Williams V. Quinn
Case No. 05-4673
(N.D. Ill.)

Interim Report to the Court

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Williams Court Monitor
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I. Scope of Report

This Interim Report to the Court describes the State's level of compliance at the end of Year Four (June 30, 2015) of the overall five year compliance schedule as outlined in the Williams Consent Decree. As in prior Reports, the Court Monitor will document current compliance status and describe compliance initiatives over the past six months (January 1, 2015 – June 30, 2015). The Court Monitor will also discuss systems issues that impact overall systems compliance. By direction of the Court, the Court Monitor will also present a review of the comparative costs of IMDs vis a vis community living.

II. Assessment of Current Status and Year-to-Date Compliance for Year Four

A. Outreach to IMD Class Members

DHS/DMH continues its contract with the National Alliance for the Mentally Ill of Greater Chicago (NAMI-GC). NAMI-GC continues to play a vital role in connecting with all new IMD admissions, providing specific information to interested Class Members, following up with Class Members who have previously declined and helping to support members during the transition phase. The Outreach workers also perform the initial Quality of Life Survey.

DMH continues to pursue a variety of initiatives to inform and encourage Class Members regarding community living options. Among the most promising are:

1) Engagement Teams – This suggestion came from the independent consultant whose report was discussed (and attached) to the January 7, 2015 Monitor's Report to the

Court.[1] DMH has moved to operationalize this concept. The basic concept is to have a small "Engagement Team" made up of Williams Ambassadors (Class Members who have moved out of IMDs), Outreach workers and staff of a community mental health provider who could provide services. The goal – on a pilot basis – is to engage ambivalent Class Members on a more intensive basis – providing opportunities to visit community settings and be clear about how supports actually work. This is a very promising new initiative by DMH.

2) Guardians Meeting – Due in part to the limited information that many guardians have about the Williams Decree, some guardians have opted not to permit their wards to take advantage of opportunities afforded them under the Decree. NAMI-GC hosted a special meeting in March 2015 for guardians of Class Members. The intent was to share information and answer questions guardians might have about Williams – with a variety of State staff, Ambassadors, Plaintiffs counsel and providers available. Despite eight commitments to attend, only one guardian showed up. Another effort will be made this summer.

[1] The consultant, Elizabeth Jones, found that outreach efforts were not providing a sufficiently intensive and individualized approach to enable many class members to make an informed decision about transition to the community. The consultant also noted that some IMDs limited access to Class Members by outreach workers; that outreach workers' limited time in the IMDs undermined their effectiveness; that some Class Members' who "refuse" to participate in Resident Reviews may actually wish to leave the IMD but require additional support to do so; and that delays in the transition process have diminished Class Members' interest and confidence in leaving the IMDs. Elizabeth Jones, Report to the Court Monitor (Dec. 9, 2014), at 5-7.

3) Increased Presence in IMDs – The NAMI-GC schedules have been rearranged so that Outreach workers are in each IMD on a more regular basis.

4) Role of Ambassadors – The Outreach workers are including Ambassadors at community meetings – some held at IMDs and some at Drop-In Centers. Over 1,100 Class Members have attended these meetings with approximately 60 Class Members requesting a Resident Review as a result of what they heard.

5) Focus Forums – In December 2014, 23 Class Members who had transitioned were asked to participate in a full day focus forum. These discussions were highly interactive and productive. The participants had multiple recommendations including the need for IMDs to provide for active skill development for Class Members. There was also strong support for the role of Ambassadors in helping Class Members understand the process and the positives of living more independently. Specific areas that could encourage interest in moving included, for example, money management, employment and voluntary/socializing opportunities.

In terms of compliance, the Court Monitor continues to find State Defendants in general compliance as relates to Outreach. DMH has continued its efforts to explore new and creative ways to engage Class Members. The Engagement Team shows real promise for those individuals who are ambivalent and/or fearful of what life outside of an institution may mean. The NAMI-GC Outreach staff have been a consistent and positive source of education and support for Class Members. Throughout all of the focus forums and consultations, the most powerful source of credibility comes from Ambassadors – peers who have been

down the transition path. It will be critical for DMH to continue and broaden the role of Ambassadors as Year Five begins.

B. Resident Reviews

DMH continues to contract with Lutheran Social Services of Illinois (LSSI) and Metropolitan Family Services (MFS) to conduct all of the Williams-required Resident Reviews. As of June 23, 2015, a cumulative total of 5,480 Resident Reviews have been completed, with 63.2% referred to transition. Once the reversals of Resident Review recommendations by the Clinical Review Team (CRT) (16% of all negative Resident Review recommendations) and successful class member appeals are included, the overall positive recommendation rate is 70%. This compares to a 67% total rate at the time of the January 7, 2015 Report to the Court.

The current Amendments to the Williams Implementation Plan (finalized on July 17, 2014) contain several requirements to enhance the Resident Review process. The current status of the major requirements is as follows:

- 90-day Re-approach – This requirement applies to Class Members who refuse a review but indicate they might be interested in the future. DMH (via the Resident Review providers) has fully implemented this requirement. The Participation Agreement with Class Members is explicit that any Class Member who expresses potential future interest will be re-approached within 90 days and also makes clear that receiving a Resident Review does not commit a Class member to ultimately move.
- Neurological/Diagnostic Evaluation – This commitment applies to approximately 125 Class Members who, as a part of the initial Resident Review evaluation, are found to exhibit potential dementia, Alzheimer's disease or other

cognitive impairment. The State's intent is to provide these additional specialized evaluations via an Intergovernmental Agreement (IGA) with the UIC Department of Psychiatry and Occupational Therapy.

At this point, the Occupational Therapy IGA has been fully executed. The Neuropsychological Assessment IGA has also been recently finalized. Both of these IGAs will take 6-8 months to implement once executed.

- Independent Psychiatric Review – This issue relates to Class Members who have received a negative community recommendation due to "acute or chronic psychiatric issues." Plaintiffs' counsel contend that many of these Class Members are struggling with acute psychiatric symptoms as a result of inadequate services they receive at the IMDs. DMH has attempted to deal with this issue through the CRT process – requiring a re-evaluation within 30 days for anyone who falls into this category. The CRT process is a records review only but would include a psychiatric consultation as part of the review team. There remains concern that this response will not adequately deal with Class Members who, by virtue of inadequate diagnosis and treatment in the IMD, are thus precluded from community transition opportunities. This issue will likely carry over to FY 2016.
- LSSI and MFS Disparity Review – DMH has continued to work with the two Resident Review agencies toward ensuring maximum consistency and thoroughness of evaluations. DMH continues to do a random sample of Resident Reviews on a monthly basis and shares results with the two Resident Review entities.
- One of the major issues is to identify Class Members strengths and not just skill deficits and/or lack of clinical

insight. DMH reports progress in terms of Resident Review narratives – reflecting improved documentation of findings.

In spite of DMH efforts, the disparities between MFS and LSSI persist – with one agency at 64% positive recommendations and the other at 84%. These are essentially flat from the prior 6-month reporting period. The previously proposed enhanced training via the UIC School of Social Work IGA has not occurred due to the fact this IGA has not yet been executed. It is not currently clear if this is a viable resource for the State; no specific training efforts are currently planned. DMH continues to conduct weekly conference calls to identify issues and discuss solutions.

Overall, the Court Monitor continues to find the State in partial compliance as relates to Resident Reviews. While DMH has undertaken important efforts, the majority of these (e.g. specialized assessments, independent psychiatric reviews) have been delayed or are not fully responsive to the need. The 20% disparity in Resident Review outcomes continues to be of high concern – with no clear explanation as to this significant differential. Hopefully, ongoing sample reviews will help to narrow the gap. Further in-depth training continues to be a recommendation, given that many Resident Reviews find Class Members ineligible for transition to the community, leaving them to remain in the IMDs contrary to their wishes. The Resident Review agencies have been very open to all training opportunities.

C. Transition Coordination and Community-based Services

DMH continues to contract with eighteen (18) community agencies to serve Williams Class Members – eleven of these providing the full mix of services and seven who provide transition services

only. As of June 23, 2015, a cumulative total of 2,979 Class Members have been referred to providers; out of this total 1,312 (as of June 30, 2015) have been "offered placement", meaning that a Class Member has either physically moved to the community or has a signed lease. The gap between the total of 2,979 referred and those "offered placement" is 1,667. This number includes multiple categories – including for example, Class Members who initially wanted to move but subsequently declined (629) and Class Members who want to move but have not been accepted by the local provider ("unable to serve" with current total at 277).

Under the terms of the Decree, DMH is required to offer placement to a minimum of 1,306 Class Members by June 30, 2015. With 1,312 offered placement by June 30, 2015, DMH has once again achieved its yearly placement target. This is a commendable achievement and reflects the ongoing attention to placement issues – including explicit provider targets (by month), weekly communication with providers, periodic meetings with CEOs, and systemic attention to barriers. All of these speak to the consistent leadership and management at DMH on Williams compliance.

However, looking to year five compliance, there remain multiple challenges. The first is the 286 Class Members as of April 30, 2015 in the "unable to serve" population – a number which continues to grow month-to-month. Table 1 below delineates the major reasons that providers have indicated for their inability to serve.

Table 1

Type of Medical Incident	Prior Reporting Period April-Sept 2014	Current Reporting Period Oct-March 2015
Medical Hospitalization	57	63
Psych Hospitalization	27	35
Death	7	7
Behavior Incidents	14	16

During the past year, DMH has moved twenty (20) "unable to serve" Class Members into a Cluster Housing project. As a part of the ongoing discussion on this issue, the State had agreed to form a workgroup that would include State staff and providers to develop a specific plan to serve the rest of this population. To the Court Monitor's knowledge, this has not yet happened. Every person in the "unable to serve" population is a Class Member who has been assessed as appropriate for living in a community setting. The Consent Decree requires the State to offer this population the opportunity to move to such a setting. It is incumbent on the State to take all reasonable steps to ensure that this group of Class Members are served in community settings. It should also be noted that the State has not moved forward with the I.P. requirement to add at least two out-of-state providers to the current provider array.

The other group of growing concern are those who have declined – after initially indicating they wanted to move. The State has requested the UIC School of Social Work to analyze this population – currently at 629 and likewise continuing to grow. As with the "unable to serve" group, it is critical to understand the reasons for these declinations and to put in place a multi-faceted plan as soon as possible. One idea that has been discussed is to expand the Engagement Team model that is being piloted for Outreach. It is certainly reasonable to assume that many of the same reasons why Class Members decline to be evaluated in the first place (e.g. lack of adequate in-depth information, fear of change) could also apply once the placement is in process. As with Outreach efforts, any plan needs to build on the successful role of Ambassadors in helping Class Members to anticipate the process and likely outcomes of placement.

Overall, the Court Monitor continues to find State defendants not in overall compliance on Transition and Community Services. The State should be commended for its persistent ability to meet annual placement targets. However, as Year Five (5) arrives, (with its

100% placement requirement) it is critical that the State develop and implement specific plans as regards the "unable to serve" population, who must be given the opportunity to transition to the community under the Consent Decree. It is likewise necessary to understand the reasons for the large number of "declines" and put in place strategies that will help to understand and address this outcome for Class Members.

D. Housing

The State continues to work across agency lines to plan for and implement a complex array of housing resources and Class Member needs. The critical partners continue to be the Governor's office (Statewide Housing Coordinator), Illinois Housing Development Authority (IHDA), DMH, the Corporation for Supportive Housing (CSH) and local providers. Key elements during recent months include:

- Cluster Apartment Model – As discussed in the January 7, 2015 Report to the Court, the first major Cluster Apartment project was successfully implemented in the Spring of 2014 at the Bryn Mawr/Belle Shore Apartments. This includes a total of 20 units and is staffed on a 24/7 basis by Thresholds. All of the 20 units have been occupied by Class Members on the "Unable to Serve" list.

  In April 2015, a second Cluster Apartment model was begun at the Crandon Apartments – with staff hired by Trilogy, another comprehensive mental health provider. This initiative will include 10 units and should be fully occupied by July 1, 2015. As with Bryn Mawr, all Class Members are from the targeted "Unable to Serve" list.
- Housing Locator Supports – The Governor's office and IHDA have been working to refine and expand the capabilities of existing software via the Statewide Referral Network and Illinois Housing Search. These are computer-

based systems that attempt to match available housing units with Class Member needs – with case managers, housing locators and care coordinators regularly tracking this housing supply.

- HUD Section 811 – IHDA was recently successful in its second HUD 811 application for FY 2014 dollars. An additional $6.14 million was awarded to Illinois, which along with the 2012 award, will provide over $18 million in total to create over 900 low income housing units for Olmstead-related populations. The State agencies continue to work toward developing and accessing these 811 units for Williams Class Members as well as other Olmstead cases. Hopefully, future reports can quantify actual placement numbers under 811. A recent initiative (under the direction of the Statewide Housing Coordinator) will create a pre-screened wait list and attempt to match applicants to available 811 units.
- Public Housing Authorities – The State continues its assertive efforts to work with local Public Housing Authorities to have dedicated units for persons with disabilities. The Chicago Housing Authority, as part of the HUD 811 2012 application, committed 400 Housing Choice Vouchers (HCVs). There has been a recent series of interviews with Olmstead Class Members (including Williams Class Members) to determine potential matches. It is not yet known what the success rate will be; the good thing about Housing Choice Vouchers is that the person can transition from State bridge subsidy to federal voucher without having to move.

  The State is also working with the Housing Authorities in Cook, Decatur and Lake Counties. The common agenda is to secure designated units and then work out the specifics in matching Olmstead Class Members to available federally –

supported units. While this is a cumbersome process, it is critical as a way of maximizing federal housing resources.

- Supervised Residential Expansion – DMH had intended to expand its supervised Residential capacity during FY 2015 – targeting Class Members whom the State determines need the structure and support of a 24 hour setting, on a time-limited basis. The current status is that one provider continues to be interested – with the potential to add 9 beds in FY 2016. Another provider will add 3 supervised beds by the end of June 2015. A potential third provider pulled out for cost reimbursement reasons.
- Role of Corporation for Supportive Housing – CSH continues to be a dynamic part of the overall Permanent Supportive Housing (PSH) initiative in Illinois. CSH plays a key role in finding housing developers and facilitating dialogue with key State entities around housing development and/or utilization of existing housing. CSH also works to ensure that strong coordination exists between the housing component and necessary clinical and support services. CSH has been a leader in sponsoring multiple training events – including its annual 3-day Supportive Housing Academy – a working session for existing and potential housing partnerships. The national CSH held its first national summit in Chicago on May 11-13, 2015, with over 650 individuals attending. The Illinois CSH office moderated a session on the Illinois experience in implementing Olmstead Decrees.

  CSH has also been involved in the development of the DMH Bridge Online Data System. CSH manages the data entry and tracks housing placements and subsidy payments across all providers.

  CSH recently completed the second Consumer Satisfaction Survey for persons who have received a Bridge subsidy;

89.5% of Class Members indicated that the bridge subsidy program and supports helped them to reach their goals.

Overall, the Court Monitor continues to find the State in compliance as relates to Housing. The collaboration across agencies continues to be a strength. The State is working intently to maximize available housing units via the Public Housing Authorities and the successful federal HUD 811 awards. The Governor's office Statewide Housing Coordinator staff has been reduced to one person (originally three); this one very capable coordinator is based in Springfield and (lacking any other resource) is having to also manage the waiting list for matching federal housing units. There is a critical need for additional housing staff resources for the Chicago area.

E. Service Enhancements

The State continues to look for ways to enhance its services array through relevant federal and/or state programs. Three noteworthy efforts include:

1. Balancing Incentive Program (BIP) – This federal program encourages States to maximize community services and reduce institutional reliance for persons with long-term needs. Illinois successfully applied and is receiving a 2% enhanced federal Medicaid match for services provided through the BIP. Williams-related services include:

    a) In-Home Recovery Supports – An intensive peer-supported service for newly-placed Class Members. To date, no providers have sought authorization for this service.
    b) Drop-In Centers – DMH has completed negotiations with two providers to add Drop-In Centers in the Hyde Park and West Loop areas.

c) Enhanced Skills Training – This service will provide hands-on basic skill development for Class Members moving into independent apartments.
d) Integrated Health Care for Complex Needs – These funds will provide training on best practices in integrating primary and mental health care. It will also provide additional advanced practice nursing positions to care for persons with significant medical needs.

2. Supported Employment – The State has developed a specific supported employment initiative for Colbert and Williams Class Members. The overall goal is to significantly increase Class Member knowledge of the very successfully Supported Employed program (referred to as Individual Placement and Support (IPS)) that Illinois has in place. This plan calls for engaging a full time project manager who will oversee an employment education outreach campaign. One of the major targets in reaching Class Members are the Drop-In Centers. This plan will be monitored for its overall success in increasing the numbers of Class Members in IPS as well as their job tenure. There are currently 99 Williams enrollees in IPS.

   The Court Monitor is very pleased with this targeted employment initiative. It is the logical next step for Class Members who have successfully transitioned. The built-in supports in the IPS program are critical both for job-seeking and job retention.

3. Comparable Services – DMH continues to fund some "comparable" community crisis services to those that were authorized for the re-purposed IMDs/SMHRFs. As in past Reports to the Court, there are four multi-provider collaboratives (three in the Chicago area and one in Kankakee) plus an additional program in the Decatur area. Each of these

five areas has multiple crisis services that include some combination of crisis assessment/linkage, discharge linkage, transitional living centers, transitional supervised residential and crisis residential. Over the past year, there have been a total of 2,165 service episodes; this total is duplicated across quarters of reporting and also across types of services. The collaboratives have working relationships with 33 hospital emergency rooms and 23 inpatient psychiatric units. One of the missing data points is how many of these services directly diverted persons from entering an IMD.

The Court Monitor continues to support this initiative in terms of the array of community crisis services that are provided. Unfortunately this program was not funded at all in the Governor's introduced budget. The Consent Decree requires that by June of 2016 the State must offer any individual with mental illness placement in a community setting before admission to an IMD. In other words, by next year, the only people who should go to IMDs are those who have no desire to live in more integrated settings. As discussed in IV.A., the comparable services initiative can be a centerpiece of planning to address the "Front Door". This program should be tightened to ensure that all potential IMD admissions are first offered needed crisis services as well as connectivity to ongoing services and supports, as required by the Decree.

F. Quality Assurance

The Court Monitor has reviewed the ongoing methods by which the State monitors and measures its quality assurance system for Williams Class Members.

1. Critical Incident Monitoring – Exhibit 1 (attached to Report) shows all of the 468 Reportable Incidents for the six-month

period of 10/1/14 through 3/31/15. The three-tiered system of reporting has remained in effect:

> 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, well-being and community stability.
>
> Level III – Significant Reportable Incidents: Situations or occurrences that could possibly disrupt community tenure.

The Court Monitor, in analyses of this Exhibit and related documents, makes the following observations;

- The respective percentages of all 468 Reportable Incidents have remained generally consistent with prior periods across the three categories – with Level I at 31 of 468, or 6.6%; Level II at 400 of 468, or 85.5%; and Level III at 37 of 468, or 7.9%.
- The total number of reportable incidents for this six-month period (468) was an 8.5% reduction from the total for the previous six-month period (512). On average, there were 1,171 transitions for this report period. During this six-month timeframe, fully 80% of all Class Members had no incidents – with the other 20% having one or more reportable incidents. This 80% without any incidents is an increase from prior periods – with 72% who were incident free in the prior period (4/1/14-9/30/14).

- Fully two-thirds (312) of all reportable incidents are for unexpected emergency room and/or hospital admission. This is not unexpected given the nature of serious mental illness. However, it continues to bear further analysis as to potential provider interventions.
- There were four (4) deaths during this period, all from natural causes.

  DMH is in the final stages of contracting with the UIC School of Nursing to do independent mortality reviews. This intergovernmental Agent (IGA) will provide not only individual mortality reviews but also a retrospective review of all 17 deaths that have occurred over the four years of implementing the Decree. These 17 deaths translate into a cumulative mortality rate of 1.5% over the years of implementation of the Decree. This rate compares very favorably to the 4.6% annual mortality rate for the Illinois Money Follows the Person (MFP) program – an initiative that also moves persons from Nursing Facilities to the community. The national MFP annual rate is approximately 6%.
- DMH is still seeking to add an additional position to assist in reviewing Level I and II incidents. There is hope this will soon become a reality.
- As noted in IV.A., there have been no provisional licenses granted for the newly-constituted SMHRFs. Hence there is no basis yet for comparison of critical incidents between SMHRFs and community settings.

2. Quality Monitoring

DMH continues to utilize ten (10) Quality Monitors who conduct onsite post transition reviews of all Class Members at 30 days, 3 months, 6 months, and 18 months. The Quality Monitors report back to the providers if there are any concerns about service gaps or unmet needs. The Quality Monitors also complete all post transition Quality of Life Surveys (see III.F.3. below).

As of April 30, 2015, fully 520 persons have lived in the community for over 18 months (see III.F.4. for discussion of community tenure). This "aging out" process (in terms of Quality Monitoring) has required DMH to make exceptions to the original protocol for Quality Monitoring to end at 18 months.

In select cases based on individual need, the Quality Monitor can recommend continued Quality Monitoring visits. This exception provides an effective safeguard for Class Members whose situations require ongoing DMH oversight.

3. Quality of Life Surveys

DMH continues to administer a standardized Quality of Life Survey pre-discharge and then at 6 months, 12 months and 18 months post discharge. The Evaluation of Care Survey (a subset of the overall Quality of Life Survey) measures Class response in seven different areas – including access to care, quality, outcome, participation in treatment planning, functioning, social connectedness, and overall satisfaction. The overall satisfaction scores – as a general measure – continue to show a significant gap between Class Member satisfaction pre-transition (IMD), at 64%, and Class Member

satisfaction post transition, at 92% at 18 months post discharge.

4. Community Tenure

Previous Reports to the Court indicate that over 85% of Class Members who have moved to the community have remained there continuously; these percentages continue. There are now 567 Class Members who have been in the community for over a year and, of those, 393 who are now approaching the two-year mark. 151 Class Members have returned to an IMD from the community. Despite this overall story of success for the large majority of Class Members, it still behooves the State to analyze and understand the factors behind successful tenure and those who return to IMDs or other settings (who still retain the right to transition to the community, if eligible).

Overall, the Court Monitor finds that the Quality Assurance System continues to be robust and effective. As the population of Class Members in the community grows, it is imperative that there be adequate DMH staff to oversee and monitor Level 1 and Level II incidents. The UIC College of nursing IGA needs to be finalized soon to ensure independent mortality reviews.

G. Budget Support

The DMH budget for Williams and other rebalancing efforts for FY 2015 was $37 million, but approximately $7 million of this was utilized for housing contracts, expenses related to a different case (Colbert v. Rauner), expenses that are administered by DHS/DMH and expenses for the Balancing Incentive Program (BIP). This leaves a net Williams 2015 budget of $30.073 million – of which DMH estimates it will spend $29.3 million. The difference in

projected vs actual is primarily due to the non-expenditure for additional supervised residential beds and the offset of Medicaid expenditures by Managed Care Organizations (MCOs).

The Governor's introduced FY 2016 budget includes $57.9 million in General Revenue funds to support Williams and related Olmstead/rebalancing expenditures. This includes an assumption of 400 additional Class Members moving during FY 2016. The Illinois legislature has included this $57.9 million in its initial budget package. However, the State has recently estimated that its initial assumption of 400 Class Members was low, and that more than 400 Class Members should be given the opportunity to transition to the community. Additionally, the larger budget disagreement looms large at the time of this Report. There is currently no approved FY 2016 budget due to fundamental divisions between the Governor and the Illinois legislature. The Parties have agreed to seek judicial intervention to ensure the continued flow of funds for Williams activities.

H. Overall Williams Compliance

The State Defendants' overall compliance status has not changed over the past six months. The State remains in general compliance as relates to Housing and Outreach – with continued strategies that need to be implemented in both areas. The State is in partial compliance as relates to Resident Reviews; the large disparity (20%) in positive recommendations between the two agencies continues to be without adequate explanation. In terms of community placements, the State has met its numeric targets, but cannot be deemed in compliance until there is major progress on the "Unable to Serve" population. The FY 2016 amendments to the Implementation Plan (once fully negotiated and approved) will likely delineate specific additional action steps on multiple fronts. The looming budget crisis must be resolved in a manner that

protects the overall functioning of State government and the specific activities needed for Williams compliance.

III. Cost Comparison of IMDs and Community Services

At the request of Judge Hart, the Court Monitor has done an analysis on the comparative costs of persons living in IMDs vis a vis those living in the community. The Court Monitor put together a Cost Comparison Workgroup to assist in this task; it was comprised of key policy and finance staff from DHS/DMH and Healthcare and Family Services (HFS) and met from February through May to discuss an overall approach, gather data and analyze results. The charts below delineate the critical data points in this analysis:

Chart 1

Williams Cost Comparison - all Inclusive (589.5 Full Year Costs)

	IMD Costs					Community Setting				
	Costs While in IMD (12 months before transition) - Total Costs	Federal Portion %	State Portion %	Net State Costs (annual per person)		Costs During First 12 Months in Community - Total Cost	Federal Portion %	State Portion %	Net State Costs (annual per person)	Differential (IMD vs Community)
1. Medical Costs	$24,440,201	$883,572 (3.6%)	$23,556,629 (96.38%)	$39,963		$13,815,406	$5,974,434 (43%)	$7,840,972 (57%)	$13,776	
2. Housing and Transition Costs						$4,984,812		(100%) $4,984,812	$8,456	
3. State Supported Community Programs (e.g. Quality Administrators, Drop-In Centers)						$6,305,881		$6,305,881 (100%)	$10,697	
4. Total Annual State Costs (per person)				$39,963					$32,929	
Net Difference (annual per person)										$7,034

Chart 2				
Williams Cost Comparison - Adjusted for Part-Year Community Placements				
	IMD Costs		Community Setting	
	Net State Costs (per person)		Net State Costs (per person)	Net Difference
[1.] Medical	$39,963		$13,776	
[2.] Housing			$7,186 [5]	
[3.] State Supported Community Programs			$9,091 [5]	
[4.] Total Annual State Costs Per	$39,963		$30,533	
[5.] Net Difference Between IMD and Community (per person)				$9,910

Footnotes

1. Medical costs represent all costs paid via HFS. For IMDs, this includes both IMD payments for daily fee-for-service (or via capitated payments) and all ancillary costs. For community services, this would include primarily ancillary services.
2. Housing costs include all state payments for Bridge subsidies plus the transition costs associated with placing persons into independent settings.
3. State Supported Programs includes all non-Medicaid services paid for entirely by the State. Specifically this includes the costs for psychiatric leadership, Williams Quality Administrators, integrated health care, Drop-In Centers, and supported employment.
4. Annualized State Costs represents the net State share of costs; it does not include the federally reimbursed portion of costs.
5. Adjusted Community Costs in Chart 2 recognizes that 412 Class Members spent the entire 12 months in uninterrupted community tenure. The remaining 177 Class Members spent some portion of the year (assumed at 6 months) not in the placement settings. These disruptions could mean a return to the IMD, dropped out of contact, moved in with family, etc. These costs could not be precisely calculated so are assumed as 6 months of expense for these 177 persons.

The Court Monitor makes the following observations about the displayed charts:

1. Approach to Cost Comparison – The Court Monitor and the workgroup discussed alternative approaches to cost comparison. It was ultimately decided to look at the actual post-placement expenses for nearly 600 Class Members who were "offered placement" as of June 30, 2013. The approach was to look at 12 months of IMD costs pre-placement and 12 months of post-placement costs for the same individuals in the community.

   This approach recognizes that there are State costs associated with the administration, monitoring, and payment of both IMDs and community programs. However, it was decided that the best "apples to apples" comparison would be to look at all pre- and post-placement costs associated with a Class Member's direct care and support. For IMDs, this included the State's fee for service (FFS) or capitated rate plus all ancillary costs (e.g. medical, dental, pharmacy, etc.). On the community side, all medical ancillary costs (including mental health services) are likewise included plus the State cost for housing and transition and other non-Medicaid services (e.g. Drop-In Centers, augmented nursing and psychiatrist support, on-site Williams Quality Administrators, etc.).

2. Major Findings
   - Federal Share – As anticipated, the HFS data shows that the State is paying over 96% of the full costs for persons in an IMD. This includes both the daily rate reimbursements and ancillary costs. This compares to a 57% State share for medically-related costs for persons in the community.
   - Incremental State Costs for Community Care – The State is forced to augment both housing costs and approved Medicaid services in order to make for a sustainable and comprehensive community array of services and supports. Going forward, the State will hopefully find ways to offset some of these expenses that are totally State dollars during this review. Examples would include Section 811 federal housing vouchers and local HUD-supported units via Public Housing Authorities. On the

services side, the State could (and should) find ways to include all direct clinical supports into the Medicaid program and hence gain the 50% federal match. The proposed 1115 Center for Medical Services (CMS) statewide waiver is being reviewed by the new administration but could provide greatly expanded federal support for mental health services (and potentially even for housing supports).

- Chart 1 versus Chart 2 – Chart 1 assumes a full 12 months of costs for all 589 Class Members. It essentially measures costs for 12 months no matter what happened to the Class Member. For example, it includes $1.2 million of intermediate care costs associated with persons who return to the IMD (either more permanently or for a limited time). Chart 1 also assumes a full year of community expenses for housing and non-Medicaid community programs. Even with these costs included, there is still a positive net State cost differential of $7,034 annually for persons in the community.

  Chart 2 can be considered a sharper comparison in that State-supported community costs are assumed for only 6 months for those 177 persons who permanently (or temporarily) exited their community tenure. With this analysis, the net State differential in expense for community programs grows to $9,910 per person per year.

  Overall, it is clear that, from a cost standpoint, it is less expensive to serve Class Members in the community in terms of net State dollars. It is also clear to the Court Monitor that the State could (and should) widen this gap through expanded efforts to maximize federal participation in both housing and Medicaid.

IV. Assessment of Major Organizational Issues Relative to Williams Compliance

The Court Monitor offers the following update regarding systemic issues that directly impact both current and future compliance.

A. Development of State Policy/Practice to Offer Alternatives to Current Admission to IMDs/SMHRFs

For the calendar year 2014, there were 918 admissions to an IMD; an admission is counted for Class Members with no prior IMD admissions. This 918 total compares to 885 for the twelve-month period of July 1, 2013 through June 30, 2014. It is clear that, to date, there has been no discernible change in policy or practice as it relates to managing the "front door" into IMDs. The State's continued reliance on the IMDs, including the substantial state financial resources used to pay for IMDs, places unnecessary financial pressure on the State's ability to comply with Consent Decree requirements for Year Five, including the requirement that in 2016 all persons be offered placement in the community before placement in an IMD.

However, the DMH has put together a workgroup that has been meeting over the past several months to analyze the reasons for IMD admissions and to begin developing a community services and spending plan for consideration by the Governor and legislature (see IV.B. for further discussion). The Court Monitor is pleased with this recent planning effort on the State's part. It clearly behooves the State to begin diverting unnecessary IMD admissions (in compliance with the Consent Decree mandate) sooner rather than later. The longer the State waits, the longer the number of persons who are admitted to IMDs must then be evaluated and placed into the community.

B. State Management, Funding and Oversight of IMDs

While the new SMHRF rules are fully in place, none of the IMDs have yet applied for provisional licenses for any of the district

levels of triage, crisis, rehabilitation or transition. The Governor's introduced budget (in line with currently available revenue) did not include any FY 2016 funding for IMDs; this may explain the delays in any applications for SMHRF designation.

The Court Monitor continues to recommend that the new administration look at critical structural changes in how the IMDs/SMHRFs are managed and funded. Any restored funding for IMDs that will occur should be made a part of the DHS/DMH budget – with the inherent accountability to manage IMD admissions, role and integral connectivity to community systems. At a minimum, the State should provide supplemental funding to DHS/DMH to provide for needed community services for persons seeking admission to IMDs, as it has begun to do through the comparable services program. This would be a wise timing decision to ensure appropriate community services are available early in year five. The findings of the DMH Front Door Workgroup have been presented to the Governor's office for review. The final decision will be considered as part of the eventual budget resolution for the State.

C. Assessment of Cross-Agency Planning

The new administration has been understandably focused on the state's budget crisis and developing requisite priorities for essential State functions. Once this initial phase is resolved, it will be critical for State leaders to develop a longer term approach to the management of Long Term Services and Supports (LTSS). Other States that have done this effectively have created clear policy, funding, and accountability systems that emphasize that (with finite State resources) community systems (and resources) need to be maximized and institutional costs minimized.

D. Assessment of Leadership/Management Capacity in the Context of Overall Rebalancing

The new administration is still in the process of filling key State leadership positions. Both the Director of Healthcare and Family Services (HFS) and the recently-appointed Director of Human Services come with important backgrounds in publicly-administered human services systems – as well as experience in Illinois. During this transition period, the Governor's office has wisely chosen to keep the Interim Director of DMH in place. This has allowed for essential continuity and steady leadership during a turbulent time. As noted in the budget section, the new administration has clearly indicated that budgetary support for Williams compliance is a top priority. The Court Monitor looks forward to working with both the State's leadership team and the plaintiffs to ensure the State's compliance with the Consent Decree.

Exhibit 1

Reportable incidents level and categories reported by agencies

Reporting period from 10/1/2014 thru 3/31/2015

Agency	Level I - Critical										Level II - Serious							Level III - Significant									
	A	B	C	D	E	F	G	H	Total	%	I	J	K	L	M	Total	%	N	O	P	Q	R	S	T	U	Total	%
Alexian Center For Mental Health	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Association For Individual Dev.	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	1	0	0	0	0	0	1	2.7
Association House of Chicago	0	0	0	0	0	1	0	0	1	3.2	4	0	0	1	0	5	1.3	1	0	0	0	0	0	0	1	2	5.4
Comm Counseling Ctr of Chicago	0	1	0	0	1	1	0	0	3	9.7	35	3	0	4	0	42	10.5	0	0	0	0	1	0	0	3	4	10.8
Cornerstone Services	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Dupage County Health Department	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Ecker Center	0	0	0	1	0	0	0	0	1	3.2	1	0	0	0	0	1	0.3	0	0	0	0	0	0	0	0	0	0.0
Grand Prairie Services	0	1	0	0	0	0	0	0	1	3.2	2	0	0	0	0	2	0.5	0	0	0	0	0	1	0	0	1	2.7
Heartland Health Outreach Inc.	0	0	0	1	0	0	0	1	2	6.5	12	2	0	5	0	19	4.8	0	0	1	0	0	1	0	1	3	8.1
Heritage Behavioral Health Center	0	0	0	0	0	1	0	0	1	3.2	3	0	0	0	0	3	0.8	0	0	0	0	0	0	0	1	1	2.7
Human Resources Dev Inst. Inc.	0	0	0	0	0	0	0	0	0	0.0	6	0	0	4	0	10	2.5	0	0	0	0	0	0	0	0	0	0.0
Human Service Center	1	2	0	0	0	0	0	0	3	9.7	19	4	0	1	0	24	6.0	0	0	0	0	0	0	0	2	2	5.4
Iroquois County Mental Health Center	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Kenneth Young Center	0	0	0	0	0	0	0	0	0	0.0	8	2	0	0	0	10	2.5	0	0	0	0	0	0	0	0	0	0.0
Lake County Health Dept. MH	0	0	0	0	0	0	0	0	0	0.0	18	8	0	1	0	27	6.8	0	1	0	0	0	0	0	1	2	5.4
New Foundation Center	0	0	0	0	0	0	0	0	0	0.0	3	0	0	0	0	3	0.8	0	0	0	0	0	0	0	0	0	0.0
Presence Health	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
The Thresholds	2	0	0	5	0	2	0	0	9	29.0	144	23	0	20	2	189	47.3	5	0	6	1	0	2	0	2	16	43.2
Trilogy Inc.	1	0	0	2	0	3	1	3	10	32.3	57	3	0	4	1	65	16.3	1	1	0	0	0	0	0	3	5	13.5
Trinity Health	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
	4	4	0	9	1	8	1	4	31		312	45	0	40	3	400		7	2	8	1	1	4	0	14	37	

Unduplicated count of CMs caused reportable incidents: 242

Total reportable incidents (Level I + Level II + Level III): 468

Legends

Level I: 31 (6.6 %)

Level II: 400 (85.5 %)

Level III 37 (7.9 %)

Level I - Critical

A - Death
B - Suicide Attempt
C - Sexual Attempt
D - Physical Assault
E - Fire
F - Criminal Activity
G - Missing Person
H - Suspected Mistreatment (Abuse, Neglect)

Level II - Serious

I - Unexpected Hospital Visit/Admission
J - Nursing Facility/SMHRF (IMD) Placement
K - Fire
L - Behavioral Incident
M - Suspected Mistreatment(Exploitation)

Level III - Significant

N - Property damage/destruction
O - Vehicle accident not requiring emergency department visit
P - Eviction for non-criminal reasons
Q - Suspected mistreatment
R - Alleged Fraud/Misuse of funds
S - Eviction for alleged criminal activity
T - Missing person
U - Criminal Activity

Unduplicated Class Members: Unduplicated # of Class Members who caused total incidents. These Class Members may or may have not been transitioned during reporting period.

Total reporable incidents Total # of reportable incidents occured during reporting period.

6/8/2015