Community Emergency Services and Support Act (CESSA) 50 ILCS 754 Quarterly Status Report July 1, 2024

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Executive Summary

The Illinois Department of Human Services/Division of Mental Health (IDHS/DMH) is pleased to submit this final quarterly report of State Fiscal Year (FY) 2024, documenting continued partnership among state officials, Statewide Advisory Committee (SAC), and Regional Advisory Committee (RAC) leaders engaged in the implementation of the Community Emergency Services and Supports Act (CESSA).

As this report is being submitted, legislation has passed both Houses of the Illinois General Assembly that extends the CESSA implementation deadline (from July 1, 2024, to July 1, 2025) and addresses other structural elements of CESSA. Those changes and their implications are described below, but as of final drafting of this report, the legislation had not yet been signed by the Governor.

CESSA implementation took major steps forward in the fourth quarter of fiscal year (FY)24. The SAC continued to enjoy robust participation and consensus from constituents across the many sectors connected under CESSA's legislative mandate. This consensus was most evident in a vision statement and values passed unanimously by the SAC at its May 2024 in-person meeting. That meeting also included meaningful conversations between SAC members and RAC Chairs and Co-Chairs from across the state. A primary outcome of that meeting is a shared commitment to communicate more clearly and co-develop activities to drive CESSA forward.

One such example of cooperative activities are the planned pre-tests and subsequent pilots for hyperlocal initiatives to test and prototype implementation of the Interim Level Risk Matrix (ILRM) at select Public Safety Answering Points (PSAPs) across the state. These tests and prototypes are intended to both engage PSAPs and provide real-world feedback on reflecting alternative crisis responses in the vendor systems used at Illinois' 911 call centers (aka PSAPs). The plans for these tests and prototypes are outlined below and in the April 1, 2024 Quarterly Report.

The majority of the 11 RACs continue to convene monthly, with varying degrees of member engagement and efficacy. Many of their official activities have centered on identifying participants for the pre-tests and pilots, with both set to begin in early FY25. With these activities, the work of the RACs is anticipated to continue to shift to a hyper-local focus. The legislative changes addressing structural issues should assist in the success of these efforts.

The specific work mandated by CESSA on protocols and standards, technology, and training continued in earnest in the fourth quarter of FY24. IDHS/DMH and its academic partner, the Behavioral Health Crisis Hub at the University of Illinois Chicago Jane Addams College of Social Work Center for Social Policy and Research (Crisis Hub) convened SAC members, representatives of the CESSA Expert Consulting Group, and members of the public for monthly and bi-monthly work sessions to address the specific mandated requirements and activities. The Protocols and Standards Subcommittee led the design and implementation of the prototype testing described above and provided important structural definition to the work of the other two Subcommittees. The Training and Education Subcommittee continued to focus on recommendations for training

plans for 911 telecommunicators, 988 counselors, and 590 Mobile Crisis Response Team staff. The Technology, Systems Integration, and Data Management Subcommittee completed their report detailing nine actions that will define the future agenda of information exchange and system development.

The Crisis Hub continues its project leadership and management as IDHS/DMH's academic partner. Crisis Hub staff support the SAC, RACs, and Subcommittees, as well as staff the engagement with PSAP system vendors and the pre-test and pilot initiatives. On June 11, 2024, the Crisis Hub successfully convened national and statewide leaders in a lively and informative symposium on alternative response attended by many CESSA leaders from across the state as well as other leaders and stakeholders. IDHS/DMH is grateful for the commitment of the Crisis Hub to this work and looks forward to their continued partnership in FY25.

Update on CESSA-Related Activities

In the fourth quarter of Fiscal Year 2024 (FY24), there were two significant activities related to CESSA with statutory amendments passing both Houses in the Illinois General Assembly and an in-person joint meeting of the Statewide Advisory Committee (SAC) and the Regional Advisory Committee (RAC) Chairs and Co-chairs. In addition, there were two significant developments in the larger Illinois behavioral crisis care continuum, which will impact the operationalization of CESSA.

1. Centerstone of Illinois (Centerstone) was awarded the competitive grant for the next three fiscal years to operate the 988 Lifeline Call Center (LCC) that will be most directly involved with 911 Public Safety Answering Points (PSAPs), mobile crisis response, and dispatch in the evolving crisis continuum.
2. On June 11, 2024, the Behavioral Health Crisis Hub at the University of Illinois Chicago (Crisis Hub) hosted a forum focused on the behavioral health crisis continuum in Illinois, which allowed stakeholders and thought leaders from across Illinois to meet with experts and discuss the future.

CESSA Statute Amendments

As of May 23, 2024, both Houses of the 103rd Illinois General Assembly passed SB 3648, sponsored by Senator Robert Peters. (The full text of the revisions is included in "Appendix A: Summary of SB 3648 Changes".) In summary, this bill would extend the CESSA implementation deadline from July 1, 2024, to July 1, 2025, and add provisions that allow for the appointment of a different RAC Chair, if specific conditions are met, and for the RACs to establish subregional committees. If signed into law by Governor JB Pritzker, these revisions would aid in implementing CESSA by helping to address some of the current barriers. IDHS/DMH is grateful to the stakeholders and advocates who introduced the bill and appreciates the support of the General Assembly in advancing this legislation

In-person SAC and RAC CESSA Meeting

This quarter, the SAC met once virtually and once in person. The May 13, 2024, SAC meeting was held in person in Springfield, Illinois, with ten SAC members present in person, three present virtually, and one member absent. The RAC Chairs and Co-Chairs were invited to attend the SAC meeting to establish direct dialogue between the two committees, to understand commonalities, and to impart challenges and barriers that RACs are experiencing. Nine RAC Chairs and Co-Chairs attended the joint meeting, which allowed both memberships to raise questions and respond, as well as to frame what each would like to see achieved in partnership.

The meeting began with the regular updates from IDHS/DMH, the Crisis Hub, and the CESSA Technical Subcommittees. Brenda Hampton, Director of Community Linkages for the Crisis Hub, then provided an overview of RAC work this quarter and invited three RAC Co-Chairs to provide overviews of the Summits recently held in their regions. (More details about the Summits are provided in the "Regional Advisory Committee Updates" section of this report.)

The presentations were followed by breakout groups for discussion. Topics included expectations that the SAC has of the RACs, priorities for the RACs for the next six months, and biggest lessons learned at this point. The two primary outcomes of these discussions were:

1. Communication regarding goals, objectives, and timelines must be clear and explicit, so that there is understanding regarding the connection between various tasks and how they relate to the implementation of CESSA.
2. The ability to establish relationships with other participants/stakeholders in the crisis continuum has provided a great opportunity to learn what role other stakeholders have in crisis service delivery. A suggestion was made to consider using strategies such as embedding 911 telecommunicators in 988 call centers and vice versa; as well as sharing detailed information about what/how each stakeholder group works daily, (e.g. *A Day in the Life,* to further build relationships and increase understanding of various crisis continuum roles).

Finally, the SAC voted on and approved the Vision and Values Statements below, originally introduced in the April 2024 SAC meeting.

SAC Vision Statement
Individuals experiencing mental health or substance-use related emergencies are deflected from unnecessary hospitalization or incarceration when appropriate and are linked with available, appropriate community services that enable the individual to recover, heal, and thrive.

SAC Values Statement

1. Demonstrate that behavioral health emergencies require responses consistent with emergency physical health care
2. Provide responses that are timely, welcoming, and coordinated, that are informed by latest research, and that reflect an appreciation for people's desire to self-direct what type of care they receive and where they receive it.
3. Assure that responses to behavioral health emergencies requiring on-scene assistance and transportation to a service provider reflect a commitment to and a partnership with community-based supports; law enforcement interventions are a last resort–they are used as only appropriate based on the totality of the circumstances.
4. Ensure the safety and well-being of all people present and/or involved in the entire process.
5. Tailor strategies to the uniqueness of each community.
6. Design systems and ensure quality using the insight and perspective of people with lived experiences.
7. Base all efforts in equity, and an understanding that care must be responsive and accessible to a person's age, gender, culture, sexual orientation, disabilities, and other needs.

Centerstone 988 LCC

IDHS/DMH announced this quarter that Centerstone, through a competitive bidding process, was awarded a FY25 grant to function as the largest Illinois call center for the 988 Suicide and Crisis Lifeline, coverage previously provided by PATH, Inc., effective July 1, 2024. Centerstone currently operates Lifeline Call Centers (LCCs) in other states, serves as a national 988 back-up call center, and houses the national 988 LGBTQI+ chat and text line. IDHS/DMH has been working closely with the call centers, as well as Vibrant Emotional Health (the national administrator of the 988 Suicide & Crisis Lifeline), to plan for the transition and does not anticipate a disruption in access to the 988 Suicide and Crisis Lifeline during the transition from PATH to Centerstone. IDHS/DMH appreciates the partnership with PATH over the past two years and looks forward to partnering with Centerstone to further promote access to crisis services in FY25

Behavioral Health Forum held on June 11, 2024

The Crisis Hub convened the "Forum on Behavioral Health Crisis Continuum in Illinois: Knowledge, Innovation, Action!" on June 11, 2024, in Chicago on the campus of the University of Illinois Chicago (UIC). The goal of the Forum was to bring together national experts, Illinois experts, and a range of individuals representing different sectors who provide services to individuals experiencing behavioral health crises to share knowledge, discuss innovations in the delivery of crisis services, and for participants to leave with plans to take action to improve the delivery of crisis services across and within all communities in Illinois.

Although the focus of this event was broader than the purview of CESSA, the focus of several sessions was on crisis response models that are alternatives to law enforcement only responses to individuals experiencing behavioral health crises, which is one of the primary goals of CESSA legislation. Forty-two members of the SAC and the RACs attended the Forum, as well as a number of the technical experts attending RAC technical subcommittee meetings. Additionally, individuals representing key constituents of CESSA work attended the Forum including legislators/ legislative staff, leadership from state and local government, 911 PSAPs, 988 lifeline call centers, mobile crisis response teams, emergency medical service providers, law enforcement and fire department personnel, behavioral health advocates, and individuals with lived expertise.

CESSA Implementation Updates

Technical Subcommittee Updates

Subcommittee on Protocols and Standards

The Protocol and Standards Technical Subcommittee (PSTSC) is continuing to focus on the task of meeting CESSA goals of developing and implementing "…guidelines for all dispatch protocols statewide to include any best practices on risk stratification methodologies and matrices that guide decisions about entities dispatched given specific types of call incidents," as stated in the PSTSC Charter.

Update on Work with PSAPs, EMD and CAD Vendors on EMD Protocols

The PSTSC has made great strides during the fourth quarter of FY24 in its work with the three emergency medical dispatch (EMD) vendors used by PSAPs across the state to incorporate the risk factors and risk acuity associated with the Interim Risk Level Matrix (IRLM) into their EMD protocols. Efforts are also being made to engage with the small number of PSAPs utilizing EMD systems developed by the resource hospital with whom they work (i.e., the independents). An update on the work occurring within each EMD vendor during this last quarter is detailed below.

PowerPhone

As reported previously, the PSTSC subject matter expert (SME) Workgroup has been working with PowerPhone, one of the primary EMD vendors, since October 2023. PowerPhone has used the workgroup's recommendations to develop the Illinois specific database that will be used to update the protocols of all PSAPs using PowerPhone Total Response Software once pre-testing and pilots have been completed and evaluated.

The dispatch decisions will be customized by each PSAP according to currently available resources within each PSAP's jurisdictional area. Three PSAPs have agreed to participate in the pre-test with the goals of: (1) testing the use of the updated protocols to ensure that they operate as intended—that is, that they identify individuals experiencing mental health crises that may not have been identified previously, and (2) assessing dispatch referrals to determine if they comport with the IRLM and the available resources within the PSAPs jurisdictional geographic area.

The timeline for implementation, as displayed below, has been updated to reflect work accomplished thus far and anticipated timelines to complete other tasks.

- November 2023 - Agreement reached on incident protocols requiring change
- February 2024 - PSTSC SME workgroup submitted recommended changes to PowerPhone
- April 2024 - PowerPhone accepted changes
- July 2024 - Protocol changes are beta tested at three sites and system goes live at the three sites ("pre-tests")

- July 2024 - Recommended Protocol modifications are submitted to EMS MDs and the Illinois Department of Public Health (IDPH) for approval per the Health Facilities and Regulations Emergency Medical Services Act (210 ILCS/50)
- August 2024 - PowerPhone begins executing changes in the pilot sites; Training developed specifically for the pilot sites is provided
- September 2024 - The pilots begin
- Winter 2024/2025 - PowerPhone begins working with PowerPhone PSAP sites throughout the state updating their software to incorporate the new protocols; Training is also provided
- Winter 2025 - PowerPhone PSAP sites go live incrementally

Priority Dispatch

The PTSTC SME Workgroup -- consisting of Crisis Hub staff, the 911 State Administrator, PSAPs using Priority Dispatch as a protocol vendor, and an individual with lived experience -- has met with Priority Dispatch, another EMD vendor, several times. A subgroup of this workgroup met with Priority Dispatch and four Priority Dispatch PSAPs on May 1, 2024, and during that meeting reviewed the EMD protocols for fit and mapping to the IRLM. The subgroup is also reviewing the Priority Dispatch police protocols that incorporate protocols other than the EMD protocols that may have a mental health component. Once these reviews are completed, another meeting will be scheduled with Priority Dispatch. The RAC Chairs and Co-Chairs have been asked to initiate discussions within their regions to identify sites to pilot the Priority Dispatch protocol changes that will be recommended.

APCO

The PTSTC SME Workgroup, that includes PSAPs using APCO International protocols, has had several meetings with APCO, the final primary EMD vendor and the world's oldest and largest organization of public safety communications professionals. APCO has provided copies of its protocols and invited the workgroup to review and make recommendations that will incorporate IRLM risk factors and acuity into its protocols. A subgroup of the SME workgroup has begun initial work on this task.

Independents

The PTSTC has been contacted by two of the independents, PSAPs currently using protocols developed by resource hospitals, to discuss changes to their protocols. The PTSTC envisions beginning to work with these PSAPs and the other four independents sometime in late June or early July 2024.

Pre-Testing and Pilot Testing the Protocols and the Dispatch Referral Process

Each vendor's protocols will be pre-tested to determine if the protocol modifications work as intended to answer the question, "Are the modifications made to the protocols identifying individuals with behavioral health issues that may not have been identified previously?" Once the pre-tests have been completed, the results/outcomes will be shared and discussed with the RAC Co-Chairs who will then share this information with the pilot test working groups within

each region for feedback. Following the pre-tests and approval by EMS MDs and IDPH, each vendor's protocols and the dispatch referral process will be pilot tested in each region and evaluated. The results of the evaluation will be shared for discussion and feedback within both the pilot workgroups as well as with each RAC Co-Chair. The feedback and recommendations made by the RACs will be shared with the PSTSC for discussion and review.

The Pre-test and Pilot Launch/Implementation Process is summarized in the following phases.

Pre-Test of Protocols Modifications

Phase 1:

1. Finalize vendor protocol changes
2. Develop evaluation plan to pre-test protocol changes
3. Provide training to pre-test PSAPs
4. Use pre-test group to test protocol changes
5. Make any necessary adjustments to the protocols

Phase 2:

1. Preview protocol changes with EMS MDs
2. Finalize PSAP level dispatch decision based on the Landscape Survey/local available resources and seek approval from EMS MDs
3. Share results of the pre-test with the pilot working groups (which include the pre-test PSAPs) within each RAC and the RAC Co-Chairs for feedback

Phase 3:

1. Finalize call transfer protocols
2. Finalize data collection and evaluation plan for pilots

Phase 4:

1. Vendors develop trainings on changes for IDPH for certification as required for Continuing Medical Education (CME) training
2. Develop trainings on all call transfer protocols and data collection plans
3. Execute trainings for 911 PSAP telecommunicators, 988 LCC counselors, Mobile Crisis Response Team (MCRT) staff

Pilot Launch

1. Vendors work with pilot sites to upload protocol software modifications
2. Use of updated protocols go live
3. On-going collection of evaluation data
4. Analysis of data
5. Share results of evaluation with RACs and pilot working groups for discussion, feedback, and recommendations
6. RAC recommendations to PSTSC for discussion/review

Subcommittee on Technology, Systems Integration and Data Management
The Technical Subcommittee on Technology, Systems Integration, and Data Management (TSIDM) is charged with researching and recommending data and information systems to support the implementation of CESSA across the regions and localities of Illinois.

This quarter saw the addition of a new Subcommittee member, bringing the total to seven members of the CESSA SAC, or their delegates, as well as representatives of the expert consulting group and a regular cadre of members of the public. The Subcommittee met four times over this quarter.

While the CESSA legislation itself does not describe how data systems will be developed, the TSDIM Charter established a number of deliverables for the Subcommittee, and those drove the development of a workplan with nine previously-reported actions. The Subcommittee focused on identifying the training needs for each element in the work plan. The Subcommittee also reviewed the Data Collection Plan for the Pre-Tests and Pilots and shared it with the RAC Chairs and Co-Chairs. ("Appendix B: Data Collection Plan for the Pre-Tests and Pilots" contains the full text of the plan, which includes the same research questions and metrics recommended by the Subcommittee to meet the expectations of the Subcommittee laid out in CESSA.) In addition, the Subcommittee discussed their focus for FY25. The Subcommittee expects to focus on data collection for the pre-tests and pilots and data system development as activities for early FY25.

Lastly, the Subcommittee compiled the outcomes and recommendations that resulted from the workplan into the TSIDM Deliverables Report, which was approved by the Subcommittee on June 17, 2024. The TSIDM Deliverables Report will provide a basis to reference as CESSA implementation progresses. (The main body of the report, minus the appendices, is available as "Appendix C: TSIDM Deliverables Report".) This report will be presented to the SAC in the first meeting of FY25 if the implementation deadline is extended.

Subcommittee on Training and Education
The Technical Subcommittee for Training and Education (TETSC) continued to focus on recommendation of training/education plans for behavioral health crisis responder staff, including training cadence, modality, and potential training resources for 988 Suicide and Crisis Lifeline staff, MCRT providers, and 911 Dispatch staff.

CESSA-mandated Trainings
The Crisis Hub conducted five well-received trainings this quarter. All five trainings met the mandate in CESSA Section 23(e), which states that adequate trainings must include, "training in respectful interaction with people experiencing mental or behavioral health crises, including the concepts of stigma and respectful language." The training topics included respectful interactions with two high-risk populations, namely people with autism spectrum disorder or developmental disabilities and people who are pregnant or postpartum. The training on the impact of implicit bias included conversations about respectful language and the prohibition of using derogatory language in communications to or about clients based on the National Association of Social Workers Code of Ethics. The training on Asian/Asian American Mental Health addressed the stigma surrounding discussing and seeking services for mental health among this population.

The Crisis Hub continued to prioritize providing training conducted by individuals with lived experience, as mandated in CESSA Section 25 (f), which states that, "training shall be provided by individuals with lived experience to the extent available." The Autism Spectrum Disorder and Developmental Disability 101 training and the Asian/Asian American Mental Health trainings were conducted by individuals with lived experience in the corresponding training topics. More details about the trainings are below:

- Autism Spectrum Disorder and Developmental Disability 101 (4/4/24) - 41 attendees, 8 continuing educational units (CEU) certificates issued
- The Impact of Implicit Bias: Self-reflections in the Workplace, Section A and B (5/9/24, 5/30/24) - 48 attendees, 18 CEU certificates issued
- Asian/Asian American Mental Health (6/6/24) - 21 attendees, 8 CEU certificates issued
- Pregnancy and Postpartum Suicide Risk (6/20/24) - 23 attendees and 5 CEU certificates issued

Training Plans

In April 2024, the TETSC received 115 comments from the RACs regarding the previously-submitted training plan content for 911 Telecommunicators, 988 LCCs, and MCRTs. The Committee Co-Chair and the Crisis Hub staff are developing "Frequently Asked Questions" in response to the comments and questions. The recommendations from the RACs are summarized below:

1. Offer training on a website with 24 /7 availability for all shifts to have access
2. Work with overlapping agencies
3. Include CESSA training for 590 and 988, specifically the courses listed in the 911 materials
4. Provide simulation calls from start to finish.
5. Include the relevant HFS-issued Provider Handbooks and policies relevant to the staff member's role and responsibilities
6. Include crisis intervention and de-escalation techniques
7. Include engaging with 3rd party callers
8. Include training about boundaries
9. Coordinate across state agencies to minimize duplication
10. Combine courses so there are fewer, or decrease the amount of training
11. Include training on respectful interactions with Immigrants, Older Adults, Re-entry, Suicide, Unhoused, Veterans, Youth, Developmental Delays, Autism, and Other Disabilities, as well as training on Self-care, Situational Awareness, Supervision, Pilots, and Care Coordination and Support Organization (CCSO) and Screening, Assessment and Support Services (SASS) programs.

Regional Advisory Committee Updates

Regional Updates

The 11 CESSA Regional Advisory Committees (RACs) continue to work to interpret and plan for the operationalization of the CESSA statewide policies and procedures within their local jurisdictions, which is a complicated and nuanced process, for which IDHS/DMH is grateful to the committed chairs and co-chairs whose local relationships will be key to the success of the efforts to restructure local response to low-level and medium-level risk crisis situations.

RAC Chairs and Co-Chairs have exerted tremendous efforts to convene each of the RACs. Several of the RACs have consistently struggled with limited attendance from membership; however, all 11 RACs have been challenged by the lack of attendance to meet a quorum, which has interfered with the ability to conduct business, and has impacted the willingness of some members to continue participating in the planning process.

This challenge is being addressed using two strategies. First, during this quarter, RACs worked with the Crisis Hub and IDHS/DMH to identify RAC members who have not attended meetings more than 50 percent of the time during the past year, and to identify potential candidates to replace those individuals not attending meetings on a regular basis. RAC Co-Chairs worked with IDHS/DMH to ensure diverse representation across members as they made new recommendations for appointment. Secondly, during the joint SAC/RAC meeting described previously, several SAC members offered to work with the RACs to recommend individuals representing stakeholder groups which they represent to serve on the RACs. Engagement of the RACs with these new appointees, if/when approved, should help to address the attendance issues noted above as well.

During this quarter, the Co-Chair for RAC #5, the southernmost region in Illinois, announced her decision to resign from this role, with a departure date of June 30, 2024. IDHS/DMH is pleased to report that the Executive Director of Centerstone has agreed to accept this role beginning in July 2025, providing an excellent opportunity to forge collaborative planning with the new 988 center and the local RAC.

Two RACs convened Summits during the quarter. In April, RAC #1 held a Summit in Dekalb. Approximately 65 people attended, representing a cross spectrum of key stakeholders who are intimately involved in the emergency response community and the changing culture of responders under CESSA (i.e., advocates, law enforcement, PSAPs, Mobile Crisis Response Teams (MCRT), EMS, Fire, ambulance providers, hospital representatives, etc.).

In June, RAC #4 held a Summit in Granite City. This RAC also had good representation from the emergency systems' responders, as well as other stakeholders, with 35 people attending. RAC #4 used the Summit to share information on what is working in the communities to address behavioral health crises, including the infusion of Mobile Crisis Response Teams, co-responder models, Living Rooms, etc.

RAC Chair and Co-Chair consultation meetings continued during this quarter. These monthly meetings are convened for the purpose of informing RAC Co-Chairs on the 'behind the scenes' work of SAC Technical Subcommittees, as well as state updates, which drive the direction of implementation under CESSA.

An emerging focus of discussion has been on challenges specific to the delivery of crisis services in rural areas, including the lack of and limited resources within rural communities, the limited ability to attract a viable and competent work force, and engagement of local stakeholders in the CESSA planning processes. A session focusing specifically on successful strategies to address the delivery of crisis services in rural areas was included in the Behavioral Health Crisis Continuum Forum described above.

As stated earlier in this report, RAC Chairs and Co-Chairs had the opportunity to attend an in-person SAC meeting in May 2024. There were several key takeaways from this meeting specific to the RACs including:

- There is a need for clear and ongoing communication to RACs, between RACs and the SAC, from RACs to stakeholders in the region who do not sit on the RACs, and for communication between RAC members and the constituent groups which they represent.
- The new fiscal year provides an opportunity for a recommitment of RAC members to CESSA work to ensure that all are working towards the same goal.
- RAC members are willing to assist in recruiting individuals from different disciplines to assist in the RACs work.

Pilots Sites

During this quarter, the PowerPhone Pilot RACs (those regions with PSAPs that have PowerPhone as the vendor) reaffirmed which PSAPs will be included as pilot sites. The RACs and corresponding PSAPs are:

- RAC #1 Ogle County and Rochelle
- RAC #2 McDonough/Schuyler
- RAC #3 Christian County/Shelby County
- RAC #5 Salem
- RAC #8 Lyons Township Area Communication Center
- RAC #9 Elgin Police Department

Additional information on the design of the PowerPhone PSAPs pre-test and pilot process, the operational intent, the evaluation time period, and expected data management can be found earlier in this report in the "PowerPhone" section.

Challenges and Opportunities

The three previous FY24 Quarterly Reports to the Illinois General Assembly identified a list of challenges that are complicating the implementation of CESSA. Mostly recently, the April 1, 2024 Quarterly Report identified six challenges, which included:

1. the medical director role,
2. implementation timeline,
3. geographic distance limitations of MCRTs to meet crisis response expectations,
4. the learning management system,
5. PSAP fiscal requirements for systems change, and
6. vendor customization of protocols.

The first two, which are addressed by SB 3648, are expanded upon below. As noted earlier in this report, SB 3648 passed both Houses of the 103rd Illinois General Assembly in May 2024. (See "Appendix A: Summary of SB 3648 Changes" for a summary of the bill's proposed revisions.)

Medical Director Role and Leader of the Regional Advisory Committees

Previous Quarterly Reports noted the challenges involved in meeting the CESSA statute that designates Emergency Medical Services (EMS) Medical Directors (MDs) as Chairs for the RACs, with the responsibility for implementing CESSA at the regional levels. EMS MDs, while recognizing the importance of this work, have noted that the time commitment required in addition to their hospital-based duties make it virtually impossible to devote the time needed to meet this responsibility. If signed into law by Governor JB Pritzker, the revisions in SB 3648 would broaden the categories eligible to fill the role and leadership of the RACs. The change in eligibility will permit the RACs whose progress has been slowed due to unfilled chair positions to move forward expeditiously to continue work on the implementation of CESSA.

Implementation Timeline

The complexities associated with CESSA implementation described in previous Quarterly Reports still stand and are noted. System changes of the magnitude necessary to implement CESSA will take multiple years at a statewide level such as the statewide effort that has been undertaken by the Commonwealth of Virginia, as noted by the Crisis Hub, IDHS/DMH and 911 State Administrator team during its July 2023 Virginia site visit. While it has been two years since the passage of this law and considerable progress has been made, as described above in the "Update on Work with PSAPs, EMD and CAD Vendors on EMD Protocols", it is anticipated that the first PSAP will not be able to change their dispatch practices until late 2024. Further, it may take several years for all PSAPs to follow suit. SB 3648 addresses this challenge by moving the implementation deadline from July 1, 2024, to July 1, 2025.

Appendix A: Summary of SB 3648 Changes

SB 3648, which amends the Community Emergency Services and Support Act (50 ILCS 754), was filed by Senator Robert Peters on February 9, 2024. As of May 23, 2024, it has passed both Chambers of the General Assembly. Excerpts of its amendments are included below.

Sec. 30(e) and Sec. 65

Amends Subsection 30(e) and Section 65 to extend CESSA's implementation deadline to July 1, 2025, from the current deadline of July 1, 2024. Excerpt:

> Sec. 30 State prohibitions.
> (e) This Section is ~~Subsections (a), (c), and (d) are~~ operative beginning on the date the 3 conditions in Section 65 are met or July 1,2025,~~2024~~ whichever is earlier.~~Subsection(b) is operative beginning on July 1, 2024.~~
>
> Sec. 65. PSAP and emergency service dispatched through a 9-1-1 PSAP; coordination of activities with mobile and behavioral health services. Each 9-1-1 PSAP and emergency service dispatched through a 9-1-1 PSAP must begin coordinating its activities with the mobile mental and behavioral health services established by the Division of Mental Health once all 3 of the following conditions are met, but not later than July 1,2025~~2024:~~

Sec. 45(c)

Amends Subsection 45(c) by expanding the allowance for the convening of meetings to include a chair appointed in agreement of the DMH and the EMS Medical Directors Committee. Excerpt:

> Sec. 45. Regional Advisory Committees.
> (c) Subject to the oversight of the Department of Human Services Division of Mental Health, the EMS Medical Directors Committee or a chair appointed in agreement of the Division of Mental Health and the EMS Medical Directors Committee is responsible for convening the meetings of the committee. Qualifications for appointment as chair under this subsection include a demonstrated understanding of the tasks of the Regional Advisory Committee as well as standing within the region as a leader capable of building consensus for the purpose of achieving the tasks assigned to the committee. Impacted units of local government may also have representatives on the committee subject to approval by the Division of Mental Health, if this participation is structured in such a way that it does not give undue weight to any of the groups represented.

Sec. 50(3) and (4)

Amends Sec. 50, including subsections (3) and (4), to permit the establishment of subregions to allow for more local management and direction of operations. Excerpt:

> Sec. 50. Regional Advisory Committee responsibilities. Each Regional Advisory Committee and subregional committee established by the Regional Advisory Committee are ~~is~~ responsible for designing the local protocols ~~protocol~~ to allow its region's or subregion's 9-1-1 call centers ~~center~~ and emergency responders to coordinate their activities with 9-8-8 as required by this Act and monitoring current operation to advise on ongoing adjustments to the local protocols. A subregional committee, which may be convened by a majority vote of a Regional Advisory Committee, must include members that are representative of all required categories of the full Regional Advisory Committee and must provide guidance to the Regional Advisory Committees on adjustments that need to be made for local level operationalization of protocols ~~protocol.~~ Included in this responsibility, each Regional Advisory Committee or subregional committee must:
>
> (3) report, geographically by police district if practical, the data collected through the direction provided by the Statewide Advisory Committee in aggregated, non-individualized monthly reports. These reports shall be available to the Regional Advisory Committee members, subregional committee members, the Department of Human Service Division of Mental Health, the Administrator of the 9-1-1 Authority, and to the public upon request;
>
> (4) convene, after the initial regional policies are established, at least every 2 years to consider amendment of the regional policies, if any, and also convene whenever a member of the Committee requests that the Committee or subregional committee consider an amendment;

Appendix B: Data Collection Plan for the Pre-Tests and Pilots

The Data Collection Plan for the Pre-Tests and Pilots was shared with the RAC Co-Chairs on June 5, 2024. The plan summarizes the recommendations for research questions and metrics for the pre-tests and pilots, as referenced in the "Subcommittee on Technology, Systems Integration and Data Management" section of this quarterly report.

CESSA Requirements

What is legally required by CESSA and where the Tech and Data Committee started:

i. the volume of calls coordinated between 9-1-1 and 9-8-8;
ii. the volume of referrals from other first responders to 9-8-8;
iii. the volume and type of calls deemed appropriate for referral to 9-8-8 but could not be served by 9-8-8 because of capacity restrictions or other reasons;
iv. the appropriate information to improve coordination between 9-1-1 and 9-8-8; and
v. the appropriate information to improve the 9-8-8 system, if the information is most appropriately gathered at the 9-1-1 PSAPs.

Questions to Respond

The questions that the Committee came up with that more comprehensively respond to the mandates above:

1. How do we know if the recommended dispatch decisions are being followed?
2. How many referrals to 988 were not able to be completed because of lack of capacity in the 988 Lifeline system? How many referrals from 988 were not able to be completed because of lack of capacity or timeliness of response in the [590] community mental health response system?
3. What data should be collected and monitored to drive improvement in Illinois' mental health crisis response system?

Question 1: How do we know if the recommended dispatch decisions are being followed? ***Data required to answer this question: The volume, type, and disposition of calls between 911, 988, and 590 providers***

Indicators approved by the subcommittee:

1. Number and percentage of behavioral health (BH) crisis calls received by 911 meeting criteria for transfer to 988 transferred to 988
    a. Total calls to 911
    b. Number of BH crisis calls received by 911
    c. Number of BH crisis calls received by 911 meeting criteria for transfer to 988

2. Number and percentage of BH crisis calls received by 988 meeting criteria for transfer to 590 transferred to 590
    a. Total calls to 988
    b. Number of BH crisis calls received by 988
    c. Number of BH crisis calls received by 988 meeting criteria for transfer to 590/MCRT
3. Number and percentage of BH crisis contacts referred from Law Enforcement (LE) or Emergency Medical Services (EMS) to 988 (need total LE BH crisis contacts)
    a. Total outgoing calls from LE or EMS to 988

Question 2: How many referrals to 988 were not able to be completed because of lack of capacity in the 988 Lifeline system? How many referrals from 988 were not able to be completed because of lack of capacity or timeliness of response in the [590] community mental health response system?
Data required to answer these questions: the volume, type and disposition of calls referred to community mental health providers but not served

Indicators approved by the subcommittee:

1. Number and percentage of BH crisis calls to 911 meeting IRLM criteria for 988 or MCRT referred to LE/EMS because recommended response type or time was not available
    a. Total number of calls
    b. Number of BH crisis calls referred to 988 by 911 PSAPs referred back to 911 PSAPs because response type or time was not available
    c. Number and percentage of BH crisis calls referred to 988 by 911 PSAPs that were dropped or not answered
    d. Number and percentage of BH crisis calls referred to MCRTs by 988 Lifeline Centers that were refused, dropped or not answered
    e. Number and percentage of BH crisis calls referred to MCRTs by 988 Lifeline Centers referred back to 911 (LE and/or EMS) after contact with the crisis caller

Question 3: What data should be collected and monitored to drive improvement in Illinois' mental health crisis response system?
Data required to answer this question: information to improve the community mental health crisis response system, including data from 911, 988, 590 and other providers

Indicators approved by the subcommittee:

1. Data identified in answer to previous questions, with monitoring of trends over time
2. Coordination response time – from initial call-answer to 911 to final resolution at 988 or transfer/dispatch to MCRT
3. Increase in number of MH crisis calls to 988 vs 911
4. MCRT response time – from dispatch to arriving on site

5. Number and percentage of operators, responders and providers across the system who are trained in the new protocols and standards
6. Number and percentage of 911 telecommunicators making referrals to 988 reflecting the RAC recommendations
7. Number and percentage of BH crisis calls referred to service providers reflecting the RAC recommendations (by region and type of service)
8. Quality of the outcomes experienced by individual consumers – satisfaction, crisis resolution, referral to and receipt of appropriate services, follow-up, other outcomes to be determined

Next Steps

Vendor Pre-tests

1. Provide this data plan to Three Pre-test Sites
2. Meet with three sites together to discuss this data collection and reporting plan,
3. Discuss the data collection available through vendor (begin with Power Phone)
4. Discuss data collection using vendor (Power Phone) systems
5. Discuss cadence for reporting
6. Create data analysis process to determine fidelity to expectations
7. Make changes to process and procedures based on analysis

Pilots

8. Provide this data plan to Pilot sites
9. Meet with each site individually to discuss this data collection and reporting plan, identify existing enablers and barriers
10. Discuss feasibility and desirability of additional data
11. Discuss data collection methodology, schedule
12. Discuss existing and/or needed data collection systems
13. Create data analysis process to determine fidelity to expectations
14. Make changes to process and procedures based on analysis

Appendix C: TSIDM Deliverables Report

The TSIDM Deliverables Report was approved by the TSIDM Subcommittee on June 17, 2024, and will provide a basis to reference as CESSA implementation progresses. The main body of the report, minus the appendices, is available on the following pages. This report will be presented to the SAC in the first meeting of FY25 if the implementation deadline is extended

TSIDM Deliverables Report Table of Contents

Introduction

This report reflects the activities and recommendations of the Community Emergency Services and Supports Act (CESSA) Technical Subcommittee on Technology, Systems Integration and Data Management (TSIDM Subcommittee) which has met from September 2022 through June 2024. The TSIDM Subcommittee is made up of members of the larger CESSA Statewide Advisory Committee (SAC) and reflects the periodic participation of members of the CESSA Expert Consultant Group and members of the public. Appendix A lists the TSIDM Subcommittee members and related CESSA Expert Consultant Group members.

The Community Emergency Services and Support Act (CESSA) signed into law on August 25, 2021:

> (c) The Statewide Advisory Committee shall recommend a system for gathering data related to the coordination of the 9-1-1 and 9-8-8 systems for purposes of allowing the parties to make ongoing improvements in that system. As practical, the system shall attempt to determine issues including, but not limited to:
>
> i. the volume of calls coordinated between 9-1-1 and 9-8-8;
> ii. the volume of referrals from other first responders to 9-8-8;
> iii. the volume and type of calls deemed appropriate for referral to 9-8-8 but could not be served by 9-8-8 because of capacity restrictions or other reasons;
> iv. the appropriate information to improve coordination between 9-1-1 and 9-8-8; and
> v. the appropriate information to improve the 9-8-8 system, if the information is most appropriately gathered at the 9-1-1 PSAPs.

The TSIDM Subcommittee members approved a Charter (Appendix B) at their first meeting that identified the following deliverables, building on the mandated elements from the legislation above:

1. Data collection plan for aggregate statewide data and regional data including an assessment of gaps in data collection or recommendations for new data fields
2. Sample reports
3. Benchmarks to measure system performance
4. Call transfer technology recommendation
5. Recommendations regarding phased implementation of new processes and systems

Based on the legislation and the Charter, the Subcommittee developed a nine-action work plan, which forms the structure for this report. As the report outlines, some of these activities are basically complete, while some will be extended beyond June 30, 2024, in accordance with the extension of the CESSA legislation to June 30, 2025. Some of the actions detailed below include the same, or similar, data elements as other actions. These data elements are repeated because they serve different purposes depending on the action. The same data element may be used to

measure the service, provide services, or coordinate the service. The nine actions are:

1. Document currently collected service data from different providers of crisis response services including 911, 988, and MCRT
2. Conduct a gap analysis and develop recommendations for comprehensive operational and evaluation data metrics
3. Describe the ideal state for data to be used for monitoring and evaluating Illinois' crisis continuum
4. Develop and approve Sample Reports
5. Develop recommendations to support the operational procedures for communicating between 911 and 988
6. Develop recommendations to support the operational procedures for communicating between 988 and MCRT
7. Develop recommendations for technical systems and infrastructure necessary to facilitate and automate data collection, including implementation
8. Develop recommendations for technical systems and infrastructure necessary to facilitate and automate contact transfers, including implementation
9. Develop recommendations for a phased training plan for each element of the work plan above

Action 1. Document currently collected service data from different providers of crisis response services including 911, 988, and MCRT

The CESSA Legislation describes, in general terms, "a system for gathering data related to the coordination of 'ongoing improvements in that system.'"

> (c)The Statewide Advisory Committee shall recommend a system for gathering data related to the coordination of the 9-1-1 and 9-8-8 systems for purposes of allowing the parties to make ongoing improvements in that system. As practical, the system shall attempt to determine issues including, but not limited to:
>
> i. the volume of calls coordinated between 9-1-1 and 9-8-8;
> ii. the volume of referrals from other first responders to 9-8-8;
> iii. the volume and type of calls deemed appropriate for referral to 9-8-8 but could not be served by 9-8-8 because of capacity restrictions or other reasons;
> iv. the appropriate information to improve coordination between 9-1-1 and 9-8-8; and
> v. the appropriate information to improve the 9-8-8 system, if the information is most appropriately gathered at the 9-1-1 PSAPs.

At the beginning of CESSA implementation, none of this information existed, for the following reasons (current as of late May, 2024):

Unavailable Information	**Reason**
the volume of calls coordinated between 9-1-1 and 9-8-8	There is currently no coordination of calls between the 911 and 988 call-taking systems.
the volume of referrals from other first responders to 9-8-8	There are currently no official and possibly no unofficial referrals between traditional first responders (police, fire, EMS) and 988.
the volume and type of calls deemed appropriate for referral to 9-8-8 but could not be served by 9-8-8 because of capacity restrictions or other reasons	This level of analysis is not available within the current 911 system.
the appropriate information to improve coordination between 9-1-1 and 9-8-8	This information will be available as efforts to connect 911 and 988 mature.
the appropriate information to improve the 9-8-8 system, if the information is most appropriately gathered at the 9-1-1 PSAPs	This level of analysis is not possible within the current 911 and 988 systems.

Early in the deliberations of the TSIDM Subcommittee, the members identified a key missing piece of the data system as described in the initial CESSA legislation. In the description above, the 911 and 988 systems are referenced, but there is no mention of the Mobile Crisis Response Teams (MCRT), the crucial component of the crisis response system that provides an in-person and on-demand community response to crises that cannot be resolved over the phone by a 988 provider but does not require a traditional first responders, such as EMS or law enforcement. Throughout the rest of the TSIDM discussions, the MCRT providers and services were recognized as integral to the CESSA environment, and especially the CESSA data ecosystem.

As of May of 2024, meaningful data is being collected from the 988 and MCRT providers, as a result of (1) federal mandates for data reporting that are passed through State of Illinois funding mechanisms, (2) data for evaluation being collected by an external evaluator, and (3) data collected by the provider themselves for their own purposes. Data for the first two purposes is standardized and available for this report, while the third source of data is individually managed by each provider for their own purposes. Metrics for the 988 system are also reported monthly by Vibrant Emotional Health, the national administrator of the 988 Suicide & Crisis Lifeline.

The data currently collected for the 988 and MCRT providers is listed fully in Appendix C, including performance standards and performance measures. Additional data items for evaluation are listed in Appendices D & E. A short excerpt of the currently collected items is listed below. An example monthly Vibrant Report is listed as Appendix F.

The 988 System is the most documented of the three cornerstones of the crisis response continuum. The Vibrant systems tracks basic performance data, including calls sent to the state, calls received by state 988 centers, and how many calls are answered, abandoned, and re-distributed to other 988 centers. 988 Suicide and Crisis Lifeline Call Centers (LCCs) in Illinois that are funded by the Illinois Department of Human Services/Division of Mental Health (IDHS/DMH) are also required to report monthly data on their operations, following metrics defined the State's contracts with the federal funder, Substance Abuse and Mental Health Services Authority (SAMHSA). Those data include operations and performance metrics like the number of staff, the number of persons receiving services, the number of referrals, and feedback about services provided. Evaluation metrics include degree of lethality encountered in the calls, the resolution, where available, and demographic information such as age, race, and gender characteristics. Evaluation data is not available for all calls.

Providers of Illinois' MCRT system, also known by the IDHS/DMH funding as Program 590, are also required to collect and report monthly operational and performance metrics as defined by the SAMHSA contract, including many of the same 988 metrics -- number of provider staff and number of persons receiving service per month – as well as additional metrics on referrals, reflecting the nature of MCRT services in Illinois. Because Illinois' MCRT program design includes peer services from an "Engagement Specialist," the participation of those peer staff is also measured and reported. Evaluation metrics for MCRT are more limited, focusing on more detail

on service statistics and adding response time metrics.

Illinois 911 Centers, also known as Public Safety Answering Points (PSAPs), are independently operating entities in the State of Illinois, and are thus not subject to an current standards for data collection or reporting. Over the first two years of CESSA, there has been much attention paid to the lack of available data from the State's PSAPs. Significant activities, such as close negotiation with the vendors who supply the PSAPs data systems and a separate initiative to create data exchange pilots involving 911 and 988 systems are both addressing the lack of 911 data standards. This is expected to continue to evolve in the third year of CESSA operations.

CESSA Pre-tests and Regional Pilots

The Protocol and Standards Technical Subcommittee Workgroup is working with each of the three national vendors who develop and provide the protocols used by PSAP telecommunicators to align their protocols with the incident types and acuity levels outlined in the Illinois Interim Risk Level Matrix (IRLM). A fourth group referred to as the "Independents", who use protocols developed by the hospitals with whom they work, will participate in this process as well.

Each vendor workgroup is comprised of several PSAP managers who utilize the vendor's protocols, other PSAP representatives/experts, individuals with lived expertise and The Behavioral Health Crisis Hub (BHCH) clinical, policy and research experts. The workgroup reviews the vendor's protocol and provides recommendations for modifications if/as necessary. The recommendations are then reviewed by the vendor who then takes the appropriate action to update the protocols. The updated protocols must then be approved by the Emergency Medical System (EMS) Medical Director of the resource hospitals with whom each of the PSAPs work, and ultimately by the Illinois Department of Public Health (DPH). EMS doctors using the protocols must complete training in the use of the protocols. Vendors will work with the PSAPs to plan and/or provide training to the PSAPs telecommunicators in the use of the updated protocols. Each PSAP's Emergency Medical Dispatch (EMD) and Computer Aided Dispatch (CAD) system must be updated with the modified protocols as response options. The implementation of the protocols with occur in two distinct phases:

Phase 1, which is referred to as a "Pretest" consists of the PSAPs in each vendor working group testing of the protocols and workflow associated with the updates to determine any "glitches" or potential changes to be made in the implementation process.

Phase 2, which is referred to as the "Regional Pilots", consists of expanding the adoption of the protocols to at least 2 PSAPs (for each protocol vendor) in each of the 11 CESSA regions, if the protocol vendor has a presence in that region. PSAP staff participating in each of the Pilots will be trained to use the updated protocols and will use the completed landscape analysis completed by each of the PSAPs that documents their locally available community resources as a basis for determining the dispatch disposition for behavioral and mental health crisis callers. Crisis callers meeting the criteria for Level 1 (minimal risk) of the IRLM will then be referred to 988 LCCs for referral to mobile crisis response teams (MCRT) for dispatch.

Phase 2 will also include pilot PSAPs working with their CAD vendor to create a way to easily query the number of calls transferred to 988, including how the call was coded in the EMD system.

A key component of both Phase 1 and Phase 2 is to evaluate the implementation process. The evaluation of Phase 2 includes the exchange of information between 911 PSAPs, 988 LCCs and MCRTs. The TSDIM Subcommittee has worked for the past two years to identify evaluation questions, data requirements and elements, key performance indicators and sample reports to evaluate CESSA implementation. These strategies and specifications, which will be described below, will be used to evaluate Phase 1 and Phase 2, providing a roadmap for implementing CESSA requirements regionally and statewide. Appendix G describes the CESSA Pre-Test and Pilot Data Collection and Reporting Initial Plan.

Action 2. Conduct a gap analysis and develop recommendations for comprehensive operational and evaluation data metrics

In Subcommittee meetings in May and September of 2023 and February 2024, the Subcommittee members reviewed the currently collected data (as described above) and identified the most important of those, as well as the data elements not yet present in the system that would be required to meet CESSA's intent regarding data.

Indicators that are being collected:

- Total calls to 911
- Total calls to 988
- Number of BH crisis calls received by 988 from the person requiring assistance
- Number of BH crisis calls received by 988 from a third party
- Total number of calls - Number and percentage of BH crisis calls to 911 meeting RAC criteria for 988 or MCRT referred to LE/EMS because recommended response type or time was not available
- MCRT response time – from dispatch to arriving on site

Indicators that are being somewhat collected:

- Number of BH crisis calls received by 988 meeting criteria for transfer to 590/MCRT - on a 988 by 988 basis

Indicators that are not being collected currently:

- Number of BH crisis calls received by 911
- Number of BH crisis calls received by 911 meeting criteria for transfer to 988
- Total outgoing calls from LE or EMS to 988
- Number of BH crisis calls referred to 988 by 911 PSAPs referred back to 911 PSAPs because response type or time was not available
- Number and percentage of BH crisis calls referred to 988 by 911 PSAPs that were dropped or not answered
- Number and percentage of BH crisis calls referred to MCRTs by 988 LCCs that were refused, dropped or not answered
- Number and percentage of BH crisis calls referred to MCRTs by 988 LCCs referred back to 911 (LE and/or EMS) after contact with the crisis caller
- Data identified in answer to previous questions, with monitoring of trends over time
- Coordination response time – from initial call-answer to 911 to final resolution at 988 or transfer/dispatch to MCRT
- Increase in number of MH crisis calls to 988 vs 911

- Number and percentage of operators, responders and providers across the system who are trained in the new protocols and standards
- Number and percentage of 911 PSAPs making referrals to 988 reflecting the RAC recommendations
- Number and percentage of BH crisis calls referred to service providers reflecting the RAC recommendations (by region and type of service)
- Quality of the outcomes experienced by individual consumers – satisfaction, crisis resolution, referral to and receipt of appropriate services, follow-up, other outcomes to be determined

Action 3. Describe necessary improvements for data to be used for monitoring and evaluating Illinois' crisis continuum

The TSIDM Subcommittee Charter originally intended this activity to describe an "ideal" state for data to be used for monitoring and evaluating. As the Subcommittee members became familiar with national and Illinois best practices, it became clear that the technical, fiscal and administrative environment in Illinois is too fractured and heterogeneous to support an ideal system state. Therefore, the Subcommittee limited itself to the initial set of data required to monitor and measure the parts of the crisis continuum related to 911, 988 and MCRT. Over the course of the first two years of CESSA deliberation and implementation, other State of Illinois initiatives have emerged to address other elements of the continuum, such as the 988 Workgroup's report on long-term sustainability of the Illinois 988 infrastructure, and the current effort to enumerate the cost of the Illinois Crisis Continuum funded by the Division of Mental Health. All in all, nine initiatives were identified by IDHS/DMH staff as aligned or connected to the crisis continuum.

In reviewing the CESSA legislation, the members of the TSIDM Subcommittee focused on both the overall system recommendations (see Actions 5-8) and the five specific legislative mandates for data, recognizing that the language allows for a "practical" and "not limited" approach to determining data system issues.

This approach resulted in restating the five issues identified by the legislation as three high-level improvements to the data system. In each case below, the legislative language is repeated, and then restated as recommended by the TSIDM Subcommittee members. They also supplied a question for each of the three sections that frame the data to be collected. As noted above on page five, a key additional element of these descriptions of initial data system deployments is the inclusion of data from the MCRT providers.

Because of the dynamic nature of the development of the crisis continuum in Illinois, the TSIDM Subcommittee focused on the work most proximate to CESSA. Within all the possible data that might be useful or relevant to the CESSA-focused crisis response continuum, the TSIDM Subcommittee identified the data below as most relevant for monitoring, performance management, and evaluation of the system-in-development. This should not be considered as the final ideal state, but an initial structure for it.

The first set of data is intended to understand the scope of use of the different components of Illinois' crisis response continuum, and to evaluate its responsiveness to the CESSA legislative mandate regarding alternative response.

i. the volume of calls coordinated between 9-1-1 and 9-8-8 (Original CESSA description)
ii. the volume of referrals from other first responders to 9-8-8 (Original CESSA description)

Restated: The volume, type, and disposition of calls between 911, 988, and 590 providers

Key question to be answered: How do we know if the recommended dispatch decisions are being followed?

Indicators approved by the subcommittee:

1. Number and percentage of BH crisis calls received by 911 meeting criteria for transfer to 988 transferred to 988
    a. Total calls to 911
    b. Number of BH crisis calls received by 911
    c. Number of BH crisis calls received by 911 meeting criteria for transfer to 988
2. Number and percentage of BH crisis calls received by 988 meeting criteria for transfer to 590 transferred to 590
    a. Total calls to 988
    b. Number of BH crisis calls received by 988
    c. Number of BH crisis calls received by 988 meeting criteria for transfer to 590/MCRT
3. Number and percentage of BH crisis contacts referred from LE or EMS to 988 (need total LE BH crisis contacts)
    a. Total outgoing calls from LE or EMS to 988

The second set of data describes the capacity of Illinois' crisis response continuum.

iii. the volume and type of calls deemed appropriate for referral to 988 but could not be served by 988 because of capacity restrictions or other reasons (Original CESSA description)

Restated: the volume, type and disposition of calls referred to community mental health providers but not served

Key questions to be answered: How many referrals to 988 were not able to be completed because of lack of capacity in the 988 Lifeline system? How many referrals from 988 were not able to be completed because of lack of capacity or timeliness of response in the [590] community mental health response system?

Indicators approved by the subcommittee:

1. Number and percentage of BH crisis calls to 911 meeting IRLM criteria for 988 or MCRT referred to LE/EMS because recommended response type or time was not available
    a. Total number of calls
    b. Number of BH crisis calls referred to 988 by 911 PSAPs referred back to 911 PSAPs because response type or time was not available

c. Number and percentage of BH crisis calls referred to 988 by 911 PSAPs that were dropped or not answered
d. Number and percentage of BH crisis calls referred to MCRTs by 988 Lifeline Centers that were refused, dropped or not answered
e. Number and percentage of BH crisis calls referred to MCRTs by 988 Lifeline Centers referred back to 911 (LE and/or EMS) after contact with the crisis caller

The final set of data addresses the legislative mandate to coordinate services and improve the overall crisis response system.

iv. the appropriate information to improve coordination between 911 and 988 (original CESSA description)

v. the appropriate information to improve the 988 system, if the information is most appropriately gathered at the 911 PSAPs (original CESSA description)

Restated: information to improve the community mental health crisis response system, including data from 911, 988, 590 and other providers

Key question to be answered: What data should be collected and monitored to drive improvement in Illinois' mental health crisis response system?

Indicators approved by the subcommittee:

1. Data identified in answer to previous questions, with monitoring of trends over time
2. Coordination response time – from initial call-answer to 911 to final resolution at 988 or transfer/dispatch to MCRT
3. Increase in number of MH crisis calls to 988 vs 911
4. MCRT response time – from dispatch to arriving on site
5. Number and percentage of operators, responders and providers across the system who are trained in the new protocols and standards
6. Number and percentage of 911 telecommunicators making referrals to 988 reflecting the RAC recommendations
7. Number and percentage of BH crisis calls referred to service providers reflecting the RAC recommendations (by region and type of service)
8. Quality of the outcomes experienced by individual consumers – satisfaction, crisis resolution, referral to and receipt of appropriate services, follow-up, other outcomes to be determined

Action 4. Develop and approve Sample Reports

The original TSIDM Subcommittee Charter identified the need for sample reports that would reflect the eventual reporting required for operations management, quality improvement, and evaluation. In the course of its deliberations, the TSIDM Subcommittee members identified four possible reports that would support CESSA implementation:

1. Illinois CESSA Crisis Continuum (CC) Service Report
    a. Service calls, referral and dispositions by type of Crisis Continuum provider
2. Illinois CESSA Administrative Report
    a. High-level summary of all CESSA operations, including advisory/convening, referral networks, administrative support
    b. Statewide and regional counts for training, communications, and data system development
    c. CQI and Change Management
3. Illinois CESSA Statewide and Regional Compliance Report
    a. Dispatch decisions, transfers and acceptance
    b. Reporting by state overall, 11 regions overall, and each EMS system within the 11 regions
4. Illinois CESSA Evaluation Report
    a. Research and Evaluation
    b. Documentation of emerging and best practices
    c. Outcomes establishment and measurement

For its initial recommendations, the Subcommittee suggested providing samples of the first two reports, recognizing that the system will need extensive development before the second two reports are relevant.

The obvious first report is a regular compilation of service activity for the different components of the crisis response continuum. This report would be consistent with the data described in Action 3 above: the volume, type, and disposition of calls between 911, 988, and 590 providers. The draft elements of this report are included in the slides presented in Appendix H below.

The second recommended report is an administrative report, including a high-level summary of all CESSA operations, including advisory and convening, referral networks and administrative support. It would include statewide and regional counts for meetings, events, and initiatives related to CESSA implementation, as well as narrative descriptions of CESSA implementation, including changes to legislation, the efforts of IDHS/DMH and its IDHS agency partners, The Behavioral Health Crisis Hub, and the different constituencies invested in CESSA implementation.

A prototype of this report is available through the current efforts of IDHS/DMH and The Behavioral Health Crisis Hub, which has produced a quarterly report required by statute for

each quarter in Fiscal Year 2024. A copy of the most recent CESSA Quarterly Report for April 1, 2024, is available as Appendix I.

Action 5. Develop recommendations to support the operational procedures for communicating between 911 and 988

The TSIDM Subcommittee has not had the opportunity to review the draft operational procedures that are being developed to support communications between 911 Public Safety Answering Point (PSAP) telecommunicators and 988 call center staff as this guidance is in the process of being reviewed and vetted. However, over the course of the last year and a half, the TSIDM Subcommittee has engaged in dialogue and discussion regarding this action. The following recommendations have been derived from those discussions as well as guidance from the National Emergency Number Association (NENA) and the National Association of State Mental Health Program Directors (NASMHPD) 988 Playbook for Public Safety Answering Points (PSAPs).

1. Execution of Memorandums of Understanding (MOUs), including Data Sharing Agreements, between 911 PSAPs and 988 LCCs defining their roles, relationships and operational procedures, and that permit identifiable information to be shared for the purpose of quality of care
2. Secure transfer of information between 911 PSAPs and 988 LCCs
3. Explicit criteria for identifying what calls should be transferred from 911 to 988 (based on dispatch criteria aligned with the Illinois Interim Risk Level Matrix and local community resources within PSAPs coverage areas)
4. Explicit criteria for determining when calls of individuals experiencing behavioral health crises should be dispatched for a co-response (Law Enforcement/Mental Health or Emergency Medical Services/Mental Health) or for a law enforcement and/or EMS response
5. Standardized data elements to be collected and reported by PSAPs that permit the tracking of outcomes for calls transferred from 911 to 988
6. Warm handoffs between 911 and 988
7. A feedback loop between 988 and 911 to communicate the outcome of warm transfers
8. Documentation (e.g. Landscape Analysis results) regarding available resources within 911 PSAP coverage areas so that PSAPs are aware of these resources when making dispatch decisions
9. Training of 911 Telecommunicators on protocols and call transfer procedures
10. Training of 988 call center staff on protocols and call transfer procedures
11. Criteria and procedures for warm transfer of calls from 988 back to 911 when appropriate
12. Adoption/creation of performance measures to monitor and evaluate transfer of calls from 911 to 988

Action 6. Develop recommendations to support the operational procedures for communicating between 988 and MCRT

Interim guidance regarding operational procedures for communication between 988 LCCs and IDHS/DMH funded MCRT was created shortly after the initiation of 988 call center services. However, the IT systems utilized by 988 LLCs and the community mental health agencies housing MCRTs are not interoperable, thus direct secure communication between these information systems is not possible. The interim solution for communication is low tech, meaning information exchange between the two entities is generally provided via telephone calls. While using this interim solution, the 988 LCCs must have a protocol in place to identify the location of the caller prior to identifying a MCRT to respond.

The state recognizes that a comprehensive information system solution needs to be developed that permits interoperability and the secure exchange of information between 988 LCCs and MCRTs that is similar to the system described above for communication and information exchange between 911 and 988. This will be addressed in the overall design of a state-of-the-art IT system that will be implemented by the state. The following data elements will need to be considered in the system design.

988 Referral of an Individual Experiencing a Crisis to MCRT

The interim guidance for 988 to MCRT requires the following information to be provided when 988 LCC specialists make a referral to the MCRT:

1. the 988 staff person's name, phone number and position
2. the name of the LCC they are calling from
3. the name of the person in crisis
4. the phone number of the person in crisis
5. the location of the person in crisis
6. a brief description of the nature of the crisis

988 Referral of a Third Party to MCRT

If a third-party caller has contacted the 988 LCC regarding an individual experiencing a behavioral health crisis, the following information is to be communicated from 988 to the MCRT:

1. the third-party caller's name and phone number
2. the third-party caller's relationship to the identified person
3. a brief synopsis of what the caller observed in the crisis
4. information regarding the location of the individual (e.g., alone or are others in proximity)
5. confirmation that questions regarding weapons and/or other lethality indicators are answered in the negative (meaning no weapons, no lethality indicators)
6. any other information obtained related to the call. (Opioid use, homelessness, etc.)
7. the name of MCRT that the call referred to

8. the name of the MCRT staff spoken to
9. any additional comments/notes related to the referral transfer, such as, reason for unavailability of MCRT to accept the call

Information From MCRT to 988 LCCs To Close the Loop

Mobile crisis response teams are expected to "close the loop" on the referral by providing information back to the 988 LCC regarding the outcome of the referral received. The following is required:

1. first and Last name initials of the person (in crisis) referred by 988 LCC.
2. date and time of the originating crisis intervention/engagement referral.
3. intervention/engagement outcome
4. phone crisis intervention resolved. [no further information needed]
5. phone intervention not resolved (specify the reason)
6. community intervention/engagement by MCRT resolved [no further information needed]
7. community intervention not resolved (specify the reason)

Actions 7 and 8 describe the two different systems that need to be created in order to meet the requirements in the CESSA legislation. One system, for aggregate data, is described in Action 7. The second system, for coordinating service, is described in Action 8.

Action 7. Develop recommendations for technical systems and infrastructure necessary to facilitate and automate data collection, including implementation

CESSA legislation requires "recommendations for a system for gathering data related to the coordination of 911 and 988 systems for purposes of allowing the parties to make ongoing improvements in the system." The legislation also specified issues to be addressed by the recommended system which have been described above. There are three disparate systems from which data is needed for this purpose: 911 PSAPs, 988 LCCs and IDHS/DMH funded community mental health agencies (CMHAs) housing mobile crisis response teams (MCRTs). The development of the kind of comprehensive system that is required for this purpose is a complex undertaking that would take at the least a year to design, develop and implement, and at the most is a multi-year project. Thus, what is needed in the interim is a system that provides a means of collecting key data elements from each system that can be used to create a minimum dataset from which the key indicators described above can be generated. The completion of Actions 1, 2 and 3 as described above provided a roadmap for the specification of this interim system including the specific data elements to be collected.

The principles underlying the development of this system include but are not limited to the following. The system should:

1. Have a secure online portal for data submission
2. Minimize the duplication of data collection and data submission for the three entities from which data will be obtained. If data for key indicators is currently being collected for other purposes such as contractual requirements, evaluation processes etc., pull that data into the interim system
3. Collect aggregate non-identifiable data; Consumer level data will not be entered into this system
4. Have the flexibility to incorporate placeholders for data elements that are desirable, but are not currently collected
5. Contain quality control mechanisms to ensure completeness of data submitted, ensure that values submitted for data elements are within established parameters, and that data is submitted within specified timeframes
6. Have the ability to generate useful standard reports for the entities submitting the data
7. Have the ability to generate reports specified by the TSIDM Subcommittee, the BHCH, IDHS/DMH and evaluators to monitor and evaluate CESSA implementation, as well as the ability to generate reports related to special studies and interests for quality improvement purposes
8. Contain prompts and instructions associated with data submitted
9. Have the flexibility to quickly incorporate new data elements as necessary

During FY2024, the Behavioral Health Crisis Hub, the Statewide 911 Administrator and the IDHS/DMH worked with the UIC Center of Clinical and Translational Science (CCTS) to design and develop specifications for this system which has been named The Illinois Crisis Data System using these principles, the issues derived from CESSA legislation and the key performance indicators developed by the TSIDM Subcommittee as a basis and touchstone.

Action 8. Develop recommendations for technical systems and infrastructure necessary to facilitate and automate contact transfers, including implementation

TSIDM Subcommittee members have had several discussions over the past year regarding the infrastructure, requirements and characteristics of technical systems that will be necessary to facilitate and automate transfers of clients between various components of the crisis care continuum. This includes 911 PSAPs, 988 LCCs, CMHAs and MCRT, and other providers operating services such as crisis stabilization units and living rooms.

These discussions have been informed by:

1. presentations from individuals/entities that have implemented and/or in the process of implementing such systems.
2. visits by IDHS/DMH staff, BHCH staff and the 911 State Administrator to several jurisdictions to see and hear, firsthand, the capabilities of each system, the requirements that drove the development of the systems, and how the systems operate
3. the Substance Abuse and Mental Health Services Administration (SAMHSA) technology specifications required to support the implementation and delivery of behavioral health crisis services as described in the National Guidelines for Behavioral Health Crisis Care National Toolkit that include "…..GPS-enabled mobile team dispatch, real-time bed-registry and coordination, centralized outpatient appointment scheduling and performance dashboards that support air traffic control-type functioning" and
4. additional research gathered by TSIDM BHCH staff regarding the requirements of technical systems that are needed to support the delivery of behavioral health crisis care service

The overarching goal is to works towards implementation of an integrated information system that uses a common platform across the crisis continuum that has the capability:

1. to effectively and efficiently gather information regarding individuals experiencing behavioral health crises that will be used to determine referral type to meet consumers' needs,
2. to transmit information for consumers requiring mobile crisis team response to a centralized dispatch center that maintains real-time information regarding availability, and location of mobile crisis response teams and that has the capacity to make active referrals to team members that are closest to these individuals assuring rapid access to crisis care, and
3. to provide a shared service referral information system component that captures and maintains real time information regarding available crisis continuum and other behavioral health services, by provider and geography, that is used to make referrals to the appropriate services based on consumers' needs.

Specific recommendations include the following:

1. a centralized dispatch system to coordinate services within the crisis continuum
2. the ability to integrate with the 911 PSAP CAD systems
3. GPS tracking that includes interface with cellphones – for MCRT and for caller
4. zip code-based tracking of callers rather than based on area code of caller's phone number
5. geolocation capacity
6. the ability to access an electronic health record that permits crisis care providers to use information from prior contacts as well as clinical information for quality and continuity of care previous health data. This could include advance directives executed by consumers
7. an automated risk assessment process (during call intake) that is used to screen callers and refer them to the right resource
8. a bed registry component
9. the ability to dispatch mobile crisis response using GPS enabled technology to enable the team that is the closest to individuals experiencing a crisis to respond rapidly
10. a referral and appointment scheduling component
11. a reporting and analytics component that is accessible to providers, system administrators and the public (e.g., dashboards and other reporting mechanisms such as standard reports for monitoring service delivery, consumer outcomes etc.)

The committee acknowledges that the development and implementation of technology which addresses these components will take time, and that all components may not be implemented at once, rather some components will need to be phased in.

Action 9. Develop recommendations for a phased training plan for each element of the work plan above

The TSIDM Subcommittee Charter tasked the TSIDM Subcommittee with creating recommendations regarding the phased implementation of new processes and systems. Successful implementation requires that the staff using the new processes and systems to be trained in the updated policies, procedures, and technology. Therefore, the TSIDM Subcommittee actions from the work plan are listed below with recommendations for training needs that would occur after the development of new policies and systems. Actions 1 and 2 are complete and do not require training recommendations.

Training Recommendations for Actions 3 through 8:

The TSIDM Subcommittee recommends that 911 PSAP telecommunicators, 590 mobile crisis response team staff, 988 crisis call operators, and managers at each of these agencies be trained in the Illinois code regarding private health information (PHI) and client confidentiality. The training should include the specific requirements that anyone who has access to or is transferring PHI data must follow.

Training Recommendations for Action 3: Describe necessary improvements for data to be used for monitoring and evaluating Illinois' crisis continuum

The Subcommittee recommends these improvements to the state of data include training on how to use and evaluate data for those involved in data collection and evaluation. Once a new data collection system is in place, the following trainings are recommended:

1. Staff at each 911 PSAP, 590 Mobile Crisis Response Team, and 988 LCC that collect data need to be trained on how to enter data into the reporting system (see also Action 7).
2. System administrators at each PSAP, 590 Mobile Crisis Response Team, and 988 LCC need to be trained on how to generate and read reports, and how to understand the report layout. (see also Action 7).
3. Emergency Medical System (EMS) Medical Directors need training on what data is being collected by the 911 PSAPs. (see also Action 7).

Training Recommendations for Action 4: Develop and approve Sample Reports

The TSIDM Subcommittee recommends different training regarding reporting based on the role of the person engaging with the report.

1. Managers and system administrators who generate the reports must be trained on how to generate the reports in the new technology system, on how they can and cannot use the report, on what the report can accomplish, and on the frequency of when required reports are due.
2. An administrator or manager of a 911 PSAP, 590 Mobile Crisis Response Team agency, or

a 988 LCC needs to be supported to understand how the different systems in the state work together.

3. If the reporting system has dashboards for public audiences, as we expect it may, the Subcommittee recommends built-in training modules be available on the website to tell users how to access the reports and cut them in different ways of interest to various audiences.

Training Recommendations for Action 5: Develop recommendations to support the operational procedures for communicating between 911 and 988

The operational procedures for communication between 911 PSAPs and 988 LCCs are still under development by bodies outside of this Subcommittee. Once the procedures are developed, the following training recommendations apply:

1. 911 PSAP telecommunicators and 988 LCC operators must be trained on the operational procedures for contact transfers.
2. We expect this will be a phased approach at each 911 PSAP and 988 LCC.

Training Recommendations for Action 6: Develop recommendations to support the operational procedures for communicating between 988 and MCRT

The operational procedures for communication between 988 LCCs and 590 Mobile Crisis Response Teams are still under development by bodies outside of this Subcommittee. Once the procedures are developed, the following training recommendations apply:

1. 988 LCC operators and 590 Mobile Crisis Response Team staff must be trained on the operational procedures for contact transfers.

Training Recommendations for Action 7: Develop recommendations for technical systems and infrastructure necessary to facilitate and automate data collection, including implementation

Once a new data collection system is in place, the TSIDM Subcommittee recommends the following trainings to support data collection:

1. Staff at each 911 PSAP, 590 Mobile Crisis Response Team, and 988 LCC that collect data need to be trained on how to enter data into the reporting system.
2. System administrators at each 911 PSAP, 590 Mobile Crisis Response Team, and 988 LCC need to be trained on how to generate and read reports, and how to understand the report layout.
3. Emergency Medical System (EMS) Medical Directors need training on what data is being collected by the 911 PSAPs.

Training Recommendations for Action 8:

Once a new provider referral system is in place, the TSIDM Subcommittee recommends the following trainings to support contact transfers:

1. All staff and managers at each 911 PSAP, 590 Mobile Crisis Response Team and 988 LCC that transfer calls or make or receive referrals need to be trained on how to use the new referral system.
2. Cross training is recommended so that 911 PSAPs, 988 LCCs, and 590 MCRT programs know what roles the other agencies play.

Conclusion

The activities and current recommendations of the CESSA TSIDM Subcommittee contained herein are made with the recognition that they address the behavioral health crisis continuum and its technological and information systems as they are at this specific point in time. The Subcommittee recognizes that the crisis continuum and its systems will evolve, and as such, additional opportunities may arise for other data and system requirements in the future. In addition, the Subcommittee will continue to monitor and reference parallel and/or related work. Lastly, Subcommittee members noted that many of the current recommendations will have fiscal implications that will need to be addressed by the Illinois General Assembly and/or IDHS/DHM before full implementation of the recommendations.

Respectfully submitted by

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