Williams v. Rauner

Case No. 05-4673

(N.D. Ill.)

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Williams Court Monitor

June 30, 2017

I. Scope of Report

The last annual Report to the Court was filed on January 3, 2017. This Interim Report primarily describes levels of activity and compliance over the past six month (January 1, 2017 –June 30, 2017). However, it should be noted that this is now the end of year six of the original five-year compliance schedule. As in the past, this Report will also discuss progress on system-wide issues that have direct bearing on overall Williams compliance.

II. Assessment of Current Status and Compliance for Year Six

A. Outreach to IMD Class Members

The basic model for performing outreach to Class Members remains the same. The National Alliance for the Mentally Ill of Greater Chicago (NAMI-GC) continues to provide a range of outreach services, including: connectivity with all IMD admissions; providing individual (and detailed) information to any Class Member with interest in community placement; follow-up with all Class Members who have previously declined; and supporting Class Members who are waiting for transition. The NAMI-GC staff also perform the initial IMD-based Quality of Life Surveys (see II.F.3 for discussion of Quality of Life Surveys). It should also be noted that NAMI-GC staff have specific IMDs to which they are assigned; as a result they have over time become very familiar with facility staff and with individual Class Members.

For the most recent six months, the following activity levels are reported:

- 248 introductory letters signed
- 240 private interviews with Class Members
- 33 contacts with guardians

- 2,940 contacts with Class Members to respond to questions or concerns.

Some of the specific activities of NAMI-GC are:

- Obtaining consent for Class Members who are recommended for a specialized assessment.
- Working as a liaison among DMH and Transition Agencies when Class Members have questions.
- Assisting Class Members when they want to change their designated provider agency.
- Assisting Class Members in connecting to Drop-In Centers while they are still at the IMD.
- Facilitating quarterly community meetings at each IMD – working with Ambassadors who provide detailed information. For the first three quarters of FY 2017, approximately 1,100 Class Members were in attendance.

The Outreach Ambassadors program continues to operate – with 14 part time Ambassadors who return to a given IMD for 8 hours/month to share their personal stories of life in the community and then answer questions.

DMH – via NAMI-GC – continues to work toward an expansion of the outreach program. The In-Home Recovery support staff will add 6 full time In-Home Recovery Support Staff who will work with Class Members during the pre-transition phase and then stay involved for up to six months after the move. This support would supplement what is provided by the mental health agency. Evidence suggests that the highest risk period is right after a Class Members moves; hence this more intensive support is right on target. The program will begin very soon and will continue in FY 2018. The overall demand remains to be determined.

In summary, the Court Monitor continues to find Defendants in general compliance as relates to outreach.

The In-Home Recovery Support Program has had delayed implementation, but now appears ready to move forward. The State appears to have resolved the issue of some IMDs limiting physical access for Ambassadors. NAMI-GC has proven to be a very good partner – demonstrating a willingness to explore new roles and improved models of engagement.

B. Resident Reviews

Lutheran Social Services of Illinois (LSSI) and Metropolitan Family Services (MFS) continue to conduct all of the Resident Reviews for Williams Class Members. As of May 16, 2017, the unduplicated total for Class Members approved for transition was 4,014; this total includes 3,833 found eligible by the Resident Review agencies; 156 eligible after review by the Clinical Review Team (CRT); and 25 found eligible after the appeal process.

1. Disparity Analysis – The Court Monitor continues to review key metrics with DMH and the Resident Review agencies; the overall percentage of positive community recommendations is one of the metrics discussed. For the most recent six months (October 1, 2016 – March 31, 2017) the disparity between LSSI (77.3% positive recommendations) and MFS (73% positive) is now at just 4%; this contrasts starkly with baseline disparities of 20%. It should be noted that MFS had a relatively higher rate of new (first time) reviews for this period which could explain the bump in positive recommendations. The combined positive rate for the two agencies for the past six months is 76% - very consistent with the prior period of 77.5%.

2. Specialized Assessments

DHS/DMH continues to contract with UIC to conduct specialized assessments for both Occupational Therapy (OT) and Neuropsychological concerns.

As relates to OT assessments, a cumulative total of 102 Class Members have been referred – with 43 of those consenting (one of whom transitioned before the assessment). Of the 42 assessed, 39 were recommended for community transition. However, only 4 of the 39 have actually transitioned as of this Report. Among other issues, the largest reason for non-movement is persons categorized as "unable to serve." This will be discussed in detail as part of the FY 2017 Implementation Plan (see II.C.2).

In terms of Neuropsychological assessments, there have been a total of 125 referrals since the beginning of this UIC contract. Twenty-eight (28) referrals have occurred during this reporting period – of which 8 have been completed and the remaining 20 have been scheduled. Of the eight evaluated, only 2 were recommended for community care. There are significant scheduling and logistical concerns with this contract – driven largely by the limited availability of open slots at UIC.

3. Re-Approach Efforts

DMH continues its practice of asking NAMI staff to re-approach all Class Members who have refused a Resident Review. NAMI is provided these names on a monthly basis and subsequently notifies the Resident Review agencies of any Class Members willing to reconsider. In the recent period, 32 Class Members at LSSI were re-approached and 20 of those (63%) completed the review. Of those 20, 16

(80%) were subsequently recommended for transition. All of this reinforces the belief that, while the overall numbers are small, it is important to give Class Members several opportunities to address this critical decision in their lives.

4. Audit of Negative Recommendations

The Court Monitor references back to the audit findings in the January 2017 Annual Report to the Court regarding those Class Members who were interested in community placement but were not recommended via the Resident Review process. The Court Monitor wants to reiterate that, while this 20% is significantly better than in the earlier years, it still represents a group of individuals who are being denied the chance to live in an integrated setting. The recommendations in the January 2017 Report are still worthy of consideration and action (see II.B. in January 2017 Report to the Court).

Overall, the Court Monitor finds that the State defendants continue to work toward compliance as relates to Resident Reviews. The Resident Review agencies (LSSI and MFS) have been consistent and reliable performers – with increasingly improved positive recommendation rates over time (now at 76%). The disparity rate between the two agencies is at its lowest level ever (4%). The negative 20% audit findings continue to argue, among other things, for more high intensity service options in the community system.

C. Transition Coordination and Community-Based Services

DHS/DMH is currently contracting with 19 community mental health providers; 15 of this total are currently accepting referrals.

1. Placement Targets

As of May 2017, 4,014 Class Members have been approved for transition. Of this total, 1,923 have been offered placement – which means a Class Member has either moved or has a signed lease. The difference between those approved and those offered placement is 2,091. The major reasons for this large gap between "approved" and "offered" are: 1) Persons who have declined after initially agreeing (647); 2) Persons who have left the IMD and are no longer accessible (665); 3) Persons designated by providers as "unable to serve" (303); 4) Persons on "hold" due in part to time-limited medical, psychiatric or behavioral issues (222); and 5) Persons who are somewhere in the transition process. If you include all of these known persons who have been recommended for transition and are somewhere in the pipeline, that number is 858. It should be noted that many of these persons in the pipeline (i.e. on hold status) have remained in IMDs for sustained periods after they expected to move to the community.

Year five (5) of the Williams Decree ended on June 30, 2016 – the original timeline established by the Decree to move all willing and recommended Class Members. Obviously, the State was far from this mark. The State's goal for year six (6) of the Decree was to move 400 persons; as of May 16, 2017, 298 Class Members had been offered placement – leaving a target of 102 persons for the last six weeks of the fiscal year. As of June 30, 2017, 380 persons were offered placement, a gap of 20 from the 400 target. The State worked very intensively with providers to remove obstacles and facilitate the maximum number of transitions. It is obvious, that, despite these efforts, there is still a

considerable distance to go to achieve compliance requirements.

2. Unable to Serve

The "Unable to Serve" population continues to be one of the major unresolved issues between the parties. The final FY2017 Implementation Plan (I.P.) describes the development and role of a clinical case review panel as a means to review and recommend regarding all of the 322 Class Members who were on the "unable to serve" list as of February 1, 2017. The DMH convened this panel as of March 2017. Several items of note include:

- DMH is now referring to this population in question as Class Members with Complexities Affecting Seamless Transition (CAST).
- The panel meets by phone every week for two hours and is composed of a psychiatrist, RN, Social Worker/ Occupational Therapist and a Certified Recovery Support Specialist (CRSS).
- The provider agency is required to submit a summary for each Class Member to be reviewed including reasons for the person being on the list and risks/resources that would need to be addressed. The agency staff meets with the panel to present relevant information and answer questions.
- As of June 7, 2017, 101 Class Members have been reviewed. The panel outcomes can include four possibilities: 1) Proceed with transition; 2) Transition pending – i.e. look, at specific services needed; 3) Remove from CAST list e.g. person no longer at IMD and has declined to participate or; 4) Recommend for transfer to skilled nursing facility.

While this panel process is far from complete, there have been several critical learnings already: 1) The list needs to be regularly updated by DMH (and provider agency); 2) DMH will add or remove names from the list and not individual providers; any new request will be reviewed in depth before being added to the list; 3) Any Class Member who refuses or declines will be referred to NAMI and the Resident Review agencies for a new Resident Review and; 4) There is the clear expectation that providers will follow through with the panel's recommendation. The Court Monitor continues to believe that, with few exceptions, these Class Members can (and should) be served in community settings.

Incentive Payment – As part of the FY 2017 I.P. the State committed to a 6-month pilot funding strategy that would pay providers an incentivized case rate for placement of those on the "unable to serve" list. The intent was to provide flexible funding so that providers could add needed staff or services in order to transition Class Members. It is assumed that this pilot is still in play, although there is no concrete evidence at the time of this Report.

It should be noted that there are no specific targets for FY 2017 or beyond for transitioning this group of Class Members.

3. Behavioral Health Transformation

The State continues to pursue a multi-faceted effort to transform the behavioral health system. At the heart of this effort is a planned multi-year shift from over-reliance on institutional care to expanded community capacity. The 1115 Behavioral Health Waiver remains under review by the

federal Center for Medicaid/Medicare Services (CMS). If approved, one of the elements will be the development of integrated health homes – which will be important for Williams Class members with complex medical needs. The State remains hopeful that CMS will approve the waiver, although there is no certainty as to approval or timeline at this point.

Overall, the State continues to be out of compliance as relates to transition of Class Members. The FY 2017 400 goal for the State was short by 20 Class Members despite a major push by DMH. However, even the 400 goal does not come close to meeting the current known need for persons to be placed. DHS/DMH staff believe that the Clinical Case Review process may reduce the number of persons on the "unable to serve" list by as much as half of the 332. However, even at an estimated half (166) this still leaves a total of 731 currently known persons to be transitioned. This number does not count new admissions who are continuing to be admitted (see II.F. for discussion of Front Door).

The State's development of the Clinical Case Review panel is commendable and, for the first time, has the potential to be fruitful in getting a handle on this population. It will be critical that DMH mandate and ensure that providers follow through on community recommendations. The decision to maintain State level control on who goes on the list into the future is also very wise.

Clearly the State has a significant course ahead before it can achieve compliance with the transition requirements of the Consent Decree. Those challenges will be even greater in the event CMS does not approve the 1115 Waiver.

D. Housing

The State's cross-agency collaboration on developing and accessing housing continues – with the core team of the Statewide Housing Coordinator (at DHS), the Illinois Housing Development Authority (IHDA), DHS/DMH, the Corporation for Supportive Housing (CSH) and local mental health providers. Highlights from the past 6 months include:

- Statewide Referral Network – DHS and IHDA partner to create new and affordable low-income housing units. The Statewide Referral Network (SRN) serves as a link for vulnerable populations to available housing. As of April 30, 2017, two Williams Class Members have located into SRN units, 60 are on the waiting list and 8 have open offers.

- HUD Section 811 Units – IHDA has worked aggressively to secure Section 811 units in new housing developments. There has been a particular focus on those properties that are desirable for Williams class members – so called Communities of Preference. As of April 2017, 144 housing units have been approved by the IHDA Board. The Section 811 Waiting List includes 56 Williams Class Members. Six Class Members have been moved into Section 811 units.

- Public Housing Authorities – As of April 30, 2017, 184 Williams and Colbert Class Members have converted from a State-supported Bridge Subsidy to a federally-supported Housing Choice Voucher (HCV) and 110 have actually been issued vouchers.

  The Housing Authority of Cook County (HACC) continues to commit 10% of its turnover vouchers to the Olmstead

Consent Decrees; this has totaled 120 units so far and will provide an additional 60 on an annual basis.

- Other Initiatives – IHDA is actively looking at other ways to leverage supportive housing resources for Class Members. For example, IHDA manages the Illinois Rental Housing Support Program, which is funded via a real estate recording fee. IHDA is looking at ways – with this program – to prioritize housing for persons who are at risk of placement in a long term care setting.

- Corporation for Supportive Housing (CSH) – DHS/DMH continues to contract with CSH to carry out a variety of specific tasks in the area of PSH. Examples from the past 6 months include:

    - Actively participate on the Interagency Council on Homelessness. The concrete goal is to provide a more uniform process for assessment and referral of homeless persons with SMI.

    - Key participation in the IHDA Affordable Housing Task Force – CSH helped develop a comprehensive Supportive Housing Work Group Report in February 2017. This five-year plan outlines needs and strategies for supportive housing across different vulnerable populations.

    - Provide the data management and liaison for the transition of persons from Bridge Subsidies to Housing Choice Vouchers.

    - Conduct periodic consumer satisfaction surveys to assess specific consumer thoughts and needs.

- Provide a variety of training experiences for mental health providers, housing locators, and landlords. For example, CSH facilitated a two-day training in January 2017 on Housing First – a national model that emphasizes the need to provide housing as an essential first service (not last) for persons with SMI or other disability.

In summary, the Court Monitor continues to find the State in compliance as relates to Housing. Both the Statewide Housing Coordinator and IHDA have worked to leverage federal and State resources to maximize housing options. IHDA has also taken on the role of outreach to landlords – an essential component toward expanding housing options for Class Members. CSH continues to provide many essential services via its policy and training supports.

E. Service Enhancements

DMH has continued its efforts to enhance services in critical areas in order to improve both the ability for Class Members to transition and also to successfully remain in the community. Examples include:

1. Supported Employment

In 2015, DHS/DMH – in collaboration with the Department on Aging (Colbert) – began a targeted employment initiative for both Williams and Colbert Class Members. This initiative has focused on improved education for staff on the importance of employment and also direct outreach to Class Members in one of the 18 Drop-In Centers. This effort has shown success – with the number of job related activities significantly increased over time. Altogether there have been 386 Williams Class Members enrolled in Supported

Employment since July 1, 2012 and 127 (33%) who have actually worked.

The Resident Review process identifies the level of interest in employment as part of the review. It is noteworthy that, in the recent six month period, over two-thirds of the respondents said they had interest in work. DMH is now cross-referencing these names back to the Supported Employment manager to ensure that these persons are appropriately given work opportunities via local providers.

2. Specialized Training

DHS (DMH) has continued to provide specialized training for provider staff via the UIC College of Nursing; this training is also done in conjunction with the Department on Aging (Colbert). There have been a series of training opportunities – with particular focus on detection and needed treatment for Class Members with concomitant medical conditions. This training has been very well received by provider staff and is a core part of the strategies to reduce the number of persons who return to IMDs.

3. Supervised Residential

DMH continues to experience the demand for Supervised Residential beds for some Class Members exiting the IMDs. DMH has contracted with Habilitative Systems, Inc. (HSI) which has added six Class Members in FY 2017. There have been a significant number of Class Members who have moved from IMDs to the community via Supervised Residential settings, including 29 total in FY 2017. DMH has also utilized Bridge Subsidies for existing Supervised Residential persons (non-Williams) who leave as this then

opens up a supervised residential slot for a Williams Class Member.

4. Eviction Prevention

DMH has a formal process to prevent eviction for Class Members who are at risk. The primary method is a teleconference call with providers, subsidy administrators, DMH staff and the Class Member. The purpose of these calls (39 in the second half of FY 2017) is to identify issues and seek solutions. Overall these calls have been successful and are also consistent with the goal of avoiding unnecessary returns to IMDs or being without stable housing.

F. Front Door – Choice and Community Alternatives

As a major part of the FY 2017 Implementation Plan, the State (via collaboration of DHS/DMH and Healthcare and Family Services (HFS)) began a front door diversion pilot in February 2017. This pilot is intended to begin a process to deal with the State's clear non-compliance with the Consent Decree requirement that, after July 1, 2016, no one whose service plan provides for placement in a community setting will be offered placement in an IMD – unless that person declines the community option. Specifically, the Williams Consent Decree required that, by this time in the implementation process, no one would be admitted to an IMD unless they had been offered and refused appropriate services in the community. The parties agreed that preventing needless institutionalization at the front door, rather than simply helping people move out of IMDs after they had been admitted, would be the best way to meet the goals of the Decree. Unfortunately, in spite of repeated requests to start developing this capacity by the Monitor and the Plaintiffs extending over many years, the Defendants failed to put themselves in a position to comply with this provision.

The pilot involves 14 Northside hospitals who have inpatient psychiatric units. DHS/DMH has contracted with three (3) community providers to provide both Medicaid and non-Medicaid (e.g. crisis stabilization and housing) services. DMH has authorized 50 Bridge Subsidies and has also funded eight (8) crisis residential beds for the Front Door pilot.

The three providers are to evaluate within three (3) business days all SMI individuals from these acute hospitals who are considered a likely referral to long term care. The goal is to then direct interested individuals into community-based care.

The pilot will run through August 2017 and will then be independently evaluated by UIC School of Social Work. The evaluation will look at overall outcomes, costs, and relative benefits associated with different service arrays. It is anticipated that the evaluation will be completed by October 2017. The State has committed ongoing funding for this pilot – with the stated intent to use the evaluation results to frame the nature and scope of Front Door efforts in the future

The Court Monitor (together with Plaintiffs) had the opportunity to visit with many of the Front Door participants in April 2017. The Monitor's impression was that the pilot is making some inroads in both identifying and diverting persons who do not need or desire long term care. Coordination issues among participants are evolving. The Monitor has expressed concern about the lack of adequate crisis stabilization beds to support the pilot. It will be incumbent on the State to provide the full array of needed services, including housing supports, before this effort can be judged as responsive to the language of the Consent Decree.

G. Quality Assurance

DHS/DMH has continued the same overall model for evaluating and monitoring the quality of care for transitioned Class Members. Major components include:

1. Reportable Incidents

Exhibit 1 (attached to Report) reflects all of the reportable incidents for the time period of October 1, 2016 – March 31, 2017. The three-tiered severity levels are the same as in previous years.

Level 1 – Urgent/Critical Incidents: Situations or outcomes that result in adverse occurrences impacting, life, wellness and safety.

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

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

In review of the 6-month Report on Incidents, the Court Monitor would make the following observations;

a) The percentage of total incidents among the three levels is very consistent with prior periods – 9.5% for Level 1, 83.6% for Level II and 6.9% for Level III.
b) The total number of incidents for the 6-months was 305; this represents a major decline (221) from the prior period (526 for the prior 6 months). It is unclear as to the reasons for the 42% decline. DMH staff point

to systemic improvements (e.g. careful screening and improved service array) as hopeful reasons.

c) As with prior periods, a small percentage of Class Members (172) accounted for all of the reportable incidents (total transitions were 1,923 as of May 16, 2017).

d) 65% of all reportable incidents (198) were due to emergency room visits and/or hospital admissions. DMH continues to monitor and staff these occurrences with providers via regular teleconference calls.

e) There were 6 (six) deaths during this period. Three of these deaths were from natural causes. The other three deaths were ruled accidental deaths by the Medical Examiner – all secondary to alcohol and/or drug ingestions.

f) UIC College of Nursing continues to do an in-depth mortality review on all deaths. The individual reviews have been completed and UIC CON will complete its mortality Root Cause Analysis Summary Report by July 2017. As noted in II.E.2., the UIC CON also provides the enhanced training for provider staff. It should also be noted that DMH is evaluating the wisdom of a system-wide standard medical protocol for managing Class Members who transition.

g) As promised, the Illinois Department of Public Health has provided the Court Monitor with the raw count of IMD reportable incidents in seven (7) categories as reflected in Exhibit 2 for the time period of October 1, 2016 – March 31, 2017. These seven are comparable in definitions to those reported by DMH in Level I – Critical. The only category that is in DMH and not on the DPH list is Suicide Attempt.

It should be noted that the reporting authority for DPH was still under the old DPH rules, since the SMHRF rules were not yet in effect. The original intent was to compare rates for the IMDs vis a vis community-based residents. There are, however, several factors that preclude this comparison at this point:

1. DPH numbers are duplicated i.e. a single incident may be counted in multiple categories.
2. The existing DPH rules do not require deaths to be reported if the death occurs in an acute hospital.
3. Rates (if counted by incidents or individuals per hundred) requires a clear denominator. This is difficult on both sides – as IMD census varies and community providers must report incidents only for the first 18 months post discharge. The Court Monitor believes that rates could still be developed but it will take concerted statistical effort to do so.

The raw numbers, taken broadly, do clearly reflect that hundreds of serious incidents do occur in IMDs on a monthly basis. It is also noteworthy that 289 incidents (55% of total) occurred in two facilities out of the 24 total.

2. Quality Monitoring

DHS/DMH continues to deploy nine (9) Quality Monitors to conduct on-site reviews on a periodic basis. The goal is to ensure that these Class Members' needs are being met, and if not, to communicate this to the provider agency.

For the most recent period, there were a total of 430 home visits conducted. As a part of its effort to provide greater

efficiency and effectiveness, DMH is putting in place a home visit audit tool to ensure adherence to visitation guidelines. DMH also intends to implement a Class Member Satisfaction Survey for approximately 20% of Class Members who have had a Quality Monitoring visit in the past 30 days. The goal is to elicit overall satisfaction with agency services and also the Quality Monitor's visit.

3. Quality of Life Surveys

The results of the Quality of Life Survey remain very consistent with prior periods. Of the seven (7) domains measured, the most significant changes in positive responses were in Quality (77.4% pre-transition) to 90.5% (18 months post-transition and overall satisfaction (65.9% pre-transition) to 90% (18 months post-transition).

4. Community Tenure

Community tenure is one measure of gauging overall success for Class Members in the community. For the most recent reporting period, there are now 19% of Class Members who have lived in the community over a year but less than 23 months and an additional 59% with community tenure over 23 months.

Overall, the Court Monitor continues to find that the State has a reasonably comprehensive and responsive Quality Assurance system. The utilization of UIC-CON for mortality reviews and training is a critical element that needs to continue. DPH is commended for their efforts to provide Incident Data on all 24 IMDs. As SMHRF rules come into play, these incidents should include other key metrics e.g. Hospitalizations. Work toward comparability needs to

continue as well as comparable State oversight of IMDs (see III.B.)

H. Budget Support

DHS/DMH estimates that it will (in FY 2017) expend $33.4 million of the $35.2 million in General Revenue funds – with the balance of the funds going to support Medicaid services. The proposed FY 2018 budget for DMH includes $43.7 million in GRF for supporting and expanding transitional and ongoing costs associated with Williams compliance. Concretely, the FY 2018 budget assumes transition of 400 additional Class Members.

The Illinois budget impasse continues. While providers are paid for Williams services (due to the court order to do so), other provider services are not reimbursed – resulting in worsening fiscal health for all providers. This budget impasse has hit a critical state and seriously undermines the State's ability to achieve compliance.The State's comptroller has indicated that the State, within the next few months, may not have funds to even pay for mandated court orders.

I. Overall Williams Compliance

The State Defendants continue to be in general compliance as relates to Outreach, Housing and Quality Assurance. As stated in the Monitor's January 2017 Report to the Court, further compliance on Resident Reviews will be dependent upon the State ensuring that the Reviews are consistent with the requirements of the Decree and that services are sufficiently available and adequate to consistently support persons with more significant needs (e.g. chronic medical conditions) in the most integrated setting appropriate. Hopefully, the 1115 waiver and other initiatives will move in this direction.

The State continues to be out of compliance as relates to transition requirements and the Front Door diversion mandates of the Decree. The Front Door pilot is a start but there is considerable work to be done before this requirement can be met.

The Parties and the Court Monitor agree that the State should develop a Compliance Plan aimed at full compliance with the Decree – including a timeline and specific actionable steps. The Defendants have begun work on a Compliance Plan – but it is unclear how soon it will be completed. As the Monitor's last report noted, it is important to put in place a clear plan and a timeline to achieve compliance. The continued failure to do so raises significant concerns.

III. Assessment of Major Organizational Issues Related to *Williams* Compliance

As with prior Reports, the following four (4) areas continue to be significant in terms of overall Williams compliance.

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

As discussed in II.F., this overdue mandate is now beginning to find some resolution. The Front Door pilot will complete its first six months at the end of August 2017 – with a full evaluation by UIC School of Social Work to follow. It is imperative that the State not only maintain the existing pilot but expand it as soon as possible (based on evaluation results) to deal with the Front Door requirements for the entire system. The Court Monitor believes that this will require the expansion of community capacity – including Bridge Subsidies for PSH and adequate crisis stabilization beds.

B. State Management, Funding and Oversight of IMDs

The State is still in the process of granting provisional licenses to the IMDs; only three of the 24 IMDs have been granted provisional licenses to-date. The primary delay is for DPH (with the active assistance of DMH) to approve the required training modules for individual IMDs. The State indicates that three IMDs do not intend to convert to SMHRFs.

The Court Monitor reviewed the status of DPH reporting unusual incidents for the 24 IMDs in II.G.1.(g) of this Report.

The other major outstanding issue is the long-standing Court Monitor recommendation that the State create a centralized team to develop policy and provide oversight and State-level management responsibility for IMDs. The Court Monitor has recommended that this team be at DHS, although it would clearly need to work across State agencies.

The DHS, in response to this recommendation, has contracted with an outside consultant group to do a feasibility study to evaluate all of the relevant issues included in this scenario. The consultants have begun their work but will require 3-4 months to complete the task.

C. Assessment of Cross-Agency Planning

The decision has been made, with the Court Monitor's support, to move the Colbert case from the Department of Aging to DHS. The principal argument is to align Colbert and Williams in a single agency – with the opportunity for improved efficiencies and strategic planning and policy development. The two primary agencies (Aging and DHS) have shown commitment to making this happen in a timely and non-disruptive manner.

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

The DHS Secretary continues to be accessible and proactive on key cross-agency policy and planning issues e.g. the movement of Colbert. The hard reality remains, however, that the budget impasse makes the task of agency leadership and rational decision-making so much more difficult.

Exhibit 1

Reportable incidents level and categories reported by agencies

Reporting period from 10/01/2016 thru 03/31/2017

Agency	Level I - Critical										Level II - Serious							Level III - Significant									
	A	B	C	D	E	F	G	H	Total	%	I	J	K	L	M	Total	%	N	O	P	Q	R	S	T	U	Total	%
Alexian Center For Mental Health	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Association For Individual Dev.	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Association House of Chicago	0	0	0	0	0	0	1	0	1	3.4	11	2	0	0	0	13	5.1	0	0	0	0	1	0	0	0	1	4.8
Comm Counseling Ctr of Chicago	0	0	0	0	0	0	0	0	0	0.0	5	2	0	0	1	8	3.1	0	0	0	0	0	0	0	0	0	0.0
Cornerstone Services	0	0	0	0	0	0	0	0	0	0.0	6	1	0	0	0	7	2.7	0	0	0	0	0	0	0	0	0	0.0
Dupage County Health Department	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Ecker Center	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Grand Prairie Services	0	0	0	3	0	0	1	0	4	13.8	11	0	2	1	0	14	5.5	0	0	0	0	0	0	0	1	1	4.8
Heartland Health Outreach Inc.	1	0	0	0	0	0	0	0	1	3.4	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Heritage Behavioral Health Center	0	0	0	0	0	0	0	0	0	0.0	14	2	0	1	0	17	6.7	0	0	0	0	0	0	0	0	0	0.0
Human Resources Dev Inst. Inc.	0	0	0	0	0	0	0	0	0	0.0	8	0	0	7	0	15	5.9	1	1	2	0	0	1	0	2	7	33.3
Human Service Center	1	0	3	0	0	0	0	0	4	13.8	7	1	0	1	0	9	3.5	0	0	0	0	0	0	0	0	0	0.0
Iroquois County Mental Health Center	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Kenneth Young Center	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
Lake County Health Dept. MH	0	0	0	0	0	0	0	0	0	0.0	3	0	0	0	0	3	1.2	0	0	0	0	0	0	0	0	0	0.0
Presence Health	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
The Thresholds	3	0	1	0	0	1	2	0	7	24.1	73	17	0	3	1	94	36.9	2	0	0	0	0	1	0	2	5	23.8
Trilogy Inc.	1	1	0	4	0	4	0	2	12	41.4	60	6	0	8	1	75	29.4	4	1	0	0	0	0	0	2	7	33.3
Trinity Health	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0	0.0
	6	1	4	7	0	5	4	2	29		198	31	2	21	3	255		7	2	2	0	1	2	0	7	21	

Unduplicated count of CMs caused reportable incidents: 172

Total reportable incidents (Level I + Level II + Level III) 305

Level I: 29 (9.5 %)

Level II: 255 (83.6 %)

Level III 21 (6.9 %)

Legends

Level I - Critical

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

Level II - Serious

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

Level III - Significant

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

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

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

06/06/2017

Exhibit 2

Illinois Department of Public Health
NF/IMDs - Reportable Incidents
10/1/16-3/31/17

Facility	1	2	3	6	8	10	13	Total
Abbott House	0	2	0	0	0	0	0	2
Albany Care	2	5	0	0	0	0	0	7
Bayside Terrace	0	14	0	0	1	0	0	15
Belmont Nursing	0	0	0	0	0	0	0	0
Bourbonnais Terrace	0	0	0	0	0	0	0	0
Bryn Mawr	1	10	0	0	0	0	0	11
Central Plaza	1	14	2	0	0	0	1	18
Clayton Res. Home	0	24	0	0	0	0	0	24
Columbus Manor	0	20	0	0	0	0	0	20
Decatur Manor	3	8	0	0	0	0	0	11
Grasmere Place	1	15	0	0	0	0	0	16
Greenwood Care	0	1	0	0	0	0	0	1
Kankakee Terrace	0	0	0	0	0	0	0	0
Lake Park Center	0	2	0	0	0	0	0	2
Lydia Health Care	1	170	3	0	1	1	0	176
Margaret Manor	0	6	0	0	0	0	0	6
Margaret Manor – N	0	4	0	0	0	0	0	4
Monroe Pavilion	0	37	0	0	0	0	0	37
Rainbow Beach	1	103	0	0	0	9	0	113
Sacred Heart	4	34	0	0	0	0	0	38
Sharon HC Woods	0	7	1	0	0	0	0	8
Skokie Meadows	0	2	0	0	0	0	0	2
Thornton Heights	0	5	1	0	1	0	0	7
Wilson Care	0	7	0	0	0	0	0	7
Totals	14	490	7	0	3	10	1	525

Key

1-Sexual assault
2-Abuse/Neglect/Maltreatment
3-All deaths
6-Assault (threat of harm)
8-Missing person > 24 hours
10-Criminal conduct
13-Fires