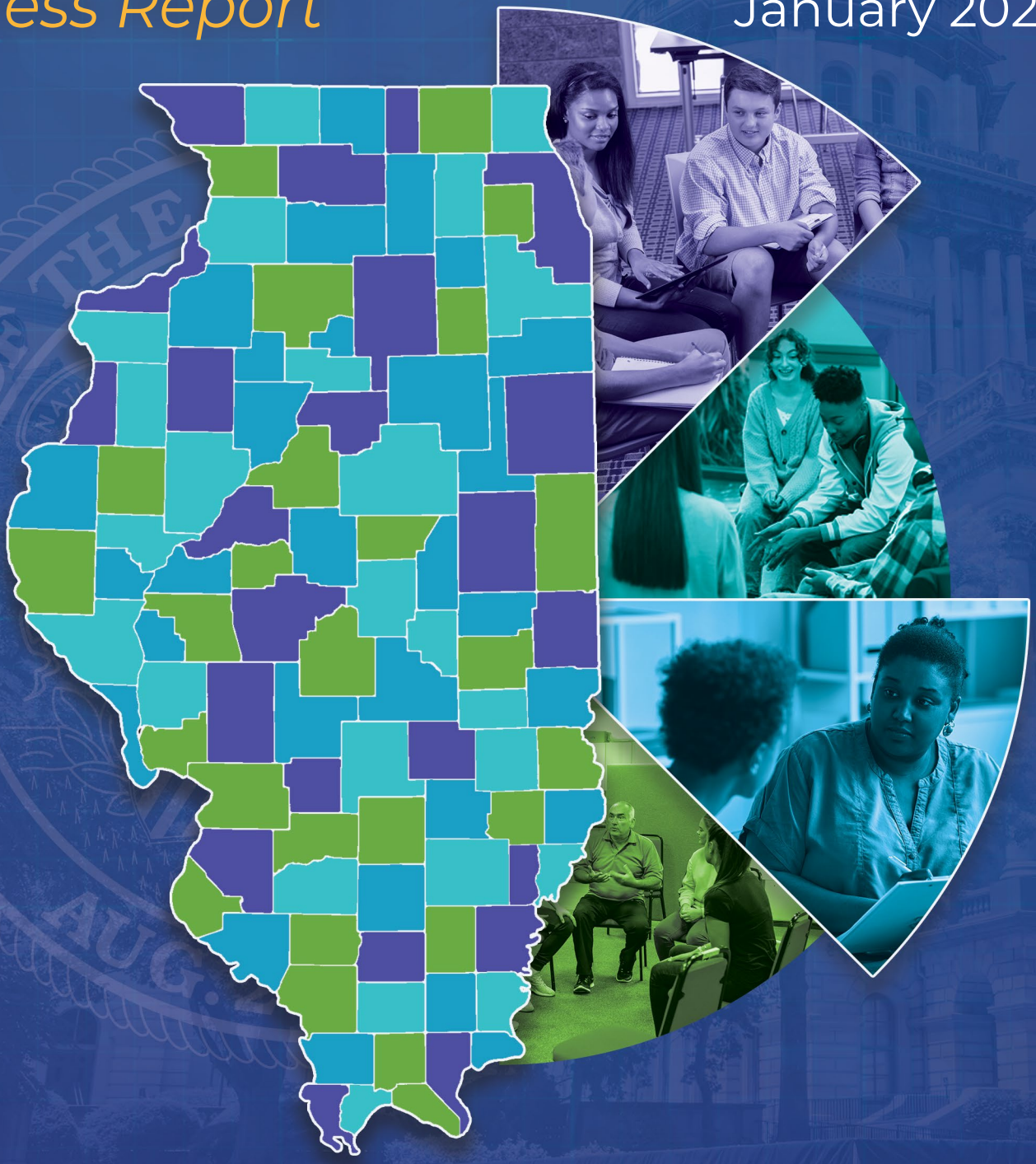
State of Illinois
Department of Human Services

Illinois Children's Behavioral Health Transformation Initiative

Progress Report

January 2024



IDHS Illinois Department of Human Services
Illinois Department of DCFS Children & Family Services
Illinois Department of Juvenile Justice
HFS Illinois Department of Healthcare and Family Services
Illinois State Board of Education
IDPH Illinois Department of Public Health

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Executive Summary

Under the leadership of Governor JB Pritzker, the State of Illinois has embarked on a comprehensive and coordinated effort to strengthen and improve behavioral health services for youth. This initiative, implemented in collaboration with a team of policy and research analysts from Chapin Hall at the University of Chicago, has robust support from the Pritzker administration and the 103rd General Assembly. The Blueprint for Transformation: A Vision for Improved Behavioral Healthcare for Illinois Children outlines a plan centered on 12 strategies to adjust capacity, streamline access, and intervene earlier to prevent acute crises.

Overall, the large group of Chapin Hall analysts, State agency leaders, provider partners, advocates, and people with lived experience who continue to work together toward system transformation have made considerable progress. Over 300 youth have received direct help from this initiative, through collaborative case management by the six child-serving state agencies to expedite placement, treatment, and services and to promote stabilization. The collaborative team has initiated or launched multiple technological innovations and developed new programs informed by rigorous analyses of youth needs; these changes are anticipated to help thousands more youth in the months and years to come. The State has learned a tremendous amount from constituents about community networks, school screening practices, and the barriers that must be overcome to enhance service delivery.

The initial implementation of the Blueprint has highlighted a set of core principles that undergird the work to improve service delivery to families. These principles will drive transformation of the youth behavioral health service system in Illinois:

- It is imperative that we ***simplify the family/youth experience by absorbing complexity behind the scenes,*** so that the State takes responsibility for the administrative tasks of identifying funding and securing needed services, while families interface simply and easily with a single portal that provides clear information and navigational assistance.
- The State is working to ***leverage technology to improve efficiency and speed processes***, making information quickly and clearly available to families, providers, and state agency partners.
- The interagency team continues to ***overcome barriers with creative solutions*** that make better use of existing resources and dissolve the boundaries between traditionally siloed state agencies.
- The Transformation Initiative has ***elevated family voice***, ensuring that solutions designed by people with lived experience have the desired impact on youth, parents, and caregivers.

This report describes progress toward transforming our system and outlines the work ahead. By identifying and addressing problems as early as possible, reducing stigma around seeking help, and equipping all system partners with the tools they need to respond, we can improve the accessibility, availability, and effectiveness of mental health interventions. This will ensure that young people in Illinois receive the help they need to thrive.

Introduction

History and Context

In February 2022, Illinois Governor JB Pritzker commissioned a report on the state of the Illinois children's behavioral health care system and a plan to transform the system to meet the needs of children and adolescents with mental health challenges. A team comprised of Chapin Hall policy and research analysts under the leadership of Dr. Dana Weiner, a child welfare and public policy expert with decades of experience collaborating with Illinois state agencies, engaged with hundreds of leaders, social service agencies, advocates, and families to understand the challenges to improving the State's response to the needs of young people with mental health challenges. The team developed a set of solutions released in February of 2023. Titled Blueprint for Transformation: A Vision for Improved Behavioral Healthcare for Illinois Children, it outlines a plan centered on 12 strategies that aim to adjust capacity, streamline access, and intervene earlier to prevent acute crises.

Dr. Weiner, now serving as the Chief Officer for Children's Behavioral Health Transformation, is working with leadership and collaboration from six child-serving agencies:

- Illinois Department of Healthcare and Family Services (HFS): This single state Medicaid agency administers and coordinates Medicaid benefits for nearly 1.5 million children, or an estimated 50% of the children in the state.
- The Department of Children and Family Services (DCFS): The child welfare agency provides child protection response to reports of abuse or neglect, placement for 22,000 youth in its custody, and in-home services to 4,000 families to prevent youth being separated from their parents or caregivers.
- The Department of Human Services (DHS) provides the State's residents with access to integrated services across the Divisions of Mental Health, Developmental Disabilities, and Substance Use Prevention and Recovery.
- The Department of Juvenile Justice (DJJ) houses and provides services to 145 youth in secure custody and 183 youth who are monitored and supported on Aftercare in communities throughout the state.
- The Illinois State Board of Education (ISBE) sets educational policies and guidelines for public and private schools and coordinates the efforts of over 850 school districts serving 2 million children in Illinois. ISBE oversees the distribution of federal Special Education funding to local districts, which can be used to support residential placement when required by a youth's Individualized Education Plan (IEP).
- The Illinois Department of Public Health (DPH) regulates inpatient care, including pediatric psychiatric hospital units, and provides education and outreach to promote awareness of mental and behavioral health concerns.

While the Blueprint is ambitious and far-reaching, it is buoyed by the commitment and collaboration of many partners from the health care delivery, technology, and financing sectors as well as broad legislative support and community engagement. Harnessing this enthusiasm, skill, and commitment requires persistent attention to the processes currently in place, the people they aim to serve, and the structures needed to support transformation.

Legislative Action

With unanimous bipartisan support, the 103rd Illinois General Assembly took historic action with the passage of Senate Bill 724, signed into law as Public Act 103-0546 by Governor JB Pritzker in August 2023. As the first piece of legislation to support the interagency work of the Children's Behavioral Health Transformation Initiative (CBHTI), the Act includes eight provisions that provide a legal foundation for transformational change in information sharing, centralized access to supports for families, and expansion of needed services. The Governor's FY24 budget includes allocations to support the technological and programmatic expansion that will be needed to fortify changes and ensure their sustainability over time.

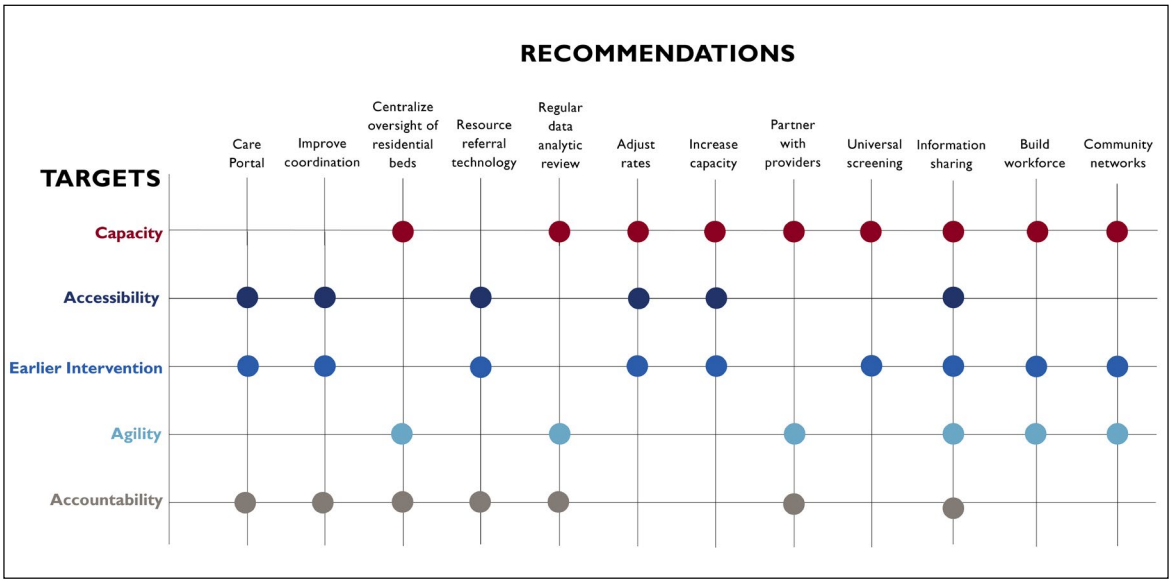
This piece of legislation included eight provisions that directly address Blueprint recommendations, requiring key changes in eligibility for services, requirements for providers, and work of State agencies. The eight relevant provisions of the law, along with lead agency and status, are listed below:

- **Landscape scan (ISBE; complete):** Requiring ISBE to build the foundation for annual mental health screenings for students in grades K–12 by conducting a landscape scan of current district-wide screening practices.
- **Leading indicators (HFS; in progress):** Requiring HFS to identify leading indicators for elevated behavioral health crisis risk and share them with Medicaid Managed Care Organizations (MCOs) and other HFS care coordination entities.
- **CCBYS expansion (DHS; in progress):** Broadening supports, expanding the population served, and lengthening the duration of placement without custody that Comprehensive Community-Based Youth Support (CCBYS) can provide to youth in crisis at risk of entering the child welfare system or juvenile detention. Expanding CCBYS will improve access to wraparound-style services to stabilize youth.
- **Interagency agreement (all; complete):** Creating an Interagency Children's Behavioral Health Services Team, consisting of DHS, HFS, DCFS, DJJ, DPH, and ISBE, and outlining the way in which representatives of these agencies will work together to achieve transformation.
- **Provider capacity reporting (DCFS; in progress):** Requiring all residential and institutional providers who receive reimbursement for children's mental health, substance use, and developmental disability services from HFS, DHS, DJJ, ISBE, or DCFS to submit staffing and occupancy numbers to DCFS to centralize oversight and management of residential treatment resources.
- **Portal development (DHS; in progress):** Creating a public-facing, centralized intake portal (the "Care Portal") hosted by the Division of Mental Health (DMH) within DHS to triage cases, manage information, and provide parents with guidance to access state programs.
- **CRSA navigational support (CBHTI; in progress):** Modifying the role of the Community and Residential Services Authority to operate as a Parent/Guardian Navigator Assistance Program.

Overview of Blueprint Recommendations

In the Blueprint, 12 recommendations are organized in three target areas: (1) Streamline and centralize, (2) Adjust capacity, and (3) Intervene earlier. The twelve recommendations are designed to accomplish five goals for system transformation as displayed in Figure 1. This set of strategies represents a multidimensional, integrated, and comprehensive approach to improving access to and availability of mental and behavioral health services for young people.

Figure 1. Recommendations to Accomplish 5 Goals for System Transformation



Given the complexity and autonomy of the six child-serving Illinois human service agencies, transformation will take time. However, work has begun on all 12 strategies to ensure that the necessary foundational tasks are accomplished.

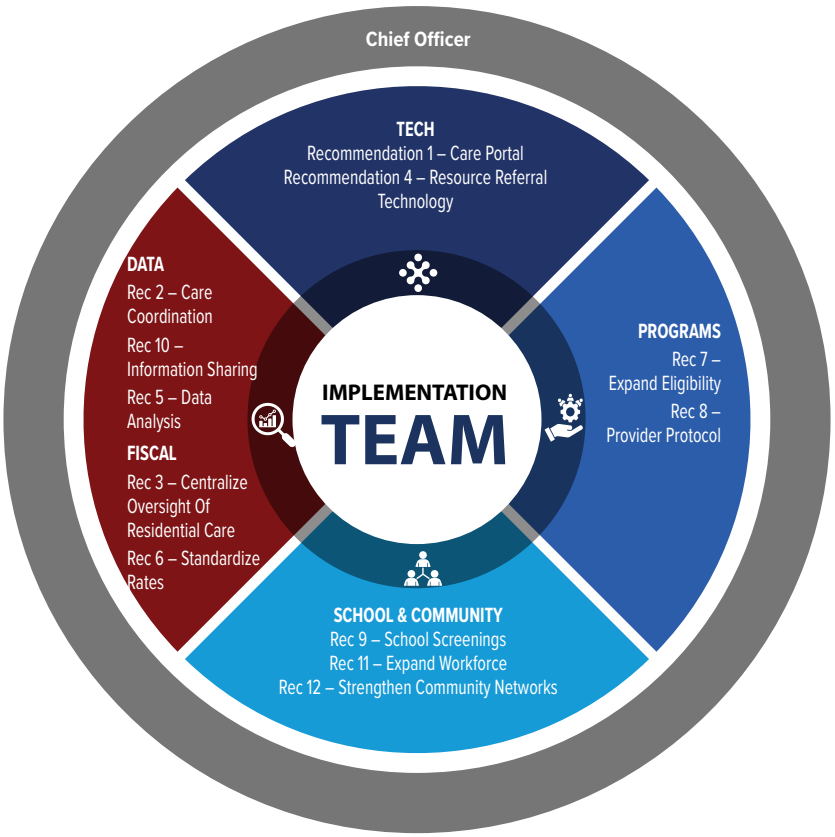
Implementation Strategy

Even the most comprehensive strategic plans do not guarantee a changed reality for children and families. Drawing on the field of implementation science and decades of experience implementing strategic initiatives in public systems, the Chapin Hall team developed an initial implementation plan that would ensure lasting change in the structures and processes for children's behavioral health care delivery. To do so, the Chief Officer established five implementation workgroups co-led by Chapin Hall and State staff and comprised of key subject matter experts from all sectors of state government. Figure 2 illustrates the structure of implementation oversight. During initial phases of implementation, other key stakeholders, provider partners, and individuals with lived experience were invited to join the implementation workgroups to discuss key decisions, vet plans, and provide feedback.

Leadership and Oversight

In implementation, it has been helpful to organize the recommendations around common tasks and the people who can accomplish them. This report provides the details on the work of the implementation teams organized around these key tasks. Each section will describe the goals and mission of the work group, progress toward key milestones, implementation considerations to inform planning, and legislative, budgetary, and other implications.

Figure 2. Implementation Workgroups



Each team began by agreeing on goals, mission, and indicators of outcomes, and by iterating methodically on a sequence of activities to achieve full implementation of each of the 12 Blueprint recommendations. In many instances, initial implementation could begin alongside planning; in these cases, the teams worked to engage diverse stakeholders, develop technical specifications, design data collection tools, and build processes that would expediate progress toward goals. This document describes the goals, plans, and accomplishments of these early implementation efforts.

Methodical Sequencing

The work on each of the 12 Blueprint recommendations is proceeding through a sequence of steps. Initial steps focus on *design*, that is, working to build consensus around a vision for change. Once the vision is clear, the groups work to *plan* for change, drafting technical specifications for systems, job descriptions for positions, or requirements for new processes. Once these plans have been finalized, the group will work to *install* new processes and systems, vetting these with participants and ensuring that processes can work as designed. Then, the group can work across sectors to *implement* the desired change. Figure 3 displays these steps in a sequence.

Figure 3. Methodical Sequencing Steps

Additionally, there are a set of considerations that will ensure that the necessary supports are aligned to promote successful transformation. Each of the teams have considered needs in these five areas:

- **Leadership, governance, and strategy:** What is the oversight and administrative structure? What are the goals? Who is responsible? Who leads?
- **Fiscal and policy alignment:** What legislative and policy changes are needed to support the new vision? What rate adjustments are needed and how will they be accomplished?
- **Data analytics and evidence use:** What analyses will inform estimates? What data and data linkage will we need to analyze the data? What best practice examples will be replicated?

- **Practice and implementation support:** What is the communication strategy? Who needs to be trained? What materials will be used for education, awareness, and training?
- **Continuous quality improvement:** What IT systems, metrics, and indicators should be installed to ensure quality implementation and positive outcomes for children and families?

Theory of Change

A "theory of change" provides a framework for articulating how and why a set of strategies is thought to be effective. It is developed collaboratively to inform implementation and evaluation by identifying root causes/problems, activities meant to address these, and proximal and distal outcomes that should be monitored. Theories of change are necessary for continuous quality improvement and formal evaluation efforts as they identify the types of data needed to measure implementation fidelity and outcomes (Permanency Innovations Initiative Training and Technical Assistance Project, 2016).[1]

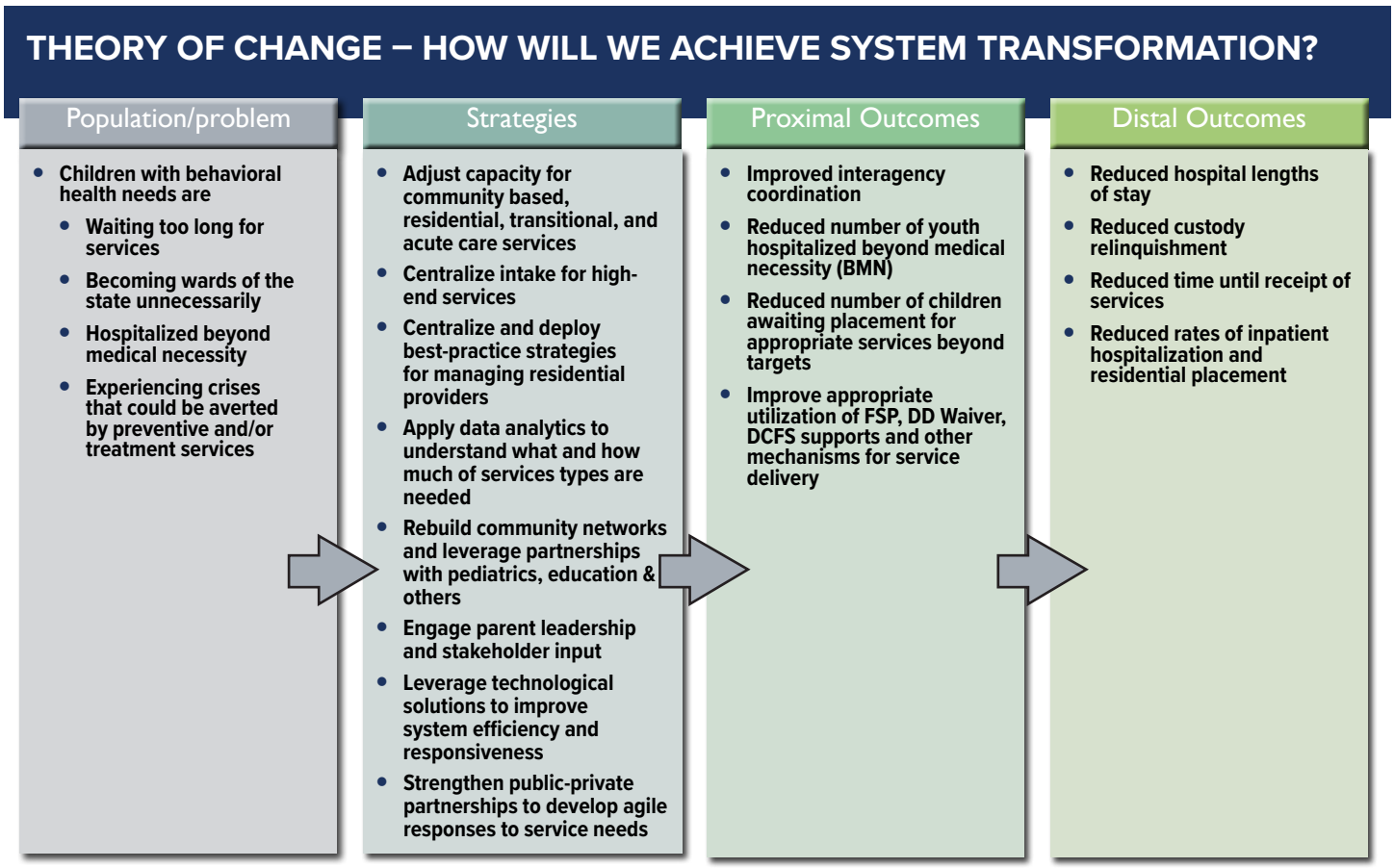
The theory of change for transforming Illinois children's behavioral health represents the views of key stakeholders, planners, and implementation teams who articulated problems and their root causes as well as desired outcome(s) and the strategies needed to achieve these. Together, the causal links they identified guide the pathway of change, from understanding the root cause of the problem to achieving the desired outcome.

To ensure accountability, monitor progress, and promote the detection of unintended consequences, this work is nested within a logic model that links the strategies with their targets and intended short- and long-term impact of transformative change. In the near term, we expect to see evidence of increased interagency collaboration, increased awareness of available resources among caregivers, more efficient and appropriate utilization of existing funding strategies, reductions in the number of children remaining in hospitals for psychiatric reasons beyond medical necessity, and reduced wait times for the most intensive treatments (such as residential treatments). In the long term, this work aims to improve the timeliness of detection of mental health service needs, reduce wait times for all service types, reduce unnecessary relinquishment of parental rights, and reduce inpatient hospitalizations. Figure 4 displays the full logic model for this work. By developing processes and technological applications as well as data linkage across state agencies, the Transformation Initiative team is working to build a foundation that will enable more formal evaluation activities to document the impact of this work.

Long-term success will be gauged through outcome measures that include shortened wait times and fewer hospitalizations. Until then, evidence of intermediate effects can be observed through the now-routine practice of interagency consultation and collaboration as well as anecdotal reports that cases addressed through the work of the interagency team are resolved faster and with more transparency than previously reported.

1. Capacity Building Center for States. (2018). *Change and implementation in practice: Theory of change*. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services

Figure 4. Logic Model for System Transformation



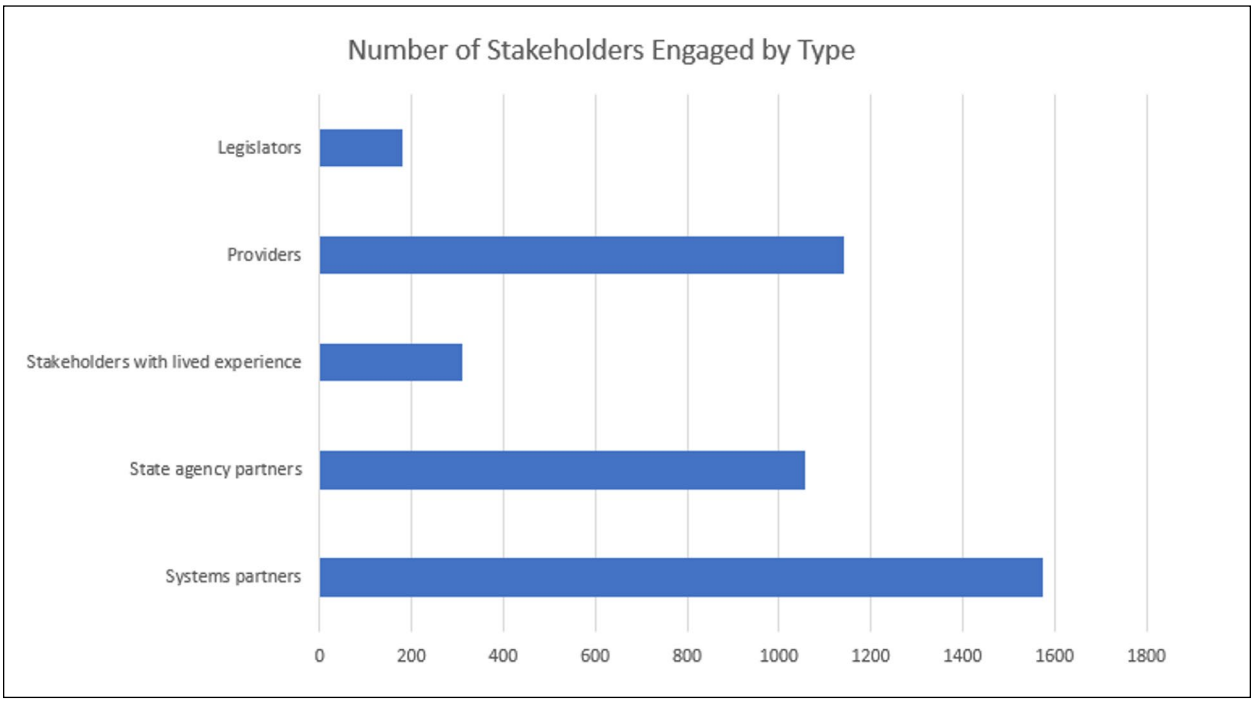
Key Drivers/Contributing Factors: Workforce shortage; agency siloes; uncoordinated legislation & policy; inconsistent rates and monitoring

Ongoing Stakeholder Engagement

Since its inception, the Transformation Initiative has been grounded in a multidimensional approach to systems change that is informed by diverse perspectives. Thus, the team has documented all the voices and perspectives that have been included in discussions to describe problems, highlight barriers, and identify solutions. In its implementation phase, the Transformation Initiative continues to engage diverse stakeholders to maintain universal engagement in the change process. Because the Blueprint for Transformation describes both technical and adaptive changes needed to achieve system transformation, and because adaptive changes require deep shifts in practice, roles, and structures, it is essential to work collaboratively with State agency partners to ensure that all participants are working toward shared goals for system improvement. Ongoing discussions with trade associations, provider networks, community groups, local health departments, parent and youth advisory boards, and other groups have been a core component of the team's implementation work.

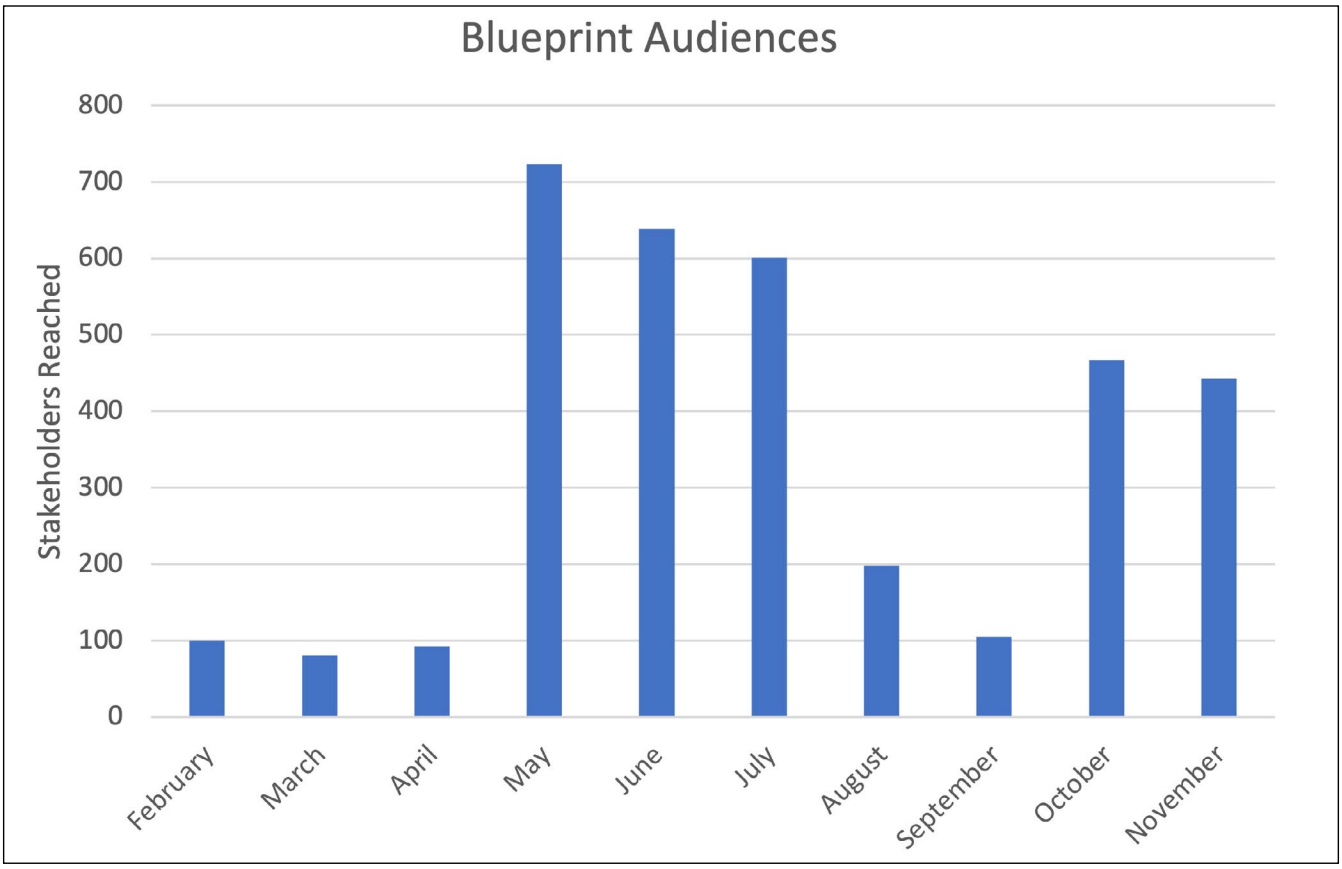
Ongoing conversations to review work streams with stakeholder groups, discuss policy changes with legislators, and engage informed participants in planning for change ensure the translation of recommendations to real changes in service planning, coordination, and delivery. Between February and November 2023, the team included over 4,255 participants. While the majority of the work has taken place in interagency implementation planning meetings with State agency partners, the team has also incorporated feedback from other system partners, providers, stakeholders with lived experience, and legislators. Figures 5-6 display the types of conversations and participants that were consulted in this process.

Figure 5. Stakeholder Engagement



In addition to overseeing the day-to-day work of implementation planning and the interagency team's efforts to expedite placement for children in need, Dr. Weiner prioritized presentations of the Blueprint and the associated implementation planning process to promote engagement, buy-in, and collaboration. She has personally engaged with 3,449 stakeholders in the last 10 months.

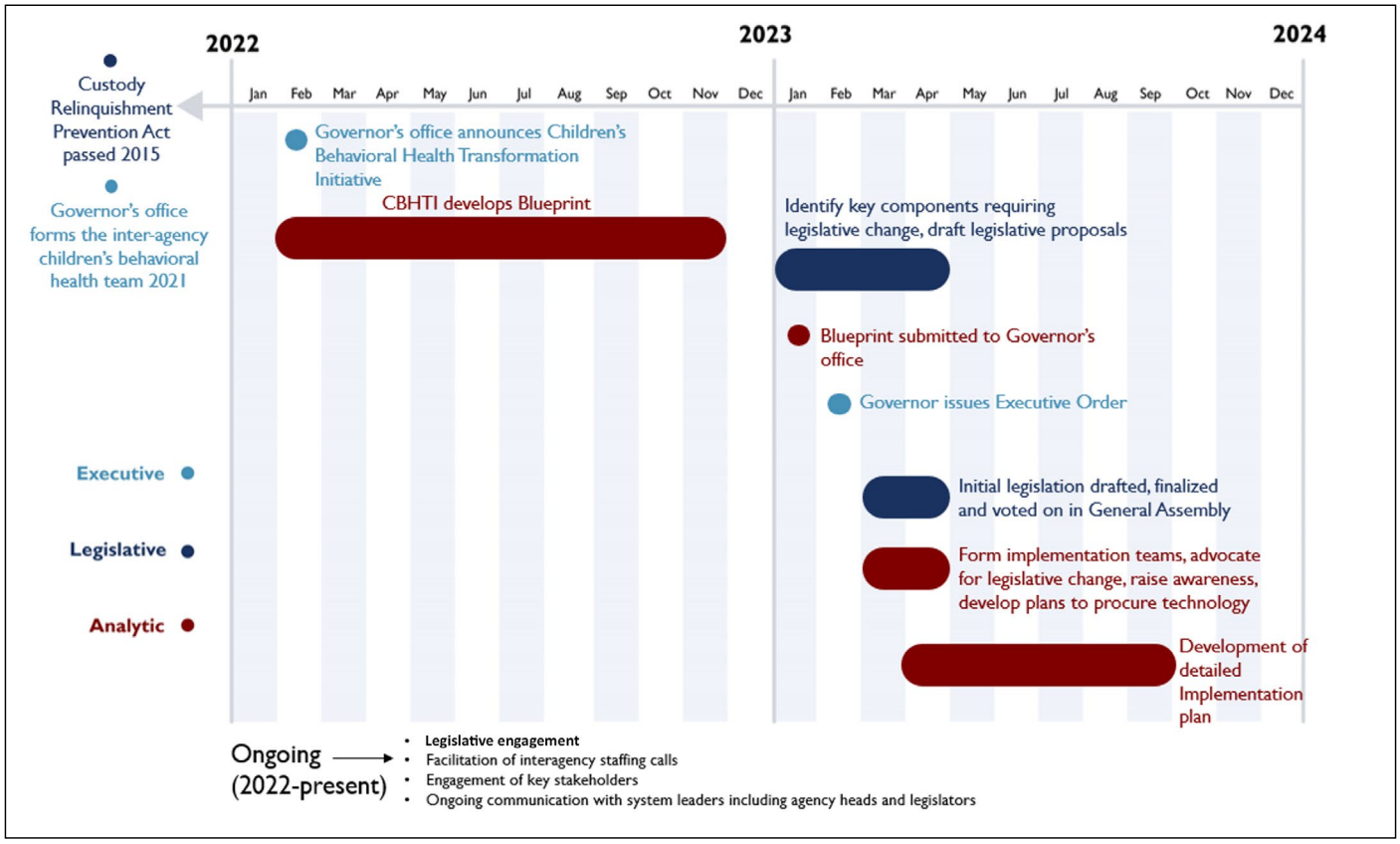
Figure 6. Stakeholder Engagement in Blueprint Presentations



Blueprint Implementation workgroups have hosted discussions, held listening sessions, provided opportunities for feedback and collaboration through "office hours," and sent out feedback forms welcoming engagement. The groups have specifically sought feedback from youth and individuals with lived experience, vetting business process maps and proposals for technological applications with them and other subject matter experts.

Collectively, this has resulted in a well-rounded realistic implementation approach and a highly informed field that is prepared for each new development as it launches. The convergence of support from the legislative and executive branches of state government with consumer and analytic communities illustrated in Figure 7 has provided hope for the reasonable achievement of shared goals: to streamline, expedite and expand access to mental health services for children and adolescents in Illinois.

Figure 7. Broad Collaboration on System Transformation



Progress Report and Detailed Implementation Plan

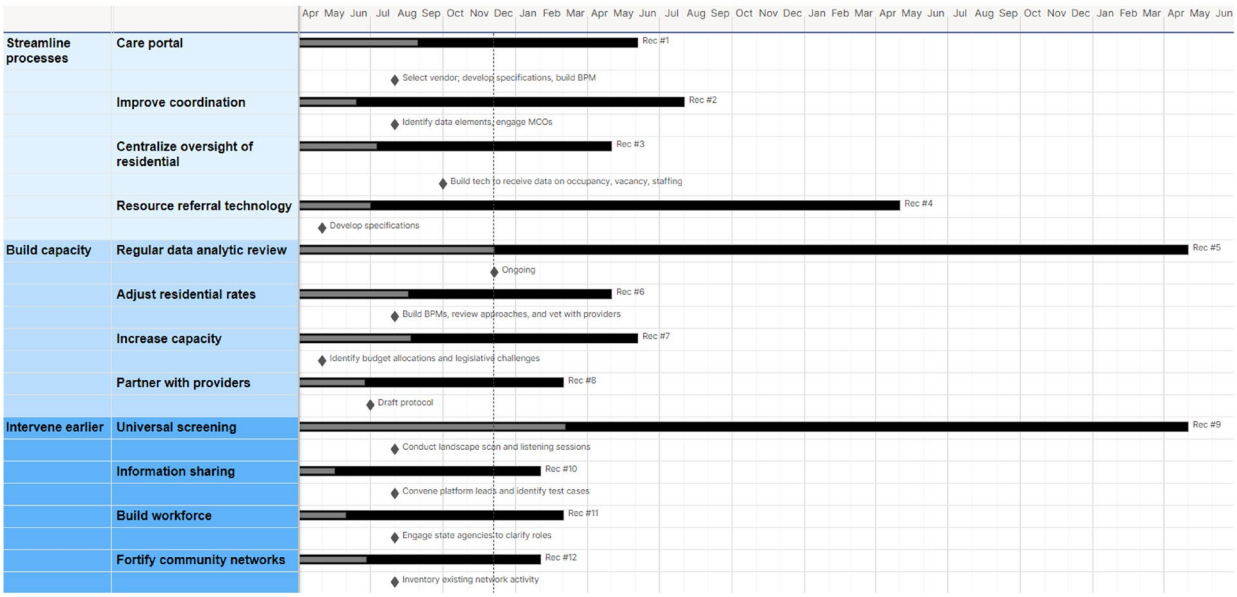
Overall, the group of Chapin Hall analysts, State agency leaders, provider partners, advocates, and people with lived experience who continue to work toward system transformation have made considerable progress. Most notably, State agency representatives now routinely collaborate not only on overcoming barriers to serving individual youth, but also on building capacity, developing technology, and understanding the complex processes around purchasing, procuring, and delivering care collaboratively.

Progress toward each of the Blueprint recommendations is displayed in Figure 8. Highlights from this period include:

- ***Technological development:*** Identification of a partner to develop the state-of-the-art Care Portal, securing a private sector investment of $1.5M to bridge the price gap. The first release of Care Portal is estimated to be complete in Summer 2024.
- ***Interagency collaboration on case resolution:*** 221 of 301 (73%) of the most challenging cases have been resolved using the interagency crisis team and the pilot portal. Lessons learned here will translate into the operation of the future Care Portal.
- ***Plans to improve early detection of mental and behavioral health service needs:*** Completion of the ISBE landscape scan documenting that 28% of school districts already conduct universal mental health (MH) screenings and another ~43% have some form of screening underway. The report identifies key elements of a path to offering universal in-school mental and behavioral health screening.
- ***Strengthening and restoring communities:*** Inventory of community networks reveals active networks in all Illinois counties but one, suggesting many potential partners to lead community-driven efforts to enhance service availability and accessibility.
- ***Streamlining and improving collaboration with private sector providers:*** Provider capacity reporting tool launched to capture residential capacity and staffing shortages statewide.

Progress toward recommendations varies across the twelve strategies as displayed in Figure 8. The length of each bar represents the time until the projected completion of the task, and the light bar within each colored bar represents the progress to date.

Figure 8. Implementation Progress



In addition to being led by the content-specific workgroups, each recommendation has a state agency "home" that has primary responsibility for its staffing, infrastructure, and implementation. Having this "home" allows State agencies to take collective responsibility for implementing components of the Blueprint and work together to ensure the interoperability of these components. Figure 9 illustrates the interaction of the six child-serving agencies in implementing Blueprint recommendations.

Figure 9. Illinois Agencies Collaboration on Implementation

BLUEPRINT RECOMMENDATIONS BY AGENCY

Recommendation	DHS	DCFS	HFS	ISBE	DJJ	DPH
Portal - Rec 1	■					
Care Coordination - Rec 2			■			
Centralize Residential Oversight - Rec 3		■				
Resource Referral Tech - Rec 4			■			
Data analytics - Rec 5						
Standardize Rates - Rec 6	■	■	■	■	■	
Expand Eligibility - Rec 7	■					
Provider Partnerships - Rec 8		■				
School Screening - Rec 9				■		
Information Sharing - Rec 10						
Expand Workforce - Rec 11	■					
Community Networks - Rec 12			■			■

The initial phase of this work has illustrated how State agency representatives can routinely work together to overcome barriers to serving individual youth, while collaboratively building capacity, developing technology, and understanding the complex processes around purchasing, procuring, and delivering care.

Think creatively to break barriers to serving young people. Since the Spring of 2022, a group of representatives from the six child-serving agencies (DCFS, DHS-Division of Developmental Disabilities, HFS, DJJ, DPH, and ISBE) have convened weekly to expedite placement and services for young people experiencing acute need for mental health treatment. This group, led by Dr. Weiner, has encountered myriad challenges. But when faced with the urgency of intensive needs in individual cases, it has been able to identify and overcome barriers to providing services. These barriers include, but are not limited to eligibility criteria, funding streams, the need for a higher adult-to-child ratio within a residential setting, judicial decisions, and the limited capacity or availability to deliver needed services due to contracting, workforce, or other issues. Inspired by successes, the group celebrates every case resolution and notes the key drivers of success for future cases. This group's work has led to the development of several strategies to streamline access to services, including starting a working group on the specific needs of youth with developmental disabilities aging out of DCFS care, improved communication with hospital personnel, and most importantly, regular inter-agency collaboration that leverages the use of secure technology and parental/youth consent to dissolve the boundaries between state agency silos. Over 300 cases have been collaboratively staffed in this way, with a resolution rate of 73%. While our system still falls short in some ways, hospitals, legislators, and families have expressed appreciation for this centralized approach. They have noted improvements in the speed and responsiveness of post-acute service delivery for youth who have experienced psychiatric hospitalization. This process has also highlighted the creative ways in which State agencies can collaborate to leverage each other's program offerings, engagement approaches, and flexible funding to ensure that all child and family needs are met. Creative solutions, in turn, inspire policy changes that can achieve lasting change. Examples of creative solutions include:

- Development of channels by which young people receiving services from Comprehensive Community-Based Youth Support (CCBYS) can become eligible for and enroll in Pathways
- Expanding the ways in which CCBYS can identify and serve eligible youth
- Consolidate residential resources for youth with juvenile justice or DCFS involvement
- Incorporate Community and Residential Services Authority (CRSA) experts as parent "navigators" for cases that are entered into the portal
- Build functionality allowing streamlined secure inter-agency communication
- Create a central repository for family documents submitted in application for residential resources

Absorb complexity within the state to simplify families' experience of seeking services. Young people and their families consistently report that the process of seeking services is cumbersome, opaque, confusing, and frustrating. With funding for new technology and authority to change longstanding protocols, the Transformation Initiative provides an opportunity for the state to absorb this complexity "behind the scenes," so that what families see and experience is simple, streamlined, and efficient. The state needs to complete work to reduce redundancy and complexity in funding streams, application processes, eligibility determination, and service delivery before we can leverage tools and linkages to ensure that families provide a single set of documents and information. Redundancy needs to be reduced so state agency representatives navigate can

systems on families' behalf to deliver a more responsive user experience. Identifying appropriate programs and securing the necessary resources can be accomplished by state partners so that families interface with fewer people and receive clearer information and more speedy resolutions.

Leverage secure technology to improve timeliness, efficiency, and effectiveness of interventions to address mental health challenges. Despite the tremendous promise of technological innovation for speeding processes, reducing redundancy, and improving access to services and information, human services lags behind other sectors in implementing technological tools for improving access and outcomes. Several technological tools are under development to speed the implementation of Blueprint recommendations, including:

- The Care Portal, to be hosted, staffed, and managed collaboratively by the Division of Mental Health in the Department of Human Services and the Transformation Initiative.
- A Statewide Resource Referral tool, to be procured and licensed by the Department of Healthcare and Family Services, that will allow easy access to information on community-based supports and services to all helping professionals and community members.
- The Provider Capacity Reporting tool, hosted by the Department of Children and Family Services, which will replace other outdated reporting mechanisms to ensure that all state agencies seeking residential treatment for youth can view available capacity.

Along with these new applications, efforts are underway to identify tools currently in use for identifying resources, making referrals, and delivering services so that these can be linked to centralized systems, ensuring seamless transitions, interoperability, and a user experience that is easy, clear, and productive.

Elevate youth and family voice to ensure that changes are accessible and have the desired impact on young people. In order to meaningfully improve the delivery of behavioral health services to young people, efforts and strategies must be driven by the needs of young people and their families. At every point in the transformation process, the team has sought to partner with adults and youth with lived experience to ensure that plans align with the goals, needs, and struggles of Illinois families. This collaboration, reflected in the broad stakeholder engagement previously described, requires that people with lived experience have multiple channels through which to convey their preferences. It also requires system leaders to prioritize this input when making and implementing plans. At several key junctures, the process of sharing strategies with families has yielded important insights that have shifted plans and, hopefully, enhanced the potential for impact. Examples include:

- Families conveyed that a key function of the new Care Portal should be to allow uploading of relevant documents so that these can be stored in a single, accessible, secure location.
- Youth in some foster care placements described challenges accessing technology that would give them the ability to seek services independently.
- Parents and young people reflected on in-school screening for mental health concerns, including preferences for how and when screening would optimally occur.

Strategies, Progress, and Plans by Recommendation

Recommendation 1:

Create a centralized Care Portal for families seeking services for children with significant and complex needs.

Agency Lead – DHS

The Blueprint highlights the potential for technology to support transformation and drive changes in the way the public system responds to people in need. First among these technological approaches, and central to the success of the Blueprint strategies, is the "Care Portal." This application will provide a centralized platform to guide families seeking behavioral health services for children and adolescents in Illinois toward the appropriate resources. Replacing the existing complex and fragmented pathways, the Care Portal will offer a unified, user-friendly interface for families, educators, and concerned individuals to navigate Illinois's children's behavioral health service system.

The Care Portal's key features will include a straightforward interface for entering relevant information about a child and their needs, secure data sharing among State agencies, a streamlined referral process, and algorithmic matching of services based on reported needs. Activity in the application will be used to generate regular reports and support a real-time dashboard of key performance metrics that will be used to monitor crucial service delivery indicators and enable continuous monitoring of the system's effectiveness.

Progress

By December 2023, several key milestones have been reached in the development of the Care Portal. They are:

- Finalizing technical specifications and a business process map that describes the operation of the portal and the flow of cases through a process for obtaining information and assistance.
- Developing position descriptions and begin hiring the staff who will manage the portal and oversee the work of responding to families seeking assistance.
- Selecting a vendor/partner to develop state-of-the-art technology, leveraging the State's master contract and vendor investment.
- Adapting, per Public Act 103-0546, the CRSA to function as navigational assistance.

The design and implementation of the Care Portal was developed in collaboration with stakeholders from across the State agencies who will be impacted by its implementation as well as providers and parents of children with behavioral health needs. As a result, the Care Portal reflects a deep commitment to equitable access and effective support for children's behavioral health needs. By leveraging technology and fostering collaboration, the Care Portal will improve access to high-quality mental health services for youth in Illinois.

There has been significant progress in implementing the Care Portal. The initial task completed was to establish an interagency working group to support and advise the development of this tool. This work group explored the viability of multiple procurement pathways, comparing funding routes to identify the best way to deliver the Care Portal in a timely way. This approach, involving iterative feedback, engagement with stakeholders, and adherence to a well-defined timeline, established a method for developing the additional work products required to implement this application.

The second major deliverable was the creation of a draft comprehensive business process map. This map answers key questions about user needs, the desired functionality of the application, and how to operationalize data collection and reporting. The work group started creating this map in February of 2023 and completed an initial draft in July. By leveraging the interagency working group, the draft business process map contains robust input from the affected agencies, service providers, and parents with lived experience. The business process map is the foundation of the Care Portal and will be critical to articulating the vision for the tool to application developers.

Additionally, as part of the development process, a set of user "personas" were created. These personas were meant to illustrate use case scenarios for all users of the Care Portal, including agency staff, providers, and parents. In addition to informing the business process map, the personas directly influenced the DMH staffing plan and position descriptions for the Care Portal. Additionally, these personas facilitated a discussion of the CRSA program and how it would be integrated into the Care Portal process.

Finally, this work led to the completion of a draft set of business requirements for the Care Portal at the end of July 2023. Meeting these requirements is essential for developers to build an application that effectively meets the needs of the target populations outlined above. As the interagency team that is guiding the development of the Care Portal engaged outside developers, vendors asked for the requirements document to provide accurate estimates of product functionality, build work product timelines, and complete cost estimates.

Plans

The next phase of work on the Care Portal will be focused in three areas:

1. Tool development in partnership with tech vendor.
2. Operational design to elaborate on identified pathways for families to receive information, referrals, and interagency assistance.
3. Hiring and staffing. The Division of Mental Health within the Department of Human Services along with the Director of Operations for the Children's Behavioral Health Transformation Initiative will have collaborative oversight of the Care Portal. Now that the first three Resource Coordinator positions have been filled, these two entities will work together to develop a roll out and training timeline for Portal staff.

Recommendation 2:

Improve coordination of service delivery, ensuring more seamless transitions and earlier detection of elevated risk.

Agency Lead – HFS

Strategy

Given the large proportion of Illinois youth covered by Medicaid and the proliferation of Medicaid Managed Care for coordinating the services and supports needed by these youth, this strategy focuses on improving the accuracy, precision, and timeliness of information accessible to Managed Care Organizations (MCOs) that can be used to detect early risks for mental health crises and intensify services as needed. Current barriers to information sharing, paired with insufficient analyses to guide the identification of lead indicators, have compromised the ability of MCOs to detect risk and intervene early. To address these challenges as called for in Public Act 103-0546, the Transformation Initiative is working to develop the field's understanding of lead indicators using analysis of linked data. Once indicators are identified, HFS and the Transformation Team will assess the feasibility of providing lead indicator data to MCOs and will develop best practice expectations for service intensity and type based on early indicators of crises.

Progress

Initial meetings to explore the possibility of data linkage resulted in a plan to leverage two of the State's interagency data linkage platforms (HHSI2 and ILDS) for data analysis that can identify lead indicators. Similarly, clinical and program partners participated in initial conversations to learn about the analytic approach and brainstorm about predictors of mental and behavioral health crises so that the project team can assess the feasibility of including these data elements in analyses. Engagement with the leaders of data linkage platforms, along with HFS partners and clinical/program staff, has resulted in the identification of a set of data elements that should be considered for inclusion in data analysis.

Plans

The next phase of work on the identification of lead indicators for improving care coordination will entail both analytic and operational components:

Analytic

1. Assessment of the feasibility of including each of the identified potential lead indicators in data analysis.
2. Building a linked dataset comprised of the potential lead indicator data elements.
3. Development of predictive risk models to identify empirically based lead indicators for mental/behavioral health crises.
4. Test predictive risk models to assess the accuracy and precision of these models.

Operational

5. Develop operational protocol to improve access to lead indicators among Medicaid MCOs
6. Work with the stakeholder group and Medicaid MCOs representatives to develop expectations for service intensity and type based on early crisis detection
7. Develop monitoring functions to ensure that Medicaid MCOs deliver the appropriate type and intensity of services when elevated risk is detected.

Recommendation 3:

Centralize oversight of residential beds to reduce duplication and enable more effective management of residential treatment resources.

Agency Lead – DCFS

Strategy

In Illinois, residential treatment may be secured and funded by one of five State agencies: DJJ, DCFS, DHS via Division of Developmental Disabilities Waiver, HFS via Family Support Program, or ISBE via local school districts for youth with Individualized Education Plans that specify need for an alternative educational environment. Residential treatment is provided by private social services agencies through contracts with State agencies, local school districts, or Medicaid enrollment. The process for setting rates for this type of treatment is complex and has evolved separately for each funding mechanism/agency. This means that providers may have different funding arrangements and rates depending on how a youth is referred; this can influence provider decisions about which youth to accept and how to manage their caseloads. These practices also impair the State's ability to effectively manage residential treatment capacity. To address these challenges, Recommendation 3 aims to create a process and structures to support centralized oversight of these resources.

Progress

Since the Spring of 2023, the Transformation Initiative has convened Contracts and Finance leaders of each child-serving agency in regular biweekly discussions about the feasibility of centralizing the oversight of residential services. This group has developed plans to synchronize pricing assumptions for residential treatment (Recommendation 6) as well as strategies for piloting single contracts for new residential programs that could meet the needs of youth whose treatment is funded by DHS, ISBE, and DCFS. Similarly, DCFS has leveraged Capital Grants to develop 110 new residential beds that will be available in the next year. While many of these beds will be used to provide treatment for youth in DCFS custody, they can also be used to provide care to youth who remain with their families but require residential treatment for behavioral health concerns."

In accordance with Public Act 103-0546, this new approach requires that providers regularly report on capacity, staffing levels, and occupancy to a central repository. While this reporting may be redundant with other processes in the near term, the Transformation team is working with providers and State agencies to identify opportunities to reduce duplication and generate reports that can be used to identify openings and capacity in real time. This will eliminate the need for slow, burdensome emailed reports of capacity and phone calls to ascertain openings. To enable this process, DCFS built a Provider Capacity Reporting Tool that sits as a module within the existing Provider Portal. In collaboration with the Transformation Initiative and DCFS Communications, the agency rolled out this tool on November 1, 2023, along with training and guidance on how to access and use it.

These initial steps have tested these agencies' ability to work collaboratively on strategies to plan for services with providers in a way that eliminated competition between them.

Plans

The next phase of work on this strategy will entail:

1. Discussion with providers to obtain insights on the use of the new Provider Capacity Reporting Tool and suggestions for reducing duplication.
2. Developing business process maps of current placement processes by each of the State agencies to ensure that reports from the new tool provide adequate timely information to agencies as they seek to match youth with appropriate residential programs.
3. Developing compliance monitoring plans to encourage timely and regular submission of provider capacity.
4. Developing reports to replace current processes for identifying available capacity.
5. Implementing strategies by agency contract offices to adjust purchasing in accordance with capacity and utilization data.
6. Opening new programs with shared agency capacity.

Recommendation 4:

Implement Resource Referral Technology to enable families to more easily link to services in their communities.

Agency Lead – HFS

Strategy

The primary goal of Resource Referral Technology (RRT) is to simplify and expedite the process of connecting families with services in their communities. This recommendation aims to overcome the current challenges of navigating the fragmented service landscape. RRT offers a comprehensive and accessible platform that can streamline access by eliminating the barriers families face when accessing community-based services.

As we implement other transformational changes that allow us to detect service needs, it will be essential to ensure that every person who might be in a position to respond by providing helpful information or referrals has access to a comprehensive, up-to-date system for referring families to community-based resources. While some communities in Illinois already access systems such as Integrated Referral and Intake System (IRIS) or 211, there is no uniform approach or interoperability between these systems. The Transformation Team is working to ensure that everyone across the state has access to comprehensive, accurate information about local services.

Progress

Initial work on developing a statewide RRT involved convening stakeholders from state agencies to identify needed functionality and understand the ways in which agencies currently manage need and resources for outpatient behavioral health. Key accomplishments during this phase have included:

1. Developing a comprehensive business process map that defines key functionality and technical requirements and aligns the RRT with the Care Portal.
2. Evaluating procurement viability and funding options to ensure sustainable development.
3. Developing a comprehensive plan for integrating the RRT within existing systems and the Care Portal.

Plans

In the next phase, HFS will work to develop the Implementation Advanced Planning Documents (IAPD) informed by consultation with other states that have successfully leveraged Medicaid funding to pay for the building and licensing of RRT. At the same time, IDPH is dedicating resources to understanding the current use of resource referral technology platforms across the state. This will be important to ensure that the initial Care Portal, which will launch prior to the development of the RRT, can link to existing platforms. These resources will also help understand lessons learned from local implementation of RRT.

Recommendation 5:

Use regular data analytic review to inform provider capacity adjustments.

Lead Agency – CBHTI

Strategy

Developing agility and ensuring that capacity is adequate to meet youth needs across the state requires regular data analysis to inform provider capacity adjustments for both residential and community-based behavioral health services. Both capacity adjustments employ spatial gap analysis, a type of geospatial analysis that compares the location of service providers to the location of clients in need of those services. Spatial gap analysis can be completed at various geographical levels (counties, designated service areas, zip codes, census tracts) but must have some measure of the difference between supply (total units of service that can be provided and accessed) and demand (total units of service needed by the target population).

The residential gap analysis conducted to inform the Blueprint used youth characteristics as well as geographic location to adjust the supply of residential treatment beds. This analytic approach can inform decisions regarding capacity, such as increasing supply in areas where the number of youth needing residential care is greater than the number of residential beds currently available, or right-sizing residential care for specific subpopulations of youth with different behavioral health needs. Recognizing the dynamic nature of youth behavioral health in Illinois, a well-functioning system can utilize gap analysis to adjust capacity on a recurring basis in response to changes in need across the state. A data system that translates and visualizes real-time supply and demand data into easily understood gap estimates and maps is vital for state agency leaders and residential providers.

As described in Appendix C of the Blueprint for Transformation: A Vision for Improved Behavioral Healthcare for Illinois Children, the Transformation Team also completed a geospatial gap analysis on the supply of community-based outpatient mental health services and the estimated prevalence of mental health service need. This analysis will be used to prioritize service areas in the context of funding opportunities as a strategy to promote equity in access to needed services. It will also serve as the methodological foundation for the development of the Adversity Index required by Public Act 103-0413.

Progress

Chapin Hall partnered with DCFS and ISBE to conduct a residential gap analysis detailing residential supply and demand levels across Illinois. The analysis allows the user to view an interactive map that shows supply, demand, and the resulting service gap at different geographic levels. This map and analysis were used as the basis for developing the Provider Capacity Reporting Tool described in Recommendation #3. The interactive map also shows how service gaps respond to changes in length of stay, for example, showing how reducing length of stay can reduce service gaps due to the availability of more beds.

Demand data were estimated for the DCFS and ISBE residential care populations using separate data from each agency. In addition to guiding the allocation of capital grants to develop needed beds, this analysis identifies subgroups of youth who might be more appropriately served in other settings. This residential care analysis can be used to guide contracting and purchasing decisions by the State agencies as they plan to develop new residential resources.

Together, these analyses have demonstrated the value of ongoing data analysis for informing resource development efforts, providing more geographically targeted service development strategies, and for monitoring progress of the Initiative itself, by illustrating changes in resource gaps.

Plans

The next phase of this work will continue to refine analytic approaches and explore opportunities to apply these analyses to refine the service array, including:

1. Working with DHS to apply adjusted service need estimate maps to future funding opportunities, prioritizing geographically underserved areas.
2. Informing the distribution of DCFS capital grants in areas (clinical and geographic) that should be prioritized for service development.
3. Developing processes for utilizing the provider capacity data (see Recommendation 3) to inform projections and capacity adjustments.

Recommendation 6:

Adjust rates, including pricing consistency for similar services across agencies.

Lead Agency – All

Strategy

With representatives from four state agencies and the Purchased Care Review Board, the fiscal implementation workgroup explored a variety of approaches to rate-setting. The group aims to improve the consistency of pricing and purchasing practices in order to better manage capacity to serve Illinois youth with behavioral health challenges who require residential treatment.

Today, each agency uses a distinct approach to rate setting that relies upon a blend of strategies, based on last year's costs as well as a complex formula that arrives at a rate specific to each combination of client and program. Depending on the agency, costs for housing, treatment, and educational components of residential care are incorporated into pricing models. The Fiscal Implementation workgroup aims to maximize federal participation by relying on Medicaid-approved rate methodologies where possible and by participating in other federal reimbursement programs (such as Title IV-E) for non-Medicaid services.

Progress

To improve the ease and transparency of contractual negotiations with providers and remove some of the incentives for preferential acceptance of referrals, five state agencies (ISBE, DCFS, DHS, DJJ and HFS) are exploring rate-setting approaches and refinements to improve the consistency and transparency of pricing for residential services. Inconsistencies in agency-specific practices arise both from differences in rate setting approaches as well as separate contracts with agency-specific requirements. The workgroup is considering modifications to rate-setting and a "test case" for simplifying (and potentially unifying) aspects of contracting.

Each agency participated in the development of a business process map that visually depicts the rate-setting process in order to identify commonalities as well as inefficiencies and potential opportunities for improvement. While rates for residential treatment may be established in a variety of ways (for example, agency worksheets and processes, Purchased Care Review Board, or Medicaid) this collaborative examination illuminates existing synergy and opportunities for synchronization. For example, 21 of the 25 in-state ISBE-approved providers (84%) have rates coordinated with the DCFS/DHS/HFS rate. Thus, current efforts are likely produce higher rates that are automatically adopted by most of these providers.

In addition to developing business process maps to depict the rate-setting process in place by DCFS, ISBE, DJJ, and DHS, the workgroup reviewed a number of approaches to pricing. The group has agreed that shifting to a "component parts" pricing approach that deconstructs rates into component parts and seeking consensus across purchasing agencies on the pricing for components would lead to consistency. The approach would still allow

for pricing that matches needs with specific program offerings. In the context of this approach, similar services performed by similar staff for children with similar needs will be paid at similar rates. Program components that lend themselves to "component parts" pricing include:

- salaries and wages by position,
- minimum education and experience requirements by position,
- child to worker ratios by position/service, and
- fringe benefits.

The workgroup also discussed practices that may contribute to inconsistency or unintended consequences, including: 1) how the lead State "rate setter" is identified (currently the agency placing the majority of youth in a facility); 2) the pre-purchasing of guaranteed beds with implications for inter-agency placement; and 3) the geographic variability in costs and how they are incorporated into rates. The workgroup is also exploring ways to address these issues outside of the rate-setting process if that is the most direct/efficient solution.

It is especially important to consider pricing and capacity as the state continues to refine and expand the array of residential options for youth requiring intensive treatment.

In the case of new resources, such as Psychiatric Rehabilitation and Treatment Facilities (PRTFs) for which the Illinois rates have not yet been established, there is an opportunity to develop a rate that could be Medicaid approved.

Plans

As DCFS continues to support the development of new facilities through capital grants, it will create opportunities to pilot rate setting and contracting approaches collaboratively developed by representatives from all of the state agencies. It is estimated that the first test of a centralized contracting strategy will occur with the program under development at West40 in the Spring of 2024.

In the near term (budget permitting), the team proposes adjustments to synchronize rates for some residential programs between DHS, ISBE, and DCFS in FY25. Subsequent steps will include:

1. Developing projections for the long-term budget implications of pricing and rate-setting adjustments.
2. Developing PRTF and exploring optimal rate-setting approaches.

Recommendation 7:

Increase capacity to serve more children and families by expanding eligibility and developing new service types.

Lead Agency – DHS

Strategy

The success of process improvements and new technology for improving the timeliness and efficiency of service linkages depends upon adequate capacity to provide services to young people who need them. The Blueprint outlines an approach that considers existing resources, identifies examples of new practices that could be implemented in Illinois, and bases future decisions about capacity adjustments on ongoing data analysis described in Recommendation 5. With support from the General Assembly through Public Act 103-0456, the DHS program designed to avert State custody (Juvenile Justice or Child Welfare) is undergoing an historic expansion, allowing both an increase in the number of youth being served *and* expanding the duration of an "emergency placement" that does not require State custody to 21 days. These changes require intensive collaboration between state agencies and private social service agencies ("providers") who deliver these services, with facilitation and leadership from the Transformation Team.

Progress

In the first year of implementation, the Transformation Team has worked with State agencies to develop and support over 4,200 additional "slots" for needed services. These include:

- Expanding CCBYS programming to serve 750 additional youth at risk of Juvenile Justice system involvement ($3 million budget allocation).
- Increasing services available to 500 children and young adults through the Children and Young Adults with Developmental Disabilities – Support Waiver via PUNS list selection ($10 million budget allocation).
- Developing over 100 additional beds in residential treatment settings for youth with behavioral or developmental disorders (through DCFS Capital grants, expected delivery late 2024).
- Enrollment of over 2000 youth in the HFS Pathways to Success program, which provides high-fidelity wraparound and other supportive services to youth with intensive behavioral health care needs.

In addition, the team has worked with DHS and HFS to identify opportunities to deliver services not typically available in Illinois. These services include *personal support workers* who can provide one-on-one, in-home support to young people with substantial behavioral health challenges in order to avoid the need for more intensive residential services and to facilitate transitions home after inpatient psychiatric stabilization.

Plans

In the next phase of this work, the Transformation team will continue to work on developing service types and ensuring that services for eligible youth can be easily accessed. This will include:

1. Work with DHS and HFS to develop a process by which youth whose CCBYS service is complete can qualify for enrollment in Pathways to Success.
2. Document that youth who are selected from PUNS or receive crisis funding are receiving in-home or residential waiver supports through either the Children and Young Adults with Developmental Disabilities – Support Waiver or the Children and Young Adults with Developmental Disabilities – Residential Waiver.
3. The development of emergency beds for the CCBYS population, along with revisions to the program manual to guide provider agencies in supporting emergency stabilization for up to 21 days.

Recommendation 8:

Partner with providers in a standard protocol to encourage consistent and transparent development of programs.

Lead Agency – DCFS

Strategy

To fortify and enhance collaborative relationships between providers and the six child-serving State agencies in Illinois, the Program implementation team aims to centralize the process of identifying and articulating the State's capacity needs to gain a more robust understanding of the service gaps and providers needed. To do this, the Team is developing a protocol for engaging and supporting providers seeking to partner with the State. The protocol will involve the identification of contracting, licensing, and technical assistance needs that will allow providers to work with State agencies in Illinois.

Progress

Each state agency participated in developing a business process map that visually depicts the steps for engaging providers in the standardized protocol process.

Based on these existing processes, the team has worked collaboratively to build a standardized protocol for contracting with the State of Illinois involving several steps, including:

1. Scope and objectives: The Program Implementation team defined the scope for building the protocol and identified the objectives it should achieve. This protocol includes streamlining the contracting and licensing process, ensuring compliance with regulations, and promoting transparency and accountability.
2. Needs assessment: The team worked with each state agency to assess the specific needs and requirements of the agency, including goals, desired outcomes, and specific regulations or policies that need to be considered in the contracting process.
3. Existing protocols and best practices: The Program implementation team, with support from the broader Blueprint implementation team, researched existing protocols and best practices for contracting with State agency providers. The team also examined successful models used by other agencies or organizations that could be adapted.
4. Draft protocol: Based on the needs assessment and best practices, the team developed a draft protocol with sections for needs assessments, precontracting activities, system navigation, licensing and contracting negotiation and execution, performance monitoring, and technical assistance.
5. Consultation and collaboration: The team shared the draft protocol with key stakeholders to seek input and feedback.

6. Legal review: With the support of the Chief Officer of the Children's Behavioral Health Transformation, the Program Implementation team consulted with legal experts on rules regarding procurement compliance with relevant laws, regulations, and policies to ensure that the protocol protects the interests of the State agencies while adhering to legal requirements.

Plans

The next phase of this work will involve the following:

1. Finalize approach with necessary approvals from relevant authorities, including the state agencies, the Chief Officer of the Children's Behavioral Health Transformation, and the Governor's Office. The Program implementation team developed a detailed implementation plan outlining the steps and timeline for rolling out the protocol.
2. Develop a central business unit to house the technology, system navigation, and communications. The team will work with leadership to identify the proper technology and technical assistance needed to activate the standardized protocol.
3. Conduct training sessions to familiarize staff involved in the contracting process with the new protocol. Communicate the protocol to all relevant parties, including potential providers, to ensure transparency and consistency.
4. Establish a process for monitoring the implementation of the protocol and evaluating its effectiveness. Regularly review and update the protocol as needed to address any challenges or changes in regulations.

Recommendation 9:

Offer universal screening in education and clinical pediatric care to detect and address mental and behavioral health problems early.

Lead Agency – ISBE

Strategy

It is essential to detect mental health problems early in childhood in order to prevent unaddressed issues from escalating into larger problems as children grow into adults. Mental and behavioral health screening within schools and pediatricians' offices, similar to hearing and vision screenings, can play a crucial role in identifying and addressing mental health issues that can be barriers to learning and development at an early stage in childhood or adolescence. Screenings help detect problems that may otherwise go unnoticed and hinder a student's ability to succeed in school and life. Recommendation 9 calls for the Illinois State Board of Education (ISBE) to develop plans to offer these screenings universally to students in Illinois.

Progress

In accordance with Public Act 103-0546, ISBE conducted a landscape scan of current district-wide screenings, recommendations for screening tools, training for staff, and linkage and referral for identified students. The purpose of the landscape scan was to determine the current practices school districts and school entities employ related to mental and behavioral health screening of students. Additionally, the landscape scan gathered data about the field's perceptions of the benefits and challenges of universal screening.

ISBE conducted this scan using two methodologies: an online feedback form distributed to all 852 Illinois school districts, Regional Offices of Education, intermediate service centers, and state authorized charter schools, and listening sessions offered across the state to parents, school personnel, and students. The feedback form provided an opportunity for districts or other public entities that provide school programming to public school students in Illinois to offer input about mental and behavioral health screening in schools. A total of 649 entities (618 school districts, 23 Regional Offices of Education, and 8 charter entities) completed the feedback form. Additionally, 557 individuals participated in 13 statewide listening sessions either virtually or in person.

The Transformation team, in partnership with ISBE, analyzed the data and incorporated the findings into a report for the governor and General Assembly with a set of recommendations regarding the implementation of universal mental and behavioral health screening of students. The report https://www.isbe.net/Documents/Lessons-Learned-Landscape-Scan-Mental-Health-Screening-IL-Schools.pdf recommends four strategies based on feedback from respondents:

1. Develop a phased approach to universal mental health screening[1] of all K-12 students enrolled in public school districts.

1 Universal mental health screening of all K-12 students means mental health screening is offered to every student in every grade enrolled in a school district each year.

2. Compile and organize resources to support school districts in improving mental health culture and climate and reducing stigma related to screening, referral, and participation in mental health services.
3. Develop guidance about mental health screening tools available for school districts to use with students and associated training for school personnel.
4. Develop policy guidance that supports school districts in implementing universal mental health screening of students.

In addition to school-focused activities, the Transformation team is also working to optimize current models of pediatric consultation—in collaboration with the IDPH, the Illinois Chapter of the American Academy of Pediatrics (AAP), and the Illinois DocAssist program—in order to improve the identification of problems and enhance the tools that clinical pediatric care providers have to provide service referrals and treatment.

Plan

1. Develop an implementation plan for the strategies outlined in the landscape scan report.
2. In collaboration with stakeholders, develop a tool for measuring capacity and readiness to inform the phased approach to implementing universal mental health screening of students.
3. Continue to collaborate with AAP, Illinois DocAssist, and other system supports to ensure that new tools and processes can improve the efficiency and effectiveness of pediatric touchpoints for identifying and addressing youth mental health concerns.

Recommendation 10:

Facilitate information sharing across State agencies to improve seamlessness and timeliness of interventions.

Lead Agency – CBHTI

Strategy

To leverage large administrative datasets to improve the state's ability to understand and respond to risk and need for services, it will be necessary to improve data linkage (of large datasets) and information sharing (at the case level). Improvements in information sharing are also necessary for both Recommendation 2 (improve the ability of managed care entities to provide a level of service calibrated to need at the case level) and Recommendation 5 (building continuous feedback loops to ensure that data analysis informs contracting for services at the system level). Recommendation 10 focuses on the infrastructure and processes by which data linkage can make these analyses feasible, reliable, and valid.

Progress

In the first year of the Transformation Initiative, data analysts worked with the state leads for two large data linkage platforms, HHSI2 and ILDS, to understand the opportunities they offer for data analysis and operational improvements. Through engagement with HFS, ISBE, and academic partners, including Chapin Hall and the Systems Center at Northern Illinois University, the team assessed the feasibility of a variety of data analytic exercises. Plans for analysis of lead indicators of mental/behavioral health crises described in Recommendation #2 will require leveraging these platforms for a comprehensive cross-system view of potential risk factors.

In addition, vendor negotiations for the Care Portal (recommendation 1) have included discussions about the importance of interoperability between systems to prevent duplication and ensure seamless service delivery. On the case level, the existing pilot Portal has provided an opportunity to overcome two of the most prominent barriers to inter-agency information sharing: legal and technological limitations. The development and approval of an interagency consent form allowed the team to test a strategy in which families give permission for interagency discussion of individual cases. The preliminary Portal, used in over 300 cases to date, has provided a successful test of a secure, private platform through which to transmit crucial information to overcome barriers to placement and services in the most challenging cases.

Plans

In the next phase of this work, we will implement the lead indicators analysis using HHSI2 and ILDS, as well as develop the Care Portal to continue to iterate practices for information sharing at the case level.

Recommendation 11:

Build the workforce using paraprofessionals and other supporting roles, with incentives and creative approaches to credentialing.

Lead Agency – DHS

Strategy

In collaboration with the Behavioral Health Workforce Center (led by Southern Illinois University's School of Medicine and the University of Illinois at Chicago School of Social Work), the Department of Healthcare and Family Services (HFS), and the Department of Human Services' Division of Mental Health (DMH), Recommendation 11 focuses on building capacity in the behavioral health workforce. This capacity increase uses paraprofessionals and supports other roles with incentives and creative approaches to credentialing. Addressing the workforce shortages will create a more stable and diverse labor force that can provide equitable access to resources among all families in Illinois.

Current efforts to diversify and strengthen the workforce require that we broaden the definition of expertise to include those with lived experience. This, in turn, requires identifying and defining the roles needed to serve youth with mental health challenges and their families. These roles consist of:

- Family peer support: Parent/caregiver who has navigated the mental health system for their child (lived expertise) with a behavior or mental health condition **(expanding)**
- Personal support worker: Individual (high school level) trained to provide intensive 1:1 in-home interventions to teach/coach caregivers and children/youth in specific evidence-based skills **(new)**
- Mental health extenders: Individuals (high school level) trained to provide prevention/early interventions and support to (nonacute) children with developmental delays or mental health needs **(new)**
- Mental health professionals: High school-level trained individuals with 100 hours of education and training **(new)**

An additional (**new**) role, for parents and caregivers who use their lived expertise and system knowledge to advocate for needs of all children impacted by the behavioral and mental health system, will be considered in the context of Recommendation 12.

Furthermore, partnering with the Behavioral Health Workforce Center on long-term strategies to expand the workforce will play a vital role in increasing access to effective services by increasing the capacity of providers to address behavioral health in traditional as well as integrated and nontraditional settings.

Progress

Regular implementation workgroup meetings have been held with representatives from HFS, DMH, ISBE, DPH, and the Behavioral Health Workforce Center. In addition, the CBHTI has consulted with other workgroups and subject matter experts on next steps for implementing strategies and recommendations.

To determine the most effective route to train and credential the peer support workforce, a broad scan of available peer support certifications in and out of state was conducted to assess certification requirements and cost of those trainings. To streamline the credentialing process and make it more accessible for individuals with lived expertise, the state will rely upon the Family Peer Support Certification administered through the Provider Assistance Training (PATH) Hub in lieu of the current statewide peer support credential, the Certified Family Partnership Professionals, managed by the Illinois Alcohol and Other Drug Abuse Professional Certification Association. The Transformation team has also been in ongoing conversations with DMH, HFS, and the Behavioral Health Workforce Center to investigate funding streams for paraprofessional, peer support, and parent leader roles.

Plan

The next phase of this work will entail:

1. Developing a plan to fund, train, and implement personal support worker roles.
2. Identifying funding streams for training, credentialing, and recruiting peer support workforce.
3. Piloting personal support workers as in-home BH aides.

Recommendation 12:

Fortify community networks by investing in local communities and parent leadership.

Lead Agency – IDPH

Strategy

Many of the strategies laid out in the Blueprint depend upon building capacity at the community level to fortify informal and formal networks of providers, stakeholders, and residents. These plans have evolved with the recognition of the many community network activities currently underway across the State. Given this, IDPH, along with DHFS and the Transformation team, will work to fortify existing networks and ensure that each includes a funded family-run organization (FROs). Family-run organizations enable families to support other families raising children, youth, and young adults with behavioral health needs. They are the ideal home for family peer supporters and parent leaders who have the supervision and coaching expertise needed to adequately support this workforce.

Additional steps will be taken to equip and train parents for parent leadership roles within existing network structures to ensure partnership with community in implementing network functions. To support parent leader training, the "Empowering Parent Leaders for Systems Change – Collaborative Curriculum" will be developed with support from Chapin Hall to prepare parents/caregivers with lived experience to inform (family-driven) change in the children's behavioral health system at the micro-, meso-, and macro level through civic engagement and advocacy.

Progress

Currently, preliminary discussions are underway with HFS's Care Coordination and Support Organizations and DPH about assistance in building and coordinating community network strategies. Plus, the Community implementation team continues to meet regularly with representatives from DMH and the Behavioral Health Workforce Education Center as well as consulting with other subject matter experts on next steps for implementing strategies and recommendations.

The team has identified active community networks throughout the state that could serve as potential community network anchors. The team developed a map to better understand currently established community networks' structures and activity level. The map illustrates networks based on Designated Service Area as well as IDPH regions so that Care Coordination and Support Organizations can coordinate with the networks in their communities. To facilitate discussions of community strengths and service gaps, the team developed a suite of geographically specific maps that list resources and supports available in each community."

In addition, funding ($13K) has been acquired for the development of the parent leader's curriculum, "Empowering Parent Leaders for Systems Change – Collaborative Curriculum" through Impact Area Funds from Chapin Hall. A cohort of parent/caregiver participants has been established to inform the development of the Collaborative Curriculum.

Plan

1. Establish community network hubs and develop plans for expectations, oversight, and communication.
2. Engage the Illinois Children's Mental Health Partnership in working with networks to identify gaps and priorities.
3. Identify and support FROs in each network.
4. Design the "Empowering Parent Leaders for Systems Change – Collaborative Curriculum".
5. Develop parent leader positions within FROs.

Strategic Implementation Support – Next Steps

This plan describes progress across all of the Transformation work, as well as identifying concrete next steps to continue to realize all of the potential in our system of agencies, private providers, stakeholders, analysts, and residents. These plans require a set of additional supports informed by implementation science and years of experience guiding the implementation of new initiatives in Illinois and across the country. Supports include but are not limited to:

Leadership, Governance & Strategy

The implementation of the Blueprint for Transformation is proceeding with guidance from a team of experienced Chapin Hall analysts in partnership with state agency leaders and parents and youth with lived experience. However, the sustainability of these strategies will require an office or state agency "home" by which the interagency work of the initiative can continue. The team continues to work with the Governor's Office to develop a strategy in which the CBHTI becomes an office for Children's Behavioral Health that can bridge gaps between state agencies, exercise authority to ensure that children's needs are prioritized over any administrative or bureaucratic barriers, and advocate for the needs of children and families. Whether this office sits within an existing child-serving partner agency or as a free-standing unit will be determined in the coming months.

Practice & Implementation Support

This plan requires a robust, coordinated, and comprehensive communication strategy to ensure public awareness of the Portal as a centralized approach to meeting service needs and inquiries, as well as to reduce stigma around seeking help for mental health challenges. The Illinois Department of Public Health, along with sister agencies, is deeply committed to raising awareness of children's mental and behavioral health challenges as part of an overarching effort to apply a public health approach to detecting and addressing children's mental health and developmental needs.

Policy and Fiscal Alignment

Throughout its implementation, the current Transformation effort has required and benefitted from support from legislators and the Governor's office Support has come in the form of sponsored bills to enact key provisions of laws necessary to change current practices and budget allocations for the expansion of service delivery and the development of new technology. In each phase of implementation, the team will consider the legislative implications as well as cost projections to ensure that changes are sustainable and supported by statute.

Data Analytics and Evidence Use

All of the changes proposed in the Blueprint are based on data analytics and evidence; ongoing partnerships with academic and analytic units as well as open communication with peer jurisdictions across the country can ensure that Illinois continues to be guided by data and evidence. As described in this report, it will be necessary to make good use of accumulated administrative data and data linkage platforms, as well as to maintain collaborative relationships with research partners to promote state-of-the-art analyses.

Continuous Quality Assurance

Each of the innovations introduced by the Blueprint is accompanied by metrics and indicators that will allow visibility and transparency for all Illinoisians to understand the progress and impact of changes. From the progress monitoring graphics included here, to regular output from the pilot Portal on the barriers and successes of collaboratively staffed cases, the Transformation team prioritizes access to information that will be expanded with new technological innovations.

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