



Division of Mental Health Williams Semi-Annual Report #7



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Division of Mental Health

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EXECUTIVE SUMMARY

This Semi-Annual Report #7 reflects the array of activities which have occurred during the State's implementation of the Williams Consent Decree during the reporting period from July 1, 2014 through December 31, 2014. We continue on a journey of evolution as we adapt our processes to ongoing challenges, working to support Class Members and assist them in maintaining community stability. Also, we are working aggressively with our State partners to assure that any changes to their systems do not have an adverse outcome on the lives and stability of those who have transitioned or will transition.

First, the roll-out of Managed Care has been a huge hurdle for Class Members and community agencies to successfully navigate as we try to insure that health care is both well coordinated and accessible. Second, we recognize the necessity to maintain avenues that stimulate open communication between the MCO vendors and the community mental health centers so that they are working on one accord, with one vision -to assure wellness and quality of life for those who have transitioned to the community.

We have actualized work products and service designs on previously introduced new concepts, such as BIP, Comparable Services, Ambassadors and Extravaganzas. We are developing services that will increase resource access for Class Members, as well as expanding and enhancing services that will divert them from front door admissions to Long Term Care facilities. We have rallied support behind Class Members who have successfully integrated into the community so that they can share messages on their personal journey of recovery and hope to others. Additionally, we have aggressively sought ways to reach those who are more reticent about their future or the paths that they may wish to undertake.

The work that the DMH has embarked upon with our sister agencies and our community partners in making these changes 'seamless undertakings' still has a way to go. However, we rise to the challenges and are committed to make living in the community a viable option for Class Members. Our efforts are dedicated to the goal that, with the appropriate level of supports and resources needed to assist them, class members will be able to live stably and comfortably in the community, with a greater degree of independence than in a long-term care facility.

The following information summarizes the progress that the State and its partners have made over the past six months in meeting the fabric of this Consent Decree for the individuals to whom we serve.

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OUTREACH AND INFORMATION DISSIMINATION

Outreach Workers

As Williams Outreach activities to Class Members entered its fourth year of operation, the momentum to aggressively share the message of hope and recovery, resilience and empowerment was more powerful than ever. The “ease” of promoting transition activities to Class Members who were both interested and invested to seek life outside of the IMDs was now overshadowed by the realities that many who remained in IMDs required a different level of encouragement and support to take the first step—opening themselves up to hear about *Moving On*. As a result, the focus of Outreach activities was redirected to that of encouragement by offering Class Members opportunities to hear from others who successfully made their personal journey towards independence.

In August 2014, DMH introduced the concept of *Moving On* Ambassadors. “Ambassadors” are Class Members who have successfully moved to the community and have expressed interest to share their stories with Class Members who are still residents of the IMDs from which they transitioned. In discussions with Outreach Workers, they thought that it would be advantageous for residents to hear from ‘friends or associates’ who shared a commonality of experiences—that of being a resident of a nursing home facility.

In preparation, Williams community agencies were requested to identify at least two to three Class Members who have successfully transitioned into community living and inquire if they were interested in serving as an Ambassador. NAMI assumed the role of primary contact with Class Members for the purpose of arranging speaking engagements for the Ambassadors to present their stories at scheduled IMD community meetings and at Drop-In Centers’ Extravaganzas. The Ambassadors’ stories were all individualized and spoken from their experience - stories about their recovery, resilience, journey in transitioning to the community, as well as their challenges, fears, and uncertainties in managing life on their own. The underlying purpose of introducing ‘Ambassadors’ during the IMD community meetings was to engage those residents who have been reluctant or unwilling to participate in any information exchange about *Moving On* or who have refused to be assessed.

To prepare for the Ambassador Community Meetings the Outreach Workers contacted the 24 IMD Administrators one month in advance and scheduled the first round of meetings for October, 2014. Flyers were made and hung at the IMDs two to three weeks prior to the meetings. To recognize the efforts of the Ambassadors in taking the time to share and speak gallantly of their experiences, each Ambassador received an honorarium of \$25.00 for his/her participation in each community meeting.

As of this writing, Outreach Workers have held one Ambassador Community Meeting at each of the 24 IMDs. The second round of meetings is scheduled for February 2015 and the third series will be held in May 2015. Approximately 580 Class Members and 36 Ambassadors have attended these meetings. Subsequently, 35 Class Members requested to be assessed at the end of those meetings. The names of these Class Members were given to DMH.

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Outreach has also assumed an active role in promoting the Williams Drop-In Centers and the Drop-in Centers "Extravaganzas". Each Drop-In Center was requested by DMH to host an "Extravaganza". This was to be the agency's own creative event with the sole purpose of reaching Class Members who had not shown an interest or desire to hear about *Moving On* or consider information about opportunities to transition. The dual purpose of the Extravaganzas was to expose Class Members to the Drop-In Centers as well as to expose them to the services and supports made available by the community agencies. The Outreach Workers attended the Extravaganzas equipped with materials, brochures, and resources. They were there to help Drop-In Center staff answer questions and to take the names of any Class Member wanting an assessment.

In July 2014, Williams Outreach Workers also developed travel guides that provided clear directions from each IMD to the Williams Drop-In Center closest to the IMD in order to encourage more residents to engage in the activities of the Centers. These travel guides were distributed to all interested residents. Also, Outreach Workers provided Class Members with brochures describing the location of all Drop-In Centers, explaining the purpose of the Centers and listing activities and events. Outreach also created a Drop-In Center Directory that lists all current Drop-In Centers, their address, hours of operation, and center coordinator name and telephone number. The underlying purpose, again, was to motivate Class Members to visit and participate in the Drop-In Centers as resources before they move into the community so that they can develop friendship ties and networking supports.

As of August 1, 2014 Outreach Workers began showing the new series of *Moving On* videos to any Class Member interested in seeing them. The new videos show Class Members in their apartments, describing their experience living outside of the IMD and working with their transition agency. Outreach Workers show the videos during their first interaction with Class Members and at community meetings at the IMDs and Drop-In Centers.

The Outreach Workers have assumed major responsibilities in several other initiatives since July 1, 2014. Outreach is working in conjunction with the UIC School of Social Work, which is conducting a study on Williams Class Members who refuse to consent to a Resident Review assessment. The Outreach Workers accompany UIC staff when they meet with Class Members to explore their reasons for refusing to consent to a Resident Review. Class Members are well acquainted with the Outreach Workers. The comfort level between the two allows Outreach workers to easily explain UIC's purpose, the intent of their work and provide an introduction to UIC staff. Also, from October through November 24, 2014, Outreach workers have aggressively worked to register Class Members, who may in the future want to live in Chicago, to the Chicago Housing Authority (CHA) Housing Choice Voucher waitlist. Residents of nursing facilities had not been afforded such an opportunity in the past, and in providing the opportunity to register, some Class Members, should their name be pulled from the lottery, will be able to receive the benefit of a tenant based permanent housing voucher.

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Quality of Life Surveys

Outreach Workers continue to complete baseline Quality of Life Surveys (QLS) with Class Members who are nearing transition from the IMDs. During this reporting period, Outreach Workers completed 85 QLSs. Outreach Workers are able to meet with Class Members outside of the IMD if the Class Member prefers. The Outreach Workers also report any incidence that is of concern or discussed while administering the QLS. One such example is in October, two of the Outreach Workers were able to file a complaint with the Department of Public Health and give support to Class Members who reported sexual abuse by a staff member at an IMD.

Outreach Activities and Contacts

In the past four and a half months, 369 Class Members signed Introductory Letters and engaged with the Outreach Workers in learning about their rights under the Williams Consent Decree and *Moving On*. Outreach Workers conducted 296 private interviews with Class Members. 2,313 Class Members approached the Outreach Workers for a 2nd, 3rd, or 4th time with questions or concerns. Approximately 85 new Class Members refused to engage with Outreach Workers when approached during this time period. 199 Class Members told Outreach Workers that they were not interested in being assessed. The names of Class Members, reasons they don't want to move and what IMD they reside in are sent to DMH on a monthly basis. Lastly, the Outreach Workers had contact with 63 guardians via telephone or in person.

Data on Class Members who refuse to engage with Outreach Workers

NAMI-Chicago Outreach Workers continue to 'in-reach' to Class Members who have been ambivalent about making a personal decision to consider *Moving On* or who have adamantly refused to engage in further discussions about the possibilities of transitioning. The following data, as captured and documented by the Outreach Workers, is an aggregate of reasons identified for refusing discussions.

Refusal Report Totals as of November 5, 2014

Total Number of Class Members – 1194 (some gave more than one answer)

Reason	# Responses	Percent
Refusing transition	673	56.4
Guardian is refusing	47	6.2
I am happy here	266	22.3
Family objects to moving	24	2.0
I am afraid because others have failed	3	0.3
Other things in my life	37	3.1
Maybe later	92	7.7
I am thinking about it	35	2.9
I want to but have not had an assessment	228	19.1
Total	1498	

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Percentage of Residents Seen as of November 5, 2014

Facility	# Beds	# Seen	Percent
Abbott House	104	178	171.15
Albany Care	385	522	135.58
Bayside Terrace	148	271	183.11
Belmont Crossing	54	91	168.52
Bourbonnais Terrace	197	289	146.70
Bryn Mar Care	170	306	180.00
Central Plaza	260	330	126.92
Clayton Residential Home	228	393	172.37
Columbus Manor Res Care	99	219	221.21
Grasmere Place	206	404	196.12
Greenwood Care	140	259	185.00
Kankakee Terrace	146	275	188.36
Lake Park Center	205	266	129.76
Lydia Healthcare Center	412	689	167.23
Margaret Manor Central	125	204	163.20
Margaret Manor North	94	246	261.70
Monroe Pavilion Health Center	136	246	180.88
Pershing Estates	134	233	173.88
Rainbow Beach Nursing Center	211	442	209.48
Sacred Heart Home	172	339	197.09
Sharon Health Care Woods	152	236	155.26
Skokie Meadows Nursing Center	111	138	124.32
Thornton Heights Terrace	220	336	152.73
Wilson Care	186	406	218.28
Total	4295	7318	170.38

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RESIDENT REVIEW

In FY15, the State partners remain committed to investigate contributing factors that may explain the disparities in percentages of positive recommendations between the two reviewing agencies. In keeping with that commitment a follow up visit was made on 8/4/14 to both Metropolitan Family Services (MFS) and Lutheran Social Services of Illinois (LSSI) to meet with the administrators and their review teams. The purpose of the meeting was to discuss the review process following a DMH training and the impact of the training on productivity numbers.

DMH completed and analyzed a random sample of 50 Resident Reviews (by agency) for Class Members not recommended for transition in September 2014. The time period covered for the sample was 01/01/14 – 07/01/14. In these reviews there were no distinguishable differences in (1) the manner that reviews are approached by LSSI and MFS or (2) the processes or decision flow leading to a determination recommendation. However, there were noted differences in how the two agencies formulated profiles of Class Members. For example: MFS focused more on brief excerpts from the past and on present symptoms and reasons to support recommendations not to transition. LSSI reflected a more rounded picture of the Class Member by integrating past and present life events, including strengths and areas needed for improvement. There were similarities in that both agencies wrote with limited detail to support critical statements. This may be a result of the lack of historical information contained in the review of the IMD records and/or difficulty gathering concrete information from the Class Members. It should also be noted that both MFS and LSSI continued to focus on Class Members limitations as opposed to documented or observed strengths that may be building blocks to transition. It is also important to note that in the areas of recommendations for further follow up there was a higher percentage of recommendations for neuropsychological testing to rule out cognitive functioning deficits within MFS recommendations (7 of 25 , 6 cognitive, 1 dementia) as compared to LSSI recommendations (2 of 25, 1 cognitive, 1 dementia). This may have some direct bearing on the characteristics of the populations served at the respective IMDs covered by the reviewing agencies and impact the rate of approval for transition.

As a means to ensure more consistency in the review process a series of recommendations were formulated and shared with MFS and LSSI for future consideration:

- 1) Reviewers should capture highlights from each section of the Resident Review Assessment along with assessment outcomes (i.e. MMSE, LOCUS, CAGE, ABC) and integrate them into the Resident Review Summary to give a snapshot of each area of the review.
- 2) When notations identifying poor ADL/IADL skills or poor insight into mental illness/ medical conditions are mentioned as barriers to transition, clarity as to whether these are skill set deficits versus skills being impacted by psychiatric symptoms would give insight into the Class Members' ability to make gains in these areas.
- 3) The Resident Review Summary should highlight the Class Member's strengths and the positive impact those strengths can play in the Class Member's road to recovery.

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- 4) A more complete picture of a Class Member’s life events, dates, frequencies and descriptions of behaviors, symptoms, and hospitalizations should be given versus the use of terms such as often, frequently, multiple, verbally or physically aggressive or symptomatic with the documentation noting when the information is limited or not available to further clarify observations or what is being reported.
- 5) Rationales as to why Class Members are not appropriate for Permanent Supportive Housing as well as other residential options should be included in the Resident Review Summary (i.e. Supported or Supervised residential settings) to illustrate that all options for possible transition were explored.

DMH continues to require LSSI and MFS to produce quarterly Performance Measure data on defined areas of productivity. The following table reflects total numbers for the current reporting period.

*Performance Measures Outcome^{1 2}

	# 1 Approached	# 2 Approached Refused	# 3 Signed Participation Agreement	# 4 Full Assessment Completed	#5 Aborted Asst'mt	#7 Recom'd for Transition	#8 Not Recom'd	#9 Staff productivity Approved	#10 Complex medical need	#11 criminal histories	#12 Staff Productivity Denied
LSSI	652	322	551	324	6	267	57	267	178	94	57
MFS	439	155	422	277	7	173	104	173	141	95	104
TOTAL	1091	477	973	601	13	440	161	440	319	189	161

Although there continue to be disparities with the percentage of positive recommendations between the two agencies, performance measure outcome data suggests that the percentage of positive recommendations continues to increase, which indicates positive transition outcomes for William Class Members. The State partners will continue to engage in weekly collaborative conference calls with MFS and LSSI in order to fine tune the review process and to trouble shoot any issues which could impede the review process. Trainings will continue to be scheduled as needed to enhance the Resident Review process.

The Division of Mental Health has also explored the feasibility of executing contracts with the University of Illinois, Departments of Psychiatry and Occupational Therapy to conduct specialized assessments on Class Members when the Resident Review outcome is the suspicion of dementia, Alzheimer’s and other brain disease or a suspicion of severe cognitive impairments that are determined as barriers to successful transition. DMH has completed and submitted all necessary paperwork for the execution of an Inter-Governmental Agreement with the University to bring these resources into fruition. Once the agreements are signed, both University Departments have indicated an estimated eight months until these assessments are completed. There are approximately 125 Class Members who will require this level of specialized assessments.

¹ Time frame from July 1, 2014 –October 31, 2014

² Data for #6 has not been omitted. Information is collected by the community agencies.

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Clinical Review

During the reporting period 84 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 84 Clinical Reviews conducted, they were all supported, i.e., in concurrence with the recommendations of the Resident Reviewers. Also, there were no appeals submitted to DMH during this period.

As the Lake County Health Department was no longer accepting referrals for transition and was no longer assuming responsibility for Clinical Review, DMH temporarily distributed the Clinical Review process for the three IMDs in Lake County to other existing Williams providers for second level reviews. In July, two new providers serving Lake County were added to the Williams roster of community agencies. DHS has contracted with Northpointe Resources, Inc., to assume Clinical Reviews in Lake County. Similarly, when Class Members express preference to live in areas where there are no existing Williams contracted agencies, these cases are distributed among the other existing Williams agencies for the Clinical Review process.

Throughout this reporting period, several quality improvement efforts were initiated to assure better management of the Clinical Review process. It came to the attention of the Clinical Review Coordinator that there were several incoming resident review referrals which were inadvertently entered into the database with the wrong codes. As a result, this gave an inaccurate account of the number of clinical reviews which needed to be conducted. However, upon reviewing the files more closely there were a large number of files which needed to be re-coded in the system. Therefore, the overall impact was an improvement in the quality and accuracy of our tracking and coding methods and a decreased number of clinical reviews to be conducted.

The Clinical Review Coordinator continues to convene weekly teleconference calls with all of the Williams agencies. During these calls, policies and procedures are continually discussed in an effort to improve the overall quality of our Clinical Review process. The calls also serve as a platform to discuss complicated issues facing a clinical review team which required feedback.

Finally, DMH issued correspondence to the Clinical Review process that mandated psychiatric consultation as part of the multidisciplinary review process when there is a recommendation not to transition due to "psychiatric crisis" situations. Subsequently, DMH acknowledged workforce issues specifically with the availability of psychiatric time, across the larger mental health system of care. As a result DMH modified this language to allow the use of other licensed professionals, APNs or psychologists, as professional consultants in lieu of a psychiatrist.

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TRANSITION COORDINATION/COMMUNITY SERVICES

The eleven (11) community mental health centers contracted to provide the full array of Williams services and the seven (7) 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. A total of 2,630 Class Members were referred to these agencies to engage and initiate transition activities, based on choice of geographic preference or provider agency. As of this date, 1095 Class Members have transitioned, have signed leases to transition or signed leases and subsequently decided not to proceed with transition.

DMH concluded negotiations and executed a FY15 contract with a consortium of two Lake County agencies. New Foundation Center assumed responsibility for hiring the Williams Quality Administrator and to develop and provide ACT services to Class Members who desire to transition from the Lake County IMDs to residences within Lake County. Northpointe Center assumed responsibility for Transition Coordination functions and conducting the Clinical Reviews. Both of these latter activities are reimbursed through a capacity grant and fee-for-service. New Foundation Center has hired its full complement of staff and has gone through extensive training with DMH. The agency is currently applying for ACT certification. In the interim, they are transitioning using Community Support.

Unable to Serve

The high profiled "Unable to Serve" list continues to be on the forefront for development of strategies to address a more challenging, complex profile of Class Members who present risk factors and safety concerns for community agencies. DMH recently had open discussions with nine states to explore their approaches or strategies to meet the needs of this population. Clearly, this issue has universal implications as states are attempting to find a workable solution for both the consumers and the agencies which are responsible for their care.

While the implementation of the Cluster Housing model had a very small impact on the overall numbers of Class Members categorized as Unable to Serve, as more and more Class Members are assessed who have transition challenges the list continues to grow. The pursuit to bring on two more Cluster Models in the upcoming months will only impact this list superficially. Nevertheless, DMH and its vendors acknowledge the problem and the need to seek a workable and logical solution that does not create high risks.

Using current compliance data for this reporting period, there are 218 Class Members (8%) who fall within this category. The chart below aggregates the categories of Class Members who have been identified as 'Unable to Serve'.

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Reasons for Unable To Serve	Count
Financial	12
Medical	41
Medical/Diabetes	20
Medication Management	33
Mental Health	100
Housing	12
Total	218

Community Tenure

An important indicator of the success in Class Members transition from the institutional setting of an IMD to the community setting of their own home is the extent to which Class Members continue to reside in these homes post IMD discharge. Eighty six percent (86%) of the individuals that have moved to the community as of November, 2014 have remained in community residential settings following their transition. The table below displays a frequency distribution showing the length of time or community tenure of Class Members still residing in permanent supported housing. While this table does not provide a conclusive picture of the extent to which Class Members will remain in the community following community transition because new Class Members are continually transitioning from IMDs, it does provide descriptive point in time information regarding the number of days that Class Members are living in community residential settings post IMD discharge. For example, the data displayed in the following table shows that approximately eight percent of the 836 Class Members for whom data was obtained have lived in their own homes for 90 days or less. An additional nine percent have remained in their own homes from 91 to 180 days, and an additional sixteen percent have between 6 and 12 months of community tenure. Slightly more than sixty six percent of class members have remained in the own homes in the community for more than a year. Of those individuals 24% are approaching two years of tenure in the community.

Community Tenure of Class Members Residing in Community Housing Post Transition from IMDs (N = 836)

Number of Days Residing in the Community	Number of Class Members	Percentage of Class Members
0 - 30	22	2.6%
31-60	21	2.5%
61-90	27	3.2%

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91-120	22	2.6%
121-150	28	3.3%
151-180	25	3.0%
181-210	25	3.0%
211-240	23	2.8%
241-270	21	2.5%
271-300	24	2.9%
301-330	20	2.4%
331-360	22	2.6%
361-390	22	2.6%
391-420	11	1.3%
421-450	31	3.7%
451-480	33	3.9%
481-510	32	3.8%
511-540	42	5.0%
541-570	42	5.0%
571-600	46	5.5%
601-630	39	4.7%
631-660	23	2.8%
661-690	34	4.1%
>690	201	24.0%
Total	836	100.0%

Characteristics of Williams Class Members Registered as of November, 2014

This analysis provides an update to previous analyses performed looking at the characteristics of Williams Class Members. As stated in previous reports, Division of Mental Health (DMH) contracted providers serving in the role of transition coordinators are contractually required to register/enroll Williams Class Members (WCMs) in the DMH Community Information System within 7 days of their initial contact with Class Members in 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 November 10, 2014 one thousand one hundred twenty-seven (1127) Williams Class Members were enrolled in the DMH Community Information System as a result of being assigned to an agency for transition coordination.

Age, Gender, Ethnicity and Hispanic Origin. Those Class Members who are registered range in age from 20 to 81 years old, with an average age of 47. Of the 1127 class members, 740 (66%) are male and 387 (34%) are female. Overall, 5.7% of class members were reported as being of Hispanic Origin. With regard to primary ethnicity, 52.9% of Class members are Black/African-American and 43.2% are

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Caucasian. A small percentage are Asian (1.5%), and a very small percentage are American Indian/Native Alaskan and Hawaiian/Pacific Islander (.5%); ethnicity was reported as unknown for 2%.

Marital Status. The majority (75%) of class members have never been married; twelve percent are divorced and another 4% are separated. Only 2.3% are married and 2 percent are widowed.

Highest Level of Education Completed. Twenty-nine percent of Class Members (29%) have earned a high school diploma and an additional 8% were reported as having earned a General Equivalency Degree (GED). Twenty-two percent (22%) of Class Members completed some high school (e.g., one, two or three years) with no diploma earned. Twenty percent (20%) have completed some college, and 5% hold a Bachelor's Degree. A small percentage (1.2%) of Class Members has completed post-secondary training and 1.0% has completed post graduate training. The highest level of education completed by approximately 3% of class members was 8th grade. Education level was not reported for approximately 10% of registered Class Members.

Residential Living Arrangement. As of November, 38% of the cohort of individuals were reported as residing in private unsupervised settings (permanent supportive housing), while 50% were reported as residing in institutional settings.

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

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

Justice System Involvement. The majority (91%) of Class Members were reported as not having any involvement with the justice system (courts, jails etc). However, .6% (n=7) had been arrested, and a very small percentage reportedly had been charged with a crime (.6%; n=7), or incarcerated in a jail or prison (.4% or 4 individuals). An additional 5 Class Members (.5%) had a status at some point of being on parole or probation. The status of 5.8% was reported as unknown at the time that the individual was registered/re-registered.

History of Mental Health Treatment. During the registration process, information is gathered regarding an individual's history of mental health treatment. Fifty-three percent (53%) have a history of continuous treatment for mental health related problems, eighty-one percent (81%) have a history of continuous residential treatment. Eighty three percent (83%) of Class Members have a history of receiving outpatient mental health services for their illnesses.

Level of Care Utilization Scale Scores Based on Assessor Recommendation. Thirty-eight percent (38%) 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-six percent (46%) were recommended for Medically Monitored Non-Residential

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Services. Six percent (6%) of Class Members were recommended for Medically Monitored Residential Services, while two percent (2%) were recommend for a Medically Managed level of Residential Services. Three percent (3%) were recommended for Low Intensity Community-Based Services, while .4% were recommended for Recovery Maintenance and Health Management. LOCUS scores were missing for approximately eight percent (8%) of the cohort.

Diagnosis. Seventy-three percent (73%) of class members had a primary diagnosis of schizophrenia and other psychotic disorders; twenty four percent (24%) were diagnosed with bipolar and mood disorders. Sixteen percent (16%) had a co-morbid substance use disorder.

Functional Impairment. The Global Assessment of Functioning (GAF) Scale (also known as Axis 5 of the DSM-IV) is used to determine functional impairment of an individual in the psychological, social and occupational spheres of their lives. The scale ranges from 1 to 100 with 1 representing lowest level of functioning or the highest level of impairment. Class members GAF scores ranged from 15 to 70 with an average of 44 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-six percent (86%) of class members were identified as having a serious functional impairment in the employment area, 82% in the financial area, 80% in Social/Group functioning and 76% in Community Living area. Sixty-two percent (62%) had a serious functional impairment in the supportive/social area, 57% in activities of daily living and 38% had a serious impairment in relation to inappropriate or dangerous behavior.

Comparison to Previous Analysis for November 2014 Cohort

The prior analysis of descriptive demographic and clinical data for Williams Class Members registered in the DMH Community Information System was performed in May 2014 for class members registered as of April 30, 2014. A comparison of the data reveals that there is very little variability in the descriptive information reported for the two cohorts.

Training Events

During the past six months, DMH convened or provided co-training to Williams (as well as Colbert) provider agencies on topics that continue to support service delivery or changes to the service delivery system of care. These trainings are listed below.

- (1) Olmstead Policy Academy Technical Assistance: Williams Collaborative Learning Institute (Dr. Carol VanderZwaag)

Dr. Carol VanderZwaag, consultant through Advocate for Human Potential (AHP), a contracted vendor of SAMHSA, initiated a Learning Collaborative Institute at the request of DMH in 2013, to address

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service challenges to Class Members who had either transitioned to the community or when in the transition process barriers exist due to complex/co-morbid medical conditions. These monthly calls continued through this reporting period exploring actual cases as Dr. VanderZwaag worked through best practice techniques and practical application to assist agencies in understanding how services could be better packaged to meet individualized needs. The contract between AHP and SAMHSA concluded in September 2014.

(2) Olmstead Policy Academy Technical Assistance: Systems Collaboration – Effective Responses to Williams Class Members with Criminal Justice Involvement (Dr. Fred Osher & Ann Marie Louison)

Dr. Fred Osher and Ann Marie Louison held a two day follow-up training for Williams provider agencies to assist the “at large” mental health network develop better collaboration with the justice system for Class Members who become justice involved. Participating partners in this training were representatives from the Chicago Police Department, Crisis Intervention Team; Cook County Adult Probation; Illinois Center for Behavioral Health & Justice and Cook County Jail. The result of these two days is a time limited, select participation group process that will conclude with well developed, functional strategies for interface. The first meeting of this group is December 4, 2014.

(3) New provider training (Northpointe Center and New Foundation)

As a result of Lake County Health Department’s decision not to expand Assertive Community Treatment, DMH elicited interest from other provider agencies in Lake County. New Foundation and Northpointe Center entered into a collaborative to provide the array of services needed to transition Williams Class Members whose interest is to reside in Lake County. Several trainings were held during this reporting period with both agencies, which included basic orientation to the Williams Consent Decree, duties and responsibilities as a transition coordination agency, the role of the Quality Administrator, Reportable Incidents and Root Cause Analysis, transition planning and collaboration with involved systems, interface approaches with IMD staff for pre-discharge and discharge planning, registration/billing/reporting and ongoing community services.

(4) PAS/MH training on Comparable Community Services

Managing the front door of long term care, including IMDs in general, is a critical factor in the PAS screening process – providing assurance that individuals who meet eligibility for this level of care need based on standard criteria may be considered as a admission candidate only if there are no community alternatives. The development of Comparable Community Services as a diversion option away from IMD/SMHRF/LTC admission is an extremely essential asset to the mental health system of care. DMH convened a training for PAS/MH agencies with the assurance that if any individual, including Williams Class Members, presents to a hospital and a recommendation is made for referral to Long Term Care, the PAS/MH agents will have available the recommended resources of Comparable Community Services for discharge planners to use as a deflection option from nursing home/SMHRF admission.

(5) Olmstead Rebalancing – MCO Training

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DMH has prioritized that Class Members must have the benefit of both ongoing mental health services and supports and necessary medical health care. With the rollout of Managed Care, it is imperative that not only the community providers have a standard process of interface with the MCO vendors, but that the MCO vendors also have information on the respective community mental health service agencies. During this period DMH, in partnership with the Department of Healthcare and Family Services and the Department on Aging hosted a three hour training for the statewide MCO vendors, with flow charts and protocols.

Service System Expansion

Budget Incentive Program (BIP)/Proposed Service Expansion

The federal Balancing Incentive Program (BIP), authorized by the Affordable Care Act, incentivizes transformation of state long-term care systems by encouraging states to shift from institutional to community-based long-term services and supports (LTSS). The purpose of the program is to improve access to non-institutional LTSS and encourage states to make structural reforms to their long-term care systems. A total of \$3 billion has been made available for distribution to states from October 1, 2012 to September 30, 2015. States that spent less than 50 percent of their total Medicaid long-term care expenditures on non-institutional LTSS during 2009 qualify to receive an enhanced Federal Medical Assistance Percentage (FMAP). Illinois qualified to earn an additional 2% FMAP from July 1, 2013 to September 30, 2015.

The federal government requires that BIP dollars be spent on new and/or expanded community-based services. Many of these services will be applicable to the Williams Consent Decree. These include:

In-Home Recovery Supports: This service will be an enhancement to the Assertive Community Treatment and Community Support Team services defined by Rule 132. It will provide intensive access to an individual with lived experience in recovery during the initial transition phase for individuals who require this additional level of support and reassurance during the transition. DHS/DMH intends to have this service available to individuals in need by January, 2015.

Peer Support Offered in Drop-In Centers: This is an expansion of a very successful service developed as a result of the Williams Consent Decree Implementation. With the addition of BIP funds, DHS/DMH has completed negotiations with two community agencies to open additional drop-in centers in early 2015. These two centers will be located in the West Loop and Hyde Park communities. There are plans to open four more drop-in centers in FY16.

Enhanced Skills Training and Assistance: This service will be an enhancement to the Assertive Community Treatment and Community Support Team services defined by Rule 132. It will provide hands-on assistance and skill development for individuals requiring a habilitative level of intervention to acquire critical basic skills for safe and successful independent apartment living. DHS/DMH intends to have this service available to individuals in need by January, 2015.

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Bidirectional Integrated Health Care for Complex Needs: This service will provide increased expertise and specialization of medical care for individuals with serious mental illnesses whose symptoms of mental illness complicate their ability to respond to medical care. BIP monies will be used to provide training to selected agencies on best practices in the integration of primary and behavioral health care, and for these agencies to hire additional nursing staff to increase their capacity to integrate primary and behavioral healthcare. A decision has been made to immediately contract with a select group of Williams provider agencies to fund an Advanced Practice Nurse position to support team services and elevate their interface with federally qualified health centers. Additionally, discussion have started with a nationally recognized consultant group to bring professional trainers to lay a foundation for the design of in-home recovery supports.

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 212 Class Members enrolled in IPS since the State's implementation of transition activities. Currently there are 91 Williams enrollees in IPS. Forty-two (42) Class Members or 20% of the Williams Class Members who received IPS Supportive Employment have worked. Twenty-one (21) of the 42 are still working.

The table below reflects the number of months of job tenure and the number of Class Members in competitive work experiences:

	Job Tenure				
	1 month	3 months	6 months	8 months	Longer than 1 year
# of Class Members	11	9	6	4	9

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 another employment.

Specialized Mental Health Recovery Support Facilities, Comparable Community Services

Five of sixteen proposals were submitted in response to a Comparable Community Services (CCS) RFI published in FY14 by DMH and were selected and offered funding. The FY14 partial year funding for these programs amounted to about \$5,262,500. The planned FY15 full year cost of these programs was to be \$13 million, however, one crisis residential project planned for the North side of Chicago could not

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move forward due to a zoning issue, reducing the total FY15 spending plan to approximately \$11,994,400. DMH continues work to secure an alternate Crisis Residential Project for the North side of Chicago.

Altogether, the CCS initiative involves 10 community providers and the operation of 30 program service projects delivering the six distinct services defined for the CCS initiative for the five target areas. Each local partnership developed those service lines they judged to be the best complement to existing public mental health service for accomplishing the challenge of creating new pathways for people who might otherwise find their way into a SMHRF level of care. Brief service descriptions for the projects funded under the Community Comparable Services initiative are as follows:

Crisis Assessment and Linkage: this service is to be provided at emergency departments within the selected service area with the intent of increasing access to lower levels of care, thus reducing unnecessary psychiatric hospital admissions.

Discharge Linkage and Coordination of Services: this service is to be provided to individuals who have been hospitalized in psychiatric beds within the selected service area and would otherwise have been referred to nursing home level of care at discharge.

Outreach to Individuals to Engage in Services: this service is to be provided to individuals who have received a crisis assessment and have a history of failed follow-through on recommended services. The purpose is to increase the likelihood of the individual or consumer receiving those services, thus decreasing the likelihood of future crisis episodes that could result in referral to nursing home level of care.

Transitional Living Centers: these centers provide immediate access to housing for individuals who are either seen for Crisis Assessment and Linkage or Discharge Linkage and Coordination of Services, and whose lack of access to housing puts them at risk of referral to nursing home level of care.

Transitional Supervised Residential: these services provide 24 hour structure and supervision within a community setting for individuals who require this level of care. The intent is to provide an alternative setting to nursing homes for discharge from psychiatric hospitalization.

Crisis Residential Program: these services are to be provided to individuals requiring 24 hour supervision due to a psychiatric crisis who can be safely managed in a non-hospital setting. The intent is to reduce unnecessary psychiatric hospitalization which could result in nursing home referral.

Since early spring 2014, the lead agency in each area has conducted regularly scheduled meetings to bring together key managers of the funded CCS service programs. Meetings have been used to overcome start-up issues, coordinate across provider or program boundaries, and find ways to integrate the newly funded CCS services into the existing local system of care. Considerable time has also been dedicated to planning in order to establish and strengthen strategic working relationships with local hospitals and, more recently, to develop or refine protocols that enhance the system's ability to intercept and re-direct individuals to the new CCS network.

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For all five CCS networks, notable progress has been made in three major areas. These are: relationships between Crisis Assessment & Linkage projects and all community hospital emergency departments (EDs) in the area; relationships between Discharge Linkage and Coordination projects and all area community hospital inpatient psychiatric units; and, relationships with the local Pre-Admission Screening (PAS) staff assigned to review level of care needs for anyone being considered for referral to a SMHRF.

Persons served

DMH has developed protocol for tracking the individuals served by these new CCS projects using its service claims database, however, some technical issues have only recently been ironed out. For the purposes of this report, provider self-reports on persons served was used as an interim measure. This means that the numbers likely contain a degree of duplication. As of this writing, the 28 operational CCS projects report to have provided a total of 1750 services to individuals since inception. The distribution by service type and area is presented in the table below.

Community Comparable Services Projects						
Area	Crisis Assessment & Linkage	Discharge Linkage & Coordination	Outreach to Individuals to Engage	Transitional Living Centers	Transitional Supervised Residential	Crisis Residential
North Chicago	28	357	331	27	n/a	n/a
South Chicago	44	93	111	18	6	n/a
South Suburbs	85	86	81	1	4	n/a
Kankakee Area	13	6	3	0	n/a	5
Decatur Area	191	256	n/a	4	n/a	n/a
All Areas	361	798	526	50	10	5

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HOUSING

Project-Based/Cluster Model Housing

In March, 2014, The Statewide Housing Coordinators (SHC) and DMH created the Williams Consent Decree pilot Clustered Housing model for persons who were previously assessed as being “Unable to Serve.” Twenty Class Members currently live in scattered site, studio-sized, supportive housing units at the Bryn Mawr/Belle Shore Apartments through individual leases. They receive Assertive Community Treatment (ACT) or Community Support Team (CST) services from Threshold’s Community Mental Health Center. Threshold maintains an office in the development that provides peer support 24-hours a day. The DMH Subsidy Administrator, Catholic Charities, entered into a Housing Assistance Payment (HAP) - like contract with Holsten Development, a private market landlord, for the 20 units (no more than 25% of units occupied by Class Members per building). Units are distributed throughout the buildings and not congregated together on one floor or section of the buildings. DMH is in discussion with two provider agencies to replicate the Cluster Housing Model. It is anticipated that we may be able to gather another 30 units, which will specifically target individuals from the Unable to Serve list. DMH currently has received one budget proposal for negotiation and is waiting for a decision from the second agencies’ Executive Staff about pursuing another site.

DMH is currently working with the Governor’s Office and the Illinois Housing Development Authority (IHDA) to identify additional housing resources to bring the pilot to scale, including units supported by the State’s newly awarded HUD Section 811 grants and in units within the IHDA development pipeline. DMH and the Statewide Housing Coordinator staff have identified potential project-based/cluster model developments on the city’s west, north and south side. One south side location is a housing development for seniors, 55 and over and has 19 Statewide Referral Network units. Many of the units are fully accessible. The owner is open to making more units available to us.

Federally Funded Housing Resources

Statewide Referral Network (SRN)

As part of the Section 811 Interagency Panel work, IHDA and the SHCs have been following up on the Panel’s assessment of some challenges with the SRN, identifying internal kinks in the system, and working on solutions in preparation for the launch of the Section 811 program. IHDA’s Asset Management department has now become quite engaged in the process to ensure good coordination and training and has just brought on a new Section 811 Coordinator to help in the effort.

In September 2014, the Housing Website Committee of the Section 811 Interagency Panel launched the “new and improved” www.ilhousingsearch.org website. A few hundred State staff and vendors benefitted from a webinar training to introduce the new features which are now fully activated for use. Also, a number of automated functions that happen behind the scenes will launch in late Fall to improve communication between IHDA and IHDA-funded developers who are supposed to maintain

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updated listings of their properties on the website and actively participate with the SRN. Additionally, the Committee continues to work with Social Serve to develop the Section 811 matching and tracking tool that will be hosted via the website and will also launch in late Fall.

Section 811

FY 2012 Section 811 Award:

IHDA and HUD have now completed the Cooperative Agreement that allows for implementation of the Section 811 program. While that was being negotiated, the four Section 811 Interagency Panel committees worked feverishly to address details of various aspects of implementing the program and to provide a useful frame for coordinating work across Consent Decrees, programs, and departments. The four committees are: Allocations, Housing Website, Training, and Public Housing Authority Resource Operationalization.

The Allocations Committee presented at the September Section 811 Interagency Panel meeting its recommended developments for Section 811 subsidy allocation Phase I. These recommendations were based on data about the geographic demand for housing by Consent Decree and MFP consumers. We are seeking to find the best match possible between the supply and demand to help ensure that the Section 811 subsidies are utilized as fully and quickly as possible. (Nonetheless, we do not expect the Section 811 program to be a solution for immediate term housing needs for a large number of our consumers.) The demand data that the committee gathered is also incorporated into IHDA's new 2015 Draft Qualified Allocation Plan (QAP) which provided points for developments that are built in communities where we have identified demand for Section 811 units. IHDA is now hard at work to obtain signed Rental Assistance Contracts (RACs) from the list of recommended developments.

To ensure that all the actors for the SRN and Section 811 programs are functioning at their best, the Training Committee is working to identify training needs and gaps. As part of this effort, the SHCs are managing a process of trying to coordinate across agencies that have training contracts with Corporation for Supportive Housing (CSH) to utilize that training resource as effectively and efficiently as possible and to figure out how to fill any training gaps that are identified.

It is clear that the HUD delays that have inhibited the State's ability to implement the program will mean that Section 811 has less near-term benefit for the Consent Decrees than might have been originally anticipated. Nevertheless, the program remains important for long-term housing infrastructure for people with disabilities across Illinois, and it should be clear that units will become steadily available, as they come online, for the consent decree populations over the next three years.

FY 2014 Section 811 application:

A 2014 Section 811 application went in to HUD in May requesting \$6.4 million for rental subsidies for 200 units. IHDA expects to hear back about award recipients in late fall of 2014.

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Public Housing Authorities

Chicago Housing Authority (CHA)

In July, 2012, the Illinois Housing Authority (IHDA) applied to HUD for Section 811 Project Rental Assistance Demonstration funding to develop housing for persons with disabilities. CHA supported this application with a commitment of 400 vouchers. CHA recently presented to its board of directors for approval, a Housing Choice Voucher Deinstitutionalization Initiative to operationalize that commitment as leverage to the Section 811 application of 400 vouchers and for an additional 200 tenant based vouchers for Williams and Colbert Class Members. Statewide Housing Coordinators and staff from IDoA and DMH have been involved over the past three years in a series of meetings with CHA to build a special admissions or preference process for Olmsted Class Members.

We are currently working to take full advantage of the opportunity to sign consumers up for CHA vouchers and units during the October 17-November 24 period during which the CHA's waiting list is open. Access to CHA resources via the newly re-opened waiting list will afford the State more public housing resources on top of the CHA's commitment to provide up to 400 units or subsidies as leverage for Illinois' initial Section 811 award.

Housing Authority of Cook County

The Housing Authority of the County of Cook (HACC) is committed to furthering Olmstead implementation by assisting Olmstead Class Members and Money Follows the Person (MFP) enrollees to transition from institutional settings into community-based living. HACC has established a preference for individuals with disabilities currently transitioning from institutional settings into community-based living. This preference will apply to up to 10% of the previous fiscal year's total LIPH unit turnover and will be given the highest priority over all other preferences in effect until the HACC reaches its targeted number of placements.

Coordinated Remedial Plan

SHCs, in partnership with IHDA, and others are beginning to create a plan to encourage other PHAs across the state to opt-in to the Remedial Plan (approved by HUD) that will allow a preference to be given to Olmstead populations. The immediate focus will be PHAs in those counties identified by the Section 811 Allocations Committee as "demand counties."

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Supervised Residential Expansion

The Williams Consent Decree clearly articulates that consenting Class Members must be afforded an opportunity to live in the community of their choice in a Permanent Supportive Housing (PSH) - Bridge Subsidy model, where the Class Member holds his/her own lease, has full rights of tenancy and receives flexible wrap-around support services, as needed. The tenant may refuse services and services are not a condition of tenancy. As DMH continues to transition Williams Class Members (WCM) out of IMDs/ SMHRFs there is clear clinical evidence that a percentage of WCMs require a level of support and 24 hour supervision that cannot be satisfied through PSH alone. DMH is addressing the need for resources that will provide an appropriate level of care for these Class Members by affording them the opportunity to move from the IMD/SMHRF to a community based supervised residential setting. In the Supervised Residential settings, WCMs are afforded 24 hour clinical staff oversight in a housing type environment that will attend to the immediate issues of living in the community safely, as well as the provision of skill training whereas the WCMs can ultimately learn and acquire the necessary daily living skills to afford them the opportunity to live independently (via PSH) in the community at some point in the future.

Currently, DMH is addressing the DHS contracting requirements in order to expand and create these resources. Using a RFI process, DMH will explore the interest and feasibility of our current pool of mental health provider agencies to develop additional supervised residential settings. Concurrently, DMH has explored potential property developers and landlords for viability of potential partnerships in identifying properties in various communities that could be quickly developed and put into use, such as existing units. The exploration with property developers and landlords looks at assessing these entities' willingness to work in a partnership to meet the needs of the WCM population, as well as, interface strategies with mental health service provider agencies to put into place the necessary level of care.

It is projected that two 10 to 12 bed Supervised Residential settings will begin the implementation phase development in February or March, 2015. The DMH mental health service provider agencies currently working with WCMs have identified a number of Class Members who could definitely benefit from utilizing this level of care as a step down and intermediate housing option until such time the Class Members are assessed to appropriate transition to PSH.

Supervised Reintegration Residential

DMH is currently conducting 'monitoring visits' to each WCM who resides in supervised residential setting to assess the individualized treatment plan in relationship to the Class Members' skill needs and progress, along with the opportunity to obtain the Class Members' perspectives and their readiness to move forward with transition to independent living. The WCMs interviewed to date demonstrate varying degrees of medical necessity requiring a supervised residential setting with most Class Members having a high degree of complex medical needs. However, all Class Members interviewed have expressed a high level of satisfaction with their living situations, whether supervised residential or scattered site Community Integrated Living Arrangement (CILA) settings. The feedback from Class Members has been positive, ranging from how much they enjoy having their own living space to how

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much they appreciate and need the support that these environments provide. Completion of all visits is expected to conclude in December 2014 with a report of findings to follow.

Housing Retreat

The Statewide Housing Coordinators are hosting a Housing Retreat on December 1, 2014. This all day event will be facilitated by Marti Knisley and Ann O'Hara from Technical Assistance Collaborative (TAC). The focus of the event is to bring together all Olmstead-based consent decree staff, Money Follows the Person staff and other departmental leadership to finalize Section 811 Implementation. The process and procedures will be determined and housing policy decisions will be made at this time.

Rule 140 – Supervised Residential Rule

As of this writing there have been no further activities initiated regarding finalization of this Rule. As reported in the Semi-Annual Report #6, DMH did reopen discussions with all trade organizations on the proposed draft Rule 140 with formal comments solicited. Responses were posted on the DMH website, <http://www.dhs.state.il.us/page.aspx?item=29751>.

Due to interruptions from multiple internal and stakeholder considerations that compromised DMH's ability to proceed, DMH advised all interested parties that the Rule would not be published until work on the rate methodology was completed. The reopening of the discussions on the rate methodology has not occurred and is not scheduled in the near future.

Rule 150 – Permanent Supportive Housing Rule

DMH was notified in early July by the Bureau of Administrative Rules and Procedures that the number used for the draft Permanent Supportive Housing Rule (Rule 150) had been given to support another Rule. The number was changed from Rule 150 to Rule 145. Thus, the new number for the draft Permanent Supportive Housing Rule is Rule 145. The draft Rule document has subsequently been changed accordingly.

In mid October 2014, DMH was asked to provide additional input on several questions raised by the Bureau's director. This information was submitted as requested. We are now waiting for a final decision on the next steps.

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

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policy discussions between DMH and housing developers, advocates, and investors with the goal of developing and leveraging quality supportive housing.

Housing Policy & Cross-Systems Partnerships

- **US Department of Housing & Urban Development**
In July, CSH met with the Special Assistant to HUD Regional Administrator Antonio Riley to discuss Olmstead implementation from HUD's perspective and implications for Illinois. CSH provided an update on the progress of Williams Consent Decree implementation.
- **Williams/Colbert Housing Focus Forum**
CSH assisted DMH with the planning and facilitation of the Williams/Colbert Housing Focus Forum in October.
- **DMH Clustered Model**
CSH convened DMH, Holsten Real Estate Development Corporation and Thresholds to assess the implementation of the clustered model. Thresholds and Holsten reported success with the model. They have identified communication strategies to ensure Class Members access housing quickly and stay housed. CSH has conducted outreach and identified potential property owners interested in an additional clustered model.
- **Cook County Bureau of Economic Development**
CSH attended the quarterly meeting of the Cook County Board of Economic Development to discuss coordination of strategic locations for new developments and possible collaborative events with mental health providers and area developers.
- **1115 Waiver Application**
Illinois is planning to implement a major Medicaid expansion that will extend eligibility by 2017 to an estimated 500,000 individuals, through a combination of "newly eligible" adults and "already eligible" clients. CSH national teams created a paper "*Creating a Medicaid Supportive Services Benefit: A Framework from Washington and Other States*". CSH Illinois distributed the paper to stakeholders in Illinois.
- **Balancing Incentive Program (BIP)**
CSH continued to participate in meetings of the Balancing Incentive Program in Springfield, which is reviewing the IDHS/HFS initiatives to expand key services with Long-Term Care Reform. CSH provided input supporting the connection of Williams' transition agency experiences and the role of housing needs as critical to identifying service needs. The work of the BIP has been folded into the scope of work of the GO-HIT (see below).
- **Governor's Office of Health and Information and Technology (GO-HIT)**
Long Term Services and Supports Definitions Sub Group (LTSS)
CSH participated in the GO-HIT LTSS Definitions Sub-Group with the goal of developing additional definitions to increase the federal Medicaid match for supportive housing.

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- Chicago Housing Authority Outreach

The Chicago Housing Authority (CHA) board approved the use of 200 Housing Choice Vouchers for the use of Class Members for the Williams and Colbert Consent Decrees. Together with the DMH, the Governor's Office Statewide Housing Coordinator and the Department on Aging, CSH met with CHA to develop a strategy to ensure Class Members have easy and clear access to the vouchers.

CSH held three webinars for the community of providers on enrolling participants in the CHA Waiting List Enrollment Period on October 30, November 4 and November 12. The webinars were attended by 90 participants.

Trainings & Presentations

- Landlord Trainings on Supportive Housing and Williams Consent Decree
CSH works closely with the DMH Housing Coordinators to deliver training presentations on the Williams Consent Decree and Bridge Subsidy directly to landlord groups. These presentations allow DMH to get a better understanding of the neighborhoods in which available housing stock is located and address any concerns or questions landlords may have. Expanding on previous trainings delivered across Chicago and other parts of Illinois, recent trainings have concentrated on where we have identified the greatest need in Chicago and Cook County. CSH delivered the following trainings to landlords:

- *Two Community Investment Corporation (CIC) Landlord Trainings, reaching 75 landlords

- *Private market landlord Serethea Matthews

- Illinois NAHRO Conference
CSH presented at two sessions at the Illinois National Association of Housing and Redevelopment Officials (NAHRO) Conference on September 7th. One presentation highlighted pathways for Public Housing Authorities to create supportive housing. The second presentation discussed establishing housing preferences, community outreach and establishing partnerships with mental health entities.
- Housing Action Illinois Conference
In October, CSH presented at the conference on how to form partnerships with developers and mental health providers with the goal of creating integrated supportive housing projects. CSH also had a table at conference and spoke with stakeholders about the Williams Consent Decree implementation process and housing needs.

CSH will present a training with DMH and Governor's Office staff on the new Money Follows the Person resources becoming available. The webinar for community provider staff will be held on December 18, 2014.

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Implementation of Bridge Subsidy Program

- **DMH Bridge Online Data System**
CSH manages, completes data entry and administers an online data tracking system for transition agencies and subsidy administrators to enter housing placement and subsidy payment tracking for individuals receiving Bridge subsidies. CSH participated in conference calls with the Collaborative, Regional Housing Support Facilitator and Housing Coordinators. As well as ensuring accurate use of the system CSH has been working extensively with DMH to clean up data entered for Williams Class Members. CSH worked with providers and state staff to update information in the system.
- **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.

Increasing Housing Availability

- CSH is working to develop three to six community profiles in locations that are near or similar to the “communities of preference” identified by Williams Class Members. The profiles build off of existing information from realtors and the Chicago Rehab Network.
- CSH is working to create project profiles of new developments coming on-line or that are already in operation with resources targeted or available to Class Members, and will be written in plain language to meet the literacy and informational needs of prospective tenants. Initial profiles are slated for Hope Springs in Springfield, The Landings of Villa Park, and Kimball Court Apartments in Homewood. All have Bridge subsidy and participate in the State Referral Network.

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REPORTABLE INCIDENTS

As reported in Semi-Annual Report #6, in May 2014, DMH modified its incident reporting process into three distinct levels noted below:

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 reporting period July 1, 2014 – November 13, 2014 the total number of reportable incidents (385) were categorized according to the three levels as follows.

Level I: 26 6.8%

Level II: 327 84.9%

Level III: 32 8.3%

Data compiled between July 1, 2014 and November 13, 2014, reflects that 204 Class Members accounted for a total of 385 reportable incidents. Ninety-one (91) Class Members accounted for two (2) or more Reportable Incidents. During this reporting period there was one death reported. A Root Cause Analysis was completed on this death and an autopsy has been requested.

The below table shows the distribution:

Unduplicated Count of CMs	# Incidents	Total Incidents	Percentage
113	1	113	29.35
48	2	91	24.94
27	3	81	21.04
7	4	28	7.27
1	5	5	1.30
3	6	18	4.68
2	7	14	3.64
1	9	9	2.34
1	10	10	2.60
1	11	11	2.86
204		385	

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The Division of Mental Health is in discussion with the University of Illinois, School of Nursing to conduct Mortality Reviews for the Williams level I Reportable Incidents that result in a death. The School of Nursing has also agreed to conduct retrospective reviews of the previous deaths, since inception. DMH is finalizing necessary paperwork and will work with the Department on Aging (Colbert) and Healthcare and Family Services (MFP) to determine the contracting mechanism with the University.

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QUALITY MANAGEMENT/QUALITY MONITORING

Quality Monitoring

Staffing and operation of the Quality Management unit has been consistent since the last report. There have been no changes in personnel or in the monitoring procedures. Eight quality monitors are assigned to the Chicago metro area. Two quality monitors are housed in Pekin Illinois to facilitate the monitoring of services to Class Members in Peoria, Decatur and the surrounding areas.

As they carry out their monitoring duties, the Quality Monitors' role as communication facilitator continues to evolve. Up to this point Class Members have had multiple contacts with the monitors and many have used these contacts to seek additional assistance, as well as resource supports from the community at large. In these instances the monitor becomes the conduit that funnels information back to the service provider. We stress the fact that monitors do not assume the role of service provider nor do they interfere with the relationship between the service provider and the Class Member.

There are a growing number of Class Members that are "aging out" of the monitoring process. After the 18th month visit the monitor's interaction with the Class Member ends. In some instances the monitor may feel that unresolved issues call for an extended monitoring period. In such cases, a request to extend the monitoring visits is submitted to the Associate Deputy Director of Transition Coordination. If approved, the Associate Deputy Director of Transition Coordination and the monitor agree on the timing of the next visit.

What is apparently critical is the feedback that DMH receives from the Quality of Life Surveys conducted by the Quality Monitors. Quality Monitors provide another level of support which then validates the inclusion of wrap around services for Class Members living in the community. The feedback obtained by the Quality Monitors on the Quality of Life Surveys provides a barometer on the care and services received by Class Members, as well as their wellness and quality of life in the community. During this reporting period, the Williams Quality Monitors completed sixty-seven (67) 6 month surveys, eighty (80) 12 month surveys and one hundred eight (108) 18 month surveys.

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BUDGET

Final spending for FY14 included \$18.4 million in grant funded services as well as \$8.6 million for Medicaid services to Class Members. In addition, administrative and operational expenditures totaled \$3.5 million.

In FY15 the Illinois General Assembly appropriated \$35.7 million in General Revenue funds and \$20 million in Special State funds dedicated to expanding home and community-based services, and other transitional assistance costs associated with the consent decree implementation. Of the \$20 million in Special State funds, DMH has budgetary approval to spend \$6 million. Expenditures thru October, 2014 include \$0.9 million for administrative and operational expenses as well as \$9.7 million in grant funded services. In addition, \$1.2 million has been expended for Medicaid services to Class Members. By the end of FY15 it is estimated that spending will total approximately \$41.7 million.

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CALLS, COMPLAINTS, GRIEVANCES, APPEALS

Calls

Between the dates of July 1, 2014 through November 1, 2014, there were a total of twenty-four calls to the Williams Call Line. Twelve calls were directly from Class Members seeking status updates on assessments/reassessments, transition, requesting an appeal or follow-up by a community agency. One call was received from a family member of a Class Member, seeking general information about the Consent Decree; and eleven calls were received from other interested parties for general information.

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 period.