State of Illinois' Behavioral Health System Report

January 27, 2025

David T. Jones
State of Illinois
Chief Behavioral Health Office

Welcome

Thank you for reading the inaugural *State of Illinois' Behavioral Health System* Report.

On April 1, 2022, I was appointed by Governor Pritzker as Illinois' first ever Chief Behavioral Health Officer (CBHO). Tasked with the mission of transforming how Illinois supports substance use, mental, emotional, and overall behavioral health and wellness for Illinoisians—especially those most in need—my office coordinates with relevant state agencies to develop recommendations for the ideal state infrastructure for behavioral health.

This report serves as a framework for private and public sectors alike, offering both foundational and historical information to articulate a clear and innovative vision for the future of the Illinois Behavioral Health system.

I want to acknowledge the pioneers who came before me in this work, who have set the stage for an evolution, ensuring we may achieve the gold standard of behavioral healthcare for all Illinoisans.

I am proud to have served as the State's first CBHO. Thank you for your support along the way.

With gratitude,

David T. Jones

Scan the QR code below to visit the CBHO's website, where a digital version of this report is available.

https://go.uillinois.edu/ChiefBehavioralHealthOfficer

David T. Jones

Chief Jones has served as the Director for the Division of Substance Use Prevention and Recovery within the Illinois Department of Human Services and as the Commissioner of the Philadelphia Department of Behavioral Health and Intellectual Disability Services. As a Behavioral Health Administrator with over 25 years of progressive and collaborative management experience, Chief Jones has produced measurable results to improve the lives of children, adults, and families with behavioral health needs.

Executive Summary

The Behavioral Health Systems Report (BHSR) is a publication from Chief Behavioral Health Officer, David T. Jones, providing a comprehensive overview of the achievements, obstacles, and targeted goals within Illinois' behavioral health system. A guiding document for both public and private sectors, the BHSR charts a course for the future of Illinois' behavioral health system. It serves to inspire change and celebrate the remarkable efforts of the Illinois Health and Human Services (IHHS) sector whose many stakeholders strive to provide exemplary behavioral health care.

Key Objectives and Strategic Framework

Structured around four overarching goals, this report uses a strategic framework to advance:

1. **Supporting High-Quality Services:** Support the delivery of high-quality, trauma-informed, community-based behavioral health services to all individuals who need them, regardless of insurance status.
2. **Streamlining Administration:** Streamline and standardize administration of publicly funded behavioral health services.
3. **Data-Driven Operations:** Ensure the administration of Illinois' behavioral health system is data-driven clinically, operationally, and financially.
4. **Maximizing Return on Investment (ROI):** Establish the necessary mechanisms to ensure improvement of the ROI for public spending on behavioral health treatment.

Structural Overview

This report includes four sections, providing a high-level understanding of the Illinois behavioral health delivery system's past, present, and proposed future.

- **Past: System Overview (Section 1)**
  - Contextualizes Illinois' service system delivery, providing a historical perspective and insight into the collaborative efforts of State Departments working towards advancing the wellbeing of Illinois residents.
- **Present: System Gains (Section 2)**
  - Highlights key recent successes from the IHHS agencies, showcasing notable achievements within the behavioral health system.
- **Future: System Gaps & Opportunities (Sections 3 & 4)**
  - Explores the challenges within current structure, presenting concrete and actionable short- and moderate-term strategies aimed at fortifying a more robust, equitable, and accessible behavioral health system.
- **Issue Spotlight: Reduction of Psychiatric Hospital Beds**
  - Spotlights the history of Illinois' significant reduction of psychiatric hospital beds and provides insight into the current, related barriers and needs of the State.
  - Current initiatives aim to invest in the expansion and sustainability of Certified Community Behavioral Health Clinics (CCBHCs) and drive cross-departmental collaborations to streamline the behavioral health crisis system.

The **action items** from the BHSR serve as a roadmap for transformative change.

Finance

- Advance a system where behavioral health workers can earn a living wage
- Simplify the community-based behavioral health fee schedule
- Unify reimbursement rates between substance use and mental health services
- Introduce a single reimbursement rate for Licensed Practitioners
- Explore VBP models for behavioral health

Innovation

- Promote innovation and performance
- Unify IDHS' Divisions of Mental Health and Substance Use Prevention and Recovery
- Strengthen the infrastructure at HFS related to behavioral health
- Develop a Unified Crisis Continuum (UCC) plan
- Establish and implement a plan to expand the use of the Integrated Assessment and Treatment Planning (IATP) tool
- Strengthen behavioral health prevention and data surveillance at IDPH

Technology & Data

- Establish a unified cost reporting system
- Assess the IATP technical platform to gain maximum utilization of data
- Incorporate all publicly funded behavioral health data into the Enterprise Data Warehouse (EDW)
- Establish independent data analytics mechanism for all IHHS Departments to access a centralized data repository

Collaboration

- Establish a form of shared governance for IHHS departments
- Continue to develop Illinois' CCBHCs
- Collaborate with Managed Care Organizations (MCOs) to identify service deserts and innovative access to care models
- Create a clinical leadership academy
- Increase education and outreach efforts regarding clinical assessment philosophy

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Preface

CBHO Priorities

Even the most complex problems require a series of simple, straightforward steps to solve. That is not to say that the final solution may not also be complex, but without taking incremental steps towards success, one loses collaboration and shared vision along the way. As such, the following report outlines the Illinois CBHO priorities. These priorities are shared here in the spirit of transparency and collaboration, as they are the foundation from which the CBHO seeks to improve the behavioral health and wellness of the people of Illinois. The CBHO embraces a population health approach that concurrently supports well-being while working with stakeholders to build better alignment, coordination, and integration of Illinois' behavioral healthcare system.

The Quintuple Aim

In 2007, the Institute for Healthcare Improvement (IHI) introduced the concept of the Triple Aim, a three-pronged approach to improving the overall performance of any healthcare system (IHI, n.d.). In 2014 and 2022, experts advocated to expand the Triple Aim to five dimensions creating the Quintuple Aim (Nundy et al., 2022):

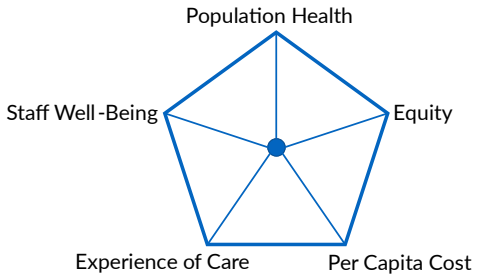


Figure 1 The Quintuple Aim

- Experience of Care: Improving the patient experience of care (including quality and satisfaction)
- Population Health: Improving the health of populations
- Per Capita Cost: Reducing the per capita cost of healthcare
- Staff Well-Being: Addressing the growing challenges of burnout to increase provider well-being
- Equity: Identifying, designing and implementing solutions to advance health equity

IHI indicates that progress within all five dimensions of the Triple Aim must be achieved if healthcare systems are to optimize health for individuals and populations. When applying the Quintuple Aim to the status of Illinois' behavioral health system, we must focus on improving service quality, increasing equitable access, reducing cost, supporting the healthcare workforce, and improving the overall mental health of the state.

Philosophy

The State's behavioral health system must **prepare for greater levels of utilization**, as we come out of the public health emergency and into a contemporary era of reduced mental health stigma and a greater

appreciation for wellness. This means that both public and privately funded providers must be prepared to serve customers[1] across the lifespan with increased capacity to meet the demands of today and tomorrow.

Additionally, significant progress must be made to **improve equity and access to services**. One only needs to look at morbidity and mortality rates among Black mothers and birthing people in Illinois or gun violence in Chicago to see systemic racism and economic hardship in many of the State's communities of color. These issues echo across the behavioral health system in the form of Social Determinants of Health (SDOH)—a growing area of focus and concern among Illinois policymakers. However, access is not just an issue for brown and black individuals, rural Illinois also lacks the full array of provider options to respond to the needs of local communities, often forcing delayed treatment and costly travel to access behavioral health services, regardless of insurance payer or status.

As we design new approaches for improving Illinois' behavioral health system, we must also **invest in proactive strategies that include prevention and early intervention**. Just as customers experience benefits from physical health preventive healthcare, behavioral health prevention saves lives and early intervention reduces complexity and cost while improving long-term. Early treatment for depression decreases suicide (Illinois Department of Public Health [IDPH], n.d.-c) administration of Naloxone reverses opioid overdoses (Illinois Department of Human Services [IDHS], 2019); prevention of Adverse Childhood Experiences (ACEs) lowers incidences of chronic health conditions in adulthood (CDC Vitalsigns, n.d.); and the list goes on. Prevention strategies take many forms, including education and awareness as well as other stigma-reduction efforts, improving access to screening and treatment, and harm-reduction programming. While it is vital that we improve service access and treatment options for customers with severe and complex conditions, Illinois must also invest resources in prevention of behavioral health conditions. And finally, the barriers of the behavioral health system noted above must be addressed through stronger coordination of benefits and efficiency in service delivery. Healthcare spending, which is not unlimited, and includes behavioral health spending, must continue to be prudently managed. Optimizing the State's health budget means that the publicly funded systems need to receive an even **greater ROI for each dollar spent on behavioral healthcare**.

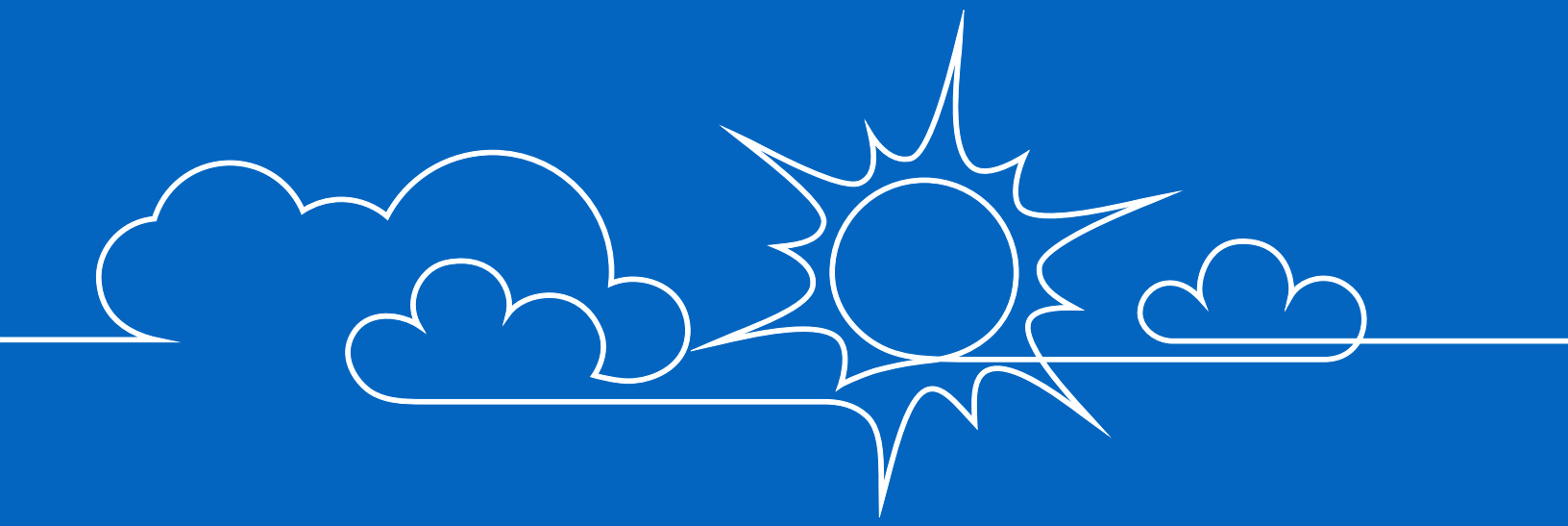
CBHO Goals and Objectives

Goal 1.	Support the delivery of high-quality, trauma-informed, community-based behavioral health services to all individuals who need them, regardless of insurance status.
Objective 1.	Assess the ability of the state to introduce targeted treatment protocols using a true 'No Wrong Door' approach to treatment.
Objective 2.	Implement policies and practices that support innovation and promote emerging and promising practices across the field.
Objective 3.	Establish safety net service protocols for crisis that provide: (1) Someone to Call, (2) Someone to Respond, and (3) A Place to Go/A Safe Place to Be (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020), for all individuals in Illinois experiencing a behavioral health crisis.

[1] This report refers to individuals receiving behavioral healthcare as customers with the exception of references to hospital settings which use the term patient. Customers are referred to globally by many terms (e.g., consumers, clients, individuals, and patients). This decision was made in the interest of clarity and respect.

Goal 2.	Streamline and standardize administration of publicly funded behavioral health services.	
	Objective 1.	Reduce duplication of infrastructure between IHHS Departments.
	Objective 2.	Support the development of infrastructure that reflects the strengths of each IHHS Department, yielding the most streamlined administrative structure possible for providers to operate within.
	Objective 3.	Assist the IHHS Departments in finding the best balance of clinical care, operational requirements, and financial constraints to offer high-quality, easily accessible services for Illinoisans.
Goal 3.	Ensure the administration of Illinois' behavioral health system is data-driven: clinically, operationally, and financially.	
	Objective 1.	Establish a single, unified data repository for the storage of publicly funded mental health, substance use disorder (SUD), and SDOH services. This includes all populations including individuals with intellectual disability (ID) and those on the autism spectrum.
	Objective 2.	Work with IHHS Department leadership to ensure that appropriate access and analysis of data is available to all units of Illinois government, as legally possible and appropriate.
Goal 4.	Establish the necessary mechanisms to ensure improvement of the ROI for public spending on behavioral health treatment.	
	Objective 1.	Identify measures that can be used by Illinois policymakers, payers, providers, and customers to understand the quality of the behavioral health system.
	Objective 2.	Reduce Illinois taxpayer burden by taking steps to ensure federal Medicaid match for expenses related to the behavioral health system.
	Objective 3.	Take steps to better understand the total operating costs for Illinois behavioral health providers receiving public funds.
	Objective 4.	Advance a system where workers can earn a living wage.

It is with these goals in mind that the following report has been prepared, outlining the framework of the existing system, certain systemic gaps of concern, and opportunities for improvement.



"Our very survival depends on our ability to stay awake, to adjust to new ideas, to remain vigilant and to face the challenge of change."

– Martin Luther King Jr.

1 | System Overview

The Illinois Health and Human Services (IHHS) Departments

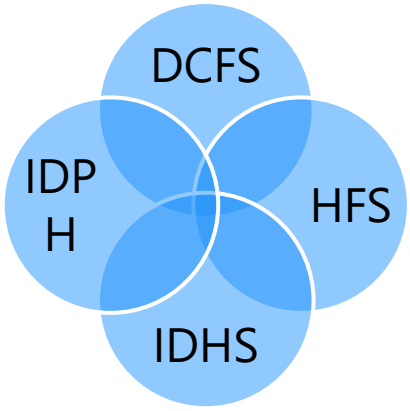


Figure 1 *The four IHHS sister Departments that work together to provide behavioral healthcare for Illinoisans.*

At its core, the IHHS system is comprised of four sister Departments working together to provide physical and behavioral healthcare to Illinoisans. This includes the Illinois Departments of: Children and Family Services (DCFS); Healthcare and Family Services (HFS); Human Services (IDHS); and Public Health (IDPH). The core IHHS Departments also collaborate with various other parts of Illinois' government agencies to advance the wellbeing of the people of Illinois, such as:

- Department of Corrections (IDOC)
- Department of Financial and Professional Regulations (IDFPR)
- Department of Insurance (IDOI)
- Department of Juvenile Justice (IDJJ)
- State Board of Education (ISBE)
- Various other departments, boards, commissions, and offices

Though each of these units of Illinois State government have separate, independent functions, these units of government come together to the structural underpinnings of Illinois' health system. The IHHS Departments and other units of Illinois government partner with private, non-for-profit, and public entities to deliver the assistance by Illinoisans. Understanding Illinois' behavioral health structures, and the interrelation of the various IHHS Departments in relation to Illinois' behavioral health system, can be confusing. The following section provides a basic overview to establish a baseline of understanding for the remainder of this report.

Department of Children and Family Services (DCFS)

Director: Heidi E. Mueller
FY23 Behavioral Health Service Spending: $32.7 million
https://dcfs.illinois.gov/

The Department of Children and Family Services (DCFS) was established in Illinois on January 1, 1964, as the nation's first cabinet-level state child welfare agency, moving child welfare responsibilities from the then Department of Mental Health. The mission of DCFS is "*to protect children who are reported to be abused or neglected and to increase their families' capacity to safely care for them; to provide for the well-being of children in our care; to provide appropriate, permanent families as quickly as possible for those children who cannot safely return home; to support early intervention and child abuse prevention activities; and to work in partnerships with communities to fulfill this mission*" (Illinois DCFS, n.d.-a). DCFS' efforts to achieves its mission to protect the

children of Illinois through child protection services and programs such as Safe Kids, Loving Homes, and Brighter Futures (Illinois DCFS, n.d.-b).

Unlike other IHHS Departments, DCFS plays the role of both State Administrator and guardian for tens of thousands of Illinois children, also known as Youth in Care. To meet the needs of the Youth in Care and ensure compliance with the B.H. v. Mueller consent decree (ACLU Illinois, n.d.), DCFS coordinates the delivery of services via Illinois' YouthCare program with HFS and purchases supplemental services and supports. Additionally, DCFS oversees the placement of approximately 1,000 children in licensed residential facilities, group homes, and similar settings. DCFS's regulatory authority as a licensing entity for childcare institutions, and its purchasing power of high-end services, places DCFS in a leadership and advocacy position for children's behavioral health services. Additionally, to achieve the reunification goals of the Department, DCFS also finds itself a strong advocate for adult mental health and substance use services, which are key to helping families heal and be reunified.

Department of Healthcare and Family Services (HFS)

Acting Director: Elizabeth M. Whitehorn
FY23 Behavioral Health Service Spending: $3.5 billion
https://hfs.illinois.gov/

The Department of Healthcare and Family Services (HFS), formerly known as the Department of Public Aid, is responsible for providing comprehensive, integrated healthcare coverage for millions of adults and children under Illinois' Medical Assistance program, which includes Medicaid and other federally supported and state funded healthcare programs. HFS also administers Illinois' child support services, which helps ensure that Illinois children receive financial support from both parents. The mission of HFS is: "*We work together to help Illinoisans access high quality healthcare and fulfill child support obligations to advance their physical, mental, and financial well-being*" (Illinois HFS, n.d.-g).

"Medicaid is the single largest payer for mental health services in the United States and is increasingly playing a larger role in the reimbursement of substance use disorder services."

–Center for Medicaid and CHIP Services (n.d.)

HFS is responsible for the administration of the State's publicly funded healthcare programs, such as Medicaid. Serving an estimated 3.9 million customers in Illinois in FY23 (HFS, n.d.-e), about 50% of all children and 30% of Illinois' population receive their healthcare coverage from HFS or one of HFS's contracted MCOs. In its role as the single state Medicaid agency, HFS is responsible for establishing the organization and standards related to recipient eligibility, service definitions, provider requirements, and MCO management—vital elements to Illinois' behavioral health ecosystem. HFS manages the entire Medicaid enterprise across multiple sister state agencies, hundreds of local units of government, including school districts. HFS' financial policy and operations maximize federal Medicaid matching dollars (Williams et al., 2023) to reduce the overall cost of healthcare to Illinois taxpayers, including accountability and claiming of federal Medicaid match in coordination with other IHHS Departments and other units of Illinois government.

Department of Human Services (IDHS)

Acting Secretary: Dulce Quintero
FY23 Behavioral Health Services Spending: $1 billion
https://www.dhs.state.il.us/page.aspx

Illinois created the Department of Human Services (IDHS) in 1997 to provide Illinois residents with streamlined access to integrated services, especially for those striving for economic independence, and others who face multiple challenges to self-sufficiency. The mission of IDHS is to provide: "*…equitable access to social/human services, supports, programs and resources to enhance the lives of all who we serve*" (IDHS, n.d-b). IDHS is comprised of six key Divisions, each with their own core focus. These include Developmental Disabilities (DDD); Early Childhood (DEC); Family and Community Services (FCS); Mental Health (DMH); Rehabilitation Services (DRS); and Substance Use Prevention and Recovery (SUPR).

DMH and SUPR are the State's mental health and substance use authorities, respectively. DMH and SUPR are responsible for ensuring children, adolescents, and adults have access to publicly funded behavioral health services. The other divisions under IDHS that directly provide services and support related to behavioral health are the DDD; DEC; FCS; and DRS. They establish a recovery-focused service vision while administering federal Block Grant funding (SAMHSA, 2024) and other federal grants, and state funding. Additionally, DMH coordinates the certification of Community Mental Health Centers (CMHCs), and operates a detention facility and multiple state-operated behavioral health hospitals across Illinois. SUPR administers the Illinois Substance Use Disorder Act (SUD Act, 2019), including licensure and compliance monitoring for substance use treatment services across Illinois, and administration of federal and state funds, such as the Cannabis Tax Revenue and Opioid Settlement Funding. The other DHS divisions also provide direct services and supports related to behavioral health.

Department of Public Health (IDPH)

Director: Dr. Sameer Vohra
FY23 Behavioral Health Service Spending: $4.2 million
https:/IDPH.illinois.gov

The Department of Public Health (IDPH) works to improve the health of communities across Illinois through disease prevention and injury; protection of food and environment; regulation of healthcare facilities, and the collection and analysis of health data. IDPH is organized into 12 offices, each of which addresses a distinct area of public health. Each office operates and supports numerous ongoing programs and is prepared to respond to extraordinary situations as they arise. The mission of IDPH is: "*The Illinois Department of Public Health is an advocate for and partner with the people of Illinois to re-envision health policy and promote health equity, prevent and protect against disease and injury, and prepare for health emergencies*" (IDPH, n.d.-a).

Establishing Illinois' public health structures, IDPH's role in the behavioral health system is one of constant vigilance, early warning, and structured response. Recognized by the federal government as the State's primary survey agency, IDPH oversees the standards for Illinois institutional providers participating in the State's Medicaid program (e.g., hospitals, and long-term care facilities) and certifies CMHCs for participation in the federal Medicare program. Additionally, IDPH tracks and reports on key public health indicators related to behavioral health, such as Illinois suicide rates, opioid overdose rates, the role of mental health in maternal health, childhood mental health risk factors, and related data elements. IDPH actively advocates for and funds prevention efforts, including working with providers, schools, community stakeholders, and others to provide additional training, screening opportunities, and consultation opportunities for those who are at risk for mental

health conditions. IDPH also monitors behavior and chronic disease data that directly relate to comorbidity with behavioral health.

Illinois Behavioral Health Service Array

Most contemporary behavioral health service systems are made up of various interventions that when considered individually are a "service" but when considered with similar interventions make up a "service continuum." Illinois has both an Institutional Service Continuum, which includes services delivered by entities that provide overnight treatment, and a Community-Based Service Continuum, or services delivered at a provider's office, in the customer's home or other natural setting, which now includes telehealth. Jurisdictions, including Illinois, have introduced various crisis interventions due to the increased focus on the nation's opioid epidemic, the introduction of suicide prevention programs, and other efforts by states to stabilize living situations. For the purposes of exploring Illinois' Service Array, the Crisis Service Continuum is being explored as an independent, safety-net infrastructure that operates in conjunction with the Community-Based and Institutional Service Continuums. The following overview of Illinois' service array explores Illinois' 1) Crisis Service Continuum, 2) Community-Based Service Continuum, and 3) Institutional Service Continuum.

Illinois Crisis Service Continuum

The SAMHSA's National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit (SAMHSA, 2020) suggests that at the core of every jurisdiction's crisis service continuum, three key components should exist:

1. Someone to Talk To[2]
2. Someone to Respond
3. A Place to Go (adults)/A Safe Place to Be (children/youth)

This three-pronged framework, Illinois' Crisis Service Continuum, or Crisis Continuum, is comprised of several legacy, population-specific initiatives, a comprehensive Medicaid-funded crisis system for children (with an expansion to Medicaid-eligible adults), and the introduction of new federal/state initiatives (the 988 Suicide and Crisis Lifeline and Mobile Crisis Response [MCR] Teams provided through the Program 590 Crisis Continuum Program), all set upon the foundation of the State's network of hospital-based emergency departments. This patchwork of initiatives and endeavors represents decades of effort from state agencies seeking to reduce suicide rates, stabilize living situations/placements, and normalize treatment and stabilization options for individuals experiencing mental health crises.

[2] For simplification purposes, "Someone to Talk To" will be characterized as "Someone to Call," as a majority of the SAMHSA's toolkit on this topic focuses on the establishment of local, regional, or statewide call centers. "A Safe Place to Be" will be characterized as "A Place to Go."

"A behavioral health crisis is a severe or acute episode of mental or emotional distress that may require immediate attention and intervention."

– David T. Jones
Chief Behavioral Health Officer

Central to the discussion of crisis programs is the fundamental definition of the term "crisis." Determining what constitutes a crisis and the definition of what a crisis is establishes the parameters for when the Crisis Continuum is engaged versus one of the State's other service continuums. For example, scheduled community-based clinical treatment or inpatient procedures are generally considered routine healthcare and would be categorized in a different part of the Service Continuum. In this document, we will consider a behavioral health crisis to be a severe or acute episode of mental or emotional distress that may require immediate attention and intervention. This can include symptoms such as suicidal thoughts, severe depression or anxiety, self-harm, harm to others, forms of distress that impair an individual's ability to function in their daily life, and in some instances, circumstances that may result in a destabilization or loss of housing[3] shelter, or placement, a risk of overdose death, severe intoxication, or substance use that places the individual or their community at risk. With this definition of behavioral health crisis, below is a general overview of Illinois' existing behavioral health Crisis Continuum with some programmatic examples.

Behavioral health phone hotlines are generally call centers designed to operate 24 hours a day, every day of the year (24/7/365) with the purpose of supporting an individual, or an individual calling on behalf of someone else, who is experiencing an acute mental health or substance use crisis. Illinois has two primary mental health hotlines operated by IDHS and HFS respectively: 988 and the Crisis and Referral Entry System (CARES). Both services screen and assess callers for acuity to determine if immediate interventions are necessary, or if Community Behavioral Health Service referrals will address the individual's need. Two key distinctions between these lines include 1) eligibility: CARES supports Medicaid-only adults and children that require public funding while 988 provides services to all individuals regardless of payer, and 2) crisis counseling vs. referral and dispatch. Callers to 988 are usually the individual experiencing the crisis, and 988 provides immediate crisis

[3] *Note this definition should not be construed to include all homelessness. While an eviction for an adult may be an event leading up to a behavioral health crisis, losing a residential treatment placement (regardless of age) or being told you cannot return to your family home as a minor would constitute a behavioral health crisis.*

counseling services over the phone. 988 crisis counselors also have access to additional resources, including MCR Teams. Calls to CARES are most often made by a third party on behalf of the individual identified to be experiencing a crisis, and CARES seeks to refer customers to the most appropriate service, including face-to-face crisis services when determined clinically appropriate.

Additionally, Illinois also operates substance use telephone helplines including the 24/7/365 line called the Illinois Helpline for Opioids and other substances. This resource supports individuals or family members seeking treatment services, recovery services, or addressing other concerns related to substance use and behavioral health needs. Beginning in 2022, this call line also administers the Medication Assisted Recovery (MAR)-Now program, which connects individuals to immediate treatment for opioid use disorders such as methadone, buprenorphine, or naltrexone. MAR-NOW also connects individuals with withdrawal management and residential treatment (IDHS, n.d.-h).

For mental health crises that require timely face-to-face interventions, Illinois has mental health crisis response teams geographically designated to respond and provide crisis stabilization and de-escalation. These teams are operated by entity-based providers of mental health services such as CMHCs. Examples of these programs include Screening, Assessment, and Support Services (SASS)/MCR, Assertive Community Treatment (ACT), and IDHS programs such as MCR Teams, and Comprehensive Community Based Youth Services (CCBYS). The primary variation of these services is eligibility criteria, but variation also exists in provider requirements, acuity, screening tools, and the available interventions provided by the crisis teams. Similarly, SUPR provides funding for community intervention and recovery support services that support individuals in need of crisis intervention.

Individuals experiencing a crisis who cannot remain in the community and need a higher level of care may require a safe place to stabilize and recover from their crisis state. For children, the SAMHSA recommends a Safe Place to Be, which is an alternative that is more family-friendly and may include services and supports brought to the family's home. In Illinois, most individuals seeking a place to go during crisis are faced with limited options, such as visiting a local emergency room or seeking admission to an inpatient psychiatric hospital.

When options are not available in a community, law enforcement is often called up to address instances of crisis, distress, and conflict with limited tools at their disposal, sometimes leading to individuals in need of behavioral health services facing incarceration. To help promote community stabilization, DMH has developed the Living Room Program (LRP), which provides individuals in crisis a safe, calming, and home-like alternative to hospitalization.

Additionally, multiple state agencies in Illinois are working on the development of Crisis Stabilization Units (CSUs), which are needed across all of Illinois. SUPR licenses community-based withdrawal management services for individuals in need of medical monitoring for acute intoxication or withdrawal. However, there continues to be a need for more broadly available and accessible stabilization programs to address a variety of substance use and behavioral health crisis needs.

Community-Based Service Continuum

Behavioral health services provided in a setting other than an institution or facility are generally considered to be community-based and/or outpatient behavioral health treatment. Community-based services can be delivered in a physician's office, a school, a home, a hospital or clinic, or any number of other settings. Community-based services generally seek to deliver clinical interventions in normalized settings that help promote functioning and recovery.

THE CONCEPT OF RECOVERY

Recovery from mental health and/or substance abuse conditions are a process of change through which individuals:

- Improve their health and wellness
- Live a self-directed life
- Strive to achieve their full potential

Four major dimensions support a life in recovery:

- **Health**: Overcoming or managing one's condition(s) or symptoms and making informed, healthy choices that support physical and emotional well-being
- **Home:** Having a stable and safe place to live
- **Purpose:** Engaging in meaningful daily activities, such as with a job or school, volunteering, caring for family, or being creative; working for independence, income, and resources to participate in society
- **Community:** Building relationships and social networks that provide support, friendship, love, and hope

Outpatient treatment across the behavioral health spectrum is generally provided in the form of screening, assessment, brief intervention, treatment planning, and therapy/counseling services, provided by licensed midlevel providers such as Licensed Clinical Social Workers (LCSWs), Licensed Clinical Professional Counselors (LCPCs), and Licensed Marriage and Family Therapists (LMFTs).

The following provides a general overview of Illinois' Community-Based and institutional services continuum:

Community Mental Health Centers (CMHCs)

Community Mental Health Centers, or CMHCs, create Illinois' mental health safety net, ensuring that local communities have general access to mental health treatment. CMHCs provide a continuum of services to best meet the needs of their local community, services that span from prevention and mental health promotion to intensive clinical treatment for children and adults. CMHCs are each unique and individualized products of their local communities, often reflecting values and seeking to meet the needs of the people they serve. CMHCs collaborate with other social services and healthcare providers to deliver integrated care and often seek grants to promote the health and wellness of their communities. Some CMHCs seek dual certification as SUD Treatment providers to ensure their community has access to integrated behavioral health services. CMHCs must be nonprofit or local government entities (Joint Committee on Administrative Rules [JCAR], 2019) and can provide the full array of Community-Based Behavioral Services (CBS) (HFS, 2022) funded by Illinois Medicaid.

Substance Use Disorder (SUD) Treatment Providers

Licensed by the IDHS-SUPR, SUD Providers are entities-based providers who deliver SUD intervention and treatment services defined by the American Society of Addiction Medicine (ASAM) (see box on page 37). With specialized training and licensure in the treatment of addiction, SUD treatment providers help address the needs of Illinois customers through the assessment and substance use treatment. SUD treatment providers utilize an array of treatment

approaches delivered by qualified staff under the clinical direction of a physician. SUD Treatment Providers may be co-located alongside more intensive substance use programs that provide services at ASAM Level 3.

Primary Care Provider (PCP)

The PCP is the foundation of America's modern managed healthcare systems. The doctor, nurse practitioner, or physician's assistant provides foundational clinical and preventative care, as well as referrals for specialized health needs to improve personal health and wellness while reducing overall medical costs. Behavioral health prevention and early intervention usually begin with the PCP, as they are available to field questions from patients and screen for early signs of behavioral health issues, depression, and SUDs. PCPs may provide access to prescription medication for the treatment of mild to moderate behavioral health conditions and coordinate treatment and care for patients with more significant behavioral health conditions who require specialty services. PCPs are generally found in individual practice, within practice groups, treatment clinics (such as federally qualified health centers [FQHCs]), or as part of large healthcare systems.

Behavioral Health Independent Providers (BHIPs)

Behavioral Health Independent Providers, or BHIPs, are a group of mid-level behavioral health providers made up of Licensed Clinical Psychologists (LCPs), LCSWs, LCPCs, and LMFTs. BHIP's provide assessments, therapy, counseling, and crisis services. BHIP's are the backbone of Illinois' publicly and privately funded community-based behavioral health system; they provide clinical leadership for entities such as CMHCs, Behavioral Health Clinics (BHCs), hospitals, clinical practices, medical groups, schools, and other healthcare providers. Generally, BHIPs are licensed individuals who have a state practice act that allows them to diagnose behavioral health conditions and make treatment recommendations, establishing them as clinical leaders across the field. Many BHIPs choose to practice independently, treating customers and can accept reimbursement from Illinois Medicaid and private insurers. Because of their overall importance, BHIPs can be difficult to recruit and retain for many healthcare organizations.

In addition to these licensed mid-level providers, the publicly funded system leverage specialized entity-based providers such as CMHCs, BHCs, and licensed SUD providers that utilize lower credentialed staff operating under the guidance of a licensed provider.

Medical Behavioral Health Specialty Providers

An extension of the physical health system, specialty providers such as psychiatrists, psychiatric nurse practitioners, and psychologists may provide advanced treatment for individuals with moderate to significant behavioral health treatment or individuals with complex conditions that require close monitoring of drug interactions and side effects. While Behavioral Health Specialty Providers may provide some outpatient treatment such as psychotherapy, they primarily conduct specialty assessments, prescribe and monitor psychotropic medications, and provide consultation to other practitioners. Behavioral Health Specialty Providers are generally scarce, with publicly funded systems and smaller/rural communities struggling to recruit, pay, and retain specialists. Behavioral Health Specialty Providers are often organized like PCPs, with most practicing within practice groups, clinics, and large healthcare systems.

Case Management/Care Coordination

Behavioral health issues often impact a person across many aspects of their life, including their spirituality, home/family, work/school, health/wellness, and community. It is common for individuals with behavioral health issues to struggle at work or school, face social consequences or jail time, have other chronic healthcare conditions, or experience challenges with worth, meaning, and happiness. Case management is an intervention in which trained professionals help an individual address their needs across the various life domains through planning, organizing, referring, and identifying services and supports. Efforts may include coordinating medical care with physical and behavioral health providers, participating in a school Individualized Education Plan (IEP) process, or providing a referral to a food bank or other social service resource to help address social needs impacting an individual's health. The advanced focus on reducing costs to treat individuals with multiple chronic or complex health situations has led to the development of specialized approaches to case management, often referred to as care coordination. The following are key examples of care coordination from Illinois' publicly funded healthcare sector.

HFS Managed Care — Care Coordination

For individuals enrolled in an HFS-contracted MCO with multiple chronic or complex conditions, HFS' MCOs assign a care coordinator to help coordinate and oversee the collaboration of treatment providers. MCO care coordination often utilizes telephonic interventions and care coordinators to support improved health outcomes by ensuring members attend appointments, address transportation challenges, and resolve other customer issues.

Pathways to Success — Care Coordination and Support Organizations (CCSOs)

Stemming from children's mental health litigation HFS has introduced CCSOs, which are specifically trained organizations offering high fidelity wraparound (HFW) and intensive care coordination (ICC) services to Illinois children that meet certain clinical qualifications. Under this model of care coordination, HFW and ICC services are delivered consistent with the Systems of Care philosophy using 10 individuals to one care coordinator (HFW) or 25 customers to one care coordinator ratios (ICC), respectively (HFS, n.d.-a).

SUPR-Funded Case Management

In conjunction with substance use treatment services, providers may offer case management services to support customers in addressing social determinants of health, accessing comprehensive care for co-occurring conditions, and managing complex physical and behavioral health needs.

Intensive Community Treatment

A customer's overall functioning and clinical presentation generally establish their diagnoses and service need. For example, individuals diagnosed with severe mental illness (SMI) or serious emotional disturbance often require services to be delivered more frequently or from a model that is designed to be more intensive, requiring them to rely upon team-based treatment and/or day treatment models.

Team-Based Care

Team-based care approaches introduce a service team, often multi-disciplinary in composition, which can help address a wide spectrum of service needs while remaining familiar with the customer. These programs and teams, such as ACT teams, are available around the clock and help customers with significant needs remain stabilized in the community while seeking to avoid emergency department presentations and other episodes of inpatient psychiatric hospitalization. Community Support Teams (CST) are a less intensive team-based model available for individuals with multiple needs. Additionally, FIRST.IL is a specialized team-based treatment approach that helps individuals experiencing the onset of a psychotic disorder with the intention of lessening the duration of untreated psychosis and improving the chances of a full recovery.

Mental Health or Substance Use Day Treatment

Often an alternative to, or step down from, inpatient psychiatric hospitalization or residential care, day treatment, or partial hospitalization programs, provide a safe, structured environment for service delivery during extended periods of the day. In these models, the customer continues to live at home, returning to the structured program on a scheduled interval where services are delivered using a schedule or routine, and treatment can be provided from a wide range of staff using various modalities. Customers can still experience isolation from school, work, or home as they attend the treatment center, but this is balanced by their ability to return to their normal environment for other parts of the day.

Institutional Service Continuum

Dating back to the mid-19th century, individuals with behavioral health issues were treated in institutional settings. Today, hospitals and residential levels of care provide support for individuals with acute and sub-acute needs, promoting safety, stabilizing crises, and seeking to individuals to normalized treatment upon discharge. Page 49 of this report includes an Issue Spotlight on the State's ongoing effort to increase the number of inpatient psychiatric beds.

The following provides a general overview of Illinois' institutional services continuum.

Mental Health

Facilities that provide room and board and clinical treatment to customers are often referred to as residential treatment facilities. In the field of behavioral health, there are several different types of residential treatment options that target specific diagnoses, conditions, populations, genders, or ages, with children being the most common customers to utilize the service. Residential treatment facilities use a congregate-care treatment approach that exposes customers to a wide range of individuals with varying degrees of illnesses and challenges. Customers are generally assigned to a specific unit or building staffed with clinical

ADDRESSING THE STIGMA:

MENTAL HEALTH FIRST AID (MHFA)

Open and honest conversations around mental health on the rise (American Psychological Association [APA], 2019) means increased opportunities for Illinoisans to access educational resources on how to assist others experiencing a mental health crisis. MHFA is an evidence-based training program administered by the National Council for Wellbeing. As explained by National Council "Just as CPR helps you assist an individual having a heart attack, MHFA helps you assist someone experiencing a mental health or substance use challenge or crisis" (National Council for Mental Wellbeing, n.d.). MHFA uses a train-the-trainer model to teach individuals how to be prepared for mental health crises, spot risks and warning signs, and develop an action plan to help the person in need. Two divisions within IDHS are partnering with community-based organizations to increase the footprint of MHFA

and technical staff responsible for the delivery of treatment and behavior management. Residential treatment settings may use physical or chemical restraint protocols and short periods of isolation to help manage customer crises or behavioral outbursts. Funding for residential treatment may differ depending upon a customer's payer source, with many customers finding that they may have to travel great distances to access treatment.

Generally provided from a free-standing facility licensed as a psychiatric hospital (most often serving children) or within a community hospital that has a distinct unit for the delivery of psychiatric services, acute inpatient hospitalization is a form of institutionalization that seeks to stabilize customers in crisis who are a danger to themselves or others. Today, inpatient psychiatric hospitalization is widely recognized as a standard treatment service and one of the most intensive service options within any insurer's array of services.

Some hospitals are licensed by IDHS-SUPR to provide withdrawal management or acute intoxication services. This depends on the level of need as determined by ASAM. Payers tend to establish utilization controls to ensure lengths of stay are consistent with industry norms to help avoid unnecessary spending and institutionalization of customers.

State-Operated Facilities

The State of Illinois operates seven state psychiatric hospitals, a treatment and detention facility, and other behavioral health facilities for individuals who require acute care treatment that cannot be sourced from another provider (IDHS, n.d.-f). These locations are administered by the IDHS and are available regardless of payer source or ability to pay.

Individuals served in the State Operated Psychiatric Hospitals (SOPHs) include patients admitted through the civil process as well as those remanded by criminal court.

2 | System Gains

Overwhelming Commitment

Governor JB Pritzker, State of Illinois Department Heads, Division Directors, and agency leadership of the IHHS Departments have committed an overwhelming number of resources, funding, and efforts to improve Illinois' behavioral health system. The following are recent highlights of system gains as a result of these investments.

State Successes[4]

- **988 Suicide and Crisis Lifeline (988).** In July 2022, Illinois launched 988, the National Suicide Prevention Lifeline transitioned to the 988 Suicide and Crisis Lifeline, a 24/7/365 three-digit phone number for anyone experiencing a mental health crisis by call, text, or chat. All 102 counties in Illinois now have primary coverage backup from an in-state center (IDHS, n.d.-a). Many call centers exceed the service standards of a 74% answer rate, with 85% of contacts connected in 20 seconds or less. (IDHS, n.d.-d). In November 2024, Illinois saw its highest-ever in-state call answer rate (92.3%) while also answering the highest-ever number of calls (12,097).
- **Certified Alcohol and Drug Counselor (CADC).** Individuals wishing to enter the substance use services field in Illinois can receive tuition payments, scholarships, internship stipends, and certification-related payments to obtain their CADC credential. The program helps with job placement, credential renewal, continuing education, and other incentives to reduce barriers to education and workforce participation. The program had 120 participating students, 462 new CADC applicants, and 232 newly credentialed professionals entering the CADC workforce in Illinois.
- **Certified Recovery Support Specialists (CRSS).** This program provides comprehensive financial support for people with lived expertise to obtain the CRSS credential at 11 different Illinois colleges and universities. They can then begin working in the behavioral health field. The State expects about 600 individuals to obtain CRSS credentials over the next three years, expanding and diversifying Illinois' behavioral health workforce (IDHS, n.d.-c). As of this writing, 904 individuals have enrolled in this program, with 449 enrolled in FY24. To date, 368 individuals have graduated.
- **Harm Reduction Community Linkages Project (HRCL).** The purpose of the HRCL Project is to support capacity building at harm reduction organizations statewide to expand their customer base and develop more comprehensive linkages to prevention, treatment, and harm reduction services for individuals with opioid use disorder (OUD) and/or SUD.
- **Healthcare Transformation Collaboratives (HTC).** The HTC program, funded through HFS, launched in 2021 in order to create partnerships and innovate ways to bridge gaps in the behavioral healthcare delivery system. HTC focused on quality behavioral healthcare in underserved communities. In FY22, the first round of nine grantees received approximately $150 million to support their collaborations (HFS, n.d.-b).
- **Living Room Program (LRP).** The LRP is an evidence-based model that offers an alternative to emergency room admissions for people in crisis. In FY23, over 18,000 customers were served in these programs by 20 Living Rooms throughout the state, serving as a critical part of the crisis services continuum (IDHS, n.d.-g). In the first three quarters of calendar year 2024, the programs had 29,330 visits by 7,712 unique customers.

[4] *This list does not include success from DCFS. Much of their great work can be found in Dana Weiner's Blueprint for Transformation.*

- **Medication Assisted Recovery (MAR).** The MAR-NOW Program is a telephonic resource through the IL Helpline for Opioids and Other Substances (Illinois Helpline, n.d.) that connects individuals to immediate medication treatment for OUDs, such as methadone, buprenorphine, or naltrexone. MAR-NOW also connects individuals with withdrawal management and residential treatment. The MAR-NOW pilot program launched in May 2022 and expanded statewide in September 2022 (IDHS, n.d.-h).
- **Pathways to Success (Pathways).** Pathways are enhanced Medicaid behavioral health services for children and youth under the age of 21. These services support individuals with complex behavioral health needs through enhanced care coordination and home and community-based services. Pathways began enrolling individuals in December 2022 (Illinois HFS, n.d.-a).
- **State of Illinois Overdose Action Plan (SOAP).** Illinois completed the SOAP in March 2022 (SOAP, 2022). The SOAP created a framework for addressing the overdose epidemic in Illinois and serves as a living document with the goal of reducing overdose deaths in Illinois. The planning process for the SOAP identified 25 high-priority recommendations, sorted into five categories: Social Equity, Justice-Involved Population and Public Safety, Prevention, Harm Reduction, and Treatment and Recovery.
- **Violence Prevention Community Support Team (VP-CST).** This Medicaid service launched on May 1, 2022, to reduce traumatic stress symptoms and increase community functions for individuals who have experienced chronic exposure to firearm violence using evidence-informed, trauma-specific interventions and techniques (HFS, n.d.-f).
- **Zero Suicide.** Multiple efforts have begun with grants from the U.S. Centers for Disease Control and Prevention (CDC), SAMSHA, and state resources to develop and implement a public health approach to prevent suicide and create a comprehensive suicide prevention program. These efforts include convening a multi-disciplinary team of experts, including the Illinois Suicide Prevention Association, epidemiologists, and peers. Special attention is paid to adolescent suicide prevention, with a focus on screening risk, linking to services, preventative childhood experiences using ACEs, and public awareness (IDPH & Illinois Suicide Prevention Alliance, 2020), (SAMHSA, 2021).

Children's Behavioral Health Transformation Initiative

In March 2022, Governor JB Pritzker launched the Children's Behavioral Health Transformation Initiative (Transformation Initiative) in response to the nationwide youth mental health crisis, naming Dr. Dana Weiner of Chapin Hall at the University of Chicago as the Director (Office of the Illinois Governor J.B. Pritzker, 2022). The purpose of the initiative is to evaluate and redesign the delivery of behavioral health services for children and adolescents in Illinois. The Transformation Initiative builds upon the substantial progress made by Illinois agencies to ensure that every young person experiencing mental or behavioral health problems can access needed services. By identifying and addressing current barriers to delivering efficient and effective care, the Transformation Initiative hopes to improve the State's ability to offer families a set of streamlined, accessible, and responsive solutions.

On February 24, 2023, the Transformation Initiative released a report titled *Blueprint for Transformation: A Vision for Improved Behavioral Healthcare for Illinois Children* (Weiner et al., 2023), which included five goals and 12 recommendations on how to redesign the delivery of behavioral health services for Illinois youth.

Dr. Dana Weiner and Chief David T. Jones are working together as champions of Illinois' behavioral health system. This report and *Blueprint for Transformation* are complimentary efforts.

3 | System Gaps

Streamlining Administrative Challenges

A central tenet of any system is the concept that the various parts work together to create a framework for operations and outcomes. However, at times, silos can occur. Silos can have an overall negative impact on the behavioral health system, often resulting in duplication of effort, confusion, conflicting policies, and system inefficiencies. The cause of siloing amongst units of government can be attributed to various sources: history (legacy operations, as in "that's how we have always done it"); finances (funding streams, budget constraints, and management of scarce resources); external forces (federal regulations, court decrees); internal forces (organizational mission, technology systems, vision); or a mix of other issues, both real and perceived. While some of these challenges are more significant than others, each can develop into significant service barriers for customers attempting to access the behavioral health system.

Retention: The staff and personnel that operate across the various IHHS Departments and other units of state government are operating in unprecedented times. Many of the IHHS Departments have experienced a significant loss of senior management and experienced staff due to the retirement of an aging state workforce. According to the Research Department at the Federal Reserve Bank of St. Louis, (FRED, 2024), the total number of public sector employees in Illinois has been declining since 2001, by a total rate of 15.3%. This means that each IHHS Department must continue to meet the new challenges faced by their organizations.

Thinning staff numbers in some areas and intense competition for new talent puts the IHHS Departments in a difficult position of not being able to recruit new managers into highly skilled positions, which often require deep subject matter expertise and knowledge of departmental operations— the kind of knowledge and expertise that is often reimbursed at a premium in the private healthcare marketplace.

Infrastructure: Beyond the challenges of maintaining a nimble workforce, many IHHS Departments are actively updating and implementing Information Technology (IT) systems that directly impact their capacity for operations. Illinois' Integrated Eligibility Systems (IES), which is shared by IDHS and HFS, Medicaid's Managed Information System (MMIS), and DCFS's Statewide Automated Child Welfare Information System (SACWIS) have all recently been or currently are being updated, disrupting and impacting operations within various parts of IDHS, HFS, and DCFS. These technical systems are the "nuts and bolts" that allow the IHHS Departments to operate. However, as new IT systems promise great gains, the challenges of migration and complexity of technical constraints often require mitigation and management just to retain existing outputs. Added requirements to adhere to new federal guidelines while ensuring integrity to Medicaid and DCFS funding

results in organizations balancing between new and old systems while managing compounding challenges. In addition to these large core IT systems, each of the IHHS Departments maintain and operate smaller provider portals that help with the data collection and information on various topical areas, adding layers of complexity and integration requirements and sometimes resulting in missed opportunities to focus on system interoperability and collaboration.

Urgency: Additionally, the pace at which the IHHS Departments are required to review and respond to issues often results in solutions that address the immediate need, but potentially conflict with or duplicate other parts of the behavioral health system. Establishing and maintaining multi-departmental collaboration requires significant effort and compromise by all parties to achieve a shared vision, including:

- Finding ways for the IHHS Departments to communicate and coordinate on new initiatives, policies, and programs at every stage of implementation is vital to the development and progress of the State's behavioral health system. Creating shared vision and roadmaps for development and implementation so that common ground is established before design decisions are made will help improve buy-in and reduce resistance to change, when necessary.
- Ensuring that existing infrastructure and resources are being utilized appropriately, instead of rebuilding and duplicating infrastructure, will reduce the cost, confusion, and redundancy experienced by providers and customers. Finding ways to support the sharing of resources will create avenues to improve collaboration between the IHHS Departments, while the sharing of knowledge will result in better overall policy development, refinement, and implementation.
- Ensuring that federal financial participation through state/federal programs, such as Medicaid and child welfare's Title-IV E is maximized will reduce taxpayer burden and ensure long-term sustainability for programs and services.

Addressing Social Determinants of Health (SDOH)

SDOH are the nonmedical factors that influence health outcomes (Compton & Shim, 2015). They are the conditions in which people are born, grow, work, live, and age, as well as the wider set of forces and systems shaping the conditions of daily life. These also include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems. SDOH[v] have a direct impact on the behavioral health and mental wellness of individuals. Factors such as a customer's zip code, poverty level, access to education, living conditions, food security, and others have the potential to compound the health and behavioral health challenges that the customer will face over their lifespan. By increasing levels of personal stress and anxiety while reducing quality options for everyday life choices, SDOH can result in increased risk of developing behavioral health conditions, or compound existing ones (CDC, 2024a). These reduced options could be related to a local grocery store closing, limited transportation options, rising rents, or any number of other factors that raise the opportunity cost for life basics beyond the reach of certain individuals and populations. These events can reduce a person's resiliency and cause or compound personal trauma. In children, a measure of the impact of personal trauma is the ACE screening tool, which shows the long-lasting impacts on whole healthcare, including a shortened lifespan (CDC, 2024b). Like falling dominos, it is impossible to stop the momentum of SDOH factors without seeking systemic responses that resist the inertia of years of inequity. As state and federal programs seek to mitigate various SDOH factors with programs targeting food, health, wellness, housing, and others, the organizations in Illinois that are prepared to focus on SDOH may have significant challenges engaging with sustainable funding systems such as Medicaid, limiting their overall ability and reach.

SDOH IMPACTS ON COMMUNITIES OF COLOR

Racism has long been toxically intertwined with America's healthcare system, which adds to the struggle for the health and wellbeing of people of color (CDC, 2021). The CDC has declared racism to be a serious threat to the public's health." Centuries of racism, both interpersonal and structural, are key drivers of health inequities. As a result, racism and discrimination at large manifests as decreased health outcomes and overall wellbeing. KFF outlines some areas of in which discrimination has a compounding impact on SDOH (Ndugga, Pillai, et al., 2024), including:

- Economic Stability (e.g., employment, income, and debt)
- Neighborhood and physical environment (e.g., housing, and transportation)
- Education (e.g., literacy, early and higher education)
- Food (e.g., food security, and health options)
- Community, Safety, and Social Context (e.g., stress, trauma, and policing)
- Health Care System (e.g., health coverage, provider access, and culturally competency)

Healthcare institutions have begun to recognize racism as a "…social determinant of health and a public health crisis (Rastetter, 2021). Therefore, to address SDOH, it is imperative to actively fight racism.

[v] *The Federal Centers for Medicare & Medicaid Services (CMS) now refers to Social Determinates of Health as Health-Related Social Needs (HRSN).*

Measuring Outcomes

The treatment of disease in the world of physical health has led to a reliance on laboratory testing and treatments that are observable and based on science. X-ray machines highlight broken bones; MRI machines provide detailed images of the inner body; and lab tests identify and verify various medical conditions. The observable nature of physical health symptomology over decades has led to a clear understanding of healthcare metrics and outcomes at the patient, provider, and payer level. By contrast, behavioral health outcomes have been harder to define, measure, and implement. A growing understanding of the nuances of behavioral health illness and its treatment, potential for relapse, management, and recovery over the last two decades have helped to transition the perspectives on behavioral health outcomes. However, even today, behavioral health outcomes are generally considered in terms of provider procedural activity (did something happen?), the patient's level of care, or total financial costs.

In many ways, this limited approach to outcome monitoring can be traced directly to the data issues discussed above, as the most readily available data on behavioral health is derived from provider claims activity (procedures, frequency, diagnosis, provider type, and costs). However, the last five to seven years has ushered in a national movement towards patient-reported outcomes and validated symptom rating scales as means for providers to collect feedback, measure engagement, and assess patient knowledge of their condition and treatment (Fortney et al., 2014). This type of information assists providers in developing an understanding of their clinical approach, improves treatment planning, and measures quality of care.

> *"For at least 20 years, leaders in our field have advocated for measurement-based care (MBC) that systematically uses validated symptom rating scales to drive clinical decision-making."*
>
> *– The Kennedy Forum (Fortney et al., 2014)*

Outcome measures are not an assessment or meant to replace clinical judgement, but rather a means of understanding the patient's perspective on treatment and progress. Patient feedback and voice are central to treatment engagement, disease management, and medication compliance—core elements of managing any chronic disease and most behavioral health conditions. The need to identify and embrace MBC offers both funders and providers an opportunity to ensure they are investing in effective treatment approaches tailored to meet the needs of each individual. Understanding the chronicity of most behavioral health conditions and the customer's journey towards recovery helps to underscore that behavioral health outcomes are not always linear. As a result, finding the right mix of indicators from providers and customers will be vital to promoting positive outcomes as well as positive returns on investment.

Combating the Overdose Epidemic

Before the COVID-19 pandemic gripped the world, Illinois, with the rest of America, was fighting to overcome an unprecedented epidemic of drug overdose deaths. The Overdose Epidemic has resulted in significant increases in fatal and nonfatal drug overdoses, fueled initially by the combination of over-prescription of opioid painkillers, and later by an illegal drug supply adulterated with potent synthetic opioids like fentanyl, and the

rise of heroin and prescription drug abuse. In response to this crisis, Illinois government responded with coordinated comprehensive efforts by nearly all levels of government.

Implementing the State's prescription drug monitoring program, the SOAP, expanding access to naloxone, and cracking down on illegal drug trafficking are just some of the strongest weapons in the State's fight. However, despite these and other efforts, the Opioid Epidemic in Illinois has not completely subsided.

The impacts of this escalation are increasingly felt in the large urban metropolitan communities as well as in rural Illinois, and the lack of access to or coordination of medical services, SUD treatment, social supports, and leveraging of harm reduction and recovery services complicate local responses. The situation was made dramatically more challenging during the COVID-19 pandemic due to the economic impacts and social isolation of public health emergencies. In November 2021, the Southern Illinois University (SIU) Medicine Department of Population Science and Policy (2021) published their report, *COVID-19 and the Rural Opioid Epidemic: Recommendations to Improve Health in Illinois*, which highlighted three key takeaways from their 2021 Rural Health Summit:

- Increase the availability of Medications for Opioid Use Disorder (MOUD) centers, including virtual treatment and remote counseling options;
- Engage justice involved populations to reduce Opioid Use Disorder; and
- Sustain and dramatically expand harm reduction services into rural areas to prevent overdoses and the spread of infectious diseases.

The IHHS Departments are fully committed to combating the Opioid Epidemic, as each actively participates in the Illinois Opioid Crisis Response Advisory Council (IDHS, n.d.-e) and work jointly to develop and implement the *State of Illinois Overdose Action Plan* (State of Illinois, 2022). However, even with existing partnership and continued collaboration, the State must continue to increase education and awareness, continue to move towards sustainable funding, and seek service innovation to make and maintain advances in the fight against overdoses.

Reducing Over-Reliance on Public Funding

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Centers for Medicare & Medicaid Services [CMS], 2023) and related statutes have had a significant impact on the availability of mental health services available for individuals with private insurance. While these advances have translated into improvements in out-of-pocket maximums, co-payments, deductibles, and covered days for individuals in Illinois with private insurance seeking behavioral health treatment, the overall difference in service definitions, provider networks, and benefit management between public payers and private insurers continues to shift much of the behavioral health burden and investment to public payers such as state Medicaid.

The history can be traced back to President John F. Kennedy's plan to transform mental health and ID treatment from institutional care to community-based care through the passage of the Community Mental Health Act of 1963 (Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, 1963). While this effort spurred the development and physical construction of CMHCs to treat individuals in the community, states were eventually left to individually determine the appropriate role of the new providers. In Illinois, public payers recognize CMHCs as the localized clinical hubs for the treatment of individuals with mental health conditions and a vital part of the State's safety net system. However, private

insurers tend to limit recognition of such entities, opting to only recognize licensed practitioners who work at these sites, instead of hiring staff with lived experience or expertise who work under the direction of licensed clinicians. Moreover, private insurers generally fail to recognize Illinois' community-based behavioral health service definitions, opting instead to purchase a less flexible set of services defined by the Current Procedural Terminology (CPT). While the CPT codes for behavioral health services can provide and promote health for general behavioral health needs, specialized treatment, including many evidence-based and emerging best practices for individuals requiring higher acuity services, is limited by this code set. This often means that individuals with private insurance are unable to access the wide range of treatment services supported by Illinois policymakers. This difference in approach means that service providers in Illinois, like CMHCs must operate without diversified funding streams as they attempt to serve as the safety net for their local communities, maintain their workforce, and meet their operational costs.

Promoting Innovation

IHHS Department leaders and policymakers have worked tirelessly to design, implement, and continuously improve Illinois' publicly funded behavioral health system, which resulted in Mental Health of America (2022) ranking Illinois 12th on its national Overall Mental Health System rankings. While this status highlights the State's commitment to serving individuals with behavioral health conditions, we can do better. As a state, we *must* do better! As competition for the State's scarce resources continues to intensify and state population/demographic changes continues to shift, the need for each public dollar spent on the behavioral health system to go further, yield more, and achieve greater outcomes is intensifying. To meet the growing demands for behavioral health service and support, Illinois requires an *innovation revolution* across all parts of the behavioral health service system.

> *"Innovation can be defined as: invention + adoption + diffusion."*
>
> *– Christopher J. Kelly and Antony J. Young (2017)*

Financing: To achieve an environment that spawns innovation in behavioral health, Illinois must first identify investment sources capable of supporting invention (novel ideas, products, services, or treatment approaches) that have the potential to lead to innovation. Such financing can take the form of micro-grants, pilot programs, and performance-based proposals from State agencies or their agents such as MCOs. In this discussion, there is also room for public-private partnerships and funding from philanthropic organizations seeking to improve Illinois' behavioral health system.

Analysis: In addition to investment, invention requires a willingness to learn what doesn't work (without harming our customers) on the greater journey to identifying what does work. This type of investment and

support also helps to change the leadership dynamic for the IHHS Departments, thus reducing the system's reliance upon a handful of policymakers to "solve" the problems of the behavioral health system; instead, it replaces that dynamic with a partnership model that seeks to constantly learn and improve from all potential sources.

Assessment: Many states seeking to improve their behavioral health systems start by completing a comprehensive financial mapping of the funding streams used to support behavioral health services and associated administrative costs. However, future efforts need to build upon the work performed to date, with a focus on determining: 1) the source of funds; 2) the requirements of the funding source; 3) the potential to optimize the funds (e.g., shift costs to Medicaid, streamline operations and reduce duplication, and identify waste); and 4) the opportunity costs of the current funding. The nature of this type of assessment is not to take away funding or eliminate State programs, but rather to keep the best parts of the current system and identify where there is opportunity for the State to improve. By increasing the State's overall ROI for behavioral health spending, new services, programs, and populations can be better supported by existing funding levels and new innovations can be funded.

Budgeting: By breaking down the budget siloing that occurs within the IHHS Departments and increasing visibility and collaborative understanding of State spending across all IHHS Departments, Illinois can close gaps and create pathways to progress. Involving public health and Medicaid in the budgeting of State Block Grant funds can create a pathway for innovation to go from pilot to program. Involving Medicaid early in the design decisions of state grants and block grant-funded efforts can ensure that initiatives more easily convert into Medicaid-funded efforts, freeing up future state/block grant funds by transferring liabilities to Medicaid. And by promoting initiatives and efforts to Medicaid-contracted MCOs, providers seeking to introduce similar initiatives or build on the success of grant programs with managed care funders have the potential to be better received and supported.

MCO: Finally, with an estimated 80% of Illinois Medicaid customers being served by an HFS-contracted MCO, new efforts to encourage MCO leadership to finance and support behavioral health invention and innovation should become a State priority. MCOs often have the benefit of a national presence, nimble infrastructures, and flexibility in service delivery system (rates, services, contracting, etc.). These benefits make the State's publicly funded MCOs an obvious partner in efforts to innovate. By identifying promising practices from other jurisdictions in which they operate, the Medicaid- contracted MCOs can rapidly prototype and partner with providers on new initiatives. Illinois' multi- billion-dollar investment in its publicly funded health plans has created new partners and funders of Illinois' behavioral health system that are positioned to help push the system forward—an opportunity that must be maximized.

4 | System Opportunities

Every year, there are dozens upon dozens of new services, system enhancements, and programs introduced across the State. While each of one represents an opportunity to improve Illinois' behavioral health system, the following items represent Illinois' strongest opportunities for short- and moderate-term investment to begin to develop a stronger, more equitable, and accessible behavioral health system.

Establishing A Shared Vision on Administrative Streamlining

Each of the IHHS Departments has distinct assets and plays a key role in the statewide administration of behavioral health services. For example, while IDPH provides statewide surveillance of healthcare entities, institutional survey activity, and state disease data collection, other units of government, such as DCFS and IDHS-SUPR license providers of specialized services. IDHS-DMH operates Illinois' state hospitals and administers federal grants, including the Mental Health Block Grant, while HFS maintains an enterprise-grade healthcare infrastructure that includes technology systems and financing systems. Moving forward, it is vital to identify the strengths of each IHHS Department while seeking to mitigate each Department's challenges, allowing the system to grow and improve as a whole. This approach will reduce the duplication of infrastructure and assist in streamlining operations between DCFS, HFS, IDHS, and IDPH, resulting in reduced costs to taxpayers and simplification for providers and customers.

IHHS Department Swim Lanes

The first step in establishing a shared vision and administrative streamlining is to identify the natural roles and organizational capacity of the IHHS Departments. Understanding that every IHHS Department brings strengths and opportunities to the table and organizing tasks and responsibilities in a manner that promotes the greatest success for the State, is in the best interest of everyone in Illinois. By creating clear swim lanes for each IHHS Department, clarity in vision and purpose can begin to be realized, accountability can be increased, and duplication can be identified and removed. While some functions and abilities might be shared amongst IHHS Departments, the following are high-level roles and responsibilities of each Department.

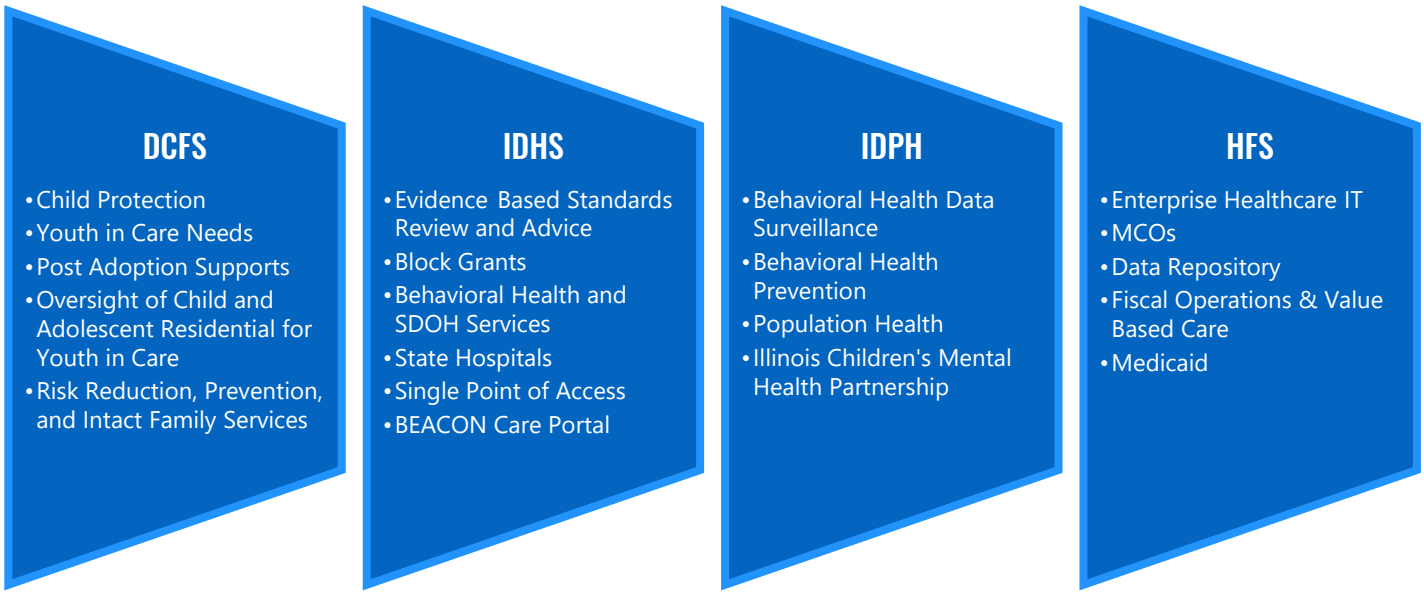


Figure 2 *IHHS Department Swim Lanes*

Department of Children and Family Services

- Administer Illinois' child protection system
- Coordinate the needs of Youth in Care
- Coordinate the services and supports needed by post adopted youth and families
- Oversee child and adolescent residential providers
- Ensures risk reduction, prevention and administers the Intact Family Services Program

Department of Human Services

- Establish evidenced-based provider Practice Standards and Quality of Care indicators for mental health, SUD, and ID disorder treatment
- Coordinate State block grants
- Organize the provision of Behavioral health and SDOH services
- Administer Illinois' SOPHs
- Maintain the centralized Care Portal for families seeking services for their children with significant and complex needs being developed as part of the *Transformation Initiative*
- Operates the Behavioral Health Care and Ongoing Navigation (BEACON) Care Portal for accessing youth behavioral health services (BEACON, n.d.)

Department of Public Health

- Perform data surveillance related to behavioral health
- Provide statewide behavioral health prevention services
- Monitor and advise on population health trends
- Houses the Illinois Children's Mental Health Partnership (IDPH, n.d.-b)

Department of Healthcare and Family Services

- Maintain Illinois' Enterprise Healthcare IT systems
- Organize and manage Illinois' MCOs
- Maintain Illinois' centralized behavioral health data repository
- Support health-related fiscal operations, including value-based care
- Administer Illinois' Medicaid program

Shared Governance

Once roles and tasks are established for each IHHS Department, the next step in establishing shared vision and administrative streamlining is to establish a shared governance. In its simplest form, shared governance could be codified within a multi-department intergovernmental agreement outlining the formation of an oversight committee to establish vision, approve spending priorities, and create a forum for leadership to engage with stakeholders. Under the direction of a formalized oversight committee or similar structure, the IHHS Departments could streamline operations, reduce duplication, and establish channels for sharing the

administration of tasks that may require enhanced collaboration in the administration of the Illinois Behavioral Health System. This work will leverage the Interagency Children's Behavioral Health Services Team established under the Interagency Children's Behavioral Health Services Act (2008) on August 11, 2023.

The CBHO recommends that:

The IHHS Departments will agree upon a form of shared governance that takes a strengths-based approach and begin to codify that structure in an interagency agreement with all parties.

Monitoring and Auditing Reviews

In addition to licensure and/or certification reviews, provider organizations also report that they are required to engage in multiple programmatic reviews or audits. All too often in the community-based service delivery system, state agencies and provider entities use the terms "audit" and "programmatic monitoring" interchangeably, potentially resulting in unexpected outcomes. While it is a standard expectation that the disbursement of state and federal funds requires active surveillance to identify and address fraud, waste, and abuse, the reality is that state and federal audits are generally limited in scope and do not occur with the type of frequency that should cause providers hesitation when considering service expansion. However, providers often express a concern that multiple state auditors are disrupting operations, requiring excess administrative efforts, and reinforcing the concept of potential financial penalties related to review outcomes. To ascertain that providers are not confusing IHHS Department efforts to ensure programmatic quality (monitoring) as a form of review with potential financial losses (auditing), the IHHS Departments should seek to better coordinate efforts to reduce total on-site engagements.

Additionally, the IHHS Departments should consider other methods of promoting quality and outcomes in place of legacy monitoring activities. The potential use of performance incentives, or payment advances, could be used to promote positive provider activities. By investing in service quality, the IHHS Departments could begin to transition the provider community from a volume-based financing system to a quality and outcomes-based system, preparing to meet the needs of tomorrow. Instruments such as VBP indicators, public report cards, and consumer feedback are among the many options for measuring quality and outcomes. Additionally, the provision of technical assistance and learning collaboratives can provide supportive mechanisms to help providers identify problematic situations and engage in course correction.

The CBHO recommends to:

Solicit provider input for the development of a concept paper which outlines the benefits of promoting innovation and performance and be submitted to the IHHS Departments.

Improving Access to Care

In its simplest form, behavioral health access is predicated upon a customer's ability to identify a need and engage the customer in a service to meet that need. In Illinois, behavioral health access is further complicated by the State's vast geography (200 miles wide and 380 miles long), a customer's source of funding (private insurance, Medicaid, other), the customer's proximity to available service providers, the availability of workforce, and various other factors. The following topics explore various opportunities for Illinois to expand access to behavioral health services.

Expand the Network of Community-Based Provider Types

In recent years new types of providers have come to the forefront, creating opportunities for expanded services and workforce development. This section highlights some promising community-based provider types.

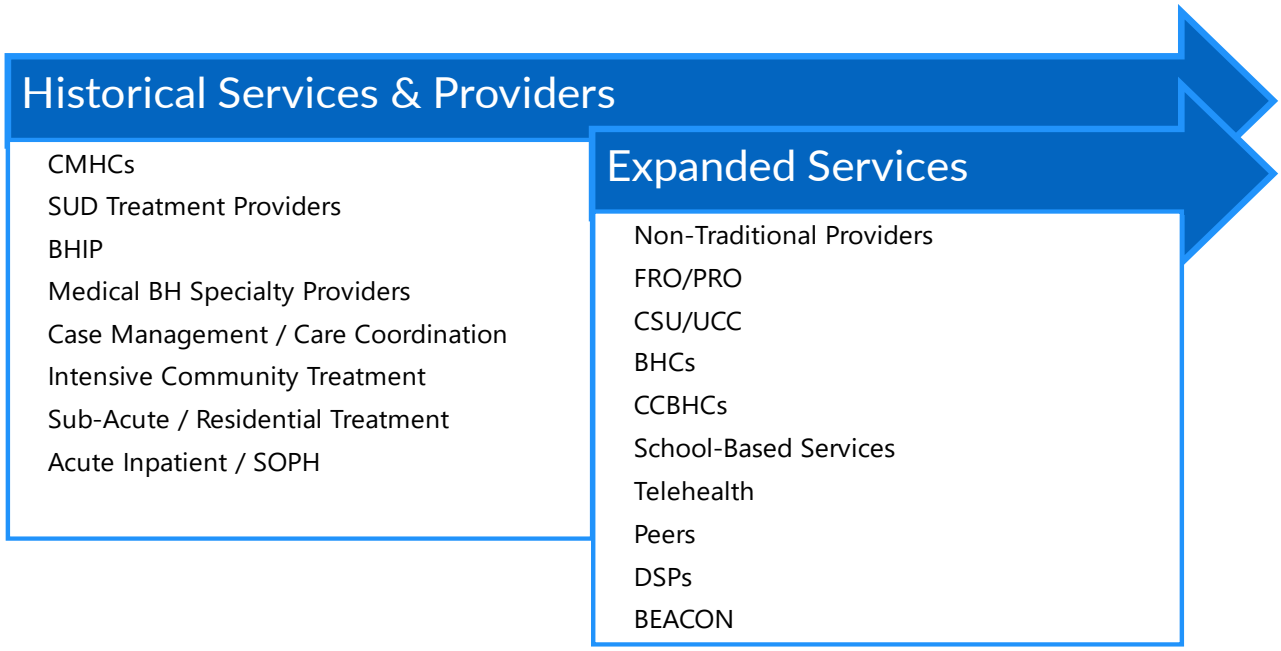


Figure 3 *Behavioral Health Community-Based Provider Types*

Non-Traditional Providers: Non-traditional healthcare providers such as peer support specialists, community health workers, hyper-local organizations, and other types of entities offer significant value to Illinois. While non-traditional providers have not historically been recognized by insurers, including Medicaid, as part of the healthcare workforce, these individuals and organizations excel at customer engagement and cultural competency, finding success working with individuals from diverse backgrounds, including those who are hesitant to seek support. Non-traditional providers often identify and break down barriers that are obvious to customers but that other healthcare professionals may miss. These non-traditional providers are generally embedded within the communities of the customers they serve, bringing an inherent authenticity and relatability to their work that helps to promote intervention, coordination, and better outcomes. Customers requiring services that target their social needs, (e.g., housing supports, employment supports, violence prevention and interruption services) benefit greatly from the deployment of non-traditional providers.

However, while these types of individual entities have invaluable capacity to promote greater access to care and ensure the success of specialized services, non-traditional provider organizations often struggle with back-office administrative functions such as eligibility identification, claims generation, and revenue cycle

management. As such, the IHHS Departments should consider what types of special supports will be required to get the most value from non-traditional providers, such as expedited and simplified pathways to Medicaid enrollment and billing and other supports provided by HFS' provider technical assistance platform and educational resource, the Medicaid Technical Assistance Center or MTAC (HFS, n.d.-d).

Family Run/Peer Run Organizations (FRO/PRO): As Illinois expands its recognition of services provided by individuals with lived experience, or peers, the State will need to define the most appropriate structure for the delivery of these services. One option is to consider the introduction of FRO/PROs as a billable provider type. FRO/PROs have been introduced in other states as a means of organizing and maintaining peer services. FRO/PROs provide the peer support workers to work alongside other peer support workers, allowing a deeper level of support and understanding that can be difficult to achieve in a more traditional provider setting. Instead of trying to work amongst a cadre of various licensed and unlicensed mental health professionals, FRO/PROs provide peer support workers with the community and environment needed to exchange ideas, share advice, and receive training and support to engage with customers seeking treatment or services.

ASAM OVERVIEW

The American Society of Addiction Medicine, or ASAM is committed to improving access to high quality, evidence based addiction prevention and treatment through their national advocacy efforts (ASAM, n.d. a). . ASAM believes in a future in which addiction prevention, treatment, remission, and recovery are accessible to all, and where they profoundly improve the health of all people. ASAM Criteria is the most widely used and comprehensive set of standards for placement, continued service, and transfer of patients with addiction and co occurring conditions. The ASAM Criteria's strength based multidimensional assessment considers a patient's needs, obstacles and liabilities, as well as their strengths, assets, resources, and support structure (ASAM, n.d. b).

Crisis Stabilization Units (CSUs) / Urgent Care Centers: As Illinois continues to experience a loss of inpatient psychiatric hospital units and beds, alternative service options such as LRPs, CSUs and Urgent Care Centers may create an alternative value proposition for the State to consider. Through a mutual learning approach, LRPs have been successfully providing crisis respite services in many locations in the State for the past four years. Providing timely intervention for individuals experiencing a mental health or SUD crisis, CSUs can provide a safe place for customers to go (or for law enforcement to bring customers who may need enhanced, immediate supports). By providing crisis stabilization services outside of a hospital setting, psychiatric boarding and overcrowding of emergency departments can be reduced. The establishment of smaller operational footprints also allows for the deployment of CSU/Urgent Care Centers sites in more remote areas—which are potentially closer to customers in rural locations—reducing the secondary trauma of having to leave one's home community to access care. As a lower-cost alternative to hospital emergency departments, CSU/Urgent Care Centers sites provide a safe, supportive environment for individuals as they work through a period of crisis and prepare to reintegrate into their normal routine, with targeted supports to help avoid future crisis.

Behavioral Health Clinics (BHCs): BHCs are entities recognized by Illinois Medicaid as capable of providing mental health services and/or Adaptive Behavioral Support (ABS) services to children with autism. BHCs were conceptualized to be smaller, leaner providers than traditional CMHCs by pairing down certain administrative requirements. BHCs are led by a qualified clinical director and generally target service delivery towards a specific set of diagnoses, target populations, or interventions. BHCs were introduced by HFS in 2018 and there are currently 98 unique BHC sites enrolled in the Illinois Medicaid program (HFS, 2022). BHCs can provide all

CBSs except for ACT and Psychosocial Rehabilitation (PSR). Ongoing efforts to promote and recruit the development of new BHCs will continue to improve access to care.

Certified Community Behavioral Health Clinics (CCBHCs): CCBHCs represent a promising development for Illinois' community-based behavioral health system. Established as a comprehensive, integrated service model, CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age (SAMHSA, n.d.). CCBHCs are required to provide access to crisis services that are available 24/7/365, as well as providing or ensuring access to the following service array:

1. Crisis Services
2. Treatment Planning
3. Screening, Assessment, Diagnosis, and Risk Assessment
4. Outpatient Mental Health and Substance Use Services
5. Targeted Case Management
6. Outpatient Primary Care Screening and Monitoring
7. Community-Based Mental Healthcare for Veterans
8. Peer, Family Support, and Counselor Services
9. Psychiatric Rehabilitation Services

To support this innovative service model, CCBHCs are reimbursed using a prospective payment model that focuses on a daily or monthly payment system. CCBHCs help states promote payment reform, as the prospective payment system transforms providers from a volume-based reimbursement model towards a value-based reimbursement model.

To date, 20 clinics and 17 providers have sought funding under the SAMHSA. These providers/sites provide CCBHC-like service capacity to approximately 33% of Illinois counties and lead the way for Illinois as they utilize SAMHSA funds to build out the necessary service capacity required to comply with Section 224 of the Protecting Access to Medicare Act of 2014 (2014). The early experiences of these SAMHSA-funded providers will help Illinois policymakers shape Illinois' CCBHC implementation, ensuring long-term sustainability. In March 2024, HFS was selected as one of ten states to participate in the CCBHC Medicaid Demonstration program. The Demonstrationbegan on October 1, 2024, and includes 19 CCBHC locations throughout the state (Office of the Illinois Governor JB Pritzker, 2024). The IHHS Departments should continue collaboration efforts to develop and deploy State policy regarding the implementation of CCBHCs for Illinois.

School-Based Services: As detailed in Dr. Weiner's report, *Blueprint for Transformation,* seeking to improve early identification and intervention of behavioral health needs with children should focus on targeting screening and intervention within schools and pediatricians' offices (Weiner et al., 2023). With over 850 school districts across the State serving Illinois' population of more than 3 million children, ongoing efforts to introduce systematic behavioral health screening and broaden the availability of federal Medicaid support for district expenditures are significant advancements in the effort to expand access to care for children. Early detection and intervention of children's behavioral health issues helps to prevent small issues from becoming larger, more persistent issues that can impact a customer across the lifespan. Additionally, school-based behavioral health services also help to promote mental health awareness, decrease stigmatism and isolation, and help students and staff feel supported.

Telehealth: The lack of available staff to meet the needs of existing providers requires the IHHS Departments to review and assess the existing service definitions and structures to ensure that staff are working at their most optimal levels. Removing any potential waste from over-credentialed services could have significant benefits to providers that struggle to recruit, hire, and retain licensed and master's-level staff. Identifying the potential for targeted training and specialized certification programs to help fill the voids of Illinois' behavioral health workforce could mean the difference between accessing services or being placed on a waiting list. Working with a wide group of providers familiar with the delivery of services, clinical experts, and educators will help the IHHS Departments identify potential within their existing service designs, which can help identify instances in which targeted training/certification could fill a significant treatment gap.

Peers: As Illinois seeks to address the behavioral health workforce shortage, service provision by individuals with lived experience, also known as peers, is a proven approach to increasing access and engagement. Often familiar with the issues faced by customers seeking services from the behavioral health system, peer support workers provide a cost-effective means of ensuring that recovery-focused supports are available. Capable of focusing on strengths, coping skills, and strategies to meet individual goals, peer support workers can expand the array of professionals available to deliver service and support. Peers also increase customer engagement, reduce stigma, and improve outcomes as they have the ability to connect, communicate, and empower customers in ways other types of clinical staff cannot.

Direct service professionals (DSPs): DSPs are individuals who provide direct support and care to individuals with a behavioral health condition. Often found in settings such as group homes, day programs, or vocational settings, DSPs can also be deployed in community-based settings to support individuals during key moments of transition, crisis, or stress. DSPs offer customers with service support that is person-centered and often focuses on specific treatment goals or objectives. DSPs can assist in skill development, behavior management, and supervision, promoting greater stability and outcomes. The IHHS Departments may want to consider a piloted introduction to DSPs and assess the ability of this professional type to reduce episodes of crisis that result in higher levels of care or emergency department visits.

The CBHO recommends IHHS Departments take all available actions that are financially feasible (while ensuring clinical integrity) to improve access to behavioral health services. To support this, the CBHO recommends:

- IDHS and HFS continue to collaborate on the implementation of Illinois' CCBHCs model under the Medicaid Demonstration.
- HFS and IDHS conduct a gap analysis to determine what resources and provider types are needed.

Streamline Illinois' Behavioral Health Crisis Service Continuum

Through the National Academy for State Health Policy (NASHP), Illinois was awarded technical assistance and participation in a one year, learning collaborative focused on the modernization of state behavioral health systems. The Illinois proposal, led by HFS, sought assistance in enhancing the State's behavioral health crisis service continuum. This request includes seeking technical assistance for: 1) cross-sector alignment of public and private payers to create a "no wrong door" approach to accessing behavioral health crisis services; and 2) establishing multi-public payer approaches to braiding state funds, with a heavy emphasis on Medicaid maximization to ensure service sustainability. Specifically, Illinois is receiving technical assistance and support in assessing Illinois' multiple co-existing crisis response program efforts and in developing a plan to establish a single Unified Crisis Continuum, or UCC, that standardizes the State's response to individuals experiencing a behavioral health crisis, regardless of insurance coverage or state payer system.

Influenced by the vision of the Governor's Office under the leadership of the CBHO, and supported by Dr. Weiner, the State's application outlined four long-term goals designed to establish a common vision between the IHHS Departments and promote financial sustainability, parity, equity, and access for the crisis service continuum. The NASHP Learning Collaborative work in 2023 produced critical interdepartmental alignment and strategic visioning, propelling them to establish a single UCC for Illinois. The CBHO will continue to work closely with the IHHS Departments on the ongoing development of Illinois' UCC.

- The CBHO will publish Illinois' progress towards a UCC and detail a plan for ongoing advancements in the stated long-term goals.

Expanding Illinois' Behavioral Health Infrastructure

Department of Human Services

The National Institute on Drug Abuse reported in 2018 that 18.2% of individuals with a mental health condition also had a comorbid SUD and that 37.9% of individuals with a SUD also had a mental illness (Han et al., 2017). With such high levels of comorbidity between mental health and SUDs, it is important to ensure Illinois' behavioral health leadership, staff, and policies promote integration and access. These aims, along with stated efforts to reduce duplication and align resources to declare priorities, create an opportunity for IDHS to review its current structural alignment for the management of mental health and substance use treatment while also introducing a new integrated approach. Under a unified Division of Behavioral Health, resources from IDHS-DMH and IDHS-SUPR will be able to collaborate on shared policy that supports customer access to care while promoting mental health/SUD integration with its community-based network of providers. Unifying the administration of mental health and substance use policy will help to establish greater equity between service delivery systems and strengthen the collective voice of IDHS as it seeks to lead Illinois toward a greater state of behavioral health wellness.

Department of Public Health

While much of any behavioral health discussion generally focuses on publicly funded services for treatment, understanding behavioral health more holistically requires better data collection than what is currently available while also providing funding and technical assistance on prevention efforts. IDPH has various data around mental health status and provision of care in Illinois; however, the data reside in various sections across the Department. Similarly, the Department has various efforts underway to address the prevention of behavioral health but does not have a singular office or section dedicated to mental health. It is vital that the Department of Public Health ensure that adequate resources and staff are focused on the collection and analysis of data that can inform State policymakers on the behavioral health and wellness of the State. IDPH should coordinate efforts across the Department on preventative measures and identify key indicators of behavioral health, alert policymakers to troubling trends, and inform the State's discussion on behavioral health wellness.

Department of Healthcare and Family Services

The IHHS Departments reported to the University of Illinois System, Office of Medicaid Innovation, for this report spending an estimated $4.9 billion on behavioral health services in state fiscal year 2023. HFS was responsible for 70%, or $3.5 billion, of those expenses. With HFS's overall investment in the behavioral health system, plus the portion of IDHS, DCFS, and IDPH reported expenses that also qualify for Medicaid funding, the significant role HFS plays in shaping Illinois' behavioral health system cannot be understated. While HFS introduced the Bureau of Behavioral Health just a few years ago, the task of managing Medicaid behavioral health services is growing at a pace greater than any single bureau could possibly address. HFS administrators should work collaboratively to ensure the alignment of State priorities while also providing additional support for the following: major state behavioral health initiatives (e.g., 988 rollout and Pathways to Success); implementation of court consent decrees (e.g., Williams, Colbert and NB); interagency coordination with other state departments operating behavioral health services (e.g., IDHS, DCFS, IDPH, ISBE, and local governments); and keeping an intensity of focus on behavioral health with HFS's contracted MCOs. Understanding that most of Illinois' behavioral health system is predicated upon the Illinois Medicaid program, it is vital to ensure that HFS has sufficient administrative resources and subject matter experts to support the role it plays in Illinois' behavioral health system.

The CBHO recommends:

- IDHS work to unify the Divisions of Mental Health and Substance Use Prevention and Recovery into a single division.
- IDPH and HFS to invest in its infrastructure to expand and strengthen their services and supports

Investing in Clinical Excellence

Clinical Leadership Academy

Creating opportunities for provider organizations to enhance the training and knowledge of their licensed clinical staff are systemic investments with the potential to return benefits with every clinical interaction that individual has for the remainder of their career. Organizations struggle to fill licensed positions, as available candidates may not have the depth of knowledge or experience that would be preferred within some

behavioral health organizations. Conversely, some licensed staff who have been in the field for years now find themselves having to adjust to standardized screening instruments and the delivery of services in a remote fashion. IDHS is uniquely positioned to design and implement a Clinical Leadership Academy targeted at helping organizations develop licensed staff capable of addressing the challenges of Illinois' changing behavioral health system.

The CBHO recommends:

IDHS partner with the IHHS Departments and existing workforce centers to plan for the introduction of a Clinical Leadership Academy to prepare behavioral health clinicians, including peers and paraprofessionals, as change agents in their own organizations.

Comprehensive Assessment of Needs and Strengths (IM+CANS)

Since the introduction of the multi-department (DCFS, HFS, and IDHS) SASS program, the Departments have struggled to understand the needs of customers, assess the quality of clinical response to those needs, and build a mechanism for determining quality outcomes. Coming out of the Illinois United for Youth statewide Systems of Care planning initiative (led by IDHS-DMH), the IHHS Departments realized the importance of establishing a standardized assessment and treatment planning framework, Pathways: Illinois Strategic Plan for Children's Mental Health.

> *"GOAL 12.1: Develop a uniform statewide approach across systems for assessment, treatment planning, and adopting quality indicators and benchmarks supporting System of Care values and principles and resulting in the development of a continuum of interventions from prevention, promotion, early interventions and treatment that covers the age spectrum from birth through transitioning young adults."*
>
> *– Pathways (Illinois United for Youth, 2013)*

In response to Pathways Goal 12.1, DCFS, IDHS, and HFS began to analyze the mental health assessment and treatment planning requirements of the legacy "Rule 132" and identify the requirements that would need to go into a standardized assessment and treatment planning tool. Driving towards the introduction of Illinois' Behavioral Health Transformation (BHT) 1115 Demonstration Waiver and corresponding transformational efforts, the Departments expanded efforts on assessments to include adults as well as children. Using a rapid prototyping approach and the benefits of Dr. John Lyon's Transformational Collaborative Outcomes Management (TCOM) philosophy and instruments (CANS for child/Adult Needs and Strength Assessment

[ANSA] for adults) (Lyons, 2022), the Departments began development of the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS).

The IM+CANS is a standardized, lifespan mental health assessment and treatment planning protocol that establishes common language between the consumer, the provider, and the payer. To support the statewide rollout of the IM+CANS and the new philosophical approach, HFS partnered with the University of Illinois at Urbana-Champaign School of Social Work (UIUC SSW) to introduce training and support for providers on the philosophy of TCOM and how to rate and score CANS/ANSA items with reliability. HFS also established the IM+CANS Training Office (subsequently renamed Provider Assistance and Training Hub [PATH]). On August 1, 2018, HFS introduced the new service of Integrated Assessment and Treatment Planning, or IATP, to the community-based service array, recognizing the IM+CANS as the selected assessment satisfying the requirements of the IATP.

At its heart, the IM+CANS is a multi-page assessment and treatment planning instrument meant to improve communication and understanding of consumer needs, service delivery, and outcomes at the provider-level. At the payer-level, the IM+CANS provides the information needed to improve nuanced population management and sets the stage for providers to introduce new pay-for-performance initiatives by being able to demonstrate outcomes other than reduced spending or avoidance of institutionalization. All the while, the IM+CANS provides the promise of systems-level big data, helping the IHHS Departments understand the mental health system in ways that often elude policymakers.

In response to provider feedback on the challenges they experience using the IM+CANs, HFS has convened the IM+CANS Provider Workgroup and has begun to collect recommendations, integrate feedback, and make updates to the IM+CANS process (HFS, n.d.-c).

The CBHO recommends:

- Establish a collaborative effort between HFS, IDHS, PATH, and the Behavioral Health Workforce Center to increase the education and outreach efforts with providers regarding the shift in philosophy of assessments.
- Establish and publish a plan to expand the use of the IATP to other providers of community-based behavioral health services.
- Assess the current technical platform used to capture the IATP data and determine the most appropriate technical pathway for the IHHS Departments to gain maximum utilization of the IATP data.

Ensuring Effective and Efficient Financial Supports

Cost Reporting

In the months and years ahead, Illinois will face daunting fiscal challenges that will require creativity and prudence. As public servants, it is the duty of each public employee to reduce waste and to seek to be effective and efficient with the monies used to establish and maintain the publicly funded behavioral health system. As stewards of Illinois resources, efforts to introduce transparency and accountability are vital to earning and keeping public trust. These goals are consistent with the Quintuple Aim principle of reducing costs, with federal expectations for programs such as Medicaid and, more generally, good government. The first step to ensuring effective and efficient financial support is to understand the cost of the goods and services being purchased. In State fiscal year 2021, the IHHS Departments reported spending nearly $2 billion on behavioral health services,

mostly made up of Medicaid spending, but even more could be done to clarify the provider costs driving their investment.

Without understanding the statewide cost profiles of the individuals and entities supplying goods and services across the behavioral health system, the IHHS Departments are unable to ensure that reimbursement rates are sufficient to promote equity and access.

For some provider types, it may be necessary to collect cost data every year or every other year; with other provider types, only three- or five-year cost-reporting cycles may be needed. Regardless, changes in marketplace conditions (as seen during the public health emergency) can have a dramatic impact on provider costs, with a trickledown effect on customer access to care. It is vital that the IHHS Departments actively monitor the behavioral health supply chain cost factors that drive provider behavior and decision-making.

The CBHO recommends

IHHS Departments collaborate to establish a unified cost reporting system for all behavioral health providers receiving State funds and introduce the necessary policies and resources to regularly collect data.

Strong and Stable Workforce

Coming out of the public health emergency, there has been an increased focus on the importance of behavioral health and personal wellness. At the same time, cost of living increases and supply chain shortages have put a new focus on how much we pay workers at fast-food restaurants, grocery stores, and retail locations, with many employers taking actions to introduce a living wage for all employees. This same sentiment needs to be embraced within the behavioral health service sector to ensure an adequate supply of staff and professionals who serve those with behavioral health needs. IHHS Departments can develop strategies to increase worker retention and attract workers to address Illinois' behavioral health workforce shortages.

The CBHO recommends:

IHHS Departments work to identify additional strategies to ensure a strong behavioral health work force.

Reimbursement Simplification, Unification, and Licensed Practitioners

As of the writing of this report, the State of Illinois pays $38.00 for every 15 minutes of therapy/counseling, or $152 per hour (HFS, 2024). However, if service is supplied in the office, then the rate is reduced to $139.36 per hour. If the same service of therapy/counseling is provided by a mental health professional instead of a qualified mental health professional, then the community and office rates are further reduced to $121.04 and $109.28 per hour, respectively. This same type of level-of-practitioner and on-site/off-site incremental rate system is the basis of the community-based mental health services system and stems from the early days of CMHCs converting from grant-based funding to Medicaid fee-for-service (FFS) activities. The benefits of this system were that providers would receive a rate differential for travel (services provided off-site) and rate enhancements for higher-qualified staff. With today's increased focus on access, engagement, and outcomes, the legacy reimbursement system provides minimal practice incentives for providers while continuing to be complex and cumbersome to bill, as well as promoting disparities in rates differing diagnoses, service types, and professional staff. Illinois is not alone among states whose rates require a broad review of rates across agencies for similar services.

Additionally, establishing alignment between the reimbursement model used by Illinois' community-based mental health providers and SUD providers will increase the State's investment in SUD services, assist the State in the fight against overdoses, and increase the integration of SUD services into the portfolio services available to the community. And while overhead costs are not less expensive for SUD providers, as they often compete with CMHCs and similar providers for staff and resources, the table below highlights that SUD providers currently face an uphill challenge when delivering community-based services, due to lower reimbursement rates.

Service	Unit	Substance Use Fee Schedule	Mental Health CBS Fee Schedule Low	Mental Health CBS Fee Schedule High
Individual Therapy	15 minutes	$25.59	$27.32	$38.00
Individual Therapy	1 hour (4 units)	$102.36	$109.28	$152.00
Difference			**+ $6.92**	**+ $49.64**
Percentage Difference			**6.76%**	**48.50%**

Table 1: *Comparison of Reimbursement Rates for Individual Therapy: FFS Costs in Community-Based Mental Health and SUD Services*

As providers across the State call attention to the scarcity and challenges of finding enough licensed practitioners (LCSWs, LCPCs, and LMFTs) to employ, the State's reimbursement models are not structured to address this problem. While the SUD system formally recognizes physicians, psychologists, social workers, counselors, and Certified Alcohol Drug Counselors (CADC), the community-based mental health system requires clinical oversight but does not provide reimbursement specific to licensed practitioners. The State could make advances in promoting stronger clinical leadership at community-based behavioral health organizations by examining reimbursement practices for all clinical services performed by a licensed or certified practitioner at the same rate (modified for travel), regardless of service provided.

Finally, as payers seek to transition away from paying for volume to paying for outcomes, simplified reimbursement models based on costs will help providers and payers alike begin to explore VBP models. VBP payment models seek to compensate healthcare providers based on the quality and effectiveness of care instead of the volume of FFS activities. This change in focus helps to promote improved customer outcomes while seeking to deliver cost savings to providers by reducing waste and administrative requirements while promoting collaboration, preventative treatments, and increased customer satisfaction.

Considering these opportunities, the CBHO recommends the State analyze and consider the following:

- A broad review of rates across agencies for similar services, potentially leading to a focused report with related recommendations.
- Align the rates of reimbursement between the SUD and CBS fee schedules, building upon rate standardization efforts underway through *The Transformation Initiative*.
- Explore introducing VBP models for behavioral health treatment.

Creating a Centralized Data Repository and Supported Multi-

Creating a Centralized Data Repository and Supported Multi-Department Utilization Plan

As discussed in Section 2 of this report (above), managing and effectively utilizing data can be challenging for the IHHS Departments. The Illinois Health and Human Services Innovation Incubator (HHSi2) project is chaired by HFS and the Illinois Governor's Office of Management and Budget (GOMB) to enable and implement interoperability and to expand data sharing across IHHS agencies and programs. Originally focused on the establishment of a new shared data platform, HHSi2 is now focused on leveraging and connecting existing platforms, foremost HFS' Enterprise Data Warehouse, or EDW. The EDW has been developed and maintained by Illinois' Medicaid program and seems to be a potential safe harbor in the storm of data. Maintained and supported by a dedicated technology vendor, HFS manages the EDW from its central office in Springfield. Today, the EDW has data feeds from the State's IES, mainframe (legacy) MMIS, IMPACT, and other sources related to supporting the Illinois Medicaid program. Given the scope of information required to support Medicaid, the platform has the obvious scalability required to be a centralized hub for all other IHHS Departments creating a centralized data repository for all publicly funded behavioral health data in Illinois. The transfer of the HHSi2 project team and data management vendor into HFS will pair IHHS' data-sharing enterprise with HFS' EDW to enhance the EDW's capacity to incorporate and integrate disparate data sources for both analytic and operational purposes.

In addition to finding a central location for data storage, the IHHS Departments also need to consider establishing a mechanism to deliver high-quality data analytics, including predictive analytics, from the centralized data repository to all IHHS Department policymakers. Such services should be provided with equal priority. Sufficient resources would be required to support multiple administrative efforts occurring in unison.

The CBHO recommends:

- HFS and the HHSi2 Project over time incorporate more publicly funded behavioral health data from the IHHS Departments into the HFS EDW.
- HFS and the HHSi2 Project over time introduce an independent data analytics mechanism for all IHHS Departments to access the newly centralized data repository.

CBHO Recommendations

Finance

Action Items

1. IHHS Departments work to identify additional strategies to ensure a strong behavioral health work force.

2. A broad review of rates across agencies for similar services, potentially leading to a focused report with related recommendations.

3. Align the rates of reimbursement between the SUD and CBS fee schedules, building upon rate standardization efforts underway through *The Transformation Initiative*.

4. Explore introducing VBP models for behavioral health treatment.

Innovation

Action Items

1. Solicit provider input for the development of a concept paper outlining the benefits of promoting innovation and performance and submit it to the IHHS Departments.

2. The CBHO will publish Illinois' progress towards a UCC and detail a plan for ongoing advancements in the stated long-term goals.

3. The IDHS will work to unify the Divisions of Mental Health and Substance Use Prevention and Recovery into a single division.

4. The IDPH and HFS to invest in its infrastructure to expand and strengthen their services and supports

5. Establish and publish a plan to expand the use of the IATP to other providers of community-based behavioral health services.

Technology and Data

Action Items

1. Assess the current technical platform used to capture the IATP data and determine the most appropriate technical pathway for the IHHS Departments to gain maximum utilization of IATP data.
2. IHHS Departments collaborate to establish a unified cost reporting system for all behavioral health providers receiving State funds and introduce the necessary policies and resources to regularly collect data.
3. HFS and the HHSi2 Project over time incorporate more publicly funded behavioral health data from the IHHS Departments into the HFS EDW.
4. HFS and the HHSi2 Project over time introduce an independent data analytics mechanism for all IHHS Departments to access the newly centralized data repository.

Collaboration

Action Items

1. The IHHS Departments will agree upon a form of shared governance that takes a strengths-based approach and begin to codify that structure in an interagency agreement with all parties.
2. The IDHS and HFS continue to collaborate on the implementation of Illinois' CCBHC model under the Medicaid Demonstration.
3. The HFS and IDHS conduct a gap analysis to determine what resources and provider types are needed.
4. The IDHS partner with the IHHS Departments and existing workforce centers to plan for the introduction of a Clinical Leadership Academy to prepare behavioral health clinicians, including peers and paraprofessionals, as change agents in their own organizations.
5. Establish a collaborative effort between HFS, IDHS, PATH, and the Behavioral Health Workforce Center to increase the education and outreach efforts with providers regarding the shift in philosophy of assessments.

Issue Spotlight: Illinois' Reduction of Psychiatric Hospital Beds

Illinois' psychiatric hospitalization capacity, often quantified as "beds," is rapidly declining.

History of Treatment of Acute Psychiatric Needs in the United States

The use of psychiatric hospitals to treat individuals experiencing acute behavioral health needs is a result of the historic role of institutions in the continuum of care. Stakeholders have approached the issue of how to *best support* an individual in need of acute behavioral health support, while navigating the influences of perception of need, funding, and politics. In the mid-19th century, the first psychiatric institutions were created. The paternalistic view of this era built secluded structures to "rescue" and remove people from their "external world" (Jansson, 2012). These psychiatric hospitals, while at first praised for their charity, were hit with limited resources and unexpected demand. This dynamic contributed to overcrowding and the facilities were exposed as "cruel and inhumane" (Yohanna, 2013) as patients were stripped of rights and allowed to languish without the goal of rehabilitation.

Deinstitutionalization, or the transition of treatment from facility-based settings to community-based settings, took off with the civil rights movement in the 1960s, spawning litigation and the concept of "least restrictive setting." The federal government backed deinstitutionalization with two key policy efforts: 1) the 1963 Community Mental Health Act (Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, 1963) which funded the building of local community mental health centers (CMHCs); and 2) the inclusion of the Institution for Mental Disease (IMD) exclusion in the SSA (1965) (Social Security Amendments of 1965, 1965). These two key policy measures of deinstitutionalization moved the financial responsibility from the federal government to the States.

THE IMD RULE

An Institution for Mental Disease, or IMD, is a federal Medicaid term added to the Social Security Act (SSA) in 1965 (Social Security Amendments of 1965, 1965). IMDs are defined as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases." In this definition, mental diseases include most mental and substance use disorders, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The SSA of 1965 went on to create the IMD payment exclusion which makes all services provided to customers in IMDs ineligible for Federal Medicaid match. This means states can have IMDs but at entirely their own cost (National Association for Children's Behavioral Health, 2022). There are some ways states can seek population specific exception or waivers related to IMDs, but the most effective way of managing this issue is to focus on community care or ensuring facility structures remain at 16 or fewer beds. Currently, Illinois does not have any additional IMD exclusion exemptions.

Illinois' Psychiatric Inpatient Capacity

The Health Facilities and Services Review Board (HFSRB) is required by statute to conduct statewide inventories of healthcare facilities such as hospitals, and to calculate the State's necessary capacity by the category of services for each of Illinois' 11 regions, known as Health Service Areas (HSAs). HFSRB's inventory published in October 2021 highlights significant losses in the category of Acute Mental Illness (AMI), which are psychiatric hospital beds. According to the HFSRB, a total of 167 AMI beds, or roughly 1 in 4 beds, were lost over a three-year period between calendar year 2020 and 2023. This bed loss was the result of 10 AMI Units closing across the State (Illinois Health Facilities and Services Review Board [HFSRB] & IDPH, 2021).

Today, there are slightly less than 4,200 AMI beds scattered across Illinois with most of the downstate capacity residing in just a handful of counties. And while some facilities have added new units or increased AMI bed count, the State's loss of psychiatric inpatient beds is far outpacing the rate of gains. The significance of these

losses is felt the hardest in parts of Illinois where unit closures or bed reductions have resulted in a complete loss of access in the county.

Out of the 10 units lost between 2020 and 2023, 60% of the counties involved no longer have any AMI bed access, requiring individuals to travel further from their communities to gain psychiatric bed access.

	Population	Medicaid Recipients	AMI Beds	AMI Beds per 1K Pop
HSA 1	659,153	195,699	66	0.100
HSA 2	644,577	179,365	147	0.228
HSA 3	551,919	161,529	182	0.330
HSA 4	804,406	215,651	223	0.277
HSA 5	585,316	189,492	55	0.094
HSA 6	5,173,146	1,585,520	1,595	0.308
HSA 7	924,885	150,379	1,154	1.248
HSA 8	1,527,949	311,773	318	0.208
HSA 9	991,709	202,709	254	0.256
HSA 10	207,398	58,325	54	0.260
HSA 11	591,011	155,109	148	0.250
Total AMI Beds			**4,196**	

Table 2 *Data from a sample of 10 HSAs, including the population, Medicaid recipients, and number of AMI beds. This data is from HFSRB & IDPH (2021).*

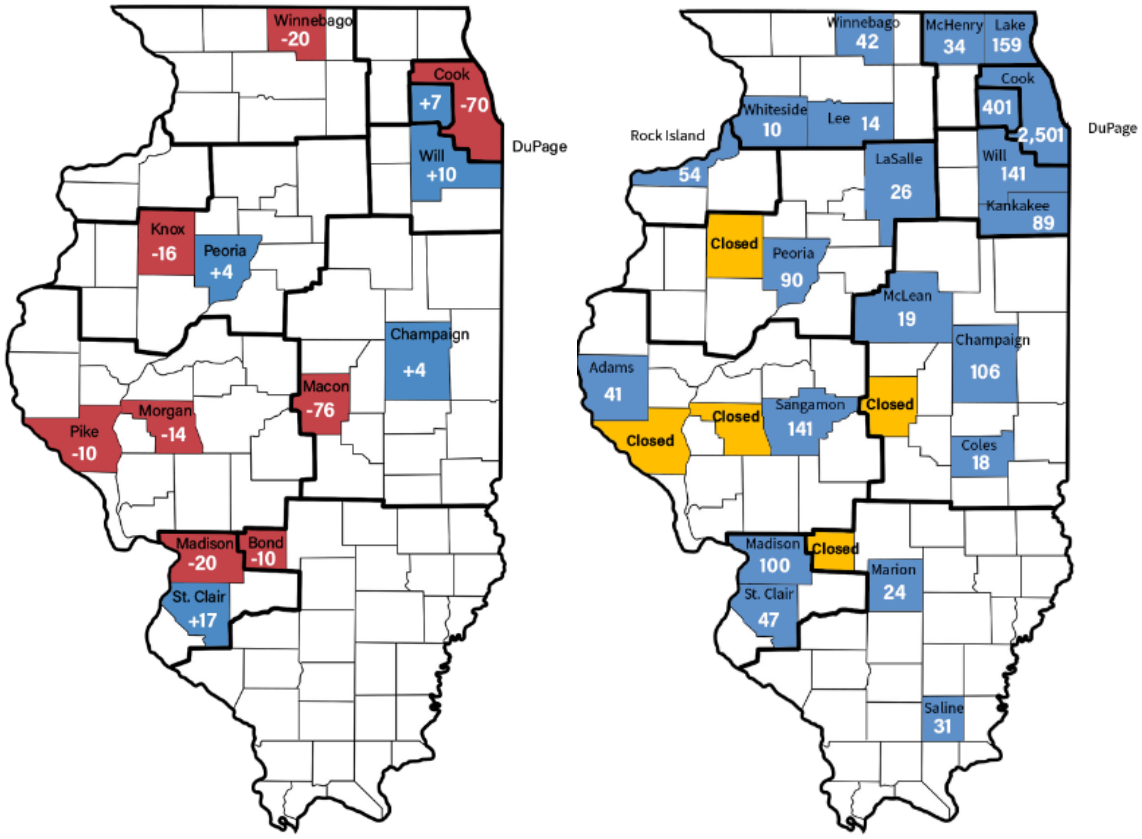


Figure 4 *AMI bed losses and gains from 2020—2023 (left) and today's AMI numbers (right)*

HFSRB Capacity Target

HFSRB currently utilizes the capacity target of .11 AMI beds per 1,000 people. This target is adjusted every three years, and does not stratify by age or hospital specialization.

[6] The Chief Behavioral Health Officer (CBHO), David T. Jones, believes this target may undercount the need for AMI beds in Illinois. In his 2022 book *Healing: Our Path From Mental Illness to Mental Health,* Thomas Insel (2022) cites contemporary need for psychiatric beds to be .4 to .6 beds per 1,000.

Regardless of the target used, Illinois needs more AMI beds. A deeper analysis of bed types and the facilities they are in would be beneficial to this capacity target interpretation.

In response to this growing issue, the CBHO is seeking to increase awareness with State leadership, the General Assembly, Governor's Office, healthcare providers, and local stakeholders. Understanding that nothing can replace the closure of a psychiatric unit or lost beds, the CBHO is hoping to promote increased access to other services across the behavioral health continuum to help support struggling communities. With an eye towards policy innovations currently being considered, such as the introduction of Crisis Stabilization Units (CSUs), Urgent Care Centers, and Certified Community Behavioral Health Clinics (CCBHCs), the CBHO hopes that a framework of alternative service options can be prioritized and deployed to locations with the greatest need. Additional updates will be provided on this topic from the CBHO as they become available.

[6] *This information is from a conversation with John Kniery of HFSRB on March 17, 2023, by phone.*

A final note from Chief David T. Jones:

> While this report is intended to highlight various elements of Illinois' behavioral health system, inform policymakers and legislators, and propose several policy enhancements to improve the behavioral health and wellbeing of the people of Illinois, it is also intended to start a dialogue amongst all of us in Illinois about the importance of behavioral health and wellbeing. If you have thoughts or feedback about this report or Illinois' behavioral health system, please feel free to share those thoughts with me via email at: omi.cbho@uillinois.edu.

List of Acronyms

988	988 Suicide and Crisis Lifeline
24/7/365	24 hours a day, 7 days per week, every day of the year
ABS	Adaptive Behavioral Support
ACES	Adverse Childhood Experiences
ACT	Assertive Community Treatment
AMI	Acute Mental Illness
ANSA	Adult Needs and Strength Assessment
ASAM	American Society of Addiction Medicine
BEACON	Behavioral Health Care and Ongoing Navigation
BH	Behavioral Health
BHC	Behavioral Health Clinic
BHIP	Behavioral Health Independent Providers
BHSR	Behavioral Health Systems Report
BHT	Illinois' Behavioral Health Transformation
CADC	Certified Alcohol Drug Counselor
CARES	Crisis And Referral Entry System
CBHO	Chief Behavioral Health Officer
CBS	Community-Based Behavioral Services
CCBHC	Certified Community Behavioral Health Clinic
CCBYS	Comprehensive Community Based Youth Services
CCSO	Care Coordination and Support Organizations
CDC	U.S. Centers for Disease Control and Prevention
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CRSS	Certified Recovery Support Specialist
CST	Community Support Team
CSU	Crisis Stabilization Units
DCFS	The Illinois Department of Children and Family Services
DDD	IDHS' Division of Development Disabilities
DEC	IDHS' Division of Early Childhood
DMH	IDHS' Division of Mental Health
DRS	IDHS' Division of Rehabilitation Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSP	Direct Service Professionals
EDW	Enterprise Data Warehouse
FCS	IDHS' Division of Family and Community Services
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FRO/PRO	Family Run/Peer Run Organizations
GOMB	The Illinois Governor's Office of Management and Budget
HFS	The Illinois Department of Healthcare and Family Services
HFSRB	Health Facilities Services Review Board
HFW	High Fidelity Wraparound
HHSi2	Illinois Health and Human Services Innovation Incubator
HRCP	Harm Reduction Community Linkages Project

HRSN	Health Related Social Needs
HSA	Health Service Areas
HTC	Healthcare Transformation Collaboratives
IATP	Integrated Assessment and Treatment Planning
ICC	Intensive Care Coordination
ID	Intellectual Disability
IDFPR	Illinois Department of Financial and Professional Regulations
IDHS	Illinois Department of Human Services
IDJJ	The Illinois Department of Juvenile Justice
IDOC	Illinois Department of Corrections
IDOI	Illinois Department of Insurance
IDPH	Illinois Department of Public Health
IEP	Individualized Education Plan
IES	Integrated Eligibility System
IHHS	Illinois Health and Human Services Departments
IHI	Institute for Healthcare Improvement
IM+CANS	Illinois Medicaid Comprehensive Assessment of Needs and Strengths
IMD	Institution for Mental Disease
ISBE	Illinois State Board of Education
IT	Information Technology
LCP	Licensed Clinical Psychologists
LCPC	Licensed Clinical Professional Counselors
LCSW	Licensed Clinical Social Workers
LMFT	Licensed Marriage and Family Therapists
LRP	Living Room Programs
MAR	Medication Assisted Recovery
MBC	Measurement-Based Care
MCO	Managed Care Organization
MCR	Mobile Crisis Response
MH	Mental Health
MHFA	Mental Health First Aid
MHPAEA	Mental Health Parity and Addiction Equity Act Of 2008
MMIS	Medicaid's Managed Information System
MOUD	Medications For Opioid Use Disorder
NASHP	National Academy for State Health Policy
OUD	Opioid Use Disorder
PATH	Provider Assistance and Training Hub
PCP	Primary Care Provider
PSR	Psychosocial Rehabilitation
ROI	Return On Investment
SACWIS	Statewide Automated Child Welfare Information System
SAMHSA	Substance Abuse and Mental Health Services Administration
SASS	Screening, Assessment, and Support Services
SDOH	Social Determinants of Health
SIU	Southern Illinois University
SMI	Severe Mental Illness
SOAP	State Overdose Action Plan
SOPH	State Operated Psychiatric Hospitals
SSA	Social Security Act
SUD	Substance Use Disorder
SUPR	IDHS' Division of Substance Use Prevention and Recovery
TCOM	Transformational Collaborative Outcomes Management
UCC	Unified Crisis Continuum
UIUC SSW	UIUC School of Social Work

VBP	Value-Based Payment
VP-CST	Violence Prevention Community Support Team

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