



Division of Mental Health Williams Semi-Annual Report #11



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EXECUTIVE SUMMARY

The State of Illinois Department of Human Services/Division of Mental Health (DHS/DMH) and its partner agencies, submit the 11th Semi-Annual Report. This report reflects implementation activities from the period of July 1, 2016 through December 30, 2016.

This first six months of FY17 officially started the sixth year of an original five year settlement. The state ended Year 5 (FY16) with several compliance issues. First, the State and Williams contracted community-based vendors did not reach its projected target to transition 400 Class Members from NF/IMDs to community-based Permanent Supportive Housing or residential alternatives. We acknowledge the conglomeration of situations that occurred in a very turbulent budgetary year, which only exacerbated operational challenges for several community mental health centers and within the mental health system at large. Even with these prevailing issues, the transitions were approximately 30 Class Members short of meeting the agreed FY16 target of 400. We acknowledge these issues and pledge to meet the goal of actualizing 400 Class Member transitions during this fiscal year.

Secondly, the State was found out of compliance in addressing what has become known as 'Strategies for Offering Choice and Community Alternatives to Long Term Care', i.e., 'Front Door' admissions. Concerted planning has occurred this reporting period to identify resources that would stimulate change in the trajectory of admissions to Long Term Care. As of this writing, the state is still in negotiations with Plaintiffs on the proposed 'Pilot'. It is our intent to aggressively move forward with the proposed approach and to evaluate the 'efficacy' of the design. The University of Illinois, School of Social Work will develop the evaluation tool, based on clearly articulated deliverables.

The classification of growing numbers of Class Members as "Unable to Serve" remains a source of contention for the Parties. The State has expanded capacity in both ACT and CST services to have greater resource capability to serve this population; we have also expanded additional Supervised Residential beds, through Habilitative System, Inc., for those who absolutely require and consent to a 24 hour staff setting, as a step toward independent living. Additionally, DMH is looking to increase nursing support for Class Members (CST and ACT) who have more complex medical conditions which currently presents a barrier to successful transition and wellness.

Finally, two pilots were initiated during this period. The Transition Coordination Pilot went into effect with St. Bernard's Hospital in August 2016. Unfortunately, this pilot has not generated the type of change outcomes that was initially conceptualized. Continuation of this pilot will be re-evaluated (see section on Pilots), as the volume of referrals has not been sufficient enough to

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warrant dedicated staff presence. Likewise, the Thresholds/Trilogy pilot (Unable to Serve population) which started in March 2016, but did not conclude until after the beginning of this reporting period, did not result in significant changes in practices. Under the Thresholds' design, the agency transitioned five Class Members out of the ten projected, but transitions were still predicated on the agency's ability to manage behavior symptoms or meet medical needs, first, before the move to the community. Under the Trilogy's design, the agency actualized transition for one Class Member (out of five), while facing ongoing challenges working within the operational culture of the IMD without support of the attending IMD psychiatrist.

We continue to learn from past experiences, while attempting to make concrete changes in practice and mode of operation. As the State shifts emphasis toward integrated health care, it will shape how community mental health centers view service delivery, how staff approach service delivery, and the hiring practices and training for those staff that render critical mental health services to a more complex population.

OUTREACH AND INFORMATION DISSEMINATION

Outreach Workers

NAMI Chicago Outreach Workers continue to provide Outreach and Information to Williams Class Members with resources that may assist them as they prepare to move from institutional living to community life. Outreach Workers share information on Class Members' rights under the Consent Decree, assist with answering questions or access the correct responses to questions, and address underlying concerns about the overall processes. Additionally, Outreach Workers continue to show the *Moving On* videos to those interested and provide information on supports and services available once the Class Member transitions to the community. NAMI Chicago works in tandem with Outreach Ambassadors.

Outreach Workers also continue to conduct baseline Quality of Life Surveys (QLS) with Class Members who are nearing transition from the IMDs. During this reporting period 63 baseline surveys were completed.

In this reporting period 338 Class Members signed Introductory Letters and engaged with the Outreach Workers to learn about their rights under the Williams Consent Decree and Moving On. Outreach Workers conducted 333 private interviews with Class Members. Outreach Workers were approached 3,908 times with questions or concerns about the process. Approximately 91 new Class Members refused to engage with Outreach Workers when approached. Lastly, the Outreach Workers made contact with 43 guardians via telephone or in person. Reasons for refusal and data on IMD residents seen are in Appendix A.

Ongoing Outreach Activities

Consent for Specialized Assessments

While conducting an assessment the Resident Reviewer may feel that additional information is necessary in order to make an informed decision about a Class Member's clinical or functional ability to safely maintain community living. Outreach Workers continue to work with DMH to obtain consents for 'specialized assessments' (Occupational Therapy or Neuro-psychological). DMH notifies NAMI when an assessment has been recommended. Outreach Workers will subsequently meet with the Class Member to explain the purpose of the assessment, review the processes and obtain the individual's consent to participate.

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Assessment Requests

NAMI works in tandem with Lutheran Social Services and Metropolitan Family Services to ensure that every Williams Class Member is afforded an opportunity to be assessed. Outreach Workers send a weekly list to the Resident Reviewer agencies documenting Class Members who have requested an assessment. This weekly communication assists Outreach Workers who inform Class Members on the status of their assessment.

Troubleshooting

Outreach Workers serve as a liaison between Class Members, transition agencies and DMH. Class Members approach Outreach Workers with questions or concerns regarding their status with the *Moving-On* program. Outreach Workers also consult with the specific community agencies and provide necessary feedback. Outreach Workers visit each IMD on a biweekly basis which allows and provides for timely follow-up.

Appeals

Once a Class Member is assigned to a transition agency, if the Class Member wishes to change agencies, he/she is required to submit a written Appeal to explain the reason for the change request. If necessary or upon request, NAMI Outreach will assist the Class Member in filing an Appeal. NAMI Outreach Workers have created a form to assist Class Members record their reasons for desiring change.

Drop-In Centers

Outreach provides Class Members with information on community-based resources which can be of advantage to them prior to moving out of the IMD. Staff is equipped with Drop-In Centers' brochures that include the centers' programming, locations and telephone numbers. Class Members are encouraged to visit the Drop-In Centers where they can communicate with others who have successfully moved into the community. Additionally, Outreach Ambassadors are equipped with Ventra cards used to provide public transportation for Class Members on visits to Drop-In Centers.

Recovery and Empowerment Statewide Call

Outreach Workers continue to provide a venue for Class Members to participate in monthly 'Recovery and Empowerment Statewide Call'. These educational forums enable the Class

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Members to feel empowered by placing an emphasis on sharing successful tools and strategies for wellness.

Outreach Ambassadors

The Outreach Ambassadors are an extension of NAMI Chicago Outreach Workers. Since November 1, 2015, fourteen Class Members have worked as paid Ambassadors, returning to the facilities for 8 hours/month to share their recovery stories on life outside the IMD, and to offer tips or advice on how to make independent living a personal success. Ambassadors receive \$10/hour for their services. NAMI Chicago is hosting a one year celebration to acknowledge eight Ambassadors who have served in this role since inception. The Ambassadors speak from a voice of commonality about their experiences while living in the IMDs. Simultaneously, Ambassadors share their individual journey on the road to community transition, as well as wellness and recovery. Ambassadors are able to answer questions about the process and speak about the services and supports available in the community.

Another opportunity for Ambassadors are quarterly community meetings held in the IMDs and at various events sponsored by the Outreach Workers and the community mental health agencies. Ambassadors receive a \$25 stipend for presenting at these meetings.

NAMI Chicago is committed to actively recruit those who are interested in serving as an Ambassador and who have a commitment to engage with Class Members who have not transitioned. Ideal candidates are well spoken and able to articulate how the Moving On program worked/is working for them. Ambassadors go through an extensive training on their role and responsibility. Concurrently, Ambassadors have been trained on etiquette protocol on how they are to conduct themselves in the facility.

RESIDENT REVIEW

As the State closed-out FY16 and entered into FY17, improvement of the Resident Review processes continued to be ongoing and fluid. One such process improvement was the implementation of the Word fillable document which launched April 1, 2016. Use of this data recording tool has led to better efficiency from the Resident Review staff by eliminating the need for multiple data entry into the system due to online glitches, and by streamlining the data entry process with the use of pre-programmed drop box selections (previously required manual entry). This tool continues to be monitored and has been modified, as needed, to ensure its functionality.

Lutheran Social Services of Illinois (LSSI) and Metropolitan Family Services (MFS) continue to approach new admission candidates for Resident Review Assessment through use of the Healthcare and Family Services (HFS) census data. Class Members who are eligible for annual re-assessments (or quarterly, upon request), those referred by NAMI, Engagement Team Members, Managed Care Organizations (MCO) and self-referral and/or guardian requests are scheduled with the Resident Reviewers according to availability.

As a means to provide opportunities for transition consideration, both LSSI and MFS send NAMI a monthly list of Class Members who have declined to participate in the Resident Review assessment. Once received, NAMI attempts to engage these Class Members on the benefit of having a Resident Review assessment, share information and educate about the *Moving On* Program, and address any questions/concerns about moving to the community. Through the screening process, the Resident Review staff continues to offer recommendations for the use of Enhanced Skills Training and In-Home Recovery Support services, as well as recommendations for Supportive Employment to strengthen successful community transitions.

DMH has weekly teleconferences and conducts random sampling of Resident Reviews to identify issues within the review process. Areas of focus in our pursuit for better quality improvement include: enhanced exploration of Class Member's interactions in the community outside of the IMD; better clarifiers when noting self-reporting on ADL and IADL's skills and actual skill level (reported/noted by staff) to present a more congruent picture of the Class Member's actual skills performance; more detailed documentation on current symptoms being exhibited, supported by specific examples of their manifestations (versus symptom profile list); more detailed documentation on the Class Member's level of participation in medication and treatment programs; and the use of clear, concise documentation to explain a Class Member's inability or difficulties in acknowledging or recognizing critical medical conditions and/or mental illness.

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The following table reflects the Quarterly Performance Measure data submitted by LSSI and MFS. The data is the total numbers for the current reporting quarter.

Performance Measures Outcome¹

	#1 Approached	#2 Approached Refused	#3 Signed Participation Agreement	#4 Full Assessment Completed	#5 Aborted Assessment	#6 Recommend for Transition	#7 Not Recommend	#8 Staff Productivity Approved	#9 Complex Medical Need	#10 Criminal Histories	#11 Staff Productivity Denied
LSSI	1231	719	1002	493	19	408	85	408	289	137	85
MFS	796	502	687	306	8	211	95	211	158	135	95
TOTAL	2027	1221	1689	799	27	619	180	619	447	272	180

Data analysis for this reporting period as compared to last reporting period shows an increase in the number of Class Members approached for Resident Review (up by 501) and an increase in the number of approvals (up by 181). The total number of denials was slightly higher (up by 40), but remained relatively close in both agencies showing only a 10 person difference (LSSI - 85 & MFS - 95). Total number of refusals have increased by 283 (938 in the previous reporting period as compared to 1221 this period), which may be indicative of the fact that Class Members were approached with greater frequency for assessment/reassessment during this time period.

SPECIALIZED ASSESSMENTS

Occupational Therapy

The University of Illinois, Department of Occupational Therapy & Disability and Human Development (OT assessments) is under contract to complete assessments for individuals with

¹ Time frame from April 1, 2016– September30, 2016

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suspected skill deficits identified as barriers to community transition from our Unable to Serve list (UST), Hold list and existing community referrals. There were no new referrals during the current reporting period due to class member declinations. However, two remaining assessments from the previous reporting period were able to be completed during this reporting period. The outcome of these two assessments was a recommendation to transition to the community with specified supports. These assessments have been forwarded to the Deputy Director of Transitions for geographical area review and agency case assignment. Consents from Class Members for an OT Assessment for the upcoming reporting period has been secured and scheduling is currently underway.

27 of the 29 OT Assessments recommending community transition from the previous recording period were sent to our contracted community mental health providers for transition consideration. Though recommended by OT for community transition with specified supports, the CMHCs reported the following reasons why community transition has not occurred for these Class Members:

Unable to Serve (Housing)	1
Hold (Housing)	2
Hold (Mental Health)	1
Agency Assignment, not yet Transitioned	5
Unable to Serve (Mental Health)	7
Unable to Serve (Medical)	2
Unable to Serve Financial	1
Declined to Transition	5
Pending Assignment	1
Unable to Locate Class Member	2

DMH will continue to work with CMHCs to better understand their rationale why certain Class Members are being identified as not able to be served within the current service array, and to determine what additional supports or services the agencies need to aid them in their ability to serve Class Members currently identified as 'Hold' or 'Unable to Serve'.

Neuropsychological

NAMI Outreach staff work to obtain Class Members' consent for both OT and Neuropsychological assessments. NAMI workers actually go into the IMD's after receiving a list of referrals from DMH to obtain signed consents for Release of Information for the UIC evaluations to be conducted. Additionally, the release of information allows Class members' medical records to be forwarded to UIC at the time of their scheduled appointment for evaluation.

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The CMHCs identify Class Members who they deem appropriate, from their assessments, for neuropsychological testing. This information is then forwarded to DMH. For those Class Members who refuse a specialized assessment, NAMI Outreach seeks to in-reach a Class Member a second time. It is the interest to ensure that Class Members are clearly informed about the nature of these assessments and to offer an opportunity for them to change their mind. DMH required NAMI Outreach to make two attempts to obtain consent.

The University of Illinois, Department of Psychiatry/Office of Dr. Neil Pliskin remains under contract to conduct the neuropsychological assessments if there is a suspicion of severe cognitive impairments, including dementia or the onset of Alzheimer's disease. This report reflects assessment activities since July 1, 2016:

- The total number of *referrals* for a neuropsychological assessment (since inception) is ninety-seven (97) which includes thirty-eight (38) referrals for this reporting period.
- Each of the 38 Class Members signed the required consent form. The breakdown across facilities is as follows:
 - a. Lydia = 20
 - b. Grasmere Place = 2
 - c. Decatur Manor = 1
 - d. Albany Care = 2
 - e. Lake Park Center = 1
 - f. Rainbow Beach = 3
 - g. Kankakee Terrace = 1
 - h. Columbus Manor = 1
 - i. Bourbonnais Terrace = 1
 - j. Thornton Heights = 2
 - k. Greenwood Care = 1
 - l. Sacred Heart = 1
 - m. Margaret Manor Central-2.
- The *actual* number of neuropsychological assessments completed for this reporting period is five (5).
- There are twelve (12) Class Members who have been scheduled from the present time through January 2017.
- At the time of this writing, UIC has not been able to provide any additional time slots beyond January 2017. They are working to reopen the schedule.

Some of the difficulty in scheduling is the result of a large number of Class Members who reside at the same facility - Lydia Healthcare. DMH has requested UIC to provide two slots on the same day for appointments in an effort to reduce Lydia's travel and staffing shortages. Lydia still has fourteen Class Members to be scheduled for appointments for a neuropsychological evaluation.

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Of the thirty-eight new referrals, two Class Members missed their scheduled appointments due to transportation problems, as reported by the IMD. Three Class Members were recommended to remain in a nursing level of care setting, reporting that transition to the community would be counter-productive based on their need for 24 hour skilled nursing support to maintain wellness and safety. These three Class Members were found to have a combination of psychiatric and medical problems which were too complex for them to handle independently in the community. They would require the same level of care they currently receive in the IMD to be successful in their attempts to transition. Due to safety and risk factors, it was deemed appropriate for them to remain in the IMD.

Of the five completed assessments, two Class Members were recommended for possible transition to a group home setting/living environment where there is onsite staff support. These two Class Members possess the ability to function independently in the community with the support of staff to help compensate for other skill deficits. One finding recommended the following, "Class member's functional impairments indicate that he would be unable to safely live independently. However, from a cognitive standpoint, his intact verbal comprehension and verbal memory in the context of intellectual disability indicate that he can understand, follow and remember basic instructions. Assuming stable psychiatric status, the Class Member could function at a level similar to his current capabilities in a less restrictive but still structured housing setting, such as a halfway house or group home". No neuropsychological assessment recommended a Class Member for transition to independent living in Permanent Supportive Housing.

Neuropsychological Assessments:

Number of Class Members (CM) identified for assessment (new)	38
Number of CM recommended to remain in a nursing level of care setting	3
Number of CM recommended for group home setting	2
Number of CM who missed the neuropsychological evaluation	2
Number of CM discharged from IMD before NAMI's consent attempt	1
Number of assessments pending (to date)	30

Clinical Review

During this reporting period, one hundred-twenty five 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 one hundred-twenty five Clinical Reviews conducted:

- Sixty-eight were supported, i.e., in concurrence with the recommendations of the Resident Reviewers;
- Nine were overturned by the clinical review team, thereby recommending community transition for those Class Members;
- Forty-eight reviews are pending completion by the CRT agencies;
- Eight appeals to the recommendation from the Resident Review/Housing options were submitted to DMH during this reporting period;

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- Two appeal recommendations were supported by DMH and found to be in agreement with the findings of the Resident Reviewer;
- Six appeals that were overturned by DMH and the Class Members were approved to transition.

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

MORTALITY REVIEWS

Mortality Reviews

The University of Illinois at Chicago, College of Nursing has conducted 9 mortality reviews during this reporting period. The purpose of these reviews is to identify patterns, themes, or behaviors surrounding the Class Member's death that could be beneficial to care coordinators and/or other community providers in their work with future individuals who transition to the community. The Mortality Review includes a formal analysis of clinical documentation received from the respective provider agency and interview(s) with the agency care management team by Ann Hruby, APN, LCPC.

DMH requested UIC to complete a Mortality Root Cause Analysis Summary Report by July 2016. This document provides a composite of each death, as well as the results of the comprehensive interviews with agencies, as well as documentation from the NF/IMDs and autopsy reports/medical examiner's reports. In the Executive Summary of this the following insights and recommendations were noted.

"After reviewing the 25 Williams' decedents' cases several gaps in care emerged. A common gap in care among all care management agencies was a lack of comprehensiveness in assessments. Another common gap was a lack of appropriate level of coordination, communication and collaboration with medical providers, and inadequate monitoring of or response to problematic symptoms or behaviors. Care teams in general did not consistently communicate with providers when decedents experienced significant worsening symptoms, or when new symptoms or problems arose.

Care management strengths were also evident. CMHCs were rated "managed above average" or "managed very well" for a majority of medical (52%), mental health (56%), and substance use disorder (53%) management. Approximately half (48%) of decedents were rated as having strong relationships with their care teams. Thresholds and Trilogy teams were identified as being particularly adept at developing these working relationships with decedents.

Medical management ratings demonstrated the lowest ratings with 32% in the "not managed" or "minimally managed" categories. This may have been particularly affected by inappropriate level of care placement of decedents with serious co-morbid medical conditions (placement on CST rather than ACT). Substance use disorder management was a frequent challenge for teams during the post-transition period. Decedents with existing substance use disorder diagnoses identified during the pre-transition period demonstrated a pattern of relapse and problems related to substance use during the post-transition period of care. Although many teams attempted multiple

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interventions and offered assistance and linkage with substance use disorder treatment or support, decedents frequently refused to engage in treatment.

UIC entered a series of recommendations as a means of assisting with quality improvement. Several of the most common recommendations are:

- The need for improved assessment and evaluation, both during the pre-transition period and ongoing during the post-transition period;
- Increased communication and coordination with providers regarding needed tests/procedures and results, including follow up to ensure that they are completed, and for any related ongoing care to be managed;
- CMHCs incorporate evidence-based practice (EBP) in their development of protocols to be implemented in every area of care management;
- Consideration should be given to the use of behavioral contracts with decedents if they are experiencing problems related to non-adherence to treatment plan or behavioral problems, such as repeated verbal assaults of staff or neighbors
- CMHCs should fully document their rationale for level of care decisions and placement, including the recorded use of risk screening tools used to support those decisions”.

The recommendations offered by UIC were incorporated into training topics for the Colbert/Williams training services that began in November. This series provides both in person and clinical webinar training targeting direct care staff, supervisory staff, Resident Reviewers, Outreach Workers and Quality Monitors.

Since inception, there have been forty-eight deaths of Class Members who have transitioned to the community. Of this cumulative number, five Mortality Reviews of the nine deaths occurring in this reporting period have been staffed with community vendors and reports submitted. Preliminarily, reports on the nine deaths are being attributed to natural causes. DMH has secured death certificates for all of the decedents through concerted efforts, and has obtained autopsy/medical examiner reports when allowed by the respective counties.

A redacted version of the Mortality Root Cause Analysis Summary Report and cover synopsis was released to the Williams community providers.

TRANSITION COORDINATION/COMMUNITY SERVICES

During this reporting period there was a formal merger of services with New Foundation and Thresholds. Thresholds assumed services for Lake County. With this consolidation there are now eight contracted Williams community mental health centers to provide the full array of Williams services:

1. Association House of Chicago
2. Community Counseling Centers of Chicago
3. Grand Prairie Services
4. Heritage Behavioral Health (Decatur)
5. Human Resource Development Institute
6. Human Service Center (Peoria)
7. Thresholds
8. Trilogy

There are nine agencies contracted to provide 'transition only'

1. Association for Individual Development
2. Alexian Center
3. Cornerstone Services in Kankakee and Will Counties
4. DuPage County Health Department
5. Ecker Center
6. Lake County
7. Kenneth Young Center
8. Presence Behavioral Health
9. Trinity Services

Transition outcomes

An accumulative total of 3735 Class Members have been recommended to transition

15.3% declined after initial approval

Declined	Count
Class Member –declined	553
Guardian/monitoring authority declined	45
Total	598

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8.4 % were determined by community mental health agencies as needing higher level of care than exists within community settings (Unable to Serve)

Reasons for Unable To Serve	Count
Financial	52
Medical	53
Medical/Diabetes	8
Medication Management	4
Mental Health	196
Housing	8
Total	321

4.5 % Class Members have been placed on hold by their assigned community health agency. This process requires agencies work with Class Members to resolve the barrier presenting transition within six months.

Reasons for Unable To Serve	Count
Hold - Class Member reluctant	18
Hold - Funding	63
Hold - Housing	31
Hold - Legal issues	4
Hold - Medical	28
Hold - Mental Health	36
Total	180

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Once approved for transition, community engagement begins. The following reflects the 16 % of Class Members unavailable for transition engagement activities:

Unable to engage	Count
Class Member – deceased	58
Refused contact with community agency	35
Inaccessible or unable to locate	573
Total	666

Related to the 1735 Class Members who have transitioned to the community, the following table represents the number of Class Members who are no longer living in their leased units.

Housing status	Count
Vacated PSH-permanently	244
Vacated PSH-temporarily	47
Total	291

QUALITY MANAGEMENT/QUALITY MONITORING

There are nine Williams Quality Monitors (WQM) assigned to ‘monitor’ the quality of life and quality of care for Class Members post community transition, and the array of services by one of the designated Williams community mental health centers. Two Quality Monitors are located in Pekin, Illinois, and are assigned to Class Members who reside in the Peoria and Decatur area and surrounding communities. The remaining WQMs are located in the Metro Chicago area.

During this reporting period, WQMs conducted 298 home visits for a total of 4343 visits since inception. As stated in previous reports, WQMs determine that: (1) comprehensive service plans accurately depict the Class Members’ needs and goals; (2) Class Members’ living environments are safe and decent for habitation; and (3) Class Members are adequately adapting to community reintegration. Quality monitoring activities technically ends after 18 months, post transition. However, in some instances the WQM may believe that unresolved issues necessitate an extended monitoring period. In such cases, additional home visits may be scheduled.

During this reporting period the Quality Monitors conducted two hundred and ninety-eight Quality of Life Surveys. Feedback from the survey provides a barometer on the care and services received by Class Members, their wellness, and their quality of life in the community. Completed survey data indicates the following:

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

In August 2016, the WQMs were reorganized, reassigned caseloads and assigned to different community mental health agencies. The reassignment was done to improve efficiency, provide more accountability, to better manage productivity and travel. Larger agencies, Thresholds and Trilogy, were divided between two quality monitors to equalize the caseloads of each monitor. One quality monitor was assigned to cover the geographical area encompassing Lake County, DuPage County and other outlying suburban areas. The remaining quality monitors in the metro area have been reassigned to Class Members and corresponding community mental health agencies. The two downstate quality monitors maintain coverage Class Member residing in the Decatur and Peoria areas.

In September 2016, three WQMs were assigned a ‘special assignment’ to conduct monitoring “wellness visit” to Class Members who have 21 months or more post transition recovery living in the community. The project was to ascertain the status of these Class Members and to assure

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that they were receiving necessary supports and services. Two hundred and eighty-two visits occurred.

The purpose of was to:

1. Have a face-to-face observation of a sample of Class Members
 - i. Assess mental status
 - ii. Assess physical wellness
 - iii. Assess quality of life and care
2. Ascertain if the Class Members have access to medications and can appropriately administer meds.
3. Determine if Class Members are being monitored by the assigned transition agency.
4. Determine if Class Members have benefits (SSI/SSDI or SNAP) and if these are still active.
5. Observe the living environment.

Examples of findings:

- One Class Member expressed concerns about the lack of access to staff on week-ends.
- An elderly Class Member received notice that she had lost her medical coverage due to the move from the IMD, but there was no notification of this change. The medical provider was resolving the issue.
- Two situations were observed in regards to apartments that appeared to be unsuitable for Class Members who have significant fall risks.
- Two clients continued to struggle with psychiatric symptoms and behavior management issues that are presenting a housing tenancy problem. The agency is attempting to address.
- One Class Member continues to drink despite a history of significant health problems.

Note: The Consent Decree does not dictate follow-up after twelve months. However, DMH will share specific consumer information from this follow-up sample with Williams Executive Directors and key leadership staff to alert them of these findings.

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Reportable Incidents

DMH captures Reportable Incidents (Level I – Critical; Level II – Serious; Level III – Significant) for each occurrence as categorized in Appendix B. For this reporting period, there has been a total of 526 incidents:

- Level I 50 (9.5%) **Urgent; Critical Incidents:** Situations or outcomes that result in adverse occurrences impacting life, wellness and safety.
- Level II 455 (86.5%) **Serious Reportable Incidents:** Situations or outcomes that could have implications affecting physical, emotional or environmental health, wellbeing and community stability.
- Level III 21 (4.0%) **Significant Reportable Incidents:** Situations or occurrences that could possibly disrupt community tenure.

As reported in the Mortality Review section, there were nine deaths (Level I) attributed, preliminarily, to natural causes. The next four highest incident categories across all three Levels are:

- Unexpected Hospital Visits/Admissions 356
- Nursing Home readmission (ICF/SNF) 49
- Behavioral Incidents 34
- Physical Assault 17

Reportable Incidents by Class Members:

Unduplicated # of CM with incidents	# of Incidents	Total Incidents	%
161	1	161	30.61
76	2	152	28.90
23	3	69	13.12
10	4	40	7.60
9	5	45	8.56
3	6	18	3.42
1	9	9	1.71
1	11	11	2.09
287		526	

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CHARACTERISTIC OF WILLIAMS CLASS MEMBERS

This analysis provides an update to previous analyses performed looking at the characteristics of Williams Class Members receiving community-based treatment. As stated in previous reports, 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 which occurs within the IMD in which the individual resides. They are also required to re-register these individuals to update key fields at six month intervals. As of April 30, 2016 three thousand three hundred thirty-three (3333) Williams Class Members were enrolled in the DMH Community Information System as a result of being assigned to an agency for transition coordination. The results of the analyses summarized below are indicative that there were very few changes in the profile of enrolled Class Members as of October 2016 in comparison to April 2016. The clinical and descriptive characteristics appear to be fairly stable for this population.

Age Group	Count	%
18 - 20	3	0.1%
21 - 24	94	2.8%
25 - 44	1160	34.8%
45 - 64	1853	55.6%
65 and over	223	6.7%

Gender	Count	%
Female	1178	35.3%
Male	2155	64.7%

Ethnicity	Count	%
American Indian/Alaskan Native	13	0.4%
Asian	48	1.4%
Black/African American	1590	47.7%
More Than One Race Reported	9	0.3%
Native Hawaiian or Other Pacific Islander	5	0.2%
Race/Ethnicity Not Available	105	3.2%
White	1563	46.9%

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Hispanic Origin	Count	%
Central American	12	0.4%
Cuban	2	0.1%
Mexican/Mexican American	93	2.8%
Not of Hispanic Origin	2945	88.4%
Other Hispanic	71	2.1%
Puerto Rican	50	1.5%
Unknown, not Classified	160	4.8%

Marital Status	Count	%
Never Married	2454	73.6%
Married	90	2.7%
Widowed	72	2.2%
Divorced	396	11.9%
Separated	100	3.0%
Unknown, declines to specify	1	0.0%
Civil Union	220	6.6%

Highest Level of Education Completed. Twenty-eight percent (28.0%) of Class Members have earned a high school diploma and an additional 6.6% were reported as having earned a General Equivalency Degree (GED). Twenty-four percent (24.0%) of Class Members completed some high school (e.g., one, two or three years) with no diploma earned. Eighteen percent (18.1%) have completed some college, and 5.39% hold a Bachelor's Degree. A small percentage (1.0%) of Class Members has completed post-secondary training and 1.2% has completed post graduate training. Education level was not reported for approximately 15.4% of registered Class Members.

Residential Living Arrangement. A large number of individuals (27.4%) were reported as residing in private unsupervised settings (permanent supportive housing), another 1.3% were reported as living in other unsupervised settings; 14.2% were reported as living in supervised settings; and 46.8% were reported as residing in institutional settings. Data was not reported for 162 individuals (4.7%), and a small percentage of individuals were reported as residing in settings other than the ones reported above.

Military Status. There were 4.4% of Class Members reported as being a veteran having formerly served in the military. There were another 8.0% of Class Members that were listed as unknown.

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Primary Language. The primary language spoken by 98.2% of Class Members English, while .5% were reported as Spanish and another .6% reported as unknown.

Justice System Involvement. The majority (84.7%) of Class Members were reported as not having any involvement with the justice system (courts, jails, etc.). However, 1.5% had been arrested, 1.0% had been charged with a crime, .7% had been incarcerated or detained. An additional 1.1% of Class Members had a status at some point of being on parole or probation. 9.3% was reported as unknown; 1.0% were reported as having a status of “Other” at the time that the individual was registered/re-registered.

History of Mental Health Treatment. During the registration process, information is gathered regarding an individual’s history of mental health treatment. Over forty-nine percent (49.2%) have a history of continuous treatment for mental health related problems, 69.5% have a history of continuous residential treatment. 62.1% have a history of living in multiple residential settings. 77.7% of Class Members have a history of receiving outpatient mental health services for their illnesses. 81.4% of Class Members reported having received previous mental health treatment.

Level of Care Utilization Scale Scores Based on Assessor Recommendation. More than twenty-seven percent (27.0%) 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-four (43.9%) percent were recommended for Medically Monitored Services: 34.7% were recommended for Non-Residential while 9.2% were recommended for Residential. 2.9% were recommended for a Medically Managed level of Residential Services. 5.7% percent were recommended for Low Intensity Community-Based Services, while 1.1% was recommended for Recovery Maintenance and Health Management. LOCUS scores were missing for approximately 19.5% of the cohort.

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

- *ICD-9 Frequencies:*
 - 70.7% of class members had a primary diagnosis of schizophrenia and other psychotic disorders
 - 20.0% were diagnosed with bipolar and mood disorders.

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- The remainder of diagnosis values fell under the following categories: Adjustment Disorders, Anxiety and Stress Disorders and Other Mental Disorders.
- *ICD-10 Frequencies:*
 - 70.6% of class members had a primary diagnosis of schizophrenia and other psychotic disorders
 - 27.2% were diagnosed with bipolar and mood disorders.
 - The remainder of diagnosis values fell under the following categories: Anxiety and Stress Disorders, Disorders usually diagnosed in infancy, childhood or adolescence and Other Mental Disorders.

Functional Impairment. The Global Assessment of Functioning (GAF) Scale (also known as Axis 5 of the DSM-IV) is used to determine functional impairment of an individual in the psychological, social and occupational spheres of their lives. The scale ranges from 1 to 100 with 1 representing lowest level of functioning or the highest level of impairment. Class members GAF scores ranged from 10 to 99 with an average of 42.5 which represents...”Serious symptoms or any serious impairment in social, occupational, or school functioning”.

Other Areas of Functional Impairment. DMH providers are asked to rate an individual’s serious functional impairment in 7 areas as part of the registration/enrollment process: Social/Group Functioning, Employment, Community Living, Financial, Supportive/Social, Daily Living Activities and Inappropriate Dangerous Behavior. Eighty-two percent (76.7%) of class members were identified as having a serious functional impairment in the employment area, 71.6% in the financial area, and 74.9% in Social/Group functioning and 68.1% in Community Living area. Sixty-three percent (63.2%) had a serious functional impairment in the supportive/social area, 54.2% in activities of daily living and 40.5% had a serious impairment in relation to inappropriate or dangerous behavior. It was also reported that 76.7% of the class members had a previous functional impairment.

Comparison to Previous Analysis for October 2015 Cohort

The prior analysis of descriptive demographic and clinical data for Williams Class Members registered in the DMH Community Information System was performed in April 2016 for class members. A comparison of the data for this period to the previous period reveals that there is little variability in the descriptive information reported for the two cohorts. The majority of values show little change while some have had a variance in the four to seven percent range.

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 continues to be the extent to which Class Members continue to reside in these homes post IMD discharge. The table below displays a frequency distribution showing the length of time or community tenure of Class Members still residing in permanent supported housing post IMD discharge. (Note that the data excludes individuals returning to IMDs who did not return to the community, and those Class Members who are deceased.) 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. The data displayed in the following table shows that over 53.8% of Class Members have lived in their own homes, after transitioning from IMDS, for more than 691 days. Approximately another 20.4% have resided in the community between 361 and 690 days.

Williams Class Members¹
Number of Days Residing in the Community as of April 30, 2015

Days of Community Tenure	N	Percentage
0 - 30	21	1.72%
31-60	20	1.64%
61-90	20	1.64%
91-120	28	2.29%
121-150	35	2.86%
151-180	26	2.13%
181-210	30	2.45%
211-240	27	2.21%
241-270	25	2.04%
271-300	23	1.88%
301-330	32	2.62%
331-360	28	2.29%
361-390	22	1.80%

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Days of Community Tenure	N	Percentage
391-420	17	1.39%
421-450	12	0.98%
451-480	23	1.88%
481-510	35	2.86%
511-540	30	2.45%
541-570	27	2.21%
571-600	29	2.37%
601-630	17	1.39%
631-660	17	1.39%
661-690	21	1.72%
>690	658	53.80%
Total	1223	

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

Williams Class Member Quality of Life Survey Report

The Division of Mental Health considers the evaluation of care provided directly to Class Members to be of paramount importance in evaluating the services received by these individuals. Quality of Life surveys, which are administered to Class Members prior to discharge from the IMDs in which they reside and at 6 month intervals post discharge (up to 18 months), are used to gather this information. Quality of Life surveys used to evaluate the Consent Decree are comprised of two separate surveys: the Lehmann Brief Quality of Life Survey and the Mental Health Statistics Improvement Program (MHSIP) Adult Evaluation of Care Survey. This report will focus on the results of the later survey.

Evaluation of Care Results

The evaluation of care survey has seven domains: (1) access to care; (2) quality and appropriateness of treatment; (3) treatment outcome; (4) participation in treatment planning; (5) satisfaction with services; (6) improvement in functioning and (7) social connectedness with others. Prior reports have noted positive change across time on nearly every one of these domains. The findings this time are much the same.

Table 1 displays the percentage of class members' positive responses for each evaluation domain across time: 30 days prior to transition from the IMD, at 6 months, 12 months and 18 months post transition to the community. The results are presented for all individuals completing the evaluation surveys regardless of whether they completed surveys at each point in time. Class Members evaluation of their satisfaction with treatment evidenced the most change across time, followed by evaluation of access to care, quality of treatment and participation in their treatment plan development. A small positive change was noted in the Class Members' evaluation of their functioning, treatment outcomes and social connectedness.

Table 1

Percentage of Positive Class Member Responses By Evaluation Domain Across Time

	Pre-Transition	6 Months	12 Months	18 Months
Evaluation Domain				
Access	76.0	89.4	90.2	90.2
Quality	77.6	91.0	92.2	92.6
Outcome	91.0	91.7	89.6	90.9
Satisfaction	65.9	87.5	89.1	90.0
Social Connectedness	89.1	90.8	90.7	89.7
Functioning	92.6	94.2	93.3	93.1
Treatment Plan participation	78.6	89.3	90.7	88.1

Table 2 displays the percentage of positive responses across time only for individuals completing the survey at the initial pre-transition point in time and at 6 months post-transition.

Table 2

Percentage of Positive Class Member Responses By Evaluation Domain Across Time Ratings Made by the Same Cohort Pre-IMD Transition and Post IMD

**Transition at 6 Months
(n=317)**

	Pre-Transition	6 Months
Evaluation Domain		
Access	77.6	92.1
Quality	80.1	93.1
Outcome	90.9	92.7
Satisfaction	66.6	89.9
Social Connectedness	91.8	91.8
Functioning	92.1	95.6
Treatment Plan participation	80.8	92.1

This "matched" survey cohort exhibits a very similar pattern as that noted above. The most positive change was noted on the following evaluation domains: satisfaction, access to care, quality of care followed by participation in treatment planning. A small degree of positive change was noted for functioning and social connectedness and evaluation of treatment outcome. A major positive change was also noted in the satisfaction domain.

Table 3 displays the percentage of positive responses across time only for individuals completing the survey at the initial pre-transition point in time and at 12 months post-transition.

Table 3

**Percentage of Positive Class Member Responses By Evaluation Domain
Across Time Ratings Made by the Same Cohort Pre-IMD Transition and
Post IMD**

Transition at 12 Months (n=222)

	Pre- Transition	12 Months
Evaluation Domain		
Access	76.1	93.7
Quality	78.8	95.5
Outcome	92.8	93.7
Satisfaction	62.6	91.9
Social Connectedness	91.4	91.4
Functioning	93.7	95.0
Treatment Plan participation	78.4	95.0

This "matched" survey cohort exhibits a very similar pattern as that noted above. Again, the most positive change was noted on the following evaluation domains: satisfaction, access to care, quality of care followed by participation in treatment planning. A small degree of positive change was noted for functioning and evaluation of treatment outcome while the social connectedness remains the same across time.

Table 4 displays results for the fourth and final comparison: the percentage of positive responses across time only for individuals completing the survey at the initial pre-transition point in time and at 18 months post-transition.

Table 4
Percentage of Positive Class Member Responses By Evaluation Domain
Across Time Ratings Made by the Same Cohort Pre-IMD Transition and Post
IMD
Transition at 18Months (n=176)

	Pre-Transition	18 Months
Evaluation Domain		
Access	73.3	89.8
Quality	78.4	91.5
Outcome	93.2	89.8
Satisfaction	65.9	89.2
Social Connectedness	90.3	90.3
Functioning	93.2	93.2
Treatment Plan participation	79.0	89.8

Again, this "matched" survey cohort exhibits a very similar pattern as those described above: The most positive change was noted on the following evaluation domains: satisfaction, access to care, quality of care followed by participation in treatment planning. No change were noted in the social connectedness and functioning domains across time. Evaluation of treatment outcomes showed a small decrease in positive responses.

Summary

In summary, generally regardless of point in time post transition, or whether the same individuals completed survey at different points in time post transition, Class Members more often evaluated satisfaction with treatment, access to treatment, quality of treatment and their ability to participate in their own treatment planning more positively post IMD transition. Class Members generally evaluated treatment outcomes and functioning positively, showing less change across time however. Social Connectedness showed the least amount of change across time, and at times a minor decrease in positive responses. The next report will provide a summary of Lehmann Quality of Life survey responses across time.

HOUSING / RESIDENTIAL OPTIONS

Section 811 and the Statewide Referral Network

The Illinois Housing Development Authority (IHDA) and the Statewide Housing Coordinator continue to provide group and individual trainings on using the online housing locator and waiting list tool to people who are connected to eligible households. Meetings with Williams and Colbert transition coordinators, housing locators and case managers stress the importance of using federally funded Section 811 PRA resources to increase the number of class members who can move to the community by accessing affordable housing resources. A Waiting List Manager, who started in January 2016, has helped the Statewide Housing Coordinator make 811 and SRN matches and keep track of the PAIR module data.

Statewide Referral Network

IHDA and DHS partnered to create quality, affordable units for supportive housing populations: individuals and families who are homeless, at risk of homelessness, and/or have disabilities, and who require access to supportive services in order to maintain housing. The Statewide Referral Network (SRN) links vulnerable populations, who are already connected to services, to affordable, available housing. SRN units are financed to be affordable for persons with extremely low incomes. They are pledged in Low Income Housing Tax Credit (LIHTC) applications to IHDA (the state-wide LIHTC administrator) and developers must sign an agreement to comply with the SRN program's terms. Points for these SRN units are given to developers for 10% or more of their development's units. Once the SRN units are listed in the online housing waiting list or PAIR module, the Statewide Housing Coordinator works to match Williams Class Members (and others eligible for SRN units) to potential units that fit their requirements for location and unit features.

In Round I for 2016, IHDA approved \$12.2M to create 955 units and in Round II, IHDA approved \$12.7M for 955 units. It is estimated 123 SRN units will come from Round I 2016 LIHTCs and 102 SRN units will come from Round II. As of November 2016, there are 36 Williams Class Members on the SRN Waiting List, 16 of which have an open offer to properties and one Class Member has been housed in a SRN unit.

Section 811 Units

IHDA has worked with Social Serve (contracted web-based housing locator) over the past year to create a new Section 811 monthly periodic poll email in addition to the SRN monthly periodic poll, to capture Section 811 unit availability information as Section 811 units are added to the portfolio. The Statewide Housing Coordinator continues to work with Social Serve on issues that arise within the Pre-Screening, Assessment, Intake and Referral (PAIR) online waiting list module to improve performance and matching. New contract negotiations for FY 2017-2018 will start at the beginning of 2017.

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IHDA continues to sign Rental Assistance Contracts (RACs) with new projects that are beginning to come online, to secure Section 811 units in new developments. When a project is 65% construction complete, the Statewide Housing Coordinator begins looking for referrals for the property. IHDA also signs Agreements for Rental Assistance Contracts (ARACs) for currently operating properties that will have open units in the near future in communities of preference.

Due to unforeseen delays with HUD in establishing the rental assistance payments process for the Section 811 Program, IHDA began bringing individual projects to its Board for approval in 2015. As of September 2016, 104 units have been Board approved. Referrals will continue to be made for persons on the PAIR module Section 811 waiting list. Anyone who is eligible for Section 811 is also eligible for the Statewide Referral Network waiting list. As of November 2016, the Section 811 Waiting List includes 36 Colbert Class Members, seven of which have an open offer to properties and one class member has been housed in a Section 811 unit.

Public Housing Authorities

As of November 7, 2016, 138 Williams and Colbert Class Members (104 Williams and 34 Colbert) have converted from a Bridge Subsidy to a CHA Housing Choice Voucher and 3 have been issued vouchers. From the Second Round of submissions (69 total), 37 vouchers have been issued and 14 people have completed the leasing process and converted a Bridge Subsidy to a CHA Housing Choice Voucher (12 Williams and 2 Colbert). Processing of the Second Round continues and a third round will be submitted before the end of 2016.

The Housing Authority of Cook County (HACC) has committed 10% of turnover vouchers to the Consent Decrees with an anticipated yield of 50 Housing Choice Vouchers (HCV), 35 PBV and Public Housing units, and 35 Non-elderly Disabled (NED) Vouchers for a total of 120 units. To date, HACC has converted 33 Williams and Colbert Class Members from Bridge Subsidy to HACC Housing Choice Vouchers. HACC have committed to provide an additional 60 vouchers annually.

Forty-one Williams Class Members currently residing in Lake County using a Bridge Subsidy are in process of certification and briefing, the second step in the process to convert to LCHA Housing Choice Vouchers. We will continue to send pre-applications from Williams Class Members in batches for processing by the LCHA. Williams Class Members who currently reside in Waukegan and North Chicago will be able to continue to live in their homes. LCHA has created interagency agreements with the Waukegan Housing Authority and the North Chicago Housing Authority so that they can administer Housing Choice Vouchers within their jurisdictions. Class Members who reside in Waukegan and North Chicago will request a reasonable accommodation in order to access the LCHA – administered HCV within Waukegan and North Chicago.

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Illinois Rental Housing Support Program (RHSP) and Long Term Operating Support (LTOS) Program

The Illinois Rental Housing Support Program is a State-funded rental assistance program developed with annual appropriation of approximately \$25-30 million. The funding comes from a \$10 real estate document recording fee collected at the county level, \$1 of which stays with the county and the balance is deposited into a RHSP fund. The RHSP is designed to provide long term assistance for permanent housing. Resources are allocated statewide based on a formula, with the Chicago administered program receiving 43% of resources. The Illinois Housing Development Authority (IHDA) administers the program for the balance of the State. IHDA then allocates rental assistance funding to local administering agencies across the State, which manage their own waiting lists.

On a per year basis, a minimum of 10% of the funding under RHSP is available as the Long Term Operating Support (LTOS) Program to provide up to fifteen years of long-term, project based, rent subsidy to newly available affordable units, in order to increase the supply of affordable housing to households earning at or below 30% of Area Median Income (AMI). RHSP (including LTOS projects) currently funds 1,175 units with rental assistance subsidy. At this time, IHDA predicts about 150 new rental assistance subsidies will be issued through the LTOS Program in FY 2017, based on an estimated range of subsidies becoming available as State funds from previous fiscal years are provided to IHDA

Innovations Accelerator Program for Housing Tenancy and Support and the 1115 Waiver

In October of 2015, the Centers for Medicare and Medicaid Services (CMS) launched a new initiative focused on quality outcomes concerning Medicaid-funded Long-Term Services and Supports (LTSS). The Medicaid Innovation Accelerator Program (IAP) is designed to build State capacity and support ongoing innovation in Medicaid. IAP is providing targeted support to states' ongoing delivery system reform efforts across four new program priority areas: (1) substance use disorders; (2) Medicaid beneficiaries with complex needs and high costs; (3) community integration - long-term services and supports, and (4) physical/mental health integration. Illinois applied for IAP's third program area, for its Housing Related Services and Partnerships focus area.

Illinois was selected in early 2016 as one of eight states in the nation to received intensive technical assistance. Illinois has a core team of agency staff from IDHFS, IHDA, and IDHS, as well as a representative from CSH. The IAP technical assistance began in February 2016 and will end in December 2016. The assistance included webinars on the basics of Medicaid, housing resources, and how to connect them, including case studies from across the country of successful partnerships. It also involved two convening's with the seven other states in Washington D.C., where states share information on their progress and have an opportunity to work directly with their technical assistance providers.

The IAP team meets regularly and has so far created a services crosswalk to determine where service funding may be currently lacking; compiled a housing assessment to look at what existing programs might be underutilized for supportive housing; created an agreed upon Supportive Housing Services definition; and worked on Illinois' 1115 Medicaid Demonstration Waiver application. The IAP team will continue to meet during the 1115 Waiver's review process to determine other Medicaid authorities and populations to provide Supportive Housing Services access.

Corporation for Supportive Housing

During this reporting period, the Corporation for Supportive Housing (CSH) continued its contract deliverables with DMH to assist in developing housing access. CSH facilitated and brokered policy discussions between DMH and housing developers, advocates, other governmental entities, and investors with the goal of leveraging quality supportive housing. This involves impacting the housing operations and client access to units, the planning and delivery of effective services, and the coordination between housing and services to get and keep the target populations in housing in the long-term.

- Housing Policy & Cross-Systems Partnerships:

Mental Health Systems Collaboration with Chicago Area Homeless Systems

Chicago and Suburban Cook homeless continua of care are developing and implementing coordinated entry systems that will provide a uniform assessment, referral, and prioritization of housing resources for people experiencing homelessness. The goals of the homeless system are to end chronic homelessness, reduce a recurrence of homelessness, and decrease the length of homelessness. CSH convened community mental health providers, people with lived experience, hospital providers, and state mental health staff to discuss how the new homeless coordinated entry systems can help identify and prioritize people with serious mental illness for supportive housing resources. This may help with the recidivism rates into state mental health hospitals and intercept people that may ultimately be referred for nursing home placement.

- Statewide Collaborative Planning for Supportive Housing:

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

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

- **Public Housing Authority Outreach:**

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

Recently CHA extended its commitment of Housing Choice Vouchers to non-Williams Bridge Subsidy consumers. CHA committed 325 additional vouchers. CSH will support this process as well to ensure smooth access to these housing resources.

Center for Medicare-Medicaid Services Innovation Accelerator Program (IAP) for Medicaid Housing-Related Services and Partnerships:

CSH joined the Illinois State Team for the CMS IAP for Medicaid Housing-Related Services and Partnerships program. This team is one of eight states to receive intensive technical assistance to create or expand Medicaid-financed services for pre-tenancy and housing tenancy supports that will apply to Long-term Services and Supports populations and those experiencing chronic homelessness. As a result of this planning, the state included Tenancy Supports in its 1115 Waiver submission in October 2016.

Trainings & Presentations

- **Landlord Trainings on Supportive Housing and Williams Consent Decree**
CSH works closely with the Statewide Housing Coordinator to deliver training presentations on the Williams Consent Decree and Bridge Subsidy directly to landlord groups. CSH delivered the following trainings to landlords:

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- October 1, 2016 – CHA Symposium and connected with over 200 landlords

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. CSH completed data reconciliation to have accurate records, and provided training to all users on new processes.

Increasing Housing Availability

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

Consumer Satisfaction with Housing and Improving Housing Assessment Process

- Consumer Housing Assessment:
During the course of Williams’ implementation, additional housing models beyond the scattered-site approach have been requested and allowed. It is recognized that in order to maximize the number of people exiting institutional care a greater range of supportive housing settings and support models will be needed, and in some cases a more intensive approach to service is also needed in addition to ACT or CST. CSH, DMH, in partnership with Resident Reviewers finalized the assessment too. The goal is to connect and be able to successfully serve additional more Class Members with housing options and lessen the number of denials of transition if persons will not be successful in the scattered-site ACT model that is the primary option.

Illinois Housing Development Authority

CSH assisted IHDA in reviewing its Qualified Allocation Plan to assure that the language and incentives for the development community align with the goals of the Consent Decrees and other

special needs populations in Illinois. CSH also completed an on-line Toolkit for housing developers, property managers, services providers, and funders that will provide comprehensive information on considerations to create six different forms of supportive housing. CSH is also holding four webinars for the community on creating supportive housing, senior supportive housing, reasonable accommodation, and marketing properties to supportive housing populations.

Supervised Residential Reintegration

Access to Supervised and Supported Residential settings is vital to assure a continuum of services with an array of options available to Class Members who may require different levels of support to transition to independent living.

During this reporting period, there have been fourteen Class Members who transitioned from an IMD to a Supervised/Supported Residential setting. Since inception of the Consent Decree, there has been a cumulative total of fifty-four (54) Class Members who have stepped-up from Long Term Care through transition opportunities made available in a Supervised/Supported Residential setting.

Eviction Prevention Strategy

DMH practices eviction prevention to help sustain positive relationships with landlords and to prevent, if possible, Class Members from eviction for a variety of reasons, which are mostly in response to tenancy violations. The method of “eviction prevention” involves a staffing teleconference with the Class Member, community agency, subsidy administrator and DMH (Housing Coordinator and other staff).

Since July 2017, DMH’s housing coordinator has scheduled a total of ninety-six teleconferences with Class Members, mental health agencies, subsidy administrators and other DMH staff. Because of multiple calls on behalf of some Class Members, there were fifty-nine unduplicated Class Members staffed, with twelve Class Members who voluntarily moved to avoid eviction; four Class Members temporarily returned to Long Term Care for medication management issues that required nursing oversight; one Class Member is pending termination of the bridge subsidy due to egregious behaviors in violation of the lease and unwillingness to engage in monthly wellness checks; three Class Members are pending warning letters due to their continued unwillingness to engage with the monthly wellness check, as well as aggression towards others; and thirty-nine Class Members were staffed to approve relocation due to a request change the living environment when the lease expires or who have been given an opportunity to move without landlords proceeding with eviction.

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For a small cohort of Class Members, there continues to be an array of different types of housing related situations that perpetually occur which create challenges for the Class Members and the community at large. Themes of these ongoing challenges includes, unauthorized squatters, other individuals using the apartment to sell drugs or perform illicit activities, Class Members “renting out” apartments, and people taking advantage of the Class Members’ naiveté. The teleconference calls are means to address these challenges before the seriousness of the matter raises to the level of eviction.

INDIVIDUAL PLACEMENT AND SUPPORT

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. The following IPS data was taken from the last IPS Supported Employment Consent Decree Counts Report dated 11-21-2016. There have been 327 *Williams* Class Members enrolled in IPS since July 1, 2012. Ninety-eight (98) Class Members or 30% of the *Williams* Class Members who received IPS Supported Employment have worked. There are currently 118 *Williams* Class Members enrolled in IPS Supported Employment and 37 (31%) of them are working.

The table below reflects the number of months of job tenure for the 43 Class Members who worked in mainstream competitive work experiences in Fiscal Year 2017 (2 of the class members held 2 jobs). The categories of employment for these Class members include Retail, Food Service, Hospitality, Administration, and Health Care. (Note: The IPS data system only tracks persons while they are receiving IPS-Specific services and supports. Once someone transitions off the IPS caseload successfully and stably employed, their working activities are no longer tracked in the IPS data system. This job tenure data reflects the number of days worked while on the active IPS caseload.)

	Job Tenure				
	31 to 45 days	91 to 120 days	121 to 150 days	151 to 180 days	Over 180 days
# of Class Members	1	5	4	1	34

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Over 180 Days	Job Titles	
	Assistant/Floater	1
	Associate	1
	Bagger	1
	Bell Ringer	1
	Cart Pusher	1
	Cashier	2
	Concessions	1
	Courtesy Clerk	3
	Crew Member	2
	CRSS/Assist Mg.	1
	Day Laborer	2
	Dishwasher	1
	Fast Food Worker	1
	Food Server	1
	Food Service Worker	1
	Fry Cook	1
	General	1
	Home Health Care Aide	1
	Industrial Cleaner	1
	LPN Home Health Aide	1
	Office Assistant	1
	Production	1
	Real estate broker	1
	Receiving Clerk	1
	Relief Doorman	1
	Sales Associate	1
	Service Clerk	1
	Unknown	1
	Utility Clerk	2
	Warehouse	1
	Total Job Titles	36

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

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In FY15, DMH developed an action plan to increase the engagement of Williams and Colbert Class Members around work. This plan included a list of strategies including hiring a project manager/employment trainer, developing an employment education and outreach campaign, providing broad based and targeted IPS training and technical assistance, building drop-in-center skill and capacity to engage Class Members around employment, and building ACT Team capacity to provide IPS and evidence-informed employment practices. Process and outcome monitoring systems are currently evaluating the effectiveness of the plan.

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

- Held an Employment Summit on September 2nd at Madden Mental Health Center to build enthusiasm around employment engagement activities at the drop-in centers as well as referrals to the IPS Supported Employment program or other employment program. The attendees at the Employment Summit included Drop-In Center Coordinators, Peer Staff that work at the Drop-In Centers, *Williams* Quality Administrators, an Employment First Manager, DMH Leadership, and IPS Employment Trainers were also present.
- Met with Drop-In Center Coordinators and their staff at all 18 Drop-In Centers.
- Continued to host monthly *Williams* Employment Learning Collaborative Conference Calls with the Drop-In Center Coordinators and *Williams* Quality Administrators.
- Continued to initiate individual meetings with the Community Mental Health Centers around having their ACT Vocational Worker implement more of the Evidence Based IPS Principles of Supported Employment.
- Continued to hold discussions with the Community Mental Health Centers on how they can improve Clinical Integration around Employment with their ACT, CST, and CSI Teams.
- Developed a third Flyer to Encourage Engagement Around Employment with the Class Members.

In this reporting period, a Survey Monkey continues to gather Employment Engagement Data on a weekly basis for *Williams* Class Members that attend the Drop-In Centers. There has been an increase in Employment Engagement Activities as well as referrals to IPS Supported Employment or other Employment Program since the last reporting period. Attached on the following pages are the Survey Monkey Questions that are asked to Drop-In Center Coordinators each week for their Employment Engagement Data.

The data collection showed that approximately 196 Employment Engagement Activities are taking place per month resulting in an average of 49 Employment Engagement Activities per week and

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occurring across the Drop-In Centers. There are 18 Drop-In Centers. One Drop-In Center was just added recently to this report and is not counted in this data.

Drop-In Center Employment Program Engagement Tracker

Keeping Employment Always Present At The Drop-In Center!

1. Please enter your Drop-In Center Site name and address.

2. Please enter your first name and last name

First Name

Last Name

3. How many Employment Engagement Activities (resume writing, mock interviews, employment related guest speakers, job search, job club group, information about benefits, discussion about work, etc.) did you host at your Drop-In Center this week?

4. How many Williams class members attended your Drop-In Center this week? Please count each Williams class member only once a week.

5. How many Williams class members at your Drop-In Center participated in Employment Engagement Activities (resume writing, mock interviews, employment related guest speakers, job search, job club group, information about benefits, discussion about work, etc.) this week? Please count each Williams class member only once a week.

6. How many Williams class members attended an Employment Engagement Activity for the FIRST time this week?

7. How many Williams class members did you refer to IPS Supported Employment or other Employment Program this week?

8. How many Colbert class members attended your Drop-In Center this week? Please count each Colbert class member only once a week.

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9. How many Colbert class members at your Drop-In Center participated in Employment Engagement Activities (resume writing, mock interviews, employment related guest speakers, job search, job club group, information about benefits, discussion about work, etc.) this week? Please count each Colbert class member only once a week.

10. How many Colbert class members attended an Employment Engagement Activity for the FIRST time this week?

11. How many Colbert class members did you refer to IPS Supported Employment or other Employment Program this week?

12. How many non-Williams/Colbert class members attended your Drop-In Center this week? Please count each non-Williams/Colbert class member only once a week.

13. How many non-Williams/Colbert class members at your Drop-In Center participated in Employment Engagement Activities (resume writing, mock interviews, employment related guest speakers, job search, job club group, information about benefits, discussion about work, etc.) this week? Please count each non-Williams/Colbert class member only once a week.

14. How many non-Williams/Colbert class members attended an Employment Engagement Activity for the FIRST time this week?

15. How many non-Williams/Colbert class members did you refer to IPS Supported Employment or other Employment Program this week?

1115 WAIVER

The State has filed an application for an 1115 Waiver Demonstration, and is awaiting a decision from Federal CMS. If approved, the waiver will allow for the expansion of several services which will benefit Class Members and others. The goals as stated in the 1115 waiver application include:

1. Rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based care
2. Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs
3. Support development of robust and sustainable behavioral health services that provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need
4. Invest in support services to address the larger needs of behavioral health members, such as housing and employment services
5. Create an enabling environment to move behavioral health providers toward outcomes- and values-based payments

In order to achieve these goals, the State will be focusing on the development of integrated health homes, which are considered a key component to successful outcomes for individuals with serious mental illnesses complicated by complex medical problems. This is a frequently identified need among the Williams population. The additional investment into support services such as housing and employment, both of which have been a focus of the Williams Implementation Plan since its inception, will provide the opportunity to further develop and sustain these necessary services. A move to outcomes- and values-based payments will allow for the State to incentivize providers whose focus is on assisting individuals in their trajectory of recovery, an essential shift in transforming the system of care to a person-centered approach.

The benefits to be obtained through the waiver include:

1. Supportive housing services
2. Supported employment services
3. Optimization of the mental health service continuum

In addition to the development of integrated health homes, the waiver will allow the State to invest funds into workforce-strengthening initiatives to address the lack of adequate numbers of essential staff to provide services. Professional shortages of psychiatrists, nurses, and occupational therapists in mental health care have all been identified as areas that could be addressed through the creation of a loan repayment program. Curriculum redesign to ensure

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focus on integration of care, as well as further development of telemedicine infrastructure is also planned.

Pending approval from Federal CMS, the State intends to begin this 1115 Waiver Demonstration on July 1, 2017. Concurrent with the waiver application the State Departments are reviewing the current Community Mental Health Medicaid Services Rule 132 to determine changes needed to allow for more providers to serve those in need of such services.

As a part of the Balancing Incentives Program (BIP), the State developed services intended to increase the supports necessary for individuals who were either identified as Unable to Serve, or determined to be at risk of being identified as such during their referral and transition phase with community providers. Despite the identified interest in providing these services, the utilization of them has been remarkably low, thus work in the past several months has been centered on a better way to meet these identified needs. The State is now planning to utilize the Williams Ambassadors to provide the support services that were previously planned through the In Home Recovery Support Services. This has several advantages. First, it increases the activity of the Williams Ambassadors, allowing the provider to employ the individuals for more hours, which will make the job a more attractive one to individuals seeking employment, and allow the provider to retain individuals in the role who might otherwise leave in favor of full time work. Next, it builds on the advantage of having individuals specifically with lived experience in the IMDs filling this role, which will add to the sense of hope instilled in the individuals in need of this extra level of support. In addition, the State believes that it will be beneficial to have the individuals who have been working in the Ambassador role, and therefore already establishing a relationship with individuals in the IMDs, to extend this role as the individual plans for and transitions to life in the community. Finally, it allows for a clearer line between the clinical work of the treatment team and the supportive function of the Ambassador. The State is currently in the process of contract negotiation for this change.

STRATEGIES FOR OFFERING CHOICE AND COMMUNITY ALTERNATIVES TO LONG TERM CARE / FRONT DOOR

To address the requirement in the Williams Consent Decree that no individual with serious mental illness, “whose Service Plan provides for placement in Community-Based Settings shall be housed or offered placement in an IMD at public expense unless, after being fully informed, he or she declines the opportunity to receive services in a Community-Based Setting.” (Decree, Par. 8(b)), the State created a dedicated Task Force of responsible agencies January 25, 2016. The Task Force is comprised of key staff from the Departments of Health and Family Services, Human Services/Division of Mental Health, Public Health and the Governor’s Office. Following a review of the SMHRF Act and the corresponding administrative codes, the Task Force completed a deep-dive of current screening and discharge practices, linkage and interventions, and explored viable options to allow provider agencies to offer the necessary supports and services in the community.

After lengthy negotiations with Plaintiffs over the past eleven months, the state submitted its Strategies for Offering Choice and Community Alternatives to Long Term Care (LTC) - the so called “Front-door Plan” – November 21, 2016. The Plan lays out the steps the State proposes to take to build capacity to offer choice in the community, a major component of which is a short-term Pilot Program that will allow for testing certain changes and inform the comprehensive system-wide rollout of the anticipated 1115 Waiver changes.

Proposed Pilot:

Targeting north and central Chicago, the six month Pilot Program will identify those services and strategies that are most effective in reducing LTC referrals. The State will enter contract negotiations with three separate provider agencies to fund services that are not currently billable to Medicaid. Provider agencies will have the flexibility to develop the following services as they deem appropriate:

- a) Mobile Crisis;
- b) Discharge Planning/Linkage/ Coordination; and
- c) Development and Provision of Community-Based Services.

Mobile Crisis and Discharge Planning teams will work with eleven hospitals to evaluate individuals experiencing crisis with serious mental illness and link them to appropriate community-based services and supports. The agency will identify the most needed services and

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residential options and will develop capacity accordingly to ensure the capacity to serve the targeted population. Funding will be flexible to allow the community providers to apportion the funding to the areas of greatest need within the community at issue, and can include expansion of current services, development of residential options, and efforts to further participation in treatment or any other service that will be identified in the contract.

Also included in the Plan, the State proposes a number of longer-term changes that will allow expansion of the pilot and ensure more sustainable community alternatives. Working with collaborations of community providers the following changes include:

- a) Crisis Response;
- b) Discharge Planning/Coordination;
- c) PASRR Reform; and
- d) Development of Community Capacity.

The State will work with the community provider Collaborative to increase capacity for Community Based Services and Settings, which will include all available options identified in the Decree including Supervised and Supported Residential options, as well as expansion of PSH (as defined by the State). In addition, with respect to Crisis services, the State may also provide flexible short-term assistance in order to assist individuals in either retaining or returning to independent community living.

SPECIALIZED MENTAL HEALTH REHABILITATION FACILITIES (SMHRF)

As of November 1, 2016, the Department of Public Health (DPH) has received 22 applications for provisional licensure to provide Recovery and Rehabilitation services. Applications have not yet been received from Bourbonnais Terrace or Kankakee Terrace, but the facilities have now indicated that they are moving forward with submission.

- DPH has undertaken physical plant (life safety code) and health inspections to determine provider compliance for issuance of the initial provisional licenses.
- DPH is working with DMH on Part 380, Section 130d [Staff Qualifications and Training Requirements]: "...The curriculum for staff training will be developed or approved by DHS-DMH and will include, but not limited to, understanding symptoms of mental illnesses; principles of evidence based practices and emerging best practices, including trauma informed care, illness management and recovery, wellness recovery action plans, crisis prevention intervention training, consumer rights, and recognizing, preventing, and mandatory reporting of abuse and neglect. Training shall also include relevant health and safety matter..." DMH has retrieved all materials gathered from the University of Illinois, School of Social Work (previous training contract) to review the training topics and proposed curricula.
- Part 380, Section 710 g)1) [Applications Process and Requirements for a Provisional Licensure): "... DHS-DMH will advise the applicants of the training that shall be completed prior to the issuance of the provisional license..." In October 2016, DMH released the blueprint for the training Modules to DPH and is working on standards to evaluate the training.
- DPH and DMH will hold ongoing meetings to solidify the training topics and training requirements.

Managed Care and the Williams Class

As of September 30, 2016, approximately 3,639 Williams Class Members resided in 24 nursing facility/institutions for mental disease. Of this total, 2,830, or just under 85%, were enrolled in a health offered by one of thirteen (13) managed care entities contracted by Healthcare and Family Services, the state Medicaid agency.

Of the Williams Class transitioned to the community (1,676 as of November 15, 2016), 1013 or just over 60% were similarly enrolled in managed care. Class members not enrolled in managed care receive Medicaid-covered services through a fee-for-service arrangement.

Pilots

St. Bernard Hospital – Transition Coordination

August 18, 2016, DMH entered into a Transition Coordination pilot with St. Bernard Hospital. The propose of this pilot was to answer the question: “if, with the resource of a Transition Coordinator – one who can access community-based option as alternatives to Long Term Care – would there be a change pattern in the volume of referrals for admission to skilled nursing facilities/IMDs for individuals diagnosed with serious mental illness or co-occurring SMI and Substance Abuse disorders?

Negotiations with St. Bernard’s administration occurred for approximately two months which finally culminated in a written agreement for one of DMH staff to serve as the Transition Coordinator. The terms of this agreement were that the staff would work in the hospital two days a week, Tuesdays and Thursday for a regular eight hour shift. There would be phone access for off-site days. Staff would work in concert with the hospital’s social workers/discharge planners. The Transition Coordinator would have access to all available resources identified by DMH Central Office, as well as resources available at the Region level and with the DMH contracted community vendors. The Transition Coordinator would maintain a weekly log of all interactions with hospital staff that resulted in a diversion from LTC admission.

The Transition Coordinator was assigned to the Social Work Department. The Social Work Department consists of a total of six social workers, two are assigned to the Psych Unit and the other four are assigned to Med/Surge Unit. The Transition Coordinator distributed flyers to educate the hospital’s social workers about available community-based resources, including the DMH warm line; Crisis hotline, and the Recovery and Empowerment state wide calls. Additionally, an array of materials was placed on the Psychiatric Unit for distribution to the patients being readied for discharge which provided information on community alternatives. During this three month period, the Transition Coordinator received one inquiry on a patient being considered for Long Term Care admission. This patient was subsequently transferred to another hospital. The Transition Coordinator had ten contacts with social workers to discuss other cases, such as children with Autism or patients who were developmentally delayed. There were three planning discussions on cases that required a referral or assistance for placement in a group home.

Although the intent for the St. Bernard Hospital pilot was solid, the volume of referrals in consideration for Long Term Care admission due to mental illness was insufficient. Even though

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St. Bernard Hospital's Emergency Department has the second highest transfer rate to Madden Mental Health Center (State Psychiatric Hospital) it is not reflected in the number of patients who are ultimately referred from the inpatient unit for Long Term Care.

A November meeting is scheduled with St. Bernard Hospital's administrators to evaluate the continuation of this pilot.

Thresholds and Trilogy Pilot

Trilogy's pilot (located on the premises of Albany Care), was to identify five Class Members from the Unable to Serve list; to engage these Class Members while residents of the facility and provide necessary services and supports that would enable them to transition to the community, at the end of the pilot period. The five Class members were identified via collaborative discussion with staff from Albany Care and Trilogy's team. Trilogy's team was staffed with a Transition Coordinator (QMHP), Occupational Therapist, Peer Support Specialist and medical staff. The team worked to coordinate care with the IMDs nursing staff, made recommendations for treatment and participated in regular meetings with the facility's staff to discuss progress. Trilogy's staff engaged Class Members in individual and group skill-building, assisted them in accessing community resources, provided counseling, as needed; provided comprehensive occupational therapy assessments, integrated health assessments, social and communication skills training, anger management and ADL and IADL skill-building. Trilogy provided an average of 5.7 hours of service per Class Member, per week. Some received more hours of services than others based on their areas of need and the frequency with which they were willing and able to engage. Of the five Class Members identified for the Pilot, one Class Member transitioned.

Barriers identified:

- The limited time frame of the Pilot did not afford sufficient time to work on more difficult to address, serious risk factors (skill deficits, behavioral, medical) that impacts safety to the Class Member and potentially others;
- The lack of access to identified/needed services to support successful transition, i.e., DD services, in-home attendant due to fall risks;
- The lack of communication/access to the facility's primary care physician and psychiatrist to provide consultation and collaboration on medical care needs
- The inability of Trilogy's medical staff (psychiatrist and internist) to become a primary care provider for the identified Class Members:
 - i. Requires a process of becoming credentialed by the IMD to care for residents in the IMD;

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- ii. Requires Trilogy's psychiatrist to be available 24/7 for on call access by IMD nursing staff
- Trilogy doctors could not bill for treatment or order tests or change medications without the IMD primary physician's authorization.

Thresholds Pilot was based on the identification of ten Class Members from the Unable to Serve list who have complex medical conditions and/or behavioral managements issues or other significant risk factors and to overlay intensive services of an ACT plus model to strengthen and support any skill deficit that may present barriers in community stabilization, plus a peer support staff. Thresholds was to immediately facilitate community transition then provide wrap-around services to meet the Class Members' needs post transition.

Thresholds identified Class Members for this pilot who were residents in NF/IMDs located on Chicago's north side. At the end of the pilot period, five Class Members had successfully transitioned to the community. However, Thresholds remains committed to transition a total of ten Class Members for this pilot.

Thresholds made efforts to reach 100 Class Members from the Unable to Serve list for this pilot. Thresholds also reached out to Class Members engaged with agencies. The results of these attempts are below:

- 18 Class Members were referred to the pilot (10 originally identified for the Pilot)
- 26 Class Members were unable to be located at the given IMD/NF – whereabouts unknown
- 5 Class Members did not want to work with Thresholds and wanted to work with another agency
- 1 Class Member had died
- 24 Class Members declined:
 - i. 22 not interested
 - ii. 2 guardians refused
- 26 Class Members were determined to remain on the Unable to Serve status:
 - i. 4 presented serious cognitive delays
 - ii. 9 had high risk medication administration needs
 - iii. 8 continued to display high risk aggression/sexual aggression
 - iv. 5 had uncontrolled psych symptoms requiring 24 hour care (i.e., smearing feces)

Five Class Members out of the original ten continue to work with Thresholds' team to increase independent living skills that will best facilitate a smooth and safe transition. An additional

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Class Member was added to transition efforts under this pilot to make the total now eleven. Of the six remaining Class Members:

- 1 Has an inspection pending;
- 1 Has viewed two apartments in the last week;
- 1 Is in the housing search;
- 1 Plans to move back in with a friend on Chicago's south side (outside of the team's service area).
- 2 Are being assessed by Thresholds' team and psychiatrist for consideration to move towards transition planning.

Barriers identified:

- Class Members were more medically and psychiatrically complicated which required increased time to assess and engage.
- Difficulty engaging IMD/NF to modify medication regimes while the Class Members were still in the NF/IMD
- Geographic preference – those who only wanted to live outside of the targeted service area for this pilot
- Criminal history (arson) failing background check

Neither pilot generated changes in practice as originally anticipated - that being immediate transition of Class Members to the community with more complication healthcare and risk factors. Both pilots continue to be cautious in their assessments facilitating transitions, particularly when there are

BUDGET

Williams Implementation Plan Semi-Annual Report #11 Budget Narrative

Final Spending for FY16 included \$23 million in grant funded services as well as \$5.3 million for Medicaid services to Class Members. Additional Medicaid services were provided through the Managed Care Organizations. Administrative and operational expenditures totaled \$2.9 million.

The FY17 Governor's Introduced Budget included \$35.2 million in General Revenue funds and \$7.2 million in Special State funds dedicated to expanding home and community-based services and other transitional assistance costs associated with the consent decree implementation. Expenditures through October, 2016, include \$0.81 million for administrative and operational expenses as well as \$7.2 million in grant funded services. In addition, \$1.5 million has been expended for Medicaid services to Class Members. By the end of FY17 it is estimated that spending will total approximately \$42.4 million.

WILLIAMS CALL LOG

During this reporting period, there were a total of 36 calls placed to the DMH's information number. The breakdown of these contacts is as follows:

- Number of calls received from Class Members 24
- Number of calls received from other residents of Nursing Homes 4
- Number of calls received from family/guardians regarding Class Members 2
- Number of calls from others seeking information about the Consent Decree 5
- Number of calls received from landlords or complaint calls 0

