 18 | 5.8% |

Data compiled for the reporting period January 1, 2016 thru April 30, 2016 reflects that 202 Class Members accounted for a total of 310 reportable incidents. Sixty-one (61) Class Members accounted for two (2) or more reportable incidents.

The table below shows the distribution:

| Unduplicated Count of CMs | # Incidents | Total Incidents | Percentage |
|---|---|---|---|
| 141 | 1 | 141 | 45.48 |
| 35 | 2 | 70 | 22.58 |
| 13 | 3 | 39 | 12.58 |
| 8 | 4 | 32 | 10.32 |
| 3 | 5 | 15 | 4.84 |
| 1 | 6 | 6 | 1.94 |
| 1 | 7 | 7 | 2.26 |
| 202 | | 310 | 100.00 |

**Mortality Reviews**

In an effort to identify patterns, themes, or behaviors surrounding Class Member deaths, DMH has contracted with the University of Illinois at Chicago, College of Nursing to conduct 25 mortality reviews for the Williams Level I reportable incidents that result in a death. This information can be beneficial to care coordinators and/or other community providers in work with future Class Members who transition to the community. The College of Nursing has also agreed to conduct retrospective reviews of the previous deaths, since inception. A decision was made to exclude mortality reviews for those Class Members who died while in hospice or as a result of a terminal illness.

Dr. Cheryl Schraeder is the lead investigator on the mortality reviews. The mortality reviews include a formal analysis of clinical documentation received from the respective provider agency and interview(s) with the agency care management team by Naomi Twigg, RN, PhD and Ann Hruby, APN. The review is a very comprehensive Root Cause Analysis process. Review documents include Medicaid Claims information, DMH documentation on Reportable Incidents, medication list, comprehensive service plan, 24 hour back-up plan, diagnosis list, hospital records, and agency assessments. The UIC team typically reviews notes from the agency's first contact with the Class Member pre-transition to the date of death. For older cases this has been a challenge and has increased the length of time to review the case due to staff turnover and changes in the agencies' data storage and retrieval systems. The review process culminates with a mortality review meeting with UIC, DMH, agency staff and other individuals related to the case.

- To date, there have been thirty-nine (39) deaths under the consent decree.
- For this reporting period there were nine (9) deaths.
- Twenty-five (25) cases have been referred to UIC.
- Sixteen (16) mortality reviews have been conducted.
- The average length of time to conduct a review, from referral to review meeting, is 3 months.

## QUALITY MANAGEMENT/QUALITY MONITORING

### Quality Monitoring

There were eight (8) Quality Monitors assigned to Class Members serviced by community mental health agencies in the Chicago and surrounding areas. Two (2) Quality Monitors with offices in Pekin Illinois were assigned to Class Members in Peoria, Decatur and surrounding areas. In March, one quality monitor in the Chicago area and the two Quality Monitors in downstate Illinois were assigned to a special 'Well Being" project designed to visit those Class Members who had surpassed 21 months living in the community. The project was to ascertain the status of the Class Members and assure that they were receiving the necessary supports and services and is ongoing.

Some of the issues found included:

- Class Member expressed concerns about the lack of access to staff on week-ends.
- Elderly Class Member had received notice that she had medical coverage due to move and lack of notification but reported medical provider was resolving the issue.
- Two story apartment unsuitable for Class Member with fall issues.
- Two clients continued to struggle with psychiatric issues which the agency appeared to be addressing sufficiently.
- One Class Member continues to drink despite history of significant problems.

In this reporting period, the Quality Monitors conducted 298 home visits to Class Members and a total of 4343 home visits since the start of the Williams program. The Quality Monitors determine that the Class Members' comprehensive service plans accurately depict the Class Members' needs and goals, that the Class Members' homes are safe and well maintained and that the Class Members are adapting to their new environment. The Quality Monitor's interaction with the Class Member ends after the 18$^{th}$ month home visit however in some instances the Quality Monitor may believe that unresolved issues call for an extension to the monitoring period. In such cases additional home visits may be scheduled.

During this reporting period, the Quality Monitors conducted Quality of Life Surveys. Feedback from the surveys provides a barometer of the care and services received by Class Members, their wellness, and their quality of life in the community.

Completed survey data indicates:

- sixty-one (61) , 30 day surveys
- eighty-nine (89) 3 month surveys
- fifty-nine (59) 6 month surveys
- forty-three (43) 12 month surveys
- thirty-nine (39) 18 month surveys
- seven (7) unscheduled surveys

**Quality Improvement Committee**

The Williams Quality Improvement Committee (QIC) meets on a quarterly basis and serves as a vehicle for stakeholders to review and make recommendations on specific system performance and risk management issues. The committee is open to consumers, family members of consumers, Class Members, Williams CMHC agency staff, NAMI-GC staff and representatives from DMH, HFS, IHDA, IDPH and the IMD industry.

The most recent QIC meeting was held on January 26, 2016. The meeting was lively and interactive. Approximately 50 individuals attended in person and many others participated via teleconference. The agenda included the following topics - outreach, Implementation Plan Amendment, housing, compliance, return to the IMD, unable to serve, compliance and reportable incidents. One of the Williams Ambassadors in attendance shared his experience of living in a nursing home for 3 ½ years and has now lived in the community for 2 years. He also offered suggestions on how to better engage the residents to consider moving out of the IMDs.

Several participants raised questions about the lack of a state budget and its implication on the Williams program. Others voiced their concerns about the potential closing of the IMDs or their conversion to SMHRFs due to the lack of a budget. There was a concern about what will happen at the end of the fifth year of the consent decree. Will residents have to move out of the IMDs? Will the facilities downsize? What is the long term plan? DMH responded that the lack of a budget has not interfered with the implementation plan activities for FY16. Although the question of when the Williams Consent Decree will end is uncertain at this point, it may be extended.

## FRONT DOOR

A group of responsible agenices has been convened to address the requirement of the state to offer alternatives other than referral into the Specialized Mental Health Recovery Support Facility (SMHRF) level of care. The participating agencies are HFS, DMH, DPH and the Governor's Office. The goals of the group are to ensure community alternatives are available for individuals assessed as being appropriate for community placement and that only those individuals that require a SMHRF level of care receive a referral to a SMHRF.

To ensure only those individuals assessed as being appropriate for SMHRF level of care are referred to SMHRFs and those assessed as being appropriate for community placement are offered an alternative referral, the group will complete a review of the current screening practices and interventions. Following a review of the SMHRF Act and the corresponding administrative codes, the group is also exploring viable options to allow provider agencies to offer similar levels of care in the community. This may require changes to current rules in the short-term and potential legislative change in the longer-term.

A plan to "narrow the front door" is currently being drafted and will be complete before the required June 30, 2016 deadline. It will include elements outlined above and a prioritization of initiatives to ensure compliance with the *Williams* consent decree.

## BUDGET

In FY16 the Illinois Governor's Revised Introduced Budget included $46.9 million in General Revenue Funds for rebalancing efforts related to the Implementation Plan. Expenditures thru April 30, 2016 include $2.1 million for administrative and operational expenses as well as $20.1 million in grant funded services. In addition, $4.1 million has been expended for Medicaid services to Class Members. By the end of FY16 it is estimated that spending will total approximately $30.1 million with the balance of the GRF appropriation to be spent on Medicaid services.

The Governor's current proposed FY17 budget for the Division of Mental Health includes $42.4 million in General Revenue Funds dedicated to expanding home and community-based services, and other transitional assistance costs associated with the consent decree implementation.

## CALLS, COMPLAINTS, GRIEVANCES, and APPEALS

### Calls

For the reporting period January 1, 2016 through April 30, 2016, there were a total of thirty-nine (39) calls to the Williams Call Line. Twenty-seven (27) calls were directly from Class Members seeking status updates on assessments/reassessments, transition, requesting appeal information or follow-up by a community agency. One call was received from a family member or guardian of a Class Member, seeking general information about the Consent Decree. Eleven (11) calls were received from other interested parties for general information about the Williams Consent Decree.

### Complaints

There were no complaints or grievances filed to the Williams Call Line during the months covered by this report.

### Appeals

There were no appeals submitted to DMH for review during this reporting period.