



Division of Mental Health Williams Semi-Annual Report #12



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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 12th Williams vs. Rauner Semi-Annual Report. This report reflects implementation activities from the period of January 1, 2017 through June 30, 2017.

The impact of the State's budget impasse continues to have a rippling effect on the productivity and momentum of community mental health vendors, which are also Williams and Colbert transition and service agencies. The Colbert Consent Decree is included in this opening statement, since many providers are common to both Colbert and Williams. What invariably affects one of the Consent Decrees will ultimately have the same effect on the other.

Implementation of the Williams Decree is part of a larger organizational mission –to provide ongoing, state-of-art community-based mental health services to individuals, children and adults, who have a serious emotional disturbance or serious mental illness. With this mission in mind, these agencies must also maintain an adequate staffing mix to assure that appropriate services and supports are available – from the receptionists, to the Intake worker, to direct care clinical/therapeutic staff (both in-office and in vivo), IT support, and a host of other critical positions that are contingent on more than Williams dollars. The ongoing State's budget crisis is now a major barrier to the delivery of community mental health services and the capability of vendors to achieve the number of transitions to fully meet compliance with both the Williams and Colbert Consent Decrees.

In spite of this situation, Williams implementation has continued to proceed successfully. As of this writing, 1913 Class Members have transitioned to the community (or have a signed lease with imminent transition) since implementation. It is with the full commitment and efforts of DMH and the providers that the goal of 400 transitions will be achieved by the end of June 30, 2017.

The Front Door Pilot is fully operational, Contracts have been fully executed, training for both hospital staff and direct community care agencies has been completed, PASRR assessments are being interfaced to anchor service design and data is being collected by the University of Illinois School of Social Work. More detailed information on the status of the Front Door Pilot will be in the respective section of this report.

To seriously explore population identified as 'Unable to Serve', which will hereafter be referenced as CAST (Complexities Affecting Seamless Transition), during the past four months DMH placed an administrative moratorium on the addition of any newly identified Class Members to the list, until the current list of CAST Class Members has been completely evaluated and exhausted. Thereafter,

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agencies must staff a Class Member with DMH before he/she is added to this list. Simultaneously, DMH has conducted weekly Clinical Case Review Panels to address Class Members currently on the CAST list. This process offers a four person panel of clinical experts (psychiatrist, registered nurse, social worker/occupational therapist and a Certified Recovery Support Specialist (CRSS), an opportunity to hear clinical, functional and service need presentations, from agencies on each Class Member on the CAST list. Following the presentation, the panelists make recommendations on the most appropriate services and supports to facilitate and actualize community transition or the most appropriate level of care needed.

Concurrently, this moratorium is allowing DMH to completely remove from the CAST list Class Members identified who are now deceased, who have left the IMD (Institute for Mental Disease) facility (whose whereabouts are unknown), and who have transitioned through other agencies, as well as those who continue to decline/refuse transition and those who have been reassessed and are no longer recommended for transition due to changes in their function/clinical needs. More information on the Clinical Case Review Panel and CAST will be in a section of this document.

As federal funding for the Balancing Incentive Program (BIP) concludes, DMH has executed a contract with NAMI Chicago to assume the support role to provide In-Home Recovery and Support. It is the state's belief that by aligning this support with a peer modeled agency it will provide the right incentive to Class Members who are struggling with achieving comfort in transitioning to independent living and who can benefit from modeling someone who is currently in recovery. DMH will be monitoring this support resource very closely in the upcoming fiscal year.

The infusion of Health Homes, changes to the State Plan, changes in allowable, billable services with the inclusion of physical health care nursing as a critical component to ACT teams, and better interface and communication with Managed Care Organization will help achieve compliance. Our eye remains on the bigger picture of sustainability and community system enhancement – ensuring that the state has the right systems in place with the right staff resources and supports (work force development) to change the trajectory away from long term care with the capability to adequately provide care in the community. For this goal to be realized, it must be approached intentionally and collectively as the state moves forward to sunset the Consent Decree.

Outreach and Information Dissemination

Outreach Workers

NAMI Chicago Outreach Workers continue to provide Class Members with resources that can assist them as they prepare to move out of IMDs. Outreach Workers provide Class Members with information on their rights under the Williams Consent Decree, help answer questions and concerns about the process, show Moving On videos to all Class Members who are interested and provide information on the supports and services available to Class Members under Moving On. NAMI Chicago continues to work in tandem with Moving On Outreach Ambassadors and Class Members who have successfully transitioned from the IMDs to the community.

Outreach Workers continue to conduct baseline Quality of Life Surveys (QLS) with Class Members who are nearing transition from IMDs. During this reporting period, 86 baseline surveys were completed.

During this reporting period 248 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 240 private interviews with Class Members. Outreach Workers were approached 2,940 times with questions or concerns about the process. Approximately 124 new Class Members refused to engage with Outreach Workers when approached. Lastly, the Outreach Workers made contact with 33 guardians via telephone or in person.

Ongoing Outreach Activities

Outreach Workers act 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 consult with the specific agency and provide feedback to the Class Member. Outreach Workers visit each IMD on a biweekly basis which allows for timely follow-up. In addition, Outreach Workers conduct the following activities:

Consent for Specialized Assessments

While conducting an assessment, the Resident Reviewer may find it necessary to gather additional information, in an effort to make a decision about a Class Member's eligibility for community living. Once DMH receives a recommendation for additional testing (neurological or occupational), Outreach Workers are alerted and contact the Class Member to explain the process and obtain their consent to participate in the testing.

Assessment Requests

NAMI Chicago Outreach Workers continue to work in conjunction with Lutheran Social Services

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and Metropolitan Family Services to ensure that every Williams Class Member has been provided an opportunity for an assessment. Outreach Workers send a weekly list to the Resident Reviewers, documenting Class Members who have requested an assessment. This weekly communication provides assistance to the Outreach Workers, who inform Class Members on the status assessment.

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 requesting this change.

Drop-In Centers

Outreach Workers provide 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 brochures from Drop-In Centers that includes the centers' programming, locations and telephone numbers. Class Members are encouraged to visit Drop-In Centers, where they can communicate with others who have successfully moved into the community. Additionally, Outreach Ambassadors are provided with preloaded transit cards, to provide public transportation for Class Members on visits to Drop-In Centers.

Quarterly Community Meetings

NAMI Chicago Outreach Workers are responsible for facilitating quarterly community meetings at each IMD. These meetings give Williams Class Members an opportunity to receive information on the Williams Consent Decree in a group setting from Williams Ambassadors. Each Ambassador receives an honorarium of \$25.00 for his/her participation in those meetings.

As of this writing, Outreach Workers have held three of the four required meetings for FY17. The last round of meetings is scheduled for June 2017. Approximately 1,100 Class Members and 40 different Ambassadors were present at these meetings. Outreach Ambassadors facilitate these meetings but Outreach Workers are on hand to provide details on the steps of the Moving On process, information on how to get involved, and advice on how to prepare for the assessment. The Moving On videos were shown at some of the meetings.

Recovery and Empowerment Statewide Call

Outreach Workers continue to provide Class Members with an opportunity to participate in the monthly 'Recovery and Empowerment Statewide Call'. The intent of these monthly educational forums is to allow transitioned Class Members to share successful tools and strategies for wellness, to further encourage those Class Members who have not yet transitioned.

Outreach Ambassadors

The Outreach Ambassadors are an extension of NAMI Chicago Outreach Workers. Since November 1, 2015, fourteen post-transition 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. Eight Ambassadors 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. Ambassadors also attend and present their stories and advice at the quarterly community meetings held in the IMDs as well as 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 as well as protocol on how they are to conduct themselves in the IMDs.

In-Home Recovery Support

In-Home Recovery Support is intended to assist pre-transition Williams Class Members by providing linkage to community resettlement resources and support throughout the transition process. This support will be provided to Class Members while they are still living in the IMD and will continue once the Class Member transitions into the community. This support will be provided in combination with the on-going team services from the community mental health center (CMHC) where the Class Member is assigned. The intent of this support is to improve the likelihood of the Class Members' ability to transition from the IMD and maintain long-term community placement.

The purpose of In-Home Recovery Support is to provide support and reassurance to Williams Class Members who are exercising new skills, adjusting to new environments, or experiencing potential stressors, as they prepare to transition from an IMD to independent community living. NAMI Chicago is partnering with the Division of Mental Health to make this support available to Williams Class Members starting immediately and continuing in FY18. The scope of programming has been developed and NAMI Chicago is preparing for the roll out.

The intake process for this program will be conducted as described below:

- I. The Division of Mental Health, Department of Human Services, will identify eligible participants for the In Home Recovery Support program.

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- a. Resident Reviewers and CMHCs will identify Class Members who may be appropriate.
- b. Resident Reviews will notify DMH by indicating that a Class Member is “Recommended for In Home Recovery and Support”.
- II. The roll out of this program will take place in a geographically specific area in order to build capacity. Areas will be city-north, city-west, or city-south.
- III. NAMI Chicago will approach eligible individuals to inform them of the In Home Recovery Support Program and offer services.
- IV. Waitlists for this program may develop based on number of In Home Recovery Support providers available and the current capacity of staff. NAMI Chicago will notify DMH when capacity is available, at which time a Class Member would be removed from the waitlist.
- V. NAMI will provide In Home Recovery and Support to identified Class Members (pre and post transition) for a duration not to exceed 6 months. Extensions may be requested.

In preparation, NAMI Chicago has researched peer supports models such as the Peer Bridger Program and has communicated with agencies that are doing similar programming. Job descriptions, an interview process, and a staff training plan have been created. In order for staff training to be comprehensive it will include the following topics:

- Medication literacy and managing medication
- Motivational Interviewing
- SOAR (Social Security Income/Social Security Disability Income Outreach Access and Recovery
- Non-Violent Crisis Intervention
- Cultural Competency
- Systems of Care
- Williams Consent Decree
- De-escalation Techniques
- Trauma Informed Care
- WRAP (Wellness Recovery Assistance Plan) Facilitation
- HOP (Honest, Open Proud) Facilitation

There will be ongoing program evaluations to determine effectiveness of the support provided. Program changes will be implemented as necessary to ensure services meet the needs of Williams Class Members.

Resident Reviews

The Division of Mental Health remains committed to quality improvement across all systems within the Williams Moving On Transition Process. Improvements in the Resident Review processes continue to be ongoing. Resident Reviewers were provided with training opportunities to enhance skills through the Colbert/Williams training series. Lutheran Social Services of Illinois and Metropolitan Family Services participated in a series of trainings conducted by the University Of Illinois, College of Nursing.

Lutheran Social Services of Illinois (LSSI) and Metropolitan Family Services (MFS) continue to approach new admission candidates for Resident Review Assessments through the use of Healthcare and Family Services (HFS) census data. Class Member assessments continue to occur annually, quarterly upon request, by referral (from NAMI, Engagement Team Members and Managed Care Organizations (MCO)) and through self-referral and/or guardian requests. Recommendations for Use of Enhanced Skills Training and In-Home Recovery Support Services, and Supportive Employment remain in place as service support options to strengthen successful community transitions.

As with previous reporting periods, as a means to provide opportunities for transition consideration, each month both LSSI and MFS send NAMI a list of Class Members who have declined to participate in the Resident Review assessment. NAMI then attempts to engage these Class Members to explain the benefits of having a Resident Review assessment, share information and educate the Class Member about the *Moving On* Program, and address any questions/concerns about moving to the community.

DMH continues to have weekly teleconferences with LSSI and MFS. During the teleconferences, a random sample of Resident Reviews is selected for discussion. This sample is used to identify issues related to the review process. Resident Reviewers are provided with feedback regarding the sampled reviews as it related to the review process. Resident Reviewers are also provided with updates and changes to the Resident Review that may have an impact on the Class Members' transition eligibility.

Performance Measures Outcome:

The following table reflects the Quarterly Performance Measure data submitted by LSSI and MFS.

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Performance Measures Outcome¹

	# 1 Approached	# 2 Approached Refused	# 3 Signed Participation Agreement	# 4 Full Assessment Complete	# 5 Aborted Assessmen	# 6 Recommend for Transition	# 7 Not Recommend	# 8 Staff Productivity Approved	# 9 Complex Medical Need	# 10 Criminal Histories	# 11 Staff Productivity Denied
LSSI	1730	1135	1414	580	15	454	126	454	267	132	126
MFS	488	217	443	268	4	197	70	197	136	121	70
TOTAL	2218	1352	1857	848	19	651	196	651	403	253	196

Data analysis for this reporting period as compared to the last reporting period shows an overall positive increase in numbers across all performance measures indicators tracked. Noteworthy exceptions to this upward trend which still show a positive outcome is a decrease in the numbers of aborted assessments, complex medical needs being identified and decreased numbers of presenting criminal histories. The rates of Class Members “not recommended to transition” remains relatively close showing a slight increase in the total cumulative number.

¹ Time frame from October 1, 2016 – April 30, 2017

Specialized Assessments

NAMI Outreach staff work in conjunction with DMH to obtain Class Member consent for both OT and/or Neuropsychological assessments. NAMI workers report to the respective IMD, after receiving a list of referrals from DMH to obtain signed consents for Release of Information for the UIC evaluations to be conducted. The release of information allows the medical record for the respective Class Members to be forwarded to UIC, prior to their scheduled appointment for evaluation.

Occupational Therapy

The University of Illinois, Department of Occupational Therapy & Disability and Human Development (OT assessments), continues to work under contract to complete assessments for individuals with suspected skill deficits identified as barriers to community transition from our Unable to Serve list (now referred to as CAST), Hold list and existing community referrals.

To date, a cumulative total of 102 Class Members have been referred and approached for OT Assessments. Of the 102 Class Members approached, 43 gave consent to participate in an OT Assessment; with one Class Member transitioning prior to the completion of the assessment. Of the 42 Class Members assessed, 39 were recommended for community transition. As of this report, all 39 Class Members have been assigned to community mental health providers for transition consideration.

Although recommended for community transition with specified supports, the community mental health providers reported the following outcomes:

Number of Community Transitions	4
Declined to Transition	7
Transition Outcome Pending	4
Unable to Serve (Mental Health)	9
Unable to Serve (Medical)	2
Unable to Serve (Housing)	2
Unable to Serve (Financial)	1
Medical Hold	2
Hold (Housing)	1
Inaccessible/Unable to Locate Class Member	3
Recent Resident Review Denial	1
Refused Recent Resident Assessments	3

DMH will continue to work with community mental health agencies to better understand the barriers impacting transition through the Clinical Case Review Process. Contractual plans are underway to continue work with the University of Illinois, Department of Occupational Therapy

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& Disability and Human Development in FY 18. It is the aim of the DMH to continue to provide these assessments as a tool to aid and support Class Members in their ability to transition to community living.

Neuropsychological

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 workers make a subsequent attempt to contact the Class Member. The intent of the second attempt is to ensure the Class Member is clearly informed about the nature of the assessment and to offer an opportunity for the Class Member to reconsider. It is the request of DMH that NAMI Outreach 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 for Class Members who are suspected of having a severe cognitive impairment, including dementia or the onset of Alzheimer's disease. This report reflects assessment activities since January 1, 2017:

- The total number of *referrals* for a neuropsychological assessment (since inception) is one hundred twenty five (125); which includes twenty-eight (28) referrals for this reporting period.
- Each of the 28 Class Members referred during this reporting period signed the required consent form. The breakdown across facilities is as follows:

a. Lydia	18
b. Grasmere Place	0
c. Decatur Manor	2
d. Albany Care	0
e. Lake Park Center	2
f. Rainbow Beach	0
g. Kankakee Terrace	0
h. Columbus Manor	0
i. Bourbonnais Terrace	1
j. Thornton Heights	1
k. Greenwood Care	1
l. Sacred Heart	1
m. Margaret Manor Central	1
n. Margaret Manor North	1

- The *actual* number of neuropsychological assessments completed for this reporting period is eight (8).

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- There are twenty (20) Class Members who have been scheduled from the present time through May 2017.
- At the time of this writing, UIC has not been able to provide any additional time slots beyond May 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 ten Class Members to be scheduled for appointments for a neuropsychological evaluation.

Of the twenty-eight new referrals, two Class Members missed their scheduled appointments due to transportation problems, as reported by the IMD. Five 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 five Class Members were found to have a combination of psychiatric and medical problems which were too complex for them to manage 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 that they maintain this level of care .

Of the eight 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 assessments have recommended a Class Member for transition to independent living in Permanent Supportive Housing. One assessment recommended the Class Member's psychiatric treatment team should decide his appropriateness for transition to a less restrictive environment due to safety concerns as the treatment team is more familiar with the Class Member's ability to function safely in the community.

Neuropsychological Assessments:

Number of Class Members (CM) identified for assessment (new)	28
Number of CM recommended to remain in a nursing level of care setting	5
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	0

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Number of assessments pending (to date)

19

Clinical Review

During this reporting period, seventy (70) 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 seventy Clinical Reviews conducted:

- Sixty-three were supported (in concurrence with the recommendations of the Resident Reviewers);
- Seven were overturned by the clinical review team, thereby recommending community transition for those Class Members;
- Twelve appeals to the recommendation from the Resident Review/Housing options were submitted to DMH during this reporting period;
- Five appeal recommendations were supported by DMH and found to be in agreement with the findings of the Resident Reviewer;
- Seven appeals were overturned by DMH with the Class Member approved to transition and assigned to a different agency based on their geographical preferences (overturned agency assignment only).

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.

As of April 11, 2017, Northpointe Resources has been removed from CRT case assignment rotation due to staffing shortages. They are in the process of seeking to fill this clinical position on the CRT team. Also, effective March 23, 2017, Community Counseling Center of Chicago resumed case assignments for CRT.

Clinical Case Review Panel

As stated in previous reports, DMH continues to proactively address the increasing number of Class Members who have been identified as Unable to Serve. As of February 1, 2017, there were 322 Class members on the Unable to Serve (UTS) list. As of this report, Class Members who were referred to as 'Unable to Serve', will now be referred to as Class Member with Complexities Affecting Seamless Transition (CAST).

In March 2017, the Division of Mental Health (DMH) initiated a Clinical Case Review Panel (CCRP) process to review the clinical and service need profiles of Class Members who had been assessed and approved for transition through the Resident Review process, but after extensive engagement and activities with the assigned community mental health provider, were identified as 'Unable to Serve' (at this time)¹.

Operational Design

- The Panel consists of a psychiatrist, registered nurse, social worker/occupational therapist and a Certified Recovery Support Specialist (CRSS).
- The Panel convenes once a week for two hours.
- Names of Class Members to be presented on a scheduled date are obtained from the CAST list and sent to the assigned agencies' Quality Administrators.
- The agency is required to submit a synopsis detailing why the Class Member has been identified as CAST, what resources are needed to facilitate transition, what risk factors exist, how the agency can/might mitigate risk factors, why the agency cannot transition, etc.
- In advance of the scheduled panel date, the panelists are provided with the detailed synopses, the Resident Review assessments and any other pertinent information available.
- On the scheduled panel date (which are conducted via teleconference), the agency is required to make a formal presentation with requested information, and respond to questions from the panelists.
- The panel convenes an off-line conversation to reach a mutually agreed-upon recommendation, which may include: (1) proceed with transition (PSH, Supervised Housing, Supported Residential or Supportive Living Facility); (2) support maintenance while exploring other recommended options; (3) remove from CAST list (died, refused²,

¹ Excluding Class Members who have no benefit incomes (SSI or SSDI)

² Class Member would not complete the Resident Review Assessment

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declined³, unable to locate); (4) more intensive SNF level of care due to medical complexities and physical decline.

- The Panel's recommendations are sent back to the respective community agency.
- Since inception on March 15, 2017, seventy (70) Class Members, assigned to six full array Williams providers, have been reviewed by the panel. All Class Members identified as CAST as of February 1, 2017 will be reviewed under this process.

Outcome and recommendations of the Panel is as follows:

Proceed with transition ⁴	Support maintenance	Remove from CAST list	SNF level of care
8	29	30	3

- Panel recommendations are recorded and sent to the agency.
- It is the expectation that agencies will abide by and follow through with the Panel's recommendations.
- Names of Class Members who refuse or decline will be removed from CAST and sent to NAMI for outreach contact, and routed to LSSI or MFS for an annual Resident Review reassessment or quarterly assessment, upon request.
- DMH will administratively add or remove names from the CAST list, as appropriate. Agencies will not have the latitude to populate or depopulate this list.

In addition (since May 1, 2017):

- If there are challenges/barriers identified that preclude transition to the community a Class Member MUST be engaged for a minimum of six months before a determination and recommendation can be made to DMH to identify the Class Member as CAST.
- Once DMH completes the initial Panel reviews of the 322 Class Members listed as CAST, agencies will submit a request to DMH for a scheduled staffing date to present any new Class Member to the Clinical Case Review Panel.
- A Class Member may only be added to CAST after a formal presentation and review by the Clinical Case Review Panel and concurrence by the panel.
- Class Members who continue to refuse or decline transition will not be listed as CAST, but will be engaged by NAMI Outreach or Ambassadors, if appropriate.

³ Class Member would not participate when re-approached by agency

⁴ The majority of recommendations have been for Supervised Residential settings

Mortality Reviews

The University of Illinois at Chicago, College of Nursing, has conducted 6 mortality reviews since the last reporting period. The purpose of these ongoing reviews continues to be the identification of 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 process continues to include a formal analysis of clinical documentation received from the respective provider agency and interview(s) with the agency care management team by Melissa Sautter, MS, APN, PMHNP-BC.

In response to recommendations offered by UIC noted in the last semi-annual report, a training series for Colbert/Williams was launched November 2016. This training series includes both in person and clinical webinar training opportunities targeting Community Mental Health Center teams (CMHC) Direct Care Staff, Supervisory Staff, Resident Reviewers, NAMI Outreach Workers and Quality Monitors. Training is scheduled to continue through June 2017.

As of this reporting period, DMH has received 4 of 6 Mortality Review Reports, which have been provided to CMHC staff for their intra-agency review and discussion. Conference calls were held with the respective CMHC teams, UIC staff and DMH to review and discuss outcome findings and recommendations from the Final Mortality Review Reports. Two remaining reports are being finalized and final report conference calls will be scheduled for May and June 2017. Preliminary findings and Coroner Reports confirmed the causes of death were attributed to the following:

- Heart Attack/Pulmonary Embolism
- Acute Renal Failure
- Drug and Alcohol Abuse
- Overdose (poppy seed tea)
- Cardiovascular Disease
- Unknown

UIC has agreed to complete a Mortality Root Cause Analysis Summary Report by July 2017. This document will provide a composite of each death, results of the comprehensive interviews with agencies, documentation obtained from the IMD and the Medical Examiner's autopsy report.

Since inception, there have been fifty-two deaths of Williams Class Members who have transitioned to the community. As a result of participating in the Mortality Review process, CMHC's have begun to take a more critical look at the current systems they have in place for transitioning Class Members. To more proactively assess and monitor Class Members' medical and psychiatric conditions, the following policies/procedures were implemented by one of the CMHC's. These procedural changes as outlined below, are examples from Human Services

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Center, which will be shared with the remaining CMHC's for review and possible adaptation for their systems:

- The Medical Director for Outpatient Services or his designee reviews the Williams referral packets to identify complex medical conditions and needs prior to enrolment in services. Depending on the medical issues HSC requests that Class Members obtain an updated H&P, EKG, or specific lab tests prior to transition to community.
- The Williams ACT RN has multiple meetings with IMD nursing staff to review the Class Members' medical history and needs upon transition, to address the concerns of the medical director and to follow through until the concerns are being resolved.
- Transition to the community is delayed if medical equipment or medical supplies are not available on the discharge date.
- Williams Class Members receive priority in scheduling psychiatric evaluation post discharge from the IMD and are being seen within the first month of transition.
- Williams Class Members can see the psychiatrist as often as necessary after transition until stable on medications.
- Williams Class Members are scheduled to see PCP within a month of transition and at least every three months or as often as needed thereafter.
- The Williams ACT RN has limited non-medical responsibility to focus on the Class Members who have chronic medical condition such as diabetes, high blood pressure, high cholesterol, sleep apnea and asthma. The RN visits Class Members in their homes and/or sees them in the clinic to check vitals, blood sugar levels, or to follow up on specific medical issues. The RN consults with PCP or specialty medical providers on Class Member' behalf to ensure continuity of care.
- Class Members diagnosed with HBP are encouraged when clinically appropriate to purchase individual blood pressure devices to monitor their blood pressure. HSC is preparing a grant submission to buy blood pressure cuffs so the recovery specialists can assist clients with tracking their blood pressure. The team nurse is educating the Class Members with personal blood pressure devices as well as the staff members on how to use the devices, what are the normal limits and when to call for help.
- The nursing staff is educating clients on symptoms of heart attack, stroke, and diabetic emergencies, as well as on mental health symptoms such as panic/anxiety attack that can mimic symptoms of medical conditions (heart attack).
- Nursing staff is educating clients on how to use medical equipment (C-PAP machines, blood pressure cuff, blood sugar monitors, etc.).
- The Williams ACT team does wellness check with each Class Member on Mondays in addition to scheduled appointments through the week.
- The weekend worker is available to every Williams Class Member who needs an extra contact on the weekend.
- Williams ACT staff is educating clients' support system- friends, peers, or family members to seek help on participant's behalf if they have medical discomfort or increased psychiatric symptoms.

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- The HSC Integrated health care committee is working on agency protocols to track clients with metabolic syndrome or other chronic medical conditions in order to continuously monitor lab values, vitals and changes in clients' status.

Contractual plans are currently underway to continue work with The University of Illinois, College of Nursing for Mortality Review in FY 18.

Transition Coordination and Community Services

The Division of Mental Health (DMH) has been charged with the transition of 400 Class Members for fiscal year 2017. Currently, 19 agencies are contracted to provide transition and offer community mental health services to Williams Class Members. Eighteen (18) Williams Consent Decree providers have transitioned Class Members throughout this process. This reporting period, fifteen Williams' providers are accepting ongoing referrals.

As of April 30, 2017, a total of 1904 Class Members have transitioned. By June 30, 2017, 123 more transitions are needed to remain in compliance with the consent decree.

This reporting period, January 1, 2017 through April 30, 2017, 355 Class Members have been approved to transition. One hundred-ten (110) have signed leases with their respective community mental health provider. As of April 30, 2017, 129 Class Members have declined to transition. However, when Class Members are reluctant or decline to transition, agencies continue to work with the Class Members in case their decision changes.

Though the cumulative total of transitions is 1904, the number of Class Members remaining in the community is 1320. DMH utilizes Williams providers to track resources for the Class Member's first twelve months in the community, then Class Members have the option of transferring to a non-Williams provider for services yet may keep their housing subsidies. Three hundred-thirteen (313) Williams Class Members have vacated housing and supportive services offered by Williams's providers.

One method of measuring transition outcomes is examining the length of time Class Members remained in the community with the supports of their local mental health centers. Over 59% of Class Members have remained in the community greater than 690 days, equaling 1.89 calendar years. The average amount of time Williams Class Members remain in the community is 872 days. The median length of stay in the community for Williams Class Members equals 658 days.

Quality Management/Quality Monitoring

During this reporting period, there was a focus on improving post-transition quality of care and services provided to Class Members by Williams Quality Monitors. Enhancing the delivery of services and improving customer service, required reorganizing the team of Williams Quality Monitors, which included the following: 1) centralizing the team of Williams Quality Monitors; 2) assigning a lead WQM for each agency; 3) implementing a home visit audit tool to track compliance with required visits; and 4) developing and implementing a survey tool to measure the Class Members' level of satisfaction with services provided.

There are currently nine Williams Quality Monitors, responsible for oversight of the quality of care, quality of life, community integration and the quality of services, provided to Williams Class Members post transition. Six of the nine WQMs worked in satellite offices in the Metro Chicago area; one of nine worked in the Central Office located in Chicago; and the remaining two were located in Pekin, which services Class Members in Peoria, Decatur and surrounding areas.

In February 2016, six of the nine monitors who worked in Metro Chicago satellite offices, were moved to the Chicago Central Office. It is anticipated that relocating the Williams Quality Monitors to the central office will: 1) increase interface with the management team; 2) build a collaborative working relationship with other individuals on the Williams team; 3) improve communication; and 4) better oversight. The Williams Quality Monitors in the Pekin office were not relocated.

As stated in previous reports, there are nineteen agencies that are contracted to provide Williams Class Members with transition related services and community mental health services. During the previous reporting period, WQMs were reorganized, reassigned caseloads and assigned to different community mental health agencies. In February 2016, each of the nine Williams Quality Monitors was assigned as the 'lead' WQM to at least one of nineteen assigned agencies. In an effort to foster a collaborative working relationship between the DMH and the community mental health agencies, the lead WQM is required to make a minimum of one agency visit per month. During the agency visit, the WQM meets with the agency's Williams Quality Administrator, to discuss concerns related to Class Member comprehensive service plans, Class Member concerns identified during home visits and any post transition concerns that could potentially have an impact on the delivery of care and services.

Williams Quality Monitors are responsible for conducting home visits, as required per the Williams Consent Decree. The initial Class Member home visit is conducted within 30 days of transition. Subsequent visits are conducted at intervals of 3 months, 6 months, 12 months and 18 months. As stated in previous reports, the purpose of the home visit is to determine that: 1) comprehensive service plans accurately reflects the Class Members' needs and goals; 2) Class Members' living environments are safe and suitable for habitation; and 3) Class Members are adequately adapting to community reintegration.

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As of April 30, 2017, WQMs have conducted 430 home visits for a total of 5950 visits since inception. Completed home visit data indicates the following visits were made during this period:

- Ninety-five (95) 30 day home visits
- Eighty-eight (90) 3 month home visits
- Seventy-one (73) 6 month home visits
- Eight-nine (90) 12 month home visits
- Seventy (70) 18 month home visits
- Ten (12) unscheduled home visits

During this reporting period, a home visit audit tracking tool was developed. The purpose of the tool is to track compliance with home visits at each of the required visit intervals. Home visit tracking audits will be conducted monthly. Monthly audits of missed home visits, will allow a comparison of data over a specified period of time, which will allow early intervention and corrective action, to ensure compliance with the required frequency of visits. This tool was not fully implemented until April 30, 2017. Therefore, there is no data for this reporting period.

WQMs also conducted 251 Quality of Life Surveys, during this reporting period. 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 surveys were conducted during this reporting period :

- Ninety (90) 30 day surveys
- Sixty (60) 6 month surveys
- Fifty-seven (57) 12 month surveys
- Forty-four (44) 18 month surveys

In March 2017, a Class Member Satisfaction Survey tool was developed. The satisfaction survey is composed of a total of 7 questions; five open-ended questions and two questions that require Class Members to give a rating on a performance scale. Survey questions were developed to determine the Class Members' satisfaction with transition services; as well as their satisfaction with and the most recent WQM visit. Class Member surveys will be conducted within 30 days of a WQM home visit. Class Members will be randomly selected to participate in the survey and participation is optional. Twenty percent of the Class Members, who have had a WQM home visit within 30 days, will be selected to participate in a Class Member Satisfaction Survey. Surveys are conducted via telephone, by the Williams Compliance Officer. The purpose of the satisfaction survey is to: 1) obtain Class Member feedback regarding the transition process; 2) assess the quality of care and the delivery of services provided by the agency; 3) determine Class Members' level of satisfaction with the Moving On program; and 4) obtain feedback regarding the WQM visit. Class Member Satisfaction Surveys will begin May 30, 2017.

Reportable Incidents

DHS/DMH captures Williams Class Member Reportable Incident information (Level I – Critical; Level II – Serious; Level III – Significant) for each qualifying occurrence. Previously, the Division of Mental Health required contracted agencies to capture and report all incidents that occurred with Williams Class Members, who were residing in the community. This reporting period, agencies have been asked to report incidents that occur within the first eighteen months of their community tenure. This period, ninety Class Members had incidents that needed to be reported. The total number of incidents for those 90 Class Members was one hundred forty-two.

From January 1, 2017 through April 30, 2017, the following represents the incidents reported for Class Members residing in the community less than eighteen months:

- 10 Level I incidents were recorded; with (1) death and (5) fires
- 121 Level II incidents were recorded; the most common of which was Unexpected Hospitalization/Admission (98)
- 11 Level III incidents were reported; with Property Damage being the most common (5).

Characteristics of Williams Class Members

This analysis provides an update to previous analyses performed of 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. This must be done within 7 days of their initial contact with the Class Members within the IMD in which the individual resides. The providers are also required to re-register these Class Members to update key fields at six month intervals. As of April 30, 2017, three thousand six hundred seventy two (3672) 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 April 2017 in comparison to December 2016. The clinical and descriptive characteristics appear to be fairly stable for this population.

Age Group	Count	%
18 - 20	3	0.1%
21 - 24	95	2.6%
25 - 44	1275	34.7%
45 - 64	2041	55.6%
65 and over	258	7.0%

Gender	Count	%
Female	1272	34.6%
Male	2400	65.4%

Ethnicity	Count	%
American Indian/Alaskan Native	14	0.4%
Asian	57	1.7%
Black/African American	1734	47.2%
More Than One Race Reported	11	0.3%
Native Hawaiian or Other Pacific Islander	5	0.1%
Race/Ethnicity Not Available	118	3.2%
White	1733	47.2%

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Hispanic Origin	Count	%
Central American	13	0.4%
Cuban	4	0.1%
Mexican/Mexican American	101	2.8%
Not of Hispanic Origin	3236	88.1%
Other Hispanic	81	2.2%
Puerto Rican	60	1.6%
Unknown, not Classified	177	4.8%

Marital Status	Count	%
Never Married	2726	74.2
Married	99	2.7%
Widowed	70	1.9%
Divorced	444	12.1%
Separated	104	2.8%
Unknown, declines to specify	229	6.2%
Civil Union	0	0.0%

Highest Level of Education Completed

Over twenty-seven percent (27.7%) of Class Members have earned a high school diploma and an additional 6.9% were reported as having earned a General Equivalency Degree (GED). Over twenty-three percent (23.4%) of Class Members completed some high school (e.g., one, two or three years) with no diploma earned. Almost nineteen percent (18.6%) have completed some college, and over five percent (5.2%) hold a Bachelor's Degree. A small percentage (1.1%) of Class Members have completed post-secondary training and over one percent (1.4%) have completed post graduate training. Education level was not reported for approximately fifteen percent (15.2%) of registered Class Members.

Residential Living Arrangement

A large number of individuals (27.8%) were reported as residing in private unsupervised settings (permanent supportive housing), another 1.4% were reported as living in other unsupervised settings; 13.9% were reported as living in supervised settings; and 44.8% were reported as residing in institutional settings. Data was not reported for 165 individuals (4.5%), and a small percentage of individuals were reported as residing in settings other than the ones reported above.

Military Status

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4.8% of Class Members reported being a veteran having formerly served in the military. There were another 8.2% of Class Members that were listed as unknown.

Primary Language

The primary language spoken by 98.0% of Class Members was English, while 0.5% reported speaking Spanish; another 0.7% reported as unknown.

Justice System Involvement

The majority (85.0%) of Class Members were reported as not having any involvement with the justice system (courts, jails, etc.). However, 1.5% had been arrested, 0.9% had been charged with a crime and 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. The involvement of the justice system for 9.0% was reported as unknown and 1.2% 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. 52.8% have a history of continuous treatment for mental health related problems, 74.2% have a history of continuous residential treatment, 67.3% have a history of living in multiple residential settings, and 83.8% of Class Members have a history of receiving outpatient mental health services for their illnesses. 89.1% of Class Members reported having received previous mental health treatment.

Level of Care Utilization Scale Scores Based on Assessor Recommendation

28.2% of the Class Members included in this analysis were recommended for high intensity community based services (level 3) by the assessor based on the results of the LOCUS assessment. An additional 43.7% percent were recommended for Medically Monitored Services: 35.1% were recommended for Non-Residential while 8.6% were recommended for Residential. 3.2% were recommended for a Medically Managed level of Residential Services. 5.1% percent were recommended for Low Intensity Community-Based Services, while 1.1% were recommended for Recovery Maintenance and Health Management. LOCUS scores were missing for approximately 18.7% 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, 2017), all new diagnosis values were required to be ICD-10. The most frequent counts are broken out in the tables below.

- *ICD-9 Frequencies:*
 - 74.2% of Class Members had a primary diagnosis of schizophrenia and other psychotic disorders.
 - 23.4% were diagnosed with bipolar and mood disorders.

- The remainder of diagnosis values fell under the following categories: Adjustment Disorders, Anxiety and Stress Disorders and Other Mental Disorders.

- *ICD-10 Frequencies:*
 - 67.6% of Class Members had a primary diagnosis of schizophrenia and other psychotic disorders.
 - 30.5% were diagnosed with bipolar and mood disorders.
 - The remainder of diagnosis values fell under the following categories: Anxiety and Stress Disorders, Disorders of childhood or adolescence and Other Mental Disorders.

Functional Impairment

The Global Assessment of Functioning (GAF) Scale is used to determine functional impairment of an individual in the psychological, social and occupational spheres of their lives. The scale ranges from 0 to 100 with 0 representing lowest level of functioning or the highest level of impairment. Class Members GAF scores ranged from 0 to 99, with an average of 42.6, 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. 74.6% of Class Members were identified as having a serious functional impairment in the employment area, 68.2% in the financial area, and 72.7% in Social/Group functioning and 65.6% in Community Living area. 61.6% had a serious functional impairment in the supportive/social area, 50.8% in activities of daily living and 39.3% had a serious impairment in relation to inappropriate or dangerous behavior. It was also reported that 75.4% 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 five to eight percent range.

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Community Tenure

An important indicator of the success in Class Members' transition from the institutional setting of an IMD to a community setting or their own home continues to be the extent to which Class Members continue to reside in the community, 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 or other residential settings, 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 59% of Class Members have lived in the community, after transitioning from IMDS, for more than 691 days. Approximately another 19% have resided in the community between 361 and 690 days.

Williams Class Members¹
Number of Days Residing in the Community as of April 30, 2017

Days of Community Tenure	N	Percentage
0 - 30	22	1.67
31-60	25	1.89
61-90	32	2.42
91-120	26	1.97
121-150	21	1.59
151-180	22	1.67
181-210	23	1.74
211-240	19	1.44
241-270	22	1.67
271-300	21	1.59
301-330	29	2.20
331-360	24	1.82
361-390	21	1.59
391-420	30	2.27
421-450	28	2.12
451-480	24	1.82
481-510	22	1.67
511-540	29	2.20

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Days of Community Tenure	N	Percentage
541-570	23	1.74
571-600	21	1.59
601-630	15	1.14
631-660	17	1.29
661-690	21	1.59
>690	783	59.32
Total	1320	

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. Quality of Life surveys, which are administered to Class Members both 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 quality of treatment, evaluation of access to care, and social connectedness. Small positive changes were noted in the Class Members' evaluation of their functioning, and participation in their treatment plan development. Treatment Outcome domain almost remain the same across time.

Table 1

Percentage of Positive Class Member Responses By Evaluation Domain Across Time

	Pre-Transition	6 Months	12 Months	18 Months
Evaluation Domain				
Access	75.6	89.8	90.7	90.5
Quality	77.4	91.7	92.8	92.2
Outcome	91.0	92.1	89.9	90.7
Satisfaction	65.9	88.3	89.5	90.0
Social Connectedness	89.5	91.2	90.7	89.6
Functioning	92.1	94.0	93.2	93.3
Treatment Plan participation	78.8	89.7	90.4	88.3

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 IMO

Transition at 6 Months
(n=347)

	Pre- Transition	6 Months
Evaluation Domain		
Access	78.4	92.3
Quality	80.4	93.8
Outcome	91.6	92.7
Satisfaction	68.0	90.1
Social Connectedness	91.9	92.3
Functioning	92.5	96.0
Treatment Plan participation	81.0	92.7

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.

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=253)

	Pre- Transition	12 Months
Evaluation Domain		
Access	75.9	93.7
Quality	79.1	96.0
Outcome	91.3	93.7
Satisfaction	63.6	92.5
Social Connectedness	90.9	91.7
Functioning	94.1	94.5
Treatment Plan participation	78.3	93.7

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 with social connectedness almost remaining 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=194)

	Pre-Transition	18 Months
Evaluation Domain		
Access	74.2	89.7
Quality	78.9	90.7
Outcome	92.8	89.2
Satisfaction	66.0	88.7
Social Connectedness	90.2	89.2
Functioning	93.8	93.3
Treatment Plan participation	79.4	89.7

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. A small degree of positive change was noted for social connectedness; Class Members evaluation of remained more or less the same across time and the evaluation of treatment outcomes and functioning showed a small decrease in positive responses.

Summary

In summary, generally regardless of point-in-time post transition, or whether the same individuals completed the survey at different points-in-time post transition, Class Members more often expressed 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, however, showing less change across time. 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 Statewide Housing Coordinator (SHC) continues 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 transition coordinators, housing locators and case managers stress the importance of using federally funded Section 811 PRA and Statewide Referral Network (SRN) resources to increase the number of Class Members who can move to the community by accessing affordable housing resources. A PAIR (Prescreening, Assessment, Intake and Referral) Administrator helps the Statewide Housing Coordinator make 811 and SRN matches and interpret PAIR module data.

Statewide Referral Network

IHDA and DHS partner 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 housing finance agency) and developers 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 the project's units. Once the SRN units are listed in the online housing waiting list or PAIR module, the PAIR Administrator works to match Williams Class Members (and others eligible for SRN units) to potential units that fit their requirements for location and unit features. As of April 30, 2017, two Williams Class Members have moved into SRN units, 60 are on the SRN waiting list and 8 have open offers for SRN units.

In LIHTC 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. There is only one application round for 2017, which is in process. IHDA is beginning to work on the Qualified Allocation Plan (QAP) development (guidance and incentives) for the next few LIHTC application rounds (beginning in 2018) and is working with Sister State Agencies to ensure that supportive housing development is incentivized in communities in ways that are beneficial to Williams Class Members and other vulnerable populations.

Section 811 Units

IHDA, through Social Serve (contracted web-based housing locator), continues to send Section 811 monthly periodic poll emails in addition to the SRN monthly periodic poll to 811 and SRN properties, 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 2018 are

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nearly complete. Enhanced accessibility matching features will be developed within the 811 and SRN waiting lists in order to better connect persons needing such features to housing opportunities within units that have those features.

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. In accordance with an Outreach Plan, IHDA is aggressively seeking opportunities to place Section 811 on properties that are within the Communities of Preference for Williams Class Members and other eligible 811 populations. When a project is 65% construction complete, the PAIR Administrator 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.

As of April 2017, 144 units have been approved by IHDA's Board. 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 April 30, 2017, the Section 811 Waiting List includes 56 Williams Class Members; a total of six Williams Class Members have been housed in Section 811 units.

Public Housing Authorities

As of April 30, 2017, 184 Williams and Colbert Class Members have converted from a Bridge Subsidy to a CHA Housing Choice Voucher and 110 have been issued vouchers. Processing of the Third Round of applications continues.

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 has committed to provide an additional 60 vouchers annually.

Thirty-five Williams Class Members currently residing in Lake County have converted to Lake County Housing Authority Housing Choice Vouchers. DMH 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.

The Decatur Housing Authority (DHA) has converted two Williams Class Members from state-funded Bridge Subsidy to federally-funded Housing Choice Vouchers (HCV). Two Williams Class Members are in process to be issued a DHA HCV.

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Illinois Rental Housing Support Program (RHSP), Long Term Operating Support (LTOS) Program, and Other IHDA Resources

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. IHDA is currently accepting applications on a rolling basis for the LTOS Program in FY 2017. Any project that is awarded LTOS during this application period is required to fill the units through the Statewide Referral Network, providing additional affordable units that can be accessed by Williams Class Members. The Statewide Referral Network preferences any Williams Class Member to the top of the SRN waiting list when units are available where Williams Class Members wish to live.

IHDA received 12 applications under their Permanent Supportive Housing (PSH) development round in the Spring of 2017, representing \$49.5M in requested funding and 209 units. Due to the strength of these applications, IHDA has added National Housing Trust Fund money to increase the funds available for these applications in order to fund more projects. The selected projects will go before IHDA's Board in June, 2017 for final approval.

IHDA is working on ways to create housing resources that could be targeted to eligible persons being diverted from nursing home placement. There are several options being explored for uses of the Rental Housing Support Program (RHSP). A SRN eligible category of "At Risk of Placement in Long Term Care" is being added, who will receive preference category 2 within available SRN housing resources (Williams Class Members and other 811 eligible populations are preference category 1 within SRN).

Corporation for Supportive Housing

Corporation for Supportive Housing (CSH) is under contract with DMH to assist in developing housing access to integrate Class Members into community-based housing options. CSH facilitates and brokers policy discussions between DMH and housing developers, advocates, other governmental entities, and investors with the goal of developing and 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 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 reduce recidivism rates into state mental health hospitals and intercept people who may ultimately be referred for nursing home placement. The convening of these groups resulted in recommendations for the coordinated entry system as well as for the provider community in order to improve communication and processes, ensuring individuals accessing mental health systems are connected with coordinated entry systems. This group also worked to identify systems gaps for this population.

- Illinois Interagency Council on Homelessness

CSH continues to participate with the Interagency Council on Homelessness (ICH) 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 is working with DASA, IDHS Statewide Housing Coordinator, and IHDA on sustainability of the ICH after federal funding ends, so that there is necessary support across the state to further the goals of preventing and ending homelessness, particularly for chronic homelessness.

- Illinois Housing Development Authority Affordable Housing Task Force

CSH attends the Illinois Housing Development Authority Task Force and represents the needs of the supportive housing community – developers, providers, and state agencies to create coordination and best practices. CSH was a key stakeholder in the development of the Supportive Housing Working Group report released in February 2017 that outlines a comprehensive need for supportive housing across populations and outlines strategies to meet the need over a five-year period.

- 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 is a liaison between the provider agencies and CHA on situations as they arise and serves as an advocate for direct service staff. CSH provides weekly updates and facilitates weekly calls with all Williams' providers and DMH staff to provide relevant updates, reports, and changes to policies and

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processes. CSH also provides similar status updates to Williams Transition Agencies regarding Housing Choice Vouchers coming from the Housing Authority of Cook County. CSH partners in engagements with Lake County Housing Authority and others at the request of the Statewide Housing Coordinator.

Trainings & Presentations

- CSH provided the following trainings for Williams Consent Decree Providers and Housing Locators during this reporting period:
 - CSH facilitated the Housing First Fidelity and Dimensions of Quality Supportive Housing training on January 12-13th, 2017. This was a two-day training focused on implementing housing first in quality supportive housing.
 - CSH prepared listings of free online-based trainings through the Supportive Housing Training Center readily accessible to Williams Providers and Housing Locators. These trainings include best practices on subjects including reasonable accommodations, appeals, building landlord networks, fair housing, dimensions of quality supportive housing, and eviction prevention.
 - CSH provided a statewide webinar entitled Advancing Options for Supportive Housing in IL through Medicaid on March 27th, 2017. The session was a federal and state policy briefing on Medicaid and the ACA and introduction to CSH On-Line Medicaid Self-Paced Tutorials. This series of webinars and curriculum is appropriate for Community Mental Health Center staff who need information on Medicaid, Managed Care, and understanding Documentation. A follow up webinar with federal and state policy updates is planned for summer of 2017.
 - CSH provided a webinar to encourage participating communities of the Data Driven Justice and Health initiative to create Frequent Users Systems Engagement initiatives that target housing and services to people with high health/behavioral health needs to stop the cycling between emergency resources.
 - Trainings planned for the future in 2017 include Property Manager and Support Services Condition as well as an Eviction Prevention Policy Development Workshop.
- CSH works closely with the Statewide Housing Coordinator to deliver training presentations on the Williams Consent Decree and Bridge Subsidy.
 - Training planned for the future in 2017 includes Eviction Prevention in Public Housing.
- CSH works to engage and network with landlords as well as provide trainings directly to landlords, property managers and developers.

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- In order to gather feedback directly from landlords, CSH will facilitate focus groups with participating landlords in summer 2017. Findings will be used to continue improving landlord communications, retention, and recruitment.
- Trainings planned for the future include Tenant Selection Plans, Reasonable Accommodation/Fair Housing, and Financing.

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

- CSH participates in regular Housing Locator Conference Calls. CSH shares information on available housing units, presents on properties available, and schedules property viewing opportunities as they arise with Housing Locators. The calls review landlord outreach strategies and actively problem solve in real-time.
- CSH continues to engage key stakeholders including developers, property managers, elected officials, and service providers in efforts to preserve and create new affordable and supportive housing units that would be available to Williams' Class Members.
- CSH conducted Developer Outreach for the Illinois Housing Development Authority Permanent Supportive Housing Development Program Applications due in February 2017.

Consumer Satisfaction with Housing and Improving Housing Assessment Process

- Consumer Satisfaction Survey
 - 2016 Williams Class Members' Housing and Services Survey Report was completed. Highlights of the report include:
 - More Class Members interested in employment services
 - Drop in centers remain important for some Class Members as an element of their transition. 40% use them at least once a week, while 30% of respondents reported they do not currently use the drop in center.
 - Education is needed regarding the requirement to transition to other subsidies. 56.9% of respondents did not know or remember they were

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required to apply for subsidies. 71.4% did not know if they had applied for subsidies.

- The 2017 Williams Class Member Housing and Services Survey will be released in May 2017.

- **Consumer Focus Groups**

Focus groups are planned for summer of 2017. Focus groups will provide more in depth feedback on areas of interest in the Satisfaction Survey.

- **Consumer Housing Assessment**

During the course of Williams' implementation, additional housing models beyond the scattered-site approach have been requested and allowed. 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, and Resident Reviewers previously created an assessment tool, and focused on implementing the tool during this reporting period. Survey responses have been collected as well as a draft summary report prepared. The goal is to connect and successfully serve additional Class Members through additional housing and services options in order to lessen the number of denials of transition for persons that will not be successful in the scattered-site ACT model that is currently the primary option.

Williams Housing Interface

There are many important factors and resources that continue to be necessary to successfully transition Class Members from the IMD into open market permanent supportive housing rental units in the communities; or alternative housing for those with more complicated medical, physical or mental health issues. It is essential to have the proper resources, process and collaboration available between DMH, Service Providers, Subsidy Administrators, Landlords and the Williams Class Members. One of these important resources includes the availability of housing. Maintaining good relationships with landlords is vital to retaining these housing resources and may require "Eviction Prevention" strategies for Class Members having difficulty maintaining a good neighbor and good tenant status.

Eviction Prevention Strategy

DMH practices eviction prevention to help sustain a positive relationships with landlords and to prevent eviction of Class Members from their perspective units for a variety of reasons which are mostly tenant provision violations. These violations may include Class Members or guests causing disturbances and/or problems that interfere with the peace of neighbors or other housing related issues. The method of "eviction prevention" involves a staffing teleconference call with the Class Member, mental health agency, subsidy administrator, and DMH (Housing Coordinator and other DMH staff).

The staffing teleconference calls enables all parties to discuss the issues related to the landlord's reason(s) to either consider eviction or as a measure to prevent eviction. DMH

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typically requests that the agency create a strategy to better assist Class Members with behaviors that may be a result of de-compensation, drug activities, disruption, prostitution or other challenging issues.

In the second half of FY 2017, the DMH housing coordinator has scheduled thirty-nine (39) total staff teleconference calls involving thirty-three (33) individual Class Members with mental health agencies, subsidy administrators, other DMH staff, and Class Members. Of the 33 Class Members, nine (9) voluntarily moved to another unit to avoid eviction, four (4) returned to IMD temporarily for short term rehab, one (1) is pending termination of the bridge subsidy due to egregious behaviors and unwillingness to engage in monthly wellness checks, three (3) have pending warning letters due to issues including an unwillingness to engage with their perspective agencies and seventeen (17) have requested to move due to expiration of their lease or are addressing their issues without landlords proceeding with eviction proceedings. Overall, the staff teleconference calls have been successful.

Lastly, there continue to be different types of challenges in the community that hinder the success of a transition due to non-medical or clinical issues. Some of the challenges reported include unauthorized squanders attempting to either sell drugs from Class Member units and/or moving into the unit, taking advantage of a vulnerable Class Member. Others issues involve bad decisions due to loneliness or isolation from society and sometimes from the care managers themselves. On a positive note, care managers are discovering better preventive strategies to help Class Members better address potential issues and make better decision

PSH Housing Resources

DMH uses an array of resources to obtain housing availability, which is shared with our contracted service provider housing representatives, also referred to as housing locators (HL). Some of the most current and ongoing resources are: ILHousingSearch.org, multiple listings provided by various real estate agencies like WPD management, Pangea LLC and other smaller scale property owners. Spreadsheets are submitted monthly by our Cook and Lake County subsidy administrator Catholic Charities for status of available project-based and scattered site units. DMH has also collaborated with a new real estate entity, Access Housing I, with PSH scattered units located in various locations throughout the Logan Square area in Chicago. DMH secured twelve (12) units through a Project Based/Master Leasing contract with Access Housing I.

In addition, DMH hosts housing locator (HL) conference calls twice a month. The HL calls cover landlord outreach strategies and housing and landlord expansion opportunities and challenges. DMH's contracted vendor, Corporation for Supportive Housing (CSH), also provides training and assistance in HL calls. CSH also provides additional information on building the Class Members "portfolio" to assist in competing for available units. This includes items such as letters of recommendation from the agency, letters explaining the program or supportive housing, letters of support for a landlord that HL currently has a relationship with or for future landlords and informational resources for HLs to provide to landlords and for supportive housing tenants. CSH also offers support to housing locator staff on addressing potential discrimination practices against Williams Class Members and reasonable accommodation requests.

Supervised Residential Expansion

As DMH continues to transition Class Members from IMDs there is clear evidence that some Class Members require a level of care and support that cannot be satisfied through direct transition to open market permanent supportive housing rental units without risk to their wellness and safety. DMH is aware that there must be a variety of 'housing' options to address the diverse clinical and therapeutic needs of Class Members. To adequately address the treatment resources needed and to adequately provide a treatment level of care for Class Members who require more support, DMH has explored opportunities to create additional Supervised Residential Program capacity.

Individual Placement & Supports

The evidence-based practice of IPS Supported Employment has been on the forefront as a service/resource to promote 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 April 28, 2017. There have been a total of 386 Williams Class Members enrolled in IPS since July 1, 2012. One hundred twenty-seven (127) Class Members or 33% of the Williams Class Members who received IPS Supported Employment have worked. There are currently 163 Williams Class Members enrolled in IPS Supported Employment and 55 (34%) of them are working.

The table below reflects the number of days of job tenure for the 66 Class Members who worked in mainstream competitive work experiences in FY17. The job titles for the Class Members that worked over 180 days are shown in the second table below (6 of the Class Members held 2 jobs). (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 is 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				
	1 to 14 days	15 to 45 days	46 to 90 days	91 to 180 days	Over 180 days
# of Class Members	4	8	9	11	40

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Over 180 Days	Job Titles	
	Ambassador	1
	Assistant/Floater	1
	Associate	1
	Bagger	1
	Bell Ringer	1
	Cart Pusher	1
	Cashier	1
	Cheese Specialist	1
	Concessions	1
	Courtesy Clerk	4
	Crew Member	3
	CRSS/Assist Mg.	1
	Day Laborer	2
	Dishwasher	1
	Fast Food Worker	1
	Food Prep	1
	Food Server	1
	Food Service Worker	1
	Fry Cook	1
	General	1
	Home Health Care Aide	1
	Housekeeper	1
	Industrial Cleaner	1
	LPN Home Health Aide	1
	Production	1
	Real Estate Broker	1
	Receiving Clerk	1
	Relief Doorman	1
	Sales Associate	1
	Service Clerk	1
	Unknown	1
	Usher	1
	Utility Clerk	2
	Warehouse	1
	Williams Ambassador	1
	Total Job Titles	40

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

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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.

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:

- A Nutrition and Exercise for Wellness and Recovery (NEW-R) Training was held on January 17 and February 28, 2017 at Madden Mental Health Center for the Drop-In Center Coordinators and Peer Staff that work at the Drop-In Centers. This Training emphasized the role nutrition and exercise can play in preparing Williams Class Members to get back into the workforce and maintain their employment.
- Continued to host monthly Williams Employment Learning Collaborative Conference Calls with the Drop-In Center Coordinators and Williams Quality Administrators. The topic of the April, 2017 Conference Call consisted of a panel of 5 Job Developers from all 5 Regions of the State of Illinois who shared their tips for building relationships with employers as they job develop.
- Met with Drop-In Center Coordinators and their staff at all 18 Drop-In Centers to continue to advocate to for IPS Supported Employment Programs or other employment programs
- Continued to initiate individual meetings with the Community Mental Health Centers around having their ACT Vocational Workers implement more of the Evidence-based IPS principles of supported employment.
- Promoted the Certified Recovery Support Specialist with an Employment Endorsement – CRSS-E credential to Community Mental Health Center Staff. The first groups that are being targeted for the CRSS-E credential are the Drop-In Center Coordinators.
- 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.

In this reporting period, 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.

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The data collection showed that approximately 264 employment engagement activities are taking place per month resulting in an average of 66 employment engagement activities per week and occurring across the 18 Drop-In Centers.

1115 Waiver

The State has filed an application for an 1115 Waiver Demonstration, and continues to await 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 focus on integration of care, as well as further development of telemedicine infrastructure is also planned.

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Due to the unanticipated delays in the approval by Federal CMS, the State now projects a start date of January 1, 2018 for this 1115 Waiver Demonstration. Concurrent with the waiver application process, the State Departments are reviewing the current Community Mental Health Medicaid Services Rule 132 to determine changes needed to allow more providers to serve those in need of such services. The new or amended Rules also have a targeted effective date of January 1, 2018.

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 developed a new strategy for providing these services by utilizing the Williams Ambassadors. 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, 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 has successfully negotiated and contracted with NAMI to increase the scope of service of the Ambassadors, and NAMI is now in the process of hiring staff to begin the additional work.

Strategies for Change

Feasibility Study

The Court Monitor requested the State explore the potential benefits and limitations of transferring fiscal oversight responsibly of 24 NF-IMD/SMHRFs from the Department of Healthcare and Family Services (HFS) to the Department of Human Services (DHS). To meet this request the State has procured the services of a consultancy firm with the required expertise and knowledge necessary to complete a full and comprehensive feasibility study, with a particular focus on the fiscal and budgetary management and oversight responsibilities that would need to transfer. A leading consideration for the study is to understand whether moving fiscal oversight from HFS to DHS would accelerate/finalize compliance to the Williams Decree, while answering whether or not it is feasible for DHS to assume NF-IMD/SMHRFs management and oversight responsibilities. The study will explore operational challenges should transfer of oversight take place and map out what financial responsibilities HFS currently has that are able to be transferred, if any. In order to complete the study important consideration will need to be given to the different state and federally funded grants, as well as relevant statutes, legislation and any other existing mandates. The study is due to start early June 2017 and is expected to be completed within three to four months.

Compliance Plan

In their letter dated February 14th, 2017, Plaintiffs' counsel requested that Defendants provide a Compliance Plan with concrete steps and goals that describe how the State will achieve compliance with the Decree. The State is currently developing a plan with a long-term system wide focus that will ultimately benefit the whole SMI population, irrespective of their status as Class Members. The plan will provide detail on not only compliance with the Decree but also how positive modifications to community infrastructure will have longer-term sustainability once a number of initiatives are fully implemented. There will be a focus on deflecting people from institutional care through the creation of a community-based, integrated system of care with incentivized payment mechanisms for providers that encourage value and improved outcomes for the individuals they serve. The three overarching goals of the plan are 1) Continue to transition NF-IMD residents that have expressed a desire for community placement and have been assessed as appropriate for transition; 2) Enhance systems that enable the transition of residents of NF-IMDs with "Complexities that Affect Seamless Transition" (Formerly referred to as "Unable to Serve"); 3) Strengthen community capacity to allow individuals "at-risk" of institutional placement a choice of community alternative options. Strategies in the plan will reflect the services and other resources of sufficient quality, scope and variety that will meet the compliance obligations under the Decree, with the objective to achieve a true rebalancing of the reliance on long-term institutional care and shift the system to one of increased community-based service delivery.

Specialized Mental Health Rehabilitation Facilities

As of May 1, 2017, the Department of Public Health (DPH) has received 24 applications for provisional licenses to provide Recovery and Rehabilitation services. Applications for two facilities (Bourbonnais Terrace & Kankakee Terrace) are currently being held for review until the required service fee is received from the facilities.

- DPH issued a Provisional License to Decatur Manor Healthcare on 4/21/17.
- DPH issued a Provisional License to Sharon Health Care Woods on 4/26/17.
- DPH is working with DMH to ensure compliance with Part 380, Section 130 d) [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.
- DPH has worked with DHS/DMH on the approved blueprint for the individual facility training modules to address Part 380, Section 710 g) 1) [Applications Process and Requirements for a Provisional Licensure]. DHS/DMH is reviewing and approving individual training programs and is working on standards to evaluate the training.
- DPH is working with DHS/DMH to ensure facilities are providing an attestation by an authorized facility representative that all required training will be completed by each individual facility.
- DPH has undertaken physical plant (Life Safety Code) and health inspections to determine provider compliance for issuance of the initial Provisional Licenses.
- DPH and DMH are conducting ongoing meetings to address training topics and training requirements.

Managed Care

As of March 31, 2017, approximately 3,646 Williams Class Members resided in 24 nursing facility/IMDs. Of this total, 3,107, or just over 85%, were enrolled in a health plan offered by one of twelve (12) managed care entities contracted by HFS, the state Medicaid agency.

Of the Williams Class Members transitioned to the community (1,847 as of March 31, 2017), 1,156 or 63% were similarly enrolled in managed care. Class Members not enrolled in managed care receive Medicaid-covered services through a fee-for-service arrangement.

Front Door Pilot

Overview

The Front Door Diversion Pilot Project (FDDPP) is a combined project from the HFS and DHS/DMH. The project is directed and managed primarily by DHS/DMH with significant support and input from HFS and the Governor's Office. The project supplements five years of ongoing work to decrease the numbers of person with mental illnesses entering long-term care (LTC) settings - nursing homes and IMDs. The project targets hospitals on Chicago's Northside that have a significant past and current history of admissions to Nursing Facilities upon discharge from their inpatient behavioral health units. The project is a six month pilot period (March through August 2017 SFY17 and SFY18) but also has been projected to continue as fully funded through December 2017 (1st and 2nd Quarters of SFY18).

Purpose

The project's overall purpose is to have an established Community Mental Health provider evaluate Medicaid (active) eligible consumers referred from an identified hospital's inpatient behavioral health unit(s). The agency will assess consumers while on the inpatient unit and determine whether that consumer could benefit from a discharge plan as developed by that agency. This discharge plan is meant to respond to all the clinical and supportive needs of that consumer such that an admission to a nursing facility level of care - nursing homes and IMD - could be avoided (Diversion). This process is called **Discharge Linkage and Coordination of Services**. Not only will these providers assess each consumer and develop an alternative discharge plan, they will continually work with the consumer upon discharge to insure that the recommended discharge plan is fully implemented. This is called **Outreach to Individuals to Engage in Services**.

Outreach to Individuals to Engage in Services is available only to those consumers who accept the community based discharge service plan as opposed to placement into a Nursing Facility. These individuals are entered into the program after receiving an affirmative determination of Nursing Facility level of care through a Level II PAS-RR screen.

In addition to supporting diversion from long-term care as its major priority, this project has the potential to also:

- a) Improve discharge planning from inpatient psychiatric units;
- b) Increase linkage to state funded community-based services;
- c) Reduce referrals of persons with serious mental illnesses to a nursing home level of care;
- d) Decrease in the length of stay for inpatient psychiatric unit;
- e) Assist in reducing the hospital re-admission rates of these persons and,
- f) Provide safe, clinically-based services that address a broad array of the individual's needs.

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Process

Once a hospital discharge planner identifies a person as a likely candidate for a referral to LTC they contact the Front Door provider to initiate a Front Door diversion assessment. Front Door providers provide this assessment within 3 business days of referral. DMH has contracted for and are finding that providers can affect this process often within 24 hours of referral. Front Door providers make recommendations available as quickly as possible so that the participant's MD, SW/discharge planner and the consumer themselves are able to review and accept, or decline, the recommendations. These recommendations should be available prior to a decision to continue with a discharge to a LTC facility.

The culmination of the Discharge Linkage and Coordination of Services process is for Front Door providers to develop a discharge plan for each participant which will:

- a) Include a recommendation on all the clinical services needed;
- b) Include a mechanism to ensure that consumers keep their appointment(s) at the next level of clinical care, including physician visits;
- c) Provide supportive services for each specific consumer need, as explained below.

As part of the Outreach to Individuals to Engage in Services, Front Door providers were specifically funded to develop and provide short-term assistance/services on behalf of participants that cannot be funded through usual Medicaid reimbursements. These distinct services may include:

- a) Emergency funding for medication, food, clothing as may be needed;
- b) Emergency funding to support placement into immediate housing or residential services at discharge, as may be needed;
- c) Funding to support associated costs related to obtaining housing, e.g. landlord fees utility deposits etc., as may be needed;
- d) Funding to support transportation cost to insure that consumers can attend community based treatment programs.

In addition to the above noted Outreach services, Front Door agencies assist participants with applications for mid and long term permanent housing or residential options.

The Division of Mental Health has also secured access for participants into the following additional levels of care or services:

- a) Two existing Living Room programs have negotiated with DMH to allow participants to seek services at their facilities;

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- b) An existing, DMH funded, eight (8) bed Crisis Residential (#860) program has, at DMH's direction, expanded their admission criteria to accept Front Door participants who can benefit from this level of care;
- c) DMH has authorized and opened 50 Permanent Supportive Housing (PSH)/Bridge subsidies for program participants.

Evaluation

DMH has contracted with the University of Illinois, School of Social Work (UIC) to independently evaluate the goals and outcomes for this project. The research questions under inquiry are:

- a) Do the numbers/percentages of members referred to community based alternatives differ month to month and in total during the pilot period from month to month and in total from the same period(s) in 2016? Does the pilot project appear to be making a difference in whether Class Members are being diverted from long term care? Are there different patterns for the three different agencies? For the participating hospitals?
- b) Do the characteristics of participants referred to community care differ from those who are not referred, from those who accept referrals and those who decline? Characteristics include client demographics; prior service history; residential/housing history; health/behavioral health history. This data will be processed and preliminary findings can be reviewed on an ongoing basis; the overall report of these findings will not be done, however, until after the pilot ends.
- c) What is the monthly average per member cost associated with providing services (non 132) and does it differ by agency? What is the monthly average per member cost associated with providing 132 services?
- d) Do the types of services (housing, clothing, transportation) that participants receive differ by agency or by participant characteristics; i.e. age, housing type, housing location, behavioral health/health need, etc.
- e) How do the characteristics of participants who discontinue service and the services they received differ from those who accept community care services?

Current Status

- a) The FDDPP has been operational since February 1, 2017 with limited services provided during February and full services to 13 of the 14 identified hospitals commencing on March 1, 2017.

Data reporting forms have been developed and modified and were finalized in April, 2017.

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Data has been received for February (1 agency) and March (3 agencies). Preliminary reports/analysis is as in below (b).

- b) Referral activity has been active since the onset with all teams evaluating 32 persons per month from all participating hospitals. A total of 122 cases were referred with 56 being deemed qualified for Front Door services. Of those, 34 diversions to community-based care occurred, representing approximately 60% of those persons seen and evaluated.
- c) Capacity resources for Supervised Residential level of care have been finalized. At present no persons have been placed into this level of care.
- d) Agencies are using the contracted funds for securing emergency or immediate housing assistance upon discharge from hospital units and several cases have progressed into the Bridge PSH application process. There are currently 21 applications for the Bridge subsidy program, which represents less than 40% of all qualified participants.
- e) Although Living Room capacity has been obtained at two existing programs, activity levels are currently unknown.
- f) Meetings were held with Plaintiff's attorneys and the Court Monitor to hold a forum with all Front Door pilot providers – agencies and hospitals. There was general consensus that the program is progressing with minor startup issues. Continued collaborative contact between agencies and hospitals will be fostered as are open lines of communication between PASRR/DMH and participating agencies.
- g) A meeting for the Court Monitor and attorneys was held to review the formalized data evaluation process with the University of Illinois School of Social Work. Consensus on the overall format and process was affirmed in general with minor discrepancies noted and resolved. The final report from UIC is expected by the end of October 2017.

Next Steps

- a) The project is expected to move into FY18 (August) to ensure a full six months' worth of data and experience with an associated, planned, budgetary extension of the project through December 2017. This is to ensure continuity of care for active program participants but also to maintain programmatic synergy should the pilot garner sufficient positive results to warrant the continuation of the project as well as possible extension of the project into other geographic areas.
- b) The final pilot data will be provided to UIC by mid-September with the anticipated receipt of their final report by October 31, 2017.

Upon review of concurrent data for the pilot and a positive analysis report from the UIC evaluation, DMH plans to use this pilot experience, in addition to the resources as also identified in 1115 waiver, section to better inform future strategic planning on the best ways to divert persons from the front door of nursing home level of care.

Budget

In FY17, the Governor's Revised Introduced Budget included \$35.2 million in General Revenue Funds for rebalancing efforts related to the Williams Implementation Plan. Expenditures thru April 30, 2017 include \$3.0 million for administrative and operational expenses as well as \$19.4 million in grant-funded services. In addition, \$5.0 million has been expended for Medicaid services to Class Members. By the end of FY17 it is estimated that spending will total approximately \$33.4 million, with the balance of the GRF appropriation to be spent on Medicaid services.

The Governor's current proposed FY18 budget for the Division of Mental Health includes \$43.7 million in General Revenue Funds dedicated to expanding home and community-based services, and other transitional assistance costs associated with the consent decree implementation.

Williams Call Log

During this reporting period, there were a total of 38 calls placed to the DMH's information number. The breakdown of these contacts is as follows:

- Number of calls received from Class Members 23
- Number of calls received from other residents of Nursing Homes 0
- Number of calls received from family/guardians regarding Class Members 1
- Number of calls from others seeking information about the Consent Decree 14
- Number of calls received from landlords or complaint calls 0

