WILLIAMS SEMI-ANNUAL REPORT #6

Illinois Department of Human Services

Division of Mental Health

Williams Semi-Annual Report #6

EXECUTIVE SUMMARY

This Semi-Annual Report reflects implementation activities in concert with the language of the Williams Consent Decree for the reporting period from December 1, 2013 through June 30, 2014. The most significant event to occur during this period was the January 10, 2014, Opinion and Order entered by U.S. District Judge Hart, that reaffirmed the intent of the Consent Decree and the Implementation Plan activities. The Court also emphasized the State's responsibility for assuring appropriate quality services and support to Class Members who transition to the community, and its continuing responsibility to monitor Class Members' wellness, recovery pursuits, rehabilitation and overall stability.

During this period, the State responded to several challenges presented by the Court Monitor and Plaintiffs' attorneys which addresses key areas of operational concern:

- Improving the rate of positive outcomes from the Resident Review determinations.
- Developing strategies to drill down and address the 'Unable to Serve" list.
- Methods to increase Class Members' consent to be assessed.
- Assuring categorical accuracy in data collection on reportable incidences.

During this period seven of the ten Williams contracted provider agencies, those located within the boundaries of Cook County, assumed transition coordination and community mental health services delivery responsibilities under the Colbert Consent Decree, for Class Members diagnosed with Serious Mental Illness. Understandably, these are two distinct Consent Decrees with two independent implementation strategies. The logic of mirroring Colbert's operations, as much as possible, under the structure of Williams for those Class Members, who have similar clinical, functional and service needs, tremendously alleviates confusion, unnecessary duplication and uncoordinated processes. It is however noteworthy to mention that during the first two to three months of this interface period the transition pace for Williams Class Members was temporarily adjusted so that these seven provider agencies would have sufficient staff/service capacity to begin transition activities for Colbert Class Members. This adjustment was an intentional, State supported decision.

We are pleased to report that by March 2014, even with an interim redirection of Williams services and resources to meet the needs of the Colbert transitions, the Williams provider agencies collectively exceeded the FY 14 revised formula methodology target number, by transitioning 864[1] Class Members to the community. The total transition count as of the completion date for this report is 919. Our goal is to transition 950 Class Members to the community by the end of June 2014.

The following information summarizes the progress that the State and its partners have made over the past six months in meeting the fabric of this Consent Decree, and to enhance the service delivery system and its ancillary supports to meet the continuous transition activities for Williams Class Members.

[1] The total transition count is based on lease signed

OUTREACH AND INFORMATION DESSIMINATION

Outreach Workers

Williams Outreach Workers maintained vigilance in their engagement with Class Members. They serve not only as role models on recovery but also impart considerable knowledge on all aspects of independent living. They also are advocates for Class Members to assure that there is timely contact by the community agencies. This is being done through weekly exchanges of information with the Associate Deputy Director of Transition.

In January 2014, Williams Outreach in concert with Williams community agencies were challenged with scheduling and hosting Community Meeting/Ice Cream Socials for Class Members in each IMD. The underlying purpose of these Ice Cream Socials was to engage those Class Members who had been reluctant or unwilling to participate in any information exchange about *Moving On* or who refused to be assessed. Approximately 1,753 Class Members attended these community meetings/socials.

These events had two components. First, community agencies were to invite three Class Members, who previously lived and transitioned from the respective IMD, to be guest speakers. These Class Members were given an honorarium of $25.00 for their messages of hope and resilience. Forty-nine (49) Class Members served as key note speakers sharing personal stories of community living and recovery. Some showed pictures of their apartments. Others talked of the freedoms they have, i.e. choosing their own food, coming and going as they please, and having money in their pockets at all times. They shared stories about the support received from the community agencies, the activities of the drop-in centers, groups attended, and the independent living skills which they are perfecting. Secondly, agencies used this opportunity to provide an overview of their services and answer questions how they will/can help support Class Members achieve independence in the community.

Quality of Life Surveys

Outreach Workers continue to conduct baseline Quality of Life Surveys (QLSs) with Class Members who are nearing transition from the IMDs. During this time period, Outreach Workers conducted 106 Quality of Life Surveys.

Outreach Activities and Contacts (numbers outreached and refused to engage via letter of introduction)

In the past four and a half months, 345 Class Members signed Introductory Letters and engaged with the Outreach Workers to hear information and ask questions about their rights under the Williams Consent Decree and *Moving On*. It continues to be true that approximately one-third of residents refuse to engage in discussions with the Outreach Workers. During this time period, 101 Class Members refused to sign the Introductory Letters.

Outreach Workers conducted 469 interviews and completed Transition Questionnaires to elicit Class Members' interests in *Moving On*. Concurrently, Outreach Workers re-approached 40 Class Members who previously refused any discussions about *Moving On*. Results of these interviews are reported in

the aggregate Table below with data on all 880 unduplicated Class Members who have been approached since October 2013.

Data on Class Members who refuse to engage with Outreach Workers

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

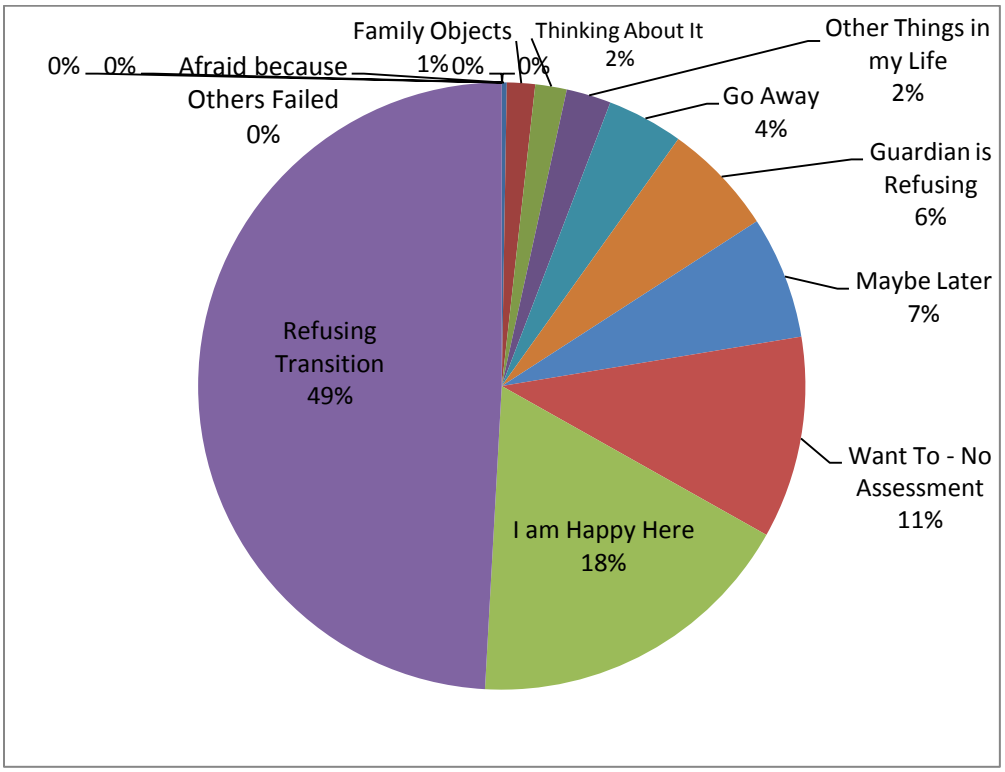
Refusal Report Totals **As of: Tuesday, May 6, 2014**

Total Number of Class Members 880 – some gave more than 1 answer

Reasons	Number of Responses	% of Respondents who answered
Refusing Transition – just said "No"	557	63.3%
Guardian is Refusing	68	7.7%
Go Away	46	5.2%
I am Happy Here	201	22.8%
Family Objects to Moving	17	1.9%
I Am Afraid Because Others Have Failed	3	0.3%
Other Things In My Life	27	3.1%
Maybe Later	74	8.4%
I am Thinking About It	19	2.2%
I want to but have not had an Assessment	122	13.9%
Total Number of Responses:	**1134**	

Reasons for Refusals of 880 Class Members

Percents add up to 100% in this chart



Resident Review

As reported in previous Semi-Annual Reports, Metropolitan Family Services (MFS) and Lutheran Social Services of Illinois (LSSI) continue to provide the Resident Review assessments for this Consent Decree. Each agency now has seven (7) licensed clinicians who have years of experiences in all aspects of community mental health services, as well as long term care. As trained clinicians, these individuals embrace the progression of recovery, and philosophically and in practice support principles of recovery. This is extremely important as their personal philosophy of care can inadvertently impact decision outcomes for transition.

As noted, DMH retrained all Resident Reviewer staff and supervisors. The underlying purpose was to assure that everyone was approaching the process from the same perspective, which is the basic premise of the Consent Decree – *to provide Plaintiffs with the opportunity to receive the services they need in the most integrated settings appropriate . . .that maximize individuals' independence, choice, opportunities to develop and use independent living skills and afford the opportunities to live similar lives to individuals without disabilities* – and that staff were appropriately identifying an array of community service needs and/or supports that would best facilitate transition. The results of that training are reflected in the productivity numbers referenced in this report.

Between the months of November 2013 through January 2014, LSSI and MFS scheduled joint face-to-face, onsite meetings with each Williams provider agency. The purpose was to (re)acquaint the Reviewers with key agency staff and to receive information on the agency's operation such as: (1) specialized services available or unique staff competencies within the agency, (2) the array of other support services available that may be unique to the agency's operations, (3) the profile of Class Members that may present barriers or challenges for the agency to engage or transition; and (4) any other information that would assist the reviewers in making informed recommendations.

Ongoing meetings continue with the Resident Review team to reinforce expectations of the Resident Review processes, expectation of staff to explore all possible indicators to make positive recommendations for transition and to discuss strategies to obtain Class Members' consent to be assessment. Within the period from December 1, 2013 through May 23, 2014, Metropolitan Family Services reported fifty-nine percent (59%) positive recommendations for transition. This is an increase of seventeen percent (17%) from the previous reporting period. Conversely, Lutheran Social Services of Illinois reported seventy-eight percent (78%) positive recommendations for transition. This is an increase of fifteen percent (15%) from the previous reporting period. Although there continues to be disparities with the percentages of positive recommendations between the two agencies, the pendulum is definitely moving in the right direction. In FY15, the State partners are committed to investigate contributing factors that may explain these differences.

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

Performance Measures Outcome[2] [3]

	# 1 Approached	# 2 Approached Refused	# 3 Signed Participation Agreement	# 4 Full Assessment Completed	#5 Aborted Asst'mt	#7 Recom'd for Transition	#8 Not Recom'd	#9 Staff prod'vity	#10 Complex medical need	#11 criminal histories
LSSI	1020	592	883	410	18	344	66	1020	198	129
MFS	686	396	604	287	4	173	114	686	147	92

The Williams Compliance Report reflects that of the date this report a total of 7,859 Resident Reviews have been initiated since inception of operations. This number includes Resident Reviews completed by the University of Illinois. Of this number, 4,132 (52.6%) of Class Members have refused to give consent for an assessment.[4] There have been 3,727 (47.4%) Resident Reviews successfully completed. Of this number 2,129 (57.1%) have been referred for community transition.

While the number of Class Members who receive a positive recommendation to transition has indeed increased, we conversely witness the phenomena of an increasing number of Class Members who are identified as 'Unable to Serve'. We will discuss the 'Unable to Serve' population under Community Services and explore strategies to address their community transition needs.

Clinical Review

During the report time period 183 Resident Reviews were received for Clinical Review (CR) and referred to one of the respective Williams provider agencies for a second level, paper review. As Resident Reviews continue to occur in Lake County and the Lake County Health Department is no longer accepting referrals for transition, these cases were distributed among the existing Williams providers for second level recommendations. Similarly, the same decision was made for cases where Class Members have expressed preference to live in areas where there are no current Williams contracted agencies. Of the 183 Clinical Reviews, there were 20 recommendations to overturn the decision. These cases have been referred to community mental health agencies to initiate transition activities. There were 163 Resident Reviews that were supported resulting in a decision for these Class Members to remain in the IMD.

Additionally, throughout this reporting period, several quality improvement efforts were initiated. It came to the attention of the Clinical Review Coordinator that there were several incoming resident review referrals which were inadvertently entered into the database with the wrong codes. As a result, this gave an inaccurate account of the number of CRs which needed to be conducted. However, upon reviewing the files more closely there were a large number of files which needed to be re-coded in the system. Therefore, the overall impact was quality improvement and improved accuracy in our tracking and coding methods resulting in a decrease in the actual number of required CR's to be conducted by a significant amount.

The Clinical Review Coordinator convenes weekly CR telephone calls with all of the Williams agencies. During these calls, policies and procedures are continually discussed in an effort to improve the overall

[2] Time frame from December 1, 2013 – May 23, 2014

[3] Data for #6 and #12 has not been omitted. Information is collected by the community agencies. PM will be revised.

[4] The University of Illinois, School of Social Work has been contracted by DMH to study Class Members' refusals. More information will be included in the section on Research.

quality of our Clinical Review process. The calls also serve as a platform to discuss complicated issues, facing a CR team which requires feedback.

TRANSITION COORDINATION/COMMUNITY SERVICES

The ten (10) community mental health centers contracted to provide the full array of Williams services and the seven (7) agencies contracted to provide 'transition only' and existing Rule 132 services continue to pursue efforts to expeditiously and effectively transition Class Members to the community. A total of 2,213 Class Members were referred to these agencies to engage and initiate transition activities, based on choice of geographic preference or provider agency. As of this date, 919 Class Members have transitioned, have signed leases to transition or signed leases and subsequently decided not to proceed with transition. Sixteen (6) Class Members began the process of moving, signed leases and ultimately decided not to move to the community.

Sixty-three (63) Class Members (2.08%) have expressed interest to transition into service areas where DMH currently does not have either a Williams contracted provider agency or a community agency that offers medically necessary ACT or CST services to meet transition needs. What is significant is that all sixty-three Class Members have been recommended for team services. This supports the speculation that Williams Class Members, overall, require greater treatment and services to successfully live and maintain independence in the community, at least during the initial months post transition.

In early 2014, DMH was informed by the executive staff from Lake County Health Department/Behavioral Health, that they would not pursue expansion to develop another Williams ACT team. The Health Department attributes this decision strictly to budgetary constraints and their analysis of the financial impact that operating this team service has created for the County Health Department. However, the County will continue to operate the existing ACT service for those Class Members who are currently in programming.

This decision clearly presented a dilemma for the State, as Resident Reviews continued to occur at the three IMDs in Lake County and Class Members were being recommended for transition. Lake County Health Department, to their credit, personally met with each Class Member who was on the waiting list for transition and provided them with a letter explaining that they were currently at service capacity and would stop future transitions. It was also explained that a new provider would be identified to assume these functions.

In early February 2014, DMH convened a series of meetings with contracted vendors in Lake County to elicit their interest in developing ACT services for Williams Class Members. Five agencies participated in the initial calls. Collectively, they decided to form a collaborative partnership assuming critical roles in the Williams implementation processes, i.e., Quality Monitoring, Transition Coordination, Clinical Review and ACT services. Subsequently, two agencies made alternate decisions not to participate. What has emerged from this planning is a newly formed collaboration between New Foundations Center (Northfield) and Northpointe Center (Zion).

DMH concluded negotiations and will execute a FY15 contract with New Foundation Center, to assume responsibility for hiring the Williams Quality Administrator and to develop and provide ACT services to Class Members who desire to transition from the Lake County IMDs to residences within Lake County. Northpointe Center will assume responsibility for the Transition Coordination functions and will conduct the Clinical Reviews. Both of these latter activities are reimbursed through a capacity grant, and fee-for-service.

New Foundation Center is currently in the process of hiring and training staff. Once completed, the agency will apply for ACT certification. When the team is certified to assure fidelity, they will then begin transition activities. It is DMH's expectation that this agency will be fully operational by July 2014.

Unable to Serve

An anomaly that has been highly profiled during this reporting period is the number of Class Members who have been approved for transition via the Resident Review process, but subsequently determined by Williams community agencies as being 'Unable to Serve'. Using current compliance data, there are 180 Class Members (8%) who fall within this category. DMH has recently done an analysis of the varying reasons why agencies have indicated difficulties serving certain profiles of Class Members. The spectrum of reasons spans across the board, from requiring skilled level nursing care to a high risk of aggressive and/or agitation behaviors. The below chart aggregates the categories of Class Members identified as 'Unable to Serve', as reported by the Williams agencies:

Unable to Serve - Reasons	Aggregate Count
Requires neurological/diagnostic testing	10
Unable to Serve – Aggression/Agitation	32
Unable to Serve – Sexual Offenses/behaviors	5
Needs Cluster Housing model w/nursing support	47
Needs Cluster Housing model general skill needs	11
Needs 24 hour Supervised Residential setting (medical/medication)	11
Needs 24 hour Supervised Residential (cognitive/MR)	6
Needs 24 hour Supervised Residential setting (behavioral management)	12
Requires skilled nursing	4
Other	
a. Unreasonable housing request	1
b. TBI	2
c. No Medicaid/No SSI	6
d. Complex medical/psychiatric	9
e. No legal residency	1
f. False Personal Info	1
g. No SMI	1
h. Severe Substance Abuse	5
i. Lack basic skills	4
j. Suicidal	1
k. Declined/Refused	3
l. Risk of harm	7
m. Moved out of state	1
TOTAL	**180**

DMH developed and funded a pilot PSH/Cluster Housing model as one strategy to address Class Members who have been identified and recommended for another level of housing to best support their transition and community stabilization. Another effort pursued has been to use available beds in existing Supervised Residential settings as a means to 'step down' Class Members who have the greatest need for on-site staffed support. More reference to both of these options will be found in the Housing Section.

Another area of concern focused attention on Class Members who 'decline' transition activities even when approved to transition through the Resident Review process. 481 Class Members (22.18%), of the 2,213 referred for transition, subsequently refuse to participate or engage in transition activities. As choice is clearly the binding premise of the Consent Decree, the decision of Class Members not to move has been highly respected. The door remains open for these individuals to change their mind, should they so desire, at a future date.

Characteristics of Williams Class Members Registered as of April, 2014

A Descriptive Analysis

Division of Mental Health's (DMH) contracted community mental health centers are required to register/enroll Williams Class Members (WCMs) in the DMH Community Information System within seven days of their initial contact with individual. They are also required to re-register these individuals and to update key fields at six month intervals. As of April 26, 2014, nine hundred and ninety-five (995) Williams Class Members were enrolled in the DMH Community Information System. This analysis provides a summary of demographic and basic clinical characteristics of this cohort. A summary of information pertaining to the comprehensive service developed for Class Members is also included.

Age, Gender, Ethnicity and Hispanic Origin

Class Members who are registered range in age from 20 to 81 years old, with an average age of 47. Of the 995 Class Members, 661 (66%) are male and 334 (34%) are female. Overall, 5.5% of Class Members were reported as being of Hispanic Origin. With regard to primary ethnicity, 53.4% of Class members are Black/African-American and 42.8% are Caucasian. A small percentage is of Asian ethnicity (2%), and a very small percentage is Native Americans, Native Alaskans or Hawaiian/Pacific Islanders (.2%); and ethnicity was reported as unknown for 1.7%.

Marital Status

The 75% of Class Members have never been married; 12% are divorced and another 4% are separated. Only 2.3% are married and 1.7 % are widowed.

Highest Level of Education Completed

Twenty-nine percent of Class Members (29%) have earned a high school diploma and an additional eight percent (8%) were reported as having earning a General Equivalency Degree (GED). Twenty-three percent (23%) of Class Members completed some high school (e.g., one, two or three years) with no diploma earned. Twenty percent (20%) have completed some college, and five percent (5%) hold a

Bachelor's Degree. A small percentage (1.1%) of Class Members has completed post-secondary training and 1.2% has completed post graduate training. The highest level of education completed by approximately three percent (3%) of class members was 8th grade. Education level was not reported for approximately nine percent (9%) of registered Class Members.

Residential Living Arrangement

As of October 31, 2014, thirty-eight percent (38%) of Williams Class Members were reported as residing in private unsupervised settings (Permanent Supportive Housing). Forty-two percent (42%) of the total census was reported as still residing in IMDs.

Military Status

Five percent (5%) of Class Members reported Veteran's status, having formerly served in one branch of the military.

Primary Language

The primary language spoken by nearly ninety-nine percent (99%) of Class Members included in this analysis was English.

Justice System Involvement

The majority (91%) of Class Members were reported as not having any involvement with the criminal justice system (courts, jails etc). However, 0.7% had been arrested and the same percentage reportedly had been charged with a crime (.7%). 4 Class Members (0.4%) had been incarcerated in a jail or prison during this period. An additional 3 Class Members (.3%) had a status at some point of being on parole or probation. The justice involved status of 5.3% was reported as unknown at the time that the individual was registered/re-registered.

History of Mental Health Treatment

During the registration process, information is gathered regarding an individual's history of mental health treatment. Fifty-six percent (56%) of the Class Members registered have a history of continuous treatment for mental health related problems; eighty-three percent (83%) have a history of formerly living in residential treatment settings; and eighty-one percent (81%) of Class Members have a history of receiving outpatient mental health services for their illnesses.

Level of Care Utilization Scale Scores Based on Assessor Recommendation

Thirty-nine percent (39%) of the Class Members included in this analysis were recommended by the assessor to receive high intensity community-based services (level 3) based on the results of the LOCUS assessment. An additional forty-three percent (43%) were recommended for Medically Monitored Non-Residential Services. A little more than five percent (5%) of Class Members were recommended for Medically Monitored Residential Services, while two percent (2%) were recommended for a Medically Managed level of Residential Services. Three percent (3%) were recommended for Low Intensity Community-Based Services, while (0.3%) was recommended for Recovery Maintenance and Health Management. LOCUS scores were missing for approximately 6.5% of the cohort.

Diagnosis and Serious Mental Illnesses

Seventy-five percent (75%) of Class Members had a primary diagnosis of schizophrenia and other psychotic disorders; twenty-three percent (23%) were diagnosed with bipolar and mood disorders. Sixteen percent (16%) had a co-morbid substance use disorder. The majority of individuals met the DMH criteria associated with serious mental illnesses.

Functional Impairment

The Global Assessment of Functioning (GAF) Scale (also known as Axis 5 of the DSM-IV) is used to determine functional impairment of an individual in the psychological, social and occupational spheres of their lives. The scale ranges from 1 to 100 with 1 representing lowest level of functioning or the highest level of impairment. Class Members' GAF scores ranged from 15 to 70 with an average of 44. This average represents . . . "Serious symptoms or any serious impairment in social, occupational, or school functioning".

Other Areas of Functional Impairment

DMH providers are asked to rate an individual's serious functional impairment in 7 areas as part of the registration/enrollment process: Social/Group Functioning, Employment, Community Living, Financial, Supportive/Social, Daily Living Activities and Inappropriate Dangerous Behavior. Eighty-six percent (86%) of Class Members were identified as having a serious functional impairment in the employment area, eighty-five percent (85%) in the financial area, eighty-three percent (83%) in Social/Group functioning and seventy-seven percent (77%) in the Community Living area. Sixty-two percent (62%) had a serious functional impairment in the supportive/social area, fifty-seven percent (57%) in activities of daily living and thirty-seven percent (37%) had a serious impairment in relation to inappropriate or dangerous behavior.

Comparison to Previous Analyses - October 30th Cohort

The prior analysis of descriptive demographic and clinical data for Williams Class Members registered in the DMH Community Information System was performed in October 2013. A comparison of the data reveals that there is very little variability in the descriptive information reported for the two cohorts.

Comprehensive Service Planning

DMH contracted Williams providers must complete a number of tasks prior to the actual move of Class Members to new residential options. One important task is the development of a cross-cutting comprehensive service plan that spans a wide array of medical and non-medical services based upon identified needs of Class Members derived from the resident review and discussion with Class Members. Once the need for specific services is identified, the agencies work with Class Members to identify the service array and pre and post transition activities. This analysis summarizes the type of services identified for cohort of individuals described above. Data are reported for 707 individuals.

Ninety-six percent (96%) of Class Members were identified as having medical needs, eighty-two percent (82%) were identified as needing coordinating access to social support services; seventy-seven percent (77%) were identified as needing assistance with public benefits. Twenty-five percent (25%) were identified as needing services to address substance use issues and twenty-five percent (25%) were identified as having need for dental related services. A little more than a quarter (28%) were identified as needing assistance with vocational skills and a small percentage (1.6%) were identified as having podiatric service needs. In addition, a small percentage were identified as needing access to social services to obtain food stamps (n=21), occupational or physical therapy (n=3), education related assistance (n=3), and the services of an optometrist (n=2).

Follow-up Appointments Established for Class Members Prior to Community Transition

Identifying the need to access ancillary services, in addition to mental health services, is only one element of comprehensive service planning. The extent to which follow-up appointments are established prior to transition is critical. The table below displays the percentage of Class Members for whom appointments were made for follow-up by service.

Service Identified for Follow-up After Transition	**Appointment Made for Follow-Up**
Medical	100%
Dental	100%
Social Support Coordination	100%

The final indicator with regard to service planning is to determine the extent to which these identified services were provided. Data for some of the services identified in the table above should be available in the Healthcare and Family Services data warehouse. As this data is made available, additional analyses may be performed.

Community Tenure

An important indicator of the success in Class Members transition from the institutional setting of an IMD to the community setting of their own home is the extent to which Class Members continue to reside in these homes post IMD discharge. Eighty six percent (86%) of the individuals that moved to the community as of May 21, 2014 have remained in community residential settings following their transition. The table below displays a frequency distribution showing the length of time or community tenure of Class Members still residing in permanent supported housing. While this table does not provide a conclusive picture of the extent to which Class Members will remain in the community following community transition because new Class Members are continually transitioning from IMDs, it does provide descriptive point in time information regarding the number of days that Class Members are living in community residential settings post IMD discharge. For example, the data displayed in table 1 shows that approximately eleven percent (11%) of the 725 Class Members for whom data was obtained have lived in their own homes for 90 days or less. An additional nine and four-tenth percent (9.4%) have remained in their own homes from 91 to 180 days, and an additional twenty-seven percent (27%) have between 6 and 12 months of community tenure. Fifty-four percent (54%) have remained in the own homes in the community for more than a year.

Community Tenure of Class Members Residing in Community Housing Post Transition from IMDs (N = 725)

Number of Days in the Community	Number of Class Members	% of Class Members
0-30	25	3.4%
31-60	23	3.2%
61-90	30	4.1%
91-120	19	2.6%
121-150	21	2.9%
151-180	28	3.9%
181-210	18	2.5%
211-240	27	3.7%
241-270	31	4.3%
271-300	35	4.8%
301-330	31	4.3%
331-360	53	7.3%
361-390	45	6.2%
391-420	44	6.1%
421-450	35	4.8%
451 or More	260	35.9%
Total	**725**	100.0%

Service System Expansion

Budget Incentive Program (BIP)/Proposed Service Expansion

The federal Balancing Incentive Program (BIP), authorized by the Affordable Care Act, incentivizes transformation of state long-term care systems by encouraging states to shift from institutional to

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

The federal government requires that BIP dollars be spent on new and/or expanded community-based services.

The following services/programs have been approved for BIP funding in Illinois for FY15 and FY16. While all services may not be applicable to the Williams Consent Decree or available to Williams Class Members, it is nevertheless a testament to the development of cross service system resources to meet the needs of persons diagnosed with serious mental illness. For this reason, reference to the expansion of services under BIP is outlined below:

PROGRAM/SERVICES	DESCRIPTION	FY15 AMOUNT
Expand Money Follows the Person Coverage	The State plans to expand its Money Follows the Person (MFP) Program for individuals with serious mental illness to areas of the state where we do not have coverage for this population. Areas of expansion will be based on a determination of a high demand and where there's sufficient MH team based services, including Assertive Community Treatment and/or Community Support Teams, to support individuals as they transition to the community. BIP Funding would be utilized to employ Behavioral Health Transition Coordinators to provide outreach to potential MFP consumers, and pre/post transition coordination services. HFS and DMH are collaborating to determine the next areas of expansion as well as the funding sources for the expansion, BIP versus MFP rebalancing funds.	$1,750,000
Expand Mental Health Rehabilitation Services in Crisis Residential Programs	Expand access to mental health crisis residential treatment. BIP funding will be used for the Medicaid Rehabilitation services provided to individuals while in this crisis residential level of care. DMH anticipates using General Revenue funds to pay for the room and board component of two (2) 8-bed residential programs. These programs will not be located in IMD's or hospitals. Setting: It is DMH and DASA's intention that the setting for Crisis Residential will be in a building that is integrated in the community, not in a hospital or nursing facility, has 8 to 10 treatment beds, and is located in the metro-Chicago area. Length of Stay: The length of stay for these services will be based upon medical necessity. DMH is currently working on defining medical necessity and service authorization requirements for Crisis Residential. Typically DMH policy includes a specific initial authorization period with defined requirements for re-authorization. Although DMH does not yet have definitive policy it	$416,000

PROGRAM/SERVICES	DESCRIPTION	FY15 AMOUNT
	is anticipated that the average length of stay in Crisis Residential will be less than 7 days.	
In-Home Recovery Support	This service will be an enhancement to Medicaid Rehabilitation Option (MRO) Rule 132 current Assertive Community Treatment (ACT) and Community Support Team (CST) services. Service Definition: Access to an individual with lived experience in recovery, who is familiar with the person transitioning, who could be called upon to provide support face to face at any hour of the day needed. Goal: To intervene prior to the onset of a crisis that could result in a return to the higher LOC. Included Activities/Interventions: Phone and face to face contact between the individual in transition and a member of the individual's treatment team who also has lived experience in recovery to provide support and reassurance as the individual is exercising new skills, adjusting to the new living environment or experiencing potential stressors. Settings/Service Locations: Provided within the individual's home and natural environment Target Population: Individuals in the early stages of transition from nursing facilities that require support and reassurance in order to exercise newly developed skills. Clinical Exclusions: If the individual meets the definition for psychiatric crisis, then crisis intervention services should be provided instead of this service. Once the crisis is resolved, recovery supports might again be necessary. Program Requirements: Accessible 24 hours/day, 7 days a week through phone call to team. Contact is with the individual transitioning by phone and/or face to face. 100% provided in natural settings. Each time this support is provided, the individual providing the service must report the provision during the next team meeting, and the team must address any indications for revision of treatment plan and discuss with the individual any needed revisions to a WRAP plan (if a WRAP plan exists.) Minimum Credential: CRSS Additional Notes: The Illinois MRO Rule 132 does not currently have a specific service called "peer supports". However, the current Rule 132 definition of Mental Health Professional (MHP) includes Certified Recovery Support Specialists (CRSS). Thus, a CRSS may provide any mental health service defined by Rule 132 for which a MHP is qualified to provide. In addition, Rule 132 requires at least one CRSS to be a part of each Assertive Community Treatment team and each Community Support Team	$500,000

PROGRAM/SERVICES	DESCRIPTION	FY15 AMOUNT
	functioning in the state. CRSS are individuals with lived experience in recover (i.e. peers) who have competed a certification process to provide services to individuals with mental illnesses. Thus, Illinois' Medicaid State Plan does currently fund peer supports, and the intention of this funding proposal is to increase access to peer supports as well as define a specific type of peer support that is required by those individuals transitioning from long term care to the community.	
Peer Support Offered in Drop-in Centers	Individuals transitioning from long term care to independent living require a place to engage with peers who have successfully transitioned our of long term care facilities and can offer hope. Projected need for 8 new drop-in centers to serve Williams and Colbert class members.	$475,000
Expand MH Rehabilitation Services in Dual Diagnosis Residential Treatment Programs	BIP funding will be used to purchase the Medicaid Rehabilitation services as defined in MRO Rule 132 for individuals in this Residential Treatment Program for individuals with dual diagnosis MI/SA. Service Definition: Residential Rehabilitation for individuals with Dual Diagnosis of both mental illness and substance use disorders. Goal: Intervention with necessary integrated dual diagnosis services to facilitate transition to community living and prevent return to higher levels of care. Included Activities/Interventions: Each individual must be offered orientation and support in Wellness Recovery Action Plan development, Relapse Prevention Plan Development, and access to self -help groups both on site, and in the community. The program must be able to provide all needed medications to individuals, and must provide all medically necessary clinical services for both mental health and substance use needs. Service Location(s): The program will be Licensed as a DHS/DASA site, and must be enrolled through the DHS/DMH enrollment process as well. Setting: It is DHS/DMH and DHS/DASA's intention that the setting for the Dual Diagnosis Residential Treatment will be in a building that is integrated in the community, not in a hospital or nursing facility, has 8 to 10 treatment beds, and is located in the metro-Chicago area. Target Population for This Service: Individuals assessed as having co-occurring disorders of substance abuse and mental health by approved DHS/DASA and DHS/DMH assessment tools who require 24 hour supervision and supports to address both issues. Service Exclusions: Except for services to plan for discharge needs, outpatient services may not be billed concurrently during the individual's stay within a Residential Rehabilitation site. Clinical Exclusions: Individuals exhibiting florid symptoms of a	$167,500

PROGRAM/SERVICES	DESCRIPTION	FY15 AMOUNT
	psychiatric disorder that are unable to be managed in a residential setting. Program Requirements: The program must be reviewed using the DDCAT and found to meet at least dual diagnosis enhanced criteria. Clinical staff must be trained in services to clients with Dual Diagnosis needs. There must be access to psychiatric services 24 hours/day, 7 days/week. Staff must be trained in crisis interventions for both Mental Health and Substance Abuse needs. The length of stay for these services will be based upon medical necessity. DMH is currently working on defining medical necessity and service authorization requirements for Dual Diagnosis Residential Treatment. Typically DHS/DMH policy includes a specific initial authorization period with defined requirements for re-authorization. Although DHS/DMH does not yet have definitive policy it is anticipated that the average length of stay in existing DHS/DASA Residential is 37 days.	
Enhanced Skills Training and Assistance	This service will be an enhancement to MRO Rule 132 current Assertive Community Treatment (ACT) and Community Support Team (CST) services. Service Definition: Hands-on assistance and skill development for individuals requiring a habilitative level of intervention to acquire critical basic skills for safe and successful independent apartment living. Goal: To provide adequate support to individuals who either have not developed the skills necessary for independent living or cannot regain them effectively within regular Community Support Service and Assertive Community Treatment parameters. Included Activities/Interventions: Occupational Therapy that focuses on ADLs, IADLs, and community re-integration skill development with the provision of hands-on assistance which is fully integrated with treatment for intensive skill development over an extended duration for individuals who cannot learn all critical skills at once, or require enhanced skill development approaches. Settings/Service Locations: Natural Settings Target Population: Individuals with significant physical, cognitive, sensory processing, and other impairments that interfere substantially with community re-integration (e.g., (Personal care (ADLs), instrumental activities of daily living (IADLs) and community participation.) Clinical Exclusions: Individuals who perform ADLs and IADLs sufficiently to maintain health, hygiene, safety, tenancy, and community/social participation with regular community support services or assertive community treatment. Program Requirements: Extensive training and expertise in skill	$150,000

PROGRAM/SERVICES	DESCRIPTION	FY15 AMOUNT
	development and transfer. Minimum Credential: Occupational Therapy Assistant with access to supervision and on-site consultation from an OT.	
Bi-directional Integrated Health Care for Complex Needs	This service will be an enhancement to MRO Rule 132 current Assertive Community Treatment (ACT) and Community Support Team (CST) services. Service Definition: Close coordination of behavioral and primary health care provision and illness management/self-management strategies to ensure that the needs of individuals with SMI or Dual MI/SA who have complex medical issues are met. Goal: Successful management of the complex needs and increased self-management capacity in individuals diagnosed with both serious mental illnesses and significant physical health issues. Included Activities/Interventions: Close bi-directional coordination and collaboration between the mental health provider, primary care physician and disease managers. Hands-on, in-home teaching and monitoring to address critical self-management and adherence issues. Settings/Service Locations: Behavioral health care and primary care offices, individual's home, telephone consultations. Target Population: Individuals who would meet the "Quadrant IV" designation under Four Quadrant Clinical Integration Model.1 Clinical Exclusions: Individuals whose medical needs cannot be managed in a home-based setting.	$267,500
PAS/RR System Interface with Universal Assessment Tool (UAT) System	Develop interface between PAR/RR Level 1 and Level II assessment data system and the to-be-developed Universal Assessment Tool system.	$600,000

Individual Placement and Support (Supported Employment)

The evidence-based practice of IPS (supported employment) has been on the forefront as a service/resource to assure full and productive recovery for individuals diagnosed with serious mental illness. There have been one hundred and seventy-nine (179) Class Members enrolled in IPS since the State's implementation of transition activities. Eighteen (18) Class Members or ten percent (10%) enrolled have obtained mainstream competitive job. All eighteen who have worked are still on the IPS caseload. Nine (9) of the Class Members are still currently employed.

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

	Job Tenure				
	1 month	3 months	6 months	9 months	12 months
# of Class Members	17	8	7	4	1

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

Specialized Mental Health Recovery Support Facilities (SMHRF) Comparable Community Services

In response to DHS/DMH's release of an RFI eliciting proposals to develop Comparable Community Services, sixteen proposals were received. Fourteen of the responses were for the geographic areas considered for this service expansion pilot. Each of the proposals was evaluated based on a standardized tool and additional factors such as geographic location to be served, number of IMD referrals from the proposed area of service and projected impact on the number of referrals to long term care. A total of five proposals were offered funding.

These agencies cover four distinct geographic areas within the Chicago and suburban Chicago areas, as well as an area in Central Illinois. DHS/DMH completed negotiations with the agencies in late December 2013 and contracts were executed by February 2014. DMH's expectation is for services to be developed and started by mid-February to March, 2014. The services developed and purchased as a result of this funding include:

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

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

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

Transitional Living Centers: these centers provide immediate access to housing for individuals who are either seen for crisis assessment and linkage or discharge linkage and coordination of services, and whose lack of access to housing puts them at risk of referral to nursing home level of care.

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

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

Transportation: DMH included the cost for transportation between levels of care in the contracts for the above services.

The table below provides a summary of the services funded by area and agency:

Area Served	Agency	Services Provided
"The Southside Collaborative" Lead Agency is HRDI This Collaborative serves the Southside Chicago area, which was responsible for approximately 800 referrals to IMDs.	HRDI	Crisis Assessment and Linkage Transitional Supervised Residential
	Thresholds	Discharge Linkage and Coordination of Services Outreach to Individuals to Engage in Services Transitional Living Centers
Lead Agency is Grand Prairie Services are provided in the South Suburbs of Chicago, an area responsible for approximately 482 IMD referrals.	Grand Prairie Services	Crisis Assessment and Linkage Transitional Living Centers Transitional Supervised Residential
	Sertoma Center	Crisis Assessment and Linkage Discharge Linkage and Coordination of Services Outreach to Individuals to Engage in Services
"The Northside Collaborative" Lead Agency is Thresholds This Collaborative serves the Northside Chicago area, which was responsible for approximately 400 referrals to IMDs.	Thresholds	Discharge Linkage and Coordination of Services Outreach to Individuals to Engage in Services
	Trilogy	Crisis Assessment and Linkage Discharge Linkage and Coordination of Services Outreach to Individuals to Engage in Services Crisis Residential Program Transitional Living Centers
	Community Counseling Centers of Chicago	Crisis Assessment and Linkage Discharge Linkage and Coordination of Services Outreach to Individuals to Engage in Services
	Neumann Family Services	Transitional Living Centers
Lead Agency is Helen Wheeler Services are provided in Kankakee County, an area responsible for 234 IMD referrals.	Helen Wheeler Center	Crisis Assessment and Linkage Discharge Linkage and Coordination of Services
	Thresholds	Outreach to Individuals to Engage in Services Transitional Living Centers
	Riverside Hospital	Crisis Residential Program
Lead Agency is Heritage Behavioral Health Center. Services are provided in Macon County, which contains one IMD in Decatur.	Heritage Behavioral Health Center	Crisis Assessment and Linkage Discharge Linkage and Coordination of Services Transitional Living Centers

The applicability of these services will, we hope, directly reduce the volume of referrals to nursing facilities by having community-based diversion resources addressing pre-hospitalization crises and post hospitalization discharge needs.

HOUSING

In January 2014, the Governor's office successfully recruited and hired two-Statewide Housing Coordinators (SHC). With these hires, it increases the work force to three Coordinators, each with specific areas of responsible focus. One staff is dedicated to coordinate housing resources for both the Williams and Colbert Consent Decrees. Support on these efforts to expand housing resources is received from the other Statewide Housing Coordinators.

- Cluster Permanent Supportive Housing - Project Base model

Holsten Properties

The Office of the Statewide Housing Coordinator (SHC) has worked closely with the Division of Mental Health to create the first Cluster Housing Model. Thresholds was pursued as the partner community agency under this pilot due to the volume of Class Members which this agency has on its Unable to Serve list. Concurrently, Thresholds agreed that they could easily identify twenty class members from this list, those who had complex medical conditions, to transition into this model located at Bryn Mawr-Belle Shore Apartments.

The property was secured in March 2014 through a project-based (Master Lease) agreement for twenty units. These units were inspected and all meet HUD Housing Quality Standards, thus are ready for occupancy. The SHC and DMH also negotiated an office space (that has been retrofitted by Holsten Properties) to be used by Thresholds' hired staff. Concurrently, the SHC was able to convince Mr. Peter Holsten to relax the application requirements and allow Thresholds to complete and submit applications for Class Members who did not have immediate access to either a birth certificate or State ID.

Thresholds contract will fund (out of Williams capacity dollars) round-the-clock, peer support staff to man the office and respond to Class Members/tenants needs, should they require on-site support, and to hire another nurse who will be dedicated to provide medical/medication support needs to Class Members/tenants. Additionally, the residents are afforded all Medicaid and non-Medicaid enhanced services available to Williams Class Members. Thresholds is targeted to have all twenty Class Members settled into their apartments by June 30, 2014. The SHC is working with DMH staff to locate future Cluster Housing models.

Villa Capital Partners

The SHC has meet with representatives of Villa Capital Partners regarding six units of project-based housing for William's Class Members desiring to live on Chicago's south side. The property owner, Villa Capital Partners (VCP), currently provides housing to thirteen William's Class Members. DMH has experienced previous success with project-base housing. The concept provides easier transition for persons with poor credit history and criminal backgrounds.

The Statewide Housing Coordinators, DMH community vendors and staff hold bi-monthly conference calls to expanded housing choices and explore housing stock availability through review of housing resource spreadsheets.

- Federally Funded Housing Resources

Statewide Referral Network (SRN)

- Established by the Illinois Housing Development Authority (IHDA) and the Governor's Office Statewide Housing Coordinators, the Statewide Referral Network is responsible for increasing coordination and collaboration among state agencies while increasing the supply of affordable housing. The SHC's office is charged with assessing and improving the SRN process to ensure that we maximize use of Low Income Housing Tax Credit units and provide supportive housing in remote areas across Illinois.

- The State developed a housing search website with detailed information on vacancies, accessibility, income requirements, rental assistance, and services. The SHC office recently led an assessment of the efficacy of www.ilhousingsearch.org, a website developed and maintained by SocialServe that helps people find and fill available rental units in Illinois. The website includes a specialized case worker portal that allows enhanced access to Williams Transitional Coordinators. In addition to conducting various listening meetings among internal and external stakeholders, the SHCs and IHDA met with staff from SocialServe to review the current services provided and to discuss methods to improve the State's providers use of this website. Services contracted with SocialServe will be expanded to include the development of a tracking system suitable for SRN units.

HUD's Section 811

- FY 2012 Section 811 Award: With the recent approval of HUD's Cooperative Agreement, Illinois is now prepared to implement its $11,989,009 Section 811 grant award which has the potential of producing over 800 supportive housing units in Illinois for persons with disabilities. Key staff from IHDA and the Statewide Housing Coordinators recently attended the Convening of Section 811 Project Rental Assistance (PRA) Demonstration Grantees at HUD's Washington D.C. headquarters. IHDA is in the process of selecting and granting awards to statewide developers and landlords. The administration of this grant is coordinated by an Interagency Panel through an Intergovernmental Agreement. Management personnel from the Division of Mental Health serve on this panel.

- 2014 New Section 811 application: IHDA, with major support from the Interagency Panel, will submit an application to HUD for additional 811 funding, by May 14, 2014.

Public Housing Authorities

- The SHCs continue to meet with Public Housing Authorities to recruit participation in the coordinated remedial plan, an authorization already provided by HUD that allows Housing Authorities in Illinois to give preference to people with disabilities. The SHCs secured commitments for up to 575 additional housing units from the Chicago Housing Authority (CHA), the Housing Authority of Cook County (HACC) and the Rockford Housing Authority (RHA) for Olmstead Class Members, including Williams Class Members, as leverage in support of the State's 2012 Section 811 application to demonstrate non-federal commitment to Olmstead implementation. The Housing Authority of Cook County (HACC)

committed to ten percent (10%) of all turnover HACC vouchers, housing units and project based rental assistance to be allocated to Olmstead Class Members as units become available, as well as seventy-five (75) Non-Elderly Housing Vouchers for persons with disabilities to be allocated through the Statewide Referral Network. Both CHA and HACC have agreed to provide additional leverage support for the States 2014 application.

Alternative Housing/Residential Pursuits

Supervised Residential Bed Options

DMH continues to explore Supervised Residential bed options with Williams contracted provider agencies that have potential bed availability. Between December 1, 2103 and May 15, 2014, a total of eight (8) Supervised Residential beds were made available to accept transitioning Williams Class Members, who meet medical necessity for this level of community service. Seven (7) Class Members were identified and successfully transitioned to these settings. Additionally, another six (6) Supervised Residential beds have been identified to serve as transition resources/supports. The residents in these beds have submitted PSH applications and will begin their housing search. Once they move to the community, these beds will be opened to other Class Members requiring this level of service as defined by medical necessity. By the end of June 2014 a total of fourteen Supervised Residential beds will have been made available as transition options for Williams Class Members. The grand total of Supervised Residential beds identified to accept Williams Class Members is 24.

Rule 140 – Residential Rule

The DMH reopened discussions with all trade groups on the previously proposed draft Rule 140. Several meetings (calls) were held with these stakeholders when formal comments were solicited. When those comments were received DMH responded formally and specifically to each of the trade group's documents. These responses are posted on the DMH website at http://www.dhs.state.il.us/page.aspx?item=29751.

Subsequent to completion of this activity, DMH had proposed to formally publish the Rule for JCAR consideration. The JCAR process and the re-assembling of the Rate Methodology workgroup were to occur in parallel. However multiple internal and stakeholder considerations compromised DMH's ability to proceed in this direction. DMH advised all interested parties in late March that the Rule would not be published until the work of the Rate Methodology workgroup was complete or near completion.
The target date for opening up the Rate Methodology workgroup is now set to begin at the end of May 2014.

Rule 150 – Permanent Supportive Housing Rule

The Draft Rule 150 remains with the DHS Office of Executive Review. All changes, language inserts and definition revisions have been made according to requests. Signatures have been received from Executive Staff. DMH is waiting for sign off and release of this document.

Corporation for Supportive Housing (CSH)

CSH is under contract with the Illinois Department of Human Services to assist the Division of Mental Health prepare the housing and service community to successfully integrate Class Members under Williams into community-based housing options. CSH facilitates and brokers policy discussions between IDHS-DMH and housing developers, advocates, providers, and investors with the goal of development and leverage of quality supportive housing.

Systems Integration Activities

- **Williams/Colbert Housing Focus Forum**
  CSH hosted its quarterly Housing Focus in February 2014. This meeting was used to solicit important feedback regarding the State Referral Network and how to strengthen the system connecting priority populations – like Williams – to quality, affordable housing options. The scope of these forums has been expanded to include input and planning on the housing needs for the Colbert Consent Decree. The forums serve as the venue to convene housing providers and service providers, exploring gaps and resources needed to address housing stock availability, accessibility and location. The information gathered is used to update state strategies and contracts for services, specifically with IHDA and its applications for Low Income Housing Tax Credit development. Attendees at the February meeting included: state agencies, service providers, Housing Authorities and supportive housing advocates.

- **Project-Based Bridge Interest Form**
  CSH created a Project-Based Bridge Interest Form to be used by developers interested in developing units for Class Members and who need operation subsidies to complete IHDA tax credit applications. The interest form was revised to align with DMH policies on Bridge Subsidy and financing of supportive housing.

Outreach and Site Visits to Landlords & Developers

Working closely with DMH and the Statewide Housing Coordinators at the Governor's Office, CSH has developed a network of landlords and landlord organizations that covers the State of Illinois. The focus of outreach has been to generate an understanding of supportive housing, educate landlords about the need for scattered-site supportive housing and to update them on the transition goals and community service supports available to tenants as a result of the Williams Consent Decree.

CSH has conducted site visits and facilitated meetings between landlords, developers and service provider agencies across Chicago and Illinois, to discuss and promote potential rehab of existing stock for PSH and also the development of new PSH buildings. Meetings were held with:

- Tangerine Development
- Burton Foundation/AID Housing Partnership
- Midwest Apartments
- New Pisgah Community Development Corporation
- Alden Foundation

Trainings & Presentations

- **Supportive Housing Academy**
  CSH delivered a Supportive Housing Academy from May 12-16. The Supportive Academy provides intensive training on creating new supportive housing projects by encompassing financing, development partnerships, policy, and service design. The Academy condensed the

key components of the national and newly updated CSH Dimensions of Quality Supportive Housing Institute into five days of training. Academy participants are offered follow-up technical assistance.

Supportive Housing Academy goals include:

- Empower agencies to identify the building blocks of sound projects that are positioned to access public and private dollars;
- Create solid project partnerships with staying power and the skills needed to develop and operate supportive housing;
- Increase the number of units effectively serving individuals and families in need of Supportive Housing;
- Develop an array of housing options including new construction, rehabilitation of single-site projects and scattered-site models

- **Transition Agency Trainings**
  CSH convened two distinct webinar training sessions in January 2014 for Williams provider agencies. The first training was titled Eviction Prevention Planning in Supportive Housing. There were thirty-five (35) participants. The second training was titled Planning for Critical Incidents. There were more than sixty (60) staff representing the Williams service provider agencies.

- **Supportive Housing Symposium**
  On January 8, 2014, CSH held a Supportive Housing Symposium which included eight trainings sessions. These training sessions concluded with a panel presentation facilitated by CSH, featuring Trilogy, Community Counseling Centers of Chicago and Thresholds, titled "Williams Providers: White paper on implementation and implication for behavioral health".

Housing Consumer Satisfaction Survey

- **Williams Consumer Satisfaction Survey**
  With DMH input on a survey design, CSH completed a PSH consumer satisfaction survey directed to Williams Class Members who have transitioned to the community. The surveys were distributed by transition agencies and completed anonymously and independently by Class Members. 461 surveys were mailed to CSH for data entry and analysis. Some findings are:

1. The number of Class Members who share apartments under one Williams provider agency is much greater compared to the volume of shared apartments among other Williams provider agencies – where there is a stronger preference for individual apartments.

2. There are several agencies that "allegedly" showed only one apartment, according to several Class Members' report, contrary to expectations (and DMH directives) of providing choice between three apartments.

3. Overall, the data shows broad satisfaction by Class Members:
   - 98% say life is better for them now that they have their own apartments.
   - 83.6 % are satisfied with their current apartment.
   - 66% knew people in their neighborhood who are not part of the Consent Decree
   - 87.6% are happy with their neighborhood, but only 74.7% are living in areas where they originally wanted to live.

- People are reporting that they are receiving the level of service they like and need.

REPORTABLE INCIDENTS (formerly Critical Incident Reports)

The State has undertaken a concerted effort to more accurately capture Reportable Incidents. During the first two years of implementation, it was important that occurrences with Class Members were tracked across all possible incidents. In year three of the Consent Decree, the State realized that it needed to take a finer-grained view of incidents to focus more particularly on events that could impact the safety and wellness of Class Members.

The State aggressively reviewed several reporting formats from across the nation to investigate patterns and approaches in collecting reportable incident information. However, it was also important that the information collected for the Williams Consent Decree remained compatible with data needed for other Rebalancing endeavors, namely Money Follows the Person and the Colbert Consent Decree. The State has adopted a uniform protocol for categorizing incidents, structured as follows:

Level I – Urgent; Critical Incidents: Situations or outcomes that result in adverse occurrences impacting life, wellness and safety.

Level II - Serious Reportable Incidents: Situations or outcomes that could have implications affecting physical, emotional or environmental health, wellbeing and community stability.

Level III – Significant Reportable Incidents: Situations or occurrences that could possibly disrupt community tenure.

Reporting under this new format began May 1, 2014 and will be reflected in the next Semi-Annual Report. The former Critical Incident report data from October 2013 through May 23, 2014 is being manually entered into the DMH tracking system in the new format. This conversion will be completed by May 30, 2014. An aggregate report will be submitted for review in June 2014.

During this report period there were three (3) deaths reported. Root Cause Analyses have been completed on these deaths. Autopsies have been requested and obtained, when possible.

Between October 1, 2013 and May 23, 2014, 265 Class Members account for all reportable incidents. One hundred and twenty (120) Class Members accounted for two (2) or more Reportable Incidents. The below table shows the distribution:

# Incidents	Unduplicated Count of CMs	Percentage
1	144	28.86%
2	64	25.65%
3	29	17.43%
4	10	8.43%
5	11	11.02%
6	5	6.01%
7	1	1.40%
8	1	1.60%

QUALITY MONITORING

Deputy Director of Licensing and Quality Management

As reported in the Semi-Annual Report #5, the position of Deputy Director of Licensing and Quality Management remains vacant. In the interim, an executive staff member of DMH has continued to provide oversight responsibility for staff and operations. In April 2014, DMH interviewed an extremely promising candidate who has perfect qualifications for this position. A second interview has been scheduled, with hope that the candidate will accept the position. If so, we anticipate that the position will be filled by July 1, 2014 (or soon thereafter).

Quality Monitoring

In the last six month, DMH has hired its full complement of ten (10) Quality Monitors. The office space for the central Illinois Quality Monitors was moved from Springfield, IL. to Pekin, IL. (outside of Peoria), to provide closer access to the service areas of Class Members, as well as co-location in a DHS office with connection to the DHS server. The two positions were filled by a RN and a social worker, respectively. These staff will provide monitoring responsibilities for the areas of Peoria, Decatur and surrounding communities. The third position was filed by a social worker and located in the Chicago office.

There has been significant evolution in the role of the Quality Monitors. As originally conceived, the Quality Unit's purpose was to monitor and provide feedback on the Williams provider agencies' compliance with the comprehensive service plan developed for each Class Member; the Class Member's settlement in the community and adaptation to independent living; and community agencies ongoing services and supports provided to each Class Member. The process anticipated a limited number of specifically timed encounters between the Quality Monitors and the Class Members. It was also anticipated that deficiencies and problems identified during these encounters would be reported to the service provider and that the Quality Monitor would limit involvement with the Class Member until the next scheduled visit. Visits are scheduled at intervals of 30 days, 3 months, 6 months, annually and 18 months post transition. This system was planned to be beneficial at two levels: first, it helps the Quality Monitor maintain objectivity in looking at provider's performance; secondly, it also assured that the Quality Monitor's role did not conflict with the provider's service delivery program.

However, as the Quality Unit solidified and began to meet its scheduled number of visits with Class Members, a previously unidentified need was discovered. A significant number of Class Members were requesting services that had not been included in the comprehensive service plan. The actual experience of establishing a residence and living independently created circumstances that often could not have been anticipated at the point of transition or reported to the community staff. It is the sharing of this information that seems to create the expectation that the Quality Monitors would be the "go to" person to provide assistance in solving basic day to day issues.

As the number of encounters between Quality Monitors and Class Members increased it became clear that limiting the role of the Quality Monitor to that of a compliance officer needed to be re-examined. As a result the role of the Quality Monitors was adjusted to be more inclusive of a 'continuum' of support for Class Members who were requesting assistance. The majority of these requests were for improved communication between the Class Member and the provider agency. When addressing these

requests the Quality Monitor functions solely as a communication facilitator. The Quality Monitors are respectful not to interfere in service delivery or to assume the role of case manager.

It is anticipated that this trend toward more interaction with Class Members will increase as the number of encounters with Quality Monitors increases. By the end of the initial 18 month period the Class Member will have met with a Quality Monitor at a minimum of five times. Each of these visits involves detailed discussions on the Class Member's experiences since moving into the community. In an increasing number of cases these conversations have lead some Class Members to view the Quality Monitor as a significant participants in their recovery, to ensure their ongoing well-being in the community and to serve as another potential resource. Ongoing experience has afforded DMH with lessons learned - how to better use Quality Monitors in those instances. The goal remains to make sure that the Class Members are well connected with the right resources and staff supports from the community agencies.

Evaluation of Quality of Life and Treatment

The assessment and evaluation of the quality of care received by Williams Class Members is multi-tiered and multi-faceted. Of utmost importance in this assessment process is the voice of Class Members to provide direct feedback regarding their quality of life and their evaluation of treatment/care received pre and post transition to community living and treatment. Two instruments are utilized to capture this information: the Mental Health Statistics Improvement Program (MHSIP) Adult Evaluation of Care Survey and the Lehman Quality of Life Survey (brief version). Both instruments are nationally known and well regarded. Both have excellent psychometric properties and are widely used in the mental health field.

The MHSIP Evaluation of Care survey is comprised of 36 items covering 6 domains: General Satisfaction with Services. Access to Care, Quality/Appropriateness of Care, Participation in Treatment Planning, Outcome associated with treatment, Social Connectedness and Functioning.

The Lehman Quality of Life Survey is comprised of the following domains: General Life Satisfaction, Daily Activities and Functioning, Family Relations, Social Relations, Work, Legal and Safety Issues, Health and a small set of selected items from the Survey used in the Money Follows the Person (MFP) initiative.

The instruments are administered before IMD discharge (within 30 days of discharge) and discharge at 6 month, 12 month and 18 month intervals, post-discharge. NAMI Outreach workers, with whom the DMH contracts, administer the instruments pre-IMD discharge. DMH Quality Monitors are responsible for administering the instruments during regularly scheduled home visits with Class Members post IMD discharge. The instruments are administered within a 30 day window of the administration due date.

Survey Analysis

Pre-IMD discharge surveys completed within the appropriate specified timeframes have been obtained for 367 Class Members. Surveys completed within the specified timeframes post IMD discharge at 6 months and 12 months have been collected for 274 and 219 Class Members respectively. The results discussed below are based on a preliminary analysis and comparison of Class Members ratings as a whole on these surveys pre and post-IMD transition and is intended only to show trends in the data observed thus far. As more surveys are completed, appropriate analytic/statistical techniques will be applied to the data to determine if the changes that are observed pre and post IMD discharge are statistically significant.

Results - Evaluation of Care

When Class Members pre-IMD transition ratings as a whole are analyzed, generally Class Member evaluations across all six of the MHSIP adult survey evaluation of care domains were more positive at 6 months post-IMD discharge than pre-IMD discharge. Thus, Class Members reported improvement in access to care, quality and appropriateness of care, participation in treatment planning, outcome as a result of treatment, social connectedness and functioning.

When the 12 month post discharge ratings are calculated for Class Members as a whole and compared to pre-IMD transition ratings, the results are similar: ratings on five of the six MHSIP adult survey evaluations of care domains were more positive at 12 months post-IMD discharge than pre-IMD discharge. When the 12 month ratings are compared to the 6 month ratings, 4 of the 6 domains are more positive. The outcomes and social connectedness domain are slightly less positive than Class Member ratings at 6 months post transition.

These results are summarized in the table below:

Domain	Pre-Transition	Post-Transition 6 Months	Post-Transition 12 Months
Access to Care	75.7%	88.4%	90.2%
Quality and Appropriateness	76.1%	89.5%	95.1%
Participation in Treatment Planning	77.8%	89.1%	94.1%
Outcome	91.6%	93.1%	88.9%
Satisfaction	63.7%	85.4%	89.3%
Social Connectedness	88.9%	93.1%	92.5%
Functioning	95.5%	96.0%	97.0%

Quality of Life Survey

Preliminary Results

The summary below presents results for items comprising the Lehman quality of life survey, comparing responses pre-IMD and post-IMD discharge.

General Life Satisfaction

In response to the item, *"How do you feel about your life in general?*, Class Members rated their general satisfaction more positively post IMD discharge: Seventy-eight percent (78%) reported that they were mostly satisfied, pleased or delighted pre-IMD discharge, while eighty-two percent (82%) reported positively for this item post-IMD discharge.

Functioning in Home, Social, School and Work Settings

In response to the item, *"Overall, how would you rate your functioning in home, social, school and work settings at the present time?"*, seventy-eight percent (78%) rated their functioning as good or excellent pre-IMD discharge while eighty percent (80%) rate their functioning as good or excellent post discharge.

When asked about specific ways in they spend their time, or about opportunities for enjoyment, forty-nine percent (49%) of Class Members reported that they were pleased or delighted about the way they spent their time pre-IMD discharge, while forty-six percent (46%) reported feeling pleased or delighted post-IMD discharge. Class Members ratings with regard to having the chance to enjoy pleasant things pre-discharge fifty-five percent (55%) vs. post discharge fifty-five percent (55%) were the same pre vs. post discharge, while the amount of fun they reported having was rated slightly more positive post IMD discharge vs. pre-discharge forty-nine percent (49%) vs. forty-six percent (46%).

Social Relations

Quality of life survey items related to social relations revolve around how often class members have the opportunity to visit/telephone someone with whom they do not live, as well as the opportunity to spend time with another person doing pre-planned activities or spend time with a significant other. The ratings for each of these items were more positive post-IMD discharge versus pre-IMD discharge. Spending time with a significant other such as a boyfriend, girlfriend or spouse showed the least amount of change pre-IMD vs. post-IMD discharge across the three items however.

Safety

Safety items revolve around how Class Members rate their safety in their neighborhood, where they live and whether they feel they have protection against being robbed or attacked. Class Members rated neighborhood safety and protection against being robbed or attacked slightly more positively post discharge. The largest change in perception post versus pre-discharge was class members' perception of safety in the residence where they live. Sixty-three percent (63%) reported feeling safer post discharge compared to forty-eight percent (48%) pre-discharge.

Health

Class Members rated their overall state of health slightly higher pre-IMD discharge versus post-IMD discharge seventy-two percent (72%) vs. sixty-eight percent (68%). When asked about their health in general, their physical condition and emotional well-being—ratings were slightly more positive pre-IMD discharge than those as post discharge/transition.

Satisfaction with Living Arrangements and Crisis Response

When asked if they like where they live, Class Members ratings were more positive post-IMD discharge in comparison to pre-discharge eighty-eight percent (88%) vs. thirty-seven percent (37%). Class Members were also more likely to reply that they know what to do in a crisis post-IMD discharge versus pre-IMD discharge ninety-nine percent (97%) vs. eighty-nine percent (89%).

Summary

As noted in the previous report, asking Williams Class Members to directly evaluate their living situation, treatment outcome, access to services, quality and appropriate of services received, satisfaction with services, safety, health and social functioning is critical for determining the impact of the Consent Decree. The general preliminary trend that we are observing based on an analysis of the quality of life survey is that Class Members are rating their living arrangements, functioning and treatment more positively post transition than pre-transition. Additional analyses will be performed to gather additional information with regard to these trends.

DECISION SUPPORT/INFORMATION TECHNOLOGY

Data Collection

The Division of Mental Health continues to require DMH contracted agencies working with Williams Class Members to submit registration/enrollment information, transition coordination and transition coordination tracking, comprehensive service planning, permanent supportive housing and permanent supportive housing outcome data to the DMH/Collaborative community information system. DMH has also continued to use its specialized database to capture detailed information on the quality of life and evaluation of treatment surveys that are being administered to Class Members prior to discharge from IMDs and at six month intervals thereafter for the first year that these individuals reside in their own housing. As reported previously, DMH also continues to update and enhance several small internal databases to manage day-to-day activities of Williams Administrative staff and Quality Managers and to assure compliance with the Consent Decree.

Resident Review Data

The Department of Healthcare and Family Services (HFS) remains responsible for maintaining and operating the Williams Resident Review database that was initially developed by its University of Illinois Chicago School of Nursing IT sub-contractor. As reported in a previous report, DMH now has responsibility for the resident review process and has contracted with two community-based agencies to perform resident reviews and to enter data directly into this system. DMH has also hired temporary staff to enter resident reviews into the system for Class Members for whom only paper reviews were completed so that this data is available for analytic purposes.

Access to Resident Review Data

The DMH continues to work with HFS to gain routine access to the resident review data for Class Members for review and analytical purposes. Until recently, DMH had been working directly with HFS staff to obtain access to this data. A decision was made in April 2014 by HFS to provide access to the database to DHS MIS staff who would then provide data files to DMH staff for analytic purposes and for use in the external evaluation conducted under an Intergovernmental Agreement with UIC. DHS MIS dedicated staff resources to work on this process. However, because of the data structure and content, DHS MIS has subsequently recommended that HFS staff who are knowledgeable with regard to the database variables, structure and data “clean the data” so that it can be used for analytical purposes. We will pursue this recommendation.

Evaluation Plan

Prior to the implementation of the Consent Decree, the Division engaged in planning to develop specific information modules to collect data to support planning, evaluation and quality assurance and monitoring activities associated with the Decree. DMH has committed to evaluating the implementation of the Consent Decree. This work has two spheres of focus: an internal and an external evaluation. The internal evaluation which is being performed by Division of Mental Health Decision Support is focusing on utilizing data collected by DMH staff through the course of the implementation and includes information such as descriptive, demographic, claims, quality of life and evaluation of care data. The external evaluation is focusing on predictive studies that will address issues that will inform the continued implementation of the Consent Decree as well as to address topical issues that impact the implementation. This information will also be used for quality improvement and planning purposes. The external evaluation is being undertaken through an Intergovernmental Agreement with the University Of Illinois Jane Adams School Of Social Work.

University of Illinois Jane Adams School of Social Work Initial Study Focus

DMH has undertaken several activities to identify issues that will be the initial focus of the external evaluation. These activities have included discussions with the Williams plaintiffs, the Williams Court Monitor and DMH staff. One important issue for all parties concerns the refusal of Williams Class Members to participate in resident reviews. As noted above, as of April 29, 2014, of the 7,557 resident reviews initiated thus far, 3,938 or fifty-two percent (52%) have been refused by Class Members. Although the decision to participate in a review is a matter of choice by Class Members, there is an interest in determining why so many individuals have chosen to remain in their IMD as opposed to transitioning to community living. The overarching strategy to obtain this information will be to conduct interviews with a representative sample of Class Members refusing resident reviews to obtain, *"in their own words"* their reasons for refusal, as well as their perception of what it means to transition to community living. A draft interview protocol developed by the UIC evaluation team is currently undergoing review by Division staff, and the interviews will be initiated as soon as possible.

Internal Evaluation

Division of Mental Health Decision Support staff continue to collect data through its community reporting system, quality of life surveys, and a specialized database developed to manage daily activities and monitoring associated with the Williams Consent Decree. Reports from some of the data generated from this internal analysis are included in other sections of this report.

BUDGET

In FY14 the Illinois General Assembly appropriated $35.5 million in General Revenue Funds and $20 million in Special State funds for rebalancing efforts related to the Implementation Plan. Expenditures thru April 1, 2014 include $2.6 million for administrative and operational expenses as well as $16.6 million in grant funded services. In addition, $6.52 million has been expended for Medicaid services to Class Members. By the end of FY14 it is estimated that spending will total approximately $35.9 million.

The Governor's current proposed FY15 for budget for the Division of Mental Health includes $32.9 million in General Revenue Funds and $20 million in Special State Funds dedicated to expanding home and community-based services, and other transitional assistance costs associated with the consent decree implementation. This budget is not recommended pending the outcome of the permanent state income tax increase debate in the legislature.

Calls, Complaints, Grievances, Appeals

Calls

Between the dates of December 2, 2013 through May 15, 2014, there were a total of thirty calls to the Williams Call Line. Twelve calls were directly from Class Members seeking status updates on assessments/reassessments, transition or follow-up by a community agency. Fourteen calls were received from residents of non-IMD nursing facilities with inquiries as to whether they could participate in the Williams Consent Decree's *Moving On.* Two calls were received from family members, seeking general information about the Consent Decree and two calls were received from other interested parties for general information.

Complaints/Grievances

There were no complaints or grievances filed to the Williams Call Line during the months covered by this report.

Appeals

There were no appeals submitted to DMH for review during this period.