FY2018
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT IMPLEMENTATION REPORT*

ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH

***NARRATIVE REPORT OF PROGRESS AND ACHIEVEMENTS IN FY2018 TOWARD THE IMPLEMENTATION OF THE SFY2018-SFY2019 COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION AND PLAN WHICH WAS SUBMITTED ON SEPTEMBER l, 2017**

Introduction

This implementation report covers the first year of a two-year Mental Health Block Grant plan for FY2018-FY2019 which was submitted to SAMHSA on September 1st, 2017. In general, this report describes our achievements, continuing progress, and documents the challenges encountered during FY2018 in working on 20 strategies related to the DMH priorities and goals that were supported by performance measures.

In accordance with formatting requirements by SAMHSA, each strategy is presented separately in a table which provides information about the priority, the goal that is being addressed, the strategy itself, the performance measure evaluating achievement and outcome, a description of how the data for the performance measure is collected and how changes are measured, and, finally, the state's report as to whether or not the strategy was achieved. Following each table, a brief review of background information, a description of our progress in FY2018, and other pertinent data are provided.

FY2018 IMPLEMENTATION REPORT

Priority #1- Design of Public Mental Health Services

1. Priority Area: **Continue to develop and improve the array of clinical and support services available for adults and children.**	2. Priority Type MENTAL HEALTH SERVICES
3. Population(s) SMI, SED:	
4. Goal of the priority area: *Assure the clinical quality and effectiveness of community-based mental health services available to adults and youth and assure the comprehensiveness of the public mental health service system design.*	
5. Objective: Conduct ongoing evaluation of the quality and outcome of community-based services in Illinois.	
6. Strategies to attain the objective: • Identify, develop and establish outcome measures (indicators) for the evaluation of community services. • Design a system to process the components and data of the evaluation. • Implement the system. • Analyze the resulting data to: (a) inform the publicly funded community service system; (b) facilitate decision making and planning; and (c) improve the quality and effectiveness of services and service delivery.	
7. Annual Performance Indicators to measure goal success: **Indicators: (1) Number of outcome measures ready for use.** **(2) Percent of providers that demonstrate their capacity for use of the outcome measures in reporting.**	
a) Baseline measurement (Initial data collected prior to and during SFY 2017): N/A	
b) First-year target/outcome measurement (Progress to end of SFY 2018): **Completion of a draft set of outcome measures for the evaluation of community services and initiation of stakeholder discussion, input, and review.**	
c) Second-year target/outcome measurement (Final to end of SFY 2019): **Completion of a prioritized list of outcome measures and initial implementation of a system of reporting which processes the data and components of the evaluation.**	
d) **Data source:** DMH information system	
e) **Description of data:** Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the State Medicaid agency, Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables. Data for specific outcome measures will be processed through this system.	
f) **Data issues/caveats that affect outcome measures**: None	
8. Report of Progress toward goal attainment **First year target: _____ Achieved ___X__ Not Achieved (If not achieved, explain why)**	

DMH has partially achieved this target, through the development of a set of performance measures used in the monitoring of community provider contracts. Full development of a draft set of outcome measures cannot be completed until the Rules governing certification and service delivery are fully revised and adopted, a process which has experienced unanticipated delays of many months. It is expected that the

Rules will be formally adopted and this process will be able to be completed within SFY19

Priority #2 Evidence Based Practices: Assertive Community Treatment (ACT)

1. Priority Area #2: **Promote Provision of Evidence Based and Evidence-Informed Practices**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED	
4. Goal of the priority area: *Promote Evidence Based Practices for individuals served in DMH funded agencies and advance the implementation of evidence-informed practices in the child and adolescent service system.*	
5. Objective: Continue to reach expected outcomes for individuals in need through provision of Assertive Community Treatment (ACT).	
6. Strategy to attain the objective: Development of a set of outcome measures designed to assess the progress of individuals served.	
7. Annual Performance Indicators to measure goal success: **Indicator**: **Number of active service slots filled in the State for persons with SMI to receive Assertive Community Treatment in FY2018 and FY2019 (National Outcome Measure).**	
a) Baseline measurement (Initial data collected prior to and during SFY2017): Baseline for 2017 not applicable to FY2018 or FY2019 as indicator has been revised to reflect service access capacity. See 7e-Description of Data.	
b) First-year target/outcome measurement (Progress to end of SFY 2018): **1,100**	
c) Second-year target/outcome measurement (Final to end of SFY 2019): **1,100**	
d) Data Source: DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting.	
e) **Description of data:** Providers of ACT services submit monthly reports of team capacity to DMH, which is monitored for system sufficiency. This information is used as a basis for developing reports, analytic purposes, and is the basis for reporting the data used to populate the URS tables**.**	
f) **Data issues/caveats that affect outcome measures:** Most ACT Teams currently operate within areas where individuals are served through Managed Care Contracts. Limited and indirect access to MCO data prevents thorough analysis of service data and outcomes. In FY 2017, the SMHA Data Reporting System reported 735 persons served in ACT, while the number of available service slots in the State totaled 1,321. This latter number is much larger in FY2018 and review of FY2017 data has revealed that issues in data reporting and protocol for the spreadsheets led to a lower number of reported service slots. The figures for FY2018 are as follows: there are 2,150 available service slots in the State and currently 1,779 individuals are being served. Through the State's work on the HHS transformation, plans have been underway to improve the interoperability of the data systems. As this continues, DMH will be able to track outcomes with greater accuracy.	
8. Report of Progress toward goal attainment **First year target: ___X__ Achieved _____ Not Achieved (If not achieved, explain why)**	

This objective has been successfully accomplished!

DMH was successful in maintaining 30 ACT teams in FY2018. The service capacity report from providers of ACT shows 1,779 individuals being served, significantly exceeding the target of 1,100 for the fiscal year. The statewide capacity of available and active ACT service slots is 2,150.

Background:
Illinois adopted and began to implement the Assertive Community Treatment (ACT) model in 1992. ACT is the most intensive specialized model of outpatient community mental health care in which a team of mental health professionals takes responsibility for a small group of program participants' day-to-day living and treatment needs. Often these consumers have a history of repeated admission to psychiatric inpatient services or excessive use of emergency services and typically require assertive outreach and support to remain connected with necessary community mental health services. Usually, previous efforts to provide linkage to necessary services have failed and their need for multiple services requires extensive coordination. The active participation of nurses, psychiatrists, and specialists trained in substance abuse is crucial to the success of the ACT model. Consistent with national trends, Illinois is moving towards outcome-based evaluations of services. With the addition of the Integrated Health Home structure in the coming fiscal year, outcome measures will begin to be the focus across the system of care, and DMH has been working with HFS on policies related to this. Once implemented, the State will have better access to outcome measures for publicly funded mental health services, including ACT.

Priority #3 Evidence Based Practices-Individual Placement and Support (IPS)

1. Priority Area: **Promote Provision of Evidence Based and Evidence-Informed Practices**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI	
4. Goal of the priority area: ***Promote Evidence Based Supportive Employment for individuals served in the publicly funded mental health service system.***	
5. Objective: During FY2018 and FY2019, maintain and support the statewide implementation of Evidence Based Supportive Employment.	
6. Strategies to attain the objective: (1) Continue the development of the state infrastructure required to support implementation and sustainability of IPS Evidence Based Supported Employment. (2) Continue to develop the integration of physical and behavioral health with employment supports and peer support statewide. (3) By the end of FY 2019, contingent upon additional funding resources, target an additional 500 consumers to acquire competitive employment in their local communities.	
7. Annual Performance Indicators to measure goal success: **Indicator: Number of consumers receiving supported employment in FY2018 and FY2019. (National Outcome Measure)**	
a) Baseline measurement (Initial data collected prior to and during SFY 2017): **- FY2016 2,208 consumers served in 45 IPS sites with fidelity to the model and 222 in 9 sites working towards fidelity =2,430 consumers.** **- FY2017 3,003 consumers served in 56 IPS sites with fidelity to the model and 183 in 6 sites working towards fidelity =3,275 consumers.**	

b) First-year target/outcome measurement (Progress to end of SFY 2018): **To serve 3,375 consumers in IPS.**
c) Second-year target/outcome measurement (Final to end of SFY 2019): **To serve 3,775 consumers in IPS.**
d) **Data source:** Data for this indicator are generated through a special web-based database created specifically for the DMH SE initiative. Fidelity and outcomes data are submitted to the DMH SE coordinator.
e) **Description of data:** As always, DMH has developed specifications for reporting that DMH funded providers must use when submitting data.
f) **Data issues/caveats that affect outcome measures:** DMH only reports data for teams that have been found to exhibit fidelity to the evidenced based practice model. DMH is working to promote fidelity in all IPS agencies and thereby expand the database.
8. Report of Progress toward goal attainment **First year target: __X___ Achieved _____ Not Achieved (If not achieved, explain why)**

This strategic objective has been successfully achieved. In FY2018, a total of 43 IPS sites with fidelity to the model served 3,157 unduplicated consumers. An additional 7 sites that were working toward fidelity but had not yet met fidelity standards served 256 consumers. In all, 3,413 consumers received supported employment services.

Background

Since 2007, DMH and DHS/Division of Rehabilitation Services (DRS) have partnered in a joint effort to increase access to Individual Placement and Support (IPS) supportive employment for persons with serious mental illnesses and to improve the coordination of psychiatric and vocational services. Locally, services are obtained through joint planning and service efforts by community mental health centers (CMHCs) and local offices of DRS. Supported Employment Services in Illinois are based on the integration of DHS Division of Rehabilitation Services (DRS) funded vocational services/resources with DMH funded mental health treatment and supportive services.

Accomplishments <u>in FY2018</u> included:

- DMH completed the fourth year of the five-year Mental Health Transformation Grant (MHTG) from SAMHSA to enhance state and community capacity to provide and expand evidence-based supported employment programs (EB-SE)/Individual Placement and Support (IPS). The Grant continues to focus on the development of the state infrastructure required to support implementation and sustainability of IPS Supported Employment. The two grant sites, Thresholds Woodlawn and Trilogy Edgewater, continued to focus on recruiting efforts to increase the number of participants served with IPS in Edgewater and Woodlawn in Year 4 of the Grant. Both Teams have served 250 participants in IPS so far. To meet our goals of participants served in IPS by the end of the grant, both teams need to serve a total of 100 more participants. We are very confident they will serve over 350 participants with IPS services before the end of this project. Both sites also continued to provide enhancements to the current IPS model including the integration of physical and behavioral health for IPS clients including *Working and Wellness*

Groups, SAMHSA 8 Dimensions of Wellness Groups, Wellness Recovery Action Plan [WRAP] for Work, and Nutrition and Exercise for Wellness and Recovery [NEW-R] groups, and financial literacy groups. DMH continued to work with the UIC Center on Mental Health Services and Research Policy to collect and analyze data.

- The Illinois Employment First Interagency Council continued to meet on a regular basis with the goals of increasing employment opportunities for persons with disabilities in Illinois.
- On May 7th, The Centers for Medicare and Medicaid Services [CMS] approved Illinois' request for a new 1115 Demonstration Waiver, the *Illinois Behavioral Health Transformation*. This approval is effective from July 1, 2018 to June 30, 2023. The Supported Employment Service Pilot in the 1115 Waiver is not scheduled to begin until the second year of demonstration and should start on July 1, 2019, or shortly thereafter. At this time, DMH waits for further guidelines and instructions from the Illinois Department of Healthcare and Family Services [HFS], our Medicaid Authority, on how the Supported Employment Service Pilot will be administered, what mental health population it will cover, and what specific supported employment services it will cover. DMH is very delighted that the 1115 Waiver was approved and is very hopeful that this Waiver will greatly help with the sustainability and scalability of IPS in Illinois.
- DMH continues to focus on engaging MCOs [in conjunction with HFS] on the business case for IPS by demonstrating cost-savings and healthier outcomes credited to IPS.
- DHS, DMH and DRS continued to work on creating an Administrative Directive for implementing IPS to citizens of Illinois with mental illness. This Administrative Directive establishes the terms and conditions that will guide the partnership and strengthen the collaboration between the Divisions targeted at developing, expanding, and improving opportunities for competitive integrated employment ***by making*** IPS ***accessible to*** citizens of Illinois with serious mental illnesses. The final draft of the Administrative Directive has been completed and sent to DHS General Counsel for final reviews.
- The Illinois Web Portal, "Pathways to Employment – Putting Illinois to Work" is continuing to see fantastic use -- http://www.illinoisips.org. We added more resources to the Web Portal as we view it as a strong IPS workforce development tool and training resource for IPS providers [and community mental health centers wanting to learn more about IPS] to use in addition to the one-on-one technical assistance they receive from Statewide DMH IPS Trainers. We are also making additions to the "IPS for Families and Natural Supporters" section as we want the section to explore the many ways that family, friends, and clients help others to gain and maintain employment. We believe engaging people's natural support systems is key for both mental health recovery and long-term career success.
- DMH has made the decision to host an Illinois IPS Conference in April of 2019. It will be the first IPS conference Illinois has hosted since June of 2013. Just as the 2013 Illinois IPS Conference did, we hope to build upon the momentum and enthusiasm of IPS in Illinois with IPS Providers, Stakeholders, and State Agencies. We have entitled the 2019 conference, "Be Part of Something Greater - IPS". We will use this conference to build the scalability of IPS by not only having IPS

Providers participate, but also inviting community mental health centers and their executive leadership who do not have IPS to participate. We are currently working on the logistics of the conference, guest speakers, and breakout sessions.

- The Division of Mental Health continued to fund 3 DMH IPS Trainer Positions [through agency contracts] to provide IPS technical assistance to IPS Agencies in Regions 1 & 2 in FY 2018 and for FY2019. Two IPS Trainers continue to help implement and provide technical assistance in Regions 1 & 2 and the other IPS Trainer continues to help Agency Drop-In Center Staff improve their skills on engagement on employment, and the role it plays in recovery as part of the Williams/Colbert Consent Decrees. In addition, we have 3 DMH state employees who are also trained and equipped to provide IPS technical assistance to IPS Agencies in Regions 3, Region 4, and Region 5 [one trainer in each Region]. Illinois has a total of 6 IPS Trainers Statewide.
- Technical assistance to increase fidelity to the IPS Supported Employment Model as well as to increase the sustainability and scalability of IPS has increased from 1,695 hours provided to the IPS sites in FY2010 to approximately 7,010 hours provided to over 2,000 staff [including agency IPS provider staff and support personnel, state employees of DHS, HFS, DCEO, DCFS, and community stakeholders] for IPS across the State in FY2018. IPS Technical Assistance Team activities have included:

    - Providing face-to-face individual consultation, teleconference/phone, and large group in-person trainings.
    - Monitoring the performance of IPS Provider Agencies and providing feed-back to improve employment outcomes.
    - Presenting at Statewide Behavioral Health Conferences and National IPS Conferences to increase the knowledge of IPS.
    - Assisting with the development of the web-based IPS Web Portal to further extend training resources.
    - Development of a CY2018 curriculum for Monthly State-wide Technical Assistance Calls and facilitating those calls with topics that focused on improving employment outcomes and integrating employment with Wellness and Recovery.
    - Working with Williams/Colbert Agency Drop-In Center Staff to better educate them on the IPS Model, educate them on the role IPS plays in recovery, and helping improve their engagement skills on talking to consumers about employment.
    - Working to implement Nutrition and Exercise for Wellness and Recovery [NEW-R] statewide by training IPS providers and community mental health centers [CHMCs] to offer NEW-R groups.
    - Collecting and analyzing IPS Data from IPS Providers entered on the DHH IPS/EBSE Web-Based Data System and using that data to improve IPS performance Statewide.

- Many community mental health centers have started to show an interest in offering IPS services to their clients and becoming an IPS Provider. DMH made IPS presentations to the following community mental health centers: Josselyn Center, Kenneth Young Center, Envision Unlimited, Grand Prairie, and Association House in

Region 1[Chicago Land Area]; Alexian Brothers, NorthPointe Resources, Ecker Center, NAMI DuPage and NAMI Barrington Area in Region 2 [Northern Illinois]; Mental Health Centers of Western Illinois in Region 4 [Central Illinois]. DMH is hopeful that these agencies will adopt the IPS model and become IPS Providers.

- The Nutrition and Exercise for Wellness and Recovery [NEW-R] State Steering Committee has continued to develop and help implement NEW-R services throughout the entire State of Illinois. DMH staff, DMH IPS Trainers, DMH CRSS Staff, both SAMHSA Site IPS Team Leaders and Employment Recovery Specialists, and other statewide recovery leaders are on the steering committee. 18 CMHCs [14 of them being IPS sites] are currently offering 24 NEW-R groups to consumers.
- During the 2018 tax season, both SAMHSA IPS Teams [with assistance from the University of Illinois at Chicago (UIC) Grant Evaluation Team], again partnered with Volunteer Income Tax Assistance [VITA] sites at the City Colleges of Chicago to help working clients get their income tax paperwork completed free of charge. A total of 20 consumers utilized the free VITA sites. This is double the number of working clients that used the services last year. We believe due to our better marketing of the VITA program and due to more financial literacy education being offered to clients, we had this great increase. We expect the number of clients using the VITA program to again greatly increase in the 2019 tax season.
- DMH is working with the Illinois Office of the Treasurer to promote Achieving a Better Life Experience [ABLE] accounts with IPS providers for working consumers in IPS. These accounts allow those with disabilities and their families to save for many daily, disability-related expenses on a tax-deferred basis – without limiting their ability to benefit from SSI, Medicaid and other federal programs.

Evidence Based Supportive Employment (EBSE) is still confronting several challenges:

- State infrastructure issues continue to make it difficult to expand access to IPS, including its funding model, data systems, quality monitoring (fidelity reviews), training, and reaching at risk populations. The SAMHSA Transformation grant is still being used to address these state infrastructure issues and to facilitate sustainability and scalability.
- There is still frequent turnover of employment specialists and IPS Supervisors who have had the extensive training and experience required to implement IPS successfully, as well as community support workers and case managers who are instrumental in integrating rehabilitation with mental health treatment thru regular team member contact. This continues to be a challenge to program sustainability.
- Current resources to provide IPS technical assistance are still insufficient to meet the needs of the growing number of IPS teams in the State. It is becoming more challenging to provide IPS trainings, conduct IPS fidelity reviews, and provide one-to-one field mentoring of IPS.
- The DMH IPS Web-based Data System still needs modernization to keep up with growth and data needs.

Total # of Fidelity Sites:	**43**
Total unduplicated # of consumers who received IPS at the fidelity sites:	**3,157**
Total # of Sites not at Fidelity:	**7**
Total unduplicated # of consumers who received IPS at the non-fidelity sites:	**256**
Total unduplicated # of consumers who received IPS:	**3,413**

Priority #4: FEP SET-ASIDE

1. Priority Area: **Use of the 10% Block Grant Set-Aside to implement Specialized Programming and Evidence – Based Services for persons experiencing First Episode Psychosis.**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED, ESMI:	
4. Goal of the priority area: ***Sustain and expand the infrastructure for evidence-based clinical programs for persons with FEP.***	
5. Objective#1: (a) Sustain the 12 teams developed in FY2017 and contingent on available funding, identify a location to develop a new FEP team by the end of FY2019.	
6. Strategies to attain the objective: Provide education, training, and ongoing consultation to staff involved in FEP programs that includes: • Strategies for Outreach and community-based education to attract and retain clients who have recently begun experiencing symptoms of psychosis or serious mental illness; • Assessment and individualized treatment planning with these individuals in the most supportive and least intrusive manner; • Psychiatric evaluation and medication management • Individual Placement and Support (IPS) programs geared towards accessing employment, job retention, and smooth transitional experiences in work life that can increase self-esteem, confidence, and stability in persons experiencing early episodes of serious mental illness. • Supportive education that helps the individual to initiate or continue in his/her educational process. • Family and Individual Psychoeducation • Counseling and Case Management • Cognitive Behavioral Therapy for Psychosis • Analyze needs of geographic areas to identify the best location of a new program • Determine the potential for success and the capacity of the candidate provider based upon criteria for Providers Selection previously formulated by the DMH FEP Team	

7. Annual Performance Indicators to measure goal success: **Indicator #1: (a) Number of sites in the State with funded FEP Programs.** **(b) The total FEP set-aside expenditures by the State for each site**
a) Baseline measurement (Initial data collected prior to and during SFY 2017): **12 funded sites**
b) First-year target/outcome measurement (Progress to end of SFY 2018): **12 Funded sites**
c) Second-year target/outcome measurement (Final to end of SFY 2019): **13 Funded Sites**
d) Data source: The DMH contractual process for this initiative included specified goals, performance measures and performance standards for each participating provider. Data is collected from participating FEP sites on an ongoing basis by statewide coordinators of the program using the Enrollee Outcomes Form which documents the program strengths, the barriers encountered, and the outcomes in terms of number of referrals and number of clients enrolled at each participating site.
e) Description of data: The Enrollee Outcomes format lists all active sites in the State. Records of contracts and funding awards for each agency are maintained by the DMH Fiscal Office. Quarterly Report Performance Forms track Training, Module Advancement, and Employment and IPS/Supported Ed Involvement. Quarterly Expenditure Reports are also completed by FEP agencies and provided to DMH.
f) Data issues/caveats that affect outcome measures: The full potential of the FEP Program may be affected by federal restrictions on eligible diagnosis.
8. Report of Progress toward goal attainment **First year target: __X___ Achieved _____ Not Achieved (If not achieved, explain why)**

5. Objective #2: Improve and maintain quality of clinical services received by FEP clients
6. Strategies to obtain objective; Training in key clinical approaches such as CBT-p, Family Psychosocial Education (FPE), Case Management, Counseling (See strategies for Objective #1) and ongoing technical assistance. Strategies specific to CBT-psychosis: • Training will be 1 full day of CBT-p Skills Training at 2 sites – 1 in Chicago and 1 in Springfield for Downstate Agencies in FY 18. • Follow-up Monthly CBT-p Training calls for all 12 FEP Teams
7. Indicators: (1) Number of training events held each year to increase knowledge and clinical competence in the delivery of FEP services in community agencies statewide. (2) Number of technical assistance meetings and teleconferences conducted by the statewide coordinators.
a) Baseline measurement (Initial data collected prior to and during SFY 2017): During the course of the fiscal year (July 2016 through June 2017), there were a total of 223 Technical Assistance and Consultative meetings between DMH coordinators, the BeST Center, and the 11 provider agencies in various combinations. These meetings included Consultations with each team once every two weeks and a regular conference call with all the team leaders once a month. Additionally, the BeST Center Consultant directly provided 18 FEP Trainings for all newly hired FEP agency staff twice monthly and weekly telephone consultation to the DMH statewide coordinators. The BeST Center's consulting psychiatrist provided three teleconference training sessions and nine learning collaborative calls in psychiatric evaluation and medication management. All meeting calls and training were 1 hour in length.

b) First-year target/outcome measurement (Progress to end of SFY 2018): (a)Training events: 21 including 1 universal event (CBT-p): 12 events for newly hired staff; and 8 training events in Family Psychoeducation. Total = 21 Trainings, (b) TA contacts = 327 including 39 individualized follow-up events for CBT-p
c) Second-year target/outcome measurement (Final to end of SFY 2019): (a) Trainings- 8 Clinical Training events, including 1 CBT-p Training for the 3 new FEP Providers, New Clinical staff IRT Training will occur 4 times during the year. Other new EBP Clinical Training will occur on the topics of Trauma Informed Care, Recovery Support Specialists & WRAP on the FEP Teams. (b) TA contacts = 400 (including 50 individualized CBT-p monthly clinical follow-up Calls to clinical staff) for 15 Providers and up to 3 state coordinators in various combination.
d) Data source: Records of teleconference calls and attendance are maintained by statewide coordinators**.**
e) Description of data: See Above
f) Data issues/caveats that affect outcome measures:
8. Report of Progress toward goal attainment **First year target: ___X__ Achieved _____ Not Achieved (If not achieved, explain why)**

Objective #3 Increase number of FEP enrollees statewide.
Strategies to obtain the objective: • Expand outreach efforts and provide public information about FIRST-II. • Each FEP Site to achieve five Marketing and Outreach events per month • Each FEP Site will achieve a minimum of five new Enrollees per Fiscal Year. • Add at least one additional FEP Site by the end of FY2019.
Indicator #3: Number of clients meeting criteria for FEP enrolled in team services statewide.
a) Baseline measurement (Initial data collected prior to and during SFY 2017): 123 enrolled by 11/30/2017
b) First-year target/outcome measurement (Progress to end of SFY 2018): 150 by June 30, 2018
c) Second-year target/outcome measurement (Final to end of SFY 2019): 225 by June 30, 2019
d) Data source: Enrollment data from each participating site aggregated by statewide coordinator retrieved from Enrollees Outcome Form at Baseline and every 6 months.
e) Description of data: Number of persons meeting eligibility criteria for FEP program enrolled at each site. Target is a minimum of 5 additional FEP Enrollees per Site Per year
f) Data issues/caveats that affect outcome measures: NONE
8. Report of Progress toward goal attainment **First year target: ___X__ Achieved _____ Not Achieved (If not achieved, explain why)**

In FY2018, the three objectives for FIRST.IL have been accomplished and two (Objectives 1 and 3) significantly surpassed the targets! Twelve (12) FEP Teams were projected but 15 Teams had become operational by June 30, 2018. The target was achieved at 125%! The program targeted 150 enrollees and 201 were enrolled by June 30, the end of the fiscal year. Additionally, the program reports 25 individuals who had been enrolled but either graduated or moved out of their service areas and were not carried as enrolled on June 30, 2018. This target was thus achieved at 150.6%!

The targets for training and technical assistance were also met and exceeded. The program provided 24 actual training events (21 were projected) that included 1 universal event (CBT-p): 15 events for newly hired staff; and 8 training events in Family Psychoeducation. There were 327 Technical Assistance consultations provided by the state coordinator staff and staff of the BeST Center in various combinations also significantly surpassing the program expectations for 288 during the course of the year.

Additionally, the program expanded to serving the ESMI population as of January 1, 2018, and 36 individuals with Bipolar Disorder with Psychotic features and Major Depression Disorder with Psychotic features were enrolled by June 30, 2018. The transition of several individuals who moved to areas of another FEP Team was monitored this year. Continuity of care was smooth, well-planned, and caringly implemented so that these persons continued to be successfully served.

Background

Early in FY2017, with technical assistance and consultation of the Best Center, DMH developed the basic infrastructure to initiate and sustain evidence-based clinical programs for persons with FEP in Illinois. By the end of October 2016, programs for persons having experienced an initial psychotic episode were established at 11 mental health agencies in the State. The statewide program has been named FIRST.IL. Outreach, engagement, treatment, and coordination of support services are currently ongoing at each site. Each participating agency site has an identified team leader, and a team that consists of at least one therapist, one case manager, an administrative lead from agency administration, and a medication prescriber. In agencies that provide supported employment services, IPS Specialists are also on the team. Each agency has responded to uniform requirements of contracting with DMH while uniquely developing their team compositions and strengths in their service environments which range from the urban Chicago Metropolitan Area to county-based rural service agencies in Greater Illinois.

In this second year of operation, technical assistance, consultation, and formal trainings were both intensive and extensive. During the course of the fiscal year (July 2017 through June 2018), there were a total of 327 Technical Assistance and Consultative meetings between DMH, the BeST Center, and the 15 provider agencies. These meetings included Consultations with each team once every two weeks and a regular conference call with all the team leaders once a month. The BeST Center Consultant directly provided 18 FEP Trainings for all newly hired FEP agency staff twice monthly and weekly telephone consultation to the DMH statewide coordinators. The BeST Center's consulting psychiatrist provided three teleconference training sessions and nine learning collaborative calls in psychiatric evaluation and medication management. All meeting calls and training were 1 hour in length.

After a full year of outreach to and active engagement of clients reporting an experience of a first episode of serious mental illness, the 15 First-IL sites reported having a cumulative enrollment of 201 clients who met criteria for eligibility for these services. The participating sites and the cumulative number of referrals and enrollees reported by each site are presented in the table below:

Agency	Number of Referrals As of 6/30/2018	Number of Clients Enrolled As of 6/30/2018
Advocate Illinois Masonic Behavioral Health Services, Chicago	52	20
Bridgeway MHC,	26	10
Centerstone	40	20
Chestnut Granite City	54	21
Chestnut Bloomington	0	0
Grand Prairie	68	19
Human Resources Development Institute	48	17
LifeLinks	29	8
Memorial Behavioral Health	56	17
Robert Young Mental Health Center	41	17
Trilogy	123	18
Thresholds – Chicago	80	20
Thresholds – Westmont	65	14
Transitions of Western Ill	2	1
Human Service Center of Peoria	0	0
TOTAL	**682**	**201**

Use of Set-Aside Funding

Set-Aside dollars are paid for:

1. The time and costs of assigning a clinician to become the designated agency staff person with expertise in clinical content and service delivery of ESMI services. Each agency was required to designate or hire at least a 0.5 FTE staff person with requisite clinical credentials to coordinate required service components for clients, to be able to reach out and engage clients in the community, and to provide therapeutic clinical services.
2. The time and costs of assigning a senior level agency staff member to a leadership role in ensuring that functions and operational integrity of the ESMI program are carried out at the agency and in collaboration with the Division of Mental Health.
3. Training, technical assistance, consultation events and sessions to develop expertise in evidence-based clinical approaches most helpful to individuals with ESMI.
4. Development of marketing materials and tools to be used for outreach and engagement of persons with ESMI and their families.

Building upon the training, infrastructure, and service delivery established through the 2015 funding, the dollars from the Ten Percent Set-Aside have been used to promote:

- Expansion of programming (using the model described above) to agencies in Region 5 (southernmost in Illinois) and generally increasing the number of agencies in the State that will have ESMI programs.
- Providing additional funding to agencies to facilitate improved implementation of program components as needed.

- Providing for DMH staff persons to furnish guidance and expertise in developing, monitoring, coordinating, and providing technical assistance to agencies in carrying out programming. In short to become the DMH experts for the provision of evidence-based services to individuals (and families as appropriate) who experience first and early episodes of a serious mental illness.
- Increasing agency participation in: (1) ongoing focused training in ESMI approaches and in related evidence-based components. (2) structuring technical assistance and consultation to meet emerging needs in the areas of program development, service delivery, outreach and engagement approaches, financial supports for treatment, and program sustainability.
- Purchasing special services that are not Medicaid reimbursable.

Non-billable costs are covered by the Illinois Mental Health Block Grant Set-Aside funds. Illinois pays agencies actual costs for those expenses related to training and non-billable time per their submitted invoices up to the maximum of their contract.

The DMH contractual process for this initiative included specified goals, performance measures and performance standards for each participating provider. This combination of data and measures is being utilized to determine the impact of the FIRST.IL initiative.

Several perceived challenges that are being addressed in training and consultation include:

- Working with participating providers to modify the treatment paradigm from a singular focus on agency services for persons with serious and continuous mental illness to include the engagement of persons in acute distress and encountering mental illness for the first time in their lives.
- Assuring the financial support required for agencies to be able to sustain their programs and to serve those individuals who should be served but lack the resources to pay for their services.
- The three new Agency Sites in Illinois have had very little experience in conducting the outreach and engagement activities that are required in the ESMI program. Adaptation and the development of skill in these areas takes significant time and slows down the implementation process.
- Coverage for CSC programming by private insurance has been problematic and only some ESMI services are being paid. In Illinois, current legislation is being considered aimed at improving and streamlining coverage by private insurance.

Priority #5: Access Data/Consumer Satisfaction Survey

1. Priority Area: **Use of Data for Planning**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s)-SMI, SED,	
4. Goal: *Use Quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support.*	
5. Objective: Continue to improve and maintain quality data collection and reporting.	

6. Strategy: Assess access to care by tracking the number of individuals who received treatment partitioned by race, gender and age.
7. Annual Performance Indicators to measure goal success: **Indicator:** **Number of adults and number of children/adolescents receiving services from publicly funded community-based providers.**
a) Baseline measurement (Initial data collected prior to and during SFY 2018): 128,000
b) First-year target/outcome measurement (Progress to end of SFY 2018): 72,500
c) Second-year target/outcome measurement (Final to end of SFY 2019): 72,000
d) Data source: Public funding streams for mental health care in Illinois are currently appropriated to multiple state agencies, one of which is DMH. Providers by contract must submit demographic, clinical information and claims data for all individuals funded by DMH and receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. The public funds appropriated to the State Medicaid Authority, DHFS, are managed separately through MCO contracts. At this point in time, there is not yet one consistent set of data points for comparative use across MCOs that is accessible to DMH. Thus, the data the State Mental Health Authority has access to for planning purposes remains limited.
e) Description of data: Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables
f) Data issues/caveats that affect outcome measures: See section d above.
8. Report of Progress toward goal attainment **First year target: ___X__ Achieved _____ Not Achieved (If not achieved, explain why)**

The target was developed based solely on SMHA claims data and did not include claims data for individuals treated in the public system whose claims are processed by MCOs. Managed Care has been implemented in Illinois for the past three years, with an increasing number of individuals' claims for publicly funded mental health care processed through the MCOs each year. In FY 2017, the SMHA processed claims for 64,403 individuals and the MCOs processed claims for an additional 64,066 for a combined total number of individuals served in the publicly funded mental health system of 128,469 in FY 2017.

Managed Care has been implemented in Illinois for the past three years and an increasing number of individuals are being served by MCOs outside of the SMHA system. It was anticipated that as the number served by MCOs grows, there will be a concomitant decrease in the reported number served in the SMHA public mental health system as has been the case since SFY2015.

DMH funded community providers are contractually required to register all individuals funded with any DMH dollars in the DMH/ASO Community Reporting Information System. All claims are submitted directly to the Department of Healthcare and Family Services Medicaid Management Information Service (DHFS/MMIS). Processing of claims is subject to business rules established by DMH, thus the linkage between

registrations of individuals for services and claims submission is being maintained. DMH reporting standards require full reporting of consumer and service data by community providers. DMH receives claims data on a weekly basis after it is processed and adjudicated by DHFS.

FY2018 MHSIP SURVEY

During FY2018 DMH surveyed 4,447 adult consumers and 1687 Caregivers of Children who received services at DMH funded community mental health centers during FY2017. Most adult respondents reported being generally satisfied with: services they received, access to services, participation in their own treatment planning, and the quality and appropriateness of the services. However, they were generally less satisfied with the results of their treatment including treatment outcomes, daily functioning as a result of treatment, and social experiences. DMH also conducted a perception of care survey of caregivers of children and adolescents who received DMH funded MH services. The process and results for both are reported below.

Adults

The Adult Consumer Survey is part of the Mental Health Statistics Improvement Program (MHSIP) Quality Report performance measures. The surveys address two goals of the Division: data-based decision-making in a continuous quality improvement environment and to enhance and expand the involvement of consumers, families and caregivers in the review, planning, evaluation and delivery of mental health services.

DMH surveyed over 4500 adult consumers who received services at DMH funded community mental health centers. Participants were chosen at random and the survey was sent to their home address. All surveys were confidential. Consumers were asked to rate their experiences on a scale of 1 to 5 whether they agreed or disagreed with 28 statements. Of 4,593 surveys attempted, 4,447 contacts were made, and 497 were completed and returned. The number of responses at nearly 11% was sufficient for statistical purposes to grade services offered. The table below provides an overview of the responses to the areas surveyed.

Areas Surveyed	*% Pos*
Reporting Positively About General Satisfaction with Services	**83%**
Reporting Positively about Access	**79%**
Reporting Positively about Participation in Treatment Planning	**78%**
Reporting Positively about Quality and Appropriateness	**81%**
Reporting Positively about Social Connectedness	**67%**
Reporting Positively about Functioning	**64%**
Reporting Positively about Outcomes	**63%**

Children and Adolescents

The Division adopted the MHSIP: Youth Services Survey for Families to collect feedback from caregivers of children ages 0 – 17 who are receiving community mental health services funded by the DMH. As with Adults, DMH is seeking to maintain the percentage of parents/caregivers reporting positive outcomes through the Youth Services Survey for Families.

The perception of care survey of caregivers of children and adolescents aged 0-17 who received DMH funded MH services was conducted in FY2018. Participants were chosen at random and the survey was sent to their home address. Adolescents aged 12-17 who had fewer than 9 service-days were excluded to protect the privacy of those seeking care before letting their caregiver know. Caregivers who received the survey were asked to rate on a scale of 1 to 5 whether they agreed or disagreed with 28 statements. Of 1,726 surveys attempted, 1,687 were contacted, and 129 were completed and returned. This 8% response rate was considered to be large enough sample for a statewide evaluation. The characteristics of the children of the respondents were the same as the characteristics of the total population served. The table below provides an overview of the responses to the areas surveyed.

Domain	***% Pos***
Reporting Positively About Cultural Sensitivity of Providers	82%
Reporting Positively about Participation in Treatment Planning	72%
Reporting Positively about Social Connectedness	81%
Reporting Positively about Access	69%
Reporting Positively about Overall Satisfaction with Care	68%
Reporting Positively about Functioning	57%
Reporting Positively about Outcomes	58%

Priority #6 Justice: Mental Health Juvenile Justice Program (MHJJ)

Priority Area: Maintain effective systems to serve the forensic needs of justice–involved consumers of services.	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED, OTHER:	
4. Goal of the priority area: *Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.*	
5. Objective; Provide an alternative to incarceration for youth with SED and link them to community based service that addresses their unique needs and strengths.	
6. Strategies to attain the objective: Maintain the Mental Health Juvenile Justice Initiative.	
7. Annual Performance Indicators to measure goal success: Indicator 2: **Number of youth served by the MHJJ Program statewide.**	
a) Baseline measurement (Initial data collected prior to and during SFY 2017): **209 enrolled in FY2017**	
b) First-year target/outcome measurement (Progress to end of SFY 2018): **200 youth to be enrolled in FY2018**	
c) Second-year target/outcome measurement (Final to end of SFY 2019): **200 youth to be enrolled in FY2019**	
d) Data source: MHJJ Program Data Base maintained internally by DMH oversight staff	
e) Description of data: Aggregate the number of youth receiving services from the Mental Health Juvenile Justice program across the year that will be compared to data from subsequent years.	
f) Data issues/caveats that affect outcome measures: None	
8. Report of Progress toward goal attainment **First year target: ___X__ Achieved _____ Not Achieved (If not achieved, explain why)**	

This strategy was very successfully accomplished in FY2018 and the target of 200 youth to be enrolled was extensively exceeded! By the end of the fiscal year 693 youth were enrolled.

Although fiscal and clinical resource limitations and reductions continued to exist in FY2017, the MHJJ Program expanded significantly in FY2018. During FY2018 there were 20 agencies operating the MHJJ program, up from the 14 agencies that had provided services earlier in FY2017. There were several new agencies that providing MHJJ services and some legacy agencies that had more robust staffing than in previous fiscal years which contributed to the significant increase in MHJJ program activity.

MHJJ continues to successfully identify youth in the juvenile justice system with serious mental illness, treat the youth in the community, improve the youth's overall functioning and support the youth from re-arrest.

The Table below offers a comparative view of activity in the program since FY2014. Compared to FY2014, the number of youth actually enrolled in the program and receiving treatment services designed to avert re-arrest, reduce the intensity of their emotional disturbance, and improve their functioning and quality of life had increased by 44% in FY2016 and the re-arrest rate dropped by 7% in FY2015[i]. The DMH contract with Northwestern University to evaluate the program was discontinued in FY2017 and the data website has been largely non-functional. As a result, more recent information about linkage and re-arrest rate is not currently available.

FY 2014	Screened	Eligible	Enrolled
	272	252	230
FY 2015	Screened	Eligible	Enrolled
	346	311	311
FY 2016	Screened	Eligible	Enrolled
	341	346	331
FY2017 Projected Based upon 14 (down from 20) agencies operating MHJJ	300	289	280
FY2017 Actual	**222**	**214**	**209**
FY2018 Actual	**927**	**748**	**693**

	FY'14	**FY'15**	**FY'16**	**FY'17**
Linked to services	91.27%	97.11%	79.0%	N/A
Re-arrest rate[ii]	22%	15%	N/A	N/A

Background

The Mental Health Juvenile Justice (MHJJ) program was designed to divert youth with serious emotional disturbances out of the juvenile justice system and into community-based care. Initially funded in CY2000 as a pilot project in just seven counties, the MHJJ program expanded to covering 29 Illinois counties, involving 20 community agencies statewide, and services provided by an estimated 60 clinicians in FY2015. The program has always sought to maintain the number of available providers.

The MHJJ program is overseen through the DHS/DMH Forensic Services Program, aims to strengthen the linkages among the courts, probation, detention, schools, mental health, and other community-based services, and recognizes that family engagement at all levels is vital to achieving best outcomes. Whenever any court personnel (Judge, attorney, probation officer, detention center staff) refers a minor who is in detention, a liaison (a masters level clinician from a community agency), with parental consent, will assess that child. These specially-trained MHJJ liaisons screen the youth for the presence of a serious mental illness such as a major affective disorder or psychosis and a functional assessment

is conducted to identify areas of functional impairment as well as areas of strength that can be leveraged in the development of an individualized action plan. Should that child have a major mental illness (with psychotic or affective disorders), the liaison will work with the family to identify appropriate community services (using a wraparound model that includes mental health, medication, substance abuse, special education and public health services). Based on this action plan, youth are linked with appropriate community-based services. MHJJ liaisons continue to monitor the progress of each youth for a period of six months. DHS provides funding for MHJJ to the community agencies from state general revenue funds (GRF). Most agencies receive funding for one liaison. Flexible spending funds may be budgeted to supplement the youth's ancillary treatment services or family stabilization if no other source of funding is available. A number of MHJJ agencies have been able to offer parent to parent support through their Family Resource Developers. MHJJ is a simple model that can be expanded to these and other juvenile justice populations and is applicable in multiple settings (urban, suburban and rural) as it makes use of existing community services at no cost to the courts.

In FY2016, the MHJJ Program expanded its eligibility criteria to include youth who are "at risk" of coming into contact with the criminal justice system. "At risk" youth have a mental illness or symptoms, may have had ancillary contact with police (e.g., school resource officers, station adjustments, and are not receiving necessary services and/or any type of intervention that could divert them from becoming more involved in the criminal justice system. As a result of this expansion, wards of the Illinois Department of Children and Family Services (DCFS) who have become justice involved and need the kind of services and monitoring for the courts that MHJJ provides, youth with mental illnesses who may have had ancillary contact with police (e.g., school resource officers, station adjustments) and would benefit from MHJJ services, and youth with significant trauma histories/symptoms who have come into contact with the justice system are now eligible.

MHJJ continues to emphasize targeted outreach to, and education of, referral sources of minority youth with serious mental illnesses. As research has shown that an estimated 75% of children in the juvenile justice system have experienced traumatic victimization, the MHJJ program has recently moved into the delivery of Trauma Informed Care as a priority for the youth it serves.

In FY2019, it is expected that the MHJJ program will change significantly due to the emergence of the Integrative Health Home (IHH). The overall purpose of MHJJ will remain, but the role of liaisons and the assessment process will shift. The model will involve outreach to justice involved and at-risk populations and coordination and collaboration with MCO's and IHH's to assist eligible youth with linkage to appropriate clinical services.

Priority #7: Recovery/Consumer Services

1. Priority Area: **Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED OTHER (Adolescents with SA or MH, Students in College, LBGTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities	
4. Goal of the priority area: *Establish and enhance the public mental health system of care based upon principles of Recovery and Resilience in which consumers and families are knowledgeable and empowered to participate and provide direction at all levels of the system and peer-run programs are increasingly utilized.*	

Certified Recovery Support Specialist Certification

5. Objective #1: Continue work to increase the number of Certified Recovery Support Specialists and to facilitate their deployment statewide.
6. Strategies to attain the objective: **Strategy #1:** Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting training for consumers and providers to help increase agencies' understanding of the role, value, function, and advantages of hiring CRSS professionals and by providing competency training events for individuals interested in the CRSS credential.
7. Annual Performance Indicators to measure goal success: **Indicator #1: Number of training events held each year to increase stakeholder understanding of the CRSS credential and to increase competency in CRSS domains.**
a) Baseline measurement (Initial data collected prior to and during SFY 2017: **15**
b) First-year target/outcome measurement (Progress to end of SFY 2018): **9**
c) Second-year target/outcome measurement (Final to end of SFY 2019): **9**
d) Data source: **Document each training event and aggregate by year for comparison across years.**
e) Description of data: Training agenda and attendance sheets documenting participation for each training event held.
f) Data issues/caveats that affect outcome measures:
8. Report of Progress toward goal attainment **First year target: __X___ Achieved _____ Not Achieved (If not achieved, explain why)**

The continuing expansion of the Certified Recovery Support Specialist (CRSS) certification was effectively addressed in FY2018.

Nine training events were held in SFY2018. Six competency training events based on a two-day curriculum were held at three locations in the State. with a total of 325 participants and three CRSS Ethics Workshops were held at the same locations in August 2017 with 325 registered participants.

As of August 2018, 233 individuals with CRSS certification were active in the State, an increase of 25 more individuals since June 2017, and all were in good standing with the Illinois Certification Board (ICB). An additional six individuals are in the application process. This reflects a 34.6% increase in the number of CRSS certified individuals since July 2015, when 173 individuals with CRSS certification were active in the State.

On October 5, 2018 Governor Rauner recognized the contribution and accomplishments of Recovery Support Specialists in Illinois by proclaiming October 2018 as RECOVERY SUPPORT CELEBRATION MONTH in Illinois, "celebrating Recovery Support Specialists as they are increasingly integrated into the fabric of our workforce and the landscape of our lives."

The Certified Recovery Support Specialist (CRSS) is a credential for those persons with lived experience who provide mental health or co-occurring mental illness and substance abuse peer support to others using unique insights gained through their personal recovery experience. The CRSS credential assures competence in advocacy, professional responsibility, mentoring, and recovery support. Certified Recovery Support Specialists have the ability to infuse the mental health system with hope and empowerment, and improve opportunities for others to:

- Develop hope for recovery
- Increase problem-solving skills
- Develop natural networks
- Participate fully in the life of the community.

The Illinois Model for Certified Recovery Support Specialist (CRSS) was developed through the collaboration of the Illinois Certification Board (ICB), the DHS Divisions of Mental Health (DMH), Rehabilitation (DRS), and Alcoholism and Substance Abuse (DASA). The credential has been accessed through the ICB since July 2007. Individuals are certified as having met specific predetermined criteria for essential competencies and skills. Individuals attending consumer conferences, statewide consumer education and support teleconferences, and regional WRAP Refresher trainings, receive CEU's toward achieving or maintaining their credential through the ICB.

The DMH Office of Recovery Support Services continues to work with other system partners, including the ICB and the Mental Health Collaborative for Access and Choice (MHCAC), to:

- Disseminate public information about the credential;
- Develop training curricula, and study materials for those seeking to obtain their CRSS credential;
- Plan and conduct Webinars and other training events for provider agencies to help increase agencies' understanding of the role, value, function, and advantages of hiring CRSS professionals.

These efforts have proven to be fruitful. The number of individuals in the State possessing the credential, active in the State, and in good standing with the Illinois

Certification Board (ICB) has steadily increased since October, 2013. The aim of DMH is to continue to increase the number certified Recovery Support Specialists in Illinois.

Wrap Training

5. **Objective #2: Increase the use and efficacy of the WRAP model**
6. **Strategy #2:** Enhance competency and encourage WRAP trained and certified facilitators to provide an increasing number of WRAP® classes in the State.
7. Annual Performance Indicators to measure goal success: **Indicator #2:** **(a) Number of WRAP Refresher trainings offered statewide each year** **(b) Number of WRAP participants each year**
a) Baseline measurement (Initial data collected prior to and during SFY 2017: **15**
b) First-year target/outcome measurement (Progress to end of SFY 2018): **20**
c) Second-year target/outcome measurement (Final to end of SFY 2019): **20**
d) Data source: Document each training event and aggregate by year for comparison across years.
e) Description of data: Training agenda and attendance sheets documenting participation for each training event held.
f) Data issues/caveats that affect outcome measures: None
8. Report of Progress toward goal attainment **First year target: ___X__ Achieved _____ Not Achieved (If not achieved, explain why)**

WRAP Refresher Training was successfully accomplished in FY2018. Sixteen refresher courses were conducted at 6 sites in the State. The courses for Regions 3&4 that had been planned separately were actually combined in four courses at one site. The total number of participants was 277. Detail is provided in the table below.

Region	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
1	7	9	16	10
2	11	6	19	30
3&4	17	30	28	27
5	18	21	8	20
Total # participants:	**53**	**66**	**71**	**87**

As of June 2018, 526 individuals have been trained and certified as WRAP Facilitators in Illinois. Of those, 214 (40.6%) are actively participating in Refresher Training.

Background

The Wellness Recovery Action Plan (WRAP) model is well established in Illinois. DMH Recovery Support Services provides annual WRAP® Facilitator Training and has trained over 400 people how to deliver WRAP® statewide since 2002. Through WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this evidence-

based practice in recovery-oriented services. A recently recognized evidence-based practice, WRAP® is a multi-week program led by certified facilitators. WRAP® teaches people living with mental illnesses how to identify and use illness self-management resources and skills that help them stay well and promote their recovery. Studies show that WRAP® improves participants' quality of life and reduces their psychiatric symptoms. The community support services WRAP® facilitators provide are Medicaid-reimbursable, making WRAP® an affordable program for many agencies. However, the majority of individuals who have completed WRAP® Facilitator Training have not gone on to provide WRAP® classes. DMH Recovery Support Services (RSS) continues to work on increasing the number of trained facilitators who are providing WRAP® classes and increase access to WRAP® Facilitator Training in Illinois.

Peer Respite Programs

5. Objective # 3: Develop and establish infrastructure for the introduction and implementation of Peer Respite (Wellness) programs in Illinois.
6. Strategy #3: Provide educational events and technical assistance to encourage consumer participation and advocacy and public education to promote this model.
7. Annual Performance Indicators to measure goal success: **Indicator #3:** **(a) Number of educational events and/or technical assistance appointments regarding Peer Respite (Wellness) held each year.** **(b) Number of programs opened during the year.**
a) Baseline measurement (Initial data collected prior to and during SFY 2017: **Not Applicable - New Objective for FY2018-FY2019**
b) First-year target/outcome measurement (Progress to end of SFY 2018): **5**
c) Second-year target/outcome measurement (Final to end of SFY 2019): **5**
d) Data source: Training Agendas and attendance sheets documenting participation.
e) Description of data: Agendas for each event and Attendance Sheets
f) Data issues/caveats that affect outcome measures: None
8. Report of Progress toward goal attainment **First year target: __X___ Achieved _____ Not Achieved (If not achieved, explain why)**

This objective has been successfully accomplished!
Educational events were held in three sites (north, central, south) to introduce the model to the recovery community. A total of 400 individuals participated in these events statewide.

Additionally, a standardized training was developed to provide technical assistance and support for organizations seeking to develop a Peer Respite, and DMH Recovery Support Services provided training for five organizations.

Peer Respites are one option in the continuum of care for individuals experiencing mental health crises. Peer Respites stand out from other options on this continuum in large part because individuals access them by choice. One of the standards of practice for Peer Respites across the nation relates to the voluntary nature of their services: individuals are "self-referred".

To gain a greater understanding of the commonalities among these programs across the states, as well as their uniquenesses, DMH Recovery Support Services began researching the Peer Respite model in 2017.

The Peer Respite model continues to be considered a valuable potential addition to the continuum of care for individuals experiencing mental health crises in Illinois. DMH Recovery Support Services will continue to offer educational events and technical assistance for any organization seeking to establish a Peer Respite in Illinois.

Consumer Education Teleconferences

5. **Objective #4: Continue to inform and empower consumers and families.**
6. **Strategy #4:** Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and families across the State.
7. Annual Performance Indicators to measure goal success: **Indicator #4:** **Number of statewide teleconferences held each year. Number of participants per teleconference.**
a) Baseline measurement (Initial data collected prior to and during SFY 2017): **10**
b) First-year target/outcome measurement (Progress to end of SFY 2018): **10**
c) Second-year target/outcome measurement (Final to end of SFY 2019): **10**
d) Data source: Document each teleconference event and aggregate by year for comparison across years.
e) Description of data: Teleconference agendas
f) Data issues/caveats that affect outcome measures: None
8. Report of Progress toward goal attainment **First year target: __X___ Achieved _____ Not Achieved (If not achieved, explain why)**

This strategy was successfully achieved in FY2018. Ten teleconferences were conducted in FY2018 with an attendance ranging from 291 to 416 persons per call and an aggregate attendance of 3,515. The dates, topics, and number of participants of each teleconference are detailed in the table below.

Adult Consumer Education Teleconferences in FY2018

Date of Call	Topic	Number of Participants
7/27/17	It's All about Relationships!	386
8/24/17	Budget for your Personal and Financial Success!	310
9/28/17	You can Conquer the Challenge of Change!	404
10/26/17	Nurture Your Physical Self!	388
01/25/18	Stories of Encountering and Overcoming Obstacles	365
02/22/18	Realizing our Power to Bounce Back	416
03/26/18	Discovering the Giving and Receiving of Support	308
04/26/18	Recognizing Learning Opportunities	291

05/22/18	Identifying Personal Steps to Move Forward	304
06/28/18	Locating Resources to Enhance Our Wellness	343

For many years, DMH has recognized the need for providing consumers with the tools they need to cogently and effectively participate in the development and evaluation of the service system. The primary focus has been to ensure that consumers of mental health services receive current, accurate, and balanced information regarding changes in the service delivery system that empowers them to take an active, participatory role in all aspects of service delivery. These calls provide a forum for discussion of information about a range of services and approaches that has included integrated health care, crisis planning, and personal wellness; new developments such as changes in service policies and procedures; and emerging issues such as thriving in challenging economic times, using presentations that are designed to advance consumers' awareness and knowledge.
of agencies that hire CRSS professionals.

Priority #8: C&A Services

1. Priority Area: **Lead in the development and implementation of statewide, unified, state –of –the-art Child and Adolescent Services to promote optimal social and emotional development for all children, adolescents, and young adults with behavioral health needs.**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SED, ESMI, Other: (Adolescents with SA or MH, Students in College, LBGTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)	
4. Goal of the priority area: ***Integrate a State of the Art Behavioral Health System in Illinois that ensures service delivery based on Systems of Care Values and Principles, family driven, and emphasizes services that are evidence-based.***	
5. Objective #1: Identify and establish the most appropriate and best criteria for diagnostic assessment of children from birth through age five that should be consistently used by community child and adolescent mental health providers.	
5. Strategies to attain the objective: a. Review options and determine if a manual will be adopted for use across Illinois. b. Develop/adopt a DSM 5-ICD 10 crosswalk for the diagnosis and billing codes. c. Identify and implement changes to the DMH reporting system. d. Collaborate with other systems that will be impacted by these changes. e. Determine any training and technical assistance needed to implement the goals and objectives. I	
Annual Performance Indicators:	

Indicator #1: Diagnostic criteria for the assessment of children from Birth to age 5 is adopted and implemented by community providers by the end of SFY2019.
a) Baseline measurement (Initial data collected prior to and during SFY 2017): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2018): **A DSM 5-ICD 10 crosswalk for the diagnosis and billing codes is drafted and adopted. (Contingent on the ICD-10 being adopted)**
c) Second-year target/outcome measurement (Final to end of SFY 2019): **The set of diagnostic criteria has been piloted and is utilized by community providers.**
d) Data source:
e) Description of data:.
f) Data issues/caveats that affect outcome measures:
8. Report of Progress toward goal attainment **First year target: _____ Achieved ___X__ Not Achieved (If not achieved, explain why)**

HFS did not accept the recommendations for using a DSM-5/ICD-10 crosswalk for the diagnosis and billing codes for children Birth to Age 5 as part of the revision of their services rule (Rule 140). DMH was able to include language that assessment and treatment must be provided in a developmentally appropriate manner in our Administrative Rule 132, the Rule for Certified Community Mental Health Centers.

5. Objective #2: Identify policies and resources necessary to assist Child and Adolescent mental health providers in moving towards a value-based purchasing system.
6. Strategies to attain the objective: a. Review clinical outcomes tools that need to be added to the Datstat System to assist providers in measuring improved clinical outcomes for children, adolescents, and families. b. Initiate and make the necessary changes to the Datstat System to incorporate the new tools. c. Determine any training and technical assistance needed to assist providers in the utilization of the tools and understanding how to measure outcomes.
7. Indicator #2: By the end of FY2019, the DATSTAT System will incorporate tools for measuring clinical outcomes that will enable C&A providers to be successful in a value based purchasing system
a) Baseline measurement (Initial data collected prior to and during SFY2017): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2018): **A set of clinical outcomes tools that need to be added to the Datstat System to assist providers in measuring improved clinical outcomes for children, adolescents, and families is drafted and reviewed.**
c) Second-year target/outcome measurement (Final to end of SFY 2019): **Providers receive training and technical assistance in the utilization of the tools in measuring outcomes.**
d) Data source: Changes to DATSTAT System include operational outcome measure tools. Provider attendance in training sessions
e) Description of data: Attendance records of training and technical assistance sessions that support providers reporting usage of the outcome measures.

f) Data issues/caveats that affect outcome measures:
8. Report of Progress toward goal attainment **First year target: __X___ Achieved _____ Not Achieved (If not achieved, explain why)**

This target which called for the drafting and review of a set of clinical tools that would be implemented and included in the Child and Adolescent Data System within two years by the end of FY2019 has been <u>superseded and already largely achieved</u> through the adoption of the IM-CANS as the statewide comprehensive assessment tool. The IM-CANS is a standardized assessment and service planning tool that will identify an individual's integrated healthcare needs and strengths across all life domains and recommend the service needs required to achieve the amelioration of a client's condition and improvement in well-being. IDHFS, the State Medicaid Authority, is now requiring the use of the IM-CANS as the tool to communicate the comprehensive assessment results of the global needs and strengths of individuals who require mental health treatment funded through Medicaid in Illinois. Given the considerable resources required to implement this mandate, it was determined that the roll out of additional mandatory clinical measures at this time would be administratively burdensome to providers. However, DMH is proceeding forward with the identification of additional clinical tools available for the assessment of children and youth which can be useful to providers and support treatment and service process for children and families. Such tools, while not mandated, would allow for a more thorough clinical assessment that can then be summarized within the IM-CANS.

5. Objective #3: Develop a trauma informed credential for C&A mental health providers similar to the trauma credential that has been developed by the Department of Children and Family Services (DCFS).
6. Strategies to attain the objective: a. Review the current DCFS trauma credential and determine if it is consistent with the needs of the larger community based system. b. Review what other states have adopted related to trauma informed credentials for providers. c. Develop an Illinois specific trauma informed credential. d. Determine any training and technical assistance needed to implement the credentialing process. e. Develop an implementation plan. f. Implement the plan.
Indicator #3: By the end of FY2019, specified curriculum-based or evidence-based trauma-informed credentialing will be available in Illinois.
a) Baseline measurement (Initial data collected prior to and during SFY 2017): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2018): **The written set of requirements, privileges, and applications of a trauma –informed credential is developed, drafted and adopted.**
c) Second-year target/outcome measurement (Final to end of SFY 2019): **The credentialing process is implemented as evidenced by the number of providers applying for the credential or having been successful in obtaining the certification.**

d) Data source: The implementation plan for initializing the use of the credential.
e) Description of data: Documentation of completion of steps necessary to implement the new credential.
f) Data issues/caveats that affect outcome measures:
8. Report of Progress toward goal attainment **First year target: ___X__ Achieved _____ Not Achieved (If not achieved, explain why)**

The Division of Mental Health collaborated with DCFS on rolling-out the National Adoption Competency Mental Health Training Initiative for Mental Health Professionals. This training, which results in 25 Continuing Education Credits and a competency certificate, consists of 10 modules focused on enhancing the competency for mental health professionals providing therapeutic or clinical services to at risk children youth and families who experience adoption, guardianship, or family disruption issues. Imbedded in this training is a Module entitled Trauma and the Impact of Adverse Experience on Brain Development and Mental Health.

Background:

Due to the extensive reform efforts that were initiated in FY2016-FY2017 in Illinois, that included the roll-out of the Health and Human Service Transformation Initiative, Governor's Children's Cabinet, and the EPSDT Litigation settlement, all of which will impact the development of a new service array and assessment process. Throughout all of these change efforts the Division of Mental Health (DMH) has taken a leadership role to ensure Systems of Care values and principles are the foundation for the strategic planning and implementation process. DMH C&A Services is working strategically in Illinois to ensure that Systems of Care values and principles are the foundation for the strategic planning and implementation process.

On February 18, 2016 Governor Bruce Rauner signed an Executive Order creating the Governor's Cabinet on Children and Youth (aka Children's Cabinet). This Cabinet was charged with the creation of a strategic vision for education, health, and human services to reduce the fragmented system that currently exists, while working to effectively identify and address any barriers to agency collaboration. This Cabinet provides funding and policy recommendations while promoting awareness of important issues facing children, adolescents and their families.

Illinois has been engaged in Health and Human Services Transformation that is designed to place a unique focus on prevention and public health; on paying for value and outcomes rather than volume; developing services that are evidence-based and data-driven; and moving the individual from institutional care to community care. This Transformation process is designed to develop a primer Health and Human Service System in Illinois which functions across the life span. Many members of the facilitation team are involved in the process and have been working to ensure systems of care values and principles are embedded into the work. To support this transformation, the Department of Healthcare and Family Services collaborated with 11 other state agencies developed an 1115 Medicaid demonstration waiver that has been approved.

A core team of individuals representing the Departments of Children and Family Services, Healthcare and Family Services, and Human Services, has worked collaboratively with John Lyons on the development of the IM-CANS (Illinois Medicaid Comprehensive Assessment of Needs and Strengths). This lifespan tool includes a physical health risk assessment so that physical health and mental health can both be addressed.

In April 2016, the six child serving systems in Illinois signed an Intergovernmental Agreement to address the mental health needs of Children and Adolescents that are at risk for psychiatric lock-out. The first accomplishment was the development of the Specialized Family Support Program Consent that allows the family to sign one consent to share information across the Departments. This "Universal Consent" is the first of its kind in Illinois and meets not only HIPPPA, but also FERPA and the Illinois Mental Health Confidentiality requirements. To date, the program group has experienced many accomplishments including the identification of the population of focus and the "front door" for entering the program.

On April 3, 2017 the six child serving systems in Illinois began accepting referrals into the Specialized Family Support Program. This program is designed to deflect eligible youth from entering DCFS care solely to obtain behavioral health treatment; provides crisis stabilization services to children at risk of custody relinquishment and their families; determines the most appropriate treatment services for the eligible population through a comprehensive, standardized assessment process; and links eligible youth and their families to services at the right intensity and level of care in a timely manner. Since the beginning of the program, there has been 44 children and adolescents referred to the program. The average age of referred youth is 15, and no children under the age of 10 have been referred.

The Illinois Children's Healthcare Foundation (ICHF) has recently announced their Children's Mental Health Initiative 2.0. This ten million dollar investment will begin with the funding community level collaborative to develop a formal implementation strategy, coordinated governance and a sustainable financial model over one year based on a System of Care philosophy. Once the communities have completed their plans, the ICHF will initiate phase two, where it will be determined which plans will receive financial support for an additional 6 years of implementation. The DMH will collaborate with these sites and ICHF to provide the necessary technical assistance and supports to expand the work to additional communities.

There are two local community SAMHSA Systems of Care grants in Illinois and the DMH will be working collaboratively with those sites also the ICHF sites to develop a learning collaborative, so the sites can learn from each other.

Priority #9: Community Integration

1. Priority Area: **Advancement of Community Integration**	**2. Priority Type:** **MENTAL HEALTH SERVICES**
3. Population(s) SMI, OTHER:	
4. Goal of the priority area:	

Complete the successful transition of residents of long term nursing homes with diagnosed SMI from this level of care to less restrictive settings, ideally, independent living in their communities with appropriate and necessary support services.
5. Objective: Transition up to 400 additional Williams Class Members each year before the sunset of the Consent Decree.
6. Strategies to attain the objective: **Through FY 2018, and perhaps beyond, through the provision of open market units rent subsidies Permanent Supportive Housing (PSH), Cluster Housing PSH models, 24 hour supervised residential settings and Community Integrated Living Arrangements (CILA), implement the transition of residents (Williams Class Members) from 24 designated Nursing Facilities (NF) (statewide) categorized as Institutes for Mental Disease (IMD) to permanent supportive housing or other housing alternatives that are safe, affordable housing and provide support services in communities of preference in a manner consistent with the national standards for this evidence based supportive housing practice.**
7. Annual Performance Indicators to measure goal success: **Indicator: Number of consumers who transition from long term institutional settings/IMDs who access appropriate permanent supportive housing or other housing options. (National Outcome Measure)**
a) Baseline measurement (Initial data collected prior to and during SFY 2017): The number of consumers transitioned by the end of SFY2017: 380 Class Members were transitioned as of June 30, 2017.
b) First-year target/outcome measurement (Progress to end of SFY 2018): 400 additional consumers were targeted by the end of SFY2018. 315 Class Members were actually transitioned to the community.
c) Second-year target/outcome measurement (Final to end of SFY 2019): 400 Class Members projected to be transitioned at the end of SFY2019. **NOTE: The Williams vs. Rauner Consent Decree was originally slated to sunset in 2016. The activities of this Consent Decree continued through FY2019 and are anticipated to be budgeted for FY2020. Continuation after the FY2020 will be dependent on negotiations between the Court Monitors, Plaintiffs' attorneys, and the court decision.**
d) Data source: Number of Williams Class Members receiving PSH Bridge Subsidies. **Note: PSH Bridge Subsidies are only available to Williams Class Members and Front Door Diversion participants.**
e) Description of data: The data for this indicator is generated from permanent supportive housing applications and subsidies paid for rental units
f) Data issues/caveats that affect outcome measures: Continuation after the FY2020 fiscal year will be dependent on negotiations between parties and the court decision.
8. Report of Progress toward goal attainment **First year target: _____ Achieved ___X__ Not Achieved (If not achieved, explain why)**

This strategy continued to be substantively addressed and accomplished in FY2018 with the transition of 315 class members from IMDs to permanent supportive housing (safe and affordable housing and support services) in communities of their preference in a manner consistent with the national standards for supportive housing practice. The numerical target of 400 for the year was 79% attained.

As of October 30, 2018, an additional 59 Class Members have been transitioned to the community, either to PSH units or to residential type settings. The goal for FY2019 is to meet the projected two-year cumulative transition total of an additional 800 Class Members.

Background: The Williams Consent Decree

The *Williams* vs. Quinn (Williams vs. Rauner) Class Action lawsuit was filed in 2005 and settled in 2010. The suit targeted an estimated 4,500 residents of former skilled nursing facilities (SNF) designated as Institutes for Mental Disease (IMDs), now classified as Specialized Mental Health Rehabilitation Facilities (SMHRFs), defined as having more than 50% of the residents with a diagnosed mental illness. The suit contended that the State violated the rights of residents by not affording them opportunities to move from these settings to the community, specifically to their own leased held apartments. The Williams Implementation Plan may be accessed at:
http://www.dhs.state.il.us/page.aspx?item=56446

The state is now entering into the ninth year of the original five-year settlement. Since implementation, 2,324 residents of SMHRFs/IMDs have been transitioned to the community. The majority of Class Members were afforded an opportunity to move into lease-held apartments made possible by the Permanent Supportive Housing model with a bridge subsidy. Others were transitioned to other housing options as appropriate to their needs. In SFY2018, the governor's introduced budget identified $44.7 million dollars to build the infrastructure for transitioning Williams Class Members and to support the development of permanent supportive housing units with an array of service supports necessary for successful transitions. The final spending for FY2018 was approximately $37.6 million dollars.

The FY2019 Governor's Introduced Budget includes $44.6 million in General Revenue funds dedicated to expanding home and community-based services and other transitional costs associated with the consent decree implementation.

Eight community mental health centers provide a full array of services and supports, including Assertive Community Treatment (ACT) and/or Community Support Teams (CST) An additional seven agencies provide transition coordination services and case management only.

The Illinois Housing Development Authority (IHDA), the Corporation for Supportive (CSH) Housing and Governor's Housing Coordinators, in partnership with DHS, have worked with developers, real estate companies and landlords to increase housing stock. In the process of transitioning interested Class Members to community housing, it is expected that the chosen community service providers will assure the provision of coordination services during transition that include: assistance with the housing search; developing a comprehensive individualized service plan that includes a risk mitigation plan and a 24 hour emergency back-up plan; assuring that entitlements are transferred and in effect; assistance with purchasing furniture and supplies; and, most importantly, assuring that

linkages are completed for requisite services, especially needed mental health services as well as medical and other necessary services and supports.

IHDA currently manages the HUD 811 project-based vouchers. There are 195 HUD 811 units available for Class Members across the Consent Decrees, as well as individuals through the Front Door Diversion Project (diverting from admission to Long Term Care).

Priority #10: Mental Health and the Military

1. Priority Area: **Coordination and facilitation of mental health services for Illinois Servicemembers, Veterans, and their Families (SMVF).**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) OTHER Service Members , Veterans, and their Families (SMVF) requiring mental health services:	
4. Goal of the priority area: ***Collaborate with military and state agency partners to improve access to home and community-based mental health services for service members, veterans, and their families.***	
5. Objective #1: Sustain a coordinated system of care	
6. Strategies to attain the objective: a). Develop and maintain partnerships with the Department of Veterans Administration, the Illinois Departments of Veterans' Affairs (IDVA), and Military Affairs (IDMA), and other agencies and organizations meeting regularly to develop, establish and maintain a coordinated system of care. b). Develop an inventory of existing behavioral health system providers and services to provide a referral system. c). Build a coordinated crisis service intervention system between the VA and community providers, with special emphasis on suicide prevention.	
6. Annual Performance Indicators to measure goal success: **Indicator #1: The number of collaborative meetings attended by DMH staff representatives that have agendas aimed at completing the strategies and coordination of services.**	
a) Baseline measurement (Initial data collected prior to and during SFY 2017): 12 were targeted in FY2017 but DMH staff actually participated in 28 meetings. The DMH manager originally assigned the responsibility for this priority retired in December 2017 and two DMH staff who are both veterans are now assigned joint responsibility for this priority.	
b) First-year target/outcome measurement (Progress to end of SFY 2018): **By the end of FY2018, twelve collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of services.**	
c) Second-year target/outcome measurement (Final to end of SFY 2019): **By the end of FY2019, twelve collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of existing services.**	
d) Data source: Meeting Minutes and records of DMH staff members assigned to this collaborative task.	
e) Description of data: See Above.	
f) Data issues/caveats that affect outcome measures: None.	
8. Report of Progress toward goal attainment **First year target: ___X__ Achieved _____ Not Achieved (If not achieved, explain why)**	

During FY2018, efforts to build and maintain an effective system of care to meet the needs of service men and women, veterans, and their families has been ongoing. Three objectives have been substantively addressed and two of the targets have been met.

Additionally, Illinois has approved the Certified Veterans Support Specialist (CVSS) credential. – A conversation is ongoing regarding the creation of a bridge for current CRSS credential holders who are veterans to be able to obtain the CVSS with minimal additional training and how to ensure that holders of the credential can receive compensation thru Medicaid which will require an amendment to the state spending/ appropriations plan.

Objective #1 – Sustain a coordinated system of care – this objective has been achieved. During the course of FY2018 DMH participated in nine (9) collaborative meetings that had agendas aimed at maintaining partnerships with the Department of Veterans Administration, the Illinois Departments of Veterans' Affairs (IDVA), and Military Affairs (IDMA), and other agencies and organizations; completing the behavioral health inventory of existing providers; monitoring the ongoing coordination of services; and facilitating a coordinated system of care. Emphasis has been placed upon coordination a crisis intervention system with a focus on suicide prevention. There is an ever-growing network of community providers in a collaborative system of care.

Objective #2: Improve quality of community mental health services to servicemen, veterans, and their families
Strategy to obtain the objective: Educate and train community providers in military and veteran clinical cultural competence.
Indicator #2. **The number of Military and Veteran 101 Clinical Cultural Competency Workshops completed during the fiscal year and the total number of participants each year.**
a) Baseline measurement (Initial data collected prior to and during SFY 2017): Although four Workshops were conducted in SFY2016, due to funding and resource limitations of the Illinois Joining Forces Foundation, Military and Veterans 101 Workshops were not conducted in SFY2017.
b) First-year target/outcome measurement (Progress to end of SFY 2018): **A plan for the resumption of Military and Veteran Clinical Cultural Competency Workshops in FY2019 under DMH sponsorship and in collaboration with IJF will be developed and finalized by the end of the fiscal year**.
c) Second-year target/outcome measurement (Final to end of SFY 2019): **Utilizing the Military and Veterans Clinical Competency curriculum, three Workshops will be conducted by the end of FY2019.**
d) Data source: Calendar dates of these events and attendance records of each.
e) Description of data: See Above.
f) Data issues/caveats that affect outcome measures: None.
8. Report of Progress toward goal attainment **First year target: __X___ Achieved _____ Not Achieved (If not achieved, explain why)**

This objective is a moving target that is ongoing and has been substantially addressed. DMH is currently working with staff from the IDVA, Smart Policy Works, as well as Illinois Joining Forces, to coordinate training throughout the State of Illinois. Military and Veteran 101 Clinical Cultural Competency Workshops were discontinued by Illinois Joining Forces in FY2017 due to its limited resources. DMH has been working on a plan for the resumption of Military and Veteran Clinical Cultural Competency Workshops in FY2019 under DMH sponsorship in collaboration with IJF. An initial step in that planning has been completed. DMH conducted a survey that indicated a growing interest in the mental health provider network in veteran services and trainings to address questions regarding treatment for veterans as well as the availability of benefits. The survey was presented to the statewide network of community mental health providers that have a standing relationship with DMH. As respondents preferred actual attendance at these workshops, plans are underway for workshops in the Chicago area to be completed with face to face attendance. In southern more rural parts of Illinois, where distances are a factor there is interest in Webinars using the same curriculum, so that the training will be available across the State.

Objective #3: Build Veteran Service Communities (VSC) throughout the state that can ensure access to Behavioral Health Services.
Strategy #3: Partner with the Department of Veterans Administration My VA Communities initiative. This initiative is a relationship building effort to ensure Veterans Administration facilities are connected and engaged with their local communities and is an ongoing effort of The Illinois Division of Mental Health coordinating through Illinois Joining Forces Behavioral Health Working Group to ensure SMVF have access to Behavioral Health Services.
Indicator #3: (a) Number of Veterans Service Communities in the State with active Behavioral Health services at end of each fiscal year. (2) An Annual Report that describes progress related to expanding the membership of the Illinois Joining Forces (IJF) Behavioral Health Working Group (BHWG), maintaining a coordinated Crisis Service Intervention System that addresses SMVF needs, and focusing on increasing the number of Veteran Service Communities (VSC) throughout the state.
a) Baseline measurement (Initial data collected prior to and during SFY 2015): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2018): **By the end of FY2018, at least 10 Veterans Service Communities statewide with active behavioral health services and a report on the status of completing the behavioral health inventory, coordination of services, and the system of care for SMVF individuals that cites collaborative accomplishments during the fiscal year.**
c) Second-year target/outcome measurement (Final to end of SFY 2019): **By the end of FY2019, 25 Veterans Service Communities statewide with active behavioral health services and a report on the status of completing the behavioral health inventory, coordination of services, and the system of care for SMVF individuals that cites collaborative accomplishments during the fiscal year.**
d) Data source: Meeting Minutes and records of DMH staff members assigned to this collaborative task.
e) Description of data: See Above.
f) Data issues/caveats that affect outcome measures: None.
8. Report of Progress toward goal attainment **First year target: _____ Achieved __X___ Not Achieved (If not achieved, explain why)**

Building Veteran Support Communities (VSC) throughout the state that can ensure access to Behavioral Health Services is not yet completed but still in process. So far two (2) Veterans Support Communities have been established in the state. Illinois Joining forces is the lead in addressing this initiative. Illinois Joining Forces, IDVA, IDHS/DMH and other community partners are working to get the VSC's up and running but the process has been slower than anticipated, especially in Greater Illinois. Further information about the Illinois Joining Forces VSC initiative is provided in the summary below.

Background:

DMH collaborates with the Illinois Departments of Veterans Affairs' and Military Affairs (National Guard and Air Guard), to coordinate and improve services for service members, veterans, and their families throughout the state. Military personnel returning from the wars in Iraq and Afghanistan are at increased risk of traumatic brain injury, post-traumatic stress disorder, depression, anxiety and other mental health symptoms as well as new-onset heavy drinking, binge drinking and other alcohol-related problems. Anxiety, depression and engagement in high risk behaviors, such as substance abuse, are more likely among adolescents in families with a deployed parent than among similar adolescents in non-deployed families (Chandra et al., 2009) Given the increasing recovery needs among returning military personnel and their families, DMH and DASA have partnered with the Illinois National Guard and Illinois Department of Veterans Affairs in order to improve access to mental health services, alcohol and other drug treatment, and recovery support services among military personnel returning from deployment and their families.

Illinois Joining Forces

DMH has actively participated in the formation and implementation of the Illinois Joining Forces Initiative and was active in the legislative process that created the Illinois Joining Forces Foundation. Public Act 098-0986, which became effective on August18, 2014, created the Illinois Joining Forces Foundation, a not-for-profit foundation. Provisions in the law for incorporation, the appointment of a Board of Directors, and the collection of funds ensures the long-term sustainability of Illinois Joining Forces, now considered to be critically important for the support of the state's military and veteran communities.

The Illinois Joining Forces (IJF) is a joint Department of Veterans' Affairs (DVA) and Department of Military Affairs (DMA) effort to better serve veterans, service members, and their families throughout the state. IJF brings together, under a common umbrella; public, non-profit, and volunteer organizations to foster increased awareness of available resources and to better partner and collaborate with participating organizations. It has been estimated that Illinois alone has as many as 500 veteran- and military-related organizations but the lack of collaboration and coherence between them has resulted in veterans and service members being frustrated and unaware of the many resources available to them.

Illinois Joining Forces (IJF) Veteran Support Community (VSC) Development Model

Illinois Joining Forces (IJF) will stand up Veteran Support Communities (VSC's) statewide to support formal and informal networks of services and supports in communities and regions for service members, veterans, and families (SMVF). The intent is to align and connect service providers, resources, programs, and services and supports along two general operational and core program lines – **Growth** related functional services and support resources generate independence; and **Wellness** related functional services and support resources that resolve crisis in the short term and in the long term develop self-support and personal development.

The essential structural components of a Veterans' Support Community (VSC) are:
Convening Authority- Local VSC determined leadership (or self-aligned) that is willing and has the capacity to convene regular VSC meetings or provide SMVF and IJF related information to their VSC network.
Core Partners - Willing and able partners that can as necessary a) represent IJF functional areas and b) integrate with IJF Working Group Subject Matter Experts (SME).
Peer Support - Peer Support capacity to assist SMVF in Growth and Wellness initiatives and programs.
Centralized Hub Organization - A Centralized Hub Organization where individuals and organizations can provide direct services and supports for SMVF within the VSC
Referral and Service Exchange Platform - A Referral and Service Exchange Platform where SMVF identified with IJF networks can be centrally referred for VSC decentralized services and supports.
Corporate Sponsorship - Corporate Sponsorship aligned and supportive of local VSC business development

At a minimum, VSC partners must have the capacity to service veterans in at least these six core functions:
Housing,
Employment
Financial Assistance
Education
Integrated Primary and Behavioral Healthcare
Women Veterans.

Once these core functions and services are represented, additional VSC attributes can be provided such as referral exchange platforms and the development of a peer-to-peer network. IJF Working Group's will provide assistance and support to the VSC providers at the community level. The intent of this IJF initiative is to establish a baseline of success with the limited resources available and establish best practices and protocols that are scalable to each unique VSC community.

For additional information about Illinois Joining Forces see their Website at illinoisjoiningforces.org

Priority #11: Integrated Health Homes

1. Priority Area: **Contingent upon CMS approval of the Illinois Application for a Section 1115 Demonstration Waiver, enhance and improve service coordination through the establishment of Integrated Health Homes.**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s)-SMI, SED,	
4. Goal: *Through the implementation of the plan cited in the DHFS application for the 1115 Waiver, develop and maintain care coordination in community mental health service agencies ensuring that persons with serious mental illness and their families can receive fully integrated and seamless services in their community.*	
5. Objective: Assist community mental health providers to successfully meet integrated Health Home certification requirements.	
6. Strategy: Provide education, focus, technical assistance, and consistent ongoing support for community mental health centers to become integrated health homes.	
7. Annual Performance Indicators to measure goal success: **Indicator: Number of community mental health providers meeting the requirements for certification as Integrated Health Homes.**	
a) Baseline measurement (Initial data collected prior to and during SFY 2018): N/A	
b) First-year target/outcome measurement (Progress to end of SFY 2018): **Not Applicable**	
c) Second-year target/outcome measurement (Final to end of SFY 2019): TBD	
d) Data source: TBD	
e) Description of data: TBD	
f) Data issues/caveats that affect outcome measures: No access to DHFS or MCO service data	
8. Report of Progress toward goal attainment **First year target: _____ Achieved ___X__ Not Achieved (If not achieved, explain why)**	

Approval of the Illinois Application for a Section 1115 Demonstration Waiver finally came through late in SFY2018. On May 7th, The Centers for Medicare and Medicaid Services [CMS] approved Illinois' request for a new 1115 Demonstration Waiver, the Illinois Behavioral Health Transformation. This approval is effective from July 1, 2018 to June 30, 2023. The Illinois Department of HealthCare and Family Services (DHFS) received approval for the operation of Integrated Health Homes in its Managed Care System. Since then DMH and DHFS leadership have been actively involved in finalizing the policy decisions regarding implementation. A credentialing process for Integrated Health Homes has been developed. Planning has proceeded rapidly and State intends to "Go Live" with IHH as of January 1, 2019 Plans call for the roll out to begin in the Chicago Metropolitan Area as of January 1st and in Greater Illinois on April 1st .

As this programming is starting in FY2019, there is no baseline data to report for FY2018. A set of objectives, strategies, indicators and targets for the initiative will be discussed and highlighted in the FY2020-FY2021 MHBG Application and Plan. An

initial description of the initiative and its first six months of progress will be available in the FY2019 Implementation Report.