Illinois

UNIFORM APPLICATION
FY 2020 Mental Health Block Grant Report

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/07/2017 - Expires 06/30/2020
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Center for Mental Health Services
Division of State and Community Systems Development

A. State Information

State Information

State DUNS Number

Number	067919071
Expiration Date	3/18/2020 12:00:00 AM

I. State Agency to be the Grantee for the Block Grant

Agency Name	Illinois Department of Human Services
Organizational Unit	Division of Mental Health
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III. State Expenditure Period (Most recent State exependiture period that is closed out)

From	7/1/2018
To	6/30/2019

IV. Date Submitted

NOTE: This field will be automatically populated when the application is submitted.

Submission Date	12/2/2019 5:47:34 PM
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Footnotes:

B. Implementation Report

MHBG Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1

Priority Area: Continue to develop and improve the array of clinical and support services available for adults and children.

Priority Type: MHS

Population(s): SMI, SED

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.

Strategies to attain the goal:

• 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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: a. Number of outcome measures ready for use by the end of each fiscal year. b. Percent of providers that demonstrate capacity to use the outcome measures in reporting.

Baseline Measurement: N/A

First-year target/outcome measurement: Completion of a draft set of outcome measures for the evaluation of community services and initiation of stakeholder discussion, input, and review.

Second-year target/outcome measurement: 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.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

DMH Information System

New Data Source*(if needed)*:

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.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
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.

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Due to administrative changes at the state level it has not been possible to develop the necessary components to evaluate community services across the State. However, DHS/DMH is moving forward in FY2020 and FY2021 with the tools now provided through the certification of community mental health centers to establish the database needed for the evaluation of the public mental health service system in Illinois.

In FY2018, DMH partially achieved the 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 could not be completed until the Rules governing certification and service delivery were fully revised and adopted. After a prolonged process due to unanticipated delays over many months, the Medicaid Rule (Rule 132) which contained the certification requirements and process for Community Mental Health Centers and defines the Medicaid Services they provide was fully revised in conjunction with DHFS into two Rules that separated the service definitions from the certification process. The new 59Ill Adm. Code 132 containing revised certification requirements and processes became effective on January 1, 2019. HFS has filed a corresponding amendment- 89Ill. Admin. Code 140 - which now includes the service definitions.

Contrary to interagency expectations, a joint working data platform for the identification of outcome measures by DHFS in collaboration with DMH has not been fully realized. A prioritized list of outcome measures and initial implementation of a system of reporting which processes the data and components of the evaluation is yet to be completed. Through the ongoing certification processes now required in Rule 132 that include periodic review, monitoring, and recertifications of Certified Community Specialty Providers and Certified Community Mental Health Centers, DHS/DMH can now identify and evaluate service shortfalls. Planning for the design and implementation of a database to process the components and data of the evaluation is now underway and has been included in the FY2020-FY2021 Plan. In FY2020 DMH will move forward with the analysis of resulting data to: (a) identify areas where access and availability of services needs to be improved; (b) inform the publicly funded community service system; and (c) facilitate decision making and planning.

How second year target was achieved *(optional)*:

Priority #: 2

Priority Area: Promote the provision of Evidence-Based and Evidence Informed Practices

Priority Type: MHS

Population(s): SMI, SED

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.

Strategies to attain the goal:

Development of a set of outcome measures designed to assess the progress of individuals served.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of active service slots filled for persons with Serious Mental Illness (SMI) who receive Assertive Community Treatment in FY2018 and FY2019 (National Outcome Measure)

Baseline Measurement: Baseline for 2017 not applicable to FY2018 or FY2019 as indicator has been revised to reflect service access capacity. See Description of Data below.

First-year target/outcome measurement: 1,100

Second-year target/outcome measurement: 1,100

New Second-year target/outcome measurement*(if needed)*:

Data Source:

DMH Funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. DMH provides data specifications to assure consistency of reporting.

New Data Source*(if needed)*:

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 and for analytic purposes, and is the basis for reporting the data used to populate the URS tables.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Most ACT Teams currently operate within areas where individuals are served through Managed Care Contracts. The claims data related to MCO funded care is currently not available to the State Mental Health Authority, and thus individual outcomes from ACT cannot be accurately measured at this time. 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. Through the State's work on the HHS transformation, plans are underway to improve the interoperability of the data systems. When this occurs, DMH will be able to track outcomes of individuals.

New 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 2018 and review of FY2017 has revealed that issues in data reporting and protocol for the spreadsheets led to 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.

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

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

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

This objective has been successfully accomplished! The target was exceeded!
In FY2019, 1,532 persons were served by Illinois ACT Teams, exceeding the target of 1,100 by 39.3%.

DMH introduced three new ACT teams and was successful in maintaining 33 ACT teams in FY2019. The service capacity report from providers of ACT shows 1,532 individuals being served, significantly exceeding the target of 1,100 for the fiscal year. The statewide capacity of available and active ACT service slots as of 6/24/19 was 1,989 with a 23% vacancy rate.

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.

Priority #: 3

Priority Area: Promote the provision of Evidence-Based and Evidence Informed Practices - Individual Placement Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Promote Evidence-Based Supportive Employment for individuals served in the publicly funded mental health service system.

Strategies to attain the goal:

Continue the development of the state infrastructure required to support implementation and sustainability of IPS Evidence Based Supportive Employment. Continue to develop the integration of physical and behavioral health with employment supports and peer support statewide. By the end of FY2019, contingent upon additional funding resources, target an additional 500 consumers to acquire competitive employment in their local communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of consumers receiving supported employment in FY2018 and FY2019 (National Outcome Measure)

Baseline Measurement: In FY2017, 3003 consumers were served in 56 IPS sites with fidelity to the model and 183 in 6 sites working towards fidelity for a total of 3,275 consumers served.

First-year target/outcome measurement: To serve 3,375 consumers in IPS.

Second-year target/outcome measurement: To serve 3,775 consumers in IPS.

New Second-year target/outcome measurement*(if needed)*:

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.

New Data Source*(if needed)*:

Description of Data:

As always, DMH has developed specifications for reporting that DMH providers must use when submitting data.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

DMH only reports data for teams that have been found to exhibit fidelity to the evidence based practice model. DMH is working to promote fidelity in all IPS agencies and thereby expand the database.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

In FY 2018, 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., exceeding the target of 3,375.

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The numerical target for FY2019 was 85.5% attained. The program experienced a 5.4% decrease from the total number served in FY2018 due to the serious setbacks cited below but continues to be robust and looking forward towards increasing activity and numbers served in FY2020. 3,228 individuals received and benefitted from IPS services in FY2019.

While staff turnover has historically been a problem issue for IPS Providers, it appeared staff turnover was at a record high during FY2019. Many IPS provider agencies not only had major employment specialist turnover during this period of time, but also had senior IPS team leader and IPS program director turnover as well. At any IPS provider, the IPS Team Leader is the most vital position and strongest advocate in referring clients to IPS and filling IPS caseloads. So, without fully staffed IPS teams to serve clients, and lacking the strong leadership advocacy of IPS due to those vacant key leadership positions, many IPS caseloads at providers agencies did not increase with new IPS intakes. IPS providers chose to limit (and in some cases closed) IPS program intake until employment specialist and IPS team leader positions were filled. With the skill set of an employment specialist position being so unique, it took IPS providers 3 to 4 months to fill all open positions – which stopped expansion of IPS. DMH believes that with new IPS provider agencies implementing IPS and tenured IPS providers now having filled key IPS staff positions, the number of clients served in IPS should increase in FY2020.

In FY2019, a total of 41 IPS sites with fidelity to the model served 2,863 unduplicated consumers. An additional 12 sites that were working toward fidelity but had not yet met fidelity standards served 365 consumers. In all, 3,228 consumers received supported employment services.

How second year target was achieved *(optional)*:

Priority #: 4

Priority Area: Use of the 10% Block Grant Set-Aside to implement specialized programming and Evidence-Based services for persons experiencing First Episode Psychosis.

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Sustain and expand the infrastructure for evidence-based clinical programs for persons with FEP.

Strategies to attain the goal:

Provide education, training, and ongoing consultation to staff involved in FEP programs that includes:
1. Strategies for outreach and community-based education to attract and retain clients who have recently begun to experience symptoms of psychosis.
2.Assessment and individualized treatment planning in the most supportive and least intrusive manner.
3. Psychiatric and medical treatment
4.Accessing employment through IPS programs, job retention, and smooth transitions in work life.
5. Supportive education.
6.Family and Individual Psycho education.
7. Counseling and Case Management
8. Cognitive Behavioral Therapy for Psychosis
9. Needs analyses of geographic areas to identify the best location for a new program.
Determine a provider's capacity and potential for success using the criteria for provider selection developed by the DMH FEP Workgroup.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of sites in the State with funded FEP programs and total FEP Set-Aside expenditures by the State for each site.

Baseline Measurement: 12 Funded sites

First-year target/outcome measurement: 12 Funded Sites

Second-year target/outcome measurement: 13 Funded Sites

New Second-year target/outcome measurement*(if needed)*:

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 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 outcomes in terms of number of referrals and number of clients enrolled at each participating site.

New Data Source*(if needed)*:

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 Education involvement. Quarterly Expenditure Reports are also completed by FEP agencies and provided to DMH.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The full potential of the FEP program may be affected by federal restrictions on eligible diagnoses.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
Twelve (12) FEP Teams were projected but 15 Teams had become operational by June 30, 2018. The target was achieved at 125%!

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

This objective was successfully accomplished by the end of FY2018 with the establishment of three additional sites. These fifteen funded sites have been successfully maintained and enhanced through FY2019. The target of 13 funded sites being operational by the end of FY2019 was exceeded.

Indicator #:	2
Indicator:	1. Number of training events held each fiscal year to increase knowledge and clinical competence and ,2. Number of technical assistance meetings and teleconferences conducted by the statewide coordinators.
Baseline Measurement:	During the course of the fiscal year (July 2016 through June 2017), there were a total of 223 Technical Assistance and Consultative meetings in various combinations between DMH, the BeST Center, and the 11 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. Additionally the BeST Center Consultant directly provided 18 FEP Trainings for all newly hired FEP agency staff as well as 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:
First-year target/outcome measurement:	(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.)
Second-year target/outcome measurement:	(a) Training Events- 8 (including 1 CBT-p Training for the 3 new FEP Providers, New Clinical staff IRT Training will occur 4 times during the year. 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 TA Calls (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.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Records of teleconference calls and attendance are maintained by the statewide coordinators.

New Data Source*(if needed)*:

Description of Data:

See Above

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

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.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

This objective was achieved in FY2019 and the targets were met. Eight training events with follow-up technical assistance as needed were conducted during the year, including 1 CBT-p Training for the 3 new FIRST.IL Providers, New Clinical staff IRT Training occurred 4 times during the year, and training events were conducted on the integration of Trauma Informed Care, Recovery, and the role of Recovery Support Specialists on Clinical Teams, and the use of the newly established Web-based Data System.
The three state coordinators tracked 408 TA contacts that included 50 individualized CBT-p monthly follow-up calls to clinical staff for all 15 Providers and up to 3 state coordinators in various combination.

Indicator #: 3

Indicator: Number of clients meeting criteria for FEP enrolled in team services statewide.

Baseline Measurement: 123 enrolled by 11/30/2017.

First-year target/outcome measurement: 150 by June 30, 2018

Second-year target/outcome measurement: 225 by June 30, 2019.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Enrollment data from each participating site aggregated by statewide coordinator retrieved from the Outcome Review Form (ORF) at Baseline and every six months.

New Data Source*(if needed)*:

Description of Data:

Number of persons meeting eligibility criteria for the FEP program enrolled at each site during each fiscal year. Target is a minimum of

five additional enrollees per site per year.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The full potential of the FEP Program may be impacted by the federal restrictions on eligible diagnosis.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

The program targeted 150 enrollees and 201 were enrolled by June 30, the end of the fiscal year. The program reports an additional 25 individuals who had been enrolled but either graduated or moved out of their service areas and therefore were not carried as enrolled on June 30, 2018. This target was thus achieved at 150.6%!

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

The target for Objective #3 was achieved and exceeded in FY2019. 225 enrollees were targeted. 243 were enrolled as of 6/27/19.

Priority #: 5

Priority Area: Use of Data for Planning

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Use Quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support.

Strategies to attain the goal:

Assess access to care by tracking the number of individuals who received treatment partitioned by race, gender, and age.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults and number of children /adolescents receiving services from DMH-funded community-based providers.

Baseline Measurement: 72,500

First-year target/outcome measurement: 72,500

Second-year target/outcome measurement: 72,000

New Second-year target/outcome measurement*(if needed)*:

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.

New Data Source*(if needed)*:

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.

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

No access to MCO data.

New Data issues/caveats that affect outcome measures:

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.

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
The combined service totals of DMH and DHFS yield a result that far exceeds the target.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

The numerical target of 72,000 was achieved in FY2019 and extensively exceeded. The department of HealthCare and Family Services (DHFS) reported reimbursing Medicaid claims for mental health services to 464 youth in their mental residential treatment program (ICG); 38,848 persons in Medicaid FFS; and 111,661 through the MCOs in Medicaid Managed Care. The combined total number served in FY2019 was 150,973.

Priority #: 6

Priority Area: Maintain effective systems to serve the forensic needs of justice-involved consumers of services

Priority Type: MHS

Population(s): SMI, SED, Other (Criminal/Juvenile Justice)

Goal of the priority area:

Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.

Strategies to attain the goal:

Maintain the Mental Health Juvenile Justice Initiative.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth served by the MHJJ Program statewide.

Baseline Measurement: 209 youth enrolled in FY2017.

First-year target/outcome measurement: 200 youth to be enrolled in FY2018

Second-year target/outcome measurement: 200 youth to be enrolled in FY2019

New Second-year target/outcome measurement*(if needed)*:

Data Source:

MHJJ Program Data Base maintained internally by DMH oversight staff.

New Data Source*(if needed)*:

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.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

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.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

This strategy was very successfully accomplished in FY2019. The target of 200 youth to be enrolled was extensively exceeded. By the end of the fiscal year 618 youth were enrolled. Although fiscal and clinical resource limitations and reductions continued to exist in FY2017, the MHJJ Program expanded significantly in FY2018. A key factor in this expansion was that the MHJJ Program expanded its eligibility criteria in FY2017 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.

During FY2019 there were 20 agencies operating the MHJJ program, up from the 14 agencies that had provided services earlier in FY2017. As noted in FY2018, several new agencies had begun providing MHJJ services and some legacy agencies that had more robust staffing than in previous fiscal years contributed to the significant increase in MHJJ program activity. By the end of FY2018, of 789 referrals that were screened, 618 were found eligible for the program and received mental health and support services.

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.

Priority #: 7

Priority Area: Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.

Priority Type: MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

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 consumer-run wellness programs are increasingly utilized.

Strategies to attain the goal:

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.
2. Enhance competency and encourage WRAP trained and certified facilitators to provide an increasing number of WRAP® classes in the State.
3. Provide educational events and technical assistance to encourage consumer participation and advocacy and provide public education to promote this model.
4. Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and families across the State.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of training events held each year to increase stakeholder understanding of the CRSS credential and to increase competency in CRSS domains.

Baseline Measurement: 15 training events in SFY 2017.

First-year target/outcome measurement: 9

Second-year target/outcome measurement: 9

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Document each training event and aggregate by year for comparison across years.

New Data Source*(if needed)*:

Description of Data:

Training agenda and attendance sheets documenting participation for each training event held.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

The continuing expansion of the Certified Recovery Support Specialist (CRSS) certification was effectively addressed in FY2018. Nine competency training events were held. Six competency 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 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.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

The continuing expansion of the Certified Recovery Support Specialist (CRSS) certification was effectively addressed and the number of training events was significantly exceeded in SFY2019. A total of 15 training events were held in SFY19. 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 2019 with 325 registered participants. An additional three training events were held in March 2019 offering CRSS Fundamentals Training, with statewide registration exceeding 400 total.

Indicator #: 2

Indicator: (a) Number of WRAP Refresher trainings offered statewide each year (b) Number of WRAP participants each year.

Baseline Measurement: 15 Refresher Training events were held in FY2017

First-year target/outcome measurement: 20 will be held in FY2018.

Second-year target/outcome measurement: 20 will be held in FY2019.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Document each training event and aggregate by year for comparison across years.

New Data Source*(if needed)*:

Description of Data:

Training agenda and attendance sheets documenting participation for each training event held.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

WRAP Refresher Training was successfully accomplished in FY2019. Sixteen refresher courses were conducted at 6 sites in the State. The total number of participants for FY2019 was over 400. As of June 2019, 558 individuals have been trained and certified as WRAP Facilitators in Illinois. Of those, 233 (41.8%) 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.

Indicator #: 3

Indicator: (a) Number of educational events and/or technical assistance appointments regarding Peer Respite held each year. (b) Number of programs opened during the year.

Baseline Measurement: Not Applicable - New objective for FY2018-FY2019.

First-year target/outcome measurement: 5

Second-year target/outcome measurement: 5

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Training agendas and attendance sheets documenting participation.

New Data Source*(if needed)*:

Description of Data:

Agendas for each event and attendance sheets.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
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.

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Although this objective was successfully accomplished in FY2018, the loss of three staff persons in the DMH Bureau of Wellness & Recovery Services in FY2019 seriously damaged efforts toward establishing infrastructure for the introduction and implementation of peer respite services. The initiative has been temporarily placed on the back burner. It was decided to discontinue this objective for FY2020 in favor of continuing efforts in other important areas.

During FY2018, 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.

How second year target was achieved *(optional)*:

Indicator #: 4

Indicator: Number of statewide teleconferences held each year and number of participants per conference call.

Baseline Measurement: 10 in SFY2017.

First-year target/outcome measurement: 10

Second-year target/outcome measurement: 10

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Document each teleconference event and aggregate by year for comparison across years.

New Data Source*(if needed)*:

Description of Data:

Teleconference agendas

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

This strategy was successfully achieved in FY2019. Ten teleconferences were conducted in SFY2019 with an attendance ranging from 303 to 411 persons per call and an aggregate attendance of 3,609.

Priority #: 8

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.

Priority Type: MHS

Population(s): SED, ESMI, Other (Adolescents w/SA and/or MH, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

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.

Strategies to attain the goal:

Objective # 1: 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.
Objective #2: 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.
Objective #3: 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.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: A set of diagnostic criteria for the assessment of children from Birth to age 5 is adopted and implemented by community providers by the end of SFY2019.

Baseline Measurement: N/A

First-year target/outcome measurement: A DSM 5-ICD10 crosswalk for the diagnosis and billing codes is drafted and adopted. (Contingent on the ICD10 being adopted).

Second-year target/outcome measurement: The set of diagnostic criteria has been piloted and is utilized by community providers.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Changes to the DMH registration system include new diagnosis and billing codes

New Data Source*(if needed)*:

Description of Data:

New ICD10 codes and diagnoses are in the system.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
The Illinois Department of Healthcare and Family Services (DHFS) did not accept the recommendations for using a DSM-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 Administrative Rule 132, the Rule for Certified Community Mental Health Centers.

How first year target was achieved *(optional)*:

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

In FY2018, the Department of HealthCare and Family Services (DHFS) 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. At that point in time, we reported the target as "Not Achieved".

In FY2019 After a prolonged process due to unanticipated delays over many months, the Medicaid Rule (Rule 132) which contained the certification requirements and process for Community Mental Health Centers and defines the Medicaid Services they provide was fully revised in conjunction with DHFS into two Rules that separated the service definitions from the certification process. The new 59Ill Adm. Code 132 containing revised certification requirements and processes became effective on January 1, 2019. DHFS has filed a corresponding amendment- 89Ill. Admin. Code 140 - which now includes the service definitions.

Rule 132 requires Certified Community Mental Health Centers to provide access to appropriate services to persons of all ages across the life span. It defines Emotional Disturbance in Children and the treatment approach required as follows (Section 132.25):

"Emotional Disturbance – For clients under age 21, symptoms of an emotional disorder contained in the DSM-5 and ICD-10-CM that is the condition that will be the main focus of treatment. For clients under age 6, DC 0-5 may be utilized to develop an age appropriate diagnosis, then the crosswalk between the DSM 5/ICD-10/DC 0-5 shall be used to identify which DSM-5/ICD-10 condition will be the main focus of treatment. Emotional disturbance does not include organic disorders such as dementia and those associated with known or unknown physical conditions such as hallucinations, amnestic disorder and delirium; psychoactive substance induced organic mental disorders; and intellectual disabilities, autism spectrum disorders or psychoactive substance use disorders."
With the adoption of Rule 132 which became effective January 1, 2019, the DSM5/ICD-10/DC0-5 crosswalk is now a valuable diagnostic tool in the treatment of Serious Emotional Disturbance. Ongoing usage and study is now required to increase its operational reliability, validity, and effectiveness. The success of its implementation will depend on the collaborative effort and process with the Department of Healthcare and Family Services.

Indicator #: 2

Indicator: 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

Baseline Measurement: N/A

First-year target/outcome measurement: 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.

Second-year target/outcome measurement: Providers receive training and technical assistance in the utilization of the tools in measuring outcomes.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Changes to the DATSTAT system include operational outcome measure tools. Provider attendance in training sessions

New Data Source*(if needed)*:

Description of Data:

Attendance records of training and technical assistance sessions that support providers reporting usage of the outcome measures

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

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 (end of FY2019) has been superseded and already largely achieved through the adoption of the IM-CANS as the statewide comprehensive assessment tool. 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.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

Indicator #: 3

Indicator: By the end of FY2019, specified curriculum-based or evidence-based trauma-informed credentialing will be available in Illinois.

Baseline Measurement:

First-year target/outcome measurement: The written set of requirements, privileges, and applications of a trauma –informed credential is developed, drafted and adopted.

Second-year target/outcome measurement: The credentialing process is implemented as evidenced by the number of providers applying for the credential or having been successful in obtaining the certification.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

The implementation plan for initializing the use of the credential.

New Data Source*(if needed)*:

Description of Data:

Documentation of completion of steps necessary to implement the new credential.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

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 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.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

The constructive collaborative work undertaken by DCFS and DMH to enhance focus and promote specialization in trauma-informed clinical work over the past two years has achieved some positive and sustaining outcomes for children, youth and families at risk in Illinois and the professionals serving them. Unfortunately, due to the recent initiation of NTI and its national centeredness, the number of individuals who have successfully completed the training in Illinois is not currently known.

The Division of Mental Health collaborated with DCFS on rolling-out the National Adoption Competency Mental Health Training Initiative for Mental Health Professionals (NTI). Illinois was one of the ten states that piloted this training initiative and provided constructive input for utilization of this training nationally. The 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.

Mental Health and Child welfare professionals are both pre-tested and post-tested on each of the 10 modules and must show increased awareness, sensitivity, and clinical responsiveness to the impact of trauma upon their clients. Certification upon completion of the training is supporting increasing professional competence and expansion of the availability of trauma-informed approaches in meeting the needs of children and youth.

Priority #: 9

Priority Area: Advancement of Community Integration

Priority Type: MHS

Population(s): SMI, Other (Adolescents w/SA and/or MH, Rural, Persons with Disablities, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Complete the successful transition of individuals with diagnosed SMI who are residents of long term nursing homes, from this level of care to the less restrictive settings. Ideally, independent living in the communities with appropriate and necessary support services.

Strategies to attain the goal:

During FY 2018 and perhaps beyond, using a range of resources including 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 vs. Rauner Class Members) from the 24 designated Nursing Facilities (NF) (statewide) that are categorized as Institutes for Mental Disease (IMD) to permanent supportive housing or other housing alternatives that provide safe, affordable housing with support services in communities of preference and, in a manner consistent with the national standards for this evidence based supportive housing practice.

Annual Performance Indicators to measure goal success

Indicator #: 1

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).

Baseline Measurement: The number of consumers to be transitioned by the end of SFY2017 - transition target number is 400. Note: 380 Class Members were transitioned as of June 30, 2017. Cumulative number of transitions: 2,052.

First-year target/outcome measurement: 400 additional consumers will be transitioned by the end of SFY2018.

Second-year target/outcome measurement: To Be Determined. NOTE: The Williams vs. Rauner Consent Decree was originally slated to sunset in 2016. The activities of this Consent Decree continued through FY2017 and are budgeted for FY2018. Continuation after the FY2018 fiscal year will be dependent on negotiations between parties and the court decision.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Individuals who receive a permanent supportive housing/bridge subsidy are not required to be registered, enrolled or engaged in

mental health treatment services. Therefore, it was necessary to create a special database to track access to and receipt of permanent supportive housing bridge subsidy.

New Data Source*(if needed)*:

Description of Data:

The data for this indicator will be generated from permanent supportive housing applications of individuals in longer term institutional settings which are stored in the special database, as well as a special PSH outcomes database.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Continuation after the FY2018 fiscal year will be dependent on negotiations between parties and the court decision.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
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.

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

During FY2019 250 individuals were successfully transitioned to independent living in the community supported by clinical services. The numerical target of 400 set to be following the Court implementation plan was attained by 63% but not achieved. The extensive planning and work required to effectively carry this process forward is continuing at a consistent pace. As of the end of the first quarter of (SFY2020 October 1,2019) 52 new transitions had been completed.

In FY2019, $32,908,200 in General Revenue funds were dedicated and spent to expand home and community-based services and other transitional costs associated with the consent decree implementation.

This strategy was also 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 had been transitioned to the community, either to PSH units or to residential type settings. The target for FY2019 was set to be in compliance with the Consent Decree by meeting the projected two-year cumulative transition total of an additional 800 Class Members.

How second year target was achieved *(optional)*:

Priority #: 10

Priority Area: Coordination and facilitation of mental health services for Illinois Service Members, Veterans, and their Families (SMVF).

Priority Type: MHS

Population(s): Other (Military Families)

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.

Strategies to attain the goal:

Objective #1- 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.
Objective #2- Educate and train community providers in military and veteran clinical cultural competence.
Objective #3-Build Veteran Service Communities (VSC) throughout the state that can ensure access to Behavioral Health Services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of collaborative meetings attended by DMH staff representatives that have agendas aimed at completing the strategies and coordination of services.

Baseline Measurement: 12 were targeted in FY2017 but DMH staff actually participated in 28 meetings. The DMH Manager originally assigned responsibility for this priority retired in December 2017, and two DMH staff who are both Veterans are now assigned joint responsibility for this priority.

First-year target/outcome measurement: 12

Second-year target/outcome measurement: 12

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Meeting Minutes and records of DMH staff members assigned to this collaborative task.

New Data Source*(if needed)*:

Description of Data:

See Above.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

This objective was achieved. By the end of FY2019, twelve collaborative meetings had been attended by DMH representatives that had agendas aimed at completing the behavioral health inventory and coordination of services. Twelve (12) meetings were previously attended in FY2018.
During FY2018 and FY2019, 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. 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.

During the course of FY2018-FY2019, DMH participated in 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; work toward completing the behavioral health inventory of existing providers; monitoring the ongoing coordination of services; and facilitating a coordinated system of care. Emphasis was 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.

Indicator #: 2

Indicator: The number of Military and Veteran 101 Clinical Cultural Competency Workshops completed during the fiscal year and the total number of participants each year.

Baseline Measurement: Although four Workshops were conducted in SFY 2016, due to funding and resource limitations of the Illinois Joining Forces Foundation, Military and Veteran 101 Workshops were not conducted in FY2017.

First-year target/outcome measurement: A plan for resumption of these Workshops in FY2019 under DMH sponsorship and in collaboration with IJF will be developed and finalized by the end of the fiscal year.

Second-year target/outcome measurement: Utilizing the Military and Veteran 101 Clinical Competency Curriculum, three (3) workshops will be conducted by the end of SFY2019.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calendar dates of these events and attendance records of each.

New Data Source*(if needed)*:

Description of Data:

See Above.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Improve quality of community mental health services to servicemen, veterans, and their families – this is a moving target that is ongoing. 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 in FY2017. 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.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

Although the numerical target of three workshops was not achieved during State Fiscal Year 2019(July 1 to June 30), substantial

planning and persistent collaborative activity resulted in the production of two workshops in the beginning months of state fiscal year 2020. Smart Policy Works and a host committee of Thresholds, Illinois Joining Forces, and the Illinois Department of Veteran Affairs on (IDVA) brought the SheServed Conference into Springfield, IL on September 17, 2019. The theme of the Conference was: Reducing Barriers to Women Veterans' Health Care and it included free registration to panels with information regarding healthcare for Women veterans, a keynote panel, and continuing education credits. The event was attended by more than 50 people. A Veterans Benefits and Services Informational will be a Region I Central Provider Network Meeting Agenda and is scheduled on December 3, 2019.

This objective has been 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.

Indicator #: 3

Indicator: (a) Number of Veterans Service Communities in the State with active Behavioral Health Services at end of each fiscal year. (b) An Annual Report that describes progress related to expanding the membership of the Behavioral Health Working Group (BHWG) of Illinois Joining Forces (IJF), maintaining a coordinated Crisis Service Intervention System that addresses SMVF needs, and increasing the number of Veteran Service Communities (VSC) throughout the state.

Baseline Measurement: N/A

First-year target/outcome measurement: 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.

Second-year target/outcome measurement: At least 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 by the end of FY2019..

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Meeting minutes and records of DMH staff members assigned to this collaborative task.

New Data Source*(if needed)*:

Description of Data:

See Above

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Build Veteran Service Communities (VSC) throughout the state that can ensure access to Behavioral Health Services – this target is not completed but in process. So far two (2) Veterans Service 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.
Additionally, Illinois has approved the Certified Veterans Support Specialist (CVSS) credential. – A conversation is ongoing regarding the creation of a bridge for current Certified Recovery Support Specialist (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.

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Building Veteran Support Communities (VSC) throughout the state that can ensure access to Behavioral Health Services has not been achieved. Illinois Joining forces is the lead in addressing this initiative. DMH has been limited to providing subject expertise and support. 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 and efforts have been inconsistent. Further information about the Illinois Joining Forces VSC initiative is provided in the summary below. So far one fully functional Veterans Support Community has been established in the state-Lake County, Illinois There are at least 15 others at various stages of development.

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 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.

How second year target was achieved *(optional)*:

Priority #: 11

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.

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Through the implementation of the plan cited in the DHFS application for the Section 1115 Waiver, develop and maintain care coordination by 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.

Strategies to attain the goal:

Provide education, focus, technical assistance, and consistent ongoing support for community mental health centers to become integrated health homes.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of community mental health providers meeting the requirements for certification as Integrated Health Homes.
Baseline Measurement:	Not Applicable- In FY2017, the SMHA participated in collaborative planning and policy setting activities with the Illinois Medicaid Authority- the Department of Health Care and Family Services (IDHFS)
First-year target/outcome measurement:	Integrated Health Homes have not been implemented as of 4-1-2018 as the 1115 Waiver has not yet been approved and funding is not available.
Second-year target/outcome measurement:	Target will be determined after the Waiver is approved and the program begins.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

TBD

New Data Source*(if needed)*:

Description of Data:

TBD

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

No access to DHFS and MCO service data.

New Data issues/caveats that affect outcome measures:

Currently, limited and indirect access to MCO data prevents thorough analysis of service data and outcomes.

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

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.

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Subsequent to administrative changes (as a result of the November 2018 election) in the Governor's Office and in the leadership of the Department of Healthcare and Family Services (IDHFS), the State Medicare/Medicaid Authority, plans for the implementation of Integrated Health Homes are currently undergoing review and consideration by IDHFS.

How second year target was achieved *(optional)*:

Footnotes:

C. State Agency Expenditure Reports

MHBG Table 3 - Set-aside for Children's Mental Health Services

Statewide Expenditures for Children's Mental Health Services			
Actual SFY 1994	**Actual SFY 2018**	**Estimated/Actual SFY 2019**	**Expense Type**
$24,236,971	$96,070,720	$66,590,990	(●) Actual ( ) Estimated

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

States and jurisdictions are required not to spend less than the amount expended in FY 1994.

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Footnotes:

C. State Agency Expenditure Reports

MHBG Table 6 - Maintenance of Effort for State Expenditures on Mental Health Services

Total Expenditures for SMHA		
Period **(A)**	**Expenditures** **(B)**	**B1(2017) + B2(2018)** **2** **(C)**
SFY 2017 (1)	$403,712,476	
SFY 2018 (2)	$465,963,370	$434,837,923
SFY 2019 (3)	$446,928,472	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

SFY 2017	Yes	X	No	
SFY 2018	Yes		No	X
SFY 2019	Yes	X	No	

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

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Footnotes: