CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

Champaign County Mental Health Board (CCMHB) Meeting Agenda
Wednesday, March 19, 2025, 5:45PM

This meeting will be held in person at the
Shields-Carter Room of the Brookens Administrative Building, 1776 East Washington Street, Urbana, IL 61802
Members of the public may attend in person or watch the meeting live through this link:
https://us02web.zoom.us/j/81393675682 ***Meeting ID: 813 9367 5682***

I. **Call to order**
II. **Roll call**
III. **Approval of Agenda***
IV. **MHB and DDB Schedules, updated MHB Timeline** (pages 3-7). *No action needed.*
V. **CCMHB Acronyms and Glossary** (pages 8-19) *No action needed.*
VI. **Public Participation/Agency Input** *See below for details.***
VII. **Chairperson's Comments – Molly McLay**
VIII. **Executive Director's Comments – Lynn Canfield**
IX. **Approval of CCMHB Board Meeting Minutes** (pages 20-24)*****
Action is requested to approve the minutes of the CCMHB's February 19, 2025 meeting.
X. **Vendor Invoice Lists** (pages 25-35)*****
Action is requested to accept the "Vendor Invoice Lists" and place them on file. For information are Additional Details for these expenditures.
XI. **Staff Report** (pages 36-69)
Included for information only is a report from Lynn Canfield. Other staff reports are deferred due to review of requests for funding.
XII. **New Business**
a) **Evaluation Capacity Building Project** (pages 70-78)*
*A decision memorandum provides an overview of the two year Evaluation Capacity Building project and requests a two-year extension.**
b) **Results of Survey on Emerging Threats** (pages 79-88)
For information only, a briefing memorandum presents recent survey results.
c) **Review of Applications for PY2026 Funding** (pages 89-93)
For information only, the packet includes a note about changes to application and review processes, a list of applications with board reviewers, and a checklist for (optional) Board member use.
XIII. **Old Business**
a) **Community Behavioral Health Needs Assessment Activities** (pages 94-118)
Information on community needs assessment activities or results (this month, a draft of community partner input) may support Board discussion and planning.
b) **disAbility Resource Expo Update** (pages 119-122)

Save the Date flyers and financial report are included for information. An oral update will be provided.

c) **AIR Update**

An oral update will be provided. The AIR website has some updates with more to come: https://champaigncountyair.com/

XIV. Public Participation/Agency Input *See below for details.***

XV. Board to Board Reports (page 123)

XVI. County Board Input

XVII. Champaign County Developmental Disabilities Board Input

XVIII. Board Announcements and Input

XIX. Adjournment

** Board action is requested.*

***Public input may be given virtually or in person.*
If the time of the meeting is not convenient, you may communicate with the Board by emailing stephanie@ccmhb.org or leon@ccmhb.org any comments for us to read aloud during the meeting.
The Chair reserves the right to limit individual time to five minutes and total time to twenty minutes.
All feedback is welcome.
The Board does not respond directly but may use input to inform future actions.
Agency representatives and others providing input which might impact Board actions should be aware of the Illinois Lobbyist Registration Act, 25 ILCS 170/1, and take appropriate steps to be in compliance with the Act.

For accessible documents or assistance with any portion of this packet, please contact us (leon@ccmhb.org).

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CCMHB 2025 Meeting Schedule

5:45PM Wednesday after the third Monday of each month
Brookens Administrative Building, 1776 East Washington Street, Urbana, IL
https://us02web.zoom.us/j/81393675682 *(if it is an option)*

January 22, 2025 – Shields-Carter Room
January 29, 2025 – *Study Session* - Shields-Carter Room
February 19, 2025 – Shields-Carter Room
March 19, 2025 – Shields-Carter Room
~~**March 26, 2025** – *Joint Meeting w CCDDB* –~~ *CANCELLED*
April 16, 2025 – *Study Session* -Shields-Carter Room
April 30, 2025 –Shields-Carter Room *(off cycle)*
May 21, 2025 – *Study Session* - Shields-Carter Room
May 28, 2025 – Shields-Carter Room (*off cycle)*
June 18, 2025 – Shields-Carter Room
July 23, 2025 – Shields-Carter Room
August 20, 2025 – Shields-Carter Room - *tentative*
September 17, 2025 – Shields-Carter Room
September 24, 2025 – *Joint Study Session w CCDDB* - Shields-Carter
October 22, 2025 – Shields-Carter Room
October 29, 2025 – *Joint Study Session w CCDDB* - Shields-Carter
November 19, 2025 – Shields-Carter Room
December 17, 2025 – Shields-Carter Room - *tentative*

This schedule is subject to change due to unforeseen circumstances.
Meeting information is posted, recorded, and archived at http://www.co.champaign.il.us/mhbddb/DDBMeetingDocs.php
Please check the website or email stephanie@ccmhb.org to confirm meeting times and locations.

All meetings and study sessions include time for members of the public to address the Board. All are welcome to attend, virtually or in person, to observe and to offer thoughts during "**Public Participation**" or **"Public Input."**
An individual's comments may be limited to five minutes, and total time for input may be limited to twenty minutes. The Board does not respond directly but may use the content to inform future actions.

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CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CCDDB 2025 Meeting Schedule

9:00AM Wednesday after the third Monday of each month
Brookens Administrative Building, 1776 East Washington Street, Urbana, IL
https://us02web.zoom.us/j/81559124557

January 22, 2025 – Shields-Carter Room
February 19, 2025 – Shields-Carter Room
March 19, 2025 – Sheilds-Carter Room
~~**March 26, 2025** 5:45PM – *joint meeting with CCMHB*~~ *CANCELLED*
April 16, 2025 – Shields-Carter Room *(off cycle)*
April 30, 2025 – Shields-Carter Room - *tentative*
May 21, 2025 – Shields-Carter Room
June 18, 2025 – Shields-Carter Room
July 23, 2025 – Shields-Carter Room
August 20, 2025 – Shields-Carter Room - *tentative*
September 17, 2025 – Shields-Carter Room
September 24, 2025 – Shields-Carter Room – *joint study session with MHB*
October 22, 2025 – Shields-Carter Room
October 29, 2025 5:45PM – Shields-Carter Room – *joint study session with MHB*
November 19, 2025 – Shields-Carter Room
December 17, 2025 – Shields-Carter Room - *tentative*

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IMPORTANT DATES

2025 Meeting Schedule with Subjects, Agency and Staff Deadlines, and PY26 Allocation Timeline

The schedule offers dates and subject matter of meetings of the Champaign County Mental Health Board. Subjects are not exclusive to any given meeting, as other matters requiring Board review or action may also be addressed. Study sessions may be scheduled on topics raised at meetings, brought by staff, or in conjunction with the CCDDB. Included are tentative dates for steps in the funding allocation process for PY26 and deadlines related to PY24 and PY25 agency contracts. **Regular meetings and study sessions are scheduled to begin at 5:45PM and may be confirmed with Board staff.**

12/20/24	*Online System opens for Applications for PY2026 Funding.*
12/31/24	*Agency PY24 Independent Audits, Reviews, Compilations due.*
1/22/25	**Regular Board Meeting** Mid-Year Program Presentations
1/29/25	**Study Session:** Mid-Year Program Presentations
1/31/25	*Agency PY25 2nd Quarter and CLC progress reports due.*
2/10/25	*Deadline for submission of applications for PY26 funding (Online system will not accept any forms after 4:30PM).*
2/19/25	**Regular Board Meeting** Discuss list of PY26 Applications and Review Process
3/19/25	**Regular Board Meeting** Discussion of PY26 Funding Requests
~~**3/26/25**~~	~~**Joint Meeting with CCDDB**~~ *CANCELLED*
4/9/25	*Program summaries released to Board, posted online with CCMHB April 16 study session packet.*

4/16/25	**Study Session** Board Review, Staff Summaries of Funding Requests
4/25/25	*Agency PY2025 3rd Quarter Reports due.*
4/30/25	**Regular Board Meeting** *(off cycle)* 2024 Annual Report
5/14/25	*Allocation recommendations released to Board, posted online with CCMHB May 21 study session packet.*
5/21/25	**Study Session:** Allocation Recommendations
5/28/25	**Regular Board Meeting** *(off cycle)* Allocation Decisions; Authorize Contracts for PY2026
6/1/25	*For contracts with a PY25-PY26 term, all updated PY26 forms should be completed and submitted by this date.*
6/17/25	*Deadline for agency application/contract revisions.* *Deadline for agency letters of engagement w/ CPA firms.*
6/18/25	**Regular Board Meeting** Draft FY2026 Budget, Election of Officers
6/20/25	*PY2026 agency contracts completed.*
6/30/25	*Agency Independent Audits, Reviews, or Compilations due. (only applies to those with calendar FY, check contract)*
7/23/25	**Regular Board Meeting**
8/20/25	**Regular Board Meeting -** *tentative*
8/29/25	*Agency PY2025 4th Quarter reports, CLC progress reports, and Annual Performance Measure Reports due.*
9/17/25	**Regular Board Meeting** Draft Three Year Plan 2025-27 with 2025 Objectives Approve DRAFT FY 2026 Budgets

9/24/25	**Joint Study Session with CCDDB**
10/22/25	**Regular Board Meeting** Draft Program Year 2027 Allocation Criteria
10/29/25	**Joint Meeting with CCDDB** I/DD Special Initiatives
10/31/25	*Agency PY2026 First Quarter Reports due.*
11/19/25	**Regular Board Meeting** Approve Three Year Plan with One Year Objectives Approve PY27 Allocation Criteria
11/28/25	*Public Notice of Funding Availability to be published by date, giving at least 21-day notice of application period.*
12/17/25	**Regular Board Meeting**– *tentative*
12/19/25	*Online system opens for applications for PY27 funding.*
12/30/25	*Agency Independent Audits, Reviews, Compilations due.*

Agency and Program Acronyms

AA- Alcoholics Anonymous
AIR – Alliance for Inclusion and Respect (formerly Anti-Stigma Alliance)
BLAST – Bulldogs Learning and Succeeding Together, at Mahomet Area Youth Club
CC – Community Choices or Courage Connection
CCCAC or CAC – (Champaign County) Children's Advocacy Center
CCCHC – Champaign County Christian Health Center
CCDDB or DDB – Champaign County Developmental Disabilities Board
CCHCC – Champaign County Health Care Consumers
CCHS – Champaign County Head Start, a department of the Champaign County Regional Planning Commission (also CCHS-EHS, for Head Start-Early Head Start)
CCMHB or MHB – Champaign County Mental Health Board
CCRPC or RPC – Champaign County Regional Planning Commission
CN - Crisis Nursery
CSCNCC - Community Service Center of Northern Champaign County, also CSC
CU TRI – CU Trauma & Resiliency Initiative
Courage Connection – previously The Center for Women in Transition
DMBGC - Don Moyer Boys & Girls Club
DREAAM – Driven to Reach Excellence and Academic Achievement for Males
DSC - Developmental Services Center
ECHO – a program of Cunningham Children's Home
ECIRMAC or RAC – East Central Illinois Refugee Mutual Assistance Center or The Refugee Center
ECMHS - Early Childhood Mental Health Services, a program of CCRPC Head Start
FD – Family Development, previously Family Development Center, a DSC program
FF - FirstFollowers
FS - Family Service of Champaign County
FST – Families Stronger Together, a program of Cunningham Children's Home
GCAP – Greater Community AIDS Project of East Central Illinois
IAG – Individual Advocacy Group, Inc., a provider of I/DD services
ISCU - Immigrant Services of Champaign-Urbana
MAYC - Mahomet Area Youth Club
NA- Narcotics Anonymous
NAMI – National Alliance on Mental Illness
PATH – regional provider of 211 information/call services
PEARLS - Program to Encourage Active Rewarding Lives
PHC – Promise Healthcare
PSC - Psychological Services Center (UIUC) or Problem Solving Courts (Drug Court)
RAC or ECIRMAC – East Central Illinois Refugee Mutual Assistance Center
RACES – Rape Advocacy, Counseling, and Education Services
RCI – Rosecrance Central Illinois
RPC or CCRPC – Champaign County Regional Planning Commission
UNCC – Urbana Neighborhood Community Connections Center
UP Center – Uniting Pride
UW or UWCC – United Way of Champaign County
WIN Recovery – Women in Need Recovery
YAC – Youth Assessment Center, a program of CCRPC

Glossary of Other Terms and Acronyms

211 – Information and referral services call service

988 – Suicide and Crisis Lifeline

ABA – Applied Behavioral Analysis, an intensive behavioral intervention targeted to autistic children and youth and others with associated behaviors.

ACA – Affordable Care Act

ACEs – Adverse Childhood Experiences

ACMHAI – Association of Community Mental Health Authorities of Illinois

ACL – federal Administration for Community Living

ACT- Acceptance Commitment Therapy

ACT – Assertive Community Treatment

ADD/ADHD – Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder

ADL – Activities of Daily Living

ALICE - Asset Limited, Income Constrained, Employed

A/N – Abuse and Neglect

ANSA – Adult Needs and Strengths Assessment

APN – Advance Practice Nurse

ARC – Attachment, Regulation, and Competency

ARMS – Automated Records Management System. Information management system used by law enforcement.

ASAM – American Society of Addiction Medicine. May be referred to in regard to assessment and criteria for patient placement in level of treatment/care.

ASD – Autism Spectrum Disorder

ASL – American Sign Language

ASQ – Ages and Stages Questionnaire. Screening tool used to evaluate a child's developmental and social emotional growth.

ASQ-SE – Ages and Stages Questionnaire – Social Emotional screen.

ATOD – Alcohol, Tobacco, and Other Drugs

BARJ - Balanced and Restorative Justice approach

BD – Behavior Disorder

BJMHS - Brief Jail Mental Health Screening Tool

CADC – Certified Alcohol and Drug Counselor, substance abuse professional providing clinical services, having met certification requirements of the Illinois Alcoholism and Other Drug Abuse Professional Certification Association.

CALAN or LAN – Child and Adolescent Local Area Network

CANS – Child and Adolescent Needs and Strengths, a multi-purpose tool to support decision making, including level of care, service planning, and monitoring of outcomes of services.

C-CARTS – Champaign County Area Rural Transit System

CATS – Child and Adolescent Trauma Screen

CBCL – Child Behavior Checklist

CBT – Cognitive Behavioral Therapy

CC – Champaign County

CCBHC – Certified Community Behavioral Health Clinic

CCBoH – Champaign County Board of Health

CCHVC - Champaign County Home Visiting Consortium

CCMHDDAC or MHDDAC – Champaign County Mental Health and Developmental Disabilities Agencies Council

CCSO – Champaign County Sheriff's Office

CDC – federal Centers for Disease Control and Prevention

CDS – Community Day Services, day programming for adults with I/DD, previously Developmental Training

CES – Coordinated Entry System

CESSA – Community Emergency Services and Support Act, an Illinois law also referred to as the Stephon Watts Act, requiring mental health professionals be dispatched to certain crisis response.

C-GAF – Children's Global Assessment of Functioning

CGAS – Children's Global Assessment Score

CHW – Community Health Worker

CILA – Community Integrated Living Arrangement, Medicaid-waiver funded residential services for people with I/DD

CIT – Crisis Intervention Team; law enforcement officer trained to respond to calls involving an individual exhibiting behaviors associated with mental illness.

CLC – Cultural and Linguistic Competence

CLST – Casey Life Skills Tool

CMS – federal Centers for Medicare and Medicaid Services

COC - Continuum of Care Program

CQL – Council on Quality and Leadership

CPTSD or c-PTSD – Complex Post-Traumatic Stress Disorder

CRSS- Certified Recovery Support Specialist

CRT – Co-Responder Team; mobile crisis response intervention coupling a CIT trained law enforcement officer with a mental health crisis worker. Also CCRT – Crisis Co-Responder Team.

CSEs – Community Service Events, as described in a funded agency's program plan, may include public events (including mass media and articles), consultations with community groups and/or caregivers, classroom presentations, and small group workshops to promote a program or educate the community. Meetings directly related to planning such events may also be counted here. Actual direct service to clientele is counted elsewhere.

CSPH – Continuum of Service Providers to the Homeless

CSPI – Childhood Severity of Psychiatric Illness. A mental health assessment instrument

CST – Community Support Team

CY – Contract Year, July 1-June 30. Also Program Year (PY), most agencies' Fiscal Year (FY)

CYFS – Center for Youth and Family Solutions (formerly Catholic Charities)

DASA – Division of Alcoholism and Substance Abuse in the Illinois Department of Human Services, renamed as IDSUPR or SUPR

DBT -- Dialectical Behavior Therapy

DCFS – Illinois Department of Children and Family Services

DECA – Devereux Early Childhood Assessment for Preschoolers

DEI – Diversity, Equity, and Inclusion

Detox – abbreviated reference to detoxification, a general reference to drug and alcohol detoxification program or services, e.g. Detox Program.

DD – Developmental Disability

DDD or IDHS DDD – Illinois Department of Human Services - Division of Developmental Disabilities

DFI – Donated Funds Initiative, source of matching funds for some CCMHB funded contracts. The Illinois Department of Human Services administers the DFI Program funded with federal Title XX Social Services Block Grant. The DFI is a "match" program meaning community-based agencies must match the DFI funding with locally generated funds. The required local match is 25 percent of the total DFI award.

DHFS – Illinois Department of Healthcare and Family Services, previously IDPA (Illinois Department of Public Aid)

DHS – Illinois Department of Human Services

DMH or IDHS DMH – Illinois Department of Human Services - Division of Mental Health

DOJ – federal Department of Justice

DSM – Diagnostic Statistical Manual

DSP – Direct Support Professional, a certification required for those serving people with I/DD

DT – Developmental Therapy (children), or Developmental Training (adults), now Community Day Services

DV – Domestic Violence

EAP – Employee Assistance Program

EBP - Evidence Based Practice

EHR – Electronic Health Record

EI – Early Intervention

EMS – Emergency Medical Services

EPDS – Edinburgh Postnatal Depression Scale – Screening tool used to identify mothers with newborn children who may be at risk for prenatal depression.

EPSDT – Early Periodic Screening Diagnosis and Treatment. Intended to provide comprehensive and preventative health care services for children under age 21 who are enrolled in Medicaid.

ER – Emergency Room

FACES – Family Adaptability and Cohesion Evaluation Scale

FAST – Family Assessment Tool

FFS – Fee for Service, reimbursement or performance-based billings are the basis of payment

FOIA – Freedom of Information Act

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Center

FTE – Full Time Equivalent is the aggregated number of employees supported by the program. Can include employees providing direct services (Direct FTE) to clients and indirect employees such as supervisors or management (Indirect FTE).

FY – Fiscal Year, which for the County is January 1 through December 31.

GAAP - Generally Accepted Accounting Principles

GAF – Global Assessment of Functioning. A subjective rating scale used by clinicians to rate a client's level of social, occupational and psychological functioning. The scale included in the DSM-IV has been replaced in the DSM-V by another instrument.

GAGAS-Generally Accepted Government Auditing Standards

GAO-Government Accountability Office

GAIN-Q – Global Appraisal of Individual Needs-Quick. Is the most basic form of the assessment tool taking about 30 minutes to complete and consists of nine items that identify and estimate the severity of problems of the youth or adult.

GAIN Short Screen - Global Appraisal of Individual Needs, is made up of 20 items (four five-item subscales). The GAIN-SS subscales identify internalizing disorders, externalizing disorders, substance use disorders, crime/violence.

GSRC – Gender and Sexuality Resource Center

GSA – Gender/Sexuality Alliances

HACC – Housing Authority of Champaign County

HBS – Home Based Support, a Medicaid-waiver program for people with I/DD

HCBS – Home and Community Based Supports, a federal Medicaid program

HEARTH Act – Homeless Emergency and Rapid Transition to Housing

HFS or IDHFS – Illinois Department of Healthcare and Family Services

HHS – federal department of Health and Human Services

HIC – Housing Inventory Counts

HIPPA – Health Insurance Portability and Accountability Act

HMIS – Homeless Management Information System

HRSA – Health Resources and Services Administration, housed within the federal Department of Health and Human Resources and responsible for Federally Qualified Health Centers.

HSSC – Homeless Services System Coordination

HUD – Housing and Urban Development

I&R – Information and Referral

ILAPSC – Illinois Association of Problem-Solving Courts

ICADV – Illinois Coalition Against Domestic Violence

ICASA – Illinois Coalition Against Sexual Assault

ICDVP – Illinois Certified Domestic Violence Professional

ICFDD – Intermediate Care Facility for the Developmentally Disabled

ICJIA – Illinois Criminal Justice Authority

ID or I/DD – Intellectual Disability or Intellectual/Developmental Disability

IDHFS or HFS – Illinois Department of Healthcare and Family Services

IDHS DDD or DDD – Illinois Department of Human Services Division of Developmental Disabilities

IDHS DMH or DMH – Illinois Department of Human Services - Division of Mental Health

IDOC – Illinois Department of Corrections

IDSUPR or SUPR – Illinois Division of Substance Use Prevention & Recovery

IECAM - Illinois Early Childhood Asset Map

IEP – Individualized Education Plan

I/ECMHC – Infant/Early Childhood Mental Health Consultation

IGA – Intergovernmental Agreement

IM+CANS – The Illinois Medicaid Comprehensive Assessment of Needs and Strengths

IOP – Intensive Outpatient Treatment

IPLAN - Illinois Project for Local Assessment of Needs, a community health assessment and planning process that is conducted every five years by local health jurisdictions in Illinois. Based on the *Assessment Protocol for Excellence in Public Health* (APEX-PH) model, IPLAN is grounded in the core functions of public health and addresses public health practice standards. The completion of IPLAN fulfills most of the requirements for Local Health Department certification under Illinois Administrative Code Section 600.400: Certified Local Health Department Code Public Health Practice Standards. The essential elements of IPLAN are:

1. an organizational capacity assessment;
2. a community health needs assessment; and
3. a community health plan, focusing on a minimum of three priority health problems.

ISBE – Illinois State Board of Education

ISC – Independent Service Coordination

ISP – Individual Service Plan

ISSA – Independent Service & Support Advocacy

JDC – Juvenile Detention Center

JJ – Juvenile Justice

JJPD – Juvenile Justice Post Detention

LAN – Local Area Network

LCPC – Licensed Clinical Professional Counselor

LCSW – Licensed Clinical Social Worker

LGTBQ + – Lesbian, Gay, Bi-Sexual, Transgender, Queer, plus all the gender identities and sexual orientations that letters and words cannot yet fully describe.

LIHEAP – Low Income Home Energy Assistance Program

LPC – Licensed Professional Counselor

MAP – Matching to Appropriate Placement, a tool focused on those seeking stable housing

MAR/MAT – Medication Assisted Recovery/Medication Assisted Treatment

MBSR – Mindfulness-Based Stress Reduction

MCO – Managed Care Organization. Entity under contract with the state to manage healthcare services for persons enrolled in Medicaid.

MCR – Mobile Crisis Response, previously SASS, a state program that provides crisis intervention for children and youth on Medicaid.

MDT – Multi-Disciplinary Team

MH – Mental Health

MHFA – Mental Health First Aid

MHDDAC or CCMHDDAC – Mental Health and Developmental Disabilities Agencies Council

MHP – Mental Health Professional. Rule 132 term, typically referring to a bachelor's level staff providing services under the supervision of a QMHP.

MI – Mental Illness, also Mental Impairment

MI – Motivational Interview

MIDD – A dual diagnosis of Mental Illness and Developmental Disability.

MISA – A dual diagnosis condition of Mental Illness and Substance Abuse

MOU – Memorandum of Understanding

MRT – Moral Reconation Therapy

NACBHDD – National Association of County Behavioral Health and Developmental Disability Directors

NACO – National Association of Counties

NADCP – National Association of Drug Court Professionals

NMT – Neurodevelopmental Model of Therapeutics

NOFA – Notice of Funding Availability

NTPC – NON Treatment Plan Clients, which may include: recipients of material assistance, non-responsive outreach cases, cases closed before a plan was written because the client did not want further service beyond first few contacts or cases assessed for another agency. It is a category of service measurement described in a funded agency's program plan. Continuing NTPCs are those without treatment plans who were served before the first day of July and actively receiving services within the first quarter of the new program year. The first quarter of the program year is the only quarter in which this data is reported. New NTPCs are those new in a given quarter.

NREPP – National Registry of Evidence-based Programs and Practices maintained by Substance Abuse Mental Health Services Administration (SAMHSA)

OCD – Obsessive-Compulsive Disorder

ODD – Oppositional Defiant Disorder

OMA – Open Meetings Act

OP – Outpatient (treatment)

OUD/SUD – Opioid Use Disorder/Substance Use Disorder

PAS – Pre-Admission Screening

PCI – Parent Child Interaction groups.

PCP – Person Centered Planning

PFS - Protective Factors Survey

PIT- Point in Time count. A count of sheltered and unsheltered homeless persons carried out on one night in the last 10 calendar days of January or at such other time as required by HUD.

PLAY – Play and Language for Autistic Youngsters. PLAY is an early intervention approach that teaches parents ways to interact with their child who has autism that promotes developmental progress.

PLL – Parenting with Love and Limits. Evidence-based group/family therapy for youth/families involved in juvenile justice system.

PLWHA – People living with HIV/AIDS

PPSP – Parent Peer Support Partner

PSR – Patient Service Representative; staff position providing support services to patients and medical staff.

PTSD – Post-Traumatic Stress Disorder

PUNS – Prioritization of Urgency of Need for Services, a database implemented by IDHS to assist with planning and prioritization of services for individuals with disabilities based on level of need.

PWD – People with Disabilities

PWI – Personal Well-being Index

PY – Program Year, July 1 to June 30. Also Contract Year (CY), often agency Fiscal Year (FY)

QCPS – Quarter Cent for Public Safety. The funding source for the Juvenile Justice Post Detention programming. May also be referred to as Quarter Cent.

QIDP – Qualified Intellectual Disabilities Professional

QMHP – Qualified Mental Health Professional. Rule 132 term that, simply stated, refers to a Master's level clinician with field experience who has been licensed.

REBT -- Rational Emotive Behavior Therapy

RFI – Request for Information

RFP – Request for Proposals

RTC – Residential Treatment Center

SA – Sexual Assault

SA – Substance Abuse

SACIS – Sexual Assault Counseling and Information Service

SAD – Seasonal Affective Disorder

SAMHSA – Substance Abuse and Mental Health Services Administration, a division of the federal Department of Health and Human Services

SAMHSA NOMs – National Outcome Measures

SASS – Screening Assessment and Support Services is a state program that provides crisis intervention for children and youth on Medicaid.

SBIRT – Screening, Brief Intervention, Referral to Treatment. SAMHSA defines SBIRT as a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

SCs – Service Contacts/Screening Contacts, phone and face-to-face contacts with consumers who may or may not have open cases in the program, can include information and referral contacts or initial screenings/assessments or crisis services, sometimes referred to as service encounter.

SDOH – Social Determinants of Health

SDQ – Strengths and Difficulties Questionnaire

Seeking Safety – present-focused treatment for clients with history of trauma and substance use

SED – Serious Emotional Disturbance

SEDS – Social Emotional Development Specialist

SEL – Social Emotional Learning

SIM – Sequential Intercept Mapping, a model developed by SAMHSA

SMI – Serious Mental Illness

SNAP – Supplemental Nutrition Assistance Program

SOAR – SSI/SSDI Outreach, Access, and Recovery, assistance with applications for Social Security Disability and Supplemental Income, provided to homeless population.

SSI – Supplemental Security Income, a program of Social Security

SSDI – Social Security Disability Insurance, a program of Social Security

SSPC – Social Skills and Prevention Coaches.

SUD – Substance Use Disorder (replaces SA – Substance Abuse)

SUPR or IDSUPR – (Illinois Division of) Substance Use Prevention & Recovery

TANF – Temporary Assistance for Needy Families

TBRA – Tenant-Based Rental Assistance

TF-CBT – Trauma-Focused Cognitive Behavioral Therapy

TPCs – Treatment Plan Clients, service participants with case records and treatment plans. Continuing TPCs are those with treatment plans written prior to the first day of July and actively receiving services within the first quarter of the new program year. The first quarter of the program year is the only quarter in which this data is reported. Essentially it is a case carried from one program year into the next. New TPCs are new clients with treatment plans written in a given quarter of the program year. Each TPC should be reported only once during a program year.

TPITOS - The Pyramid Infant-Toddler Observation Scale, used by Champaign County Head Start

TPOT - Teaching Pyramid Observation Tool, used by Champaign County Head Start

TCU DS - Texas University Drug Screening tool

VAWA - Violence Against Women Act

VOCA - Victims of Crime Act

WHODAS – World Health Organization Disability Assessment Schedule, a generic assessment instrument for health and disability, used across all diseases, including mental and addictive disorders. The instrument covers 6 domains: Cognition, Mobility; Self-care; Getting along; Life activities; and Participation. Replaces the Global Assessment of Functioning in the DSM-V.

WIOA – Workforce Innovation and Opportunity Act

WIC – Women, Infants, and Children, A food assistance program for pregnant women, new mothers and young children eat well and stay healthy.

WRAP – Wellness Recovery Action Plan, a manualized group intervention for adults that guides participants through identifying and understanding their personal wellness resources and helps them develop an individualized plan to use these resources daily to manage their mental illness.

YASI – Youth Assessment and Screening Instrument, assesses risks, needs, and protective factors in youth, used in Champaign County by Youth Assessment Center and Juvenile Detention Center.

CHAMPAIGN COUNTY MENTAL HEALTH BOARD REGULAR MEETING

Minutes—February 19, 2025

This meeting was held at the Brookens Administrative Center, Urbana, IL and remotely.

5:45 p.m.

MEMBERS PRESENT:	Joe Omo-Osagie, Tony Nichols, Molly McLay, Chris Miner, Elaine Palencia, Kyle Patterson (arrived 6:05 pm), Emily Rodriguez, Jane Sprandel, Jon Paul Youakim
STAFF PRESENT:	Kim Bowdry, Leon Bryson, Lynn Canfield, Stephanie Howard-Gallo
OTHERS PRESENT:	Rachel Jackson, UIUC; Brenda Eakins, GROW; Cindy Crawford, Community Services Center of Northern Champaign County (CSCNCC); Andrew Muller, Joel Fletcher, Champaign County States Attorney's Office; David Dorman, Maria Jimenez, Immigrant Services of CU; Jessica Smith, DSC: Ann Pearcy, Cunningham Children's Home

CALL TO ORDER:

CCMHB President McLay called the meeting to order at 5:45 p.m.

ROLL CALL:

Roll call was taken, and a quorum was present.

APPROVAL OF AGENDA:

The agenda was approved.

CCDDB and CCMHB SCHEDULES:

Updated copies of CCDDB and CCMHB meeting schedules and CCMHB allocation timeline were included in the packet. The March 26, 2025 meeting will be cancelled.

ACRONYMS and GLOSSARY:

A list of commonly used acronyms was included for information.

CITIZEN INPUT / PUBLIC PARTICIPATION:

None.

OTHER BUSINESS - Closed Session:

Dr. Youakim recused himself from the Closed Session.

> **MOTION: At 5:54 p.m. Ms. Sprandel moved to enter into Closed Session Pursuant to 5 ILCS 120/2(c)(11) to consider litigation which is pending against or on behalf of Champaign County, and litigation that is probable or imminent against Champaign County. The following individuals joined this closed session: members of the Champaign County Mental Health Board, Executive Director Canfield, Operations and Compliance Coordinator Howard-Gallo, and Assistant State's Attorney Fletcher. Ms. Rodriquez seconded the motion. A roll call vote was taken and the motion passed unanimously.**
>
> **MOTION: Ms. McLay moved to enter into Closed Session for Semi-Annual Closed Session Minutes Review Pursuant to 5 ILCS 120/2(c)(21). The following individuals will join this closed session: members of the Champaign County Mental Health Board, Executive Director Canfield, and Operations and Compliance Coordinator Howard Gallo. Ms. Palencia seconded the motion. A roll call vote was taken and the motion passed.**

The CCMHB returned to Open Session at 6:20 p.m.

> **MOTION: Ms. McLay moved to accept the February 19, 2020, February 26, 2020, and July 21, 2021 closed session minutes as revised and to continue maintaining them as closed. Ms. Palencia seconded the motion. A roll call vote was taken and the motion passed unanimously.**

PRESIDENT'S COMMENTS:

Ms. McLay stated the board supports our mental health programs and all community members.

EXECUTIVE DIRECTOR'S COMMENTS:

No comments.

APPROVAL OF CCMHB MINUTES:

Minutes from the 1/22/25 meeting and the 1/29/25 study session were included in the packet.

MOTION: Ms. Sprandel moved to approve the meeting minutes from 1/22/25 and 1/29/25. Mr. Miner seconded the motion. A voice vote was taken, and the motion passed unanimously.

VENDOR INVOICE LISTS:

Vendor Invoice Lists were included in the Board packet.

MOTION: Ms. Sprandel moved to accept the Vendor Invoice Lists. Dr. Youakim seconded the motion. A voice vote was taken, and the motion passed unanimously.

STAFF REPORTS:

Staff reports from Kim Bowdry, Leon Bryson, Stephanie Howard-Gallo, and Chris Wilson were included in the packet.

NEW BUSINESS:

2024 Mental Health Crisis Intervention Reports & Court Cases:
For information only was a report on collected by the Champaign County State's Attorney's Office Civil Division for 2024. ASA Andrew Muller presented. Board members were given an opportunity to ask questions following the presentation.

Review of Applications for PY2026 Funding:
For information only, the packet included a briefing memorandum on the process of reviewing requests for funding, with a checklist for Board member use. A list of successful applications was included in the packet.

OLD BUSINESS:

Evaluation Capacity Building Project Update:
An oral update was provided by a representative from the Evaluation Team.

Community Behavioral Health Needs Assessment Activities:
Deferred.

disAbility Resource Expo Update:

Deferred.

Special Agency Request:
A Decision Memorandum provided background information to support the Board's discussion of action requested by Immigrant Services of CU (ISCU), Urbana Neighborhood Connections Center (UNCC), and Women in Need Recovery (WIN). Letters form ISCU, UNCC, and WIN were included in the packet.

Immigrant Servies of CU (ISCU) requested the CCMHB give full consideration to their PY2026 application despite a late audit. They expect the PY24 audit to be completed by late May 2025. Board members discussed late audits and the Board's responsibilities. David Dorman and Maria Jimenez from ISCU were present to answer Board questions and provide additional information.

> **MOTION: Ms. Rodriguez moved to consider Immigrant Services of CU Program Year 2026 funding request. Ms. Palencia seconded the motion. A voice vote was taken. The motion passed.**

Urbana Neighborhood Connections Center (UNCC) requested full consideration to their PY2026 application despite a PY2024 audit not being available. A representative from UNCC was not present to answer Board questions.

> **MOTION: Ms. Sprandel moved to consider Urbana Neighborhood Connections Center Program Year 2026 funding request. Dr. Youakim seconded the motion. A voice vote was taken and the motion passed.**

Women in Need Recovery (WIN) requested the Board waive the suspension of payments while waiting for the completed PY24 audit, which is anticipated March 31, 2025. A representative from WIN was not present to answer Board questions.

> **MOTION: Ms. McLay moved to continue the suspension of payments on the WIN Recovery Program Year 2025 contract until the PY24 audit is submitted and any follow-up issues resolved or until the Board decides to resume payment. Ms. Sprandel seconded the motion. A roll call vote was taken. Miner abstained. The motion passed.**

PY2025 Second Quarter MHB Program Activity Reports:
For information only, funded program service reports were included in the packet

SUCCESSES AND AGENCY INPUT:

None.

BOARD TO BOARD REPORTS:

None.

COUNTY BOARD INPUT:

Ms. Rodriguez stated they are bracing for economic distress locally.

CCDDB INPUT:

The CCDDB met earlier in the day.

BOARD ANNOUNCEMENTS AND INPUT:

Dr. Youakim announced on May 19th there will be a mental health conference for providers at the IHotel in Champaign.

ADJOURNMENT:

The meeting adjourned at 8:15 p.m.

Respectfully
Submitted by: Stephanie Howard-Gallo
CCMHB/CCDDB Operations and Compliance Coordinator

**Minutes are in draft form and subject to CCMHB approval.*

Champaign County, IL

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
1 CHAMPAIGN COUNTY TREASURER										
Feb'25 IDDSI25-089 CHECK DATE: 02/07/2025		02/01/2025	020725A	42593	19,336.00	19,336.00	02/28/2025	INV	PD	IDDSI25-089 Community
OCAFY24 FUND2101 GC CHECK DATE: 02/28/2025		02/26/2025	022825A	43353	1,306.03	1,306.03	03/07/2025	INV	PD	OCA FY24 BILLING
OCAFY24 FUND2101 TA CHECK DATE: 02/28/2025		02/26/2025	022825A	43364	113.68	113.68	03/07/2025	INV	PD	OCA FY24 BILLING
					20,755.71					
		3 INVOICES			20,755.71					

** END OF REPORT - Generated by Chris M. Wilson **

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
18805 C-U AT HOME										
Feb'25 MHB25-021		02/01/2025	020725A	42616	21,391.00	21,391.00	02/28/2025	INV	PD	MHB25-021 Shelter Case
CHECK DATE: 02/07/2025										
1 CHAMPAIGN COUNTY TREASURER										
Feb'25 MHB24-006		02/01/2025	020725A	42596	5,325.00	5,325.00	02/28/2025	INV	PD	MHB24-006 Children's A
CHECK DATE: 02/07/2025										
Feb'25 MHB24-025		02/01/2025	020725A	42591	6,362.00	6,362.00	02/28/2025	INV	PD	MHB24-025 Youth Assess
CHECK DATE: 02/07/2025										
Feb'25 MHB25-004		02/01/2025	020725A	42590	4,523.00	4,523.00	02/28/2025	INV	PD	MHB25-004 Homeless Ser
CHECK DATE: 02/07/2025										
Feb'25 MHB25-026		02/01/2025	020725A	42589	32,371.00	32,371.00	02/28/2025	INV	PD	MHB25-026 Early Childh
CHECK DATE: 02/07/2025										
Feb'25 Office Rent		02/01/2025	020725A	42595	2,196.78	2,196.78	02/28/2025	INV	PD	Feb'25 Office Rent 053
CHECK DATE: 02/07/2025										
MHB/DDB 2024 IT		02/14/2025	022125A	43137	1,250.36	1,250.36	02/28/2025	INV	PD	MHB/DDB 2024 IT Billin
CHECK DATE: 02/21/2025										
OCAFY24 FUND2090 GC		02/26/2025	022825A	43353	7,480.67	7,480.67	03/07/2025	INV	PD	OCA FY24 BILLING
CHECK DATE: 02/28/2025										
OCAFY24 FUND2090 TA		02/26/2025	022825A	43364	651.04	651.04	03/07/2025	INV	PD	OCA FY24 BILLING
CHECK DATE: 02/28/2025										
OCAFY24 FUND2108 GC		02/26/2025	022825A	43353	2,288.20	2,288.20	03/07/2025	INV	PD	OCA FY24 BILLING
CHECK DATE: 02/28/2025										
OCAFY24 FUND2108 TA		02/26/2025	022825A	43364	199.14	199.14	03/07/2025	INV	PD	OCA FY24 BILLING
CHECK DATE: 02/28/2025										
					62,647.19					
18259 CHAMPAIGN COUNTY HEALTH CARE CONSUMERS										
Feb'25 MHB24-044		02/01/2025	020725A	504956	7,208.00	7,208.00	02/28/2025	INV	PD	MHB24-044 CHW Outreach
CHECK DATE: 02/07/2025										
Feb'25 MHB24-045		02/01/2025	020725A	504956	7,512.00	7,512.00	02/28/2025	INV	PD	MHB24-045 Justice Invo
CHECK DATE: 02/07/2025										
Feb'25 MHB25-066		02/01/2025	020725A	504956	8,750.00	8,750.00	02/28/2025	INV	PD	MHB25-066 Disability A
CHECK DATE: 02/07/2025										
					23,470.00					
10148 COMMUNITY SERVICE CENTER OF NORTHERN										

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
Feb'25 MHB24-008		02/01/2025	020725A	42633	5,717.00	5,717.00	02/28/2025	INV	PD	MHB24-008 Resource Con
CHECK DATE: 02/07/2025										
10163 CRISIS NURSERY										
Feb'25 MHB24-005		02/01/2025	020725A	42636	7,500.00	7,500.00	02/28/2025	INV	PD	MHB24-005 Beyond Blue
CHECK DATE: 02/07/2025										
18305 CUNNINGHAM CHILDRENS HOME										
Feb'25 MHB25-018		02/01/2025	020725A	42640	16,975.00	16,975.00	02/28/2025	INV	PD	MHB25-018 ECHO Housing
CHECK DATE: 02/07/2025										
Feb'25 MHB25-036		02/01/2025	020725A	42640	23,511.00	23,511.00	02/28/2025	INV	PD	MHB25-036 Families Str
CHECK DATE: 02/07/2025										
					40,486.00					
10170 DEVELOPMENTAL SERVICES CENTER OF										
Feb'25 MHB24-012		02/01/2025	020725A	42647	54,681.00	54,681.00	02/28/2025	INV	PD	MHB24-012 Family Devel
CHECK DATE: 02/07/2025										
10175 DON MOYER BOYS & GIRLS CLUB										
Feb'25 MHB25-015		02/01/2025	020725A	42652	7,131.00	7,131.00	02/28/2025	INV	PD	MHB25-015 CU Change
CHECK DATE: 02/07/2025										
10185 EAST CNTRL IL REFUGEE MUTUAL ASSIST CTR										
Feb'25 MHB24-001		02/01/2025	020725A	42654	5,166.00	5,166.00	02/28/2025	INV	PD	MHB24-001 Family Suppo
CHECK DATE: 02/07/2025										
Jan'25 MHB24-001		01/01/2025	020725A	42654	5,166.00	5,166.00	01/31/2025	INV	PD	MHB24-001 Family Suppo
CHECK DATE: 02/07/2025										
					10,332.00					
100 EMPLOYEE VENDOR										
Bryson 1/29/25 FY24		01/15/2025	020725A	42803	18.43	18.43	02/28/2025	INV	PD	Travel Log 11/20/24 -
CHECK DATE: 02/07/2025						PAYEE: Bryson, Leon				
18343 FAMILY SERVICE OF CHAMPAIGN COUNTY										
Jan'25 MHB24-014		01/01/2025	020725A	42666	2,500.00	2,500.00	01/31/2025	INV	PD	MHB24-014 Counseling
CHECK DATE: 02/07/2025										
Jan'25 MHB24-016		01/01/2025	020725A	42666	2,410.00	2,410.00	01/31/2025	INV	PD	MHB24-016 Self Help Ce

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
CHECK DATE: 02/07/2025										
Jan'25 MHB24-017		01/01/2025	020725A	42666	14,865.00	14,865.00	01/31/2025	INV	PD	MHB24-017 Senior Couns
CHECK DATE: 02/07/2025										
					19,775.00					
20173 GREATER COMMUNITY AIDS PROJECT OF EAST CENTRAL IL										
Feb'25 MHB25-022		02/01/2025	020725A	504963	5,130.00	5,130.00	02/28/2025	INV	PD	MHB25-022 Advocacy, Ca
CHECK DATE: 02/07/2025										
10242 GROW IN ILLINOIS										
Feb'25 MHB25-011		02/01/2025	020725A	42675	13,140.00	13,140.00	02/28/2025	INV	PD	MHB25-011 Peer Support
CHECK DATE: 02/07/2025										
10263 I3 BROADBAND - CU										
4023543-1		02/04/2025	021425A	42963	144.95	144.95	03/04/2025	INV	PD	Acct # 460579
CHECK DATE: 02/14/2025										
10358 AUTOMATED COMMUNICATIONS, INC.										
437118		02/10/2025	022125A	43241	147.10	147.10	03/12/2025	INV	PD	Expo - Tri-Fold Sponso
CHECK DATE: 02/21/2025										
10348 MCS OFFICE TECHNOLOGIES INC										
01-708235		02/01/2025	021425A	505019	609.00	609.00	03/03/2025	INV	PD	Feb'25 MHB Managed IT
CHECK DATE: 02/14/2025										
01-708341		02/12/2025	022125A	505072	33.75	33.75	03/14/2025	INV	PD	Service Ticket # 48401
CHECK DATE: 02/21/2025										
					642.75					
18413 PROMISE HEALTHCARE										
Feb'25 MHB24-013		02/01/2025	020725A	42729	27,500.00	27,500.00	02/28/2025	INV	PD	MHB24-013 Mental Healt
CHECK DATE: 02/07/2025										
Feb'25 MHB24-041		02/01/2025	020725A	42729	8,923.00	8,923.00	02/28/2025	INV	PD	MHB24-041 Wellness
CHECK DATE: 02/07/2025										
					36,423.00					
10464 RAPE, ADVOCACY, COUNSELING & EDUCATION SERVICES										
Feb'25 MHB24-002		02/01/2025	020725A	42731	6,250.00	6,250.00	02/28/2025	INV	PD	MHB24-002 Sexual Viole
CHECK DATE: 02/07/2025										

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
Feb'25 MHB24-035		02/01/2025	020725A	42731	11,666.00	11,666.00	02/28/2025	INV	PD	MHB24-035 Sexual Traum
CHECK DATE: 02/07/2025										
					17,916.00					
10488 ROSECRANCE, INC.										
Feb'25 MHB25-019		02/01/2025	020725A	42741	7,052.00	7,052.00	02/28/2025	INV	PD	MHB25-019 Benefits Cas
CHECK DATE: 02/07/2025										
Feb'25 MHB25-020		02/01/2025	020725A	42741	28,000.00	28,000.00	02/28/2025	INV	PD	MHB25-020 Criminal Jus
CHECK DATE: 02/07/2025										
Feb'25 MHB25-023		02/01/2025	020725A	42741	8,333.00	8,333.00	02/28/2025	INV	PD	MHB25-023 Recovery Hom
CHECK DATE: 02/07/2025										
Feb'25 MHB25-030		02/01/2025	020725A	42741	8,333.00	8,333.00	02/28/2025	INV	PD	MHB25-030 Crisis Co-Re
CHECK DATE: 02/07/2025										
					51,718.00					
10563 TROPHYTIME, INC.										
138727		02/12/2025	022125A	505082	10.00	10.00	03/14/2025	INV	PD	Plastic Signage
CHECK DATE: 02/21/2025										
10583 UNIVERSITY OF ILLINOIS										
Feb'25 Award 112237		02/01/2025	020725A	42760	10,730.00	10,730.00	02/28/2025	INV	PD	Feb'25 MHB23-039 Build
CHECK DATE: 02/07/2025										
10595 UP CENTER OF CHAMPAIGN COUNTY										
Feb'25 MHB25-009		02/01/2025	020725A	42765	15,838.00	15,838.00	02/28/2025	INV	PD	MHB25-009 Children, Yo
CHECK DATE: 02/07/2025										
10597 URBANA ADULT EDUCATION										
Feb'25 MHB25-042		02/01/2025	020725A	42771	6,726.00	6,726.00	02/28/2025	INV	PD	MHB25-042 C-U Early
CHECK DATE: 02/07/2025										
Jan'25 MHB25-042		01/01/2025	020725A	42771	6,726.00	6,726.00	01/31/2025	INV	PD	MHB25-042 C-U Early
CHECK DATE: 02/07/2025										
					13,452.00					
10638 ELAN FINANCIAL SERVICES										
3930 2/11/25		02/11/2025	022125A	43279	660.19	660.19	03/07/2025	INV	PD	Acct # 479851004957393
CHECK DATE: 02/21/2025										

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
46 INVOICES					419,100.61					

** END OF REPORT - Generated by Chris M. Wilson **

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ACCOUNT DETAIL HISTORY FOR 2025 02 TO 2025 02

ORG / OBJECT / PROJ / YR/PR	JNL	EFF DATE	SRC	REF1	REF2	REF3	CHECK #	OB	AMOUNT	NET LEDGER BALANCE
20000154 501001 STATIONERY AND PRINTING										
25/02	196	02/14/25	API	010358		83983	43241		147.10	147.10
W 022125A Expo - Tri-Fold Sponsorship Br MARTIN ONE SOURCE IN										
LEDGER BALANCES --- DEBITS:					147.10	CREDITS:		.00	NET:	147.10
20000154 501002 OFFICE SUPPLIES										
25/02	196	02/14/25	API	010563		83985	505082		10.00	10.00
W 022125A Plastic Signage						TROPHYTIME, INC.				
LEDGER BALANCES --- DEBITS:					10.00	CREDITS:		.00	NET:	10.00
20000154 501004 POSTAGE, UPS, FEDEX										
25/02	444	02/25/25	API	010578		85301			157.10	157.10
W 030725A Jan 25 MHB Postage Used						UNITED STATES POST O				
25/02	444	02/25/25	API	010578		85301			133.92	291.02
W 030725A Feb 25 MHB Postage Used						UNITED STATES POST O				
LEDGER BALANCES --- DEBITS:					291.02	CREDITS:		.00	NET:	291.02
20000154 502001 PROFESSIONAL SERVICES										
25/02	35	02/01/25	API	010583	MHB23-039	82672	42760		10,730.00	10,730.00
W 020725A Feb'25 MHB23-039 Building Agen UNIVERSITY OF ILLINO										
25/02	443	02/11/25	API	018807	281	84463			651.99	11,381.99
W 030725A FY24 County Audit Progress Bil CLIFTONLARSONALLEN L										
25/02	443	02/11/25	API	018807	281	84463			114.86	11,496.85
W 030725A FY24 County Audit Progress Bil CLIFTONLARSONALLEN L										
25/02	443	02/11/25	API	018807	281	84463			199.31	11,696.16
W 030725A FY24 County Audit Progress Bil CLIFTONLARSONALLEN L										
LEDGER BALANCES --- DEBITS:					11,696.16	CREDITS:		.00	NET:	11,696.16

ACCOUNT DETAIL HISTORY FOR 2025 02 TO 2025 02

ORG / OBJECT / PROJ / YR/PR / JNL / EFF DATE / SRC / REF1 / REF2 / REF3 / CHECK # / OB	AMOUNT	NET LEDGER BALANCE
20000154 502002 OUTSIDE SERVICES		
25/02 113 02/04/25 API 010348 MHB25-040 83156 505019	609.00	609.00
W 021425A Feb'25 MHB Managed IT Service MCS OFFICE TECHNOLOG		
25/02 196 02/14/25 API 010348 83984 505072	33.75	642.75
W 022125A Service Ticket # 48401 - Setti MCS OFFICE TECHNOLOG		
LEDGER BALANCES --- DEBITS: 642.75 CREDITS: .00	NET:	642.75
20000154 502003 TRAVEL COSTS		
25/02 229 02/18/25 API 010638 84108 43279	660.19	660.19
W 022125A Hyatt Place Washington DC 1/20 VISA CARDMEMBER SERV		
LEDGER BALANCES --- DEBITS: 660.19 CREDITS: .00	NET:	660.19
20000154 502013 RENT		
25/02 35 02/01/25 API 000001 203 82673 42595	2,196.78	2,196.78
W 020725A Feb'25 Office Rent 053 CCT		
LEDGER BALANCES --- DEBITS: 2,196.78 CREDITS: .00	NET:	2,196.78
20000154 502025 CONTRIBUTIONS & GRANTS		
25/02 35 02/01/25 API 000001 MHB24-006 82645 42596	5,325.00	5,325.00
W 020725A Feb'25 MHB24-006 Children's Ad CCT		
25/02 35 02/01/25 API 000001 MHB25-026 82649 42589	32,371.00	37,696.00
W 020725A Feb'25 MHB25-026 Early Childho CCT		
25/02 35 02/01/25 API 000001 MHB25-004 82650 42590	4,523.00	42,219.00
W 020725A Feb'25 MHB25-004 Homeless Serv CCT		
25/02 35 02/01/25 API 000001 MHB24-025 82651 42591	6,362.00	48,581.00
W 020725A Feb'25 MHB24-025 Youth Assessm CCT		

Champaign County, IL

ACCOUNT DETAIL HISTORY FOR 2025 02 TO 2025 02

ORG / OBJECT / PROJ / YR/PR	JNL	EFF DATE	SRC	REF1	REF2	REF3	CHECK #	OB	AMOUNT	NET LEDGER BALANCE
25/02	35	02/01/25	API	010148	MHB24-008	82652		42633	5,717.00	54,298.00
W 020725A		Feb'25	MHB24-008 Resource Conn			COMMUNITY SERVICE CE				
25/02	35	02/01/25	API	010163	MHB24-005	82653		42636	7,500.00	61,798.00
W 020725A		Feb'25	MHB24-005 Beyond Blue -			CRISIS NURSERY				
25/02	35	02/01/25	API	010170	MHB24-012	82658		42647	54,681.00	116,479.00
W 020725A		Feb'25	MHB24-012 Family Develo			DEVELOPMENTAL SERVIC				
25/02	35	02/01/25	API	010175	MHB25-015	82659		42652	7,131.00	123,610.00
W 020725A		Feb'25	MHB25-015 CU Change			DON MOYER BOYS & GIR				
25/02	35	02/01/25	API	010185	MHB24-001	82800		42654	5,166.00	128,776.00
W 020725A		Feb'25	MHB24-001 Family Suppor			EAST CNTRL IL REFUGE				
25/02	35	02/01/25	API	010242	MHB25-011	82661		42675	13,140.00	141,916.00
W 020725A		Feb'25	MHB25-011 Peer Support			GROW IN ILLINOIS				
25/02	35	02/01/25	API	010464	MHB24-035	82664		42731	11,666.00	153,582.00
W 020725A		Feb'25	MHB24-035 Sexual Trauma			RAPE, ADVOCACY, COUN				
25/02	35	02/01/25	API	010464	MHB24-002	82665		42731	6,250.00	159,832.00
W 020725A		Feb'25	MHB24-002 Sexual Violen			RAPE, ADVOCACY, COUN				
25/02	35	02/01/25	API	010488	MHB25-019	82666		42741	7,052.00	166,884.00
W 020725A		Feb'25	MHB25-019 Benefits Case			ROSECRANCE, INC.				
25/02	35	02/01/25	API	010488	MHB25-020	82668		42741	28,000.00	194,884.00
W 020725A		Feb'25	MHB25-020 Criminal Just			ROSECRANCE, INC.				
25/02	35	02/01/25	API	010488	MHB25-030	82669		42741	8,333.00	203,217.00
W 020725A		Feb'25	MHB25-030 Crisis Co-Res			ROSECRANCE, INC.				
25/02	35	02/01/25	API	010488	MHB25-023	82670		42741	8,333.00	211,550.00
W 020725A		Feb'25	MHB25-023 Recovery Home			ROSECRANCE, INC.				
25/02	35	02/01/25	API	010595	MHB25-009	82671		42765	15,838.00	227,388.00
W 020725A		Feb'25	MHB25-009 Children, You			UP CENTER OF CHAMPAI				
25/02	35	02/01/25	API	010597	MHB25-042	82657		42771	6,726.00	234,114.00

Champaign County, IL

ACCOUNT DETAIL HISTORY FOR 2025 02 TO 2025 02

ORG / OBJECT / PROJ / YR/PR	JNL	EFF DATE	SRC	REF1	REF2	REF3	CHECK #	OB	AMOUNT	NET LEDGER BALANCE
W 020725A	Feb'25			MHB25-042	C-U Early	URBANA ADULT EDUCATI				
25/02	35	02/01/25	API	018259	MHB24-044	82646		504956	7,208.00	241,322.00
W 020725A	Feb'25			MHB24-044	CHW Outreach	CHAMPAIGN COUNTY HEA				
25/02	35	02/01/25	API	018259	MHB25-066	82647		504956	8,750.00	250,072.00
W 020725A	Feb'25			MHB25-066	Disability Ap	CHAMPAIGN COUNTY HEA				
25/02	35	02/01/25	API	018259	MHB24-045	82648		504956	7,512.00	257,584.00
W 020725A	Feb'25			MHB24-045	Justice Invol	CHAMPAIGN COUNTY HEA				
25/02	35	02/01/25	API	018305	MHB25-018	82654		42640	16,975.00	274,559.00
W 020725A	Feb'25			MHB25-018	ECHO Housing	CUNNINGHAM CHILDRENS				
25/02	35	02/01/25	API	018305	MHB25-036	82655		42640	23,511.00	298,070.00
W 020725A	Feb'25			MHB25-036	Families Stro	CUNNINGHAM CHILDRENS				
25/02	35	02/01/25	API	018413	MHB24-013	82662		42729	27,500.00	325,570.00
W 020725A	Feb'25			MHB24-013	Mental Health	PROMISE HEALTHCARE				
25/02	35	02/01/25	API	018413	MHB24-041	82663		42729	8,923.00	334,493.00
W 020725A	Feb'25			MHB24-041	Wellness	PROMISE HEALTHCARE				
25/02	35	02/01/25	API	018805	MHB25-021	82656		42616	21,391.00	355,884.00
W 020725A	Feb'25			MHB25-021	Shelter Case	C-U AT HOME				
25/02	35	02/01/25	API	020173	MHB25-022	82660		504963	5,130.00	361,014.00
W 020725A	Feb'25			MHB25-022	Advocacy, Car	GREATER COMMUNITY				
25/02	428	02/28/25	API	018092	MHB25-007	85198			10,669.00	371,683.00
W 030725A	Feb'25			MHB25-007	Courage Conne	COURAGE CONNECTION				
25/02	428	02/28/25	API	018343	MHB24-014	85200			2,500.00	374,183.00
W 030725A	Feb'25			MHB24-014	Counseling	FAMILY SERVICE OF CH				
25/02	428	02/28/25	API	018343	MHB24-016	85201			2,410.00	376,593.00
W 030725A	Feb'25			MHB24-016	Self Help Cen	FAMILY SERVICE OF CH				
25/02	428	02/28/25	API	018343	MHB24-017	85204			14,865.00	391,458.00
W 030725A	Feb'25			MHB24-017	Senior Counse	FAMILY SERVICE OF CH				

ACCOUNT DETAIL HISTORY FOR 2025 02 TO 2025 02

ORG / OBJECT / PROJ / YR/PR	JNL	EFF DATE	SRC	REF1	REF2	REF3	CHECK #	OB	AMOUNT	NET LEDGER BALANCE
LEDGER BALANCES --- DEBITS:					391,458.00	CREDITS:		.00	NET:	391,458.00
20000154 502047 SOFTWARE LICENSE & SAAS										
25/02	349	02/11/25	API	010569 207	83978		505129		8,926.53	8,926.53
W 022825A Munis Annual SaaaS Fees 1/1/25 TYLER TECHNOLOGIES I										
LEDGER BALANCES --- DEBITS:					8,926.53	CREDITS:		.00	NET:	8,926.53
20000154 502048 PHONE/INTERNET										
25/02	113	02/04/25	API	010263	83154		42963		144.95	144.95
W 021425A Internet Service 3/4/25 - 4/3/ I3 BROADBAND - CU										
25/02	220	02/10/25	API	018287	83663		43185		51.67	196.62
W 022125A MHB CONSOLIDATED COMMUNI										
LEDGER BALANCES --- DEBITS:					196.62	CREDITS:		.00	NET:	196.62
GRAND TOTAL --- DEBITS:					416,225.15	CREDITS:		.00	NET:	416,225.15

46 Records printed

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Briefing Memorandum

Date: March 19, 2025
To: Members, Champaign County Developmental Disabilities Board (CCDDB),
Members, Champaign County Mental Health Board (CCMHB),
Champaign County Executive and Members, Champaign County Board (CCB),
Members, Association of Mental Health Authorities of Illinois (ACMHAI)
From: Lynn Canfield, Executive Director, CCDDB and CCMHB, and
Legislative Committee Co-Chair, ACMHAI
Re: **Legislative & Policy Conferences** of National Association of Counties (NACo) and National Association of Behavioral Health and Developmental Disabilities Directors (NACBHDD)

From March 1 through March 6, 2025, I participated in sessions of the Legislative and Policy Conferences of NACBHDD and NACo, along with their board meetings. Below are notes from these sessions and meetings, with some links to additional information which may be of interest.

I have been active with NACBHDD and NACo for ten years, currently serving as Vice President of NACBHDD, new board member of NACO, and member of NACo Healthy Counties Advisory Board, Resilient Counties Advisory Board, Stepping Up/Familiar Faces, and Health Policy Steering Committee. So much of the good work being done in Champaign County informs these policy platforms, especially for community-based care for people with intellectual and developmental disabilities (I/DD), very young children and their families, youth with multi-system involvement, and people who have behavioral health needs and justice involvement.

NACO Health Steering Committee

Discussion of timely health policy issues relevant to counties, such as addressing hunger as a social determinant of health, youth mental health, and cybersecurity in healthcare settings, and to consider policy resolutions to shape NACo's federal advocacy.

Chair Phyllis Randall made opening comments, welcomed new members, introduced committee and subcommittee leadership, and reviewed the agenda.

"Federal Partner Spotlight: US Dept of Health and Human Services"

Darcie Johnston, newly appointed Principal Deputy Director, Office of the Secretary, Office of Intergovernmental and External Affairs, U.S. Dept of HHS.

- The US healthcare system is failing, chronic disease skyrocketing, .e.g. The system treats symptoms rather than disease, need new initiative with radical accountability.
- MAHA commission will have a 100-day report on what is making people sick and then a strategy to restore health. No more industry-controlled research. Fund studies

on why disease is rising; promote healthy food in partnership with farmers; focus on prevention not pharmaceuticals.
- Priorities: end the COVID 19 mandates (let parents make decisions), lower drug prices, cost transparency, withdraw from WHO due to mismanagement of COVID, no taxpayer funded abortion, no transgender surgery, a Starlink investment to help manage the system. This is an opportunity to transform healthcare and rebuild trust.
- Need the help and collaboration of counties.

"Safeguarding Support for Home and Community Based Care"

Medicaid-funded home- and community-based services (HCBS) are essential lifelines for millions of individuals, including those with IDD, older adults, and people with complex medical needs. As HCBS continues to expand access to care, fostering community integration and reducing reliance on institutional settings, proposed Medicaid cuts threaten to weaken these vital services. This panel examined the broad-reaching implications of Medicaid funding reductions, including increased strain on the direct care workforce, rising per-user costs and growing disparities in service availability across states… strategies to advocate for sustainable funding and policy solutions that protect and strengthen HCBS for all who rely on them.

Greg Puckett, Mercer County, WV, introduced panelists and moderated.

Matt Salo, CEO, Salo Health Strategies
- Overview of Medicaid and how HCBS and waivers relate. Managed Care not as typical with the long-term care IDD and complex support needs, although Managed Long Term Supports are increasing.
- Congressional debate to finance tax cuts but balance this with cuts to programs. Local and state governments are not likely to be able to pick up the difference if these funds are reduced. Millions of people rely on these programs, as do their families.

Stephen McCall, Director of Research, PHI
- Particular impact on the workforce, across levels of service intensity, from institutional to home care. Home Care Workers support people with daily activities, independence in the community, health support, and link to care teams, which can prevent ED visits. Daily social supports are especially important in view of the loneliness epidemic.
- Majority of workers are women, Black, Hispanic/Latino, and not acknowledged for their role. While not highly credentialed, their work is very important.
- Demand for this workforce has more than doubled in one decade, will grow more than any other occupation (700k+ new jobs) in the next decade, while 4.8 m workers will leave the field in this time, with total job openings projected at 5.5m.
- Highly challenging work, even disabling in some cases. Job quality is misaligned with this demand, and median hourly pay is $16.13.
- 46% work part time, with $22k median annual, 40% in low-income households, and 58% rely on public assistance, including 36% with Mediaid coverage.
- The work has lots of windshield time and logistical barriers to full time work. 2/3 of spending on this type of care is from HCBS which was enhanced the last few years,

when states have had extra funding which ends next week. Medicaid has a big role in financing and shaping these jobs.
- The high cost of steep Medicaid cuts will be: less funding for care and jobs; reduced access to coverage for workers; rippling economic impacts. Federal Medical Assistance Percentage (FMAP) reductions are on the table. Work requirements are challenging. Significant impact on local economies. Is the greater burden from taxes or from care gaps? https://PHInational.org has workforce data center, per state.

Lisa Harootunian, Director of Health, Bipartisan Policy Center
- Balancing accountability, fiscal responsibility, and HCBS access: in 2021, 44% of Long Term Services and Supports (LTSS) spending was Medicaid; in 2020, $124.6b (62.5%) was spent on HCBS and $74.8b (37.5%) on institutional services; over 4m people rely on HCBS (an optional benefit), and demand is rising, longstanding shortage of direct care professionals.
- Federal policy solutions to these challenges? The system is very complex and burdensome for states to administer and for individuals to navigate, and there are great inequities within and between states. How can the program work better without causing loss of services? Key challenges to the workforce shortage are inadequate support for direct care staff, untargeted workforce programs reducing the number of new workers, and insufficient data which limits policymakers' ability to understand and address the shortage.
- Create sustainable, supportive environments: strengthen transparency and oversight of payment rates and compensation; national study on relationship between enhanced FMAP and workforce; National Health Care Workforce Commission funding to perform comprehensive evaluation of the health care workforce; establish a refundable tax credit for caregivers, up to $3k for LTSS expenses.
- Grow the # of new workers: strengthen recruitment and training; increase # of permanent employment-based visas and expedite the visa process; implement a legalization program for qualifying foreign-born workers, e.g., a minimum 180 days of direct caregiving labor over last two years; create certified direct care worker status which is valid for 5 years and renewable, toward lawful permanent resident status.
- Improve data on workforce characteristics, emphasizing the need for reforms, clarity about the unpaid workforce. lharootunian@bipartisanpolicy.org

Questions:

How to promote awareness, given the heightened fear and anxiety?
- Acknowledge that Medicaid is a government program (federal PLUS state and local); rather than expecting people to understand how these all work together, be clear that big changes will impact most of us, in ways not always obvious. Do the best you can with available data.

What can be done for those not eligible for Medicaid and therefore with no support?
- There is not a long-term care policy nationally, and because Medicaid is a low-income needs-tested program as our default, you don't get care until you have impoverished yourself to qualify. This wouldn't exist if we had a sensible, humane policy. LTSS are expensive, and while HCBS is a more affordable alternative, it's an optional program, and states may have to reduce access to its services in order to

manage their own spending. Uncertainty about what is going to happen, esp as per capita caps offers savings but create a significant risk of loss of services.

"Roundtable Discussion: Advancing Collaborative Care through Federal Policy and Intergovernmental Partnerships"

… to advance Collaborative Care—the integration of mental health, behavioral health and substance use treatments into primary care… federal policy can enhance this model, improve care coordination and strengthen partnerships among counties, states and federal government.

Chair Randall offered a brief overview of integrative care and the role of counties in facilitating integrative care as owners and operators of health and mental health systems.

"Federal Support for Integrative Care: Implementing the IBH Model in MI"

Julia Rupp, CEO, West Michigan Community Mental Health

- Overview of Centers for Medicare and Medicaid Services (CMS) Innovation in Behavioral Health (IBH) Demonstration Program. https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model
- Few states applied for this opportunity due to other innovations. Most efforts focus on whole-person care, with recent interest in addressing social needs. An 8-year cooperative agreement, with CMS heavily involved for technical assistance (TA), plus financing support, though not a great amount.
- Care Delivery Framework includes conveners who implement and provide the structure and addresses how to integrate all federal Medicaid efforts into this one, including health homes, behavioral health homes, and Certified Community Behavioral Health Clinics (CCBHCs) Outpatient services plus primary care. Additional funding directly to the practice participants. Value-based Medicare payments. Data exchange across all parties.
- Michigan's implementation and the role of county/local mental health facilities role in implementing the model: built on what they already have, lots of CCBHCs and an early adopter of Value Based Care (VBC), though only on the behavioral health side. The heavy lift is creating VBCs that include physical healthcare savings. Smaller providers, e.g., of support for housing, food, and other health-related social needs, are struggling. While there are shared care plans, we can't see Medicare data and often not substance use disorder (SUD) data.
- Elements of the model that can be adapted by local governments for enhanced integrative care: replicate the 'convening' structure; expand current ones to include all who need to be at the table to talk about the whole person; for population needs assessment, some counties use the one the hospitals create; identify metrics that are important to your community; use value-based payments (VBP) to pay for outcomes.

Break-out Discussion Questions:

1. *Funding & Reimbursement Models*
   - How have existing Medicaid waivers (e.g., 1115, Health Homes) supported integrated care in your county, and where are there gaps in eligibility, funding, or implementation?

- What challenges do counties face in transitioning to value-based payment models, and how could federal policies better support this shift?

2. *Workforce & Capacity Building*
   - What federal workforce programs (e.g., loan repayment, telehealth funding) have been most effective in expanding integrated care teams, and what additional supports are needed?
   - How could federal policies better support the use of community health workers and peer support specialists in integrated care models?
3. Data Sharing & Care Coordination
   - What barriers do counties face in sharing behavioral health data due to privacy regulations (e.g., 42 CFR Part 2), and what changes would improve care coordination?
   - How effective are current federal efforts to promote interoperability, and what additional policy changes are needed to facilitate seamless data sharing?

Group Report-Outs.
Our reports back to the full group were very similar: we should emphasize that this work already focuses on efficiency and eliminating waste and fraud; we believe in continuing with the innovations already in place (through waivers, etc.); workforce challenges loom over all of the work; support for behavioral health is broad; need to improve the sharing of data for care coordination and for proving success; need rates structure, including for peer supports; focus on prevention, health related social needs, cost shift data, and return on investment (ROI.)

NACO Health Steering Committee Business Meeting

"Panel Discussion: Health Priorities in the 119th Congress"

Bipartisan Congressional policy staff on priorities for key committees in the 119th Congress.

Chair Randall spoke on counties' role in healthcare and Medicaid financing, introduced the panel, and posed questions for discussion.

Panel Q&A:

With lots of work on behavioral health reform, where is bipartisan agreement for action and policies?

Charlotte Rock, Senior Health Policy Advisor, Senate Committee on Finance (Majority).

- Update on approval of nominations. Good history of bipartisan wins on the Senate side, accomplishments in mental health (MH) and SUD last year. A lot of work in front of us, including healthcare in rural communities, long term payment stability, cost transparency, underlying issues with chronic disease, etc. Focus on budget reconciliation right now, with a narrow window for Senate. How to make Medicaid run more efficiently, esp concern about the growth rate in Medicaid. Safe Harbor for Provider Taxes is one solution being considered. Transparency in how much states can use to draw down federal funds. Streamline programs, make them more efficient.

Joshua Sheinkman, Staff Director, U.S. Senate Committee on Finance (Minority).

- Good timing, as federal funding runs out in two weeks. Short term patches are not cutting it, as providers need more stability and security. Hope to pass and adopt within long term funding for Congress. Provisions we worked on to lower drug prices were thrown out in December. Need to work on rural, MH/SUD, etc. Democrats are not invited to the table for the two budget bills where Medicaid and other safety net programs are on the chopping block.

David Jurbala, Defense Fellow, Rep. Gerry Connolly (D-VA)

- Veterans care legislation "Not Just a Number Act" would increase data collection on veteran suicide, expand to all VA benefit programs. Better education may be less of a financial burden.

Given challenges in health care system, esp the much-needed home health care workforce, many of whom are undocumented or have temporary status, what is the intersection between these?

- Charlotte: Senate committee doesn't have jurisdiction over immigration policy, but we know the workforce issues went from bad to worse during the pandemic. Regulatory relief esp for rural, leveraging telehealth and other digital health options, let us know what's working well for you.
- Joshua: boss focuses on behavioral health, esp youth residential facilities "Warehouses of Neglect" with maltreatment. A bill to invest in community-based access, care. With immigration, even people legitimately here and working have been swept up.
- David: (to a question about veteran PTSD, getting into the system, and high rates of suicide loss) – reducing wait times and increasing education about available care are critically important because even two weeks is too long for many. Funding MH providers in the community, enabling veterans to access them through the community, and building up that network. Hope to reauthorize the grant program for two more years and increase the funding for it.

How do we have policy solutions to improve access to healthcare in rural communities (hospital and community care), workforce, and infrastructure?

- Joshua: threats of Medicaid cuts will hit folks across the country, including rural residents. It supports children, elderly, people with disabilities, rural members, all of the most vulnerable. Need money to maintain existing programs let alone the expansions. Keep raising concerns with your congressmen and senators. Hospitals are often the economic drivers locally so their closure can be devastating.

Any studies about the impact of cutting preventive services, leading to higher costs and worse personal health outcomes, esp rural? How much $ they save, etc.

- Charlotte: boss knows Medicaid serves a high need population, but we need to look at Medicaid and make sure the dollars are being spent most effectively. We need to have the hard conversations about what works and doesn't work. NACO can keep making recommendations on streamlining SNAP and Medicaid programs.

How can counties leverage resources to reduce veteran suicide?

- David: help people navigate VA bureaucracy; rural residents don't always have good access to services, so support facilities through Medicaid funding.

Given how important the federal government is to our work, how do we collaborate to shape policies that improve health and well-being?

- David: military community and congressman Connelly appreciate NACO.
- Charlotte: know who is working on what, learn from us how the policies work.

- Joshua: meet with your elected officials using specific examples and have them visit facilities within their jurisdictions, more effective than reading about them.

"Committee Business Meeting"

Health Resolutions and Platform Changes Received Within 30 Day Deadline: Policy resolutions are generally single-purpose documents addressing a specific issue or piece of legislation. Resolutions draw attention to a topic of current concern, clarify parts of the broadly worded platform, or set policy in areas not covered by the platform. Resolutions and platform changes are valid until NACo's 2025 Annual Conference. "Emergency" resolutions are federal legislative or regulatory matters that could not have been foreseen 30 days prior to the conference. Steering committees receiving these may consider them only if two-thirds of the steering committee members present vote to review them.

Chair Randall reminded that the NACO Platform is different from Interim policy resolutions, reviewed the standards for policy resolutions, that their focus is federal, and that the background is not part of the policy.

Barry Buchanan, Whatcom County, WA, served as parliamentarian and prompted the resolutions sponsors to introduce each.

Proposed Interim Resolution Declaring Food Security in Rural Areas a Public Health Priority (Health Steering Committee, Agriculture and Rural Affairs Steering Committee)
Sponsor Barry Buchanan: amendments striking some background, to focus on support for existing federal programs, supply and distribution of healthy food, and planning for permanent structural solutions. Friendly amendment accepted. One member read national evidence of the benefits of healthy food in early life for later disease prevention and good health. *PASSED.*

Proposed Interim Resolution in Support of Increased Funding for Uterine Fibroid Education, Research and Treatment
Sponsor Donna Miller, Cook County: background, with data, additional risk to Black women, funding to improve maternal mortality and health outcomes for all women. High cost of fibroid treatment. Moved and seconded. Chair thanked cook county and Hon Miller for this. *PASSED.*

Proposed Interim Resolution in Support of Preventative Health
Sponsor Bill Lowry, Cook County: for preventive care and screenings at no cost to uninsured patients, promote research and innovation to enhance early detection. Counties cover such services using 40-50% of their budgets. Will promote decreased costs in long term care, longer life, etc. People with insurance have access to these. Positive fiscal impact on all counties. Some discussion, praising preventive health care, thanking the sponsor, discussion of costs counties bear as safety net payer and in the long term higher cost needs for less preventive care. *PASSED.*

Proposed Interim Resolution Clarifying Treatment of Distinct Facilities Located on the Same Campus under Federal IMD Law
Sponsor Steve Ding, San Joaquin County, CA: to clarify that up to 10 institutions (of different types, e.g., hospitals, nursing facilities, other) can be located on the same campus but not combing the number of beds across facilities for the purpose of evaluating whether an institution

is an IMD. Friendly amendment was accepted. Discussion of main body of resolution to clarify this is in addition to other NACO resolutions related to IMD. *PASSED.*

Proposed Interim Resolution on Securing Increased Reimbursements to Pharmacies and Other Healthcare Providers in Rural Communities (Health Steering Committee, Agriculture and Rural Affairs Steering Committee)
Sponsor Julie Ehemann, Shelby County, OH: aging population versus access to pharmacies and health care due to unfair insurance practices. Discussion: thank you to the sponsor; should include compounding or any other reimbursable services because we need better reimbursement for everything; definition of a 'pharmacy dessert' includes 10-mile radius. *PASSED.*

Proposed Interim Resolution on Eligibility of Veterans with Non-punitive Other Than Honorable Discharges for Health Benefits (Human Services and Education Steering Committee, Health Steering Committee)
Sponsor James Zenner, Director, Dept of Military and Veteran Affairs, LA County, CA: esp discharges which could be linked to various traumas experienced in service, with some rates doubled over those of Vietnam era, because discharges keep them from accessing VA care. Question about 'other than honorable' if sexual misconduct, how to determine if related to trauma. Amendment to include reversal of all dishonorable discharges, including posthumous, due to 'don't ask don't tell' and reinstate all benefits, as this issue has not been fully addressed. Question about transgender vets. Question about people who had childhood PTSD. Procedural point – the primary committee was Human Services so they will have to accept the amendment. The amendment passed. Motion and second of the amended resolution. *PASSED.*

Proposed Interim Resolution to Reduce the Frequency of Reevaluations for Home and Community-Based Services (HCBS)
Sponsor: Barb Brekke, Scott County, MN. Esp with initial and annual evals for those with HCBS, which is not realistic for those with DDs. Reduce to every three years or upon request or if there is a significant change. *PASSED.*

Emergency resolutions must have policy implications and been unforeseen 30 days ago, require 2/3 majority vote to consider, and have separate consideration with simple majority to approve.

Proposed Emergency Resolution on Expanding Prescribing Authority to Include Advanced Practice Nurses.
Sponsor Ben West, Clackamas County, OR. For CMS to expand reimbursement and prescribing authority. Discussion on whether to consider: PAs fighting for this for years, but big pushback from medical community while the need related to MH keeps growing; corrections to the policy statement (nurse practitioners and physician assistants) 2/3 majority vote allowing it to be considered. With the rules suspended, vote to approve the resolution *PASSED.*

Proposed Emergency Resolution on Medicaid Cuts.
To urge congress to protect Medicaid for our most vulnerable residents by preventing harmful funding cuts that will equate to massive cost shifts to counties while collaborating with counties to reduce demonstrated waste, fraud, and abuse. Discussion – block grant would be a cut, so

that's included. 2/3 majority vote allowing it to be considered. With the rules suspended, vote to approve the resolution *PASSED.*

"Advocacy Agenda & Congressional Meeting Preview for the 2025 Legislative Conference"

Committee liaison Blaire Bryant… on key advocacy priorities for the committee based on the discussions taking place at the meeting, and the committee policy priority survey… federal policy agenda, highlight critical issues counties will bring to Capitol Hill, and offer guidance on effective congressional engagement… legislative developments and strategic insights.

- Review of policy priorities - Preventing Harmful Medicaid Cuts is one. Congress has a tough job finding $880m in savings, but Medicaid is a tough place to take it. Per capita caps would limit funding per beneficiary, straining state and county resources and leading to hospital closures. Work requirements do not bring big savings and are hard for beneficiaries and add administrative burden for states and counties. Reduced FMAP will cause loss of coverage for millions, increase medical debt, and increase uncompensated care costs for providers. The Medicaid Fiscal Accountability Rule (MFAR) is back and would reduce local ability to raise their share of reimbursement.
- Other priorities of the Health Committee: fund federal rural health programs under FORHP; strengthen Medicare and Medicaid; incentivize rural health professionals; expand rural telehealth. Ongoing: addressing the Medicaid Inmate Exclusion policy, building the health care workforce, building local crisis infrastructure, protecting funding for public health services, and improving health care access and equity.
- Bipartisan mental health priorities in the 119th Congress are Youth Mental Health, Medicaid IMD Reform, and Opioid Overdose Prevention.

NACO Healthy Counties Advisory Board Meeting

Hon. Janet Thompson, HCAB Chair and Commissioner, Boone County, MO

- Introduced the topic of food as medicine, food insecurity, importance of chocolate (fair trade dark sample provided), introduced leadership and thanked sponsors. In her most prosperous school system, 70% of children are on free/reduced lunch. Stigma and negative health outcomes. Food insecurity is increasing, but counties can implement targeted solutions, such as food banks with services, public health screening to include questions about food, and coordination of effort.

"Counties and Food Insecurity"

Food insecurity and the lack of access to affordable and nutritious food often corresponds with poorer health outcomes and increased risk for chronic health conditions.

Aaron Goldstein, Senior Manager, Local Government Relations, Share Our Strength

- 14m children live in food insecure (FI) households, trend rising. In 2023, 13% of all households were FI. 17% of those with children were FI. Rates higher for households with children, 34% if run by single mother, 26% for Hispanic families; 1 in 5 children lived in FI households in 2023.

- In 2021 a record low of FI, mostly due to increased SNAP benefits and enhanced child tax credit, but when the programs ended in 2023, the rates rose again, so we know that government programs work. States with high OR low SNAP participation can experience high rates of FI. Rural communities very vulnerable.
- Congress is considering SNAP and Summer Electronic Benefit Transfer (EBT) cuts, which will drastically increase rates. Protect access to SNAP. Summer is the hungriest time of year for children; parks rec lunch only reaches 1 in 7; grocery benefit program for summer can help; bulk meal pickup for rural communities (USDA) can provide 14 days of meals at a time; not all states participate in these helpful programs, some run through community action or education. American Public Human Services Corp offers supports. Align SNAP and other efforts.

"Integrating Food and Nutrition Supports into Other Systems of Care"

County governments, as administrators of programs for low-income residents, are uniquely positioned to foster cross-systems collaboration. By integrating food and nutrition supports into a variety of settings, county leaders can increase access to and awareness of the resources that combat food insecurity.

Julie Hiett, VP and General Manager, Population Health, Netsmart

- Not just access to food but what kind of food. Background on what Netsmart does for counties' technology needs, across the care continuum.
- 50% of variations in health and mortality are related to social determinants of health (SDOH). 21% of those experiencing homelessness reported mental health symptoms. Integrate across supports (healthcare, schools, libraries) to eliminate care siloes.

Breakout Discussion recommendations for data sharing and health/justice coordinating council.

NACO Midsize County Caucus Exploratory Committee Meeting

… focus on establishing key priorities and objectives to guide the caucus's efforts in advocating for the unique needs of midsize communities.

Hon. Gary Moore, Judge/Executive, Boone County, Ky.

- Introduced the topic and co-chairs, who discussed their hopes for the task force.
- 56% of counties fit in this category, have both urban and rural issues, etc.
- Each task force member shared insights: suburban/urban areas with transition to rural; large or rural caucus meetings informative but not always a fit; many midsize counties are growing, have ag and tourist industries; some gain population from rural neighbors, often due to their loss of healthcare providers and other resources; some have universities as the economic driver; some manufacturing increasing, with stress on public services like fire dept; growth and development are common concerns.
- On NACO's to do list for a long time, and the Exec Committee now needs to act.

Brett Mattson, Legislative Director – Justice & Public Safet

- Purpose of exploratory committee, potential impacts of a formal Caucus to enhance NACo advocacy efforts and membership engagement. Quick turnaround, hopefully ready by Western Interstate Region meeting. (This meeting room was packed.)

"Open Member Discussion on Goals & Priorities"

Challenges facing midsize counties… potential priorities and structure of the caucus.

- Concerns about competitive funding; homelessness in communities outside the population center, how to serve folks effectively; transportation barriers; lack of affordable housing, and cost of housing driving homelessness; water, including threats to sole source aquifers, wastewater management, and new demands; can't access USDA rural development funds for rural areas due to total population, so some larger counties may fit better here due to not being monotypic and benefiting from policy priorities developed through this group; pollution including of waterways; broadband connectivity is a basic utility now but many of our communities do not have adequate capacity yet; mental health and opioid use issues; climate change and climate disasters including loss of usable coastal land to salt from seawater; increased partnerships across local and state and federal governments, with discrepancies per jurisdiction; system is taxed by some programming; loss of hospitals, and helicopters can go fast enough; community development block grants (CDBG) important, though some thresholds may no longer be appropriate; how to build economic opportunities where there is decrease of farmland (tax policies, innovations to attract good jobs); looking for help to continue cleaning up contaminated sites with loss of EPA support; air quality across communities and states; emergency managers say it's not always worth filing for disaster funding; wealth disparities and the need for economic development opportunities requiring a high tech STEM workforce; non-attainment zone problems with electricity generation, need tax abatements or incentives to allow power companies to transition to newer technologies.
- NACO leadership joined us to affirm the group's importance. Less about size and more about the mix and interaction of rural, urban, and suburban qualities, and the limits that impact mid-size counties due to this mixture.
- Task force discussion of population size parameters and name. LUC and RAC are redefining their own documents now, so some of the questions related to complexity versus size will be sorted out. The group's ability to meet will also depend on sponsorship funding. Mid-size and Metropolitan Areas (MMA or MAMA), applying to 923 counties potentially. Subcommittee organization within the broader committee. Purchasing partnerships. This special purpose task force will end, and input from today will be used by NACo staff to create a structure and priorities one-pager (for review in April), proposal to the board in May, hope to start with next fiscal year and possible inaugural meeting at annual meeting. NACo president will appoint chairs as they do with RAC and LUC. Focus some workshops on the needs of this group.

NACO Session

"Federal Immigration Policy Impacts on Counties"

Impacts of recent and proposed changes to immigration policy on local economies… how these policy shifts may influence workforce availability, economic stability, and service delivery in affected sectors, with a focus on the child care and agriculture workforces, as well as counties as employers… workforce needs and local economies amid evolving immigration policies.

James O'Neill, Director of Legislative Affairs, American Business Immigration Coalition

- Workforce and Immigration Solutions. ABIC is bipartisan, seeks ethical solutions.
- Review of changes to work authorization programs: resolution in both chambers to repeal extensions made by the prior administration shorten the runway for renewal documents; temporary protected status ended for 300K Venezuelans so their work authorizations are ending; ending Temporary Protected Status (TPS) for others, e.g., El Salvadoreans here for over 30 years; ended two programs of prior admin (work auth as part of parolee status); changes to asylum and refugee system are being considered; refugee resettlement program was closed but reopened in a limited fashion; several changes in enforcement of immigration law, including the end of sensitive zones so that churches, hospitals, schools are now open to enforcement; mandatory indefinite detention for those even accused of a crime, e.g., theft.
- Disruptions in workforce: in CA, many not showing up to work, not just among undocumented laborers but also those with a family member at home who might be.
- Reduced foot traffic in Hispanic areas of cities, even among people with legal status.
- Increased workplace enforcement. DHS has two ways to enforce immigration law at a business, including county government: I9 form audits (work auth verification) leading to fines; oversight raid searching for individuals, with follow-up audit.
- Social Security 'no match' letters may go out, but mismatches can result from many types of error; don't fire people based on these, can be a civil rights violation.
- Severe workforce crisis across industries already, with millions of workers needed. Immigrants are 1/3 of hotel staff, up to 80% of restaurant workers; undocumented workers are a significant portion of hospitality, construction, food, etc. The impacts of raids on communities and local economies are very significant, with ripple effects.
- Reforms supported by ABIC: permanent residency for Dreamers (DACA is likely to be terminated); legitimate asylum claims – expand eligibility for seasonal workers, there are 3X as many applications as approved each year; the average undocumented worker has been here 8 years, paying taxes, so those with no criminal record should remain in the workforce; support the President's ideas for permanent green card to all who graduate a US university and a solution for dreamers. https://abic.us/

Samantha Ayoub, Associate Economist, American Farm Bureau Federation

- Farm Bureau has 6m members. Labor shortages have been exacerbated.
- Structural changes in rural communities, as populations become both older AND younger, increasing the need for child care and elder care.
- 40-45% of ag workers are undocumented; 17% of these work in ag, the largest proportion; temporary worker programs are10 months max; still need hand workers in these fields; administrative complexity is a barrier for H-2A temporary ag workers, and fewer than 10k American workers apply for these jobs.

- Rise in use of third party labor contractors to bring people into the country to do these jobs, renting people out to different farms during the year.
- H-2B non-ag workers do landscaping and food processing, part of ag supply chain.
- Adverse effect wage rate, unpredictable wage raises. Admin costs before wage costs are also high. If these were domestic workers, would save over $300k per year in admin costs. Increases in application costs; H-2A wage rule has changed. Certification changes and required payment rates change if certain activities are included in the work (i.e., driving a tractor) even if not all hours in the 40 hr week.
- No workforce solutions. Cost-prohibitive to farmers. May have to import food. https://www.fb.org/

Anne Hedgepeth, Senior VP of Policy and Research, Child Care Aware

- Childcare resource and referral systems. Data, professional development, serving as hubs in their communities. Childcare and early learning a mixed group, including multi-site, center and home based, private and public. 624,300 childcare businesses in 2022. A large part of the economy, employing about 1.5m people.
- 25% of children birth to 5 are in immigrant families; 5.2m children have at least one undocumented parent, but 4.4 children are US citizens.
- Childcare workforce is 22% immigrant, foreign-born women. Big impacts from policy changes due to big gap already, not meeting needs of all children and families.
- How childcare is funded: much of the cost is picked up by parents; local, state, and federal funding for childcare and development programs, with different names per state, combining state or local match with federal; block grants with conditions related to the child; state and local governments can choose to serve more and pay for that, e.g., Head Start, migrant and seasonal Head Start. Some federal funding streams come with requirements which impact this.
- Changes to enforcement - no more sensitive zones, including childcare settings. Great concern for impact of trauma on children. https://www.childcareaware.org/

Karl Eckhart, VP State and Local Government Affairs, National Association of Home Builders

- Oversees state and local advocacy resources for home-builders associations, and administering State and Local Issues Funds (SLIF).
- The raids are real. ICE comes to the jobsite looking for one person, and then no one shows up for the next five days.
- It takes 28 different trades to build a house. Most builders employ one person, and the rest are subcontracted. Immigrants are crucial to the trades. 30% are immigrants.
- We need more workers to build more homes and then help the price of homes decrease. Need more visas to avoid competing with ag. More training of young people to come into residential construction. Look at CONSTRUCTS Act https://www.congress.gov/bill/118th-congress/senate-bill/4980
- https://www.nahb.org/

Questions:

Local govts plan for natural disaster response, but do we have a plan to respond to the unprecedented crisis of so many children worried for their parents?

- Free public trainings on employer rights and responsibilities related to documentation and protecting people and businesses, partnering for legal services, planning for childcare and guardianship and even pickup from school.

Afghan asylum seekers plus women still there or waiting in Pakistan, in dangerous situations, so is there a pathway for uniting those families and keeping our promise to our Afghan allies?

- Outside the panel's control, hoping for a bipartisan bill they'd urge congress to pass.

Children are in that position because of decisions their parents made, so families should put plans in place for long term care for their children - what are you doing to train them to do this?

- H-2A workers are often trying to take financial opportunity back to their home country. Employers have a risk related to pointing people out, so they do better to advocate for legal pathways and access. Business sector has been asking for immigration reform for 25 years, so we need the help of electeds to move it forward.
- During COVID, immigrants working in food (meat processing) were essential workers in very high-risk settings so the new threat is an injustice.

Is there movement to get dairy separated, since it takes two years to become a skilled laborer?

- Farm Workforce Modernization Act - https://www.congress.gov/bill/118th-congress/house-bill/4319. The 10-month rule with H-2A is simply a regulatory decision, as 'seasonal' is not a major part of the act, mentioned only once, so year-round work should and could be included. Attempted to address this for 37 years. Need to create pathways for citizenship or remaining long-term, with expansions to H-2A to ensure that we don't end up back in this situation, for ag and all industries.

NACo Board of Directors Forum

Amanda Karras, Local Government Legal Center (LGLC).

- Overview of LGLC, which focuses on the Supreme Court and federal courts.
- Some impacts on SCOTUS so far, filing briefs related to local authority/autonomy and then expansion of liability: the filing on Grants Pass (criminal citations for homeless encampment, public camping should be a local policy matter) is often cited by SCOTUS; offers guidance on Lindke v Freed Case (local govt employees and officials on social media and when you are running afoul of first amendment protection) so we can train people on this, and the court zeroed in on the LGLC test which was based on authority (use disclaimer, etc.)
- Ten more important cases relevant to local govts, mostly about limiting liability. Wins in Lackey v Stinnie (limiting attorney fees) and in EMD Sales v Carrera (limiting overtime exemptions.)
- Highlight San Francisco v EPA, whether the Clean Water Act allows EPA or similar entities to impose generic prohibitions. Compliance with permits shields from liability and penalties. EPA put in some non-specific generic prohibitions. SF wanted clarity. The Ninth Circuit sided with EPA. Implications for local govts are high penalties for violations, so by the time it gets to SCOTUS, it will have been costly.
- LGLC Education includes summaries on SCOTUS findings and webinars including on the federal Executive Orders. https://imla.org/local-government-legal-center/

NACO President James Gore, CEO Matt Chase, and Amanda Karras, on Executive Orders.

- Temporary restraining orders on the full-scale funding freeze. States having trouble because the order was enforced. Judgement related to it upheld the restraining order.
- Two buckets: state and local govt with existing federal contracts already signed, and you did the work and wait for reimbursement, but some are paused for various reasons (no appointed cabinet secretary at the time, related to DEI, or other); congress has appropriated the money to agencies who have not yet awarded it to contracts, and these could be impounded and not spent (though Nixon was blocked from doing this) but there is no budget for this fiscal year yet. Call your federal agency and ask why your money is held up and develop a solution, possibly rewriting the grant agreement.
- Broadband program of last administration didn't work, money is still sitting there.
- Discuss what we need, including ARPA-like investments.
- Expect and hope for clarification from the SCOTUS.
- Majority of ICE detainer requests are voluntary, warrantless, hold up to 48 hours.
- The themes of these executive orders will be a big part of our work going forward. We will get a review of the 70 and then track them.

Mark Ritacco and Eryn Hurley on NACO Proposed Resolutions.

- Four resolutions relate to immigration (birthright citizenship, ensuring continuation of legal asylum, reinstating Cuban-Haitian-Nicaraguan-Venezuelan process, and other.)
- Review of the resolution review and approval process.
- Due to years of close margins in Congress, many things are getting done through executive orders.
- In the current fiscal year which began Oct 1, 2024, we are still operating under continuing resolutions, with this one to expire March 14. Complicated by Republican one seat majority and federal funding freeze, causing Democrats to push back more.
- A disaster supplemental could move by itself, but this is also newly politicized due to question of the role of Federal Emergency Management Agency (FEMA) and subsequent review counsel. We do want more clarity, quicker reimbursements, etc., as counties cannot recover without assistance from other govt. Historically bipartisan but now complicated.
- The budget reconciliation (required, not discretionary) is a big deal now, with trillions of dollars difference between revenue and spending.
- NACO's Short-Term Federal Priorities are Disaster Reform, Secure Rural Schools, Counties and Medicaid, Tax Exempt Municipal Bonds, County Human Services. Lots of detail on each, with e.g., potential costs down the line if municipal bonds are not exempt (average $6500 increase in homeowner tax bill.) These are at risk because by eliminating the tax-exempt status, the federal govt would raise an est $364bn in new federal revenues. This IS private investment in infrastructure, as the federal govt has nothing to do with it. Market-driven voter approved infrastructure improvements.
- Tax cuts have to be fed by a different area, as there are no new revenue areas. The discretionary budget submitted by the President to Congress is the biggest part. The laundry list of items released in 40-50 pages, with provisions stored for budget impact for years, among which they'll probe for weakness and see who objects.
- House Budget Plan v Senate Budget Plan: they need to come to a consensus on one bill to send to the President for approval, which is still being worked out.

- On the 'cutting' side, they need $1.5 trillion in cuts over ten years, but they really want $2 trillion. Each committee has a number to cut. House Energy and Commerce has been given a number, and nothing else they do comes close to Medicaid spending.
- Even though not all counties have a direct role with Medicaid, all states do. Counties with hospitals and nursing homes are even more vulnerable. Many have indigent care responsibilities. Cost-cutting ideas include converting Medicaid to a block grant program, to per capita cap, or changing state match requirements; each option has been coming off the table. Every state has a provider tax for health care providers and hospitals – they tax and then give them the higher reimbursement rate back. Removing these would add the need for states to cover from general funds.
- Lots of conversation about healthcare overall. 25% of Americans get healthcare through Medicaid. Of the 79m, 37m are children (comprising 40% of all US children). The vast majority of these children have parents with health insurance through work. Progress on behavioral health, much of which is through Medicaid. How do we tackle rural Emergency Medical Services (EMS)? What happens to rural hospitals? 15% of rural provider revenue comes from Medicaid.
- We understand the federal debt is not sustainable. We are trying to be an intergovernmental partner and think this through, not simply shifting costs.
- Board members should focus on these webinars and share with state associations.
- No projection on these plans for reducing the debt.

NACo Board of Directors Business Meeting

President Gore called to order, introduced prayers and speakers.

Invocation given by **Hon Bernard Carvalho Jr,** Councilmember, Kauai Co, HI.
Pledge of Allegiance led by **Hon JD Clark,** NACO First VP.

"Intergovernmental Affairs Update from the White House"

Special remarks by **Alex Meyer**, new Director of the White House Office of Intergovernmental Affairs, and his deputy director, **Christine Serrano Glassner.**

- Deputy Director Glassner was a mayor until Jan 20, with lots of experience working with counties. She sees much room for growth and improvement in counties. She and her team will be available to help solve our problems at the federal level. "Let us be your guide when it comes to federal agencies."
- Director Meyer understands how important counties are, focus on 'bottom up.' He intends to put pressure on federal agencies to turn around major issues which impact us, said these agencies have a lot of emails and phone calls unanswered, and wants them to do better. What comes from states and counties needs to be handled first.
- Dep Dir Glassner reminded all of the federal expo within NACo's meetings.

President Gore led approval of minutes, nominations to NACO board of directors, reports from the Audit Committee and Finance Standing Committee (approved by voice vote), and appointment of Matt Prochaska to parliamentarian.

"Proposal to recognize a new Affinity Group, the National Association of Native County Officials and Allies."

Hon Lena Fowler, Supervisor Coconino County, AZ.

- Background on this national peer network.
- Statements on why it will matter were offered by officials from Minnesota, Hawaii, and Montana. Positive comments from board members.
- Motion to recognize this affinity group was approved by voice vote.

Standing Committee Reports

- President Gore, Credentials and Nominating Standing Committee
- Hon Renee Couch, Membership Standing Committee – 85% of counties, parishes, etc are represented
- Hon Greg Puckett, Programs and Services Standing Committee – strengthen outreach to newly elected officials.
- Hon. Greg Weiss, IT Standing Committee – cybersecurity remains top concern, AI integrated with other priorities, website accessibility, emergency technologies.
- Counties are 2% of the US Workforce.

Business meeting adjourned.

Board convenes as the Resolutions Committee.

For those with NACO website access, the full text of proposed resolutions is available here - https://naco.sharefile.com/share/view/s745b7a37f0584b7a8df050481f3ad4a3
If you do not have access, please contact me for details.

AGRICULTURE AND RURAL AFFAIRS STEERING COMMITTEE
Approved cross-claiming of two resolutions with other committee's resolutions.

COMMUNITY, ECONOMIC & WORKFORCE DEVELOPMENT STEERING COMMITTEE
Proposed Interim Resolutions on: Community Development Block Grant – Disaster Recovery Program Permanent Reauthorization; Community Development Block Grant Program Reauthorization; Ensuring Non-discrimination Practices in the Federal Government *(this was pulled from consent agenda and discussed later);* Homelessness Assistance; Incentivizing Production of Housing Through Federal Tax Code; and Supporting the Use of the Federal Government's Uniform Appraisal Dataset in Assessments. *Approved all but the one.*

ENVIRONMENT, ENERGY & LAND USE STEERING COMMITTEE
Proposed Interim Policy Resolutions on: Permitting Reform Policy; Supporting PFAS Passive Receiver Protections for Local Governments; Opposing the Department of Energy National Interest; and Electric Transmission Corridors (NIETC). *Approved.*

FINANCE, PENSIONS & INTERGOVERNMENTAL AFFAIRS STEERING COMMITTEE

Proposed Interim Resolutions on: Supporting the Continued Role of Federal Entities in Election Assistance for Counties; and Urging Congressional Action to Exempt Poll Worker Pay from Federal Taxes *Approved.*

HEALTH STEERING COMMITTEE
Proposed Interim Resolutions: Clarifying Treatment of Distinct Facilities Located on the Same Campus under Federal IMD Law; Declaring Food Security in Rural Areas a Public Health Priority; in Support of Increased Funding for Uterine Fibroid Education, Research and Treatment; in Support of Preventative Health; on Securing Increased Reimbursements to Pharmacies and Other Healthcare Providers in Rural Communities; to Reduce the Frequency of Reevaluations for Home and Community-Based Services (HCBS); and Emergency Resolutions Expanding Prescribing Authority to Include Advanced Practice Nurses and on Medicaid Cuts. *Approved.*

HUMAN SERVICES & EDUCATION STEERING COMMITTEE
Proposed Interim Resolutions on: Eligibility of Veterans with Non-punitive Other Than Honorable Discharges for Health Benefits; Ensuring a Clear and Fair Vetting Process for Migrants; Ensuring the Continuation of Asylum; Federal Agencies Respecting and Granting Protection to "Sensitive Locations"; Protecting Safety Net Programs from Harmful Cuts; Protecting Section 1 of the 14th Amendment of the US Constitution and Ensuring the Right to Birthright Citizenship; and Reinstating the CHNV (Cuban, Haitian, Nicaraguan, and Venezuelan) Parole Program. *Approved. The committee asks that more Republican members become involved.*

JUSTICE & PUBLIC SAFETY STEERING COMMITTEE
Proposed Interim Resolutions to: Advocate for the Restructuring and Strengthening of the Federal Emergency Management Agency (FEMA); and Support the Adoption of a Damages Cap on Federal Civil Rights Claims. *Approved.*

PUBLIC LANDS STEERING COMMITTEE
Proposed Interim Resolutions: Encouraging Federal Land Management Agencies to Utilize Existing Studies and Promote Efficient Siting of Infrastructure Projects; on Allowance of 'Mechanized' Equipment as Appropriate in Wilderness by the U.S. Forest Service; on Wildfires; Opposing Nationwide Resource Management Planning & Supporting Federal Land Management Agencies Amending Plans Locally at the Field Office and Forest Unit level; and to Codify Federal Agency Adherence to the Administrative Procedures Act. *Approved.*

TELECOMMUNICATIONS AND TECHNOLOGY STEERING COMMITTEE
Proposed Interim Resolutions on: 911.gov Program Reauthorization; and Funding for 911 Public Safety Emergency Telecommunications. *Approved.*

TRANSPORTATION STEERING COMMITTEE
Proposed Interim Resolutions: in Support of Federal Support for Federal Safety Standards for Lithium-Ion Batteries in Micromobility Devices; in Support of Transportation Project-Specific Permitting; and Reform in FY2026 Surface Transportation Reauthorization Legislation. *Approved.*

Discussion of Proposed Interim Resolution Ensuring Non-Discrimination Practices…

- This had been overwhelmingly approved by the steering committee, with 6 or 7 opposing votes. The cosponsors, David Stout and Sarah Benatar, provided overview. One who opposed the vote spoke to the process, that things should be worked out prior to going in front of all.
- Discussion of process. Pulling things off the consent calendar/agenda is not always negative, just that more discussion will be beneficial. As many speaking for as against? Yes, 3 comments on each side. No further point of order discussion.
- Next to the substance. The EO doesn't change federal laws, protected classes are still protected. Motion/second/discussion: opposition - this is superfluous and political; North Carolina members have left NACO due to feeling it was partisan, so this reads like using NACO as a political tool (suggests using 2/3) so that we will not be perceived as a united voice; if there is no non-discrimination language in fed contracts but we as a county adopt such lg, there could be a conflict; notes that the 1960s EO was rescinded therefore no longer has programs or practices in place to ensure non-disc – is this true?; can fed agencies even reinstall the programs? And does this apply to everything we do or e.g., roadways?
- Remanded back to the committee to answer questions for the annual meeting.

"State of Mental Health Policy in America"

Special remarks by **former U.S. Senator Roy Blunt (R-MO)**.

- Collaborated with Senator Debbie Stabenow for a dozen years, esp on mental health.
- Community mental health centers one solution. They took the Community Mental Health Act (CMHA), the last bill signed by JFK, back to the floor 50 years later and pointed out that the cost of institutional care was to be shifted to community care way back then. Treating mental health saves money later. Treat it like physical health.
- The model requires several services 24/7. Started with 10 pilot states, of which 9 have continued and tracked data to show whether this is true, also alleviating pressure on emergency rooms and police departments. In MO, they save $579 per Medicaid client. The police and sheriffs have a place to take someone. People with mental illness are more likely to be the victim of a crime than the perpetrator.
- Senators Blunt and Stabenow used these positive results from the pilots to advocate for permanent funding (and savings) and to allow the other 40 states to do this… 60 years after the CMHA was signed and made the commitment. NIH data on MI.
- Blunt also chaired the appropriations committee. Telehealth is another important innovation. There is at least one CCBHC in each of 46 states.
- https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics
- His bipartisan work with Sen Stabenow was historic, so we gave a standing ovation.

Caucus Reports

- Large Urban County Caucus (LUCC), **Hon. David Crowley,** Chair reviewed priorities: support resilience, workforce, disaster preparation (collab with state and fed), and advance economic stability. LUC fly-in will be in DC and symposium in Milwaukee County.

- Rural Action Caucus (RAC), **Hon. Lena Fowler,** Chair spoke of leadership development, regional partnership, creative funding, and solving the housing issue.
- Western Interstate Region (WIR), **Hon. John Peters,** First VP on public lands work.

Matt Chase, CEO.

- Thanked the exec committee and board for all of their work keeping the association together during tough times. Thanks to Mark Ritacco for overall planning, all the staff for their work.
- NACO Blueprint for 2030 will be presented in May and July, to build an inclusive organization that sticks to our lane of the county's role in intergovernmental work.
- National trends in state level policy. How to harness expertise and purchasing powers to drive the US forward from the grassroots up.

NACBHDD Spring Board Meeting

Kyle Kessler, KS, Past Chair did call to order, introductions, and meeting overview.

Dave Kisher and Chris Cotton, Netsmart

- Update and efforts related to data infrastructure for CCBHCs, health homes, IBHs.
- Leading conversations around technology that reduces the burden of multiple tech providers, pulls the right data, and can be shared with partners across systems.

Keynote Presentation

Daniel Chao, Head of CAO Coach/Congressional Staff Academy and former Chief of Staff

- CAO Coaches was launched in 2021, after the House authorized a plan to create a new office to train House members and staff in how to do their work, modernization of congress. The group includes 4 former Chiefs of staff, 2 former district directors, with 125 combined years of experience, nonpartisan/bipartisan, offering confidential coaching and panels based on the needs.
- Prepping for a shutdown. Then for working with the budget you have. New member orientations. Private website with templates, samples, tip sheets, video content, 101-style tutorial series, position specific pages, and 'life as a staffer.'
- May develop a similar support for Senate staffers.
- Calendar with deadlines related to communications, legislative, external/official will influence your goals - when/how to tackle, when to move on, pause, or nix and move on. Staff are navigating unprecedented levels of calls and visits from angry, anxious constituents. District outreach and engagement is critical, rethinking how to engage with federal agencies; these folks are the first to have data, info, stories. New constituencies that weren't involved. Previously unaligned or less engaged press.
- White House/Executive Branch Engagement. Don't neglect local, regional, and state entities that still need to work with the member's office.
- Legislative. Leverage for caucus memberships; report language; bipartisan engagement (limited but still exists).
- Communications, present in every other category; amplify and receive comms, monitor constituent trends; phone logs and constituent letters are important.

- Internal Office Structure/Housekeeping. Follow-up, what to give back, self-care, recruitment and training of interns and fellows, knowing members' needs and preferences to avoid having to backtrack when a member changes their minds, what you can influence and what you can't, where you can be flexible and where you can't.
- Bountiful Opportunities Exist!

Jonah Cunningham, NACBHDD CEO reviewed fact sheets, toolkit, policy platform, meetings.

Committee and Affiliate Reports

- Past President Kyle Kessler, KS – Jonah's review and contract; appreciation of Bob Sheehan and Cherryl Ramirez for getting us through difficult years and transitions.
- NACo Board Representative – Lynn Canfield, IL – summary of meetings.
- I/DD-Jonah on behalf of Adam Herman, OH
- Behavioral Health and Justice-Annie Uetz, IA
- Directors of State Associations Committee (DSAC)-Kyle Kessler, KS
- Strategic Planning Advisory Group-Rene Hurtado, TX
- National Association of Rural Mental Health (NARMH)-Shauna Reitmeier, MN

Strategic Planning Update

Jonah C. Cunningham/Christopher Wimbush

- Four Foundational Units: Board Governance, Staffing & Infrastructure, Marketing & Brand Identity, Partnerships & Membership
- Implementation of plan: Interim Policy Platform, Policy Advocacy Toolkit, Increased Conference Attendance, Leverage Technology to Assist Staff
- The process of developing the plan went well, a good start for us. If the board reviews alignment with the plan, staff will know that's their priority. It is relevant to the day-to-day work. Annual plans can help, but so much can't be done in one year. A two- to four-year Strategic Plan can support flexibility and be a filter for saying no. Possible committees for governance.
- Strategic plan updates at future board meetings. Possibly two conferences a year.

CLOSED SESSION *– variety of business.*

NACBHDD L&P Conference

"State of the States in 2025"

Policies that start on the federal level are often implemented on the state and local levels. Compounding this is that each state has a unique culture and political make up which can demonstrate in different approaches to behavioral health and I/DD policy.

Bob Sheehan, MI, received a certificate of appreciation, introduced the panel, and moderated.

David Coe, VA, Colonial Behavioral Health in Williamsburg

- Local Community Services Boards (CSB), serving the historic triangle. Our CSB is the quasi-governmental provider of BH and DD services for the region. VA has five regions, all members of the Virginia Association of CSBs. Proud to be plugging along but find ourselves in unimagined times.

Jinny Palin, MN, Minnesota Association of Community Mental Health Programs (MACMHP)

- As it's only been 9 years, surprised to be thought of as seasoned. Currently 38 members. One of several statewide associations but with the broadest scope, providing a continuum of MH services.

Kyle Kessler, KS

- Represent 26 now-CCBHCs around the state. Had 998 rather than 988. Having all members going in the same direction has helped. Challenges in bigger regions.

Adam Herman, OH

- Lead the association of county boards of DD. Ohio is unique in separating DD boards from county behavioral health authorities. Primarily fund services through property taxes (1.5bn) and share Medicaid burden with the state, which pays 55% of match, and have a say in the services. Some urban metro DD boards have BH programs.

Discussion of priorities.

- Jinny: some continue as before the election: investments, Medicaid rates reform, ensuring licensed providers can focus on direct care by streamlining regulations. MN was one of the first six CCBHC states, has codified it as a benefit in their state plan, and hope to continue to evolve it. SAMHSA criteria included in the state plan so it would be harder to change. Building up national data by sticking to the model. Since the election and budget forecast, keeping an eye on the federal threats, but the budget will be in the red in 2026 and 2027, so shift to policy work. The Medicaid rates reform would cost half a bn (all outpatient fee-for-service categories.) MN will likely be a 50/50 split, and senate may lose its one seat majority; everything that moves will have to be bipartisan, which is hard to strategize.

- Bob recalled when that happened in MI, asked about challenges. Jinny said some of the federal rhetoric has found its way to state level; tracking some bills of concern, pulling back DEI, social determinants of health, and health related social needs. Basic health plan was expanded to cover non-residents, but this may go away. Work with paid family leave may stop. Concern about Medicaid every day.

- Kyle: some of this is similar in KS. Continued commitment to CCBHC. Workforce initiatives including universities, state Medicaid agency, providers. Spending on telehealth was too high. Not the same kind of election cycle in KS, lots of situations where 2-3k votes decided an election. Two years from now could be different so prepare for all scenarios and know who to call.

- Adam: trying to establish a separate Bureau of Labor Statistics (BLS) classification to build the Direct Support Professional (DSP) workforce. Ohio was operating off of a

very old rates structure. Lack of funding created multiple challenges, and the pandemic prolonged the rates restructuring because services were reshuffled, but it made the workforce shortage even worse. Collaboration of providers and family groups to make the case to legislators through compelling testimony. Moved from $13.75 an hour to $16 through prior successful advocacy, now to $19 in the second year. This is not sustainable because other industries with lower risk still pay better. We need to tie incremental increases to costs of doing business so we don't have to keep doing this every few years, while political fortunes change. Property taxes pay a significant portion of Medicaid services, but prop taxes are quite high in Ohio due to funding so much of local government. Taxes go up significantly and raise some ire, so increases in these rates have to come from the state's general revenue fund. Many more children are coming into early intervention, and there is also a multisystem youth surge. All of the agencies had a portion of children and youth services and were siloed, so the governor established a commission. Need to find a different way to get services to children who don't have I/DD but are labeled that way just so they can have some resources. Gov proposed $30m for children with BH challenges.

- David: since 2011, VA in a DOJ settlement related to IDD and can exit now. Prompted considerable investment in DD services. The closing of all but one training centers, with major increase in waiver services. State is funding the last 3000 slots over the next two years, for the highest need folks, but the workforce can't match the needs. VA has one state agency for IDD and all BH, has had trouble getting those waiver slots out timely, so there's a lot of pressure from DOJ. That gets transferred to the CSBs. The governor did make investments in BH as promised. The state dedicated land to building one of these centers, but we don't have the land yet. CCBHC has not been done in VA as in MN. Gubernatorial election this year. Ready to propose a new model to each of the candidates as they're identified. The private sector is complicating crisis response; some areas have atrocious rates and response times because people are jamming up the lines on purpose. Crucial to the public BH system. Good things are happening but within a difficult context.

"Issues Affecting Access to Care"

Ensuring access to behavioral health and I/DD services is critical to strengthening the health of our communities… there are many factors affecting the ability to connect individuals to care…

Jinny Palin introduced the panel and moderated.

Angela Kimball, Chief Advocacy Officer of "inseparable'.

- Four priority areas (youth MH, access to care, crisis response, MH workforce).
- In 20 states, passed 57 pieces of legislation (8 of these were in IL.)
- Engage with state lobbyists on 3 main strategies.
  Diversify funding streams: significant deficits in many states, esp blue ones (e.g., loss of ARPA funds), potential loss of Medicaid; state efforts like school Medicaid expansion, which half of states have already done, and crisis telecom surcharge.

Expand the behavioral health workforce: with severe workforce shortages, states can enhance reimbursement rates, loan repayment, reform licensure and credentialing (e.g., UT SB26, 2024).
Improve health plan coverage: rules can limit access; states can improve patient protections in statutes (e.g., IL HB5395, 2024, CO HB1002, 2025), 'no diagnosis' for Medicaid mental health services (e.g., CO HB174, 2023).

Sarah Hohman, Director of Government Affairs, National Association of Rural Health Clinics.

- Advocacy and education are primary goals.
- Rural Health Clinics (a CMS designation) have enhanced Medicaid and Medicare reimbursement, which helps to attract and retain professionals and stay in business.
- 5600 RHCs in 47 states, primary and specialty care, serving 62% of rural US citizens.
- Only up to 49% of an RHC's services can be mental/behavioral health, often related to how coded, so they are working to reintroduce the 118th congress RHC Burden Reduction Act to eliminate the barrier of 1977 language (IMD). Some pushback from CCBHC advocates, but many areas served by RHCs would not be able to support CCBHC anyway. Seeking a clean strike of that provision.
- Rely on reimbursement as there has not been a grant program solely; it's hard to write competitive grants with low staffing rates. A workforce bill solely for RHCs would provide startup funds to cover initial salary as a new provider builds up their panel, then sustainable through reimbursement.
- Big challenge is no reimbursement for services to the uninsured.

Michele Gazda, Associate Director of Health Policy, Bipartisan Policy Center.

- Policy areas: health care delivery system redesign; safe and secure social media use; and prevention, early identification, and intervention.
- Had in mind some conservative approaches to fiscal responsibility. For redesign, strengthening and growing the BH workforce, enforce screening and treatment requirements, integrate BH and primary care in pediatric settings, improve youth services (high acuity BH needs and multisystem involvement), strengthen crisis stabilization services for youth.
- Telehealth seen as a major part of the solution. mgazda@bipartisanpolicy.org

Marianne Gibson, Program Director on Health Team, National Governors Association (NGA).

- History of the NGA. Represent all 55 state and territory governors. Proud of our bipartisanship. NGA Center for Best Practices. Numerous areas, policy briefs by subject matter experts. In person convenings, webinars, TA (9-12 months).
- Next Generation Knowledge Exchange Network States and Territories (includes IL) with TA topic areas: healthcare workforce; workforce supply data; scholarship and loan repayment; apprenticeships; childcare, housing, and other non-monetary subsidies; workforce wellness; scope of practice. Can be done by aligning state agency strategic plans with a singular state strategic plan for workforce, partnering with private sector, issuing EOs, looking at regulatory and rule changes. Another policy academy has 3 of 4 states/territories working on BH workforce; charters with roles/responsibilities; translating policy to non-policy folks.

- Discussion of the new challenges, hyperpartisan environment, threats to Medicaid, harsh fiscal realities, difficulty reaching the right person. Every district is impacted by family safety. Waiting for reauthorization of some popular bipartisan programs. Ensuring access to physical and behavioral healthcare are among top five bipartisan priorities. States will have hard decisions to make regarding access. Be ready to make substantive changes when federal circumstances change. There is so much energy to do the right thing to improve access, on both sides of the aisle. Resilience is a focus even where 'social emotional' is not spoken of.
- Shared values behind closed doors. Always opportunities for collaboration.

Special Lunchtime Presentation

Anita Everette, Director Center for MH Services (CMHS), SAMHSA.

- Overview of SAMHSA. CCBHC Expansion; Select CMHS Crisis Activities and Services; Minority Serving Institutions (MSI(training.
- Review of 9 core services of CCBHCs: crisis, outpatient MH and SUD, person and family centered treatment planning, screening/diagnosis/risk assessment, psychiatric rehab services, outpatient primary care screening and monitoring, targeted case management, peer and family support and counselor services, and community based MH care for veterans.
- Doing CCBHCs for over ten years, adding 10 new demonstration states each year. Lots of complexity regarding the types of funding they receive. Currently about 500 across 46 states. 18 states are participating in Section 223 CCBHC Medicaid demonstration (this includes IL,) but most demonstration states are not statewide and are instead adding sites over time. SAMHSA grants are for startups or performance improvement. Positive broad outcomes are social connectedness, attending school/employed/retired, and positive functioning in everyday life.
- Three core components of crisis services: someone to contact (988 suicide and crisis lifeline), someone to respond (mobile crisis teams), and a safe place for help (crisis stabilization). Regional Crisis Contact Centers funded through MH block grants, CCBHC expansion, and 988 grants. Mobile Crisis Teams (MCTs) through MHBG, CCBHC expansion, and community crisis response partnership program. Crisis Receiving and Stabilization Facilities through MHBG and CCBHC expansion.
- Planned Crisis Services: 14 new call centers, 170 MCTs, 27 Children's MCTs, more.
- Community Crisis Response Partnerships Overview. Through 25 grant recipients, 29k individuals were screened for suicide ideation, 13k referred to crisis or other mental health services, and 4700 were diverted from law enforcement.
- SAMSHA's SMI Training and TA Center. Working on access to Clozaril for those with schizophrenia not responding well to other meds due to side effects. Physicians may get TA from experts, usually within a day.
- More programs, treatment and recovery support. Homelessness programs and resources. PATH, TIEH, and SOAR.

"Crisis Response Presentation Panel #1: User Experiences, Crisis Lines, and System Transformation"

The crisis continuum of someone to contact, someone to respond,, and a safe place to go requires coordination between behavioral health care, emergency services, law enforcement,

and other sectors… 988 user experiences, coordination of pre-existing local crisis lines, and efforts to transform the system.

Jonathan Purtle, New York University School of Global Public Health.

- Study #1 was on how 988 is financed.
  Ten states have fees. Per capita (5 states) average $1.80. Assess and compare perceptions of the extent to which 5 domains of financing factors: have positively influenced 988 implementation; and are important to moving forward. Showed big differences between how these are perceived.
- Study #2 was on public preferences for 988 and other crisis services.
  Nationally representative survey of (5k) adults. How likely to use 988, another crisis line, an MH professional, a friend or family member, or someone in their religious network. Looked at demographic factors associated with preferences.
  Found five distinct groups:
  Seek Help Anywhere (23% of total) – likely to use all sources. Black, non-Hispanic.
  Seek Help Nowhere (21% of total) – none of them would use 988, strong feelings about not reaching out to any of the sources. No college education, male.
  Definitely not 988 Yes Friends and Family Distressed (13% of total)– 61% would use friend, none 988, serious distress in last 30 days.
  Relatively Indifferent and Not Distressed (17% of total) - not young adults, Black, non-Hispanic.
  Seek Help Most Places but Not Religious Network (26% of total).
- https://onlinelibrary.wiley.com/doi/10.1002/wps.21285

Cherryl Ramirez, OR on Evolution of the Oregon Crisis System.

- All three legs of the crisis continuum. Service delivery structure of Community Mental Health Programs (CMHP.)
- Evolution of mobile crisis response in OR, funded by a patchwork. The two 988 call centers, at $39.5m, are funded with a special tax and through Medicaid.
- Still have crisis lines, for which call volume has not decreased since adding 988; it actually increased 10% total statewide. In the Portland area, calls increased by 16%. Higher mobile crisis response rate to these calls than to 988, so there's still a need to keep and fund the county crisis lines until 988 is fully accepted and utilized.
- Status of Mobile Crisis and Ongoing Challenges: new requirements following the Crisis Now model (Jan 2023); transitioning in 2023 and 2024 due to workforce retention challenges; goal to be eligible for higher federal match, but 40% of crisis services are funded by Medicaid. Grassroots mobile crisis worker training academy!
- Current Mobile Crisis Coverage: some areas have the 2-person awake coverage 24/7.
- Challenges to expansion: reporting requirements; 2 person team (one a QMHP) 24/7.
- Ensure continuation of county/CMHP crisis line funding in contract with CMHPs, funding the gap of the true cost of crisis services, which is about $59m /2 years.

Jennifer Battle, VP Community Access and Engagement, The Harris Center for MH and IDD.

- Overview of The Harris Center and reach of services: 792k adult MH services, 315k IDD services, 191k child MH services, etc.

- Local Authority Service Areas. Texas has 254 counties, with 39 local BH authorities operating local crisis hotlines and mobile crisis outreach teams. Four local authorities answer 988 calls throughout the state; an additional center is statewide backup.
- The Harris Center Crisis Continuum components: Neuropsychiatric Center, Mobile Crisis Outreach Team, Crisis Intervention Response Team, Homeless Outreach Team, Chronic Consumer Stabilization Initiative, Clinician and Officer Remote Evaluation, Rapid Response Pilot, ARPA Subrecipient Rapid Response, etc.

Mark Hensen, Director of Federal Advocacy and Government Affairs for the Trevor Project.

- Bipartisan support for MH has grown, less agreement on details. Showing data and telling the stories does make a difference.
- How crisis work with LGBTQ+ youth has gone. Ideas and strategies to include high risk populations and build trust. Trevor has 24/7 support via call, text, and chat, resolved over 500k contacts last year. Demand grows. Prevention includes peer-to-peer counseling, training for institutions, and research.
- 4x as likely to consider suicide. 12% attempted. 84% of youth surveyed want to access MH care but over half were unable, due to various barriers. 10% of US identifies as LGBTQ+, and a higher percentage of young people.
- Trevor has often been the option of last resort, sometimes the entry point to all MH services. Goal is a well-resourced crisis line with well-trained staff. Implement practices to eliminate barriers to care (including building trust.) Support further developing the continuum of care.
- In two years, 988 served over 14m contacts; referrals to veterans' crisis and LGBTQI crisis care. Nonpartisan, apolitical support for building out the continuum of care. Many don't believe the MH system can offer the care they need. Concerns are similar to other high-risk communities, e.g., cost, fear of reaching out, fear of sharing concerns, fear someone would call police or institutionalize them, fear of being outed.
- Trevor has worked on reducing stigma and incorporated people with lived experience. Continuous quality improvement. Need knowledge of high-risk populations across the system because another reason people don't access care is having ONE bad experience when they did reach out. https://www.thetrevorproject.org/

John Palmieri, Acting Director of 988 & BH Crisis Coordinating Office, SAMHSA.

- Lead federal org for 988 & BH crisis services transformation. Partners with the FCC and US Dept of Veterans Affairs.
- Data collection, quality standards, oversight and funding for 988, 988 Lifeline a network of over 200 local and state funded crisis centers.
- Lots of priorities, trying to focus on what will be most impactful: localized routing for calls and eventually text; continued capacity building and response rates; national evaluation plan; workforce burnout; post 988 contact connectivity and follow up services; increase 988 awareness, familiarity and trust; and grant programs.

Panel Q&A:

How can we use technology and what are limitations?

- Cherryl: better connection of electronic health records to reduce duplication of data entry in multiple systems; eliminating multiple reporting; tech doesn't solve all the problems as this is best with human contact.
- Mark: must make it easier for the caller, who may struggle to decide to reach out for help; concerns about privacy higher with high-risk pops trying to reach the most tailored services available.
- Jennifer: quality assurance reviews on 3% of incoming calls, a huge number for a center with no additional resources to do that, so using limited AI to cut down on manual staff time; public safety designation for 988 centers (like 911) would help with more resources; tech is a big reason people quit; second big reason is abusive callers and no protection for team.

What gives us hope?

988 growth since its implementation.

"Crisis Response Presentation Panel #2: Other Crisis Lines, Rural Crisis, and Crisis Stabilization"

... coordination of crisis lines, approaches to rural crisis response, crisis stabilization.

Rene Hurtado, Emergence Health, TX. Moderated and introduced the panel.

Travis Atkinson, TBD Solutions, MI.

- Danger of overserving.
- Produced National Crisis Residential Funding Survey and Crisis Residential Best Practices Handbook and two surveys about how crisis providers were experiencing the pandemic: 1/3 were seeing increase, 1/3 same, and 1/3 seeing decrease.
- 3 Policy Considerations:
  Disparate service offerings lead to disparate outcomes: crisis stabilization centers all defined differently; compare San Diego County, smaller but with lots of crisis beds, to Cook County, which has zero crisis beds; substantial savings through crisis care, saving Austin-Travis County health care system $2.8m annually; people in recovery really can be helpful.
  True alternatives must look and function differently: lower hospitalization rate, etc.
  System funding must be reliable with accountability for provider performance: show cost savings in a fiscally conservative environment; reimagine payments for some crisis services from fee for service to risk sharing/value-based models.

Chip Johnston, MI.

- Following a community tragedy, a proposed solution was collaboration of county-based community mental health provider and sheriff's office. Engaged Ferris State University researcher to study the results of these efforts.
- Demographics of 32 participants over 10 months: mean age was 36.35; 27 adults and 5 juveniles; 19 male, 12 female, 1 other; 16 white, 14 Black, 2 other.
- Call Occurrence data confirmed 'blue flu' with majority of calls in January and March, starts in September, and most calls on the weekdays.
- Call disposition: 11 suicidal, 8 suicidal and BH, 5 possible psychosis and BH, 1 SUD, 1 MH, 2 welfare check. Instead of jail they went to ED, ED and psych, etc.

- Stopped taking data in October due to end of fiscal year; came to talk with Sheriff and County commissioners, with 911 in the room, who said they seemed to be missing many calls and added an option in their data system to get a true idea.
- Immediate access to services; increased community goodwill and support for county-wide network; bridged cultures and increased trust between MH, law enforcement, and first responders; partners will have final report in October.

Ted Lutterman, National Association of State Mental Health Program Directors **(**NASMHPD) Research Institute.

- Work with state depts of MH and SUD. Looking for where they're at with crisis continuum and where TA is needed. Reports on website, state level data for all 50, on crisis services continuum, crisis contact centers, and mobile crisis teams.
- 202 "988" and 425 other contact centers. 1820 mobile crisis teams. 576 less-than-24-hour crisis stabilization facilities, and 693 crisis residential programs.
- Expenditures Supporting BH Crisis Services: because crisis services are provided without regard to pay source, the public system has been covering where people have private insurance; some states are now seeking parity on this, so private insurance will cover crisis services in all states.
- Many states are putting their data on public dashboards so you can see what is happening across the system; collecting measures of the impact of crisis services, mostly of use of services, as it is hard to assess suicides averted. https://nri-inc.org

Billina Shaw, Senior Medical Advisor, Center for MH Services, SAMHSA.

- Leverage existing resources to inform the work: environmental scans, state-level crisis service definitions and standards, peer reviewed literature, best and promising practices, elevating exemplars.
- The right level at the right time, in that not everyone needs to go into a locked unit. Evidence-informed. Developmentally appropriate. Recovery oriented. Systems based. Person centered. Standardization and Sustainability are the two main frames for this.
- Advocates in the peer community were clear that 'warm line' was a peer term and should be honored, so other emotional support lines will be differentiated.
- Community outreach teams are not crisis but postvention. Emergency, crisis, and crisis related services; with emergency the high intensity (emtala-like), then referral based. 2025 National Guidelines.
- Rural communities have had a hard time implementing the "crisisnow" model, so flexibility is needed in system development. (https://crisisnow.com/)
- Core principles: administrative structure, oversight, and policy; communication and community engagement; BH crisis care; mobile crisis toolkit is granular, addressing specific concerns, in 13 chapters. 2020 guidelines didn't have much on 'how to'.

Panel Q&A:

What level of coordination needs to happen, given this tangled set of lines?

- Dr. Shaw: other data use agreements, connecting EHRs, connectivity, data matching.
- Ted: no wrong door, easier to get to the right service, make sure the response is not an untrained officer with a gun.

- Chip: UP was an early test site, a huge place with 300k people with one area code, so now the call is switched in to the local center.

Other thoughts or words of wisdom on rural response?

- Ted: outside of Tulsa they couldn't get teams staffed so they used iPads, programmed to connect to grand lake crisis teams, which reduced use of hospital and jail so now all law enforcement vehicles have these iPads and connect people via facetime to crisis workers.
- Travis: Ohio contracts for crisis services, need collab relationships for common ground/values and not being afraid to use data to manage a crisis benefit; we should not use tactics of power with our partners, esp when we are being challenged.
- Dr. Shaw: in rural communities, the relational part can be overshadowed by MOUs.
- Chip: hard to get some partners to sign MOUs; many places had dial up until recently.

"Closing Keynote – SAMHSA: Advancing Behavioral Health"

Tom Coderre, Deputy Assistant Secretary, SAMHSA

- Make America Healthy Again. Overview of SAMHSA. MH and SU Policies, - Programs, and Supports. Workforce. Resources.
- MAHA Agenda: gain understanding, investigate, and address root causes of US health crisis; lower chronic disease rates; end childhood chronic disease; address rising MH disorders, obesity, diabetes, and other chronic diseases.
- SAMHSA will support the executive agenda, providing relevant resources.
- Decline in overdose deaths, very promising, attributed to the work of counties and states to address. Partners at DEA also note less potent substances.
- Multifront Advances, including Naloxone Saturation, involving 26 states, DC, and Puerto Rico, through a policy academy, collaboration with universities, websites with naloxone locators, and awareness campaigns. 41% increase in naloxone kits.
- Ongoing implementation of 42 CFR Part 8; historic changes, videos on SAMHSA's youtube, treating Opioid Use Disorder (OUD) as a chronic health disease, promoting recovery, strengthening the workforce.
- Recently published briefs and guidelines: mobile medication units and health clinics, xylazine and drug mixtures, OUD in older adults, OUD in Pregnant and Parenting women, meds for OUD.
- Advancing Evidence-based Prevention: policy academy, SDOH toolkit, incorporate young people and their families to inform the work, e.g., the FentAlert Challenge.
- Updates on 988 and crisis care system.
- Commitment to addressing SMI and SUD.
- Children's MH Initiative: Systems of Care - integrating all areas, even DD, and expanding access to care.
- Enhancing access to MH services through CCBHC, the fastest growing program; 2024 data show improvements in three positive outcomes and reductions in five negative outcomes (decrease homeless, incarceration, emergency room visits, etc.)
- Addressing Kids Online Health and Safety: respond to rising youth anxiety; resources are family media plans, conversation cards, strategies for parents, online portal for TA from healthcare experts.
- Expanding school-based MH supports and services; Project AWARE and Trauma-informed Support Services (TISS), with 5k school staff trained in TI Care.

- Workforce – https://samhsa.gov/technical-assistance Centers of Excellence and Training; BH Workforce Career Navigator (for aspiring BH professionals, requirements per state). www.samhsa.gov/988toolkit and www.samhsa.gov/grants

Questions:

Relationship between SAMHSA and CMS?

- Important to protect BH initiatives from any cuts or changes in Medicaid.

IMD rule changes?

- Defer to Congress, but this would be game-changing for BH.

What gives you hope?

As a person in recovery, having rebuilt my life over the last 21 years with the sense of community allows me to have a lot of hope anyway. Through working at SAMHSA and in government, I know that the winds of change blow in and out, but behavioral health issues are extremely important regardless of party. We may have to do this work with fewer people, but hopefully grant funding will continue to flow to communities. Going backwards is not an option.

"Legislative Panel"

Congressional leaders are instrumental in this time of transformation for behavioral health and I/DD. Lead staffers focused on behavioral health and I/DD. Some who were invited chose not to join us, and those who joined us asked that the content of the discussion remain private. Many items discussed have been addressed in other conference session notes. Both staffers were very optimistic about the future despite immense challenges in this moment.

"Health Policy Insiders Perspective"

With a new Congress and Administration, this year is anticipated to be a dynamic time for health policy… perspectives from experts in mental health, substance use, and I/DD federal advocacy.

Jonah introduced the panel and posed questions.

Andrew Kesser has worked on SUD policy for 20 years; NIH research, clinical, SAMHSA.

Al Guida has clients in DC including Netsmart and crisis textline.

- Can't imagine the chaos we're all dealing with; will clarify the January Office of Management and Budget (OMB) memorandum and other budget issues.

Dara Lieberman, Director of Government Relations at Trust for America's Health.

- Public health policy and research and advocacy, to strengthen the public health system, population level, equity as a foundation.
- Talk to legislators to keep people healthy in the first place. https://www.tfah.org/

Alyce Aguilar, Senior Director of Federal Relations at ANCOR

- Primarily HCBS providers, to sustain the services we have in communities, already fragile system. Ensuring accessibility, then strengthening the service sector. Serves a broad spectrum of members. https://www.ancor.org/

Panel Q&A:

Difference between appropriations and reconciliations?

- January OMB memo froze $3 trillion in federal spending (FY24 dollars), shut down Medicaid portals in many states. Largely reversed through federal court injunction. There is an FY25 continuing resolution (at FY24 levels) which ends March 14. Without it there will likely be govt shutdown.
- Then reconciliation process for the year moving forward, also covers next ten years of federal spending for programs such as Medicaid, as there are only six operations under Health Committee (NIH and CDC included.) House and Senate still have to negotiate because they didn't pass the same reconciliation bills, most spending is Medicaid; likely April before reconciliation process gets underway.
- Traffic jam now, since they will have to do FY26 by September.

Priorities under mandatory or discretionary funding?

- ANCOR is very concerned about this budget reconciliation process and Medicaid. The House reconciliation instructs the House Education and Commerce committee to cut from it deeply, but new house members don't know about these programs and services, so our focus is on educating them. Would love additional focus on workforce so that HCBS services are available to people; there had been bipartisan support for a standard classification for DSPs.
- For public health, similar framing, offensive strategy, but given the unusual and huge threat, we have to focus on education, report on vision for strengthening public health (support for CDC, which includes behavioral health) at the population level, and prevention. Focus on how cutting this federal workforce impacts your state.

- This priority is not as bipartisan when it comes to spending. DOGE looks like a reality, so we need to show how these programs work. We want increased workforce and recovery community and care but are not optimistic about increases.
- Providers are committed to whole person care, so cutting other programs does not make sense. Despite dramatic decreases in overdose deaths, the narrative on public health approach to SUD is being undone by new priorities and rhetoric about borders (which were not changed, proving that the prevention approach is what worked.)

Prevention funding?

- Budget reconciliation is currently used to extend tax cuts with a simple majority. $2b of CDC funding is in prevention (total budget around $9b), so this is a big hole for the appropriations committee to fill, of discretionary programs.

Impacts of federal lay-offs?

- SAMHSA employs 600, lost 95 probationary staff, resulting in closure of 3 regional offices off the top. Memoranda indicate planned reductions in 50-70% range; their budget is block grants for MH and opioid, flowing to the states, plus about 40 line items. Not sure what will happen even where there is a powerful lobby such as CDC has; CDC currently intervening in measles outbreak in TX, doing so on their own.

Grace Pennix described communication and committee efforts.

Jonah offered a certificate of appreciation to **Kyle Kessler**, Past Chair.

"Partners in Progress: Federal Partners"

Impactful policy hinges on cross-sector relationships, especially those spanning between local and federal authorities. By understanding federal efforts related to behavioral health and I/DD policy, local providers can better utilize available resources.

Jonah introduced the topic and panelists.

Mary Sowers, Executive Director, National Association of State Director of DD Services.

- Members are state DD directors. Medicaid challenges and opportunities. NASDDDS Medicaid primer reinforces the message that IDD systems are Medicaid systems, with HCBS the largest share of services for them. Current threat has implications for IDD.
- Overview of the budget reconciliation process, current state of play; senate budget resolution with reconciliation versus house budget resolution with the $880m cuts instruction which put Medicaid on the table.
- Policy and practices that impede progress today are based on the myth that people with IDD can't have MH conditions, experience trauma, or benefit from treatment. Led to exclusions from rehabilitative benefits, coverage and medical necessity policies, clinical availability, and providers unwilling to offer treatment. While accommodation may be needed, providers don't need to learn something new.
- Removing siloed support is urgent and essential. Too many people fall through cracks between systems, so NASDDDS is working with other associations to bring together.
- Effective Quality Supports, from Policy to Practice, to reduce law enforcement and emergency room contacts, case of eventual medical assessment revealing migraines.
- The Link Center Partner Organizations, funded by Administration for Community Living (ACL), includes NASDDDS, NADD, NASMHPD, NASHIA, with advocacy groups and collaborators. https://acl.gov/TheLinkCenter
- Overview of possible Medicaid changes. As lawmakers consider Medicaid reforms, state financing, federal financing, other policy changes. https://www.nasddds.org/

Kirsten Beronio, Senior Advisor, National Association of State Mental Health Directors.

- Primarily technical assistance. Work with SAMHSA and CMS to promote the priorities and interests of state MH directors. Share funding opportunities, peer to peer learning, policy papers and toolkits, webinars, and learning communities.
- High priority topics: cross-cutting focus on Medicaid; 988 and Crisis Response; CCBHC; promoting evidence-based practices (e.g., coordinated specialty care); peer support and recovery (questions about supervision requirements have been left to states to decide); Home and Community-Based Services (partnering with NASDDDS and NASHIA on this, esp through the Link Center); CCBHC expansion; Workforce Solutions Jam and related efforts. https://nasmhpd.org/

Rob Morrison, Executive Director, National Association of State Alcohol and Drug Agency Directors (NASADAD.)

- Came to DC in 1993. In addition to state directors, NASADAD works with affinity partners from the prevention and treatment networks, women's services, etc. Already lots of talk about potential changes, so we need to continue being clear about opioid and other SUD and the positive impacts of existing programs.
- Primary prevention for SUD funding has come from block grants but not much $.

- Distinct changes in Medicaid covering treatment will have a domino effect across the continuum. Those of us working prior to the Affordable Care Act (ACA) will remember some of the hardships we might expect to see come around again.
- Still have work to do on messaging on the opportunities crisis services present related to SUD; we need to be more specific now. The underlying bill for 988 didn't mention SUD at all, but after it passed, people talked about needing crisis services for SUD too, so we're a bit behind; need expertise in mobile crisis response.
- Also on the criminal justice and reentry side. Workforce problems in this area too.
- For maternal OUD, there is continued lack of family-centered, long-term services, determined by a person's condition. Limits such as 30 days are arbitrary and not appropriate, leaving us to fill the gaps. https://nasadad.org/

Discussion:

- Turnover and wage issues in IDD, so looking for other ways to retain staff, such as creative benefits. Clinical shortage also impacts IDD. Workforce a challenge across the board; focus on integration and expanding the pool of workers who can help with conditions (beyond physicians, psychiatrists, counselors). Need to understand the SUD prevention workforce capacity and gaps. Looking at technology solutions.

Will your associations have to merge, including the association for those aging with physical disabilities and other related groups, due to funding losses?

- All will be involved in upcoming symposium, esp with their increasing partnership.

How can we reduce the administrative burden on providers, which is another driver of high staff turnover, as states are very risk-averse?

- It is about more than the reimbursement rates and inflexible service categories; 1115s can also address some of the burden, at least offloading from practitioners, a longer term project. Choosing between recovery services and medication administration seems like a mistake. Traditional clinical approach is not easily applied to MH and SUD. In opioid crisis, other providers may feel overlooked, and muddling the prevention issues, which should be seen across the language; demystify some of the language of primary prevention.

What gives you hope?

- The broad interest of many people and groups hasn't changed; momentum should continue. Young people are very engaged and open on MH and SUD topics, way more aware than in the past. Creating solutions as discussed.
- In terms of policy, hopeful that these issues continue to be bipartisan, though it may be hard right now to see how that will continue.
- People with IDD are not monolithic, and our systems seem finally aligned to acknowledge the breadth.

Jonah reviewed our mission, vision, and values, all of which we touched on today.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

DECISION MEMORANDUM

DATE: March 19, 2025
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Kim Bowdry and Leon Bryson, Associate Directors, and Lynn Canfield, Executive Director
SUBJECT: Evaluation Capacity Building Years Three and Four

Background and Purpose:

When a seven-year "Evaluation Capacity Building" project ended in summer of 2022, agency partners, along with members and staff of the CCMHB and Champaign County Developmental Disabilities Board (CCDDB), expressed interest in a subsequent project to enhance agency capacity for collecting and reporting data on outcomes, which helps the Boards in their planning and communication with the public.

A Request for Proposals for Evaluation Capacity Building Project was conducted, resulting in a contract for a new evaluation project. RFP2022-10 is posted at ccmhddbrds.org and https://www.co.champaign.il.us/bids. Meeting recordings and minutes can be viewed at https://www.co.champaign.il.us/mhbddb/MeetingInfo.php.

Family Resiliency Center's extensive proposal resulted in a two-year contract which ends April 30, 2025. This memorandum offers an update on evaluation project activities, with a suggested action to continue the project for another two years.

Overview of FRC Evaluation Team Activities – Years 1 and 2:

The evaluation team conducted assessments to determine approaches most helpful to the Boards and funded agencies. A report on the results of Group

Level Assessment was presented to each board at January 2024 meetings. This can be reviewed within the CCMHB meeting packet, pages 103-117.

An executive summary of the first-year report was presented to each Board in May 2024 and in June, the full report, which can be reviewed within the CCMHB meeting packet, pages 146-210.

The **needs assessment** consisted of a group level assessment event, 2 surveys, 13 interviews and focus groups, and the review of 64 agency reports. In total, perspectives of 76 agency staff, agency leaders, and evaluators informed the findings and direction of evaluation activities.

The evaluation team provided evaluation **technical assistance and capacity building** to three programs in Years 1 and 2 and added a fourth program in Year 2. This has led to the development of surveys based on published literature and participant feedback, data collection systems that provide greater efficiency and organization for tracking process data and outcome data, and the development of data analysis skills. The team has informally met, as needed, with other programs and agencies to support evaluation capacity and learn about the needs of local agencies.

A **working group** of 3-6 agency representatives was developed in Year 1 and continues to meet every other week, biweekly in Year 2. Working group participants discuss their evaluation experiences and provide focus and content input on training, microlearning, and other activities developed by the evaluation team to increase relevance to agencies.

In Fall 2024, the evaluation team hosted a **workshop** on identifying program outcomes and using the measures repository/bank which had been created by the prior evaluation team and updated by the current team. Planning for future trainings and microlearnings is underway.

Microlearning videos on the following topics are posted here (https://www.familyresiliency.illinois.edu/resources/microlearning-videos.)

Logic Model – Inputs
Logic Model – Outputs
Logic Model – Outcomes
Logic Model – An Example of Creating a Logic Model from Inputs through Outcomes

How to Avoid Overpromising & Underdelivering
Process & Outcome Evaluation

Evaluation Team Activities – Years 3 and 4:

Attached is a proposed Two-Year renewal which includes budget details, personnel responsibilities and roles, and scope of work similar to the original comprehensive proposal but updated using input from participants and CCDDB-CCMHB staff and board members.

In late January to mid-February, we used a brief, fully optional and anonymous survey to understand agency experiences with this project.

Responses included expressions of interest in learning more about how to organize data, use a logic model, receive technical assistance, and define meaningful and measurable outcomes for special populations (such as adults with developmental disabilities) or for unique services (such as peer support and mentoring.)

From the survey responses, we also abstracted two concerns that are outside the control of the Evaluation Capacity Building project team and that we wish to address here:

1. *Uncertainty about how programs are selected for intensive support.*

   The Evaluation team has not made those decisions. Instead, Board staff have identified candidates through the review of funding applications and included these in our recommendations for funding awards. During the contracting process, Board staff and agency staff have determined the feasibility.

2. *Guidance on what are deemed appropriate outcome measures and effective methods for measuring them, to improve grant applications and program structures.*

   When Board staff review applications, we critique the proposed outcomes to point out where revisions should be made IF a contract is awarded rather than used as a factor in determining whether to award

one. This issue was also raised last year, but we are committed to keeping application and allocation decision processes fair and open.

Because the intent is to improve communication of a program's impact on the people it serves, outcome measures and tools will be of value to many service providers, regardless of funding source. The Evaluation team makes their trainings and toolkits public so that any organization interested in using these strategies will have access to them, and CCDDB-CCMHB staff link these resources on our application site's public page and within related public documents. With this survey feedback, we will continue access to all resources developed through the current and any future similar contract.

Budget Impact:

The current contract is for a twenty-four-month period, from May 1 to April 30. The first full year of the contract had a cost of $125,003 and the second year, $128,765, for a total cost of $253,768. Per RFP2022-010, the parties have an option to renew the contract for another two years. If the parties exercise this option and continue with similar annual cost increases, the third year would cost **$133,826** and the fourth **$137,860**, for a total of **$271,686**.

With a start date of May 1, and using the administrative cost split defined in the Intergovernmental Agreement between the CCDDB and CCMHB, this results in the following costs per fiscal year per Board:

- The remaining obligation for the second year of the current contract, for January through April 2025, is $42,925.
  Eight payments on a third-year contract, for May through December 2025, add $89,216.
- The **2025 total** of $132,141 is split, $55,697 DDB and $76,444 MHB.

- Four payments on the third year of the contract, for January through April 2026, are $44,610.
  Eight payments on the fourth year, for May through December 2026, add $91,904.
- The **2026 total** of $136,514 is split, $57,541 DDB and $78,973 MHB.

- The remaining obligation for the final year of the contract, for January through April 2027, is $45,956.
- The **2027 total** of $45,956 is split, $19,370 DDB and $26,586 MHB.

Decision Section:

Motion to authorize the Executive Director to enter into a twenty-four month extension to the contract with the Family Resiliency Center for the support as proposed, with a start date of May 1, 2025, end date of April 30, 2027, and total cost of $271,686, pending approval by the CCDDB.

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

Champaign County Developmental Disabilities & Champaign County Mental Health Boards

Evaluation Capacity Building Project

Two-Year Renewal

05/01/2025-04/30/2027

Budget Justification

The Family Resiliency Center (FRC) at the University of Illinois Urbana-Champaign submits this budget justification for a two-year continuation of the evaluation capacity building project. FRC will continue evaluation technical assistance and training activities and deliverables from May 1, 2025 – April 30, 2027. This budget reflects approximately a 3% increase per year, consistent with the previous two years. This accounts for changes in fringe rates and cost of living adjustments.

Budget

We estimate the cost of the continued capacity building activities at **$133,826 in year 3 and $137,860 in year 4** (Table 1) for a **total of $271,686**. These costs are inclusive of salaries ($80,530 in year 3; $82,947 in year 4), fringe ($29,492 in year 3; $30,376 in year 4), and materials and supplies ($1,500 in year 3; $1,560 in year 4) as well as indirect costs ($22,304 in year 3 and $22,977 in year 4) calculated at 20% per the Champaign County Developmental Disabilities Board Requirements and Guidelines for Allocation of Funds: https://www.co.champaign.il.us/mhbddb/PDFS/DDB_Funding_Guidelines_122021_FINAL.pdf

Fringe benefits applied have been calculated by a method approved by the Federal Government. Fringe benefits are charged at a rate of 45.86% on senior personnel salary. Fringe benefits for graduate research assistant salaries are charged at a rate of 10.35%. Hourly salary is calculated at 7.66% fringe, hourly student benefits are calculated at a rate of .01%.

Table 1. Budget by Category and Year

Cost Category	**Year 3**	**Year 4**
Salary	$ 80,530	$ 82,947
Fringe	$ 29,492	$ 30,376
Materials/ Supplies	$ 300	$ 360
Honoraria	$ 1,200	$ 1,200
Indirect Costs	$ 22,304	$ 22,977
Total	$133,826	$137,860

The evaluation team is prepared to continue conducting rigorous capacity building and technical assistance to help agencies develop sustainable evaluation tools and competencies to best serve their reporting, programming, and service goals and objectives.

The majority of the proposed work is focused on training development and implementation; mentoring, technical assistance, coaching, and consultation; collaboration with the Boards; continuous assessment of needs and readiness; project management; and reporting. We will leverage UIUC resources including the Center for Innovation in Teacher and Learning (CITL), an online survey platform, Box, MediaSpace, and other in-kind resources available to FRC that are included in the cost proposal.

Personnel, Effort, and Roles

Dariotis. Dr. Dariotis will have administrative oversight of the entire project including supervision of technical assistance implementation and evaluation design changes. She will develop microlearnings and in-person trainings on topics identified by agencies, Boards, working group members, and within her expertise (e.g., survey design and instrument development modules, participatory methods). She will attend board meetings, regularly update board staff on progress, and write annual reports.

Underland. Dr. Underland will provide support for the project including developing microlearnings and trainings on topics within his expertise (e.g., storytelling, reporting) and support website needs.

Eldreth. Dr. Eldreth will serve as lead data manager and online programmer (e.g., survey programming) as well as provide technical assistance and develop online microlearnings. She will attend board meetings (as needed) and assist in report writing.

Jackson-Gordon. Dr. Jackson-Gordon will lead project management and continued readiness and needs assessment, and technical assistance sessions with chosen agencies. She will develop in-person trainings and microlearnings on identified topics within her expertise (e.g., measurement, participatory methods). She will attend board meetings, regularly update board staff on progress, and write annual reports.

Sloane. Dr. Sloane will provide secondary support for data management needs and online programming, provide technical assistance support, and develop online microlearnings.

Postdoc/ graduate research assistant. A graduate research assistant will assist with data collection and technical assistance sessions with chosen agencies. They will support the development and implementation of microlearnings and in-person trainings.

Materials/ Supplies

Funds are allocated for Years 3 and 4 for materials and supplies to support trainings (e.g., post-its, markers, flipcharts, food, etc.).

Honoraria

Funds are allocated in Years 3 and 4 for working group member honoraria for participating in biweekly or monthly working group meetings.

Scope of Work

Proposed Activities – Evaluation Plan

We will ***accomplish the following proposed activities***:

1. **On-demand microlearnings and virtual/ in-person trainings**. Continue creating a resource bank of on-demand microlearnings that all Board and Agency personnel can access. These will be archived so that they can be reached at any time. On-demand recordings will range in length from ~5 minutes to 1 hour (at most), depending on topic area. In-person and virtual trainings will be offered for identified topic areas needing more instruction and hands-on practice than microlearnings can offer. We anticipate 2-4 microlearnings and 1-2 intensive workshop trainings per year.

   Example training topics are below (Note: final choices will be informed by the results of the readiness and needs assessments and made in consultation with Boards):
   a. *Evaluation Capacity Knowledge* – e.g. how to develop an evaluation plan
   b. *Evaluation Capacity Skills* – e.g. how to choose appropriate data-collection methods and instruments
   c. *Leadership* – e.g. how to apply principles of team science and participatory research
   d. *Culture* – e.g. how to apply culturally appropriate evaluation approaches
   e. *Systems and Structures* – e.g. how to coordinate a readiness assessment to identify current and future system and infrastructure needs to attain goals and meet deliverables.
   f. *Communication* – e.g. how implement best practices in reporting and storytelling

2. **Automated Processes and Efficiencies.** Identify opportunities within existing systems to create efficiencies through automated processes. Help Boards design and develop user-friendly, automated systems (e.g., templates for inputting data and generating reports with figures and tables necessitating minimal reformatting; programming outcome indicator instruments into online survey platforms that calculate results and create reports for agencies), as needed and appropriate.

3. **Intensive Technical Assistance (TA).** Up to three agencies will be chosen, in consultation with the Boards, for one-on-one TA experiences.

4. **Train-the-Trainer (TTT).** Develop a cross-agency mentoring approach to enhance the transfer of learning and leverage sustainable evaluation practices. Continue the working group, recruit new members, and move toward a community of practice.

Deliverables

1. Annual report
   a. Description of evaluation capacity building activities and progress
   b. Recommendations for agencies, Boards, and evaluation team for subsequent year

(e.g., areas for automated processes, efficiencies, resources/ tools)

c. Implementation of metrics for agency intensive technical assistance and cross-agency mentoring program

2. Microlearning repository (asynchronous learning)
3. Virtual. in-person workshops/ trainings
4. Intensive technical assistance with up to three target agencies, annually
5. Measures bank (programmed into an online survey platform, if preferred and feasible)
6. Cross-agency mentoring program

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

BRIEFING MEMORANDUM

DATE: March 19, 2025
TO: Champaign County Mental Health Board (CCMHB)
FROM: Leon Bryson, Associate Director
SUBJECT: Results of Agency Survey on Emerging Threats

Background and Purpose:

Service providers and stakeholders had been expecting hardship in 2025, due to the loss of ARPA funds and likely reductions in State of Illinois appropriations for human services. It is difficult enough for all to plan for these, but the first few months of 2025 federal activities complicated expectations even more.

Among Executive Orders issued by President Trump are some directing changes to funding and regulatory systems many rely on. Changes included elimination of diversity, equity, and inclusion initiatives and a 'freeze' on payment disbursement for thousands of government grant and loan programs, impacting millions of individuals. A new department has terminated thousands of federal employees, many administering programs relevant to our work, and the US House and Senate negotiations on budget reconciliation appear poised to destroy Medicaid. States, local governments, and other agencies rely on public funds to provide childcare, housing support, food assistance, education grants, law enforcement and public safety supports, mental health and substance use treatment, and services for the elderly, people with disabilities, veterans and active-duty members of the military, and rural families, to name a few.

While we wait for resolution of major budget decisions and implementation of federal executive orders, local service providers might already see impacts on their staff or clients and may be facing a reduction in force or service capacity.

On February 18th, CCDDB-CCMHB staff launched a brief survey to see how these emerging changes may affect agencies and the people they serve. The survey was anonymous, completely optional, and results were kept confidential. Agencies and other stakeholders received an email containing a link to the Google Forms survey. The survey took no longer than 10 minutes to complete and had a deadline of March 7th. The results are attached.

Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.
We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

Unknown. Are in a watch and wait situation.

Current or anticipated effects on the people you serve:

Same

Current or anticipated effects on resources your staff or clients rely on:

Same

Other details we should know:

Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.
We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

Federal websites down, inactive.

Current or anticipated effects on the people you serve:

Same

Current or anticipated effects on resources your staff or clients rely on:

Same

Other details we should know:

Cannot access critical healthcare information from immunizations, sexual health, etc..

Emerging Threats Survey

Please share anything you are comfortable with us making public for the
purposes of CCMHB and/or CCDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.
We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

At this time we are not experiencing any effects, other than the stress and uncertainty of the current state of human services.

Current or anticipated effects on the people you serve:

If medicaid waivers (DDD and DRS) are affected by cuts, that would have an impact on our agency's funding and budget. It would also have a huge impact on the ability of many, many people with I/DD to ensure their basic needs are met. If funding for HBS were interrupted, it would eliminate support for many people for example. And for many people working in the I/DD field, work as PSWs directly employed by people or families is their main source of income. Interruption could put their financial security at great risk.

Current or anticipated effects on resources your staff or clients rely on:

Our clients are often some of the most vulnerable citizens. They rely on a robust social services system - medicaid, medicare, social security, waiver services, food stamps, housing vouchers, LIHEAP, ADA protections, etc. It seems that all of these things are at potential threat from our current administration. As individuals who frequently do not have a strong safety net, changes or the elimination of any of these programs could have monumental affects. That would put additional pressure on our local systems to be able to support people with fewer and fewer resources.

Other details we should know:

Emerging Threats Survey

Please share anything you are comfortable with us making public for the
purposes of CCMHB and/or CCDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.
We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

Federal funding cuts will cause our staff to drop to 50% FTE

Current or anticipated effects on the people you serve:

Our housing will lose funding, displacing several immunocompromised individuals, some with several medical conditions.

Current or anticipated effects on resources your staff or clients rely on:

Our office and food pantry are located in our transitional housing facility. If there are federal funding cuts, our staff will lose their workspace, and we will be forced to discontinue our food pantry.

Other details we should know:

Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.
We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

If federal cuts happen, unfortunately, staff cuts may become a real possibility

Current or anticipated effects on the people you serve:

If federal grant for lifespan respite is cut, this will effect all caregivers statewide caring for a loved one of any age with any disability not being able to receive an emergency respite stipend. The IRC will continue to work on grant objectives to improve respite statewide but funding cuts will result in the lack of emergency respite funding.

Current or anticipated effects on resources your staff or clients rely on:

From July through January, over 275 caregivers were supported by a voucher stipend and linked to longer term more sustainable support.

Other details we should know:

Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.
We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

Current or anticipated effects on the people you serve:

More poverty, less housing

Current or anticipated effects on resources your staff or clients rely on:

Reduction in gra t monet

Other details we should know:

Prison population likely to grow.

Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.
We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

There are not currently or any anticipated effects to our staff as long as our funding sources for operations are not affected.

Current or anticipated effects on the people you serve:

The anticipated effects to the people we serve depends on possible reductions/suspension to the EFSP and USDA food programs, both of which could significantly reduce the amount of food we have to distribute.

Current or anticipated effects on resources your staff or clients rely on:

For our clients, we are concerned about possible reductions/suspension to the EFSP food funding and USDA commodities distributions, both of which will greatly reduce the amount of food we have to distribute. For our staff, the effects are none as long as our funding sources for operations are not affected.

Other details we should know:

If agencies that see clients here onsite are effected, there will be client impacts. We are watching all the changes being made very carefully and are unsure, at this time, of all the possible effects long term.

Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.
We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

We don't have federal funding

Current or anticipated effects on the people you serve:

N/A

Current or anticipated effects on resources your staff or clients rely on:

I'm not sure. I have only heard from some providers. I don't think anyone knows for sure at this point.

Other details we should know:

Emerging Threats Survey

Please share anything you are comfortable with us making public for the purposes of CCMHB and/or CCDDB planning. This survey will be available until March 7, 2025 with information to be included in the March Board packets.
We want to learn how your organization has been or will be impacted by recent or possible federal funding and regulatory changes.

Current or anticipated effects on your staff:

Staff are concerned about their employment and the impact on their clients.

Current or anticipated effects on the people you serve:

Clients are at risk of facing reduced services and longer waiting times for therapy.

Current or anticipated effects on resources your staff or clients rely on:

Support for transportation, clothing, and agency supplies are all likely to be impacted.

Other details we should know:

Our agency is at risk of losing about 20% of its budget and these funds are all used to support direct service staff. The agency is still working to make up for the loss of a quarter of the agency's budget at the start of FY24 that was a result of the actions of the first time this administration was in office.

From: Lynn Canfield
To: Lynn Canfield
Subject: FW: The review process - changes and important dates SO FAR
Date: Sunday, March 9, 2025 4:38:49 PM

From: Lynn Canfield <lynn@ccmhb.org>
Date: December 2, 2024 at 8:06:46 AM CST
To: Molly McLay <mollymclay@gmail.com>
Subject: The review process - changes and important dates SO FAR

Through our conversations with board members, each other, staff, and even stakeholder input, I have already made a few changes and can plan on others. There is a lot for you to think about regarding how board members proceed, but hopefully the following will take some items off of your plate, leaving you time to work through the board-specific stuff.

One loose end:

> Stephanie did get the NOFA into the News Gazette, county website, and our application site, all in time (must be three weeks prior to opening the system, so Nov 29). She contacted the Daily Illini and Smile Politely but didn't get responses back in time to make that publication deadline. She DID share it with the county for their facebook page, which is maintained by **their** staff, and which posts can be shared by anyone who wants to. So that's progress though not exactly what you and Tony had identified.

Changes in the application:

- **rewording** of the simple question about coordination with similar/related programs **to get more details** (because despite the current, shallow requirements for some kind of collaboration, many board members and agency staff and people served are pointing to this as a particular local barrier)
- **rewording** of the participant outcome sections **to offer clarity and links to more info** (lots of input from the evaluation team)
- **rewording** of the open question about how people shape programs **to include those with lived experience** in the planning and operation of program activities beyond individual service plans
- a few other tweaks based on staff input (mostly clarifying)

Changes in the staff review:

- Staff reviews will be **finished one week earlier**, so the board can begin review during April 16 study session rather than April 23, and continue at the April 30 regular meeting.
- **Removal** of some details (e.g., %s) which distracted from the financial

analysis and **reordering** of items which may have seemed or been redundant. The new template is attached (we update this every year using whatever we learned last time around.)

- Stephanie (or others) may provide **historical details on compliance** of any agency with a current late report or application.
- I need to check on PRIOR year evaluation project target programs to make sure we include that detail in the reviews. The only MHB target program right now is CU change which has a two year contract and won't need to reapply this spring. There is also a workgroup, so we could note which agencies are involved that way.
- Leon is open to providing the **brief intros on each program**. A first draft template is attached but will benefit from further direction.

Changes in board review:

- I will provide a preliminary estimate of affordable total allocations earlier in the process (Feb or March). It will have to be changed later, but it seems to add tension to the board process to have no **ballpark figure** to work with. I could add a rough target amount to the bottom of a funding request spreadsheet, but I would hope that's for board use only, maybe not making it public right away.
- If you have time, it might be good for you (or you and Jon?) to **assign the reviewers**. I can provide a template spreadsheet if that helps, but that's the easy part. Last year's final version is attached. I am not aware of any conflicts of interest, but if a board member lets us know privately, we can take care to avoid assigning them to something they shouldn't talk about.
- Updated **board review checklist** (attached), to which you might have further changes.
- April 16 and April 30 are scheduled for these reviews, but the 30th will have other business (minutes, claims, annual report, no staff reports other than maybe mine). As a result I booked the room for May 7. You could decide (as late as May 4) to call a **special meeting/study session for May 7**.
- May 21 is study session to discuss the **staff recommendations** or other allocation scenario. Usually we just provide the draft memo plus a spreadsheet to see the amounts. Perhaps some other materials would be helpful.
- May 28 is a regular board meeting, great if the board can **approve a majority of funding awards**. There will be some other business too,

but nothing as important. If some awards are not finalized at that meeting, it is reasonable to hold them until the regular June board meeting, which is often very light on action and at which time I might have a better budget estimate.

Lynn Canfield
Executive Director, CCDDB/CCMHB
1776 E. Washington St., Urbana, IL 61802
217.367.5703
https://www.champaigncountyil.gov/MHBDDB/MHBDDB.php
https://ccmhddbrds.org

<MHB PY25 Reviewers Revised 41724.xlsx>
<0 PY26 MHB program summary template.docx>
<MHB Review Process - PY26 Checklist.docx>
<Template for Staff Intro to Each Program Funding Request.docx>

CCMHB PY2026 Funding Requests with Reviewers

Agency	Program	Request	Reviewer Team
**indicates need for PY24 audit*			
CCRPC - Community Services	Youth Assessment Center	$76,350	*Youakim/Omo-Osagie*
CC Children's Advocacy Center	CC Children's Advocacy Center	$63,911	*Patterson/Nichols*
CC Christian Health Center*	CCCHC Community Mental Health Program	$100,000	*Sprandel/Miner*
CC Health Care Consumers	CHW Outreach and Benefits Enrollment	$97,139	*Palencia/Rodriguez*
	Justice Involved CHW Services & Benefits	$103,284	*Sprandel/Miner*
CSCNCC	Resource Connection	$70,667	*Youakim/Omo-Osagie*
Crisis Nursery	Beyond Blue Champaign County	$90,000	*Patterson/Nichols*
DSC - I/DD Program	Family Development	$702,000	*Sprandel/Miner*
ECIRMAC (Refugee Ctr)	Family Support & Strengthening	$75,441	*Youakim/Omo-Osagie*
Family Service	Counseling	$143,322	*Patterson/Nichols*
	Self-Help Center	$38,191	*Palencia/Rodriguez*
	Senior Counseling & Advocacy	$214,360	*Sprandel/Miner*
Immigrant Services of CU*	Immigrant Mental Health Program- *RETURNING*	$200,256	*Patterson/Nichols*
Promise Healthcare	Mental Health Services	$360,000	*Palencia/Rodriguez*
	PHC Wellness	$125,000	*Youakim/Omo-Osagie*
RACES	Sexual Trauma Therapy Services	$196,205	*Sprandel/Miner*
	Sexual Violence Prevention Education	$108,115	*Palencia/Rodriguez*
UNCC*	Community Study Center - *RETURNING*	$382,180	*Youakim/Omo-Osagie*
WIN Recovery*	Community Support Re-Entry Houses	$183,000	*Patterson/Nichols*
	Win Resilience Resource Ctr- *NEW*	$270,000	*Palencia/Rodriguez*
	Chair McLay will provide supplementary review on all applications.		
	In addition, any board member may provide supplementary review on any application.		
**indicates need for PY24 audit*			
	Early estimate of available PY26 amounts	*Requests*	*Differences*
Total (after 2 yr obligations - see below)	**$3,145,004**	**$3,599,421**	**-$454,417**
For MH/SUD=	**$2,462,340**	**$2,897,421**	**-$435,081**
For DD=	**$682,664**	**$702,000**	**-$19,336**
Other PY26 obligations are PY25-PY26 contracts totaling $3,089,066.			
PY25-PY26 MH/SUD contracts =$2,831,786 , PY25-PY26 IDD contracts = $257,280.			

CCMHB Application Review Template

Minimal responsiveness *(staff confirm first)*:	Y/N	concerns/comments
1. Eligible per questionnaire if new. Eligible per compliance if incumbent.		
2. Recent audit, review, compilation, or audited balance sheet if new. Recent audit or review with no concerns if incumbent.		
3. All application forms submitted on time.		
4. Relates to MI, SUD, or I/DD.		
5. Other pay sources have been maximized.		
6. Relationships with providers of similar or related services.		

CCMHB Priority Categories: check appropriate

Strengthening the Behavioral Health Workforce _____
Safety and Crisis Stabilization _____
Healing from Interpersonal Violence _____
Closing the Gaps in Access and Care _____
Thriving Children, Youth, and Families _____
Collaboration with CCDDB: Young Children and their Families _____

Best Value Considerations:	Y/N	concerns/comments
Is there a clear connection between the budget plan and the program activities?		
Are measurable, meaningful participant outcomes included? Are the access measures and utilization targets reasonable?		
Do the people served have a say in their own service plan? How are program activities impacted by people with lived experience?		
Does the program plan narrative add program-specific strategies (beyond the agency CLCP) to engage underserved populations?		
Does the application address whether and how rural residents may use the program?		
Is inclusion in the community (anti-stigma) described at the individual level? Through program activities?		
Does the application describe use of virtual supports and training?		
Is an evidence-based, evidence-informed, promising, or innovative approach identified?		
Are staff credentials/specialized training identified?		
Are other resources identified, with efforts to leverage them demonstrated?		

Champaign County Community Partner Assessment Survey

DRAFT Report 11/6/2024

Report updated 02/25/2025

Champaign-Urbana Public Health District (CUPHD) Community Partner Assessment: Participating Organizations

Carle Foundation Hospital

Carle Illinois College of Medicine

Champaign County Emergency Management Agency

Champaign Fire Department

Champaign Police Department

Champaign Unit 4 School District

Champaign-Urbana Mass Transit District

City of Champaign-Neighborhood Services Department

City of Champaign-Department of Equity & Engagement

City of Urbana

CRIS Healthy Aging

Don Moyer Boys & Girls Club

Family Resiliency Center at UIUC

Family Service of Champaign County

Feeding Our Kids

Habitat for Humanity of Champaign County

Healthy Champaign County

Illinois Department of Public Health

Immigrant Services of Champaign-Urbana

McKinley Health Center-Health Education Department

Office of Strategic Initiatives, University of Illinois System

Promise Healthcare

Rape Advocacy, Counseling, & Education Services (RACES)

Sola Gratia Farm

The Housing Authority of Champaign County

United Way of Champaign County

University of Illinois Chicago's Division of Specialized Care for Children

University of Illinois Extension

Urbana Park District

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Contents

Executive Summary

1. ***Community Partners Profile***
   - CPA data shows that the responding organizations were primarily non-profits (39%), followed by colleges/universities (19%) and city government agencies (16%), with notable gaps in participation from hospitals, clinics, tribal agencies, and private businesses, emphasizing opportunities to engage these critical sectors in future efforts.
   - Nearly half of organizations report that their leadership (48%), management (52%), and frontline staff (55%) reflect community demographics, while smaller proportions disagree or are unsure about demographic alignment in these areas.
   - A majority of organizations demonstrate a strong commitment to equity, with 85% having a dedicated diversity, equity, and inclusion (DEI) person and team, 78% addressing external equity issues, and 63% incorporating equity advancement into staff job requirements, supported by a range of staff roles focused on equity, including board members, outreach coordinators, human rights officers, and DEI officers.
2. ***Motivations for CHIP Participation and Resources Organizations are Willing to Provide***
   - CPA data show that organizations prioritized joining a Community Health Improvement Partnership (CHIP) to improve program efficiency and reduce duplication (69%), enhance communication across groups (55%), and drive sustainable social change (41%), with additional interests in resource sharing, launching initiatives, building networks, and strengthening government-community communication.
   - Organizations support MAPP activities through resources like meeting spaces (59%), staff time for engagement (52%), and active participation (45%), while serving diverse populations, including Black/African American, Hispanic/ Latina(o), Asian, and Indigenous communities, with opportunities for growth in data coordination, health equity advocacy, leadership development, and engaging underrepresented sectors like private clinics and tribal organizations.
3. ***Needs Assessment Practice***
   - More than half of the participating organizations conduct needs assessments as part of their work. These organizations reported collecting data on demographics (67%), access and utilization (52%), program performance (48%), and social determinants of health (41%). They primarily gather this information through surveys (61%), data tracking systems (57%), notes (43%), and feedback forms (39%).
4. ***Addressing Health Inequities***
   - Organizations prioritize social determinants of health, education, family well-being, and public health (63%), with additional focus on disability and independent living (56%), healthcare access, youth development (48% each), housing (44%), and racial justice (37%).
   - Organizations address key social determinants of health by focusing on economic stability (56%), neighborhood and built environment (52%), and healthcare access and quality (41%), while also engaging in education access and social/community context, addressing critical issues like poverty, housing, transportation, health literacy, and community cohesion.
   - Organizations prioritize mental and behavioral health (63%), healthcare access (44%), and health equity (41%), while also addressing family/maternal health, injury and violence prevention, and chronic diseases like asthma, diabetes, and cardiovascular conditions.

5. ***Core Activities of the Organization***
    - Participating organizations identified their core competencies as community engagement and partnerships, access to care, and communication and education, with additional strengths in workforce development, policy creation, and program evaluation, all aimed at enhancing health and well-being.
6. ***Communications and Community Engagement***
    - The findings show that most organizations prioritize community engagement and partnerships (82%) and communication and education (74%) to improve health and well-being, with additional focus on policies, assessments, workforce development, evaluation, access to care, and strengthening infrastructure, while fewer engage in hazard investigations (26%) or utilize legal and regulatory authority (22%).
    - Most organizations (67%) prioritize informing the community by sharing relevant information. Fewer organizations focus on involving the community in decision-making (15%) highlighting a potential need for adoption of a participatory approach. An equal proportion collaborate with community members to build leadership capacity (15%) in implementation of decisions. A small percentage (4%) consult the community for input, and none delegate decision-making to foster community-driven leadership and equity. This indicates that while sharing information is a priority, there is limited emphasis on deeper engagement and democratic participation.
    - Community organizations actively engage with diverse racial and ethnic populations, with the highest engagement among Hispanic/ Latina(o) (93%), Black/African American (90%), and Asian (90%) communities, Table 7. For the LGBTQIA+ community, 90% provide some form of service, including 21% offering dedicated support. Significant efforts also focus on immigrants, refugees, and non-English speakers (76%). For individuals with disabilities, 86% provide some form of service, including 48% offering dedicated support, while 66% offer access to interpretation and translation services.
7. ***Policy and Advocacy Work***
    - Most organizations focus on educating decision-makers (67%), responding to their requests (52%), and building relationships (48%), while some leverage these connections to influence policy development (30%) or advocate for changes (33%), with fewer engaging in capacity-building, lobbying, or mobilizing public opinion, and minimal involvement in voter outreach (7%) or legal advocacy (4%).

Background

The Community Partner Assessment (CPA) helps us understand the organizations involved in the 2025 Community Health Improvement Plan (CHIP)—who they are, what motivates them, and how they contribute. Most participating organizations are non-profits, schools, and government agencies, but fewer hospitals, clinics, tribal agencies, and private businesses are engaged.

Many organizations prioritize diversity, equity, and inclusion (DEI), with leadership reflecting community demographics and equity-focused roles embedded in their work. Their main reasons for participating in CHIP include improving program effectiveness, enhancing communication, and driving long-term social change. They contribute resources like meeting space, staff time, and participation, but there are opportunities to expand their involvement in data sharing, leadership development, and health equity advocacy.

A strong focus on health equity is evident, with organizations working on issues like economic stability, neighborhood safety, healthcare access, education, housing, and racial justice. Key health priorities include mental health, healthcare access, maternal health, chronic disease prevention, and violence prevention.

While community engagement is a priority, most organizations focus on sharing information rather than involving the community in decision-making. There is room to strengthen leadership opportunities and ensure communities have a stronger voice in shaping health initiatives.

Policy and advocacy efforts mainly involve educating decision-makers and building relationships, with fewer organizations actively working to influence policies, advocate for change, or engage in voter outreach and legal advocacy.

The CPA findings emphasize the need for stronger partnerships, cross-sector collaboration, and inclusive community engagement to advance health equity. By working together—especially with historically underserved groups—we can build a healthier, more equitable future. These insights will help guide CHIP's next steps toward meaningful community-driven progress.

Introduction

Health Equity and MAPP 2.0

Health equity, as defined by the World Health Organization, is the absence of unfair, avoidable, or remediable differences among groups of people, regardless of social, economic, demographic, or geographic factors. It emphasizes health as a fundamental human right, achieved when everyone can reach their full potential for health and well-being (Source: WHO).

Mobilizing Action through Planning and Partnerships (MAPP 2.0) is a community health planning framework designed to address health equity. It provides a structure for communities to assess pressing population health issues, engage broad stakeholders, and align resources across sectors for strategic action. MAPP 2.0 culminates in the development of a Community Health Needs Assessment (CHNA) and a Community Health Improvement Plan (CHIP).

MAPP 2.0's framework emphasizes:

- Policy, systems, and environmental changes.
- The alignment of resources toward shared goals.
- Community engagement to guide collaborative efforts.

Phases of MAPP 2.0

1. Build the Community Health Improvement Foundation – Establish the groundwork for collaboration and action.
2. Tell the Community Story – Collect and analyze data to understand health needs and challenges.
3. Continuously Improve the Community – Develop and implement strategies to drive sustainable improvements.

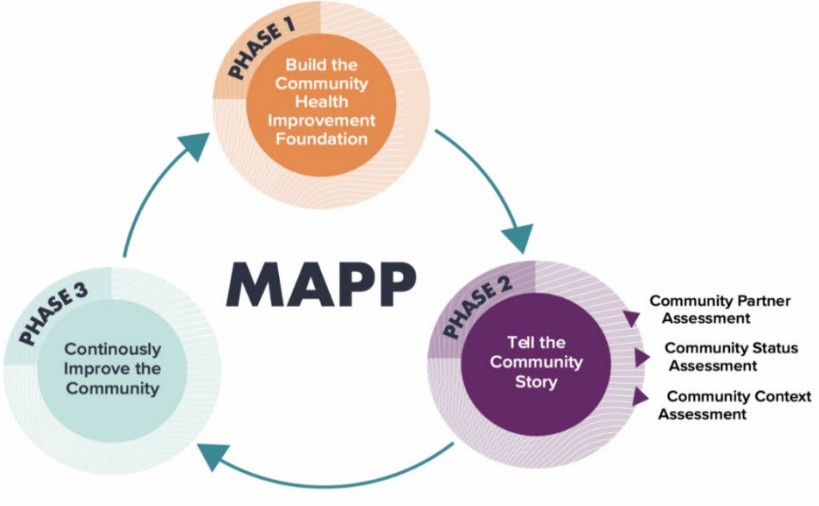

Figure 1: Overview of MAPP 2.0 Components, showing the three phases and their key elements.

Source: https://visiblenetworklabs.com/2023/08/22/social-network-analysis-and-the-mapp-2-0-framework-for-community-health-improvement/#elementor-toc__heading-anchor-0

Community Partner Assessment (CPA)

The Community Partner Assessment is a vital element of Phase 2 of MAPP, supporting the "Tell the Community Story" process. It is also a cornerstone of the 2025 Community Health Improvement Plan, aimed at understanding, maintaining, and building community health infrastructure in Champaign County.

The CPA focuses on achieving health equity by fostering collaboration among partner agencies. It ensures public health agencies work alongside peer agencies on equal footing to guide ownership of community health planning. Partner agencies benefit from:

- Networking with organizations, agencies, and funders.
- Accessing and leveraging data to address key issues.
- Collaborating to advance policy solutions.
- Joining efforts to improve community health and conditions.

The CPA, along with the Community Status Assessment (CSA) and the Community Context Assessment (CCA), contributes to a comprehensive evaluation of health and well-being in the community.

Methodology

The Champaign Executive Committee met to create a list of community health stakeholders. During this meeting, members suggested names and agencies to be invited to partner. A review of the partner list added new members, and updated contact information from existing partners.

Initial Meeting: A meeting was held to introduce the CPA as well as orient partners to how it will be used in community health planning. This orientation session covered the purpose and goals of the CPA and introduced the survey we asked all participating organizations to complete on behalf of their organization.

Survey: A survey was distributed to partners via Survey Monkey. Partners then had 2 weeks to respond and a reminder email was sent before the deadline. Each agency was only allowed to submit one survey response, and participants were encouraged to identify key staff within their organizations to assist with survey completion.

Review summary report: CUPHD staff completed a draft summary report and participants were then sent a copy and asked to review its contents. CUPHD requested feedback on what stood out to participants, what surprised participants, what work still remained, and what our greatest strengths as a group were. The larger group then met to discuss the draft summary report to gather feedback for the final report.

Creation of final report: input from the larger group, along with the draft summary report, and survey results were then shared with CUPHD's Data Team. This team put together the 2nd and final draft of the CPA report.

Key Characteristics of CPA Participating Organizations

The CPA allows community partners to look critically at their (1) individual systems, processes, and capacities; and (2) collective capacity as a network of community partners to address health inequities.

Community Partners Profile

Most responding organizations (n=31) are non-profits (39%), followed by colleges/universities (19%) and city government agencies (16%), Figure 2. Other types include emergency response, social services, state government agencies, housing providers, and mental health providers. Faith-based groups, grassroots organizations, and educational institutions were also present. Notably, hospitals, clinics, tribal agencies, or private businesses did not participate, highlighting potential sectors for engagement.

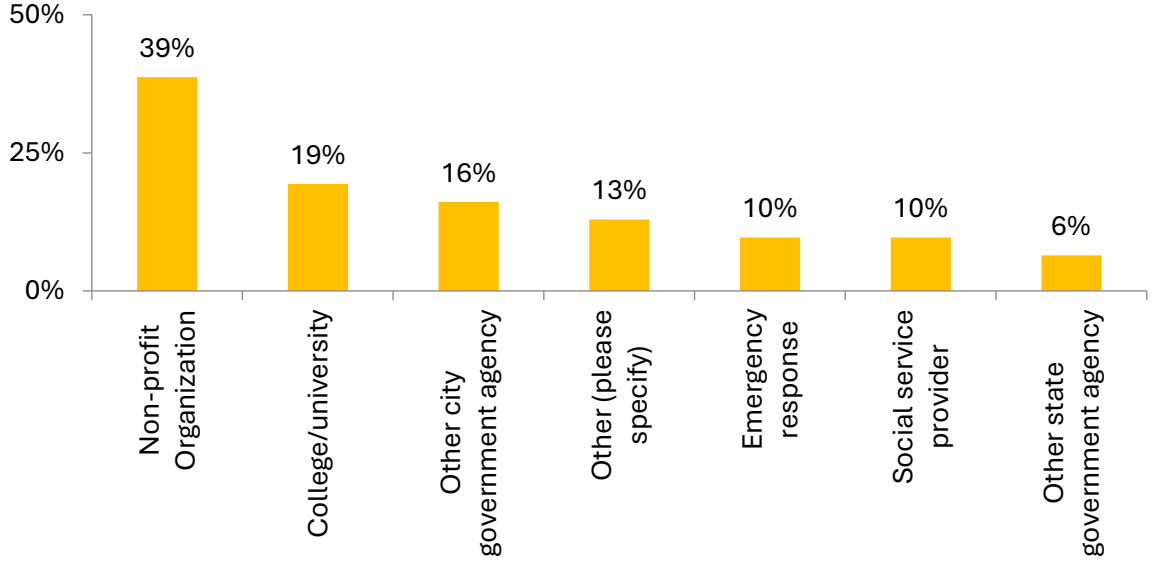

Figure 2: How Would You Describe Your Organization?

Overview of CPA Participants

See Figure 3, (n=31)

- **42%:** Engaged in community health improvement efforts.
- **90%:** Involved in or facilitated community-led decision-making policies, actions, and/or programs.
- **48%:** Have leadership staff whose demographics align with the communities they serve.
- **52%:** Have management staff whose demographics align with the communities they serve.

- **55%:** Have administrative or frontline staff whose demographics align with the communities they serve.

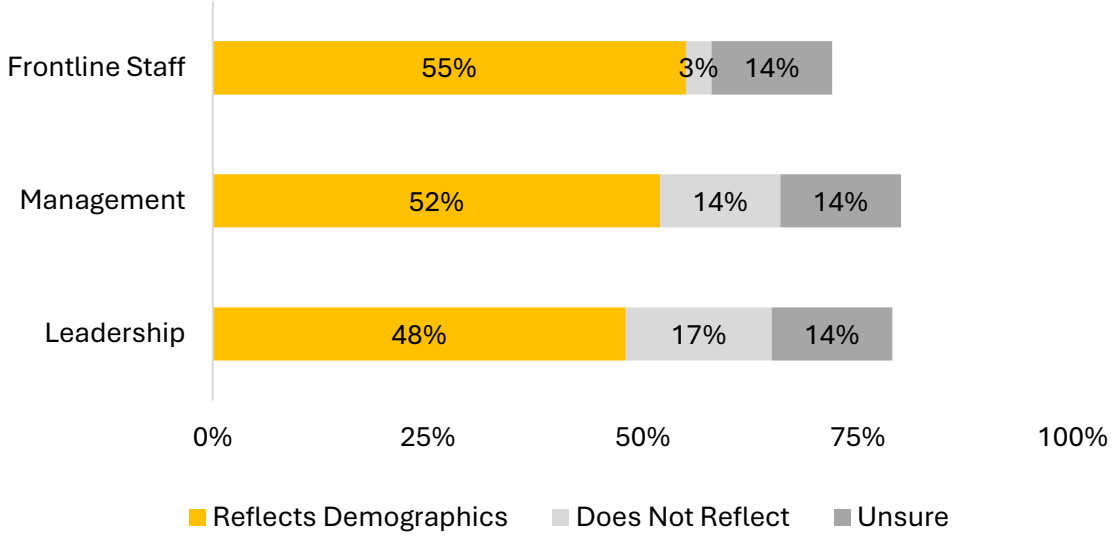

Figure 3: Demographic Representation Across Organizational Roles

Commitment to Equity

- **Internal DEI Focus:** **85%** of respondents confirm their organization has a dedicated person for diversity, equity, and inclusion.
- **External Equity Focus:** **78%** agree that at least one person addresses equity issues externally in the community.
- **Equity Team:** **85%** confirm their organization has a team dedicated to advancing equity.
- **Job Requirements:** **63%** agree that advancing equity is part of all or most staff job requirements.
- **Staff positions working to address equity:** Board Members, Outreach/Education Coordinator, ED, Director, Human Rights Officer, Web Accessibility Coordinator, Title VI Officer, Disadvantaged Business Enterprise Liaison Officer, Dean, Case Manager, Vice Presidents, Community Relations Manager, Chief ADA Officer, Chief DEI Officer

Why Join a Community Health Improvement Partnership?

The top interests for joining a community health improvement partnership include efficient program delivery and avoiding duplicated efforts (69%), increasing communication among groups (55%), and creating long-term, permanent social change (41%). Other goals highlight pooling resources (34%) and planning community-wide initiatives (31%), emphasizing collaboration and improved communication to drive lasting social impact.

See Figure 4, (n=29)

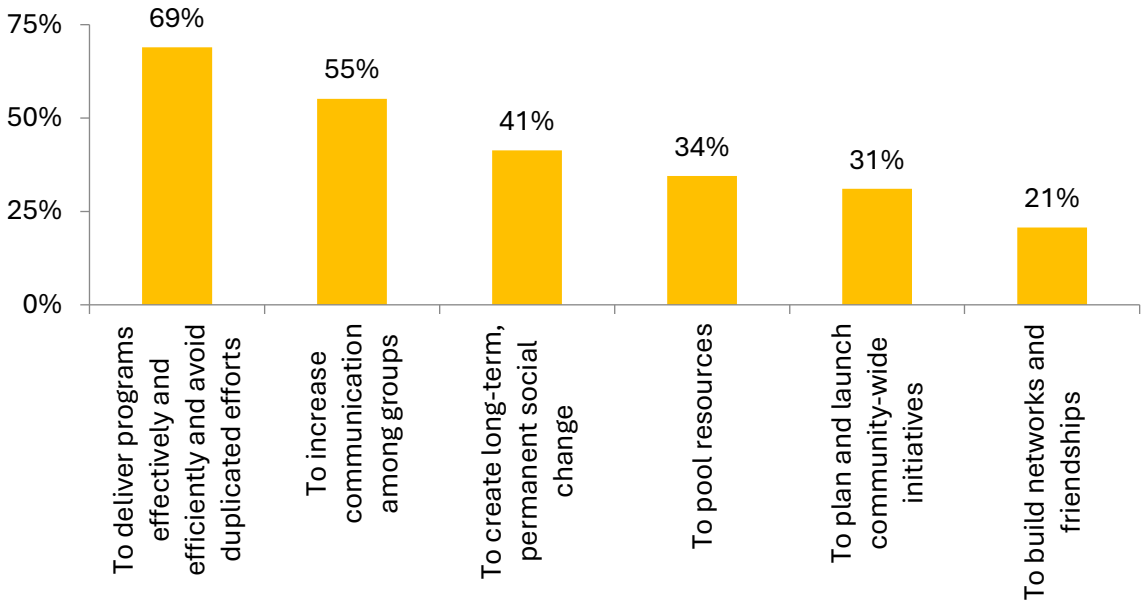

Figure 4: Top Interests of Organizations in Joining a Community Health Improvement Partnership

Additional interests include:

- **34%:** Pooling resources.
- **31%:** Launching community-wide initiatives.
- **21%:** Building collaborative networks.
- **14%:** Improving communication between government and communities.
- **3%**: Addressing stereotypes or fostering political power for services.

Capacity Building Goals

One goal of MAPP is to help build the collective capacity of our network and connect partners. Organizations wish to grow the following capacities as a part of our partnership:

1. Coalition and Alliance Building: Many organizations wish to strengthen collaborations with partners, connect resources, and build lasting coalitions.
2. Advocacy and Grassroots Lobbying: Expanding their role in advocating for systemic change is a priority for several groups.
3. Community Engagement and Organizing: They seek more effective communication and community involvement to boost awareness of services and build safer environments.
4. Resource Development: More human and capital resources, along with partnerships, are desired to support operations and growth initiatives.

Needs Assessment Practices Among Participating Organizations

n=27

- Over half of participating organizations (56% or 15) conduct needs assessments as part of their work.
    - Of these, 60% (9) share their findings with the collaborative.

Types of Data Collected:

- Demographic information (67%).
- Access and utilization data (52%).
- Service/program evaluation and performance data (48%).
- Data on social determinants of health (SDOH) (41%).

Common Data Collection Methods:

- Surveys (61%).
- Data tracking systems (57%).
- Notes (43%).
- Feedback forms (39%).

Additional Methods:

- Focus groups (35%).
- Secondary data sources (35%).
- Interviews (30%).
- Participatory research (13%).

In terms of data skills, conducting needs assessment (63%) was the strongest skill, followed by survey design and analysis (54%). Half of the respondents had experience in focus group facilitation and interviewing (50% each). Lower levels of skills were noted in detailed notetaking or transcription (42%), participatory research (42%), and facilitating community meetings (46%), Table 1.

Table 1: Data Skills Held by the Organization

Data Skill	Percentage
Conducting needs assessment	63%
Survey design and analysis	54%
Focus group facilitation	50%
Interviewing	50%
Facilitating community meetings	46%
Detailed notetaking or transcription	42%
Participatory research	42%

Shared Growth Opportunities

Expanding coordination between agencies in data collection and advocacy for health equity are areas for shared growth. There is potential for enhancing leadership development within target communities and engaging underrepresented sectors such as private clinics and tribal organizations.

Key Findings of the CPA

10 Essential Public Health Services

The 10 Essential Public Health Services (EPHS) describe the public health activities that all communities should undertake.

To achieve equity, the EPHS actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities

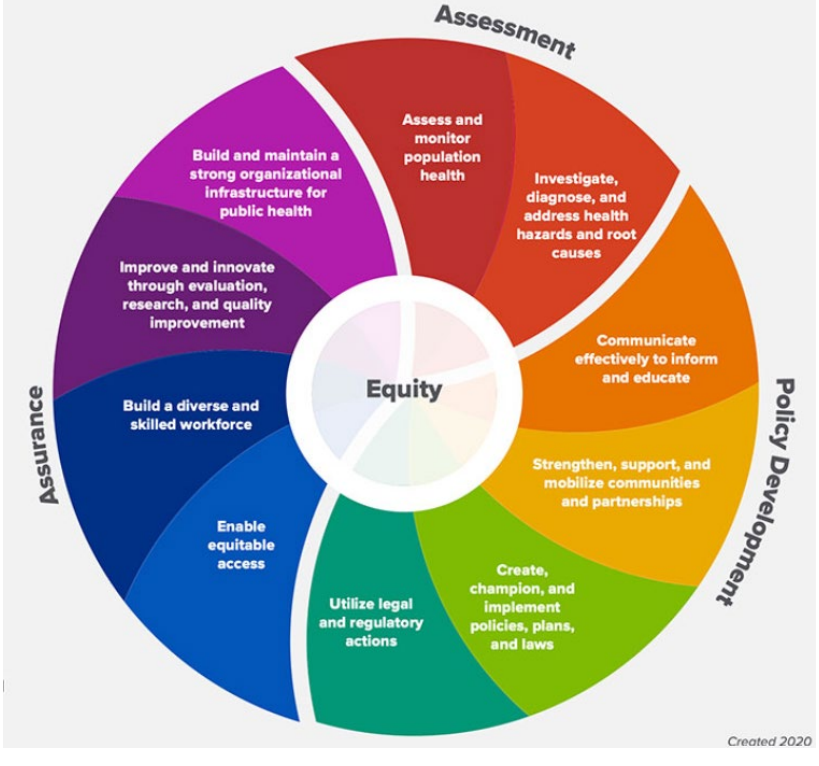

Figure 5: 10 Essential Public Health Services
Source: https://www.cdc.gov/public-health-gateway/php/about/index.html

Areas of Focus

The majority of organizations focus on social determinants of health (Figure 5), education, family well-being, and public health (all 63%). Additionally, disability and independent living are emphasized by 56%. Other notable areas include healthcare access and youth development (48% each), housing (44%), and racial justice (37%).

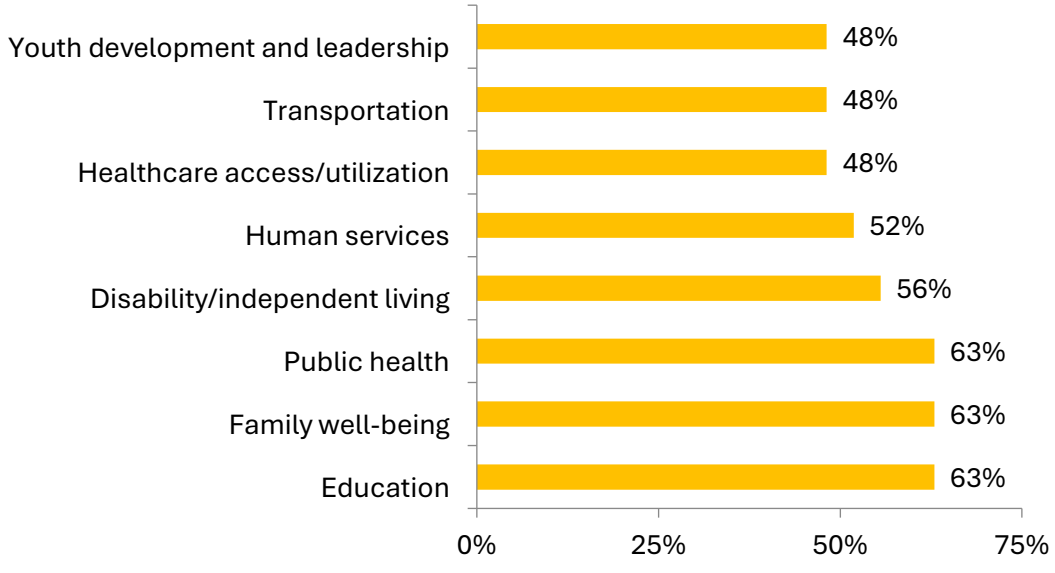

Figure 6: Categories the Organizations Works On/With

Resource Contributions

Organizations can provide a range of resources to support MAPP activities (Table 2), including physical space for meetings (59%), staff time for community engagement (52%), and active participation in MAPP efforts (45%). Additional contributions include social media capabilities (34%), staff time for relationship-building (24%), and policy or advocacy expertise (21%), Table 2. There is also a need for increased support in areas such as funding, media connections, and resources like food or interpretation services.

Table 2: Resources Contributed by the Organization to Support MAPP Activities

Resource Provided by Organizations	Percentage
Physical space for meetings	59%
Staff time for community engagement	52%
Active participation in MAPP efforts	45%
Social media capabilities	34%
Staff time for relationship-building	24%
Policy or advocacy expertise	21%

Summary of Work in Social Determinants of Health

I. **Economic Stability:** A significant **56%** of organizations focus heavily on economic stability, addressing issues such as poverty, employment, food security, and housing stability.

II. **Education Access and Services:** **33%** prioritize education's impact on health extensively, while 48% address it to a lesser extent, covering literacy, high school graduation, and early childhood education.

III. **Healthcare Access and Quality:** **41%** work extensively on improving healthcare access and quality, tackling areas like health services, primary care, insurance, and health literacy. Another 48% engage to a lesser extent.

IV. **Neighborhood and Built Environment:** **52%** place strong emphasis on improving housing quality, transportation access, healthy food availability, and environmental safety.

V. **Social and Community Context:** Focus is evenly split, with **41%** working extensively and another 41% to a lesser degree on community cohesion, civic participation, workplace conditions, and addressing violence and incarceration.

Health Topics and Core Activities

Organizations focus on mental and behavioral health (63%), healthcare access (44%), and health equity (41%). Other areas of focus include family/maternal health, injury and violence prevention, and chronic diseases such as asthma, diabetes, and cardiovascular conditions, Figure 6.

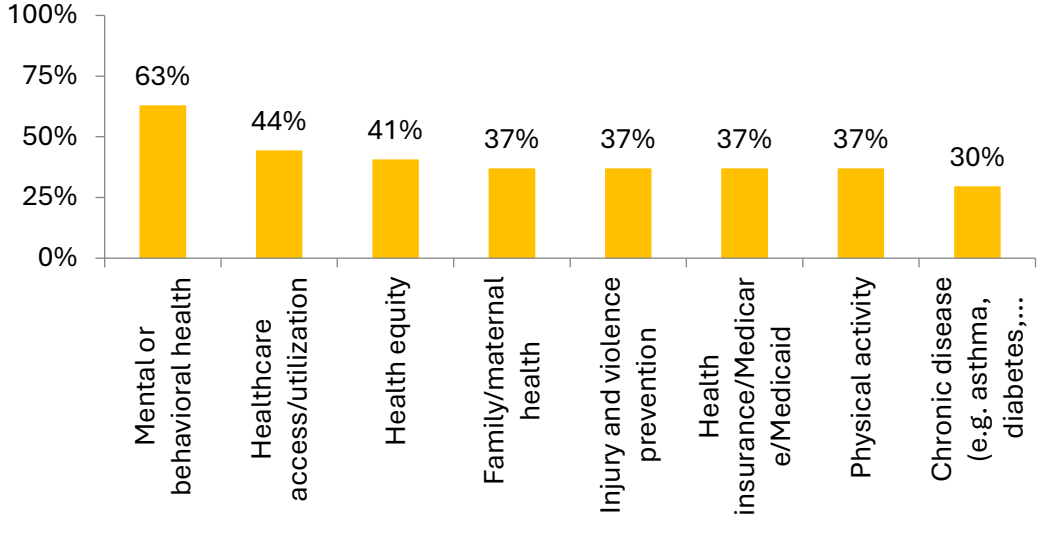

Figure 7: Health Topics Addressed by Organizations

A significant majority (82%) engage in community partnerships to improve health, while others focus on communication and education (74%), policy development (59%), and conducting community assessments (52%). Workforce development and healthcare access are also key areas of focus (52%), Figure 7.

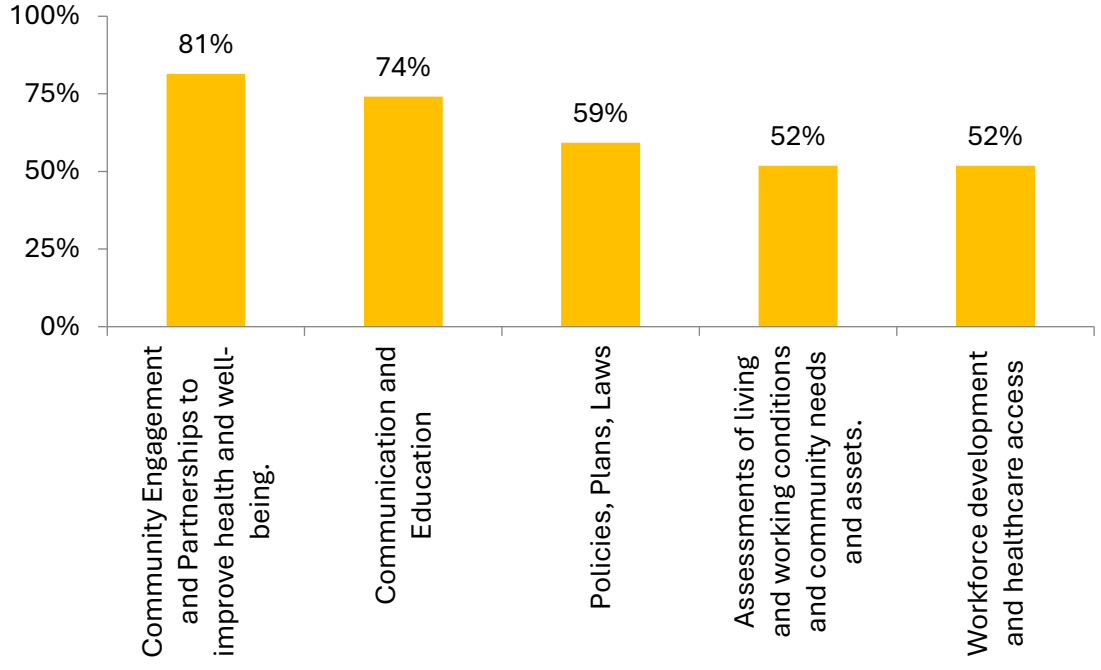

Figure 8: Activities Regularly Conducted by Organizations

Local organizations use various strategies, including community-focused communications (78%), research and policy analysis (74%), and alliance or coalition-building (63%). Many prioritize providing social and health services (56%) and leadership development (56%), Table 3. Other approaches include addressing systemic inequities, advocating for policy change, healing from community trauma, narrative change, and movement-building.

Table 3: Strategies Used by Organizations to Do Their Work

Strategies	Percentage
Community-focused communications	78%
Research and policy analysis	74%
Alliance or coalition-building	63%
Providing social and health services	56%
Leadership development	56%

Capacities Related to 10 Essential Public Health Services

The findings indicate that most organizations prioritize community engagement and partnerships (82%) and communication and education (74%) to enhance health and well-being. Over half focus on policies, plans, and laws (59%), conduct assessments (52%), and support workforce development (52%). Other key activities include evaluation and research (48%), ensuring access to care (44%), and strengthening

organizational infrastructure (44%). Less commonly, organizations engage in hazard investigations (26%) and use legal and regulatory authority (22%) to protect public health, Figure 8.

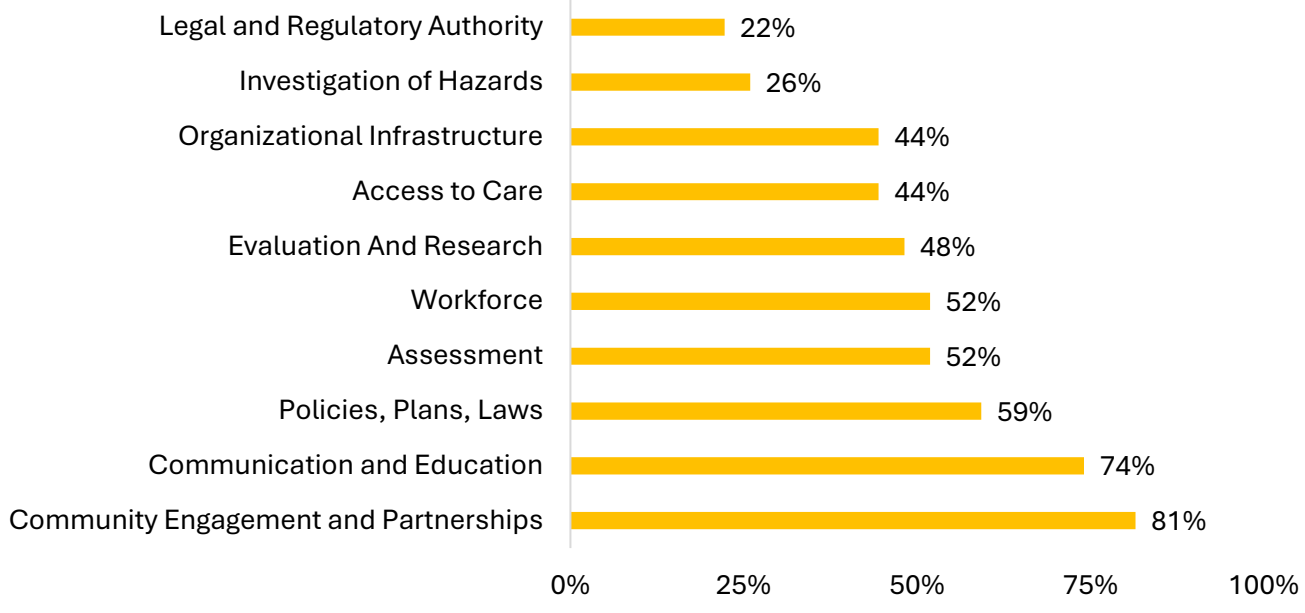

Figure 9: Activities Regularly Conducted by Organizations

The organizations identified their top 1-3 core competencies or strengths as follows:

- **Community Engagement & Partnerships:** Many organizations emphasized the importance of strengthening, supporting, and mobilizing communities to enhance health and well-being.
- **Access to Care:** Ensuring equitable access to healthcare and providing social services was commonly highlighted.
- **Communication & Education:** Educating communities on health and well-being, as well as effectively communicating with the public, was also a key strength.
- **Other competencies:** Additional strengths mentioned included workforce development, policy creation, and program evaluation.

Communications and Community Engagement

Organizations use a variety of communication methods: internal newsletters (59%), external newsletters (52%), and press releases (59%), Table 4. Social media is the most commonly used, with 89% leveraging it for outreach. However, only 22% engage in ethnicity-specific outreach.

Table 4: Communication Methods Used by Organizations

Communication Method	Percentage
Social media outreach (e.g., Facebook, Twitter)	89%
Internal newsletters to staff	59%
Media contact list for press advisories/releases	59%
Press releases/press conferences	59%

Social media is the most commonly used, with 89% leveraging it for outreach. However, only 22% engage in ethnicity-specific outreach.

When it comes to media presence, 85% of organizations believe they have a strong presence. Additionally, 81% report having robust communication infrastructure, and 69% have a clear communication strategy. All partners (100%) acknowledge having good relationships with other organizations, while 80% apply an equity lens to their communications.

Organizations reach and engage with their target populations through various methods:

- **Extensive outreach efforts: 66%**
- **Receiving many clients: 55%**
- **Receiving referrals from target populations: 52%**
- **Located in neighborhoods of target populations: 48%**
- **Hiring staff/interpreters who speak target languages: 45%**
- **Hiring racially/ethnically representative staff: 38%**
- **Supporting leadership development: 31%**
- **External Equity Focus: 78%**

The summary reveals that most organizations (67%) prioritize informing the community by sharing relevant information. Fewer organizations focus on involving the community in decision-making (15%) highlighting a potential need for adoption of a participatory approach. An equal proportion collaborate with community members to build leadership capacity (15%) in implementation of decisions. A small percentage (4%) consult the community for input, and none delegate decision-making to foster community-driven leadership and equity. This indicates that while sharing information is a priority, there is limited emphasis on deeper engagement and democratic participation, Table 5.

Table 5: Community Engagement Practices Implemented by the Organizations

Community Engagement Practices	Percentage
Informing the community	67%
Involving the community in decision-making	15%
Collaborating to build leadership capacity	15%
Consulting the community for input	4%
Delegating decision-making	0%

Table 6 below shows the languages spoken by staff, with the majority of staff speaking English (97%), followed by Spanish (83%). A smaller percentage of staff speak French (31%) and Chinese (24%), while Other languages* are spoken by less than 10% each.

Table 6: Languages Spoken by Staff

Languages Spoken by Staff	Percentage
English	97%
Spanish	83%
French	31%
Chinese	24%
Other languages*	<10% each

** Other languages include Dari, Pashto, Tagalog, Vietnamese, Q'anjob'al, Albanian, Arabic, ASL, Cambodian, German, Ilocano, Laos, Swahili, Kikuyu, Kapampangan, Ilocano.*

Community organizations actively engage with diverse racial and ethnic populations, with the highest engagement among Hispanic/ Latina(o) (93%), Black/African American (90%), and Asian (90%) communities, Table 7. For the LGBTQIA+ community, 90% provide some form of service, including 21% offering dedicated support. Significant efforts also focus on immigrants, refugees, and non-English speakers (76%). For individuals with disabilities, 86% provide some form of service, including 48% offering dedicated support, while 66% offer access to interpretation and translation services.

Table 7: Engagements/ Services Provided by the Organizations

Group	Engagement/Service Provided
Hispanic/ Latina(o)	93%
Black/African American	90%
Asian	90%
LGBTQIA+	90%
People with Disabilities	86%
Immigrants/Refugees/Non-English Speakers	76%
Interpretation/Translation	66%

The priority populations identified in the provided document include:

- Low-income and marginalized groups
- Immigrants, refugees, and asylum seekers
- Residents of Urbana and Champaign, especially those below the poverty line or at the ALICE threshold
- Survivors of sexual violence
- Medical students engaging in community outreach
- Children, adolescents, and pregnant individuals
- Crime victims and historically marginalized communities
- Older adults (60+)
- University of Illinois students

The focus varies across different programs and community needs, emphasizing underserved, low-income, and marginalized populations.

Organizations most commonly engage the community through presentations and social media, both at 70%, Figure 9. Other frequent methods include surveys (56%), fact sheets (52%), and community forums or events (44%). Additional approaches include customer or patient satisfaction surveys, public comments, advocacy, and partnerships with community-based organizations, each at 33%. Less commonly used methods are videos (30%), open houses (26%), billboards (22%), focus groups (22%), and citizen advisory committees (19%). Interactive workshops, community-driven planning, and consensus-building are employed occasionally, while community organizing and polling are rarely used. Participatory budgeting and open planning forums with citizen polling are not utilized.

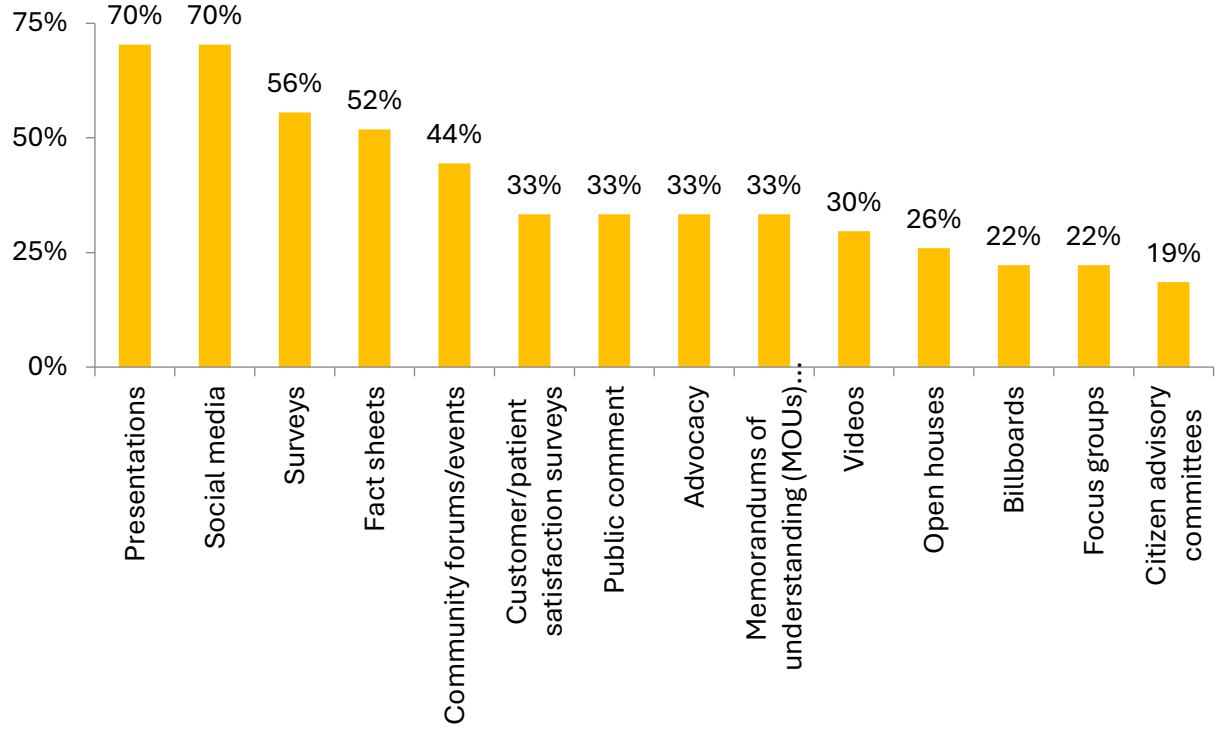

Figure 10: Top Methods of Community Engagement Used by the Organizations

Policy and Advocacy Work

Most organizations focus on educating decision-makers (67%), responding to their requests (52%), and building close relationships with them (48%). Some leverage relationships to gain access to decision-makers (44%), develop policies (30%), or advocate for policy changes (33%). Fewer engage in capacity-building for policy advocacy (15%), lobbying for changes (19%), or mobilizing public opinion (4%). No contributions to political campaigns or PACs were reported, and voter outreach (7%) and legal advocacy (4%) were minimal.

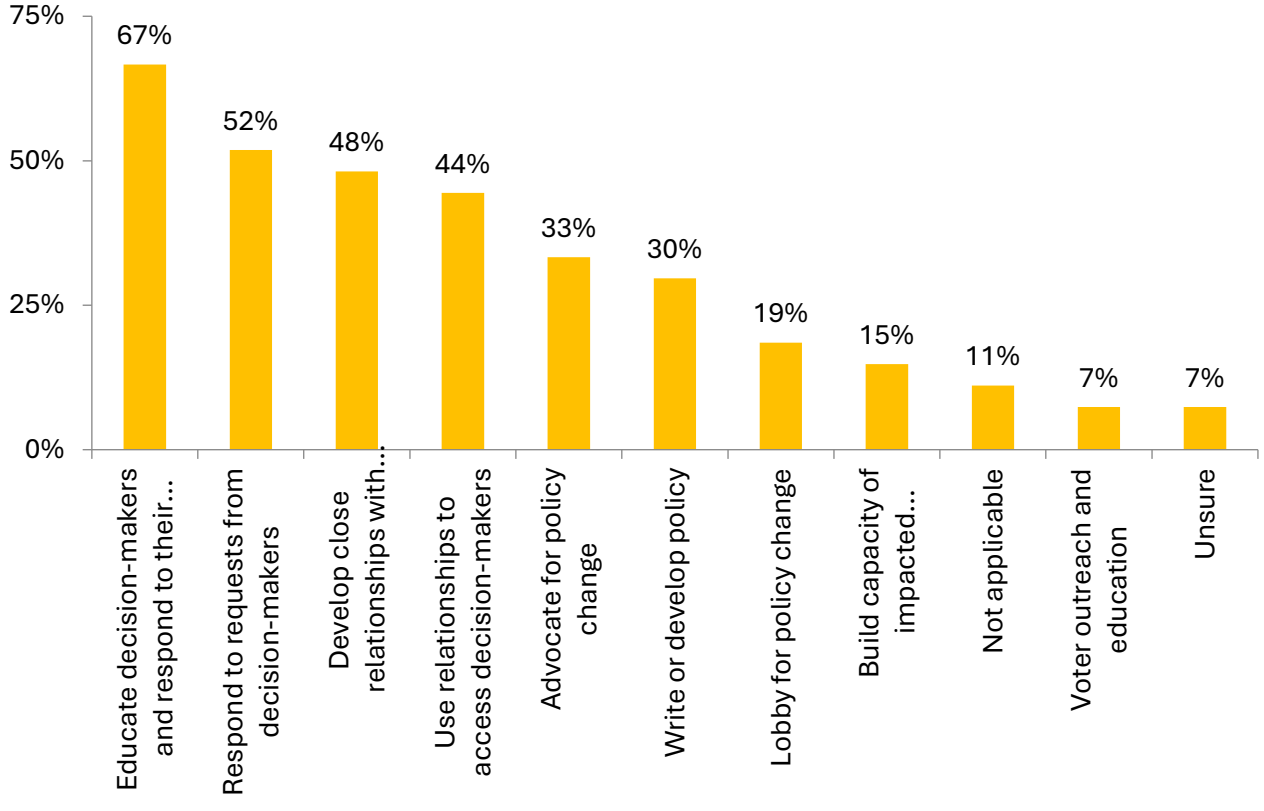

Figure 11: Policy and Advocacy Activities of the Organizations

Conclusion

The Community Partner Assessment (CPA), as part of the 2025 Community Health Improvement Plan, serves as a critical tool for coordinating agencies to achieve shared community health goals. The strong commitment to community engagement and partnerships, particularly in supporting marginalized populations, provides a solid foundation for collective impact. However, there are opportunities to broaden sector engagement, increase community participation in decision-making, and strengthen advocacy efforts for systemic policy change.

Insights from this report, along with the Community Status Assessment, Community Context Assessment, and Community Health Needs Assessment, will inform the development of the 2025 Community Health Improvement Plan. By addressing these gaps and leveraging collective strengths, the CPA can further advance health equity and drive meaningful, community-driven progress toward long-term social change.

Addendum

Click here to access the Champaign County Community Partner Assessment Survey

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Champaign County, IL

PROJECT BUDGET REPORT

FOR 01/01/2025 - 12/31/2025

			Original Budget	Net Budget Amendments	Revised Budget	Requisitions	Encumbrances	Actuals	Available Budget	Percent Used
Project: DisExpo - disABILITY Resource Expo										
E DisExpo	-COMM	-OPER SUPP - Supplies	0.00	2,500.00	2,500.00	0.00	0.00	0.00	2,500.00	0.00%
E DisExpo	-COMM	-STA PRINT - Print	0.00	5,000.00	5,000.00	0.00	0.00	147.10	4,852.90	2.94%
E DisExpo	-COMM	-Uniform - Clothing	0.00	1,000.00	1,000.00	0.00	0.00	0.00	1,000.00	0.00%
TOTALS for Phase/Source: COMM -			0.00	8,500.00	8,500.00	0.00	0.00	147.10	8,352.90	1.73%
F DisExpo	-MISC REV	-OtherMisc - Spons Fee	0.00	-15,000.00	-15,000.00	0.00	0.00	0.00	-15,000.00	0.00%
TOTALS for Phase/Source: MISC REV -			0.00	-15,000.00	-15,000.00	0.00	0.00	0.00	-15,000.00	0.00%
E DisExpo	-SERVICES	-JB REQ TRV- Job Travel	0.00	200.00	200.00	0.00	0.00	11.62	188.38	5.81%
E DisExpo	-SERVICES	-LEGAL ADV - Advert	0.00	5,000.00	5,000.00	0.00	0.00	0.00	5,000.00	0.00%
E DisExpo	-SERVICES	-PR - PR	0.00	500.00	500.00	0.00	0.00	0.00	500.00	0.00%
E DisExpo	-SERVICES	-PROF SVC - Prof Svc	0.00	50,000.00	50,000.00	0.00	0.00	2,500.00	47,500.00	5.00%
E DisExpo	-SERVICES	-Rent - Rentals	0.00	12,500.00	12,500.00	0.00	0.00	0.00	12,500.00	0.00%
TOTALS for Phase/Source: SERVICES -			0.00	68,200.00	68,200.00	0.00	0.00	2,511.62	65,688.38	3.68%
EXPENSE TOTALS for Project: DisExpo - disABILITY Resource Expo			0.00	76,700.00	76,700.00	0.00	0.00	2,658.72	74,041.28	3.47%
FUNDING SOURCE TOTALS for Project: DisExpo - disABILITY Resource Expo			0.00	-15,000.00	-15,000.00	0.00	0.00	0.00	-15,000.00	0.00%
TOTALS for Project: DisExpo - disABILITY Resource Expo			0.00	61,700.00	61,700.00	0.00	0.00	2,658.72	59,041.28	
TOTALS FOR EXPENSE STRINGS			0.00	76,700.00	76,700.00	0.00	0.00	2,658.72	74,041.28	1.09
TOTALS FOR FUNDING SOURCE STRINGS			0.00	-15,000.00	-15,000.00	0.00	0.00	0.00	-15,000.00	0.00

Champaign County, IL

PROJECT BUDGET REPORT

FOR 01/01/2025 - 12/31/2025

Original Budget	Net Budget Amendments	Revised Budget	Requisitions	Encumbrances	Actuals	Available Budget	Percent Used

REPORT TOTAL

Original Budget	Net Budget Amendments	Revised Budget	Requisitions	Encumbrances	Actuals	Available Budget
0.00	61,700.00	61,700.00	0.00	0.00	2,658.72	59,041.28

CCMHB 2025 Board to Board Liaison

	Jane Sprandel	Kyle Patterson	Chris Miner	Elaine Palencia	Emily Rodriguez	Jon Paul Youakim	Joe Omo-Osagie	Molly McLay	Anthony Nichols
Courage Connection (4th Mon., 5:30pm)									
CCRPC (Head Start and Community Services)									
Cunningham Children's Home (meets qtrly)									
Children's Advocacy Ctr (4th Thurs., 9 am)									
CC Health Care Consumers(4th Thurs., 6 p.m.)									
Christian Health Center (last Sat., 10 a.m.)									
Community Service Ctr (3rd Thurs., 4:30 pm)									
Crisis Nursery (2nd Wed., 5:30 pm)									
CU at Home (4th Wed., 8 am)									
CU Early (Unit 116 mtg)									
Don Moyer (3rd Tues., 7 am)									
DSC (4th Thurs., 5:30 pm)									
ECIRMAC (Refugee Ctr (2nd Tues., 4 pm)									
Family Service (2nd Mon., noon)									
First Followers (generally 3rd Fri., 5 pm)									
GCAP (??)									
GROW in IL (last Mon., 7 pm)									
Promise Healthcare (4th Tues., 6 pm)						X			
RACES (3rd Thurs., 6 pm)									
Rosecrance (last Tues, 4:30 pm)									
Terrapin Station Sober Living									
UP Center (2nd Wed., 6:30 pm)									
WIN Recovery (2nd Monday, 5:30 p.m.)									
Expo Committees (various)	X								
Community Coalition (2nd Wed., 3:30pm)				X					
Student Mental Health Collab (1st Mon., 11AM, in person 2-3x/semester)								X	