EXECUTIVE SUMMARY

The Williams Semi-Annual Report #4 has been prepared in accordance with the requirements of the Consent Decree resulting from the Williams v. Quinn lawsuit. This report describes Williams implementation activities December 1, 2012 through May 31, 2013.

During this time period 1) the Year II Williams Implementation Plan Update and Amendments were negotiated and filed with the Court and 2) the Parties and the Court Monitor agreed to file a motion to the Court to alter the Consent Decree to extend the deadline to complete Resident Reviews on all consenting Class Members, to change the calculation that determines the Year III transition benchmark, and to amend the Implementation Plan with strategies to improve Resident Review and Transition outcomes.

One could say that improving Resident Review and Transition outcomes accurately depicts the theme for the time period covered by this report. To date, 56.5% of Class Members approached have agreed to participate in the Resident Review process and 57% of Class Members assessed have been referred to transition. The State continues to work toward improving these results and the efforts described in this report are to that end. Considerable efforts were also directed toward ensuring that services provided are consistent, of high quality and meet the needs of the Williams Class Members. Lastly, the State is working to meet both the mandated Year II benchmark of 640 Class Members transitioned to the community by June 30, 2013 and the newly established Resident Review completion benchmark of September 30, 2013. The State anticipates accomplishing both of these benchmarks and reports that, as of May 31, 2013, 592 Class Members have transitioned to Permanent Supportive Housing or executed leases and 4073 Class Members have been approached for Resident Reviews.

Efforts to meet these goals span all of the components of the Implementation Plan as reflected in the initiatives listed below:

- Evaluation of the Resident Review Instrument
- Completion and implementation of the Resident Review Database
- Utilization of Olmstead Technical Assistance from SAMSHA contractors and the Technical Assistance Collaborative
- Development of new initiatives to improve Resident Review Refusal Rate
- Maximization of existing community service taxonomy to meet the needs of Williams Class Members
- Enhancement of existing community services to meet the needs of Williams Class Members
- Enhancement of the stock of Permanent Supportive Housing in Illinois and of the availability of State and Federal rental subsidies to increase the ability of the State to transition residents from Bridge Subsidy to long term rental subsidy options
- Consideration of alternative housing models for Class Members who require more intensive services
- Initiation of Quality Monitoring visits to transitioned Class Members

The body of this report includes details and outcomes on these important initiatives.

OUTREACH AND INFORMATION DISSEMINATION

Outreach Workers continue to disseminate information and materials regarding the Williams Consent Decree in all of the Nursing Facilities/Institutes for Mental Disease (NF/IMD). New admissions to the IMDs are offered private interviews to review Outreach information in accordance with the Williams Consent Decree Implementation Plan. Effective January 1, 2013, Outreach Workers began conducting a second round of private interviews with existing Class Members to review the Consent Decree, the opportunities afforded Williams Class Members, and to simply answer any questions that Class Members may have.
Because of the frequency of their visits, Outreach Workers are generally welcomed as familiar visitors by Class Members who regularly seek them out to assist in resolving issues. They help sort out communication issues such as lost assessment and transition notification letters as well as notification letter misunderstandings. They are sometimes asked to reach out to guardians and family. Outreach Workers regularly contact DMH staff, transition agency staff, family members and others for clarification and accurate information.

Outreach Workers are mindful of the need for resources for Class Members and their families. They frequently conduct community meetings during IMD visits and have introduced Class Members to the monthly Statewide Recovery Empowerment Calls. These calls have resonated with some Class Members so much that they participate independent of Outreach Worker visits. They are equipped with NAMI of Greater Chicago's Referral Database with more than 1500 referral resources for persons with Serious Mental Illness and provide them as requested.

To date, Outreach Workers have made contact with 5132 Williams Class Members: 3331 (61%) consenting Williams Class Members have received private informational sessions with 1801 (39%) refusals.

Quality of Life Surveys

Quality of Life surveys were conducted by Outreach Workers in the period covered by this report just prior to the Class Member's discharge from the IMD and 6 months post transition. Quality of Life survey results can be found in the Transition Coordination/Community Service section of this report.

Williams Informational Line

The Williams Informational Phone Line, operated through the Department of Human Services/Division of Mental Health's (DHS/DMH) contract with the Illinois Mental Health Collaborative for Access and Choice is a live response telephone line, operated five days a week for eight hours daily. The Williams Informational Line has received 401 calls during this reporting period with questions regarding Williams Consent Decree issues. 312 (77.81%) of these calls were from Williams Class Members; 9 (2.24%) were from family/friends of Williams Class Members and 80 (19.95%) calls were from non-Class Members.

RESIDENT REVIEW

DHS/DMH contracted with Lutheran Social Services of Illinois (LSSI) and Metropolitan Family Services (MFS) to conduct Resident Reviews for the Williams Consent Decree implementation in FY13. LSSI and MFS hired the necessary staff, received intensive training by DHS/DMH, and began conducting Resident Reviews on a full-time basis in December 2012. To date, 4073 Class Members have been approached for Resident Reviews with 1841 Class Members (45.2%) refusing. 2208 Resident Reviews were completed with 1263 (57%) Class Members referred for transition and 949 (43 %) Class Members referred to Clinical Review.

During the time period covered by this report the Williams Resident Review process was evaluated for efficiency and efficacy in response to 1) concerns about the consistently high Resident Review refusal rate and Clinical Review referral rate, and 2) the State's commitment to complete Resident Reviews on all consenting Class Members by June 30, 2013, in accordance with the Williams Consent Decree. This process was evaluated internally by the Williams Management Team as well as externally via a focus forum attended by LSSI, MFS, Trilogy, Inc., Thresholds, Human Resource Development Institute (HRDI) and Community Counseling Center of Chicago (C4). These community agencies were selected because of their experience conducting Resident Reviews and/or providing community mental health services. The attendees of the focus forum were tasked with:

- Reviewing the existing Resident Review tool and its effectiveness in gathering pertinent information to identify service needs;
- Determining if this tool could be streamlined for better efficiency;
- Identifying services and supports that are currently unavailable in Illinois' existing service taxonomy.

Each group was asked to identify elements of the Resident Review tool that they considered essential to retain in the review process or unnecessary. The group determined that most of the elements of the Resident Review tool are important enough to keep. The group did not, however, think that all of the efforts utilized in identification of interests, goals, desires, etc. were critical to the Resident Review assessment process. Each service agency identified this information as an important component of their engagement phase with Class Members, since they are required to do strengths based assessments and have incorporated such into their preliminary discussions with Class Members and in the treatment planning processes. Both service and Resident Review agencies were adamant that motivational discussions to stimulate Class Members to consider transition options enthusiastically be included in the Resident Review process.

When asked to describe the types of Class Members that require services unavailable in the current service taxonomy, the group identified the following:

- Complex/co-morbid medical conditions which require high levels of nursing support (example: brittle diabetic, wound care, etc.)
- High predictors for criminogenic risk factors (anti-social behaviors/personality disorders and sociopathic behaviors)
- Uncontrolled substance abuse/drug usage and mental illness
- Risks of falls or severe seizure disorders – requiring 24 hour staff presence
- Histories of arson
- Histories of attempted suicide, homicide or self injurious behaviors and
- Histories of extreme aggression or risk to others when medication non-compliant

As a result of these processes, DHS/DMH came to the following conclusions:

- The existing Resident Review instrument should continue to be used. The "abbreviated" tool required 5 hours for completion, essentially the same amount time as the existing tool.
- The Resident Review tool should be augmented with robust instruments to identify service system planning for Class Members who have complex/co-morbid medical conditions and high criminogenic risk factors (anti-social behaviors/personality disorders, substance abuse and mental illness.
- A three month extension to the June 30th deadline should be requested to complete Resident Reviews on all consenting Class Members prescribed by the Consent Decree.
- DHS/DMH should seek best practices in other states/models and/or national experts who can provide training in the areas where service deficits are noted to provide training to DHS/DMH and Williams agencies' staff

The request to extend the June 30th deadline to complete the Resident Reviews on all consenting Class Members was presented to the Plaintiffs and the Court Monitor. After some discussion, the Parties agreed to modify the Consent Decree effective July 1, 2013 to:

- Extend the deadline to complete the Resident Reviews on all consenting Class Members by three months to and including September 30, 2013.
- Change the calculation to determine the Year III transition benchmark from 40% of all Class Members deemed appropriate for transition and who desire to transition to 40% of all Class Members who consent to be assessed and
- Require the Parties and the Monitor to confer and engage in negotiations to modify the Implementation Plan, the results of which are to be filed with the Court by June 30, 2013, addressing the following issues:
    - Revision of the evaluation and re-evaluation process so that when an individual is not recommended for transition to a community-based setting, the services and supports that would make the transition possible are clearly identified.
    - Enhancement of the Illinois community mental health service taxonomy so that a larger percentage of Williams Class Members can successfully transition to the community.
    - The development of strategies to positively improve the Resident Review Refusal rate.

Clinical Review

In the first five months of FY13 second level paper Clinical Reviews were conducted by DHS/DMH staff and the community mental health agencies included in the 2012 Pilot Project. Effective December 2012, 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 chosen by the Class Member for Clinical Review. As of today, 949 Resident Reviews were referred to Clinical Review, with 138 (14.5%) recommendations overturned and referred to community mental health agencies for transition to the community.

TRANSITION COORDINATION/COMMUNITY SERVICES

The Williams community mental health service provider network has expanded to 17 community mental health agencies. Included are the four original agencies: Thresholds (Chicago), Trilogy Inc. (Chicago), Community Counseling Center of Chicago (Chicago), Human Service Center (Peoria) and the five agencies contracted in September 2012: Lake County Mental Health (Waukegan), Human Resource Development Institute (Chicago), Association House (Chicago), Grand Prairie Behavioral Health Services (Tinley Park) and Heartland Health Outreach (Chicago). These agencies provide the full range of Rule 132 Medicaid services as well as the non-Medicaid billable services and supports developed for Williams Class Members.

DHS/DMH initiated community visits to the five FY13 newly contracted Williams provider agencies noted above during the time period covered by this report. These visits served to reinforce the State's expectations of a Williams contracted mental health service provider and to re-affirm the agencies' commitment to address the transitional, service and support needs of Class Members in a manner that assures the ongoing integrity of the Williams initiative.

Contracts were executed during the time period covered by this report with eight additional agencies to provide community mental health services in response to the geographic preferences of Williams Class Members: Heritage Behavioral Health Center, Inc. (Decatur), Cornerstone Services (Joliet), Ecker Center (Elgin), Iroquois County Mental Health (Watseka), Alexian Brothers Center (Arlington Heights), Dupage County Health Department (Wheaton), New Foundations Center (Northfield), Kenneth Young Center (Elk Grove Village). At this time, these agencies may provide limited services but, they are interested and willing to evaluate their ability to meet the needs of the Williams Class Members who have a desire to live in their service areas. They are encouraged to expand their service array and to be innovative in their approach to meet the needs of Williams Class Members but not to accept referrals if they are unable to provide the services necessary for these Class Members' successful integration into the community.

As of the date of this report, 1413 Class Members have been referred to the Williams agencies based on Class Member preference. To date, 592 Williams Class Members have been transitioned to the community or have leases signed with transition imminent. Only 26 (1.8%) Class Members have requested transition to communities that are not served by the Williams provider network. Efforts continue to provide housing and services for these Class Members in the communities of their choice. .

Utilization of Community Services

The table below summarizes the service utilization for Williams Class Members between December, 2012 and April, 2013. During this timeframe, 342 individuals were assessed for community service needs, and had individualized treatment plans developed. 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 (which is billed as case management and community support individual) was provided to 468 individuals. 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 has been provided to 155 individuals during this time period. CSG, a community-based service that assists in generalizing the service to the individual's natural environment, has been provided to 62 individuals.

Once an individual transitions from the IMD, team services of Assertive Community Treatment (ACT) and 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 273 individuals were served by 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, have been provided to 18 individuals. Crisis Intervention Services, which provide interventions aimed at stabilizing a psychiatric crisis, were required by 40 individuals during this period, while 3 individuals received some skill training and support within a residential setting of a community provider.

PAID CLAIM AMOUNT, SERVICE UNITS AND NUMBER OF WILLIAMS CLASS MEMBERS RECEIVING SERVICES DECEMBER 1, 2012 TO APRIL 30, 2013

SERVICE TYPE	PAID CLAIMS AMOUNT BY SERVICE	SERVICE UNITS	UNDUPLICATED COUNT OF CLASS MEMBERS BY SERVICE*
Assessment and Treatment Planning	$63,760.69	3,423	342
Assertive Community Treatment (ACT)	$784,290.27	26,813	132
Case Management – LOCUS Administration	$11,255.58	261	244
Case Management and Community Support (Individual)	$481,071.46	24,901	468
Community Support Group	$14,943.09	2,736	62
Community Support Team (CST)	$355,569.14	17,317	147
Psychosocial Rehabilitation	$68,017.02	8,537	155
Therapy/Counseling	$5,478.51	332	18
Community Support Residential/Group/Individual	$4,019.92	108	3
Crisis Intervention (Other)	$16,691.35	78	40
Grand Total	$1,805,097.03	84,506	1,611**

Notes pertaining to the above table:
* The count of Class Members receiving each type of service is unduplicated.
** The total count of Class Members across services represents a duplicated count as individuals may have received multiple types of services.

Proposed Service Expansion

The State has continued to work on the identification of needs and planning for the development of additional services needed by some Class Members for successful transition consistent with the terms of the Consent Decree. An interdepartmental workgroup was formed to address this task has held several internal meetings, as well as teleconferences with officials from the New Jersey Department of Mental Health and a provider of the Residential Intensive Support Team (RIST) model in New Jersey. Several recommendations have been made as a result of this work.

Recovery Supports

The first recommended additional service would 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/accompanying to activities such as support groups. In addition, the provision of a supportive presence during the early phases of transition would 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 would be provided by individuals with a Certified Recovery Support Specialist (CRSS) credential, and would 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 would 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 would 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 would 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 would have to score as "Dual Diagnosis Enhanced" on the Dual Diagnoses Capability in Addiction Treatment (DDCAT), 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.

Enhanced Skills Training and Assistance

This service would assist individuals who cannot manage ADLs[1] and IADLs[2] 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 typically learn how to facilitate skill performance on the job. The assessments of the reasons underlying the performance deficits lack sophistication. Typically, there is no assessment done that really seeks to understand the factors contributing to ineffective and unsafe 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.
- To address this issue, it is recommended that mental health provider agencies be encouraged to recruit and hire Occupational Therapy practitioners, who are uniquely qualified to address these issues. These clinicians would provide evaluation and interventions to improve performance of ADLs, IADLs, and health rest and sleep routines, which are particularly relevant to living safely in the community.

Bi-Directional Healthcare

While not technically a specific service, this model of a service system 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. This would include close bi-directional coordination and collaboration between the mental health provider, primary care physician and disease managers, as well as hands-on, in-home teaching and monitoring to address critical self-management and adherence issues.

[1] ADLs (taking care of one's own body, i.e., personal care)

[2] IADLs (Activities to support daily life within the home and community that often require more complex interactions than self care used in ADL, e.g. communication management, community mobility, health management, home management, safety and emergency maintenance)

Individuals in need of this service are those who would meet the "Quadrant IV" designation under Four Quadrant Clinical Integration Model.[3] Their services would 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 Occupational Therapy assessments and services.

Meetings are ongoing within Healthcare and Family Services (HFS) and DHS to determine funding mechanisms and develop necessary policies and procedures for implementation, which is anticipated in early FY2014.

Characteristics of Williams Class Members Registered as of March 29, 2013

Division of Mental Health (DMH) 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 7 days of their initial contact with Class Members which occurs within the IMD in which the individual resides. As of March 29, 2013, four hundred and nine Williams Class Members were enrolled in the DMH Community Information System. 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 21 to 76 yrs old, with an average age of 46. Of the 409 Class Members, 270 (66%) are male and 139 (34%) are female. Overall, 6.7% of Class Members were reported as being of Hispanic Origin. With regard to primary ethnicity, 56.7% of Class Members are Black/African-American and 40.6% are Caucasian. A very small percentage are Asian (1.5%) or Native Hawaiian/Pacific Islander (.2%); ethnicity was reported as unknown for 1.0%.

Marital Status

The majority (76%) of Class Members have never been married; twelve percent are divorced and another 5% are separated. Only 2% are married and 1 percent is widowed.

Highest Level of Education Completed

The highest level of education completed by approximately 2% of Class Members was 8th grade. Twenty-five (25%) of Class Members completed some high school (e.g., one, two or three years) with no diploma earned. A little over a quarter (27.4%) have earned a high school diploma and an additional 10% were reported as having earning a General Equivalency Degree (GED). Eighteen percent (18%) 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 1.5% has completed post graduate training. Education level was not reported for approximately 10% of registered Class Members.

Residential Living Arrangement

As of March 29th, 40% of the cohort of individuals were reported as residing in private unsupervised settings (permanent supportive housing), while 48% were reported as residing in IMDs.

[3] Mauer, B. *Behavioral Health/Primary Care Integration:* The Four Quadrant Model and Evidence- Based Practices. tional Council for Community Behavioral Healthcare pp. 3-7. February, 2006.

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 (92%) of Class Members were reported as not having any involvement with the justice system (courts, jails etc). However, 6.1% had been detained in jail, and a very small percentage reportedly had been arrested, charged with a crime, or incarcerated in a jail or prison (.6% or 3 individuals). An additional 2 Class Members (.4%) had a status at some point of being on parole or probation.

History of Mental Health Treatment
During the registration process, information is gathered regarding an individual's history of mental health treatment. Ninety-four (94%) of Class Members have a previous history of treatment, 90% have received continuous mental health treatment in residential settings, and 85% have previously received outpatient services for their illnesses.

Level of Care Utilization Scale Scores Based on Assessor Recommendation
A little less than half (47%) 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. Forty-three percent were recommended for Medically Monitored Non-Residential Services.

Diagnosis
Seventy-five percent of Class Members had a primary diagnosis of schizophrenia and other psychotic disorders; 24% were diagnosed with 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 65 with an average of 44.5 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. Ninety percent (90%) of Class Members were identified as having a serious functional impairment in the employment area, 85% in the financial area, 82% in Social/Group functioning and 73% in Community Living area. Fifty-two percent (52%) had a serious functional impairment in the supportive/social area, 49% in activities of daily living and 27% had a serious impairment in relation to inappropriate or dangerous behavior.

Quality of Life Survey Results

The Williams Consent Decree Quality of Life Survey is comprised of three surveys: the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Evaluation of Care Survey, selected components of the Lehman Quality of Life Survey and a subset of questions from the Quality of Life Survey used for the Illinois Money Follows the Person (MFP) initiative. The survey is administered prior to Class Members discharge from the IMD, at six months post discharge and 12 months post discharge. This information is critical to evaluate the outcomes for Class Members in that the surveys ask Class Members directly to evaluate their care and to assess their social, family, physical health and safety/legal issues. The initial surveys are administered by the team of Outreach Workers who have contracted with DHS/DMH to provide outreach services. Follow-up surveys, once individuals are discharged, are conducted by DHS/DMH quality monitors.

Displayed below are the results of the initial survey (prior to discharge) for a small subset of items from the Quality of Life surveys for 118 Class Members that have transitioned to community living. Please note that because the number of surveys represents a relatively small percentage of individuals engaged in transition coordination, and the surveys were not randomly selected, the results should not be generalized to the entire group of individuals described in this report. The information reported below is intended to provide the reader with a snapshot of a sample of Class Members assessment of their quality of life while still residing in their current residential setting. As more data is collected, future reports will include a focus on surveys conducted post discharge as well as comparisons pre-discharge and post-discharge.

Evaluation of the Services Received in the IMD

In response to a question that asked Class Members if they like the services that they are receiving in the IMD, 72% agreed or strongly agreed. 15% stated they were neutral while 12.7% disagreed or strongly disagreed that the like the services they are receiving.

Recovery

Hope is important aspect of recovery, and having staff believe that one can recover is important as well. 86% of Class Members reported that they strongly agree or agree that staff believe that they can grow, change and recover. Only 4.2% of the individuals completing survey disagreed or strongly disagreed with this statement.

General Life Satisfaction

When asked how they felt about their life in general, approximately 6% of Class Member reported that they were unhappy or mostly dissatisfied. 16% said that they were equally satisfied or dissatisfied and 24% said they were mostly satisfied. 54% stated that they were pleased or delighted.

Assessment of functioning in Home, Social, School and Work Settings

When asked how they would rate their functioning at home, social, school or work settings, 30% stated that their functioning was excellent; another 48% rated their functioning as good and another 20% rated their functioning as fair. Further, 44% stated that they are pleased or delighted with how they spend their time, 33% reportedly being mostly satisfied; 15% were equally satisfied or dissatisfied. Approximately 7.5% reported that they were mostly dissatisfied, unhappy or that the way they spent their time was terrible.

Social Relationships

Interaction with others is a building step for developing satisfying social relationships with others. Social connectedness and interaction is an important factor with regard to recovery. Roughly one-third of the individuals responding to this question reported that do not spend time with someone who doesn't live with them. Another 30% report that they interact with someone not living within them at least once a month or less than once a month. However, 33% reported that they have developed social relationships with someone who doesn't live with them and they visit with these individuals once a day or once a week.

Assessment of Health, Physical Condition and Emotional Well Being

In response to a question asking Class Members to rate their health, approximately 65% of individuals rated their health as excellent or good; 28% rated their health as fair and 5% rated their health as poor. These individuals were also asked how they would rate their physical condition. 39% reported being pleased or delighted, 29% were mostly satisfied, 20% stated that they had mixed feelings (e.g. equally satisfied and dissatisfied) and 12.1% reported being mostly dissatisfied or unhappy, or thought their physical condition was terrible. With regard to emotional well-being, approximately 48% reported being pleased or delighted, 29% were mostly satisfied, 17% had mixed feelings and 6 % reported being mostly dissatisfied or unhappy.

Safety of Environment

In response to being asked if they had been a victim of a violent crime in the past year, only 3.5% replied yes. When asked if they were the victim of a non-violent crime, such as burglary, theft of your property or money, or being cheated, approximately 25% of the individuals reported that they have been a victim of this type of crime. Approximately 5% reported feeling unsafe where they live (e.g. terrible, unhappy or mostly dissatisfied); 20% reported mixed feelings—equally happy and unhappy; 75% reported being satisfied, pleased or delighted.

Community Tenure

A primary positive outcome for Class Members may be measured by the length of their community tenure once discharged from an IMD. Because transition to community living is an on-going process for Williams Class Members, the length of time that individuals reside in the community at this point is a rolling number. The data presented in the table below displays the unduplicated count of Class Members who have resided in the community for a number of days ranging from less than a month to over a full year. The summary below does not include the 36 individuals that were readmitted to an IMD after discharge.

Length of Stay in the Community after IMD Discharge		
Number of Days In The Community	Number of Class Members	% Total Number of Class Members
1 to 30	42	10.77%
31 - 60	43	11.03%
61 -90	34	8.72%
91 - 120	42	10.77%
121 - 150	44	11.28%
151 - 180	75	19.23%
181 - 210	38	9.74%
211 - 240	11	2.82%
241 - 270	25	6.41%
271 - 300	22	5.64%
301 - 330	6	1.54%
331 - 360	5	1.28%
>360	3	0.77%
Total Number of Class Members	**390**	**100%**

Critical Incidents

DHS/DMH contracted agencies providing transition coordination and services to Class Members are responsible for reporting critical incidents that occur to individuals to whom they are assigned by the Division of Mental Health. Critical incidents reported occurred while Class Members were still residing in IMDs as well as after individuals transitioned to community living. Thus far, critical incidents have been reported by 11 agencies. A total of 234 incidents have been reported for 135 individuals.

Type of Incident Reported

The type of incidents and associated number of these incidents are presented in the table below.

Type of Incident	Number	Percent of Total
Psychiatric	89	38.03%
Medical	73	31.2%
Criminal Activity	30	12.82%
Other	12	5.13%
Substance Abuse	11	4.7%
Housing	7	2.99%
Accident	5	2.14%
Deceased	4	1.71%
Missing	3	1.28%
Total	**234**	**100%**

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 were participating in criminal activities. Four individuals died after they had transitioned to the community. These deaths have been the subject of root cause analyses to determine the ultimate cause of the death.

The number of critical incidents for Class Members ranged from 1 to 8 as displayed in the table below. The majority (63.7%) of individuals for whom critical incidents were reported experienced only one critical incident.

# of Critical Incidents	Unduplicated Class Member Count	Percentage of Total
8	1	0.74%
7	1	0.74%
6	1	0.74%
5	4	2.96%
4	6	4.44%
3	9	6.67%
2	27	20.00%
1	86	63.70%
Total	**135**	**100.00%**

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. The Permanent Supportive Housing activities listed below occurred during the time period covered by this report:

- On April 17, 2013 the State received Department of Housing and Urban Development (HUD) Approval of its Coordinated Remedial Plan for a streamlined process by which Public Housing Authorities can request HUD approval of preferences for Olmstead Class Members, Money Follows the Person (MFP) enrollees, and persons transitioning from State Operated Developmental Centers (SODC). This Approval grants prior Civil Rights approval to preferences adopted voluntarily by Public Housing Authorities to allow Olmstead Class Members and other defined populations to be referred for available public housing assistance either in the Housing Voucher Program, existing Public Housing Units or units subsidized by Public Housing Authorities with Project Based Vouchers.
- In February, 2013 a training was conducted for the Williams agency Housing Locators on:
    - Methods for identifying scattered site housing options and sources to search for unit availability including the state funded web search engine IL Housing Search Caseworker Portal and housing resources made available through IHDA programs.
    - Techniques in Landlord negotiation regarding rents, utilities and amenities as well as providing specific content to landlords on supports that are in place to prevent evictions or to respond to critical incidents in an immediate fashion.
    - Fair Housing regulations and circumstances when reasonable accommodations can be requested and methods for requesting reasonable accommodations
- In February, 2013 Illinois was one of 13 states to successfully secure a HUD 811 funding award under the Frank Melville Act which will provide up to 825 project based rental subsidies for a term of twenty years in developments where not more than 25% of the units are assisted with Section 811 Project Rental Assistance Demonstration rental subsidy. In addition, the HUD 811 application enables Illinois to secure over 700 units from three Illinois Public Housing Authorities between 2012-2014 for Olmstead Class Members and MFP enrollees, i.e., the Chicago Housing Authority, the Housing Authority of Cook County and the Rockford Housing Authority. IHDA is presently negotiating the specific terms of the Cooperative Agreement with HUD regarding implementation of Section 811 assistance and it is anticipated that further information on the availability of Section 811 rental subsidies to Williams Class Members will be published in the next semi-annual report. It is reasonable to predict that Section 811 units will become available in the fourth quarter of 2013 or the first quarter of 2013 depending on the pace of the HUD rollout of the program.
- Outreach efforts continued to developers, landlords and service providers to expand the Statewide Referral Network.
    - The State Housing team collaborated with a community mental health agency located in the south suburbs to host a "Meet and Greet" for local landlords to familiarize them with the Williams initiative and the benefits it offers to landlords which include secure rental subsidies, a rich array of community based services

as well as mechanisms for landlords to obtain support in the event of a critical incident.
    - 19 training presentations on the Williams Consent Decree and Bridge Subsidy were delivered to landlord groups. These presentations allowed DMH to concentrate on geographic areas that have been identified as being desirable to Class Members, to understand better the available housing stock in those areas and to address any concerns or questions those landlords may have.
- Meetings were facilitated between landlords, developers and community mental health agencies to promote the development of Permanent Supportive Housing units through the rehabilitation of existing housing stock as well as new construction.
- A training was developed and presented by CSH, Illinois Housing Council, Metropolitan Planning Council and the GO to help current and prospective projects prepare upcoming applications to IHDA and focused on the need for service partnerships for supportive housing and State Referral Network processes and performance.
- The Williams Housing Locator Technical Assistance initiative was developed to promote consistent communication between DHS/ DMH Statewide Housing Coordinators, Corporation for Supportive Housing, the Governor's Office Statewide Housing Coordination Team and community mental health agency Housing Locators. Housing Locators are community mental health agency staff designated to assist transition coordinators with the housing location component of the transition process. Housing Locators are expected to initiate contact and sustain relationships with landlords in the geographic areas served by their respective agencies and to be referral sources for housing choices for Williams Class Members. Bi-weekly teleconferences are conducted primarily to address current housing supply and tenant selection issues. Housing Locators utilize the calls to describe the issues they are facing in the housing location process which often include a) difficulty identifying Permanent Supportive Housing in certain geographic areas, b) difficulty finding housing for Class Members who have criminal backgrounds and/or adverse credit histories, and c) landlords who unlawfully discriminate against Class Members. During the time period covered by this report, direct outreach to certain landlords resulted from housing locator reports of refusal to rent to Williams Class Members. These landlords were coached regarding the Williams Consent Decree, Bridge Subsidies, community mental health services and supports, eviction prevention strategies and landlord communication protocols.

Alternative Housing Models

While Permanent Supportive Housing continues to be the presumptive choice for Williams Class Members, DHS/DMH is exploring alternative housing models to meet the needs of those Class Members who may need or want additional skill development and support in order to feel confident in transitioning to independent living.

<u>Clustered Model</u>

A workgroup was formed from the Williams Housing Focus Forums convened quarterly by the Corporation for Supportive Housing to study "clustered housing models". The workgroup was tasked with creating a plan for a "clustered model" that serves Class Members with service needs that could better be met if a number of Class Members lived in apartments that are proximate to each other or "clustered" in a given location with no more than 25% of Class Members housed in any one location. The Corporation for Supportive Housing conducted a focus forum attended by representatives from the developer community, provider agencies and property management companies to review similar existing models and to develop such a model for Williams Class Members. A "clustered model" that would serve the needs of

Williams Class Members and effectively utilize Bridge subsidies effectively was loosely defined and the service provider was tasked with submitting a proposal to DHS/DMH that specifically defines the service model and associated costs.

Residential

Residential settings have historically not been viewed as an acceptable transitional option for Williams Class Members. DHS/DMH's estimate is that there are between 7% - 10% of Class Members who, with the best wrap around support services available, would require 24 hour onsite staff presence to ensure their safety and support in the community. This population has major skills deficits that could adversely impact their health, safety and welfare. They are at high risk for medical complications, and need constant monitoring of basic functions. These needs should not be barriers to transition from the IMD, but would preclude living in an apartment, at this time. The proposed option is to use existing vacancies in DHS/DMH funded Supervised and/or Supportive Residential settings as an interim, time limited transition resource. In such settings, Class Members can receive more individualized attention based on their recovery goals, focus on maximizing needed skills and work towards readiness to live productively in the community.

This option would have very strict criteria for admission of Class Members and utilization management protocols to ensure that once medical necessity for this level of care no longer exists, the Class Member would immediately begin the transition process with the Williams provider agency to Permanent Supportive Housing. Utilizing Residential settings as transitional options for a limited number of Class Members will afford them the opportunity to move from the IMD rather than languish in these settings due to concerns about their safety and/or the safety of the community.

PATHWAYS Illinois:

DHS/DMH is in discussions with PATHWAYS New York for the replication of this model in Illinois – a combination of Assertive Community Treatment and Permanent Supportive Housing. Meetings continue with the PATHWAYS executive team during the remaining months of FY13 to assure that they have full information on Illinois' Medicaid billable services, (specifically the service requirements for ACT) and the non- Medicaid enhanced services, i.e., Drop-In Center, Williams Quality Administrator, Transition Activities, Clinical Review and Individual Placement and Supports for accurate fiscal planning. At this time it is anticipated that PATHWAYS will create three ACT teams to serve no more than 180 Class Members. DMH has a particular interest in PATHWAYS meeting the needs of those Class Members who have co-occurring substance abuse and mental illnesses and/or criminogenic risk factors. This organization cites success with this population and is excited to pursue this opportunity.

DHS/DMH is exploring some different capitation models in its contract negotiations with Pathways New York. In addition to providing the full array of transition activities and ACT services, PATHWAYS Illinois will serve as its own Subsidy Administration entity for Permanent Supportive Housing. This responsibility includes: (a) income verification (annual re-verification), (b) execution of the HAP contract with the landlord (which commits to the subsidized portion of the rent), (c) conducting the initial inspection and annual re-inspections of the unit (using HUD's Housing Quality Standards), (d) payment of security deposits and utility connections (non-arrearage), and (e) timely payment of monthly subsidized rent amounts.
DHS/DMH will continue to work with PATHWAYS to ensure that they have all pertinent information detailing how to become an Illinois provider, as well as information on accreditation and Rule 132 Medicaid certification requirements.

PSH Rule 150
Rule 150 has been sent for Executive Review. Based on feedback from the initial review, DHS/DMH has been requested to rewrite portions of this Rule to better clarify language or incorporate more definitions. This work product is on target for completion early in FY2014.

Residential Rule
DHS/DMH's work on a Residential Rule, which was placed on hold while the State directed its resources towards the 2011 Specialized Mental Health Rehabilitation Facilities Act Rules, will be resumed in the near future.

Williams Class Member Housing Stability Maintenance
Once the Williams Class Member is transitioned into the Permanent Supportive Housing unit of his or her choice it is critical to monitor any housing related issues reported that could potentially jeopardize the Class Member's health and welfare, the Class Member's lease, his or her future ability to secure housing and/or threaten the State's relationship with a landlord who has the ability to provide Permanent Supportive Housing for other Williams Class Members. DHS/ DMH Statewide Housing Coordinators routinely conduct teleconferences with Williams Quality Administrators, the DHS/DMH Associate Deputy Director of Transition Coordination, community agency transition coordinators, Bridge Subsidy Administrators, Regional Supportive Housing Facilitators and other pertinent parties, e.g., psychiatrists, registered nurses, family members, to determine strategies to avoid further escalation of such issues. Some of these reports pertaining to housing issues stem from poor medical and/or money management, pest infestation, relationships, lack of social skills, substance abuse, predators and other negative influences.

DHS/DMH Housing Coordinators conducted approximately 90 Housing teleconferences during the time period covered by this report. As a result of these calls, 35 Bridge Subsidies were terminated: 25 Class Members returned to the NF/IMD, 5 Class Members elected to withdraw from the program to live with family members and 2 Class Members were incarcerated, notwithstanding painstaking efforts to remedy each of the Class Member's challenges.

QUALITY

Director of Licensing and Quality Management
An acting Director of Licensing and Quality Management is in place until the position is permanently filled.

Quality Monitoring
Williams Quality Monitors have conducted a total of three hundred and thirty-five (335)[4] home visits to Class Members during this period[5]. These monitoring visits serve several purposes. First, the visits are used to ascertain the Class Member's success in community transition and settlement, i.e., ability to meet basic needs; responsiveness of the provider agency to the Class Member's needs and supports; skills enhancements that are occurring post transition (money management, self-travel, etc.); housekeeping and home maintenance; socialization vs. isolation; psychiatric and medical stabilization, etc. Secondly, the visits are used to conduct the second level Quality of Life Surveys. Williams Quality Monitors have completed a total of one hundred and twenty-four (124) initial Quality of Life Surveys and sixty (60) six months post-transition Quality of Life Surveys. An analysis of the Quality of Life Surveys' frequencies can be found in the Transition Coordination/Community Services section of this report.

Williams Quality Monitors have been very instrumental as a feedback conduit to the community agencies when situations are found that require immediate follow-up and intervention. These staff serve, not only as the eyes for the State, to assure that quality of care is occurring, but as a secondary support for Class Members to assure them that there is a comprehensive network of care in the community to assist with their recovery.

Quality Monitors are also actively engaged in completing Resident Review Quality Assurance Tool surveys. This is being done to ensure that the Resident Review documentation is thoroughly completed and that required components of this tool are addressed.

During this reporting period, two Quality Monitors terminated employment with DMH. Both staff worked out of the Springfield office. These positions, with a service area of Peoria and Decatur, have been posted for rehiring. In the interim, Chicago-based Quality Monitors will conduct reviews of the Comprehensive Service Plans, meet with Class Members in their homes (or desired locations) and complete Quality of Life Surveys.

Quality Improvement Committee (QIC)
The QIC meets quarterly and serves as a vehicle for stakeholders review and recommendations on specific system performances and risk management issues. Members of the Quality Improvement Committee include consumers, family members of consumers, Class Members, community mental health center staff and representatives from DHS/DMH, HFS, IHDA, IDPH and the IMD industry.

<u>December 2012</u>
Outreach, Resident Review and Transition data were presented along with Critical Incident data. Representatives from NAMI-GC, Trilogy and Thresholds provided field perspectives regarding Outreach and Transition activities. Discussion topics were: Peer Involvement, Potential Housing Shortage North side of Chicago, Housing Retention and Public Relations.

[4] This number reflects both duplicate unduplicated counts
[5] The reporting period is from December 1, 2012 – May 15, 2013

March 2013
Outreach, Resident Review, Transition and Critical Incident data were presented. Representatives from NAMI-GC, C4 and Lake County Mental Health provided field perspectives. Discussion topics included: High Resident Review Refusal Rate, Significant Refusal Rate post referral, and Outreach Video Message.
The Division has developed strategies that incorporate the recommendations of the Committee.

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 review that can be filed by telephone, email or U.S. postal mail.

Williams Class Members filed 20 first level appeals. 18 first level appeals were regarding Resident Review findings, 1 first level appeal was regarding housing options offered and 1 first level appeal was regarding the transition agency assigned. 2 of the first level appeals pertaining to Resident Review findings were overturned in favor of the Class Members.

Williams Class Members filed 2 second level appeals: Both second level appeals were regarding Resident Review findings and in both cases the Resident Review findings were supported.

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.

Williams Class Members filed three complaints which all involved the assigned community mental health agency decision not to transition the Class Member. One of the three complaints was resolved in accord with the Class Member.

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 Coded, the Mental Health and Disabilities Confidentiality Act, the Health Insurance Portability Act (HIPPAA), and the State's administrative rules and State contracts.

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

DECISION SUPPORT/INFORMATION TECHNOLOGY

DHS/DMH continues to require DHS/ DMH contracted agencies working with Williams Class Members 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. During the past 6 months, DHS/DMH and its' Administrative Services Organization (ASO), the Illinois Mental Health Collaborative for Access and Choice, have provided intensive training in this arena to community agency staff working with Class Members to transition to the community. On-going technical assistance also continues to be provided as needed. DHS/DMH has also initiated data integrity checks to assure the validity and reliability of data being submitted for Class Members.
DHS/DMH has also designed a database to capture detailed information on the quality of life and evaluation of treatment surveys that are being administered to Class Members prior to discharge from IMDs and at six month intervals thereafter for the first year that these individuals reside in their own housing. As reported previously, DHS/DMH also continues to update and enhance several small internal databases to manage day-to-day activities of Williams Administrative staff and Quality Managers and to assure compliance with the Consent Decree.

The Department of Healthcare and Family Services (HFS) continues to remain responsible for capturing Resident Review data for Class Members in a database that their University of Illinois at Chicago (UIC) Information Technology (IT) contractor designed specifically for this purpose. UIC resident review contract staff continues to enter resident review data for the reviews that they performed into the UIC database. During the last six months, however, HFS has assumed responsibility for the database itself. HFS now houses the database and the associated code underlying the database. DHS/ DMH continues to work with HFS to obtain access to resident review raw data which is stored in the database. During the next few months, DHS/DMH and HFS will discuss the role that this database will continue to play in the capture of resident review data.

As described in the last semi-annual report, DHS/DMH has assumed responsibility for the Williams Pre-Admission Screening Process. Designated community agencies now are responsible for conducting Resident Reviews under DHS/DMH contract. These agencies are also responsible for entering the raw data and the results of the resident reviews into Word fillable forms. They had also begun the process of entering data for the reviews that they conduct into the HFS/UIC Resident Review database. The agencies and key DHS/DMH Williams staff were provided with training by the UIC database contractor to assure that understand the nuances and requirements for entering this data. However, the submission of this data to the UIC database has been placed on hold until DMH staff and DMH contracted providers performing the reviews have the ability to generate a full complete PDF copy of Class Members resident reviews. The UIC IT contractor is currently updating reporting procedures to accomplish this goal.

BUDGET

In FY13 the Illinois General Assembly appropriated $16.75 million in General Revenue funds and $20 million in Special State funds for rebalancing efforts related to the Implementation Plan. Expenditures thru May 15, 2013 include $2.3 million for administrative and operational expenses as well as $12.4 million in grant funded services. In addition, $2.87 million has been expended for Medicaid services to Class Members. By the end of FY13 it is estimated that spending will total approximately $21 million.

The Governor's introduced budget for the Department of Human Services/Division of Mental Health for FY14 includes $35.9 million in General Revenue funds and $20 million in Special State funds dedicated to expanding home and community-based services associated with the Consent Decree implementation.

OTHER PERTINENT ACTIVITIES

Brainstorming

In April 2013, DHS/DMH convened an intense two day meeting with consultants, to explore process changes and/or new strategies that could be rapidly employed to meet two primary key metrics:

- To improve the number Class Members that consent to a Resident Review assessment
  and
- To improve the number of assessed Class Members that are referred to transition by Resident Reviewers

DHS/DMH staff participated in this session across all disciplines including Community Services, Region Operations, Information System, Williams staff and executive leadership. The Williams Court Monitor, Dennis Jones, framed the process, outlining the metrics named above and the desired outcomes. i.e., measurable strategies with short-term definitive time lines.

The discussion crossed the spectrum from looking at ACT - to investigate if adjusting the ratio of staff to Class Members downward for those with greater need, thus increasing the length of time that staff can spend with Class Members producing possible better outcomes – to adding medical skill supplement (as a Medicaid benefit under Community Support). The group gave serious thought to the proposed New Service Definitions (see the Transition/Community Services section) that may include: (a) in-home non-clinical supports; (b) dual diagnosis Residential Treatment ; (c) bi-directional integrated health care for complex medical needs and (e) enhanced skills training and assistance. Also discussed was the use of existing Supervised and Supported Residential beds to make transition possible for a small percentage of Class Members who would otherwise not be afforded transition options (see the Housing section). Accompanying the discussion on strategies were the operational issues of rate and rate structure, State Plan vs. Rule changes, work force development, training and staff competencies.

The outcome of this two day process, a Work Plan with specific tasks, responsible parties and target dates was shared at the May 17, 2013 Parties meeting. The key objectives agreed are:

- 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 Class Members' Incentives to consent to a Resident Review;
- Improve efficiencies in ACT service delivery;
- Enhance training opportunities; and
- Implement Utilization Coordination to oversee and manage access to residential setting for a limited cohort of Class Members.

Medicaid Eligibility/Spend-down

The issue of sustaining Medicaid eligibility for individuals whose incomes exceed an established threshold of poverty is an ongoing challenge for the State with implications for Williams Class Members, who, in many cases, were not able to transition to the community due to their spend-down classifications. The spend-down amount serves as a "deductible" that must be satisfied before Medicaid eligibility is established. Williams Class Members require

Medicaid eligibility to access Medicaid billable services, i.e., medical care and mental health services.

As of the date of this report, HFS has identified 775 Williams Class Members, whose incomes (post IMD transition) would exceed the Medicaid eligibility threshold of $956.00. The amount of income that exceeds $956.00 establishes the spend-down amount. For Williams Class Members, these spend-down amounts range from less than $100.00 (192 Class Members) to greater than $1,000 (29 Class Members). The majority of Class Members' incomes with spend-down fall between $200.00 and $500.00 per month.

DHS/DMH initiated a Pilot project to address this issue from April 2013 to December 2013 with a full evaluation of the results scheduled for February 2014. This Pilot adjusts contracts of the Williams provider agencies so that these agencies can "advance pay" to Healthcare and Family Services (HFS) the spend-down deductible, and thereby maintain Class Members' Medicaid eligibility. HFS and DMH will jointly train Williams's providers so that they are aware of their responsibilities as authorized representative payee for spend-down, as well as their fiscal responsibility for reconciliation.

Olmstead Technical Assistance

DHS/DMH has been in discussions with the Olmstead Academy Technical Assistance consultant organization, Advocates for Human Potential (AHP), regarding training areas critical to fully meeting the needs of Williams Class Members.

It was agreed that the first training area addressed would be service delivery and support for Class Members who have co-morbid complex, medical conditions including those with co-occurring substance abuse disorders. DHS/DMH requested the services of an expert consultant in this area to develop a training module for addressing transition activities and community stability for Class Members who have complex medical needs. A series of Technical Assistance calls were held with AHP, DHS/DMH and the expert consultant to better understand our system/service needs and to develop a plan of execution. It was agreed that the consultant will visit Illinois in May 2013 to a) evaluate the medical needs of Williams Class Members and how these needs are historically addressed in an institutional setting through visits to several IMDs, b) assess how well the Williams community agencies are positioned to address these needs post transition and c) convene DHS/DMH staff to begin outlining training expectations.

Pertinent materials were provided to the consultant to prepare for this visit including a) data regarding each of the nine contracted Williams agencies, b) case records of four Class Members who were found not appropriate to transition to the community due to severe medical conditions, c) Williams training manuals, d) Medicaid Rule 132 Service Definitions and e) the Medicaid Service and Reimbursement Guide.

The second area to be addressed will be training on techniques to better serve people who have criminogenic risk factors and SMI, often with co-occurring substance abuse. As more Class Members transition to the community it is inevitable that there will be those who have extensive criminal histories. Our goal is to develop the right strategies of treatment to effectively serve this population with minimal negative outcomes to them and the community. The AHP has been instrumental in scheduling dialogue with the State of Florida, which seems to be a pioneer in specialized ACT services to a high risk, forensic population. Florida also has risk assessment tools that Illinois is interested in reviewing for possible adoption. AHP is

working to schedule both a videoconference for DHS/DMH and Florida's ACT/F (Forensic) staff as well as a site visit to assess our training needs and to begin to develop a training curriculum.

Evaluation and Services Research

The ultimate goal of the Williams vs. Quinn Consent Decree and the Implementation Plan that has been developed is to "assure that each person choosing to move from an IMD has the best opportunity for a successful transition to community living". Successful transition is multifaceted and encompasses a range of outcomes as well as a range of processes that contribute to the successful transition of Class Members. DHS/ DMH has made a commitment to monitor both process and outcomes associated with the transition process. DHS/ DMH is undertaking two strands of work with regard to evaluating the Implementation Plan and the transition of Class Members to the community. The first strand focuses on an internal evaluation process using quality, process and outcome data submitted by Williams providers as part of the submission of data required contractually by DHS/ DMH. DHS/DMH will be conducting descriptive studies of the population, as well as studies of outcomes associated with key indicators established specifically for the Consent Decree. The internal evaluation also produces data that is used to support the continuous quality improvement process and plan that has been developed for the Consent Decree. The second strand of evaluation research focuses on an external evaluation. Per the Implementation Plan, .." DHS/DMH will contract with an external research entity to evaluate the approaches used in the *Williams* Implementation Plan and provide an independent analysis". DHS/DMH is in the midst of contracting with the University of Illinois Jane Adams College of Social Work to perform this work. The external evaluation will focus on salient issues such as determining the factors that lead to the successful transition and community integration of Class Members, factors that impact Class Members decision not to engage in the transition process, and the impact of approaches to service delivery that impact the transition process and associated outcomes. This information will be used to assist the State in its planning efforts as the Consent Decree continues to be implemented.