Williams v. Rauner

Case No. 05-4673

(N.D. Ill.)

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Williams Court Monitor

January 3, 2017

I. Scope of Report

This annual Report to the Court describes the State's level of compliance at the six-month point of Year Six of the original five-year compliance schedule in the Williams Decree. As in prior Reports, the Court Monitor will detail specific compliance efforts for the past six months (July 1, 2016 –December 31, 2016) and will also continue to track system issues that directly impact overall compliance.

II. Assessment of Current Status Toward Achievement of Compliance

A. Outreach to IMD Class Members

The National Alliance for the Mentally Ill of Greater Chicago (NAMI-GC) continues as the contracted agency that performs a variety of outreach services for Class Members. These include: connecting with all new IMD admissions; providing detailed information to any Class Member who has interest in a community alternative; following up with Class Members who have previously declined to participate; and supporting Class Members who are in the process of transitioning. The NAMI-GC staff also continue to perform the initial IMD-based Quality of Life Surveys (see II.F.3 Quality of Life Surveys).

For the most recent 6-month reporting period, NAMI-GC reports that there have been:

- 338 introductory letters signed
- 333 private interviews with Class Members
- 43 contacts with guardians
- 3,908 contacts with Class Members to answer questions or respond to concerns

As in the past, NAMI-GC continues to delineate the specific reasons that a Class Member has refused to participate in the Resident Review process. While the majority of those approached

have refused, there continues to be a significant number who also have some level of interest in a community option. This percentage was at 28% in the most recent period, which is lower than the prior period which was over 40%.

DMH is reviewing ways to build on the Ambassador program. One of the concrete proposals is for NAMI-GC to hire six (6) full time Ambassadors who would serve as In-Home Recovery and Support staff. This expanded role would entail working intensively with Class Members during the transition phase. This thrust is to engage during the pre-transition period and then to stay involved post-transition to help Class Members deal with specific practical issues as well as general anxieties and fears. This new initiative would be in addition to the existing 14 Ambassadors who work part time. DMH would commit to an evaluation of this new program – with the potential for expansion as demand grows.

The State has also committed to fix the issue of limiting physical access for Ambassadors in some IMDs. The State's intent is to clarify and enforce the policy that all IMDs must provide reasonable, private space for engagement opportunities by Ambassadors meeting with Class Members. The communication on this issue will be via a cross-agency (DPH, HFS and DHS) Providers Notice – augmented by individual phone calls with each IMD administrator.

In summary, the Court Monitor continues to find State Defendants in general compliance on its outreach efforts. The State's intent to expand the Ambassador program via the hiring and training of six (6) full time Ambassadors is seen as a very positive step. Clearly Ambassadors are in the best position to engage and support Class Members before, during and after transition. It is also critical that the State remove any and all barriers (e.g. physical access to natural, private conversational areas) for the existing Ambassador program. The Court Monitor also continues to believe that some Class Members require more intensive engagement in order to

make an informed choice about community living. The engagement team model (as identified in the 2015 Elizabeth Jones report) should be revisited by the State –given its overall success.

B. Resident Reviews

Lutheran Social Services of Illinois (LSSI) and Metropolitan Family Services (MFS) continue to perform all of the Resident Review for Williams Class Members. As of November 15, 2016, the unduplicated total for Class Members approved for transition was 3,762; this total includes 3,582 found eligible for transition by the Resident Review agencies, 156 found eligible after review by the Clinical Review Teams (CRT); and 24 found eligible via the appeal process. The cumulative percentage of persons who are recommended for transition after the Resident Reviews, CRT and appeal process is now at 73% – continuing the upward trend from prior periods.

1. Disparity Analysis

The Court Monitor continues to track and discuss with DMH and the Resident Review agencies the disparity in positive recommendations between the two agencies. In review of the most recent six months (April 1, 2016 – September 30, 2016) the disparity between LSSI (83% positive recommendations) and MFS (69%) is now at 14%; this contrasts with historic levels of a 20% disparity. The overall combined eligibility rate for the recent six month period is now at 77.5%; this percentage does not include Class Members found eligible through CRT or appeal overturns.

A couple of probes were performed to further test the disparity. The first was to look at the level of CRT overturns by each agency. This analysis shows that the percentage of overturns was pretty comparable – with LSSI actually

slightly higher on a percentage basis. This suggests comparability in terms of review process. The second probe was more informative. At the Court Monitor's request, MFS backed out the two largest IMDs, but located on the southside – ones that also have a reputation for taking Class Members that other IMDs refuse. With these two IMDs excluded, the MFS positive approval rate goes to 73% (from 69%). This analysis would tend to support DMH's belief that, on balance, the residents of southside IMDs reviewed by MFS may serve Class Members with more significant service needs.

2. Specialized Assessments

DHS/DMH continues its two contracts with UIC – one for Occupational Therapy and the other for Neuropsychological evaluations.

In terms of Occupational Therapy assessments, there were no new referrals during this reporting period. Of the cumulative total of 29 Class Members receiving OT assessments, 27 were recommended for community transition. Unfortunately none of these Class Members have transitioned. There were a variety of reasons given by providers; the most prevalent (11) was Class Members being categorized as "Unable to Serve." This folds into the larger "unable to serve" issues – to be discussed as part of the FY 2017 Implementation Plan status (see II.C.2.).

The Neuropsychological assessments are performed via the UIC Department of Psychiatry for Class Members who may have severe cognitive impairments or dementia. There have been 38 referrals during this reporting period, but only five of those have been completed. Of those five, two Class Members have been recommended for transition.

3. Re-Approach Efforts

   DMH continues its process of re-approaching Class Members who have previously refused to engage in the Resident Review process. These Class Members names are provided to NAMI on a monthly basis. For this reporting period LSSI re-approached 63 Class Members of whom 40 (63%) completed the Resident Review process. Of the 40 reviewed, 31 (78%) were subsequently recommended for transition and are now in the placement queue. This reinforces the importance of gently but consistently engaging with Class Members who have understandable concerns about the transition opportunity.

4. Audit of Negative Recommendations or Community Transition

   As noted earlier in this Report, the current percentage of Class Members found eligible for transition by the two Resident Review agencies is now at 77.5%. If the CRT/appeal process is factored in, the overall positive rate is approximately 80% – which is a marked increase since Years 1 and 2 of the Consent Decree. Nevertheless, there are still 1 in 5 Class Members who indicate they want to live in a community setting and are being denied that opportunity

   The Court Monitor did a randomly sampled audit of 47 denied cases. The reasons for denial fall largely into four categories:

   - Uncontrollable psychiatric symptoms – e.g. active delusions leading to unsafe behaviors
   - Aggressive behaviors – e.g. significant impulse control with frequent aggressive acts.

- Significant cognitive impairments/dementia – e.g. inability to perform basic activities of daily living.
- Serious medical symptoms – e.g. diabetes requiring insulin injections.

The Court Monitor would note that, in the mind of the Resident Reviewers, almost all of these conditions fall into the category of a safety risk – typically to the Class Member but occasionally to others. These conditions are not different in kind – only in degree – to those who are transitioning. The question remains – what to do with this population of interested but perhaps relatively more challenging Class Members.

The Court Monitor believes there is both an obligation and an opportunity to serve most of these individuals. Several thoughts/recommendations occur:

1.) Contract with an independent psychiatrist to evaluate those Class Members with uncontrolled psychiatric symptoms. Utilize the State's oversight authority to ensure attending IMD physicians work collaboratively.
2.) Utilize supervised settings for persons with dementia – as outlined in the Consent Decree.
3.) Provide additional medical support for ACT Teams serving persons with significant medical care needs.
4.) Provide additional support for ACT/CST providers serving persons with limited impulse control. Find successful models from other states.

These are not intended as an all-inclusive set of recommendations. Rather they are consistent with a range of strategies that the State needs to adopt for the remaining issues in Williams.

> Overall, the Court Monitor finds that the State Defendants continue to make progress toward compliance as relates to Resident Reviews. The Resident Review agencies have demonstrated a high level of consistency and professionalism. The most recent combined approved rate of 77.5% is at its highest point. The findings from the audit of ineligibility determinations reflect not so much a negative about the Resident Review findings as it does an under-developed community system. There needs to be an in-depth look at systemic approaches for transitioning Class Members with more significant needs who should be found eligible for transition.

C. Transition Coordination and Community-Based Services

DHS/DMH is currently contracting with 17 community mental health providers – eight (8) of which provide the full array of mental health services and nine (9) that provide transition services only.

1. Placement Targets

As of November 15, 2016, 3,762 Class Members have been approved for transition. Of this number, 1,742 have been offered placement – meaning a Class Members has moved or has signed a lease. The difference between those approved (3,762) and those offered placement (1,742) is 2,020. The major categories that make up this large difference are: 1) Persons who declined after initially opting to move (578); 2) Persons who have left the IMD and are no longer accessible (608); 3) Persons designated by provider as “unable to serve” (322); 4) Persons on “hold” due to time-limited medical, psychiatric or behavioral issues (165); and

5) Persons who are somewhere in the transition queue (413). If you include all of those Class Members who are in the transition phase, the total is 900. The ongoing concern is the length of time it takes from original positive recommendation to actual placement – with the inherent reality that Class Members lose hope.

Year Five (5) of the Williams Decree ended on June 30, 2016. The original timeline called for all willing and recommended Class Members to be moved by the end of Year Five – which is not anywhere near a reality. The State recognizes this fact, but has indicated that the maximum number of Class Members it can move in Year Six (6) is 400. Unfortunately, the pace of movements since July 1, 2016 is well below the 400 annual goal. As of November 15, 2016, 98 Class Members had been offered placement; this is a monthly rate of nearly 22. In order for the State to meet its 400 goal, the monthly pace for the remaining months will need to be 40 per month – nearly double the current rate. DMH staff have engaged in recent discussions with provider CEOs and other senior staff to understand the reasons for the shortfalls and taken active steps to improve performance.

2. Unable to Serve

The "Unable to Serve" population has been an ongoing source of discussion and legal dispute between the parties. It continues as a major element of negotiating the Implementation Plan for FY 2017. As noted earlier, this category stands at 322 Class Members as of November 15, 2016 and continues to increase month to month.

- Clinical Case Review Panels

DHS has proposed a new strategy for FY2017 to address the "unable to serve" problem. It calls for the

development of ongoing Case Review Panels. These panels would review information from providers as to what services are needed to enable community transition.

The negotiations regarding the additional functions of the panel continue. Among the questions that remain are the necessary qualifications for panel members who should have knowledge and experience regarding community living. There is also the overriding question as to the purpose of the panels which, in the Court Monitor's view, should not be to allow/justify continued non-placement but rather to explore what is needed to successfully place these Class Members. The Clinical Case Review Panels won't facilitate the transition of this population to the community, unless there are concrete recommendations as to community resources and services that are needed for a successful placement.

- Incentive Payment

DHS has also proposed a 6-month pilot funding strategy that would pay providers a case rate payment incentive for placement of those on the "unable to serve" list. It should be noted that this proposal is consistent with one of the major recommendations of consultants engaged to review this population in the spring of 2016.

At this juncture there are no specific state numeric targets for the placement of "unable to serve" during FY 2017.

3. Behavioral Health Transformation

   The State has committed to a major multi-year transformation of the behavioral health system. One of the core elements of this transformation is congruent with the Williams Decree – mainly to avoid unnecessary institutionalization for people with SMI. The State has filed an 1115 Behavioral Health Waiver with the Center for Medicare/Medicaid Services (CMS). It is, however, unclear how long this federal review (and hopefully approval) process will take.

Overall, the State is clearly out of compliance as relates to transition of Class Members. Even the 400 goal for FY 2017 does not approach the State's own determination of needed placements; even without the "unable to serve" population counted, the current number of transitions needed is at 578. If all of the "unable to serve" are included, the number is at 900.

Of further concern is that even the 400 goal of FY 2017 transitions is at serious risk – given the current pace. The "unable to serve" conundrum continues. Despite past efforts, there is no clear action plan to ensure that this group of Class Members receive the needed services to effectuate the eligibility determinations of the Resident Review process.

On the positive side, the State is to be commended for its leadership in pursuing a major behavioral health transformation in Illinois. If effectuated, this should fundamentally change the trajectory as it relates to persons with SMI ending up in long term care facilities who have no need (or desire) to be there. The problem is that compliance with the Williams Decree requires action steps now that are much more aggressive than the proposed longer term reform.

The negotiations regarding the FY 2017 Implementation Plan continue. Hopefully, the major issues, including how the state will transition Class Members in the "unable to serve" population, can be successfully resolved. The Court Monitor continues to believe that, with minor exceptions, this population can and should be served in the community..

D. Housing

The State continues its cross-agency partnership model in developing and accessing needed housing resources for Williams Class Members. The partnership continues to include the Statewide Housing Coordinator (located at DHS), Illinois Housing Development Authority (IDHA), DHS/DMH, Corporation for Supportive Housing (CSH) and local mental health providers. Among the major housing efforts are:

- HUD Section 811 – This HUD-funded initiative continues (via IHDA) to build or renovate new housing units for priority populations (including Williams). As of November 2016, there were 36 Williams Class Members on the waiting list, 16 of whom have an open offer to properties and one who has been housed.

  Over the past year, IHDA and the Statewide Housing Coordinator have continued regular individual and group trainings on using the online housing locator and waiting list tool. It is also noted that the State (via DHS) has hired a full-time Waiting List Manager to facilitate matches to 811 and also the Statewide Referral Network (SRN).

- Public Housing Authorities

  As of November 7, 2016, 104 Williams Class Members have converted from a State-funded Bridge Subsidy to a

federally-supported Housing Choice Voucher (HCV). This conversion process is ongoing and hopefully will continue to maximize federal resources to every degree possible.

The Housing Authority of Cook County (HACC) continues to commit 10% of its turnover vouchers toward the Consent Decree; this will amount to a total of 120 units. HACC has converted 33 Williams/Colbert Class Members from the Bridge Subsidy to Housing Choice Vouchers (HCV).

- Medicaid Innovation Accelerator program (IAP) – This technical assistance effort from CMS is designed to help states innovate via Medicaid-supported programs to support community-based housing services. It does not pay for new housing; rather it can help pay (via Medicaid) for the critical support services needed for people in integrated housing. The Illinois IAP team has been meeting regularly and has identified specific target areas for improving housing supports.

- Corporation for Supportive Housing (CSH)

  DHS/DMH continues its contract with CSH to perform a range of policy and training-related initiatives. Specific areas of focus during the past 6 months include:

  - Participation on the Interagency Council on Homelessness – with the goal to increase not only supportive housing but also service needs.
  - Participation in the IHDA Supportive Housing Work Group – with the development of an updated Statewide Supportive Housing Needs Report.
  - Manage the DMH Bridge Online Data System – with CSH doing all the data reconciliation and needed training for all providers.

- Actively participate in housing locator conference calls – with the goal of problem-solving specific housing searches, housing applications, and housing support issues.
- Working with DMH and the Resident Reviewers to evaluate housing needs and housing options – specifically for high-need Class Members.
- Participate with DMH on conference calls specifically to avoid a Class Member eviction due to tenancy violations.

Overall, the Court Monitor continues to find the State in compliance as it relates to Housing. The efforts to maximize federal HUD funding continues to move – with the obvious help to limited State dollars. IHDA and the Statewide Housing Coordinator continue to partner and bring energy and leadership. IHDA, via its Director, has committed to work on the whole area of landlord development as a part of its mission. This is a huge plus – especially given the critical need for more high intensity units.

E. Service Enhancements

DHS/DMH continues to explore and utilize services that are intended to improve the service array. Examples include:

1. Supported Employment – DMH has actively collaborated with the Department on Aging (Colbert Decree) to implement a new supported employment initiative for Williams and Colbert Class Members. This initiative began in October 2015 with the hiring of a full-time manager. In general the effort has been to increase education and outreach to Class Members, provide targeted training to staff about the importance of work and actively engage Class Members who are enrolled in one of the 18 Drop-In Centers.

This initiative is showing success – with noted increases in all of the key metrics. The project manager has been highly visible – connecting to the Drop-In Centers, sponsoring employment training activities and working broadly with the mental health providers to incorporate employment into an integrated care plan.

Overall, there have been 327 Williams Class Members who have enrolled in supported employment since July 2012. Of this group 98 (30%) have worked in some capacity. It is important that this initiative continue to educate staff and encourage Class Members regarding the multiple positives of a work experience.

2. Special Pilots

As part of the FY 2016 Implementation Plan, DHS/DMH initiated service pilots that were targeted toward the Front Door issues (see II.F) and the "Unable to Serve" populations (see II.c.). As regards the Front Door pilot, only one of the two planned Hospitals approached by DMH participated (St. Bernard Hospital). The outcome was that during a 3-month period, only one potential long term care patient was identified and this person was transferred to another hospital. Hence the lack of volume made this pilot unsuccessful.

There were two pilots targeted toward the "Unable to Serve" population. The Trilogy pilot was intended to work intensively with five (5) Class Members at Albany Care; of the five (5) only one Class Member transitioned. Among the reasons cited for lack of success was the lack of access by Trilogy medical staff to the primary care and psychiatric physicians at Albany Care. This issue of non-cooperation by

IMD medical staff is one of the systemic problems that must to be solved.

The second "Unable to Serve" pilot was via Thresholds. The goal was to identify and transition ten (10) Class Members off of the "Unable to Serve" list. At this time five (5) have transitioned. This pilot continues with Threshold committed to place a full 10. It will be important to analyze this pilot to identify the specific supports needed to transition the larger "Unable to Serve" population.

3. Return to IMD

One of the issues in the UIC IMD study regarding why a small percentage of Class Members return to IMDs is the need for additional training for providers. To this end the State has contracted with the UIC School of Nursing – in collaboration with the Department of Aging (Colbert). A series of training events have been developed – with a heavy emphasis on the detection and treatment on specific medical conditions e.g. diabetes.

The State has also negotiated contracts for the expansion of Assertive Community Treatment (ACT), and Community Support Teams (CST) teams. DMH has also contracted for the inclusion of medical nurses for both ACT and CST teams in order to deal with the issues of medical acuity. It is clear that the responses to the Return to IMD study overlaps very heavily with the "Unable to Serve" issue. The State must provide more intensive medical supports to complement existing ACT and CST services.

F. Front Door – Choice and Community Alternatives

As part of the ongoing negotiation on the FY 2017 Implementation Plan (I.P.), the State has created an interagency work group. DHS submitted its proposed approach to the Monitor and Plaintiffs on November 21, 2016.

The State is clearly out of compliance as relates to the Consent Decree language that states, after July 1, 2016, no one whose service plan provides for placement in a community setting will be offered placement in an IMD – unless that person declines the community option.

The State's proposal, acknowledging that it is out of compliance, is to take a stepped approach toward eventual compliance on this issue. The key element is a proposed pilot targeting 11 acute care hospitals in north and central Chicago. The intent is to contract with three (3) community providers who would be paid for both Medicaid services and non-Medicaid services. The proposed funding methodology would be somewhat flexible but with the intent to provide mobile crisis services, discharge planning and linkage to community-based services, and expansion of community-based residential options for those leaving acute care facilities who might otherwise be placed in institutional care. The intent of this pilot is to evaluate a service/intervention model – with an eye to adapting or replicating it for the entire IMD and long term care diversion effort. UIC will be engaged to do what the State envisions as a "real time" (monthly) evaluation component.

Unresolved issues surround the State's obligation to make additional permanent supported housing (PSH) resources available to individuals participating in the pilot. There is the need for clarification as to what exactly will be evaluated during and after the pilot phase. It is unclear as to how quickly this (and other)

unresolved issues will be negotiated toward a final I.P. for FY 2017.

It is also unclear at this point as to what the State will do to resolve the Front Door issue if the proposed 1115 waiver is not approved. It is critical that the Parties resolve this and other issues as part of the compliance/exit plan (see II.1.).

G. Quality Assurance

The State continues its Quality Assurance system to evaluate and monitor the overall quality of care for Williams Class Members who have transitioned to the community.

1. Reportable Incidents

Exhibit 1 (attached to the Report) shows all of the reportable incidents that occurred between April 1, 2016 and September 30, 2016. The same three-tiered process of measuring severity is used:

> 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 has reviewed this Report in detail with DMH staff as well as other quality-related reports. As relates to the Incident Report, the following is noted:

a) In comparison to the prior 6-month period, the relative percentages across the 3 categories has remained pretty consistent – 9.5% for Level I, 86.5% for Level II and 4% for Level III.
b) The total incidents for the 6 months was 526 – a decline of 53 from the prior period. When measured as a percentage of total persons transitioned, the percentage has declined from prior periods.
c) For this period, 83% of Class Members did not experience any reportable incident – with 17% (287 Class Members) having had one or more incidents. This percentage of persons without any incidents is slightly higher than prior periods.
d) As in prior periods, nearly 68% of all Reportable Incidents were due to emergency room visits and/or hospital admissions. DMH continues to track and staff these incidents with providers as part of a regular teleconference.
e) There were nine (9) deaths of transitioned Class Members during this time period. While DMH awaits the final autopsy results on eight of the nine, the initial indication is that all of these deaths were from natural causes.
f) UIC College of Nursing completed its Mortality Root Cause Analysis Report during the summer of 2016. The report indicates that, as relates to 25 cases reviewed in-depth, the majority of cases showed that the decedents were managed above average or very well. However, there were strong recommendations about ways to improve the overall medical management of Class Members. UIC specifically called for improved identification of medical symptoms

and improved coordination with medical care providers.

All of these recommendations have been reviewed/discussed with providers and are at the heart of the UIC-CON training series that is now underway.

g) DMH has (via replacement) now hired an RN as part of its monitoring team. This should strengthen the medical capacity at the State oversight level.

2. Quality Monitoring

DHS/DMH continues to employ nine (9) Williams Quality Monitors who conduct periodic on-site reviews of how well Class Members are succeeding post-transition. For the recent 6 months, there were 298 home visits for a total of 4,343 home visits since the inception of Williams.

The Quality Monitoring program is in the process of being reorganized – with the intent of maximizing staff efficiency and productivity.

DMH continues to evaluate its overall practice of doing monitoring only for 18 months. A recent special review occurred for 282 Class Members at the 21+ month level. There were enough concerns raised that DMH is continuing to look at its 18 month protocol. There will also be discussion with providers to ensure that they are knowledgeable of and responsive to Class Members who are struggling in one way or another.

3. Quality of Life Surveys (SOL)

The Quality of Life Survey process continues with the initial survey done pre-transition at the IMD and then at 6 months (up to 18 months) post discharge. As with past Reports, there was improvement noted from pre to post discharge on all seven (7) of the domains measured. The most notable areas of change in positive responses were in Quality at 77.6% (pre) and 92.6% (18 months post) and also in overall satisfaction 65.9% (pre) and 90% (18 months post).

4. Community Tenure

As of December 2016, there are now 658 Class Members (53.8% of total) who have lived in the community for over 690 days (23 months). An additional 19% are between 12 months and 23 months.

Overall, the Court Monitor continues to find that DHS/DMH has a responsive and reasonably comprehensive Quality Assurance system. The Mortality Review conducted by UIC shed light on some service areas that need attention – namely greater understanding and responsivity to medical conditions. DMH is to be commended for immediately using this report to structure a series of mandatory training opportunities that deal directly with the UIC recommendations. The addition of an RN as part of the DMH quality team will also add medical oversight capacity going forward.

H. Budget Support

The FY 2017 Introduced Budget included $35.2 million in General Revenue funds and $7.2 million in Special State funds for purposes of supporting the Consent Decree. The estimated FY 2017 expenditure is the full budget of $42.4 million. This includes an

assumption that 400 new Class Members will be placed in FY 2017.

The overall budget impasse in Illinois continues – without any resolution in sight. Providers continue to be paid for Williams services because of the ongoing Federal Court mandate to do so. However, providers do not routinely get paid for other non-Court mandated costs – resulting in a level of fiscal instability that makes needed growth all the more difficult. The budget impasse continues to threaten the State's ability to achieve compliance on Williams.

I. Overall Williams Compliance

State Defendants continue to be in general compliance as relates to Outreach, Housing and Quality Assurance. Further progress on compliance in Resident Reviews will be contingent on the State developing consistent and scaleable service systems for persons with more significant needs (e.g. chronic medical conditions). It will also require the State to take a much stronger role as relates to individual IMDs who refuse to cooperate with needed medical/psychiatric evaluations and review of current medications.

The State is out of compliance as relates to transition requirements and the Front Door diversion mandates of the Decree. Negotiations on the FY 2017 I.P. continue in good faith by the parties but it is unclear at the time of this Report whether a final resolution is possible.

The Court Monitor strongly recommends that the Defendants develop, and the Parties agree, on a timeline to develop a plan toward full compliance and exit from the Decree. At this point, there is no end point in sight. While the unresolved issues are not easy ones, nevertheless it is important to put a clear plan and timeline to achieve compliance in place.

III. Assessment of Major Organizational Issues Relative to Williams Compliance

As in past Reports, the following four (4) areas continue to have relevance to overall Williams compliance:

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

As described in II.F. this is now an overdue mandate and a critical element of the negotiations regarding the FY 2017 I.P. There are two critical pieces; the first is what the scope of the Front Door pilot needs to include; the second is how quickly this pilot, once evaluated, can move to deal with the entirety of the Front Door mandate. The Court Monitor believes that the pilot needs to be sufficiently inclusive of needed services so as to truly offer individuals a community alternative; this will need to include not only crisis stabilization services but sufficient permanent supportive housing (PSH) bridge subsidy resources for persons who need PSH to avoid IMD admission.

B. State Management, Funding and Oversight of IMDs

The State continues to move toward partial implementation of the SMHRF Act. Twenty-two of the 24 current IMDs have applied for provisional licenses and the other two will soon apply. The next major step in the process is for the Department of Public Health (with the assistance of DMH) to develop and implement required training for IMD staff. Once this is completed, provisional licenses can be issued.

The Court Monitor has had multiple discussions with DPH and DMH regarding the common reporting of critical incidents – with the goal of finally developing comparable definitions between IMDs (SMHRFs) and transitioned Class members. The discussions

have led to an agreement that the common reporting will include seven (7) areas out of Section 380.530 (Incidents, Accidents and Emergency Care) of the final rules for SMHRFs. These seven (7) areas include:

1) Sexual assault
2) Abuse, neglect or other maltreatment
3) All deaths, including deaths of consumers who have been transferred to a hospital
4) Assault
5) Missing persons after 24 hours
6) Criminal conduct, including arrests and other interactions with police
7) Fires

These seven (7) areas are also a part of the Level I Reportable Incidents for DMH – thus allowing future comparability in terms of Incident Rates.

The understanding is that DPH will use its existing rules to report on four of these (sexual assault, abuse/neglect, assault and fires) for the time period of October 1, 2016 – March 31, 2017. This will be included in the Monitor's July 2017 Report to the Court. Beyond that, as the conversion to SMHRFs occurs, all seven (7) will be included. In the future, there should be discussion about adding other key areas for measurement e.g. medical and psychiatric hospitalizations.

The second major issue has been the Court Monitor's ongoing recommendation that the State create a centralized team to develop policy and provide oversight and State-level management responsibility for IMDs. It is recommended that this unit be placed at DHS with sufficient authority to work across all relevant State agencies. The Front Door discussions have continued to highlight the need for consistent policy and practice for not only IMDs but also for all Skilled Nursing Facilities (SNFs).

The State continues to affirm its right to set policy for its operations – with which the Court Monitor concurs. However, the State has indicated, as part of the I.P. discussions, a willingness to formally respond to this recommendation by the spring of 2017.

C. Assessment of Cross-Agency Planning

The development and submission of the Federal CMS 1115 Waiver is a prime example of the major human service agencies of State government working together at the highest levels. The over-arching commitment to right-size the role of long term care facilities is clear. The critical task is in operationalizing this – particularly in the face of the budget impasse.

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

The DHS Secretary has continued to be very directly involved in Williams discussions/negotiations regarding the FY 2017 I.P. and beyond. This has directly impacted the nature of the discussions and the ability to find appropriate resolutions. That said, tough issues remain and the lack of political will to resolve the budget impasse continues to make all these issues even harder.

Appendix - B

Reportable incidents level and categories reported by agencies

Reporting period from 4/1/2016 thru 9/30/2016

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	1	0	0	0	0	1	0.2	0	0	0	0	0	0	0	0	0	0.0
Association House of Chicago	0	0	0	1	0	0	0	0	1	2.0	9	2	0	0	0	11	2.4	2	0	0	0	1	0	0	0	3	14.3
Comm Counseling Ctr of Chicago	0	0	0	1	0	0	2	0	3	6.0	23	0	0	5	1	29	6.4	0	0	0	0	0	1	0	0	1	4.8
Cornerstone Services	0	0	0	0	0	1	0	0	1	2.0	5	0	0	0	0	5	1.1	0	1	0	0	0	0	0	0	1	4.8
Dupage County Health Department	0	0	0	0	0	0	0	0	0	0.0	1	1	0	0	0	2	0.4	0	0	0	0	0	0	0	0	0	0.0
Ecker 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
Grand Prairie Services	0	0	0	0	0	0	1	0	1	2.0	9	1	0	0	0	10	2.2	0	2	0	0	0	0	0	0	2	9.5
Heartland Health Outreach Inc.	1	0	1	0	0	1	3	0	6	12.0	2	0	0	0	0	2	0.4	0	0	0	0	0	0	0	0	0	0.0
Heritage Behavioral Health Center	0	0	2	1	0	0	0	0	3	6.0	9	2	0	5	0	16	3.5	0	0	0	0	0	0	0	0	0	0.0
Human Resources Dev Inst. Inc.	1	0	0	0	0	0	0	0	1	2.0	2	2	6	13	2	25	5.5	1	0	0	0	0	0	0	1	2	9.5
Human Service Center	2	0	0	1	0	0	0	0	3	6.0	26	4	0	0	0	30	6.6	0	0	0	0	0	0	0	0	0	0.0
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	1	0	1	2.0	1	0	0	0	0	1	0.2	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	4	2	0	0	0	6	1.3	0	0	0	0	0	0	0	0	0	0.0
New Foundation Center	0	0	0	1	0	0	1	0	2	4.0	9	2	0	1	0	12	2.6	0	0	0	0	0	0	0	1	1	4.8
Presence Health	0	0	0	0	0	0	0	0	0	0.0	1	0	0	0	0	1	0.2	0	0	0	0	0	0	0	0	0	0.0
The Thresholds	4	0	0	8	0	1	2	0	15	30.0	176	19	1	0	1	197	43.3	0	1	1	0	0	0	0	3	5	23.8
Trilogy Inc.	1	1	0	4	0	2	1	4	13	26.0	77	13	0	10	5	105	23.1	1	1	1	1	0	0	1	1	6	28.6
Trinity Health	0	0	0	0	0	0	0	0	0	0.0	1	1	0	0	0	2	0.4	0	0	0	0	0	0	0	0	0	0.0
	9	1	3	17	0	5	11	4	50		356	49	7	34	9	455		4	5	2	1	1	1	1	6	21	

Unduplicated count of CMs caused reportable incidents: 287

Total reportable incidents (Level I + Level II + Level III) 526

Level I: 50 (9.5 %)

Level II: 455 (86.5 %)

Level III 21 (4.0 %)

Legends

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/SNHRF (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.

11/28/2016