**CHAMPAIGN COUNTY MENTAL HEALTH BOARD**

**CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY**

***PLEASE REMEMBER this meeting is being audio recorded.***
***Speak clearly into the microphone during the meeting.***

# Champaign County Developmental Disabilities Board (CCDDB) AGENDA

**Wednesday, March 20, 2019**
Brookens Administrative Building, Lyle Shields Room
1776 E. Washington St., Urbana, IL 61802
**8 AM**

1. Call to Order
2. Roll Call
3. Approval of Agenda*
4. Citizen Input/Public Participation
   *At the chairperson's discretion, public participation may be limited to five minutes per person.*
5. President's Comments – Ms. Deb Ruesch
6. Executive Director's Report – Lynn Canfield
7. Approval of CCDDB Board Meeting Minutes* **(pages 3-6)**
   *Minutes from 02/20/19 are included. Board action is requested.*
8. Financial Information* **(pages7-8)**
   *A copy of the claims report is included in the packet. Action is requested.*
9. New Business
   A. Community Choices Matching Funds Request* **(pages 9-20)**
      *A Decision Memorandum requesting approval of matching funds for an Illinois Council on Developmental Disabilities grant. Action is requested.*
   B. Program Year 2018 Service Activity Data, I/DD **(pages 21-30)**
      *A Briefing Memorandum detailing specific services delivered and offering limited insight into the actual cost of I/DD services is included for information only.*
   C. Update on Legislative and Policy Conferences **(pages 31-49)**
      *A Briefing Memorandum summarizing activities of the March 2019 NACBHDD and NACO Legislative and Policy Conferences is included in the packet for information only.*
   D. Board Direction
      *This item supports board discussion of planning and funding. No action is requested.*

E. Successes and Other Agency Information

*Funded program providers and self-advocates are invited to give oral reports on individuals' successes. At the chairperson's discretion, other agency information may be limited to five minutes per agency.*

10. Old Business

A. Meeting Schedules **(pages 50-53)**

*Copies of CCDDB and CCMHB meeting schedules and CCDDB allocation process timeline are included in the packet for information.*

B. Acronyms **(pages 54-60)**

*A list of useful acronyms is included for information.*

11. CCMHB Input

12. Staff Reports

*Reports from Kim Bowdry* **(pages 61-67)**, *Stephanie Howard-Gallo* **(page 68)**, *Chris Wilson* **(pages 69-70)**, *and Shandra Summerville* **(pages 71-72)** *are included for information.*

13. Board Announcements

14. Adjournment

**Board action requested*

7

# *CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY (CCDDB)*
# *BOARD MEETING*

*Minutes –February 20, 2019*

*Brookens Administrative Center*
*Lyle Shields Room*
*1776 E. Washington St.*
*Urbana, IL*

*8:00 a.m.*

| | |
|---|---|
| **MEMBERS PRESENT:** | William Gingold, Gail Kennedy, Deb Ruesch |
| **MEMBERS EXCUSED:** | David Happ, Cheryl Hanley-Maxwell |
| **STAFF PRESENT:** | Kim Bowdry, Lynn Canfield, Stephanie Howard-Gallo, Chris Wilson, Shandra Summerville |
| **OTHERS PRESENT:** | Danielle Matthews, Ron Bribriesco, Laura Bennett, Dale Morrissey, Vickie Tolf, Annette Becherer, Jenna Mathews, Patty Walters, Developmental Services Center (DSC); Lisa Benson, Katie Harmon, Elise Belknap, Regional Planning Commission (RPC); Becca Obuchowski, Community Choices; Kathy Kessler, Rosecrance, Inc., Amy Slagell, CU Able; Imelda Liong, PACE |

## CALL TO ORDER:

Ms. Deb Ruesch, CCDDB President called the meeting to order at 8:00 a.m.

## ROLL CALL:

Roll call was taken and a quorum was present.

## APPROVAL OF AGENDA:

The agenda was in the packet for review. The agenda was approved.

**CITIZEN INPUT:**

None.

**PRESIDENT'S COMMENTS:**

Ms. Ruesch discussed the new minimum wage increase in Illinois.

**EXECUTIVE DIRECTOR'S COMMENTS:**

Ms. Canfield discussed DSP wages and the minimum wage increase. She also reviewed the application review process.

**APPROVAL OF CCDDB MINUTES:**

Minutes from the January 23, 2019 meeting were included in the Board packet.

> **MOTION: Dr. Gingold moved to approve the meeting minutes from January 23, 2019. Dr. Kennedy seconded the motion. The motion passed unanimously.**

**FINANCIAL INFORMATION:**

A copy of expenditures was included in the Board packet.

> **MOTION: Dr. Gingold moved to approve the claims report as presented. Dr. Kennedy seconded the motion. The motion passed unanimously.**

**NEW BUSINESS:**

**Mid-Year Progress Report:**
Imelda Liong from Persons Assuming Control of their Environment (PACE) provided a progress report on the Consumer Control in Personal Support Program. A copy of her presentation was distributed. Board members were given an opportunity to ask questions.

**Early Payoff of CILA Mortgage:**
A Decision Memorandum on paying off the CILA Mortgage early was included in the packet. The memorandum gave a history of the original purchases and an overview of financial information. In addition to the CCMHB paying off the CILA mortgage, the CCDDB is being requested to review and approve necessary modifications to the Intergovernmental Agreement between the CCDDB and the CCMHB.

**MOTION: Ms. Ruesch moved to authorize the Executive Director to complete the changes to the 2019 CILA fund as described in the Decision Memorandum, in order to facilitate early payoff of the mortgage by the CCMHB. Dr. Kennedy seconded the motion. A roll call vote was taken. The motion passed unanimously.**

**MOTION: Ms. Ruesch moved to authorize, by the President's signature, revisions to the Addendum to Intergovernmental Agreement between the CCDDB and the CCMHB, provided the CCMHB agrees to the same provisions. Dr. Kennedy seconded the motion. A roll call vote was taken. The motion passed unanimously.**

**Nomination for National Association of Counties 2019 Achievement Award:**
A Decision Memorandum authorizing the Executive Director to complete a nomination for a NACO Achievement Award was included in the Board packet.

**MOTION: Ms. Ruesch moved to authorize the Executive Director to complete the nomination of the Independent Service Coordination Unit's program for a NACO 2019 Achievement Award. Dr. Kennedy seconded the motion. A voice vote was taken and the motion passed unanimously.**

**MOTION: Ms. Ruesch moved to authorize, by the President's signature, an attached Joint Letter of Support as supplement to the nomination. Dr. Kennedy seconded the motion. A voice vote was taken and the motion passed unanimously.**

**FY2020 Application for Funding:**
A list of applications by priority for FY2020 funding for I/DD programs was included in the Board packet.

**Board Direction:**
No discussion.

**Successes and Agency Information:**
Annette Becherer from DSC shared some success stories. Dale Morrissey discussed the minimum wage increase in Illinois.

**OLD BUSINESS:**

**PY2019 2nd Quarter Service Data:**
Second Quarter I/DD hours of direct service reported in all funded programs was included in the Board packet.

**PY2019 2nd Quarter Program Reports:**
Second quarter reports were included in the packet for information only.

**Meeting Schedules:**
Copies of the CCDDB and CCMHB meeting schedules were included in the packet for information only.

**Acronym Sheet:**
A list of useful acronyms was included for information only.

**CCMHB Input:**
The CCMHB will meet this evening. The CCMHB will vote on the CILA Decision Memorandum and the NACO Decision Memorandum. The CCMHB will elect new officers.

## STAFF REPORTS:

Staff reports from Kim Bowdry and Stephanie Howard-Gallo were included in the packet for review.

## BOARD ANNOUNCEMENTS:

None.

## ADJOURNMENT:

The meeting adjourned at 9:00 a.m.
Respectfully Submitted by: Stephanie Howard-Gallo

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

| VENDOR NO | VENDOR NAME | TRN DTE | B N | TR CD | TRANS NO | PO NO | CHECK NUMBER | CHECK DATE | ACCOUNT NUMBER | ACCOUNT DESCRIPTION | ITEM DESCRIPTION | EXPENDITURE AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *** FUND NO. 108 | DEVLPMNTL DISABILITY FUND | | | | | | | | | | | |
| *** DEPT NO. 050 | DEVLMNTL DISABILITY BOARD | | | | | | | | | | | |
| 90 | CHAMPAIGN COUNTY TREASURER | | | | | | | | MENT HLTH BD FND 090 | | | |
| | | 2/04/19 | 02 | VR | 108- 19 | | 587708 | 2/13/19 | 108-050-533.07-00 | PROFESSIONAL SERVICES | FEB ADMIN FEE | 28,129.00 |
| | | | | | | | | | | | VENDOR TOTAL | 28,129.00 * |
| 161 | CHAMPAIGN COUNTY TREASURER | | | | | | | | REG PLAN COMM FND075 | | | |
| | | 2/04/19 | 02 | VR | 108- 11 | | 587713 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB DECISION SUPPOR | 9,969.00 |
| | | | | | | | | | | | VENDOR TOTAL | 9,969.00 * |
| 11587 | CU ABLE | | | | | | | | | | | |
| | | 2/04/19 | 02 | VR | 108- 13 | | 587745 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB COMM OUTREACH | 1,273.00 |
| | | | | | | | | | | | VENDOR TOTAL | 1,273.00 * |
| 18203 | COMMUNITY CHOICE, INC | | | | | | | | SUITE 419 | | | |
| | | 2/04/19 | 02 | VR | 108- 14 | | 587767 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB COMMUNITY LIVIN | 6,041.00 |
| | | 2/04/19 | 02 | VR | 108- 14 | | 587767 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB CUSTOM EMPLOY | 7,250.00 |
| | | 2/04/19 | 02 | VR | 108- 14 | | 587767 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB SELF DETERMINAT | 9,666.00 |
| | | | | | | | | | | | VENDOR TOTAL | 22,957.00 * |
| 22300 | DEVELOPMENTAL SERVICES CENTER OF | | | | | | | | CHAMPAIGN COUNTY INC | | | |
| | | 2/04/19 | 02 | VR | 108- 15 | | 587786 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB APARTMENT SVCS | 35,821.00 |
| | | 2/04/19 | 02 | VR | 108- 15 | | 587786 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB CLINICAL SVCS | 14,500.00 |
| | | 2/04/19 | 02 | VR | 108- 15 | | 587786 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB COMMUNITY EMPLO | 30,114.00 |
| | | 2/04/19 | 02 | VR | 108- 15 | | 587786 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB COMMUNITY FIRST | 66,583.00 |
| | | 2/04/19 | 02 | VR | 108- 15 | | 587786 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB CONNECTIONS | 7,083.00 |
| | | 2/04/19 | 02 | VR | 108- 15 | | 587786 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB EMPLOYMENT FIRS | 6,667.00 |
| | | 2/04/19 | 02 | VR | 108- 15 | | 587786 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB INDIV/FAMILY SU | 33,702.00 |
| | | 2/04/19 | 02 | VR | 108- 15 | | 587786 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB SERVICE COORD | 34,237.00 |
| | | | | | | | | | | | VENDOR TOTAL | 228,707.00 * |
| 22816 | DOWN SYNDROME NETWORK | | | | | | | | | | | |
| | | 2/04/19 | 02 | VR | 108- 12 | | 587788 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB DOWN SYNDROME | 1,250.00 |
| | | | | | | | | | | | VENDOR TOTAL | 1,250.00 * |

| VENDOR NO | VENDOR NAME | TRN DTE | B N | TR CD | TRANS NO | PO NO | CHECK NUMBER | CHECK DATE | ACCOUNT NUMBER | ACCOUNT DESCRIPTION | ITEM DESCRIPTION | EXPENDITURE AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *** FUND NO. 108 DEVLPMNTL DISABILITY FUND | | | | | | | | | | | | |
| 54930 | PERSONS ASSUMING CONTROL OF THEIR ENVIROMENT, INC | | | | | | | | | | | |
| | | 2/04/19 | 02 | VR | 108- 16 | | 587863 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB CONSUMER CONROL | 1,750.00 |
| | | 2/04/19 | 02 | VR | 108- 16 | | 587863 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB OP FOR INDEPEND | 4,083.00 |
| | | | | | | | | | | | VENDOR TOTAL | 5,833.00 * |
| 61780 | ROSECRANCE, INC. | | | | | | | | | | | |
| | | 2/04/19 | 02 | VR | 108- 17 | | 587886 | 2/13/19 | 108-050-533.92-00 | CONTRIBUTIONS & GRANTS | FEB COORD SVC DD/MI | 2,929.00 |
| | | | | | | | | | | | VENDOR TOTAL | 2,929.00 * |
| | | | | | | | | | | DEVLMNTL DISABILITY BOARD | DEPARTMENT TOTAL | 301,047.00 * |
| | | | | | | | | | | DEVLPMNTL DISABILITY FUND | FUND TOTAL | 301,047.00 * |
| | | | | | | | | | | | REPORT TOTAL ***** | 634,726.91 * |

8

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY

# DECISION MEMORANDUM

Date: March 20, 2019
To: Members, Champaign County Developmental Disabilities Board
From: Kim Bowdry, Associate Director
Subject: Community Choices Matching Funds Request

## Background

Over the past two years, Community Choices members and staff have worked towards creating a guide and training for health care professionals. The training has been provided to local providers on how to best support and interact with patients who have I/DD.

Community Choices has applied for a two-year grant from the Illinois Council on Developmental Disabilities (ICDD) to provide funding to continue and expand on Self-Advocates' work and training with local health care professionals. The Executive Director of Community Choices has written a formal request (attached) for the CCDDB to provide 21% matching funds towards the budget of the project.

Also attached are the Notice of Funds Available (RFP) from ICDD, the Community Choices budget summary, and "The Health Care Professionals' Guide to Working with Patients with Developmental Disabilities."

## Impact

Community Choices has requested $71,000 from the Illinois Council on Developmental Disabilities to finance this project over two years. The program total budget is $90,000. The request for the CCDDB is to allow Community Choices to reserve $19,000 from the FY20 CCDDB grant for matching funds from FY20 for the ICDD grant. If awarded the ICDD grant, Community Choices would then decrease the total request from the CCDDB for the Self-Determination Support funds for FY20 from $138,000 to $119,000. This would ensure program continuity without an assumption of future funding from the CCDDB.

Funding from the ICDD would allow Community Choices to expand on the work currently being done with health care professionals in the Self-Determination Support program. Newly developed personalized tools for people with I/DD, to use when working with people supporting them, will be presented and taught during workshops co-led and taught by self-advocates. Community Choices will collaborate with health care providers to use these tools to address the rights and needs of patients with I/DD.

## Decision Section

Motion to approve the match of $19,000 as described in the attached document and contingent upon the award of the Illinois Council on Developmental Disabilities grant:

_______ Approved
_______ Denied
_______ Modified
_______ Additional Information Needed



BROOKENS ADMINISTRATIVE CENTER • 1776 E. WASHINGTON STREET • URBANA, ILLINOIS 61802

PHONE (217) 367-5703 • FAX (217) 367-5741

March 7th, 2019

Dear CCDDB/CCMHB Staff and Board,

Community Choices is in the process of applying for a two-year grant from the Illinois Council on Developmental Disabilities (ICDD) that would provide funding for the continuation of a Medical Advocacy project focusing on the rights and interactions people with I/DD have with healthcare professionals. For the past two years CC members with disabilities and staff have been working to develop a Health Care Professionals guide and provide training to local providers on how best to support and interact with patients who have I/DD. The new project would involve the development of personalized tools for people with I/DD to design with the support people in their lives. These will be presented and taught during workshops co-lead by self-advocates. We will also collaborate with local healthcare providers to give them a better context and better tools for addressing the rights and needs of their patients with I/DD.

We are excited at the possibility of being able to build on our previous work and hopeful that the Champaign County Developmental Disabilities Board will support us in doing so. The grant from ICDD requires 20% matching funds toward the total project budget. We will be requesting $71,000 from the ICDD to fund this project over 2 years. **Our request to the board is that, should our Self-Determination grant be funded in future years (FY20 and FY21), you allow us to use $9,500 of approved CCDDB funding from each year's grant as matching funds – a total of $19,000. Additionally, should we be awarded the ICDD funding, we would also decrease our total request for Self-Determination funds for FY20 from $138,000 to $119,000.**

Funding from the CCDDB, through our Self-Determination grant, has allowed us to build the capacity to take on projects like this Medical Advocacy grant and continues to allow us to invest in our members with I/DD to provide them with the support, connection, and resources necessary to do meaningful advocacy work. We hope that you will see this as an opportunity for Community Choices to leverage our local dollars to bring in additional funding sources, continue to develop as an organization and affect larger systems through innovative projects and initiatives.

Attached you will find a copy of the ICDD Call for Investment as well as the *Health Care Professionals' Guide to Working with Patients with Developmental Disabilities*. This guide was developed in FY18 and FY19 by self-advocates working with Community Choices and local healthcare providers. It will be the basis for ongoing work on the ICDD project. We are happy to provide any additional documentation needed or requested by the CCDDB Board or Staff to consider this request.

Respectfully,

Rebecca Obuchowski
Executive Director



44 E Main, Suite 419, Champaign IL 61820 • (217) 621-1090 • www.communitychoicesinc.org

# THE HEALTHCARE PROFESSIONALS' GUIDE TO WORKING WITH PATIENTS WITH DEVELOPMENTAL DISABILITIES

| GOAL | WHAT PATIENTS CAN DO | WHAT HCPS CAN DO | WHAT SUPPORT PEOPLE CAN DO |
|---|---|---|---|
| **HCPS UNDERSTAND THAT I HAVE A ROLE AND VOICE IN MY HEALTHCARE - IT'S MY BODY** | Make a list of questions ahead of time (prioritize items before you come)<br>Give a list of questions/topics to the tech when you are just starting an appointment<br>Bring a medicine list or pill bottles - this saves lots of time for other issues and conversation<br>Write down symptoms experienced and when ahead of time | Communicate to the patient that you are there for them<br>Encourage the patient to be honest | Ask the patient before hand how they want you to be involved<br>Let the patient explain who the support person is and why you are there<br>Help the patient prepare for the appointment<br>Help review with the patient after the appointment |
| **HCPS ADJUST TO HOW I COMMUNICATE AND RESPOND IN A WAY I CAN UNDERSTAND** | Find a communication style that works for you and practice how it can help at an appointment<br>Bring communication tools with you<br>Help HCPs understand why you are using a communication support and how it works<br>Request a 30 minute appointment and explain that a communication need is a reason for it<br>Use automated systems to send messages to providers ahead of appointments (48-72 hours ahead) | Use pictures to help explain things<br>Use notes to record important information about the patient's communication preferences - bring in the support staff to help make this possible<br>OK a 30 minute appointment when people need more time to communicate<br>Connect with nurses and other office support people about when someone might have communication needs<br>Ask patients if they need more time to process or consider options<br>Slow down and explain things using plain language without being patronizing. Be patient and kind<br>Let the patient know that you understood what they are saying or communicating | Help the patient prepare for the appointment<br>Talk with the patient about supporting them to use an online communication portal<br>Use automated systems to send messages to providers ahead of appointments (48-72 hours ahead)<br>Take notes during the appointment<br>Help review with the patient after the appointment |
| **HCPS FOCUS ON ME AND USE MY SUPPORT PEOPLE AS A RESOURCE NOT A STAND-IN FOR ME** | Make sure the doctors know who they have permission to talk to<br>Let the clinic know that you will need someone or some support during your appointment - have them add it to an appointment note | Find a way to talk to the patient alone and ask them what they want<br>Ask the patient who you have permission to talk to<br>Help other HCPs when a patient and support person might not agree on something<br>Be open with patients about when and why support people can and cannot be present | Ask the patient before hand how they want you to be involved<br>Let the front desk or office staff know you are available to support someone<br>Let the patient explain who the support person is and why they are there |

**PLEASE UNDERSTAND HOW MY DISABILITY COULD AFFECT MY CARE, BUT TREAT ME LIKE ANYONE ELSE.**

| Expenses | Column A Total Column Expenses | Column B Council Funds Requested | Column C Match Funding |
|---|---|---|---|
| Salary/Wages | $ 71,510 | $ 54,000 | $ 17,510 |
| Benefits | $ 10,300 | $ 10,000 | $ 300 |
| Consultant/Contractual Fees | $ 1,100 | $ 700 | $ 400 |
| In-State Transportation | $ 1,200 | $ 1,200 | $ - |
| Out-of-State Transportation | $ - | | |
| Printing | $ - | | |
| Publications | $ 500 | $ 500 | |
| Postage | $ - | | |
| Consumable Supplies | $ 1,200 | $ 1,200 | |
| Equipment Rental/Maintenance | $ - | | |
| Telephone/FAX/Internet | $ 600 | $ 600 | |
| Occupancy | $ 2,390 | $ 1,600 | $ 790 |
| Equipment Purchases | $ - | | |
| Indirect Costs | $ 1,200 | $ 1,200 | |
| Miscellaneous | $ - | | |
| **Grand Total** | $ 90,000 | $ 71,000 | $ 19,000 |
| | | | $ 9,500.00 Per Year for 2 Years |

**Please ensure that the percentage of Council Funds Requested and the percentage of Total Match Funds equals 100%.**

| | | |
|---|---|---|
| Total Council Funds Requested (B) | $71,000.00 | *79%* |
| Total Match Funds ( C) | $19,000.00 | *21%* |
| Total Project Expenses (A) | $90,000.00 | *100%* |

| *Community Choices FY20 Budget* | SD - County | ICDD Match | New FY20 DDB |
|---|---|---|---|
| **INCOME** | | | |
| Fundraising/Small Grants | | | |
| Special Events | | | |
| Grants | | | |
| CCMHB/CCDDB | 138,000 | | 119,000 |
| CCDDB Subcontract: E1st | | | |
| ICDD | | | |
| Fee for Service | | | |
| Illinois - Home-based Services | | | |
| Illinois - Employment | | | |
| Private Pay | | | |
| TOTAL INCOME | 138,000 | | 119,000 |
| **EXPENSES** | | | |
| Employee Salaries | 104,377 | 17,510 | 86,867 |
| BENEFITS TOTAL: | 18,182 | 300 | 17,882 |
| TOTAL Professional Fees | 5,541 | 400 | 5,141 |
| Staff Training/Conferences | 700 | | 700 |
| Supplies/Consumables | 2,300 | | 2,300 |
| Occupancy | 3,500 | 790 | 2,710 |
| General Operating | 2,000 | | 2,000 |
| Transportation | 1,400 | | 1,400 |
| TOTAL EXPENSES | 138,000 | 19,000 | 119,000 |

# Notice of Funds Available (RFP)

Illinois Council on Developmental Disabilities

## 19 - Medical Advocacy: Medical Advocacy: Understanding Rights and Interactions with People with Intellectual and Developmental Disabilities

### Specifications

| Posted | Applications Due | Start Date | End Date | Amount | Match | Poverty Match | Council Staff |
|---|---|---|---|---|---|---|---|
| Feb 27, 2019 | Mar 20, 2019 | Jun 01, 2019 | May 31, 2021 | $200,000.00 | $0.01 | $0.00 | Margaret Harkness |

### General Information

A Call for Investment (CFI) is the way the Council asks for proposals for projects that will help the Council achieve the goals outlined in its five–year state plan.

The Council has given you an outcome for the project and you will need to submit a proposal using a web based system called DD Suite (www.ddsuite.org)

Staff Contact:
If you have any questions regarding the CFI packet or using DD Suite, please contact Margie Harkness at (312) 814-2080 or Margaret.Harkness@Illinois.gov.

Informational Webinar:
An informational conference call will be held on Friday, February 15, 2018 from 10:00 to 11:00 AM (CDT).

We will go through the process of how to send in a proposal using DD Suite. You can also ask questions about the CFI during the call.

There are some things you will need to do before the informational conference call:

First – sign up for the conference call.

Contact Theresa Casson at
Voice: 217-782-9696
TTY: 888-261-2717
FAX: 217-524-5339
e-mail: Theresa.casson@illinois.gov

Second – Get an account on DD Suite. For instructions, on www.ddsuite.org click the Help icon at upper right. Under the Contents list, choose “Accounts and Organizations”. If you have trouble or have questions, please call Margie Harkness (312) 814-2080 or Margaret.Harkness@Illinois.gov

If you need information in alternate format, or require an accommodation, contact Theresa Casson at least one week in advance.

Please RSVP for the webinar by Wednesday, February 13, 2018.
Call in information will be e-mailed on Thursday, February 14, 2018.

## Council Mission and Performance Objective

The mission of the Illinois Council on Developmental Disabilities (hereafter referred to as "The Council") is to help lead change in Illinois so all people with intellectual/developmental disabilities exercise their right to equal opportunity and freedom.

The Council's vision is that "every person in Illinois has the same rights, opportunities, and the ability to exercise choices so they can achieve self-worth and personal fulfillment in all aspects of life."

The Council recognizes that healthcare provision is changing rapidly and remains one of the top concerns identified by people with developmental disabilities for many reasons. People face barriers on an individual basis finding insurance, locating doctors and therapists, getting appointments, finding offices that are fully accessible, being treated respectfully, getting treatment recommendations in an understandable way, following prescriptions and referrals, keeping treatment coordinated between providers, etc. Many people are encountering changes in the field such as telehealth, walk-in clinics, managed care, physician's assistants and need to learn to navigate these new options. Managed care comes with requirements to understand. Healthcare providers may not have sufficient training in treating people with intellectual and developmental disabilities, nor the knowledge of resources and referrals which would be beneficial. Time is always critical, so that having ready access to referral information and a thoughtful approach to communicating treatment recommendations is needed. Strategies to assess and serve people with intellectual and developmental disabilities and ensure their buy-in and compliance to recommendations are often helpful to many other if not all patients.

Within Illinois, there are 203,188 people with intellectual and developmental disabilities (2015 census information). All need quality healthcare like anyone else.

The Council welcomes proposals that tie into the following Objective from our current 2017-2021 Five Year State Plan. The Council expects projects to begin by June 2019 and end within 2 years.

Council Objective:

By September 30, 2011, individuals with intellectual and developmental disabilities, their families, and other stakeholders will have access to coordinated, streamlined information about services, supports, and other assistance.

This CFI targets (apply for either or both):

A. Individuals with IDD and their family members will know their rights and have the information they need to get their medical care needs adequately and sensitively met.

B. Healthcare professionals and/or office staff have knowledge and ready access to information so they effectively and sensitively communicate with patients with IDD and provide quality healthcare service, and can quickly access information such as how to assure healthcare coverage and referrals so the patient is able to follow treatment recommendations.

## Givens

Givens for Target A:

1. Proposers describe who they plan to empower and what part of the state will be targeted if not statewide. Projects that either specifically or as a sub-effort target unserved or underserved groups, such as Spanish speaking people are welcomed.
2. Projects build new capacity in Illinois for training and information provision that remains after the project with ICDD ends. Describe how these educational opportunities and information will be most widely disseminated and become an accessible knowledge base to those who need and want that information. The Council desires products which will be available beyond a one-time training.
3. Individuals and family members will have access to information and self-advocacy skills to empower them to access healthcare meeting the needs of the person with IDD. Describe the means by which they will get this information in a way so that they are able to understand and act using it.
4. Information shared will include:

- Rights in medical care
- Effectively getting care in various settings as healthcare provision shifts to include walk-in clinics, telehealth, physician assistants and nurse practitioners.
- Ensuring coordination of care and that medical providers have necessary medical histories.
- How to advocate and get what is needed by interactions with doctors and others such as office staff, pharmacists, and managed care coordinators.
- Understanding the basics of what to look for in a health care plan and enrolling in a plan of choice

Givens for Target B:

1. Proposers describe who they plan to reach (healthcare provider, related staff) and what part of the state will be targeted if not statewide.
2. Projects build new capacity in Illinois for training and information provision that remains after the project with ICDD ends. Describe how educational opportunities and information will be most widely disseminated and become an accessible knowledge base to those who need and want that information.
3. Healthcare providers (health coordinators, office staff, etc.) will be educated to effectively and sensitively communicate with patients with IDD. They will have ready access to information allowing them to assist their patients to access healthcare and follow treatment recommendations. Describe the means by which they will get this information in a way so that the medical practice demonstrates sensitivity and ability to meet the healthcare needs of its patients with IDD.
4. Information shared will include:

- Rights of people with IDD in medical care – to have their assent/consent if at all possible even if there is a guardian or healthcare power of attorney
- Disability etiquette and accessible office
- Ensuring coordination of care and that all relevant heath information is available to every provider working with the person.
- Basic knowledge of services and supports for PWIDD so referrals can be made as needed to facilitate treatment compliance.

## Assumptions

Resources and curricula are readily available, so needn't be developed from scratch. See attachment 7 with some projects and materials known to Developmental Disability Councils.

## General Requirements for Proposals

The Council requests that you follow our policies. These may be viewed at https://www.illinois.gov/icdd/Pages/Council.aspx or you may request a hard copy by contacting our receptionist at 217-792-9696.

All Council projects must promote integration/inclusion of people with intellectual and developmental disabilities.

The Council follows the federal definition of intellectual and developmental disabilities. If you are not familiar with it, please refer to the Additional Information attachment. Customers included in your performance target must meet this definition.

The Council also encourages outreach to unserved and underserved populations. These include individuals from racial and ethnic minority backgrounds, disadvantaged individuals, individuals with limited English proficiency, and individuals from underserved geographic (rural and urban) and poverty areas.

Proposers must sign, scan, and attach the signature page with your application – See attachment in DD Suite.

## Portfolio

The Council hopes to invest in multiple projects. The Council has a total of $200,000 available for both Target A and Target B. Make the case for the funds needed to successfully reach your project's target and do not assume it will necessarily be a 50/50 split between the targets. The Council anticipates funding either one proposal each for Target A Target B, or one proposal which covers both targets.The project period is two years.

Proposals are welcomed from all types of entities and organizations, formal and informal. The awardee must have a tax ID number in order to receive Council funds.

The Council may choose not to fund or may negotiate and adjust the funding amount of this CFI at the time of an award.

## Budget

Complete the Budget in DD Suite. The Council wants to see budgets which are cost effective and reasonable to meet the proposed project activities and reach the project's stated performance target. The Council has a total of $200,000 available.

A match amount must be included in the budget. Match may include in-kind contributions, but cannot include other federal funds.

Required match is 20%

Match funds are defined as any allowable expenses that do not come from other federal dollars. Match funds may include in-kind supports, volunteer time or other non-federal sources of funds. Any in-kind or volunteer time used as match must have a value attributed to it that is directly related to the Council project. Match funds used for Council projects cannot be used as federal match for any other project you may be involved in.

Council funds used for this project must not replace or supplant, in any way, non-federal funds for already existing services. In other words, Council funds cannot be used to pay for a program or a portion of a program that is currently being funded through other non-federal dollars. You cannot use Council funds to cover something already funded to allow redirecting the original money to another use.

Other funds may be, and are encouraged to be, part of a sustainability plan and intentionally sought or used as a match or funds leveraged for a project.

Ensure that you calculate your match as a percentage of the total project budget, not the total amount requested from the Council. Please double-check your budget before submitting it, as we often see mistakes during the review process.

Council funds may not be used for entertainment expenses.

Council funds may not be used for capital expenditures or acquisition (construction, remodeling, or purchase of buildings). The Council does not wish to purchase or lease vehicles.

## Submission

Proposals must be submitted through DD Suite on or before 4:00 p.m. on: March 20, 2019. Instructions for using DD Suite can be found under Help in DD Suite and on the Council's website at www.illinois.gov/icdd/

PROPOSALS THAT ARE FAXED, MAILED, HANDWRITTEN, AND/OR LATE WILL NOT BE ACCEPTED

## Review and Selection

After submission of your proposal, the Council will conduct a due diligence selection process. Decisions are made by the review team at each step of the process. No applicant is guaranteed a telephone and/or personal interview. If you have questions about this process, you may contact the assigned staff member.

The selection process is as follows:

1. Paper review. The purpose of the paper review is to gain a general understanding of what is being proposed, and to disqualify proposals that do not either address all elements or meet the requirements of this funding opportunity.

2. Telephone interview. If the review team wishes to obtain more detail about your proposed project and hear more about why you think the project you designed is a good way to reach our target, they will conduct a telephone interview. If the review team does not fully understand a proposal, they will conduct a telephone interview. If the review team understands what you propose to do sufficiently to reach consensus about your proposal, you may not be asked for a telephone interview.

After the paper review and, if necessary, a telephone interview, the review team will make decisions on which proposals move forward to a personal interview. Decisions are made using the outcome-based framework in looking at elements of the proposal. That is, will the investment of Council funds in a proposer's project assist us in achieving the performance target and intent of this funding opportunity to benefit people with developmental disabilities and their families. The review team will also look for:

- A clear and measurable performance target(s);
- Milestones which give an implementation strategy and timeframes to reach your PT;
- Applicant and staff capability and expertise to achieve the PTs; and
- A budget which supports achieving the PT in a reasonable and cost effective manner.

3. Second Telephone interview. During a second telephone interview, selected applicants will be given the opportunity to clarify any remaining questions and to elaborate, substantiate and generally build upon the proposal submitted. The project director and other key people should be available for the interview. The review team will then discuss and reach consensus based upon the factors outlined above.

Verification/References. After the completion of interviews, the review team may contact previous customers or other persons familiar with the applicant's work.

After a review of proposals received for this project, the Illinois Council on Developmental Disabilities may choose not to fund or may reduce the amount of this Call for Investment at the time of an award.

## Important Dates

Informational Session: February 15, 2019 at 10 a.m.

Applications Due (via DD Suite): March 20, 2019 by 4:00 p.m.

Telephone Interviews (if needed): April 9, 2019

Second Telephone Interviews (if needed): April 16, 2019

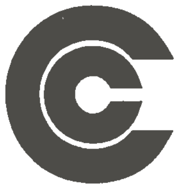
Awards Announced: May 9, 2019

NOTE: Applicants must be available for the dates of the telephone interviews should they be required. These dates cannot be changed, so please block the entire day on your calendar. The key people responsible for implementing the project should be available for both the 1st and 2nd telephone interview dates.

## Supporting Documents

- Additional Information: Additional Information Packet _ Version 2.0-2018.pdf
- What to Include in Your Proposal: What to Include in Your CFI Proposal _ Version 2.1 Med Advoc-2018.pdf
- Budget Definitions : Budget Definitions _ Version 2.0-2018.pdf
- Budget Excel Sheet : Budget Form Template (1).xlsx

- Performance Measures FAQ & Examples Guidance Document: Finalized ICDD Grantee Performance Measures FAQ & Examples Guidance Document 2019.pdf
- Signature page: Signature Page 2019 CFI _ IL Council on DD.pdf
- Resources related to medical advocacy training: Medical Advocacy Resources.pdf



CHAMPAIGN COUNTY MENTAL HEALTH BOARD

9.B.

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY

# BRIEFING MEMORANDUM

DATE: March 20, 2019
TO: Members, Champaign County Developmental Disabilities Board (CCDDB)
FROM: Lynn Canfield, Executive Director, Kim Bowdry, Associate Director for I/DD
SUBJECT: Program Year 2018 Service Activity Data, I/DD

## Background:

In PY2018, CCDDB/CCMHB staff implemented a new data collection system for programs serving people with I/DD. Agencies provided a much higher level of detail about specific service activities delivered to individuals. Because not all reported in the same way, on the same categories, or for the full year, conclusions to be made from these data are someone limited and not easily compared across programs. However, we are able to begin picturing what these local funds pay for and for whom. This document offers a first sample of what we might discover from the existing information and may also prove useful for identifying how to improve data collection and reporting strategies.

Attached is a document, Utilization Summaries for FY2018 CCDDB and CCMHB ID/DD Programs, which was shared with the Board in Fall of 2018. Of that comprehensive list, the following programs reported service activity data for specific people served.

Beginning in July 2017:

- Champaign County Regional Planning Commission Head Start/Early Head Start, "Social Emotional Disabilities Services"
- Champaign County Regional Planning Commission Community Services, "Decision Support Person for CCDDB"
- Illinois Association of Microboards and Cooperatives, "Building Inclusive Communities"
- PACE, Inc., "Opportunities for Independence"
- Rosecrance, "Coordination of Services – DD/MI"

Beginning in October 2017:

- CTF Illinois, "Advocacy Center"
- CTF Illinois, "Nursing Services"
- Community Choices, "Customized Employment"
- Community Choices, "Community Living"
- UCP-Land of Lincoln, "Vocational Services"

Beginning in November 2017:

- Developmental Services Center, "Community Employment"
- Developmental Services Center, "Apartment Services"

Beginning in December 2017:

- Developmental Services Center, "Family Development Center"
- Developmental Services Center, "Service Coordination"
- Developmental Services Center, "Integrated/Site-Based Services – Community First"
- Developmental Services Center, "Clinical Services"
- Developmental Services Center, "Individual and Family Support"

## Sample Findings

### Programs and People NOT Represented in the New Service Claims System

- Some programs did not report on specific individuals, due to the nature of the service. These include all support networks and some programs focused on system change (e.g., training of stakeholders). The total cost of these contracts was $289,802, or 7.2% of the total CCMHB and CCDDB investments in I/DD services. Utilization data for these programs are included in the attachment.
  - CU Able, $13,802
  - CC Down Syndrome Network, $15,000
  - DSC Connections, $85,000
  - DSC Employment First, $80,000
  - Community Choices Self-Determination Support, $96,000
- Some programs did not report on individuals who benefit from the service activities indirectly. Such Non Treatment Plan Clients include: children in classrooms being observed and teachers and parents being trained or coached (DSC Family Development and Head Start/Early Head Start); adults with DD who attend day program with state funding (DSC Integrated/Site Based); and children and adults registering on PUNS. As a result of the total program cost including services of indirect benefit, the unit cost for these programs appears higher.
  - CCRPC Head Start/Early Head Start Social-Emotional services benefited 39 NTPCs
  - DSC Integrated/Site Based services benefited 114 NTPCs

### Programs and People with Service Level Data

- Of the programs reporting on specific individuals and service activities, we learn that there were **667 unduplicated adults or older children** and **655 unduplicated young children.**
- The levels of service (and therefore program costs) vary greatly, presumably based on assessed needs. Several examples of partial year cost profiles are offered below.
- Of the unduplicated adults and older children served during PY2018, **34% had state waiver funding as well.**
- Of the unduplicated adults and older children served during PY2018, **78% were enrolled or re-enrolled in PUNS**.
- Of the unduplicated adults and older children served during PY2018, **29% had DDB/MHB funding only**.
- An individual may receive services from more than one agency and more than one program within a single agency.
  - 398 people were served by **one agency only**;
  - 166 people were served by two agencies;
  - 14 people were served by three agencies; and
  - 2 people were served by four agencies.

  - 352 people were served in **one program only**;
  - 141 people were served in two programs;
  - 66 people were served in three programs;
  - 42 people were served in four programs;
  - 10 people were served in five programs; and
  - 3 people were served in six programs.

## Profiles of People with Multiple Program Involvement

Involvement with multiple agencies and multiple programs may be appropriate to a person's service needs and preferences. This should be justified by a person's individual service plan. We want to strike a balance between full service with good options and meeting the needs of as many people as possible.

- Of the **14 people served by three agencies**:
  - all were served by CCRPC ISC Decision Support program;
  - 4 were served by Community Choices (Community Living), with three of these served by Rosecrance and one by PACE;
  - 7 were also served by DSC, with four of them also served by Rosecrance (one had HBS funding), 1 by PACE, 1 at CTF Advocacy Center, and 1 by IAMC;
  - 2 others were also served by PACE, 1 with UCP, and 1 with IAMC; and
  - 1 more was also served by Rosecrance and UCP.
- Of the **2 people served by four agencies**:
  - 1 was served by CCRPC ISC Decision Support program, CTF Advocacy Center, DSC's Individual and Family Support, and IAMC, with DDB/MHB funding only; and
  - 1 was served by CCRPC ISC Decision Support program, DSC's Apartment Services and Service Coordianation, PACE, and Rosecrance, with DDB funding only.

- Of the **10 people served in five programs**:
  - 2 were served by CCRPC ISC Decision Support program and DSC's Service Coordination, Integrated/Site Based, Community Employment, and Apartment Services programs, with DDB funding only;
  - 5 were served by CCRPC ISC Decision Support and DSC's Service Coordination, Integrated/Site Based, Clinical, and Apartment Services, all of them with DDB funding only;
  - 1 was served by CCRPC ISC Decision Support and DSC's Service Coordination, Community Employment, Clinical, and Apartment Services, DDB funding only;
  - 1 was served by CCRPC ISC Decision Support, DSC's Service Coordination, Clinical, and Apartment Services, and Rosecrance, with DDB funding only; and
  - 1 was served by CCRPC ISC Decision Support, DSC's Service Coordination and Apartment Services, PACE Opportunities for Independence, and Rosecrance, with DDB funding only.
- Of the **3 people served in six programs**:
  - 2 were served by CCRPC ISC Decision Support program and DSC's Service Coordination, Integrated/Site Based, Community Employment, Clinical, and Apartment Services, DDB funding only;
  - 1 was served by CCRPC ISC Decision Support program and DSC's Service Coordination, Integrated/Site Based, Individual & Family Support, Clinical, and Apartment Services, DDB/MHB funding only.

## Samples of Total Cost of Services for People

For the purpose of understanding how people in Champaign County use local funding, the following profiles are based on the hours of service activity reported by agencies for specific individuals. It is helpful to note that no agency program contracts were fee for service, so the 'unit costs' used in this discussion were determined by total audited payments divided by the total of direct service hours per program. A second caution regarding this use of 'unit cost' is that not all programs report hours in comparable ways: the DSC Integrated Site Based Services program offering indirect benefit to NTPCs (see "Programs and People NOT Represented in the New Service Claims System" above) reports direct service hours for TPCs only, which increases the unit cost. A third and very important caution lies with the uneven reporting periods; programs which began reporting in July 2017 will be overrepresented in the cost profiles which follow, with inflated percentages of the total, while programs which began reporting in December 2017 are underrepresented. For

this reason, we hesitated to provide the following analysis. However, the 16 profiles do fairly demonstrate how differently people utilize the locally funded programs.

- Person A participated in **3 programs, 2 agencies** for a partial annual cost of $3,346.13:
  - 26% of (10 month) total was in Community Choices Community Living, $876.36
  - 70% of (10 month) total was in Community Choices Customized Employment, $2,325.67
  - 4% of (12 month) total was in CCRPC ISC Decision Support, $144.10
- Person B participated in **3 programs, 2 agencies** for a partial annual cost of $1,304.55:
  - 80% of (10 month) total was in Community Choices Community Living, $1,041.18
  - 9% of (10 month) total was in Community Choices Customized Employment, $119.27
  - 11% of (12 month) total was in CCRPC ISC Decision Support, $144.10
- Person C participated in **4 programs, 4 agencies** for a partial annual cost of $7,888.04:
  - 67% of (10 month) total was in CTF Illinois Advocacy Center, $5,321.05
  - 2% of (10 month) total was in Community Choices Customized Employment, $159.02
  - 3% of (12 month) total was in CCRPC ISC Decision Support, $252.18
  - 27% of (8 month) total was in DSC Individual & Family Support, $2,155.79
- Person D participated in **4 programs, 2 agencies** for a partial annual cost of $9,381.32:
  - 3% of (12 month) total was in CCRPC ISC Decision Support, $252.18
  - 31% of (8 month) total was in DSC Individual & Family Support, $2,890.18
  - 62% of (9 month) total was in DSC Integrated Site-Based/Community First, $5,831.60
  - 4% of (8 month) total was in DSC Service Coordination, $407.36
- Person E participated in **6 programs, 2 agencies** for a partial annual cost of $25,038.09:
  - 1% of (12 month) total was in CCRPC ISC Decision Support, $180.13
  - 24% of (9 month) total was in DSC Apartment Services, $6,058.06
  - 11% of (8 month) total was in DSC Clinical Services, $2,704.33
  - 3% of (9 month) total was in DSC Community Employment, $702.57
  - 59% of (9 month) total was in DSC Integrated Site-Based/Community First, $14,719.30
  - 3% of (8 month) total was in DSC Service Coordination, $673.70
- Person F participated in **3 programs, 1 agency** for a partial annual cost of $6,995.77:
  - 64% of (9 month) total was in DSC Apartment Services, $4,469.85
  - 16% of (9 month) total was in DSC Community Employment, $1,115.84
  - 20% of (8 month) total was in DSC Service Coordination, $1,410.08
  - This person also receives waiver-funding through Home Based Support.
- Person G participated in **4 programs, 2 agencies** for a partial annual cost of $11,495.57:
  - 2% of (12 month) total was in CCRPC ISC Decision Support, $216.15
  - 14% of (9 month) total was in DSC Apartment Services, $1,646.04
  - 81% of (9 month) total was in DSC Community Employment, $9,257.36
  - 3% of (8 month) total was in DSC Service Coordination, $376.02
- Person H participated in **5 programs, 4 agencies** for a partial annual cost of $1,642.29:
  - 15% of (12 month) total was in CCRPC ISC Decision Support, $252.18
  - 7% of (9 month) total was in DSC Apartment Services, $113.52
  - 41% of (12 month) total was in Rosecrance Coord MI/DD, $678.21
  - 5% of (12 month) total was in PACE Opportunities, $81.35
  - 31% of (8 month) total was in DSC Service Coordination, $517.03
- Person I participated in **5 programs, 2 agencies** for a partial annual cost of $34,758.21:
  - 1% of (12 month) total was in CCRPC ISC Decision Support, $432.30
  - 25% of (9 month) total was in DSC Apartment Services, $8,769.42
  - 16% of (9 month) total was in DSC Community Employment, $678.21
  - 53% of (9 month) total was in DSC Integrated Site-Based/Community First, $18,312.20
  - 5% of (8 month) total was in DSC Service Coordination, $1,582.42
- Person J participated in **6 programs, 2 agencies** for a partial annual cost of $16,692.36:

- 1% of (12 month) total was in CCRPC ISC Decision Support, $144.10
- 41% of (9 month) total was in DSC Apartment Services, $6,839.58
- 15% of (8 month) total was in DSC Clinical Services, $2,454.70
- 20% of (9 month) total was in DSC Community Employment, $3,347.53
- 18% of (9 month) total was in DSC Integrated Site-Based/Community First, $3,013.40
- 5% of (8 month) total was in DSC Service Coordination, $893.05

- Person K participated in **4 programs, 2 agencies** for a partial annual cost of $7,432.37:
  - 2% of (12 month) total was in CCRPC ISC Decision Support, $142.63
  - 68% of (8 month) total was in DSC Clinical Services, $5,034.21
  - 23% of (9 month) total was in DSC Integrated Site-Based/Community First, $1,738.50
  - 5% of (8 month) total was in DSC Service Coordination, $517.03
- Person L participated in **5 programs, 2 agencies** for a partial annual cost of $28,631.74:
  - 1% of (12 month) total was in CCRPC ISC Decision Support, $324.23
  - 23% of (9 month) total was in DSC Apartment Services, $6,513.21
  - 6% of (8 month) total was in DSC Clinical Services, $1,830.62
  - 49% of (9 month) total was in DSC Integrated Site-Based/Community First, $14,072.70
  - 21% of (8 month) total was in DSC Service Coordination, $5,890.98
  - this individual was experiencing poor health, therefore an increase in supports.
- Person M participated in **5 programs, 2 agencies** for a partial annual cost of $23,610.05:
  - 1% of (12 month) total was in CCRPC ISC Decision Support, $288.20
  - 27% of (9 month) total was in DSC Apartment Services, $6,371.31
  - 11% of (8 month) total was in DSC Clinical Services, $2,621.12
  - 56% of (9 month) total was in DSC Integrated Site-Based/Community First, $13,279.70
  - 4% of (8 month) total was in DSC Service Coordination, $1,049.72
- Person N participated in **6 programs, 2 agencies** for a partial annual cost of $26,869.43:
  - 1% of (12 month) total was in CCRPC ISC Decision Support, $144.10
  - 27% of (9 month) total was in DSC Apartment Services, $7,307.85
  - 13% of (8 month) total was in DSC Clinical Services, $3,536.43
  - 52% of (9 month) total was in DSC Integrated Site-Based/Community First, $14,036.10
  - 0% of (8 month) total was in DSC Individual & Family Support, $11.85
  - 7% of (8 month) total was in DSC Service Coordination, $1,833.10
- Person O participated in **4 programs, 2 agencies** for a partial annual cost of $17,933.77:
  - 1% of (12 month) total was in CCRPC ISC Decision Support, $180.13
  - 2% of (9 month) total was in DSC Community Employment, $330.62
  - 96% of (9 month) total was in DSC Integrated Site-Based/Community First, $17,141.00
  - 2% of (8 month) total was in DSC Service Coordination, $282.02
- Person P participated in **3 programs, 1 agency** for a partial annual cost of $6,671.18:
  - 54% of (9 month) total was in DSC Apartment Services, $3,590.07
  - 1% of (8 month) total was in DSC Clinical Services, $41.61
  - 46% of (8 month) total was in DSC Service Coordination, $3,039.50

In order to understand how these service mixes came to be, the person-centered plan of each individual identifies the needs and preferences that each service will support, along with goals developed by the individual with their team. These plans should be available through each participating service provider and are meant to be the driver of each person's unique set of services.

# Utilization Summaries for FY2018 CCDDB and CCMHB ID/DD Programs

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## *Priority: Comprehensive Services for Young Children*

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*Champaign County Regional Planning Commission Head Start/Early Head Start*
**Social Emotional Disabilities Services** $55,645 (CCMHB)

**Services:** Program seeks to identify and address social-emotional concerns in the early childhood period, as well as to promote mental health among all Head Start children. The social-emotional portion of the program focuses on aiding the development of self-regulation, problem solving skills, emotional literacy, empathy, and appropriate social skills. Accomplishments in these areas will affect a child's ability to play, love, learn and work within the home, school and other environments. All fit together to form the foundation of a mentally healthy person. **Utilization targets:** 60 TPC, 55 NTPC, 1 CSE, 600 SC, 8 Other (newsletter articles, staff training). **Utilization actual:** 56 TPC, 39 NTPC, 21 CSE, 2142 SC, 7 Other (newsletter articles, staff training).

*Developmental Services Center* **Family Development Center** $562,280

**Services:** Serves children birth to five years, with or at risk of developmental disabilities and their families. FDC responds to needs with culturally responsive, innovative, evidence-based services. Early detection and prompt, appropriate intervention can improve developmental outcomes for children with delays and disabilities and children living in at-risk environments. Family-centered intervention maximizes the gifts and capacities of families to provide responsive intervention within familiar routines and environments. **Utilization targets:** 655 TPC, 200 SC, 300 CSE. **Utilization actual:** 669 TPC, 203 SC, 574 CSE.

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## *Priority: Parent and Self-Advocacy Support*

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*CU Able* **CU Able Community Outreach** $13,802

**Services:** Networking, education and social opportunities for families of people with disabilities, regardless of disability type. Monthly meetings for caregivers of people with disabilities, professionals and students from the University of Illinois and Parkland. Online community is an extremely important part of community allowing for quick feedback and provide support at all hours of the day. Annual Moms Retreat provides opportunity for respite for female caregivers to come together for networking, relaxation and educational opportunities. **Utilization targets:** 42 TPC, 15 NTPC, 150 SC, 4 CSE. **Utilization actual:** 53 TPC, 53 NTPC, 169 SC, 17 CSE.

*Champaign County Down Syndrome Network* **CC Down Syndrome Network** $15,000

**Services:** Support to families and people with Down Syndrome. New parent packets, books, DVD's, home and hospital visits, are ways they offer support. The DSN offers support at Individualized Education Program (IEP) meetings. Monthly meetings, annual conferences, workshops, social events, presentations, and the annual Buddy Walk are held. The DSN sponsors a newsletter and a website. **Utilization targets:** 145 TPC, 50 NTPC, 20 CSE. **Utilization actual:** 193 TPC, 251 NTPC, 27 CSE.

*Community Choices* **Self Determination Support** $96,000 (CCMHB)

**Services:** Leadership & Self-Advocacy: a two-tiered Leadership Class, co-developed by self-advocates, focusing on fostering leadership skills and putting leadership into action. Family Support & Education: a public monthly meeting, to learn best practices and options, community family, and a family specific support group. Building Community: options for adults with disabilities to become engaged with others. **Utilization targets:** 135 NTPC, 1762 SC, 4 CSE. **Utilization actual:** 166 NTPC, 1968 SC, 5 CSE.

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## *Priority: Planning and Case Management*

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*Champaign County Regional Planning Commission Community Services,* **Decision Support Person for CCDDB** $86,460

**Services:** Targets people with developmental disabilities (DD) transitioning from an ISBE setting, in need of adult services. ISC staff continue to assess persons transitioning from other counties that are eligible for and may or may not be receiving DHS waiver funding, that have not yet been assessed for service preferences will be targeted. Transition Consultants assist people/families in conflict free transition planning. Conflict free transition planning allows for better matching of individualized services. **Utilization targets:** 48 TPC, 100 NTPC, 100 SC, 40 CSE. **Utilization actual:** 58 TPC, 298 NTPC, 476 SC, 73 CSE.

*Developmental Services Center* **Service Coordination** $410,838

**Services:** Serves children and adults with I/DD who request support to enhance or maintain their highest level of independence in the community, at work, and in their home. Focusing on the hopes, dreams, and aspirations, serve as the basis of planning and outcomes for that person. With each person as the center of their team, Case Coordinators work closely with all members of each person's team assuring the most person–centered and effective coordination. **Utilization targets:** 296 TPC, 20 NTPC, 160 SC, 2 CSE. **Utilization actual:** 279 TPC, 47 NTPC, 152 SC, 1 CSE.

*Illinois Association of Microboards and Cooperatives* **Building Inclusive Communities** $52,750

**Services:** Services include a person-centered plan using PATH (Planning Alternative Tomorrows with Hope) with a group that includes family and one or more non-family members with strong community connections. Once the person's hopes, dreams, needs and interests have been identified, the team develops concrete steps leading to positive outcomes. Teams meet regularly to maintain the plan, celebrate accomplishments, discuss barriers and ways to address them, assign next steps and set the next meeting date. **Utilization targets:** 23 TPC, 200 SC, 3 CSE. **Utilization actual:** 15 TPC, 251 SC, 6 CSE.

*PACE, Inc.* **Opportunities for Independence** $40,546

**Services:** Serves people with I/DD in an Independent Living Philosophy based program to grow and/or maintain independence. Provides core services: Information and Referral, Individual and Systemic Advocacy, Independent Living Skills Training, Peer Support and Transition services. Services extend beyond Person-Centered Planning and represent Consumer Control. Consumer Control contains person-centered planning and goes beyond that to persons with disabilities directing program development, center administration and providing services. **Utilization targets:** 20 TPC, 30 NTPC, 500 SC, 25 CSE. **Utilization actual:** 33 TPC, 14 NTPC, 855.5 SC, 26 CSE.

*Rosecrance Champaign/Urbana* **Coordination of Services – DD/MI** $34,126

**Services:** Emphasis is placed on serving people who are presently in residential settings for persons with I/DD, are living in other settings (families, friends, or self) but are struggling in caring for self in these environments or are at-risk of hospitalization or homelessness due to inadequate supports for their co-occurring conditions. Focus is to ensure that services are coordinated effectively, that consistent

messages and language are used by service providers; and that service needs receive appropriate priority in both systems of care. **Utilization targets:** 36 TPC, 15 SC, 12 CSE. **Utilization actual:** 24 TPC, 18 SC, 15 CSE.

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## *Priority: Employment, Social*

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### *CTF Illinois* **Advocacy Center** $60,000

**Services:** The mission of CTF ILLINOIS Advocacy Center of Champaign is to empower each individual we support to live the life they want to live. As advocates, we develop the tools and experiences we need to take greater control over our lives. We help speak up for people in the community who feel they have no voice, lobby local and state government to bring about change and work in the community. We also contribute to our community by organizing community events, joining social clubs and volunteering at local businesses and organizations. **Utilization targets:** 15 TPC, 0 SC, 12 CSE. **Utilization actual:** 3 TPC, 18 SC, 4 CSE.

### *Community Choices* **Customized Employment** $74,103

**Services:** focus on individualizing relationships between employees and employers resulting in mutually beneficial relationships. Discovery identifies strengths, needs and desires of people seeking employment. Job Matching identifies employers and learns about needs and meeting those needs through customized employment. Short-term Support develops accommodations, support, and provides limited job coaching. Long-term Support provides support to maintain and expand employment. **Utilization targets:** 36 TPC, 1001 SC, 4 CSE. **Utilization actual:** 36 TPC, 989 SC, 4 CSE.

### *Developmental Services Center* **Community Employment** $361,370

**Services:** Assists people to obtain and keep jobs. Including a person-centered job discovery; business exploration, online research and speaking/listening to others' regarding job experiences; resume/portfolio development; interview prep and meetings with potential employers; identifying niches in local businesses that emphasize the job seeker's strengths; advocating for accommodations; self-advocacy support; provision of benefits information; discussion/experiential opportunities for soft skills; develop and maintain long-term business relationships. **Utilization targets:** 55 TPC, 2 CSE, 2 SC. **Utilization actual:** 70 TPC, 0 CSE, 1 SC.

### *Developmental Services Center* **Connections** $85,000

**Services:** Focused on building connection, companionship and contribution in the broader community and pursues creative employment possibilities. People have expressed a desire to expand on interest in art nurturing their creative self, fostering community engagement and pursuing a desire for employment opportunities. Individual and small group activities will occur during the day. Services are driven by each person. **Utilization targets:** 15 TPC, 15 NTPC, 4 CSE, 2 SC **Utilization actual:** 19 TPC, 11 NTPC, 2 CSE, 4 SC.

### *Developmental Services Center* **Employment First** (with Community Choices) $80,000

**Services:** Emphasis and priorities include: individual and family education events; ongoing staff development to facilitate DSC's shift in culture to more community and employment focused outcomes; continued business/employer outreach to provide education and certification for disability awareness for employers; establishing and maintaining relationships with all newly certified businesses; engaging in communication and advocacy with various state agencies/representatives around Employment First implementation. **Utilization targets:** 50 NTPC, 2 CSE. **Utilization actual:** 67 NTPC, 17 CSE.

*Developmental Services Center* **Integrated/Site-Based Services – Community 1st** $799,090

**Services:** Serves those receiving community and site-based services, transitioning from a center-based model to community connection and involvement. Efforts to support people in strengthening connections with friends, family and community through volunteering, civic duty, citizenship and self-advocacy opportunities; enhancing quality of life through recreational activities, social events, educational and other areas of interest; access to new acquaintances; and job exploration in interest area and detection of support for employment goals. **Utilization targets:** 53 TPC, 25 NTPC, 4 SC, 4 CSE. **Utilization actual:** 49 TPC, 114 NTPC, 4 SC, 4 CSE.

*United Cerebral Palsy - Land of Lincoln* **Vocational Services** $34,590

**Services:** Vocational support services to people with I/DD, ages 18-55, in Champaign County. Services include extended job coaching and case management to employed people and vocational training and job development to people seeking employment or improvement of skills. Job coaching/support services allow people to continue working in their community, receive promotions, and have the opportunity to increase hours. People looking for employment receive vocational training to help prepare them for the workforce and to increase employability skills. **Utilization targets**: 20 TPC, 60 SC, 25 CSE. **Utilization actual**: 17 TPC, 33 SC, 23 CSE.

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## *Priority: Flexible Family Support*

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*Developmental Services Center* **Clinical Services** $174,000

**Services:** Provides clinical supports and services to children and adults with ID/DD. Consultants under contract include one Licensed Clinical Psychologist, two Licensed Clinical Social Workers, three Licensed Clinical Professional Counselors, one Licensed Professional Counselor and one Psychiatrist. Consultants meet with people at their private practice, at the person's home or DSC locations. People schedule their appointments or receive support from family and/or DSC staff members for scheduling and transportation. **Utilization targets:** 63 TPC, 3 NTPC, 15 SC, 2 CSE. **Utilization actual:** 67 TPC, 6 NTPC, 11 SC, 1 CSE.

*Developmental Services Center* **Individual & Family Support** $392,649 (CCMHB)

**Services:** Program serves children and adults with ID/DD with priority consideration given to individuals with severe behavioral, medical or support needs. Program is a flexible and effective type of choice-driven service to people and families. People may choose to purchase services from an agency or an independent contractor/vendor. Program continues to provide creative planning, intervention and home/community support, collaborating with families, teachers and other members of the person's support circle. **Utilization targets:** 17 TPC, 26 NTPC, 5 SC, 2 CSE. **Utilization actual:** 19 TPC, 41 NTPC, 6 SC, 1 CSE.

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## *Priority: Independent Living*

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*CTF Illinois* **Nursing Services** $6,000

**Services:** 24 hr. residential services for seven people in Champaign. Some are aging and have developed related medical issues. Nursing services include, but are not limited to: coordination of medical nursing care, medication training for staff, quality assurance of medical concerns and medication errors, regular

site visits, medication checks and physician order sheet review, quarterly medication, annual assessments, on call 24/7 for emergencies and providing information to ISC for the development of the person centered plans. **Utilization targets:** 7 TPC, 228 SC. **Utilization actual:** 7 TPC, 407 SC.

*Community Choices* **Community Living** $63,000 (CCMHB)

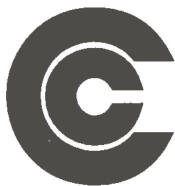
**Services:** COMMUNITY TRANSITIONAL SUPPORT – A four-phase model for supporting individuals with developmental disabilities to move into the community. PERSONAL DEVELOPMENT TRAINING includes small classes and 1-on-1 instruction. Eight sessions of hands-on, interactive instruction are held throughout the year. Each class focuses on different topics and people can take multiple sessions to build skills and confidence so they can continue their lifelong learning in integrated settings in the community. **Utilization targets:** 15 TPC, 12 NTPCs, 2 CSE, 1370 SC. **Utilization actual:** 18 TPC, 20 NTPC, 3 CSE, 1807 SC.

*Developmental Services Center* **Apartment Services** $417,341

**Services:** Supports people with ID/DD who reside in their own home in the community. The program has three primary goals: promote independence by learning/maintaining skills within a safe environment; provide long-term/on-going support in areas that cannot be mastered; provide increased support as needed due to aging, deteriorating health or other chronic conditions that jeopardize their ability to maintain their independence. Emergency Response is available to support for those needing assistance after hours and on the weekends. **Utilization targets:** 60 TPC. **Utilization actual:** 59 TPC.

*Individual Advocacy Group,* **CILA Expansion** $100,000 (CCMHB and CCDDB)

This annual investment pays for mortgage and property management costs of two of the three local small group homes run by Individual Advocacy Group, which was selected in 2014 through an RFP process to provide services to people with ID/DD living in 2-4 MHB/DDB owned-homes. **Utilization:** 7 TPCs with staffing ratios from 1:4 to 2:3 and a choice between IAG 'Flexible Day Experience' and community day programs run by other local providers.



**CHAMPAIGN COUNTY MENTAL HEALTH BOARD**

**CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY**

9.C.

# BRIEFING MEMORANDUM

DATE: March 20, 2019
TO: Members, Champaign County Mental Health Board (CCMHB), Champaign County Developmental Disabilities Board (CCDDB), Champaign County Board, and Association of Community Mental Health Authorities of Illinois (ACMHAI)
FROM: Lynn Canfield, Executive Director, CCMHB/CCDDB
RE: Legislative and Policy Conferences of National Association of Counties (NACO) and National Association of Behavioral Health and Developmental Disabilities Directors (NACHBDD) and Meetings of the Data Driven Justice Initiative

## Background

From March 2 through 6, I attended Legislative and Policy Conferences of the National Association of Counties (NACo) and National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) in Washington, DC. As NACBHDD's liaison to the NACo Health Committee and Vice Chair of Behavioral Health Subcommittee, I participated in related meetings. I also attended sessions of the Data Driven Justice Initiative, which Champaign County joined in 2016. The following notes may be of interest to members of the CCDDB, CCMHB, CCB, and ACMHAI.

## NACo Health Steering Committee, Joint Subcommittee Meeting

### "Combating Substance Abuse through Improved Access to Behavioral Health Information Technology and Data"

*Section 6001 of the SUPPORT for Patients and Communities Act, signed into law last October, included a provision to pilot incentive payments for behavioral health providers to adopt electronic health record technology as a means of improving quality and coordination of care through electronic documentation and the exchange of information, opening the door to learn how data can support developing community-based approaches to the opioid crisis. To lobby for innovative responses, we need health information technology (HIT) to include behavioral health data.*

- **Al Guida, Guide Consulting Services**, on why behavioral health providers don't use HIT, what has been done so far, and what the opportunities are today:
- The new provision amends the earlier HIT law which applied to acute care providers (hospitals, FQHCs, psychiatrists) but not post-acute (community based mental health centers, psychologists, etc). 72,000 people died in 2018 of opioid overdoses, not really a post-acute care population, but that's where their care would be found. Primarily due to comorbid chronic diseases (lung cancer, heart, HIV/AIDS, Hep C), average life expectancy of people with SMI is 53, compared with average Americans (late 70s).
- Purpose of the Center for Medicare Medicaid Innovation (CMMI) is to reduce health care costs and improve outcomes through a range of demonstrations, but they don't have adequate resources.
- Some opportunities: a 5-state Medicaid demonstration expanding access to people with Opioid Use Disorder (OUD); a Medicare bundled payment project, primarily for methadone clinics; and expanded access to care for people with related addictions.



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- Medicalizing care for OUD through Vivitrol (if clean and sober) and Buprenorphine (like methadone but causes dependency not addiction) available as prescription. Electronic Health Records (EHR) needed because 15% of buprenorphine prescriptions end up on the street, and because it operates like other oral meds and contraindicates with Xanax, anti-anxiety meds, and opioids, with risk of renal failure and respiratory depression. With an EHR listing all of the patient's other meds, a physician will be able to avoid this. Many comorbid illnesses in this population, and EHR allows exchange between addiction providers and others. MAT demonstration programs need EHR $ to operate like acute care providers, which they are.
- **John Rancourt, Office of the National Coordinator for Health IT**:
  Requires interoperability. Focus on 21st Century CURES Act. $1m penalty for blocking exchange of info, exceptions defined in the proposed rule: protecting privacy of some data, addresses business practices (e.g., high costs connecting IT systems of competitors). This rule is in the comment period. Also creates a "trust exchange framework and common agreement" Addressing challenges of providers using the EHR.
- Coordinating with CDC, HRSA, etc. Enhancements are needed in Prescription Drug Monitoring Program, interstate data sharing, integration of info from PDMP into the physician's data, education of providers (CDC prescribing guidelines, etc.), care coordination and making sure info gets from one provider to another, Public Health reporting, and certification. Proposed rule has a Request for Information currently.
- Get to know state Medicaid Health IT colleagues (counties need infrastructure, funding is available for some EHRs and PDMPs); Get to know state PDMP coordinator; Get to know state Health IT coordinator. (Could be the same person in all three roles.)
- Are jail health providers part of this? Interoperability with jail and prisons systems is important, info does get lost, so it's an area of need, esp loss of Medicaid eligibility. Financing this remains mostly a county responsibility. This is an important gap to our members, and integrating these systems should be a priority.
- Counties are uniquely positioned to provide care coordination. Of 17 pilot communities, which have shared behavioral health data back to the 'beacon sites'? A barrier in 42 CFR Part xxx. Many are trying to work through these barriers. A financial analysis of getting mental health data to flow back to beacon sites (to connect 20 or 40 sites alone) showed multi-millions in savings.
- Better if rolled out as a single nationwide platform to begin with, rather than paying incentives to communities establishing them, attempting to leverage the marketplace. More questions: data mining, law enforcement access, etc.

## "Medicaid Waivers: An Overview of Current Opportunities"

*CMS (federal) approves waivers that allow states to expand eligibility and benefits. Overview of how waivers can be used to address issues from long-term care to mental health, with examples of local Medicaid waiver implementation.*

- **Judith Cash, Center for Medicaid & CHIP Services, CMS**, on Medicaid Waiver 1115 Demonstrations. Counties are where things get done, including eligibility work. Demonstrations include waivers, experimenting with and learning from communities. Examples: physical and behavioral health integration, substance use disorder treatment, delivery system reform. CMS works with states to determine if these approaches align with federal CMS goals.
- 1115 authority to: waive sections (e.g., eligibility); to approve (and offer matching fund). Budget neutrality is enforced over the full period of the waiver, not annually. Demonstrations are a shared state/federal agreement; rules apply until CMS says they don't.
- Monitoring evaluation: often not getting good data from states on the impact, so this effort is increased. Leads to policy decisions to go forward, expand, or stop.
- 1115 SUD Demonstration Initiative gives states limited expenditure authority where IMD exclusion applies. In exchange, states give comprehensive care services, with goals of reduced readmissions, lower cost of care, and similar. 1115 SMI/SEC Initiative goals include continuity of care.
- **Dr. Teeb Al Samarrai, CMMI and physician,** on sustaining Medicare, Medicaid, and CHIP:
- CCMI was established under the ACA to create innovative payment models (lower costs, better health).
- Accountable Health Communities Model was first, focused on health related social needs, 31 bridge organizations, how to screen and connect people to local services.
- Integrated Care for Kids Model (NOFO closes June 10) to create child and family centered services in response to fragmented systems of care for children.
- Maternal Opioid Misuse Model (NOFO closes May 6) to align maternal and infant services for best health.
- Emergency Triage Treat and Transport Model to provide additional services where currently 911 and EMS services transport to hospitals.

- **Ron Manderscheid, NACBHDD and NARMH, adjunct Professor at Johns Hopkins & USC,** on Medicaid coverage and jail, framed as a civil rights/constitutional issue, and updates:
- Up to 90% of people in city and county jails may have SUD, SMI, I/DD, or co-occurring disorders.
- 11% of Medicaid beneficiaries use MH services, 1% SUD (higher now, as ACA improved care for SUD.)
- 30% of Medicaid expenditures are for those with MI. High cost because we aren't doing it right. Approved and pending 1115 waivers are primarily around behavioral health, many focusing on relief from the IMD exclusion (SUD and MH) in order to do community residential care (rather than hospital), as has been done successfully in CA for SUD. Only VT has a waiver for MH, so we need to work toward more of these.
- Use waivers to address the Social Determinants of Health - housing instability, transportation insecurity, food insecurity, interpersonal violence, toxic stress, etc - which contribute to lower life expectancy, poor health, and high cost of care.
- Address Uncompensated Care Pools, which used to come through Medicaid and Medicare; ACA was to reduce this, but recent changes have reversed the progress.
- With CMS and CMMI, develop waivers to permit use of Medicaid funds for those pre-adjudicated and to improve the care of those in jails and prisons.
- Q&A: waiting for guidance on work requirements - Arkansas fully implemented, Indiana incremental, in litigation with two states, a number of others pending. IMD exclusion work is in progress. Reports on every state's progress toward MHSUD parity. Counties' opportunities for innovation are improved by better coordination with agencies (CMS). Managed care organizations are looking for counties that do care coordination well. Let's put together a NACO 1115 waiver to test impact of addressing social determinants of health; CMMI does have a design and an interest in pilot counties, and we see improvements in health when we invest in education, transportation, and the like, but CMS can't pay for them.

## "Early Childhood Luncheon: Leading Local Efforts to Reach Young Children"

*Strong evidence shows that when counties invest in the first three years of a child's life, the returns for the community are the highest, and these investments can reduce the need for more expensive interventions later in an individual's life. Early childhood investments help to support a thriving community and positively impact children's outcomes that span into adulthood. This luncheon was supported by the National Collaborative for Infants and Toddlers, funded through the Pritzker Children's Initiative, of which Champaign County was a pilot community.*

- **Mary Ann Borgeson, NACo First VP, Douglas Cty, NB** on background and aims of the National Collaborative for Infants & Toddlers, most brain development occurs birth to 3, highest returns on investment through prenatal to 3 programs.
- **Ngozi Lawal, Center for the Study of Social Policy**, moderated the panel discussion, which was recorded, at https://www.naco.org/resources/video/livestream-leading-local-efforts-reach-young-children.
- **Janet Thompson, Boone County, MO.** Primarily rural, with U of Missouri, so education, medicine, insurance, agriculture are the industries. Disparities in health, economic and educational achievement, in rural, African American, and grad student populations. Ramping up the home visiting program. Simply increasing the number of home visits doesn't work, so community liaisons build trust and identify specific challenges faced by families. Nurses work with pregnant women and connect them to systems.
- **Crystal Kelly, Watauga Cty, NC.** Similar to Boone. Rural with Appalachian State University, about 50K people, with a very small child population, so that resources are not directed to them. The area has lots of second homes, 93% Caucasian, with very wide economic disparities due to intergenerational poverty while the housing market continues to climb. Every NC county has a Smart Start Initiative, identifying needs. Working on earlier identification due to being a child care desert, taking a universal perspective (that all families need support), and building supports as they go; improving the child care infrastructure to attract new families to the area; taking responsibility for education from birth, some with faith-based org support.
- **George P. Hartwick III, Dauphin Cty, PA.** Need to address housing and other social needs. The Hershey/Harrisburg areas very diverse, rural, suburban, and urban, with 280K people, 28% African American, large Hispanic and growing Butanese populations. Industries are agriculture, tourism, biotech, manufacturing, and state government. PA is a state-run, county-administered state, so only responsible for the early intervention, identifying I/DD. Three state agencies have authority over early childhood, making coordination of the systems of care the best investment: home visiting and nurse partnership; expansion of EI; cultural competence. Find those 4,683 children at risk and provide appropriate services.
- Convey the importance of prenatal to 3 with messages on the brain science, return on investment data, or other. The science is compelling (90% of brain development during these years). Educating business owners, Chambers of Commerce, and parents. Children thrive in family relationships, so families need to

be supported by the community. Young children are compelling, so spread the information through United Ways, e.g. Use collaboratives of child care/day care providers to share ideas, including elementary educators and admins. Children don't grow up in a petri dish. A children's mental health tax in Boone County initially failed but passed when citizen-driven and supported by a coalition, including Head Start, providers for older children, business community, and United Way - a 'cradle to career alliance' with a message of economic development by improving the best start we can give very young children. Education about trauma-informed care and resiliency, using the ACEs model, building trust and allowing all partners (including elected officials) to work from the same place.

- Counties pass individual resolutions supporting these early strategies. Push state stakeholders to work with the counties, who know how the approaches work. Demand to be engaged. In MO, use of Children's Services Fund and data sharing agreements across providers so that service gaps are easily identified. In PA, Block Grant Counties have full flexibility over state dollars; as services are built out, funds saved can be reinvested.
- States should not plan without counties. Use listening sessions, 4E money, casino tax, other braided funding opportunities, and restructure around evidence-based models. Creative use of current funds and priorities, including line items from general fund budget. Working across siloed systems, to avoid duplication or gaps in service. Use the 'pay for success' model of Corporation for Supportive Housing: reduce financial stresses companies face later by investing in earlier supports.
- IEPs are on the rise across the country. K-Readiness is a priority, but children are way behind. Prenatal support should extend to perinatal, as parent support matters. Rather than prenatal to 3, prenatal to 25! Track comprehensive data, with care for privacy protections; these should be worked out by state legislatures. Universal intake system. Check out PA Keystone Stars http://www.pakeys.org/keystone-stars/.

## NACo Health Steering Committee, Policy Coordinating Committee

### "NACo Programming of Interest to Health Policy Steering Committee"

- **Kirsty Fontaine, Program Manager for Health, NACo.** Educational resources for county members; commitments through resolutions; design of outcome oriented, holistic approaches. NACo Health Portfolio includes: Healthiest Cities and Counties Challenge - a competition using EBPs; Rural Impact County Challenge - reducing poverty, county health rankings; Healthy Counties Initiative - health advocates and corporate partners on improving access and information, increasing health equity, data interoperability; RW Johnson Foundation - affordable housing, to attain full health potential; Hilton Foundation - health equity.
- **Rashida Brown, Associate Program Director for Human Services, NACo.** Best practices in national models, modernizing human service systems; partnership with Pritzker Children's Initiative - high quality early learning to improve K-Readiness, targeted assistance to 8 counties (including us!) for better outcomes; innovations in early childhood, including financing and innovative use of data, through online tools, peer learning networks, and workshops; resolutions templates at www.naco.org/NCIT.
- **Kathy Rowings, Associate Program Director for Justice, NACo.** Stepping Up Initiative (475 counties) in its fourth year, asking counties to move it forward with self-assessment tool and Stepping Up Month of Action. MacArthur Foundation partnership with publications on the needs of justice-involved individuals who have SUDs, with webinars and a report on successful collaborations (e.g., data and analysis through county/university partnerships). Four 'data driven justice initiative' pilot communities.

### "Health Resolutions 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. These resolutions are valid until NACo's 2019 Annual Conference.*

- **Phil Serna, Sacramento Cty, CA,** on Proposed Resolution Reducing Disparities in African American Child Deaths. Sponsor: Sacramento County, CA. Successes in addressing this issue in Sacramento County. 20 years of data on child deaths showed the rate for AA children 2-3 times higher than all other groups. No clear answer about what had been done to address it, so they dug deeper into the reviews, using heat map to find the areas, working with clergy and community leaders to understand what is needed. This became a steering committee, now with physicians and public health. Implementation/strategic plan to reduce deaths by 2020. Concrete suggestions, identification of causes, investment of $32m, resulting in decreased

disparity and rates of death and improved pregnancy and birth outcomes. First5sacramento.net. Federal funding and implementation of initiatives. Question about child deaths attributed to third-party homicides. More support for data on deaths of children up to 18. Approved.

- **Steven Singer** on Proposed Resolution Supporting Funding the Supporting and Improving Rural EMS Needs Grants. Sponsor: International Association of Fire Chiefs. Fund the SIREN Act, within the approved farm bill, with $20m for EMS training and services. Approved.
- **Renee Beniak, MI** on Proposed Resolution Supporting Better Regulation, Better Staffing in Nursing Homes. Sponsor: National Association of County Health Facilities. Revised since comments at July meeting. CMS fines lead to lockout which can prevent nurse aide trainings for a long period, even if the fines were imposed for unrelated reasons. Improve coordination with CMS toward clearer regulations which support high standards but are manageable, even by state survey agencies. Amended to specify more narrowly what is to be streamlined. Supports CMS initiative "Patients Over Paperwork," which NACo staff has not fully reviewed. Approved (14 to 13).

## "Overview of NACo's Health Priorities and Legislative Accomplishments"

- **Blaire Bryant, Associate Legislative Director, Health, NACo.** Last year successes: Support for Patients and Communities; Opioid legislation. Currently working on:
- Medicaid Reentry Act, At Risk Medicaid Protection Act, and IMD Care Act. Best practices in health care for those in reentry from corrections; restore benefits 30 days prior to discharge, suspend (rather than terminate) Medicaid for justice-involved youth; IMD Care Act partially lifts the exclusion in the Opioid legislation, to improve services.
- Building Our Largest Dementia Centers, Alzheimers Disease & Healthy Aging Program.
- Initiative to promote mental health, treatment for substance use disorders, and criminal justice reform (includes repeal of Medicaid Inmate Exclusion for those pre-adjudicated.)
- Legislative priorities: federal/state/local structure for financing and delivering Medicaid services while maximizing flexibility to support local systems of care; advance legislation and administrative changes that will enhance counties' abilities to provide adequate services for people with MI; provide targeted funding and administrative changes to help counties combat addiction and its effects; ensure federal funding and integrity of key health safety net programs while preserving local public health and prevention efforts.
- Additional priorities: ensure investments in health care for older adults; address intergenerational poverty, especially related to health; protect counties' ability to provide quality health benefits to their employees.

## "Taking the Pulse of Congress: Prognosis for Health Legislation"

- **Rodney Whitlock, McDermott + Consulting** with Washington Health Care Update.
  Overview of political considerations of current legislative leadership. Significant 'extenders' package coming up, for Community Health Centers, Disproportionate Share Hospital Payments, 340B program, etc. Legislators need to know the value these have to local communities, and that cutting them will cause harm.
- Drug pricing will be discussed. Politics pose a big potential barrier to making progress in policy.
- Funding is needed to support the many pieces of legislation passed last year related to SUD and MH.
- Addressing the process problem and not the outcomes that don't make sense, due to media coverage and the fact that simple solutions aren't the best. And it's already 2020, with surprises beyond those of 2017 (i.e., addressing 'repeal and replace legislation.) Possible 2021 threats include local hospital construction requiring federal approval.
- **Nick Macchione, VP Health Committee,** stressed localism in action. Move our focus from fidelity to the program to fidelity to the cause. Committee to collaborate with CMS on 1115 waiver for counties.

## "Healthy County Advisory Board Meeting"

*Supporting youth development and well-being is critical to shaping individual futures and the future of counties, states and the nation. In a rapidly changing world, counties must be innovative and strategic in preventing substance use and abuse among youth populations.*

- **Kirsty Fontaine, NACo,** on youth substance use prevention and health equity. While focus on opioids is a national burden, counties have specific substance use issues. New NACo project will develop a report/landscape highlighting needs, gaps, and opportunities, based on focus group input and individual county interviews. Aligned with priorities: youth substance use; connecting the unconnected, most

vulnerable people; public health, public safety, and justice. NACo-CMS collaboration should include SAMHSA, which also needs to know about local challenges and solutions.

- **Barriers and solutions to developing and sustaining multi-sector partnerships in programming:** School systems, PTAs, and school boards, with a high proportion of local taxes and data from risk assessment, have information we need; SAMHSA funding is typically state level rather than county; classification of opioids doesn't keep up with changes in the drugs; burden of cost of autopsies in opioid related deaths; young people vaping; addictions starting with prescribed drugs, underreporting of youth suicides; inconsistent engagement across public systems; partnering with school systems for decision support on social service grant funding.
- CDC grants can be local but bring the challenge of speaking their language; several federal agencies have projects which respond well to local coalition work; Baltimore City Youth Fund https://bcyfund.org/ supports many grassroots projects, uses local tax fund, has a greater than 50% youth governance; with combined resources, collocating services in one building with input from the students on what they need.
- Risk of opioid use is higher with depression, and depression is higher with youth, so target youth mental health, assess for opioids and MH at primary care and specialty care providers; educate and address on ACEs and social determinants of health and trauma, especially through a community coalition.
- Depression screening in our own workforce, use of EAP, addressing stigma; location of long-term evidence-based treatments; read the report http://opioidaction.org/
- Use of workforce investment and water agency and parks funding to build youth (18-24) job skills, employment opportunities, and confidence; refocus from mental illness to mental health and proactive youth engagement, improving the parks and rec programs.
- Ohio Opioid Action Alliance https://preventionactionalliance.org/ and the Don't Live in Denial campaign.
- Address secondary trauma of providers to reduce turnover, screening of all, including veterans and families dealing with SUD or incarceration; countywide youth summit to reduce high tobacco/juul use, followed by system stakeholders, and certification of tobacco-free apartment complexes; multi-sector approach with screening in all; Family Access Center referrals from schools and law enforcement, addressing stigma; faith community led summits, so that services connect to people no matter where they start; working across silos, using text access to clinicians, and programs to support grandparents raising grandchildren; unstable funding to address stigma in middle school; MH counselors in every school but they are not paid well, hard to recruit and retain; workforce shortage generally.
- Mayor's Office of African American Male Engagement connects resources, for 120 days, to people 'on the corners' based on a coalition of faith based and public entities. Multi-sector approach is a best practice.
- To continue this conversation in July, Kirsty will summarize today's remarks: stigma, beyond opioids, juul/vape/tobacco use, youth integration into the solution process. Virtual focus group info in newsletter.

"County Cannabis Roundtable"

- States at the table shared their status wrt medicinal, recreational, neither, or both; counties' permits.
- **Joe Kron and Saphira Galoob, federal lobbyists**, with a brief overview:
  For local control, the STATES Act (Sens Gardner and Warren, with 6 D and 4 R sponsors) creates an exemption to the Controlled Substances Act and has provisions for banking and hemp. The politics of cannabis not so much party divided as generational. States should be in the driver's seat; some bills would take cannabis completely off the schedules, not likely to decrease the confusion associated with hemp production (e.g.). Promote an exemption and then reparation, also complex to reconcile with each state. Address tax reform, banking, Safe Banking Act (introduced), some veterans use, tribal lands, etc.
- Every year there is movement in appropriations, so to protect all parties in the medical marijuana industry, DOJ is defunded for all related actions. Expand this to amendments in three other areas (all industry stakeholders, banking access, veterans' access) in order to fully protect from federal interference. It's crucial that as regulated cannabis is introduced, local authorities have control to enact rules as they see fit. Coast Guard should be added. Federal legislation will be driven by states' actions as states come on board.
- California Cannabis Authority is a County Joint Powers Authority researching common powers to gather and manage cannabis regulatory or taxing authority. Analyze data from multiple sources on many points. Over 500 banks nationally are contributing data. CCA and NCS Analytics Partnership helps businesses stay in compliance on the regulatory or taxing side. Discussion of the large data platform: comparisons of internal accounting systems, bank deposits, high risks (e.g., manipulation of sales numbers, payments to mega-church, hidden bank accounts). This partnership helps banks as well as local tax projections. https://www.counties.org/sites/main/files/file-attachments/california_cannabis_authority_cca.pdf

- Concerns of communities: 'bags of cash' experience, so federal Safe Banking Act is important. Behavioral health providers are concerned about impact on brain development and cannabis-induced psychosis; invest new revenue in treatment and prevention. Don't mix cannabis and gaming. Need to understand drug interactions and contraindications. High taxes on the product could keep growers in the black market. Understanding the relationship between purity and impact on brain.

## NACBHDD Board Meeting

### "Committee Reports"

- Committee Chairs provided updates on:
  Executive – director evaluation, new officers, first meeting today; Budget – good position; State Association Directors - develop conference topics and policy directions; Behavioral Health - framing outcome measures and tools for people, systems, and population-based; I/DD - workforce, capacity, outcomes, technology, value-based payment, dual diagnosis, crisis; Communications – website; and National Association of Rural Mental Health – partnering with the Mountain Plains Mental Health Technology Transfer Center on conferences, recruiting members due to farm crisis.

### "Review Progress on NACBHDD Strategic Directions"

- Identity: white paper on 7 roles - Planner, Policy Developer, Preventer, Protector, Partner, Purchaser, Provider - applies differently in some states, including with relation to safety net and health plans, which have no experience with justice-involved ppl; MCOs lack outcomes data; Secretary of HHS wants to manage Medicaid with 1115s and promote social supports; in the integration of everything, need a way to pay for social determinants of health; NC is newly approved to use their savings from 1115 for these.
- Workforce: mentoring young board members as part of succession planning; emeritus and senior fellows, most recently with the Decarceration Initiative; experienced members sharing info to NACo; use of team-based assessments; core curriculum for competencies in working with those dually diagnosed (MI/SUD); work with primary care providers, who are resistant to serving those with MI; "ED Bridge" in CA for buprenorphine at emergency depts; Universities at Shady Grove summer interdisciplinary program on health and human services is informative; wage increases for direct support professionals (in MI, IL, NY) with other changes to front line roles.
- Parity: Kennedy Forum has model legislation for every state; need civil penalties for non-compliance findings; work with state health insurance commissioners - without parity in insurance (not just Medicaid but commercial), nothing else happens downstream; crisis services should be covered by all plans.
- Behavioral Health and Justice/Public Safety: Dr. Manderscheid convened DOJ and HHS staff for a day, discovered they'd never met each other; next step was to be supported by gov't but fell through, so he will have to reconvene; Technical Assistance Collaborative will host a meeting on justice involvement with relation to Olmstead, possibly test cases through the Bazelon Center; public-private partnerships in TX.
- Cross-System Coordination: possibly a white paper on best practices to reaching outcomes.
- Respond Effectively to External Pressures: share developments through waivers; Kaiser Family Foundation site is searchable and best source: https://www.kff.org/search/?s=1115+waivers; continue advocating to retain Medicaid for pre-adjudicated youth and adults.

### "State Updates"

*How is Medicaid working for those with justice involvement? How is it helping to prevent incarceration of persons with behavioral health and I/DD?*

- NY – Vivitrol bill, for prisons and jails, but not likely to pass. Addiction treatment in jails; suspension of benefits working okay, but now the responsibility for Medicaid applicants goes to state; workgroup of DAs, PDs, and providers but not great result; now a template for court order regarding info. Four counties with diversion project grants. Trying for a GAINS Center project statewide. Frame the pre-adjudication issue as civil rights, because only the person's setting has changed.
- TX – reinstatement of Medicaid after suspension is a challenge due to communication; latest phases of 1115; general revenue was used for special projects at local level for diversion from justice system.
- VA – expansion of data exchange between criminal justice and behavioral health. In 2018, proposed legislation for contracts for services in jails lacked provisions for the specific services, so a group is now

developing minimum standards for in-jail services; I/DD not included, but screening for DD will be among the standards. Establish a Medicaid redesign around behavioral health, hope to address I/DD.

- MD – an expansion state. Mandate for crisis services, routinely diverting people; crisis providers respond with the police, do an assessment; counties pay for the social service eligibility worker to go into the jail. In response to opioid crisis, anyone can walk into a fire or police station and say they need help with SUD, be seen by EMS, be taken to a safe place and then to treatment, if indicated. 64% of those served in 1.5 years go to treatment and don't revolve back through; providers go out and look for them if they don't come in for treatment. Fire stations expected 5 a month but see 5 a day; hospitals and justice are saving a fortune, getting national attention. CIT training of officers; residential substance use funds now fee for service; Specialty Courts creating some access.
- MI – sequential intercept model working broadly (good case management could be Intercept -1). Non-Medicaid money from liquor tax for jail services. Medicaid expansion got people more MH services. Lots of CIT training, early identification, and funding of community-based supports for those Incompetent to Stand Trial waiting for restoration. Staff indicate at exit interviews that they don't want to do emergency services. State's enrollment process for opioid users is not great.
- TX – just starting to move on opioid use disorders. Two years ago, target treatment for those with justice-involvement. Need to address bail reform.
- CA – bail reform passed. Successful legislation around pre-arrest diversion of people with MI or SUD to treatment center. Presumptive eligibility for those in re-entry or release, making it quicker for them to get on Medicaid. Reimbursement for recovery support services.
- OR – 'fitness-to-proceed' issue, for those with behavioral health disorders and justice involvement; bill to require law enforcement to communicate with community mental health providers prior to sending them to state hospitals. Bill for funding for community restoration, crisis stabilization centers, rapid assessment process. Civil commitment workgroup. Bill to extend holds/keep people in community longer. Behavioral health justice reinvestment initiative is a unique grant, with housing and crisis stabilization. Use eligibility workers in the jails; need pay for performance (lowered recidivism) to reinvest in supports.
- UT – justice reinvestment. Partial expansion of Medicaid to 100% of poverty, while seeking waivers. Sales tax increases to fund the system might not be enough. High opioid use and suicide rates.
- IL – expansion state, budget woes, legal medical marijuana, moving toward legalization of adult use. 1115 projects include IMD exclusion for substance use treatment; state plan amendments add integrated health homes but process delayed. Minimum wage increase.

## NACBHDD Legislative and Policy Conference

### "Progress on Medicaid"

- **Kelly Hansen, NY** on Transition to Medicaid Managed Care for Adults:
  NY has $78b in Medicaid, 6.5m ppl enrolled of total pop 19.5m. To get MH/SUD services in managed care, Health and Recovery Plan (HARP) implemented first in NYC in 2015. 1915i state plan HCBS is similar to an 1115; conflict free case management hard to do in rural areas; this plan keeps inpatient and partial hospitalization, MH clinic, and moves in opioid outpatient, etc. Success with adding housing, educational, employment supports but design is a challenge; residential redesign includes clinic to rehab off-site; NY waiver adds mobile crisis intervention (24/7) and other licensed MHPs off-site – this was a good collaboration with counties; short term respite is the most frequently used, then peer support and family support and training.
- Loss of targeted case management as it converts to health home care coordination; fight for low caseloads (10-12); peers should start at the moment of enrollment rather than after going through the health home, so now people can go around the health home to get HCBS services.
- 170k ppl are eligible for HARP eligible, 137k enrolled, 40k Health Home enrolled, 28K HCBS assessed, and only 3900 HCBS claims, so what happened? Care managers don't understand the HCBS services, seem scared of these enrollees, leading to high (40%) turnover and no change in the spending for these services. Local HCBS providers get $ through counties but had to become Medicaid billers; focus on data over patients. Adjustments to make: attention to the complexity, time delays, standardization of forms and processes, and workforce,
- **Tom Renfree, CA** on 1115 Medicaid Waiver for the Drug Medi-Cal Organized Delivery System:

2,196 opioid overdose deaths, 429 fentanyl overdose deaths, 4,281 opioid ED visits, more prescriptions than people. Drug Medi-Cal ODS is an 1115 demonstration; 24 counties moved through the planning process and are now implementing services, 84% of CA represented. Access to treatment not covered before, evidence based treatment for SUD, integrate SUD with mental and physical health care; includes case management, residential, withdrawal management, recovery services, physician consultation, MAT.

- Those under 21 are eligible under EPSDT mandate. Waiver includes IMD exclusion for SUD, allowing Medicaid billing for residential treatment regardless of # of beds. Expands workforce by adding LPNs and LPHCs. People access evidence-based services where they live. 24/7 call-in for brief screening and referral.
- Better engagement in treatment and higher satisfaction with the care. UCLA evaluating the program. Increase in residential treatment and calls to the 24/7 access line. Need ongoing training and assistance, as there are growing pains with the access line. Burden of documentation. Working with criminal justice requires additional administrative structure (training, etc.) Overall, positive impact on people and systems.
- **Carol Backstrom, Harbage Consulting** on lessons learned from early adopters of 1115 waivers. Harbage worked with CA on the implementation. From interviews with counties who've piloted these waivers, SUD treatment is successfully mainstreamed into the larger health care landscape, whole person care, and SUD is reframed as a chronic disease. Counties now acting as health plans, contracting directly with providers, doing quality improvement and beneficiary relations (rights, protections); strong local leadership, positive relationships with providers, and ongoing communications plan are key. Flexible use of funds, to increase rates, reimburse case management, reinvest freed up SAMHSA funds, expand staff.
- **Roxanne Kennedy, NJ** on Managed Care plans in NJ: Within expansion benefit, added outpatient SUD beyond methadone, which they had been doing. SUD waiver a little different from CA. Long-term residential treatment and short-term detox, peer recovery, and case management. Behavioral health homes and Certified Community Behavioral Health Center (CCBHC) pilot state, include veterans with PTSD, children. CCBHC gets very good outcomes but is expensive, so moving toward state plan amendment. 5 of the CCBHC programs were awarded an extension grant. Return on investment studies are being done with the 5 behavioral health homes for adults and children. Long term supports are in managed care (for DD too), proving difficult for the MC plans to manage, to create adequate networks on behalf of the special populations. Office based addiction treatment (not focused on opioid only, as alcoholism costs more over the long term) and MATs. Two NJ universities are involved (workforce and research). Finding physicians willing to be participating providers. Other states have similar challenges.
- **Dr. Manderscheid** asked about the relationship between mental health and addiction. NJ providers refer for indicated services. CA billing structures are not conducive, but SUD assessment includes some screening for MI; advocating for a similar waiver in 2020, with IMD exclusion for MH services. NY to develop integrated licensure (primary care, MH, addictions) and payment reform, raised the threshold to 55% before MH license is required. NJ also has issues with licensure. Tend to the privacy issues as you develop data exchanges. Caution when moving from state rates to MC rates, holding some for value-based payments (incentive rates).
- **Charlie Curry, former Administrator of SAMHSA**: states' drive the action in MH and SUD but counties are where it gets done. Solutions only come at the local level, where SAMHSA goes to inform policy, with nuance and the actual people using and receiving services. While some warn to move away from carve-outs and do carve-ins to support integrated care, a lot of good comes through local pilots. 'One size fits all' is disastrous. Counties foster the vision of recovery.

"Solving Workforce Issues at the State Level"

- **Wayne Lindstrom, New Mexico Behavioral Health Collaborative:**
  Poor state, geographically large, unique challenges. Aging workforce with no one moving there to cover. 5th largest state but only 2m residents; 178K folks with behavioral health needs are served. Data on who is practicing and where; mapped out density of who does SUD, MH, etc. across the state; only have benchmarks for psychiatry, need them for other MH to determine if we have adequate workforce for the population. Hoping the federal govt. will establish those for states to follow. Depression, anxiety, and trauma-related diagnoses are most common. Opioid and alcohol are top SUDs.
- Convened statewide task force of providers, stakeholders, higher ed, licensing boards, independent practice associations, state agencies. Surveyed clinicians in all counties about ability to meet the needs in their area; found gap consisting of those not licensed but graduated; supervision was an expensive issue; reciprocity, recruitment, pay, burnout also identified. Created CBH Workforce Development Team.

- Tele-supervision a key solution, targeting masters level clinicians in rural areas in public behavioral health to increase independent licensure. Took the high cost out of it. Rate Incentives such as group therapy settings, after school hours, in community settings, case management delivered in the community, and ACT teams. 20% higher rates for nights and weekends. Pay staff more to work nights weekends and holidays with bonuses. Waived some rules, such as who prescribes, types of service reimbursable, to increase workforce. Put rules in policy manuals (vs rules and regs) so it's easier to turn around revisions when you need them. Interns and clinical consultation covered, even the placement of interns is covered.
- See treatfirst.org. Up to 4 sessions with peer support or other professionals allow them to treat people first before doing all the paperwork, which tends to lose people for the 2nd visit. 'No-show'rate has gone down to 17%. Identified and removed many unfunded mandates.

"Key Developments in the Medicaid Program"

- **Kirsten Beronio, CMS**: brief overview of Medicaid, state control over nature and scope, with federal approval and some mandated services. Ten states don't cover methadone but will have to, with exceptions to be defined; new optional benefit for pediatric centers; flexibility around the IMD exclusion – coverage for neo-natal/post-partum care outside the IMD facility; new demonstration program to strategize around the SUD capacity issue and pharmacy benefits; guidance on neonatal abstinence syndrome; guidance on the SUPPORT for Patients and Communities Act passed last October; implementation of parity within Medicaid; provisions in CMS rule in Medicaid and CHIP which don't exist on the private insurance side which address special limits on coverage of behavioral health benefits.
- SUD Treatment Delivery System Issues: lack of providers, MAT increasing but overdose rates still high, withdrawal management needed, serious co-morbid conditions often not identified and addressed. Overarching goals will be to increase rates of identification and treatment, use EBP and SUD specific standards, provider capacity including MATs, comprehensive strategies.
- SMI and SED initiative: supported by 21st Century CURES Act, to treat people earlier, address comorbid conditions and high suicide rates, and timely follow up care; continuum of care should include crisis response; states to work on access to community-based care and significant reporting on metrics.
- **Lindsey Browning, Nat'l Ass'n of Medicaid Directors**, on engaging with state Medicaid directors: NAMD serves the 56 people running Medicaid programs, with peer learning, sharing their concerns with legislators, collecting and sharing data across the states.
- Medicaid covers 1 in 5 Americans, is the largest payer of behavioral health services, can be up to 30% of a state's budget, predominantly contracted through Managed Care.
- Nearly 25% of Medicaid directors are new, due to changes in governors; new directors bring diverse experience to complex program, populations, accountabilities, and political nature of the work. Expectations on them have changed: greater public and legislative accountability and pressure; politicized.
- New activity around expansion in several states. Ballot initiative to expand failed in Montana. Coverage for childless adults changing; work-requirements (job training, volunteer activities) make expansion more politically feasible; partial expansion is another emerging strategy. Medicaid directors don't want anyone to lose coverage, so are working on engagement and outreach, and need help to develop the relevant exemptions needed to reach the most vulnerable people.
- Prescription drug costs are a key driver; must cover all FDA approved drugs, and new high cost specialty drugs are coming into the market. Pharmacy benefit managers are new. A cross-payer issue nationwide. State Medicaid strategies to address this are a preferred drug list, negotiated rebates with manufacturers, and transparency and public accountability to drive change, e.g., data on whether a drug really does achieve its outcomes. 'Netflix subscription' model of LA. Building the capacity for MAT while addressing quality of care (and how to assess it); payment mechanisms to incentivize capacity and quality. Vehicles are 1115 IMD waivers, Support Act state plan option, CMMI models.
- Comments and questions: we don't really have the capacity anymore to have those kinds of supportive dialogues with state Medicaid directors. Realities of Vivitrol include low actual use, due to panic in the days just prior leading people to use (alcohol too, not just narcotics). Workforce and prescribing issues also limit MAT programs; want MAT in jails (NY is planning to submit a waiver for it). If CMS is interested in justice involved individuals, know that when they are processed they lose benefits and have long delays to turn it back on; connection to care is a priority for CMS, which launched a large set of FAQs in response, but jails and prisons are supposed to be providing care. Intersection of parity, integration, and actuarily sound rates (currently based on claims data, artificially splitting into medical, behavioral, and

pharmaceutical categories – a challenge to coordination), need to get past this, to spend 'medical' money on 'behavioral,' as parity might not be the solution.

## "State Brain Drain"

- **Brian Sims, National Association of State Mental Health Program Directors,** on the changing frontline, administrative, and policy staff. Workforce issue has powerful parallels with harm reduction and prevention. Connections everywhere, so we listen to what the staff say to us: overview and workforce challenges (esp in inner cities and minority communities), understanding trauma, holistic approach with resiliency and recovery. Association members (medical directors) post questions to the listserv and develop national dialog. Integration of care puts people together. Workforce now is different from 10 years ago and also 5 years ago.
- "Beyond Beds" – housing and homelessness, special populations, etc. and the vital role of state psychiatric hospitals, the need for 'excellence centers.'
- Workforce threats include poor salary, low morale, lack of validation, issues no one working in the system can solve. When you ask people why they're working, the answer is overwhelmingly - to retire. This has other impacts. People appreciate simple things like a brief discussion before every meeting focused on the good work of one person (very specific positives). Workplace stressors are physical exertion, lack of opportunity for growth, fear of job loss, not learning anything, low compensation. Populations served are often primarily minority members, not matched by the workforce. In Baltimore, they trained over 80 agencies and 1900 staff in system transformation, also trained trainers; this led to partnership and collaboration, shared vision. Asked if they believed in the people they served; opens the door to anyone who wants to work in the system.
- Staff feel: pressured to do more with less; encouraged to be creative, which can make you a target; mixed messages (e.g., customer service); impossible to keep personal issues from impacting work. 61% of men and 51% of women have something traumatic in their lives, including loss, chronic stressors, abuse. Don't minimize faith: physical, intellectual, emotional, social, occupational, and spiritual contribute to wellness. Workplace complaints regarding religion are rising.
- Solutions? Realize the widespread effect of trauma, recognize signs and symptoms, respond by fully integrating knowledge about trauma into policies. Cultivate motivation; workforce health and wellbeing are money savers. Staff can identify what will help them, e.g., training on triggers, then recognize others' triggers and step in early to intervene; leads to a safer and more attractive work environment.

## "The Federal Approach to Services for Mental and Substance Use Disorders: An Update from SAMHSA"

- **Elinore McCance -Katz, Assistant Secretary for Mental Health and Substance Abuse, SAMHSA:** In 2017, over 46m (19% of) Americans had MI, 18.7m (7.6%) had SUD, and 8.5m (3.4%) had both, totaling nearly 57m people. SAMHSA to be more responsive to the needs of those with SMI and their families, and children at risk and living with mental disorders. Increase suicide prevention efforts, interventions for opioid/other drug use, education and outreach; address parity; use data to inform policy and determine effectiveness of programs.
- Approach: talking with states and counties; interdepartmental coordinating committee on SMI; engage public through treatment locator project, fact sheets (healthy pregnancy, privacy rules, etc.), media outreach; and liaison with other agencies.
- In 2017, 11.4m ppl misused opioids and 2.1m had Opioid Use Disorder (OUD), but 55% sought treatment. Hydrocodone still the highest used (decreasing), then oxycodone, then prescribed fentanyl. Most fentanyl deaths are related to fentanyl trafficked into the states; heroin use and pain relief med use are not declining enough compared with all of the initiatives to address their use, but heroin initiation dropped significantly. Synthetic opioids contaminate street heroin, contributing to the very steep increase in deaths; regular heroin use is a major risk factor, as is non-medical use of prescription opioids.
- Combatting the opioid crisis through funding to states for discretionary programs: $50b to tribes, 15% to hardest hit states; states to answer clinical and admin questions. Naloxone distribution and first responder training = $49m. Medication Assisted Treatment - Prescription Drug and Opioid Addiction (MAT PDOA) program for pharmacotherapy implementation = $89m. Pregnant and Post-Partum Women program (residential and outpatient) = $29.9m. Updates on MAT and "Kratom" at National Survey Data on Drug Use and Health - nsduhweb.rti.org.

- Criminal justice programs with MAT, drug courts (adult, juvenile, family, and offender re-entry). Recovery coaches training and placement in communities and EDs. Reinstatement of Drug Abuse Warning Network. Pain management guidelines, MAT training, and suicidality. Practitioner training programs, including grants to universities, DATA waiver trainings - 59,000 trained so far, 10,000 are NPs or PAs, but many are still hesitant to prescribe, so SUD education should begin at undergraduate level.
- Interagency collaborations: USDA – rural areas, recovery housing; DEA – telehealth rules; OCR – privacy laws; NIDA/NIH – "Healing Communities"; IHS – training and services for native communities; CMS – 1115 waivers for SUD and comprehensive levels of care; HRSA – loan repayment for addiction professionals, DATA waiver training, and address HIV issues; Surgeon General – naloxone advisory, marijuana data.
- SAMHSA budget increased 35% since 2017, much for mental health: MH block grant; CCBHCs and integrated care; criminal justice diversion (esp pre arrest); transition aged youth; suicide prevention; MHFA and CIT; National Child Traumatic Stress Initiative; establishment of Assertive Community Treatment (ACT) grant program; Assisted Outpatient Treatment (AOT) grants; children's MH initiatives; new consultation program for infants/toddlers with signs of SED; Office of Disaster Assistance.
- Training/Education Initiatives: EBP, psychotropic use, management of risk of metabolic syndrome, AOT, Clozapine, Eating Disorders Technology Transfer Center, Privacy Technology Transfer Center.
- Collaborations: Federal Commission on School Safety Report; integration of services and Medicaid billing in schools; CMI coordinating committee with several goals.
- Advancing prevention, treatment, and recovery support: reducing tobacco use, prevention technical assistance; PSAs on marijuana, kratom, stimulants, suicide prevention, co-occurring disorders.
- Improving data collection, analysis, and dissemination and program and policy evaluation: policy lab; buprenorphine survey; other substance use by youth with history of marijuana use; collaboration with Center for Behavioral Health Statistics and Quality on diagnosis and outcomes for all grant programs; reestablishment of DAWN; prevalence study; info on nicotine delivery products; info on Kratom.
- Strengthening healthcare practitioner trainin: the regional Technology Transfer Centers on many subjects, with funding from the older model of contracted TA which had been available to SAMHSA grantees only. Everyone can use these centers, even if not a grantee. Put $40m back into grants. Project ECHO type trainings, Centers of Excellence, EBP website. Combined efforts oriented to all health professionals. Integration of peers into services!
- Most changes driven by 21st Century CURES, to shift from serving the 'worried well' to those with significant conditions.
- The registry of EBPs was removed because evidence was not strong and included price lists with very high rates to for-profit companies. It is replaced with multi-departmental review of all EBPs on the SAMHSA site; get assistance for the use of EBPs from the regional Transfer Centers.
- Comment: Support for peers in emergency departments has had great impact in MD, tied to mobile crisis and law enforcement training. Has helped changed attitudes. Transportation to treatment is critical.

"Creating a Trauma-Informed State: Removing the BS (Blame and Shame) Through Education and Community Support"

- **Mary Beth Vogel-Ferguson, University of UT**: work primarily related to folks with public benefits, TANF family employment program, about how the programs work for them. Impact of trauma has been huge in the lives of many. Using ACEs to expand from the focus on adoption of health risk behaviors. Info at http://kpjrfilms.co. 10 questions. Comparison of ACEs scores of TANF participants with general population of UT showed strong relationship between ACEs and use of public benefits. In interviews, people shared they'd never had an opportunity to share their stories, stigma around childhood issues. Dept of Workforce Services adopted the ACEs screening, as absenteeism/financial problems/job loss also correlate strongly.
- Trauma Awareness Seminars: definition (emotional response to an event rather than the event itself); impact (esp in childhood); how to build resiliency (still have responsibilities to others); secondary or vicarious trauma; self-care as a tool to mitigate secondary trauma.
- All were invited to these 67 seminars, from Workforce Services, MH providers, Law Enforcement, Judiciary, daycare providers, faith leaders, etc. Evaluations indicated: need to connect to everyday life and work; helpful for self-care for secondary trauma (support front line staff with 'mental health' days off);

build resilience in clients, reduce triggers, recognize trauma; memory loss caused by trauma (so don't be quick to call out a 'lie').

- Implementation challenges: policy structures in agencies, defensive of stereotypes, self-identification of trauma impact. Service providers scored higher than general pop but lower than TANF recipients.
- Personal takeaways from training = new insights into parenting and other family, as much as they were about clients. A public health crisis, not only for front line staff but supervisors and administrators; all who engage with others should engage in a trauma-informed way. Also true of policy makers. Personal experience guides interests. "Having us determine our own ACE score builds empathy. I liked that!" Building resiliency as work counselors, avoid burnout through self-care. Workers don't like being mad at their clients/customers; more compassion, especially for those brave enough to walk through the door.
- Intergenerational Poverty Mitigation Act: acknowledging his childhood trauma, the lieutenant governor wants to make UT a trauma-informed state. Resilient Utah uses SAMHSA's "Concept of Trauma and Guidance for a Trauma-Informed Approach" and the important, clear impact of peer supports. Design process starts with determining what is already being done through community asset mapping. Survey went out to agencies with a brief video message from the Lt Gov. The resulting community needs assessment included 2500 people, all but one county, all traditional and nontraditional providers they could think of (libraries!) Don't just treat trauma but view interactions through the lens of trauma: rather than 'what's wrong with you?' ask 'what happened to you?' 75% of respondents thought trauma-informed approach was appropriate to their group, 60% had already taken steps, 76% would be interested in future collaborations to build a trauma-informed State.
- Public service campaign. Primary care providers are resistant because they don't know what to do with the answers people are likely to give to the screening. Normalizing the idea, as part of family history.
- Comments: CA governor committed $100m to trauma-informed care, focus on young children, but how to convince governor to address secondary trauma and lifespan? Use data on high turnover related to trauma (firefighters, e.g.) and other cost benefit analysis; kids come with parents, so parents need resources as well. For UT agency to become recovery-oriented, a whole culture change was needed; frontline staff recognize it; think also about secretaries, maintenance staff, CEOs.

## "Discussion of 2019 NACBHDD Legislative Agenda"

- **Ron Manderscheid** with overview.
  Contact Adrienne Mikler 410-222-7858 about Safe Stations Initiative or see https://www.aacounty.org/departments/sao/rehab-programs/safe-stations/index.html.
- NACO and National Sheriffs Association initiative to change federal law to permit Medicaid billing for pre-adjudicated people in jail. Yesterday the National District Attorneys Association signed on. Capitol Hill Briefing is the kickoff: *"more than 11.4 million individuals are admitted into 2,785 county-operated jails every year. Counties are responsible for the health care of individuals when they are in jail awaiting trial, and often shoulder a substantial financial burden for providing care, even if an individual is eligible for Medicaid, veterans' health benefits or other federal health coverage."*
- NACO Health Committee (see above) on 1115 waivers, meetings of leadership of CMS and Health Cmte to craft an 1115 waiver to allow Medicaid FFP for same. Other 1115 waiver opportunities: NC social determinants of health (housing, jobs, food); HHS Secretary recognizes the need for social services but hasn't said HHS should pay for them; 16% of ppl with behavioral health needs don't have insurance; states can still apply for 1115 waivers to use DSRIP payments; Kaiser website is more current than CMS.
- Repeal of Individual Mandate contributes to uninsurance rate, making DSRIP payments necessary. CA and OR are proposing individual mandates through other legislation. Concern about future changes to ACA; challenges by 17 attorneys general, amicus briefs; block granting of Medicaid would force states to take on the costs and political problems associated with the program, but we would seek an expansion of Medicaid.
- Parity legislation outlined, templates for each state on Kennedy forum website. 2016 Parity Task Force recommendations have not been implemented; after ten years, it's been very poorly enforced, need civil penalties for commercial insurers who violate the rule.
- 2018 legislation put $8.5b into Opioid Use Disorder over a ten year period; a bigger investment is needed. Link between OUD and depression. If 20% of youth have depression, we should respond. Primary care offices screen for depression but so should specialty care. There should also be SUD screening. Increase funds for drug use prevention and treatment, not just for reduction of supply. Playbooks at National Quality Forum website: https://store.qualityforum.org/?utm_source=nqf_landing_page

- Support availability of medications, including protected classes of medications for behavioral health, important for those who move from health systems to county jails and have poor outcomes from a change to meds within the new setting's formulary.
- Whether single payer system or dramatic expansion of Medicaid, change must be phased. Insurance plans will must have parity, permit certain classes of providers to practice (in underserved areas, e.g.)
- Telehealth partially addresses provider shortages but relies on digital infrastructure, which underserved communities also tend to lack. Loan repayment programs help, but many have required serving all, could narrow to serving Medicaid recipients. Concern on the Hill about the new farm bill: will it address the growing farm crisis and consequences? NARMH is working on this issue.
- **Tom Renfree, CA and Mitch Anderson, WA**: when meeting with representatives, identify the NACBHDD issue and connect it to state and local impact stories.
- Brief comments from **Blaire Bryant, NACo, Lauren Alfred Levin, Sandy Hook Promise,** and **Jonah Cunningham, Trust for America's Health** https://www.tfah.org and Pain in the Nation program www.paininthenation.org. Opportunity for and need to educate the many new members of congress about the role of counties in health care and criminal justice.

"Value Purchasing for I/DD Services"

- **Mary Sowers, National Association of State Developmental Disabilities Directors:** Buying services that have a positive impact on those served and their families. Value-Based Payment models range from rewarding for performance in FFS to capitation, including alternative models and population-based ones. Performance-based payment strategies link financial incentives to positive outcomes (quality of life too). Category 1 is fee for service with no link to quality and value; Category 2 is FFS with link; Category 3 is alternative payment methods within FFS (incentives for meeting expectations of contract -if savings are yielded, shared with provider and funder, but also risk sharing); Category 4 is population-based payment (integrated finance and delivery system.) Strategies: pay for performance, clinical episode payment (great for hip replacement), shared savings/ risk, capitation or global payments.
- Innovation Accelerator Program (IAP) – technical support for reducing SUDs, improved care for those with complex needs/high costs, promotion of community integration through long-term services, and physical/mental health integration; also works with states on data analytics, performance improvement, quality measurement, and VBP and financial simulations.
- Key Steps for I/DD Systems: Identify problem or desired outcome. E.g., improving integration of acute care, behavioral health, and long term supports, using LifeCourse framework (examines how a state's policies impact people across the lifespan); reducing cross-system cost, as 50% of people with I/DD are eligible for Medicaid and Medicare. Look at data on the 'as is' state. Identify gaps. Determine program features to include. Use National Core Indicators for provider performance, individual, and system outcomes metrics. Provider Readiness (business competencies, financial readiness, technology, quality measurement, care siloes, communication barriers), Payment and Administration Model, Infrastructure/Partner Identification, and Defining Success: Methods of Monitoring and Course Corrections (avoid unintended consequences).
- Emerging Interest Areas: pay for performance in employment services; workforce issues such as career ladder; individual quality outcomes; accountable provider models; system transformation.
- Examples of IAP for Home and Community Based Services are in MO, OH, WI.
  MO: VBP across Medicaid program offices (for personal care) and one for I/DD; to increase independence and decrease reliance on publicly funded services; identifying quality indicators.
  OH: providers share in risk and reward for achieving quality metrics; because they have a complicated structure of state and county funding, they changed the approach so that FFS rates increased with DSPs increased competency trainings and tenure, increasing the allure of the work.
  WI: managed care system with per person capitated rate; performance improvement strategy to withhold for incentive payment.
- Key Elements of VBP Strategy: Leadership commitment, clear objectives, identified measures of success, starting point, payment strategies to move the needle, meaningful stakeholder engagement and education, and strategies to support change and monitor efficacy.
- Depends on the flexibility of 1915c, other FFS delivery systems, and other authority overlays to achieve the desired payment methodologies. E.g., provider payments cease when community employment is most successful, so how do you incent agencies for this valued outcome? Pilot results will help. Restructure

payment systems for integration of behavioral health and I/DD services. EBPs like Individual Placement and Support (in 24 states, including IL) could work for people with I/DD.

"Working with the Justice Community"

- **Ron Manderscheid** – View the Capitol Hill Briefing: https://www.naco.org/resources/video/capitol-hill-briefing-reimagining-health-care-county-jails. A briefing in May to add consideration for inmates with I/DD (esp transition youth). More programming with Sheriffs Association in future conferences.
- **Dave Mahoney, Sheriff, Dane County, WI** –About 200 people are sent home from Dane Cty jail to serve their sentence with electronic monitoring; successful program since 2007, not widely supported at the outset. 97% success rate, with the 3% being things like getting off the bus on the way home from work and having a drink. Those who become engaged with justice system are in fact our neighbors: 5% of those in jail/prison are predators; 95% are there because we're mad at them (chronic drunk driver, addict, SMI). At Dane Cty jail, there are no MH beds, but 80% are drug addicts and 43% on psychotropic meds. What can we do with community-based programs to alleviate this pressure and treat people appropriately?
- Dane County has one of the cruelest jails in the country: a person using a wheelchair was there, and the only place he could be put was solitary confinement, where he stayed for months; now developing a humane, modern facility with dorm style rooms and a medical/mental health unit - of necessity, since there still is not a better option. Currently have the appropriate staff (RN, etc.) If we aren't going to provide restoration and recovery facilities, we at least need to improve criminal justice facilities.
- Frontline officers have to be willing to look at diversion options, as they have a lot of discretion. Also need judiciary to believe in these approaches, alternatives to confinement and creating a record. WI spends a huge amount on prisons and very little on treatment, missing the opportunity to address root causes. Community court: trained practitioners talk to offenders about impact on the community. MATs: Vivitrol can work, but also success with methadone and naltrexone. Mental health diversion: especially with a judge or prosecutor trained in MH.
- Once asked AG Holder what it would take for him to sue himself under Civil Rights Act! Legislation in WI requires that people move out of the jail after 90 days, keeps DOC from using jail improperly. Individuals can spend 20 years in the LA County jail.
- As duly elected officers of their communities, sheriffs must design jails that reflect the values of their communities. Do we want to warehouse people? In townhall meetings, he learned that most people didn't know about the jail, so hundreds of tours later, community groups are clear that it is not what they want. Adding MH care, programs, and working toward success at discharge with continuity of care, housing, educational, and support opportunities. Now have a parenting program, to address underlying causes; more people want this than they have space for. Partnering with school of library science, adding vending machine with books for every child who visits an incarcerated parent, plus reading support programs. Visitors have couches, not hard chairs. CIT for all deputies working in the jail; starting a mental health training program; trained officers respond along with a mental health provider.
- While these ultimately should be community-based programs, they still fall to law enforcement. Continue developing alternatives, diversion programs which may need to be highly individualized. Create an MH program within the jail, under the authority of the county. Discharge and reentry planning, with case workers aware of their clients' location and meds, to ensure continuity into and out of the facility.
- NACO and Sheriffs Association Task Force on continuity of services and Medicaid coverage, impact on behavioral health. Consider this: a high school freshman has the vision of legislation that would ban allincarceration of people with mental illness.
- **Indira Harris, Immigration and Customs Enforcement**, on behavioral health supports within the agency. US Public Health Service (6700 professionals, the only like this in the world) with mission to promote the security of the nation, a sea service stationed within SAMHSA, HRSA, CDC, FDA, NIH, and ICE. 201k screenings, 25K dental, 29k medical, 27k emergency, 110k physicals, and health care to 15k patients in 23 detention facilities. Charged with oversight of high-quality, culturally-sensitive patient care, with BH training. Consultation to providers, tele-behavioral health services, 93 providers including psychiatrists, psych MH NPs, psychologists, clinical social workers. As with state mental health facilities, there are staff shortages. Patients in need of higher level care are transported to facilities more ready to provide that care. Many have trauma prior to or related to entering the country. Collaborations with Columbia Regional Care Center, Larkin Community Hospital, and smaller for coping skills (esp building insight), therapeutic groups, and med stabilization, prior to integrating back into detention facilities. Service

agreements with jails and community partners due to lack of capacity to house all detainees. Work with RNs to ensure quality. Need more therapeutic programming in the 23 facilities.

## "National Update on Suicide and Suicide Prevention"

*Americans' average life expectancy has declined over the last two years, due to the opioid use disorder epidemic and increases in suicides.*

- **Matthew Taylor, Nat'l Suicide Prevention Lifeline** on Integrated Continuums of Care: the critical role of local crisis call centers and the National Suicide Prevention Lifeline.
- In 2017, 10.6m adults had serious thoughts of suicide, 3.2m made suicide plans, 1.2m made plans and attempted, 1.4m attempted, 0.2m made no plans and attempted. 1/3 who had thoughts made plans, and 1/8 who had thoughts made an attempt. From 1999 to 2016, suicide deaths increased 25%. High ACEs correlate very highly with drug use, smoking, and suicide. ½ of Americans know someone who died by suicide. ½ report it was a close person, and the loss had a big emotional impact. For every one who dies by suicide, 280 think about it and do not, suggesting that resiliency is the norm. Very helpful to hear messages of those who have thought, recovered, and moved through it.
- How call routing works: 1-800-273-8255 is the National Lifeline. Promote it, even if we have a county crisis number. "Press 1 for Veteran," and the call is transferred to one of three veteran crisis lines; "Press 2" routes to Spanish sub-network; if no prompt, call is routed to the local crisis center, where if unable to answer, it is routed to national backup network. Some states have many centers and volunteer to join the network. The mission is to reach and serve all persons at risk in the US.
- In 2005, 46k calls, and last year 2.2m (640k were veterans). Over 14m calls answered since inception. Vast majority of calls get de-escalated. Affiliated, local, regional, and state centers are underfunded. 88,615 calls from Illinois, with FL, NY, CA, and TX higher; most rates proportional to population. Data on call volume and outcomes, (including 500k abandoned calls) with projections of increased use. Not good news with regard to funding. Very high increases followed two celebrity suicides.
- Importance of resource shifting toward crisis call centers' critical behavioral health role: among students in grades 9-12, 17% report thoughts and 8% attempts; increased rates in young adults. Call centers can be initial point of entry into system, host information and referral and PSA messaging, offer extensive training (including police), and lead to careers in the field. Staff trained in EBP deescalate and help direct away from ED use. 86% of centers provide follow up calls, the most cost-effective intervention in public health. Costs and consequences of status quo: 1/8 ED visits were psychiatric emergencies and SUD; mood disorder sixth most common hospitalization; high cost to waiting for MH assessment; 3x longer in ED than for physical emergencies; Medicare and Medicaid patients have higher admission and readmission rates due to behavioral health needs.
- See http://crisisnow.com for optimal model for revamping crisis services. Helpful when applying for federal grants. Call center ROI: 2fold when using crisis center model for follow up, in reducing unnecessary ED visits and hospitalizations. $1 yields from $18-$106 in 'social return'. Better at reducing emotional distress and suicidality. 'Assist' model has strong evidence base. 80% of callers said it helped them feel safe, and half said the call response was the main reason they didn't attempt. Most communities' crisis systems have been handed over to law enforcement, inefficient and not the right care. Crisis should include real time coordination, centrally deployed 24/7 responders, with call centers which adhere to 'Lifeline standards' and act as air traffic controllers, with best practices in follow up care.
- Lifeline structure trends and effectiveness: a network of independently operated and funded crisis lines. Factor in lifeline call volume. Funded to manage a complex routing system, plus certification, but not for services; they establish best practices and offer technical assistance. Services are expected of cities, counties, and states. Callers get that 30 second pre-recorded message, and if centers don't answer within 30 seconds, Lifeline pulls it back, but it's 106 seconds to the caller. If no timely response, callers are likely to use 911. IL in-state answer rate is 29% (TX, NY, and GA are also very low, CA a little better). There are 180 call centers currently. When a center joins, they can determine their area and hours of operation.
- Most sustainable: local centers have strongest connection to resources; best shared at state and county levels. SAMHSA recognizes the value and requires states to have 70% of higher in-state rates to qualify for Prevention grants. If fully funded, Lifeline would be at $55m rather than $10m. mtaylor@vibrant.org (Champaign County, like much of IL, is not connected; our calls are answered primarily in MD.)

## NACO Data-Driven Justice Initiative Sessions

"Reimagining County Behavioral Health Crisis Response Systems and Policies"

*Without alternatives to jails and emergency rooms, law enforcement and other first responders have few options for diverting people who are experiencing a behavioral health crisis. NACo is partnering with Arnold Ventures to improve America's crisis response system through the Data-Driven Justice project: counties use engagement strategies to build regional/state support to redesign crisis response systems and link people to effective treatment.*

- **Robb Gray, Arnold Ventures**: crafting public policy; focus on diversion strategies which also improve personal outcomes; challenges faced by communities. 7x more people with MI/SUD in jails/prisons than in treatment. A small number cycle through homeless and hospital services with poor outcomes. Look at root causes through the Data Driven Justice Initiative and divert people to community-based treatment and services. Address tough situations through collaboration. Create and implement crisis response systems, stabilization facilities, connect to community services. What barriers have we run into with reimagining options for first responders/law enforcement? Advice on reimagining crisis intervention response systems?
- **Margie Balfour, Pima County, AZ**:
  Police have CIT and training to identify MH crisis/need for treatment, but they are often stuck waiting at ED if no other options, making jail a more practical option. Need appropriate options. EMS calls also problematic, e.g., panic/anxiety with chest pains, and they're only paid to take people to EDs. Reframe mission of crisis center, treat law enforcement as a customer too, don't add criteria which make them choose jail and ED. Pima Cty had a bond election for facility to decrease jail use, partnered with a bike trail project; a second bond built a county psych hospital. All are on campus of county hospital (with level 2 trauma), with 24/7 services for adults and children. County paid for buildings only, funding for services includes Medicaid. If you're paying for a robust crisis system, you want people to use it instead of hospital, so now funded by SAMHSA, county, state, and Centene.
- Ask who is feeling the pain with our current systems (police, ED, payers, hospitals), gather them for problem solving. Counties have special powers, e.g. data sharing to 'ping' provider upon admission. Data platform starts with jail and jail medical provider, through the county; data reports required via the lease. Show this is a priority; all programs have a home if there's a coordinator. Local tragedy added momentum.
- Staffing of crisis center: nurses, behavioral health techs, social workers, peers. Urgent care, walk-in (connection to services, crisis, med refills) turnaround in two hours. If too acute, 24-hour observation unit, appropriate to psych consult, with the philosophy that quickly responding with supports can prevent longer term hospitalization; 60% go home the next day, freeing up a bed.
- **Michael Daniels, Franklin County, OH**:
  First need buy-in from law enforcement acknowledging the illness. Public disturbance, e.g. did a crime really occur? Divert to 24/7 crisis response center (ambulatory and law enforcement) - almost always full now. In OH, if EMS provides any support, they have to transport to ED. Client can refuse transport, risking arrest. Legislative changes are needed to support transport to crisis center. A center can sound like a magic black box where you put people to get cured. Ask the hospitals if they'd like a place that would help us guarantee we'd not bring people to their EDs anymore, and if they say yes, ask them to help pay for it. Medicaid MCOs have come on board to help prevent use of private hospital care.
- Work closely with 911 operators, full CIT training modified for them. Public information and awareness helps families recognize signs early in order to avoid the 911 moment and use of police. Increased ability to resolve situations on site (police or mobile crisis response). Changing attitudes about the MH crisis. Form a coordinating council to get all the right parties to the table: coroner, prosecutor, judges, and those mentioned above. The leader should be a county commissioner or judge, esp with control over the budget. Those counties which have been successful can identify that one champion. Who is the single person coordinating Stepping Up? It takes a decade or more. Repeal of IMD exclusion would be helpful. We still treat addiction as shameful rather than as a disease. HIPAA should cover. 42 CFR part 2 is archaic and should be removed. Terminating Medicaid for pre-adjudicated people is a civil rights violation.
- **Lynn Overmann, Arnold Ventures**: homelessness/housing shortage; crisis stabilization centers; state by state impact of privacy rules; legislative barriers and data sharing.

"Data Driven Justice Initiative Workshop: The Future of County Behavioral Health Crisis Response Systems"

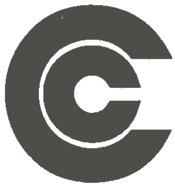
- **Lynn Overmann** on Data Driven Justice Initiative:

Every year 11m people cycle through 3,100 local jails, costing over $20b. Stakeholders from 26 counties had the same problem, the social safety net not working for many with MI/SUD who end up in jails instead. We need to get people where they're most likely to get treatment. Status quo is expensive and ineffective. 64% in jails have MI, 44% have chronic health problems, 68% SUD. People are housed in jails and EDs, not getting treatment, cycling back in. Get meaningful data into the hands of those who need it, e.g., combine police and EMS data and compare with hospitalizations. DDJ Pilot Sites were supported with project manager and data scientist to find the highest utilizers. Data can help us find those with lots of calls but also tell the story to stakeholders: the homeless, ED, jail, MI/SUD provider systems don't talk to each other through data or otherwise, but if we did, we'd solve the problems together. Beyond this, we need to solve the systemic problems so that no one becomes a frequent utilizer. Once all systems are at the table, reorient emergency response systems to support safe response, effective crisis stabilization, and diversion to community-based treatment and services for vulnerable populations. Reduce costs by removing inefficiency, and reduce harm to people and providers.

- **Sonya Khan, Middlesex Sheriff's Office, MA** on building partnerships:
  Sheriff has a background in public health policy, so housing her role and this project in the Sheriff's Office made sense. Urban centers, affluent suburban areas, and rural. Large population with 23% of state's population plus 54 cities and towns but no county level government = not the infrastructure ready to tackle county-wide issues.
- Sharing data as a solution, in environment where people are comfortable sharing data, answering the 'divert to what' question. Data Integration Goals (link police data, recruit healthcare partners, ID frequent utilizers, develop systematic cross-system relationships); Stakeholder Engagement Goals (break down data silos, expand beyond Middlesex County, sustainability); and Diversion Program Building Goals. Started with 10 dataset-pilot and healthcare data analysis pilot. Convincing police departments to work on this was easy, many have MH workers or social workers doing co-response or follow-up. Also bringing in hospital association, EMS, and elected and admin officials. DDJ police partners have provided good information back about the scope of the problem, some info from healthcare too.
- Many clinicians are funded by DMH but won't share data; statewide, hospitals are gathering data on this population and may help by building out de-identified data. Also working with Office of Medicaid: MassHealth programming and data sharing, administration level engagement, and a restoration center commission.
- **Erin Dalton, Arnold Ventures**, on defining and identifying frequent utilizers:
  Not sure yet the most efficient data sets for identification, so start with what you have; any additional data set will add value; be aware of limitations. For operational use like engaging with individuals, the last 18-24 months data will be better than big (5 year) data. Multiple police and service agencies, so simply coordinating across law enforcement data is great, then adding in substance use data. Will people be available for resources, and reach them at point of crisis rather than later; range of interventions. High utilizers of ED mostly women until crossed with criminal justice, then they're men. Likelihood of impact is like 80/20 but smaller. Canary in the coal mine: do the charges for frequent utilizers say more about the jurisdiction than about the people living there? E.g., decriminalize trespass on the beach.
- **Alma Castro, Long Beach, CA** on building diversion strategies:
  Large county, large city with a health department, fire, police, jail. 'Design thinking' approach, start with five years' data, top 5% of those with 11 or more citations and jail bookings = 875 individuals. Stakeholders pushed for the relevant client list, so translating to data of previous 18 months. Because they have control over city government, they signed data agreements across 25 city departments. Updates monthly. Now working on OpenLattice data integration. With the 18-month period, focus on those with 3+ arrests, plus those with 2+ if non-violent crime, SUD charge, or transient. They created intercept points (Street/Community, Jail, and Pre-Trial) for referring to multidisciplinary team wraparound, service coordination, and follow up. When all who are doing business as usual start sharing data and focusing on frequent utilizers, what data elements lead to best care, and what makes a difference?
- **David Schwindt, Johnson Couty, IA** on piloting and testing tools to support first responders:
  160k total population. Wanted to support and evaluate Housing First (impact on those cycling through) and CIT for all officers. Started with dispatch data (easy to access, to prove the use case), then law enforcement data (# contacts, amount of time, nature of contact) to determine eligibility for Housing First, then mobile crisis data. Soon to add ambulance and university data. A hole in the data was continuity across law enforcement agencies. Piloting OpenLattice's crisis report, easy and quick to complete and can be modified

per question. Officers fill this in, and the system will send referral to Shelter House if indicated, to connect through to resources. Want to get all LE agencies adding and using the data.

- **Margie Balfour, Pima County, AZ** on leveraging available federal and state funding to optimize care: Creative funding of crisis continuum, more than a collection of services: accountability (a single source) including financing; collaboration; data. AZ behavioral health system structure: 15 huge counties, 3 regions; Southern region has 8 counties, 6 tribal nations; Medicaid funding with expansion; last state to have Medicaid but first to have managed care, so never in fee for service. State RFPs out for regional behavioral health managers, and Centene has Southern region, and they contract out for things like crisis services. SAMHSA funds too, but managed per region. A well-organized system with centralized planning, accountability, and alignment of clinical and financial goals (psychiatrist also wants their patients out of jail and hospital), pushing down for strategic service design. Law enforcement a preferred customer. A person in crisis calls crisis line, 80% resolved on phone, 72% resolved in the field, 65% discharged from crisis facility to community, 80% remain stable in community-based care. Crisis response center built by bond. Officers have many options for people and no wrong door. There is a crisis dog and two dogs at the jail!
- **Breakout Sessions:** *Each table was assigned a topic with a set of questions to answer, for a list of actionable ideas to advance the field based on strategic categories listed:*
- State Advocacy Strategies to Support Comprehensive Crisis Response and Pre-Arrest Diversion:
  Federal funds to communities.
- How to Leverage Existing Funding to Support Comprehensive Crisis Response Systems:
  Get everyone at the table. Show that it works, with data, and include personal stories of success. Make diversion easier with better access - if going to the crisis center is harder than jail, why wouldn't they use jail? Pay for a lease with the shared data rather than money. Change Medicaid rules to provisional enrollment upon release.
- Share Your Ideas for Strengthening the DDJ Network & What Additional Resources Would Help Advance Your DDJ Efforts:
  Use the county's commitment to the principles, since they already agreed to it. Most lack the time to get the data-sharing agreements from all partners. Not a geographic or size focus but based on specific barriers faced. Packets and offline resources with the webinars. HIPAA barriers – there is a law enforcement exception, help providers understand. Cost savings to build more momentum for DDJ, with communities' examples. Framing (Milwaukee Cty) – Evidence Based Decision making project includes risk assessment tool, PSA, universal screening, robust pre-trial services. Agreement to standards and practices could help communities beyond the initial sites.
- Using Data to Identify and Understand the Needs of Frequent Utilizers:
  Bexar County, TX has several definitions of high utilizers. Data from overburdened healthcare providers propelled the establishment of Bexar Cty crisis services with centralized system at Law Enforcement level – cost $30m to start, later used $ from savings from healthcare, contracted with psych services. Champaign Cty used 5+ and now 4+ jail bookings per year and occasionally compare with behavioral health and healthcare providers' service data or HMIS. McLean Cty uses jail plus HMIS, automatically compared. Fairfax Cty uses several, e.g., 6 or more 911 calls in 60 days. Johnson Cty uses 6+ bookings in 2 years, custodial arrests booked into jail. Authority over specialty court eligibility and other diversion options. Resistance to diversion from judiciary and prosecutors. Washington State has combined MH and SUD and redefined regional supports. Bexar Cty shares data out to all stakeholders, monthly core group mtg and every other month Mental Health Consortium. Start with a champion who can speak compellingly or a person whose job it is to do the circuit (the pain points). In Johnson Cty, of top 15 names from 911 dispatch, most were chronically homeless but one was a newly elected council member who runs a service where staff all had phones in his name. Contact data are as important as arrest. Law enforcement and EMTs can stabilize a person on the scene, so they won't show up as a high utilizer. Incident reports written on all calls, to justify federal funding. Understand how police departments report data. Orange Cty, FL – Sheriffs can get federal funding. Having only a data analyst helps.
- **Catie Bialick**: expect new resources on crisis services and facilities, with case studies on communities which have already built this out; 50 state scan of barriers to pre-arrest diversion systems; working with more communities; another round of pilot investments to crisis response systems; guidance on data-sharing.
- **Lynn Overmann**: to figure out how to support a broader network of communities, to operationalize the cross-system work, as granular as MOUs and as functional as shared data platforms, and as transformational as going to the states; how to access federal funds for solving these problems; more travel opportunities; and another national gathering.



CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY

10.A.

# CCDDB 2019 Meeting Schedule

**Board Meetings**
**8:00AM except where noted**
**Brookens Administrative Building**
**1776 East Washington Street, Urbana, IL**

January 23, 2019 – Lyle Shields Room (8AM)

February 20, 2019 – Lyle Shields Room (8AM)

March 20, 2019 – Lyle Shields Room (8AM)

*March 27, 2019 – Lyle Shields Room (5:30PM) – study session*

April 24, 2019 – Lyle Shields Room (8AM)

May 22, 2019 – Lyle Shields Room (8AM)

June 26, 2019 – Lyle Shields Room (8AM)

July 17, 2019 – John Dimit Conference Room (8AM)

September 18, 2019 – John Dimit Conference Room (8AM)

October 23, 2019 – Lyle Shields Room (8AM)

October 30, 2019 – Lyle Shields Room (5:30PM) Joint Study Session

November 20, 2019 – John Dimit Conference Room (8AM)

December 18, 2019 – John Dimit Conference Room (8AM)

***This schedule is subject to change due to unforeseen circumstances.***
***Please call the CCMHB/CCDDB office to confirm all meetings.***



BROOKENS ADMINISTRATIVE CENTER • 1776 E. WASHINGTON STREET • URBANA, ILLINOIS 61802

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**DRAFT**

**July 2018 to June 2019 Meeting Schedule with Subject and Allocation Timeline**

The schedule provides the dates and subject matter of meetings of the Champaign County Developmental Disabilities Board through June 2019. The subjects are not exclusive to any given meeting, as other matters requiring Board review or action may also be addressed or may replace the subject listed. Study sessions may be scheduled; topics will be based on issues raised at meetings, brought by staff, or in conjunction with the Champaign County Mental Health Board. Regular meetings of the CCDDB are usually at 8AM; study sessions at 5:30PM. Included with meeting dates are tentative dates for steps in the funding allocation process for Program Year 2020 (July 1, 2019 – June 30, 2020) and deadlines related to current (PY2019) agency contracts.

| | |
|---|---|
| 07/25/18 | **Regular Board Meeting (Dimit Conference Room)**<br>Election of Officers |
| *08/31/18* | *Agency PY2018 Fourth Quarter and Year End Reports Due* |
| 09/26/18 – 8AM | **Regular Board Meeting (Dimit Conference Room)** |
| 10/24/18 – 7:30AM | **Regular Board Meeting (Dimit Conference Room)**<br>Draft Three Year Plan 2019-2021 with FY19 Objectives<br>Release Draft Program Year 2020 Allocation Criteria |
| *10/26/18* | *Agency PY2019 First Quarter Reports Due* |
| *10/31/18* | *Agency Independent Audits Due* |
| 11/14/18 – 8AM | **Regular Board Meeting (Lyle Shields Room)** |
| 11/28/18 – 5:30PM | **Study Session – Housing (John Dimit Room)** |
| *12/12/18* | *Public Notice to be published on or before this date, giving at least 21-day notice of application period.* |
| ~~12/19/18 – 7:30AM~~ | ~~**Regular Board Meeting**~~ ***cancelled***<br>~~Approve Three Year Plan with One Year Objectives~~<br>~~Allocation Decision Support – PY20 Allocation Criteria~~ |
| *01/04/19* | *CCMHB/CCDDB Online System opens for Agency Registration and Applications for PY20 Funding.* |
| 01/23/19 | **Regular Board Meeting** |
| *1/25/19* | *Agency PY2019 Second Quarter Reports Due* |
| *02/08/19* | *Agency deadline for submission of applications for PY2020 funding. Online system will not accept forms after 4:30PM.* |

| | |
|---|---|
| 02/20/19 | **Regular Board Meeting**<br>List of Requests for PY20 Funding |
| 03/20/19 | **Regular Board Meeting** |
| 03/27/19 | Study Session, 5:30PM<br>Navigating the Online Application and Reporting System |
| *04/17/19* | *Program summaries released to Board, copies posted online with the CCDDB April 24, 2019 Board meeting agenda* |
| 04/24/19 | **Regular Board Meeting**<br>Program Summaries Review and Discussion |
| *04/26/19* | *Agency PY2019 Third Quarter Reports Due* |
| *05/15/19* | *Allocation recommendations released to Board, copies posted online with the CCDDB May 22, 2019 Board meeting agenda.* |
| 05/22/19 | **Regular Board Meeting**<br>Allocation Decisions<br>Authorize Contracts for PY2020 |
| *05/23/19-06/05/19* | *Contract Negotiations* |
| 06/26/19 | **Regular Board Meeting**<br>Approve FY2020 Draft Budget |
| *06/27/19* | *PY20 Contracts completed/First Payment Authorized* |

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY

# CCMHB 2019 Meeting Schedule

**First Wednesday after the third Monday of each month--5:30 p.m.**
**Brookens Administrative Center**
**Lyle Shields Room**
**1776 E. Washington St., Urbana, IL (unless noted otherwise)**

***January 23, 2019***
***January 30, 2019 – SPECIAL MEETING and study session***
***February 20, 2019***
***February 27, 2019 – study session***
***March 20, 2019***
***March 27, 2019 – study session (optional, re: online review)***
***April 17, 2019***
***April 24, 2019 – study session***
***May 15, 2019 – study session***
***May 22, 2019***
***June 19, 2019***
***July 17, 2019 – John Dimit Conference Room***
***September 18, 2019 – John Dimit Conference Room***
***September 25, 2019 – study session***
***October 23, 2019***
***October 30, 2019 – study session***
***November 20, 2019 – John Dimit Conference Room***
***December 18, 2019 (tentative) – John Dimit Conference Room***

***This schedule is subject to change due to unforeseen circumstances. Please call the CCMHB-CCDDB office to confirm all meetings.***



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10.B.

**Agency and Program acronyms**

CC – Community Choices
CCDDB – Champaign County Developmental Disabilities Board
CCHS – Champaign County Head Start, a program of the Regional Planning Commission
CCMHB – Champaign County Mental Health Board
CCRPC – Champaign County Regional Planning Commission
DSC - Developmental Services Center
DSN – Down Syndrome Network
FDC – Family Development Center
PACE – Persons Assuming Control of their Environment, Inc.
RCI – Rosecrance Central Illinois
RPC – Champaign County Regional Planning Commission
UCP – United Cerebral Palsy

**Glossary of Other Terms and Acronyms**

211 – Similar to 411 or 911. Provides telephone access to information and referral services.

AAC – Augmentative and Alternative Communication

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

ABLE Act – Achieving a Better Life Experience Act. A tax advantage investment program which allows people with blindness or disabilities the option to save for disability related expenses without putting their federal means-tested benefits at risk.

ACA – Affordable Care Act

ACMHAI – Association of Community Mental Health Authorities of Illinois

ADA – Americans with Disabilities Act

ADD – Attention Deficit Disorder

ADHD – Attention Deficit/Hyperactivity Disorder

ADL – Activities of Daily Living

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.

BD – Behavior Disorder

BSP – Behavior Support Plan

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

CARF- Council on Accreditation of Rehabilitation Facilities

CC – Champaign County

CDS – Community Day Services, formerly "Developmental Training"

CFC – Child and Family Connections Agency

CFCM – Conflict Free Case Management

C-GAF – Children's Global Assessment of Functioning

CILA – Community Integrated Living Arrangement

CLC – Cultural and Linguistic Competence

CMS – Center for Medicare and Medicaid Services, the federal agency administering these programs.

CNA – Certified Nursing Assistant

COTA – Certified Occupational Therapy Assistant

CP – Cerebral Palsy

CQL – Council on Quality and Leadership

CSEs - Community Service Events. A category of service measurement on the Part II Utilization form. Activity to be performed should also be described in the Part I Program Plan form-Utilization section. It relates to the number of 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. Activity (meetings) directly related to planning such events may also be counted here. Actual direct service to clientele is counted elsewhere.

CUSR – Champaign Urbana Special Recreation, offered by the park districts.

CY – Contract Year, runs from July to following June. For example, CY18 is July 1, 2017 to June 30, 2018. May also be referred to as Program Year – PY. Most contracted agency Fiscal

Years are also from July 1 to June 30 and may be interpreted as such when referenced in a Program Summary e.g. FY18.

DCFS – (Illinois) Department of Children and Family Services.

DD – Developmental Disability

DDD – Division of Developmental Disabilities

DHFS – (Illinois) Department of Healthcare and Family Services. Previously known as IDPA (Illinois Department of Public Aid)

DHS – (Illinois) Department of Human Services

DOJ – (US) Department of Justice

DRS – (Illinois) Division of Rehabilitation Services

DSM – Diagnostic Statistical Manual.

DSP – Direct Support Professional

DT – Developmental Training, now "Community Day Services"

DT – Developmental Therapy, Developmental Therapist

Dx – Diagnosis

ED – Emotional Disorder

EI – Early Intervention

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.

ED – Emergency Department

ER – Emergency Room

FAPE – Free and Appropriate Public Education

FFS – Fee For Service. Type of contract that uses performance-based billings as the method of payment.

FOIA – Freedom of Information Act.

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.

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.

HBS – Home Based Services, also referred to as HBSS or HBSP

HCBS – Home and Community Based Services

HI – Hearing Impairment or Health Impairment

Hx – History

ICAP – Inventory for Client and Agency Planning

ICDD – Illinois Council for Developmental Disabilities

ICFDD – Intermediate Care Facility for the Developmentally Disabled

ID – Intellectual Disability

IDEA – Individuals with Disabilities Education Act

IDOC – Illinois Department of Corrections

IDPH – Illinois Department of Public Health

IDT – Interdisciplinary Team

IEP – Individualized Education Plan

IFSP – Individualized Family Service Plan

IPLAN - Illinois Project for Local Assessment of Needs. The Illinois Project for Local Assessment of Needs (IPLAN) is 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.

I&R – Information and Referral

ISBE – Illinois State Board of Education

ISC – Independent Service Coordination

ISP – Individual Service Plan, Individual Success Plan

ISSA – Independent Service & Support Advocacy

LCPC – Licensed Clinical Professional Counselor

LCSW – Licensed Clinical Social Worker

LD – Learning Disability

LGTBQ – Lesbian, Gay, Bi-Sexual, Transgender, Queer

LPC – Licensed Professional Counselor

LPN – Licensed Practical Nurse

MCO – Managed Care Organization

MDC – Multidisciplinary Conference

MDT – Multidisciplinary Team

MH – Mental Health

MHP - Mental Health Professional, a bachelors level staff providing services under the supervision of a QMHP.

MI – Mental Illness

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

MSW – Master of Social Work

NCI – National Core Indicators

NOS – Not Otherwise Specified

NTPC -- NON - Treatment Plan Clients. Persons engaged in a given quarter with case records but no treatment plan. 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, providing an actual number of those served in the prior program year and a projection for the coming program year on the Part II utilization form. The actual activity to be performed should also be described in the Part I Program Form, Utilization section. Similar to TPCs, they may be divided into two groups: New TPCS – first contact within any quarter of the plan year; Continuing NTPCs - those 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 Continuing NTPCs are reported.

OMA – Open Meetings Act.

OT – Occupational Therapy, Occupational Therapist

OTR – Registered Occupational Therapist

PAS – Pre-Admission Screening

PASS – Plan for Achieving Self Support (Social Security Administration)

PCI – Parent Child Interaction groups.

PCP – Person Centered Planning, Primary Care Physician

PDD – Pervasive Developmental Disorders

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.

PRN – when necessary, as needed (i.e., medication)

PSH – Permanent Supportive Housing

PT – Physical Therapy, Physical Therapist

PTSD – Post-Traumatic Stress Disorder

PUNS – Prioritization of Urgency of Need for Services. PUNS is a database implemented by the Illinois Department of Human Services to assist with planning and prioritization of services for individuals with disabilities based on level of need. An individual's classification of need may be emergency, critical, or planning.

PY – Program Year, runs from July to following June. For example, PY18 is July 1, 2017 to June 30, 2018. May also be referred to as Contract Year (CY) and is often the Agency Fiscal Year (FY).

QIDP – Qualified Intellectual Disabilities Professional

QMHP – Qualified Mental Health Professional, a Master's level clinician with field experience who has been licensed.

RCCSEC – Rural Champaign County Special Education Cooperative

RD – Registered Dietician

RN – Registered Nurse

RT – Recreational Therapy, Recreational Therapist

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

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

SCs - Service Contacts/Screening Contacts. The number of phone and face-to-face contacts with eligible persons who may or may not have open cases in the program. Can include information and referral contacts or initial screenings/assessments or crisis services. May sometimes be referred to as a service encounter (SE). It is a category of service measurement providing a picture of the volume of activity in the prior program year and a projection for the coming program year on the Part II form, and the activity to be performed should be described in the Part I Program Plan form-Utilization section.

SEDS – Social Emotional Development Specialist

SEL – Social Emotional Learning

SF – Service Facilitation, now called "Self-Direction Assistance"

SH – Supportive Housing

SIB – Self-Injurious Behavior

SIB-R – Scales of Independent Behavior-Revised

SLI – Speech/Language Impairment

SLP – Speech Language Pathologist

SPD – Sensory Processing Disorder

SSA – Social Security Administration

SSDI – Social Security Disability Insurance

SSI – Supplemental Security Income

SST – Support Services Team

SUD – Substance Use Disorder

SW – Social Worker

TIC – Trauma Informed Care

TPC – Transition Planning Committee

TPCs - Treatment Plan Clients - service recipients with case records and treatment plans. It is a category of service measurement providing an actual number of those served in the prior program year and a projection for the coming program year on the Part II Utilization form, and the actual activity to be performed should also be described in the Part I Program Plan form -Utilization section. Treatment Plan Clients may be divided into two groups: 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); New NTPCs are those newly served, with treatment plans, in any quarter of the program year.

VI – Visual Impairment

VR – Vocational Rehabilitation

WHODAS – World Health Organization Disability Assessment Schedule. It is a generic assessment instrument for health and disability and can be 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

12

**Kim Bowdry, Associate Director for Intellectual & Developmental Disabilities**
**Staff Report – March 2019**

**Program Summaries**: I have started reviewing CCDDB FY 20 Applications for funding and completing program summaries on those applications.

**DisABILITY Resource Expo**: I participated in a planning meeting for the DisABILITY Resource Expo Steering Committee on February 26, 2019 and a Children's Committee meeting at the Vineyard on March 7, 2019. The 12th Annual DisABILITY Resource Expo is scheduled for March 30, 2019 at the Vineyard Church.

Volunteers are still needed: http://www.disabilityresourceexpo.org/volunteer/

**Learning Opportunities**: On March 7, 2019 the fifth workshop was held at the Champaign Public Library. I assisted Chris Wilson in organizing and promoting the "Bookkeeping 101 for the Non-Profit Organization" workshop.

I met with a few community members about presenting at upcoming Case Management Workshops.

**Other activities**: I participated in the February MHDDAC meeting. I participated in an "ADHD & Emotions" webinar. I attended the Transition Roundtable, hosted by the Transition Planning Committee. I also participated in a "Reading, Math and the Brain: Connecting the Research & Practices That Work" webinar.

**Community Coalition Planning Committee**: I participated in a meeting of the Community Coalition Planning Meeting Committee. I also participated in Youth Race Talks at Mahomet Seymour High School and Centennial High School. The Youth Race Talks are an open dialogue between students, led by Donna Tanner-Harold.

**LEAP Training**: I participated in the LEAP Training (Leaders in Employing All People). The training was provided by Community Choices and DSC staff and offered to all County Departments. Community Choices and DSC collaborate on their efforts to increase local employment opportunities for people with disabilities.

**PUNS Selection & Reports**: The Illinois Department of Human Services-Division of Developmental Disabilities selected fifteen people from Champaign County from the PUNS database in June 2018. Seven of those 15 people have received award letters - six for Home Based Services (HBS) and one for CILA. Three people have refused services. Five people continue to work with a CCRPC ISC to complete the pre-admission screening (PAS) process.

Attached is the updated PUNS Summary by County and Selection Detail for Champaign County. I have also included the Division of Developmental Disabilities Prioritization of Urgency of

Needs for Services (PUNS) Summary of Total and Active PUNS By Zip Code and the Summary of PUNS - Total of All Clients by ISC Agency (Including closed records).

## Division of Developmental Disabilities

### Prioritization of Urgency of Needs for Services (PUNS)

### Summary By County and Selection Detail

March 07, 2019

**County: Champaign**

**Reason for PUNS or PUNS Update**

| | |
|---|---|
| New | 55 |
| Annual Update | 291 |
| Change of category (Emergency, Planning, or Critical) | 45 |
| Change of service needs (more or less) - unchanged category (Emergency, Planning, or Critical) | 39 |
| Person is fully served or is not requesting any supports within the next five (5) years | 189 |
| Moved to another state, close PUNS | 20 |
| Person withdraws, close PUNS | 25 |
| Deceased | 15 |
| Individual Stayed in ICF/DD | 1 |
| Individual Moved to ICF/DD | 2 |
| Individual Determined Clinically Ineligible | 5 |
| Unable to locate | 40 |
| Submitted in error | 1 |
| Other, close PUNS | 170 |

**EMERGENCY NEED(Person needs in-home or day supports immediately)**

| | |
|---|---|
| 1. Individual needs immediate support to stay in their own home/family home (short term - 90 days or less); e.g., hospitalization of care giver or temporary illness of an individual living in their own home. | 7 |
| 2. Individual needs immediate support to stay in their own home/family home or maintain their employment situation (long term); e.g., due to the person's serious health or behavioral issues. | 7 |
| 3. Care giver needs immediate support to keep their family member at home (short term - 90 days or less); e.g., family member recuperating from illness and needs short term enhanced supports. | 4 |
| 4. Care giver needs immediate support to keep their family member at home (long term); e.g., care giver is permanently disabled or is terminally ill and needs long term enhanced supports immediately to keep their family member at home. | 5 |

**EMERGENCY NEED(Person needs out-of-home supports immediately)**

| | |
|---|---|
| 1. Care giver is unable or unwilling to continue providing care (e.g., person has been abandoned). | 19 |
| 2. Death of the care giver with no other supports available. | 3 |
| 3. Person has been commited by the court or is at risk of incarceration. | 2 |
| 4. Person is living in a setting where there is suspicion of abuse or neglect. | 5 |
| 5. Person is in an exceedingly expensive or inappropriate placement and immediately needs a new plaec to live (for example, an acute care hospital, a mental health placement, a homeless shelter, etc.). | 6 |
| 6. Other crisis, Specify: | 68 |

**CRITICAL NEED(Person needs supports within one year)**

| | |
|---|---|
| 1. Individual or care giver will need support within the next year in order for the individual to continue living in their current situation. | 166 |
| 2. Person has a care giver (age 60+) and will need supports within the next year. | 103 |
| 3. Person has an ill care giver who will be unable to continue providing care within the next year. | 23 |
| 4. Person has behavior(s) that warrant additional supports to live in their own home or family home. | 88 |
| 5. Individual personal care needs cannot be met by current care givers or the person's health has deteriorated. | 27 |
| 6. There has been a death or other family crisis, requiring additional supports. | 11 |
| 7. Person has a care giver who would be unable to work if services are not provided. | 68 |
| 8. Person or care giver needs an alternative living arrangement. | 30 |
| 9. Person has graduated or left school in the past 10 years, or will be graduating in the next 3 years. | 193 |
| 10. Person is living in an inappropriate place, awaiting a proper place (can manage for the short term; e.g., persons aging out of children's residential services). | 8 |
| 11. Person moved from another state where they were receiving residential, day and/or in-home supports. | 11 |
| 12. The state has plans to assist the person in moving within the next year (from a state-operated or private Intermediate Care Facility for People with Developmental Disabilites, nursing home or state hospital). | 1 |
| 13. Person is losing eligibilty for Department of Children and Family Services supports in the next year. | 6 |
| 15. Person is losing eligibility for Intermediate Care Facility for People with Developmental Disabilities supports in the next year. | 1 |

## *Division of Developmental Disabilities*
### Prioritization of Urgency of Needs for Services (PUNS)
### Summary By County and Selection Detail

March 07, 2019

| | |
|---|---|
| 17. Person is residing in an out-of-home residential setting and is losing funding from the public school system. | 6 |
| 18. Person is losing eligibility for Individual Care Grants supports through the mental health system in the next year. | 1 |
| 20. Person wants to leave current setting within the next year. | 10 |
| 21. Person needs services within the next year for some other reason, specify: | 33 |

**PLANNING FOR NEED(Person's needs for service is more than a year away but less than 5 years away, or the care giver is older than 60 years)**

| | |
|---|---|
| 1. Person is not currently in need of services, but will need service if something happens to the care giver. | 139 |
| 2. Person lives in a large setting, and person/family has expressed a desire to move (or the state plans to move the person). | 1 |
| 3. Person is dissatisfied with current residential services and wishes to move to a different residential setting. | 1 |
| 4. Person wishes to move to a different geographic location in Illinois. | 3 |
| 5. Person currently lives in out-of-home residential setting and wishes to live in own home. | 1 |
| 6. Person currently lives in out-of-home residential setting and wishes to return to parents' home and parents concur. | 1 |
| 8. Person or care giver needs increased supports. | 34 |
| 9. Person is losing eligibility for Department of Children and Family Services supports within 1-5 years. | 3 |
| 13. Person is residing in an out-of-home residential setting and is losing funding from the public school system within 1-5 years. | 1 |
| 14. Other, Explain: | 5 |

**EXISTING SUPPORTS AND SERVICES**

| | |
|---|---|
| Respite Supports (24 Hour) | 10 |
| Respite Supports (<24 hour) | 14 |
| Behavioral Supports (includes behavioral intervention, therapy and counseling) | 145 |
| Physical Therapy | 37 |
| Occupational Therapy | 98 |
| Speech Therapy | 132 |
| Education | 185 |
| Assistive Technology | 47 |
| Homemaker/Chore Services | 2 |
| Adaptions to Home or Vehicle | 7 |
| Personal Support under a Home-Based Program, Which Could Be Funded By Developmental Disabilites, Division of Rehabilitation Services or Department on Aging (can include habilitation, personal care, respite, retirement supports, budgeting, etc.) | 65 |
| Medical Equipment/Supplies | 31 |
| Nursing Services in the Home, Provided Intermittently | 6 |
| Other Individual Supports | 141 |

**TRANPORTATION**

| | |
|---|---|
| Transportation (include trip/mileage reimbursement) | 141 |
| Other Transportation Service | 295 |
| Senior Adult Day Services | 1 |
| Developmental Training | 95 |
| "Regular Work"/Sheltered Employment | 83 |
| Supported Employment | 90 |
| Vocational and Educational Programs Funded By the Division of Rehabilitation Services | 65 |
| Other Day Supports (e.g. volunteering, community experience) | 32 |

**RESIDENTIAL SUPPORTS**

| | |
|---|---|
| Community Integrated Living Arrangement (CILA)/Family | 3 |
| Community Integrated Living Arrangement (CILA)/Intermittent | 5 |
| Community Integrated Living Arrangement (CILA)/Host Family | 1 |
| Community Integrated Living Arrangement (CILA)/24 Hour | 31 |
| Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) 16 or Fewer People | 1 |
| Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) 17 or More People | 1 |

*Division of Developmental Disabilities*

**Prioritization of Urgency of Needs for Services (PUNS)**

**Summary By County and Selection Detail**

March 07, 2019

| | |
|---|---|
| Skilled Nursing Facility/Pediatrics (SNF/PED) | 5 |
| Supported Living Arrangement | 8 |
| Shelter Care/Board Home | 1 |
| Children's Residential Services | 5 |
| Child Care Institutions (Including Residential Schools) | 9 |
| Children's Foster Care | 1 |
| Other Residential Support (including homeless shelters) | 12 |
| **SUPPORTS NEEDED** | |
| Personal Support (includes habilitation, personal care and intermittent respite services) | 358 |
| Respite Supports (24 hours or greater) | 29 |
| Behavioral Supports (includes behavioral intervention, therapy and counseling) | 132 |
| Physical Therapy | 44 |
| Occupational Therapy | 82 |
| Speech Therapy | 101 |
| Assistive Technology | 56 |
| Adaptations to Home or Vehicle | 17 |
| Nursing Services in the Home, Provided Intermittently | 5 |
| Other Individual Supports | 74 |
| **TRANSPORTATION NEEDED** | |
| Transportation (include trip/mileage reimbursement) | 336 |
| Other Transportation Service | 334 |
| **VOCATIONAL OR OTHER STRUCTURED ACTIVITIES** | |
| Support to work at home (e.g., self employment or earning at home) | 8 |
| Support to work in the community | 266 |
| Support to engage in work/activities in a disability setting | 128 |
| **RESIDENTIAL SUPPORTS NEEDED** | |
| Out-of-home residential services with less than 24-hour supports | 90 |
| Out-of-home residential services with 24-hour supports | 86 |

http://www.dhs.state.il.us/OneNetLibrary/27897/documents/DD%20Reports/PUNS/PUNS_by_county_and_selection_detail110916.pdf

## Division of Developmental Disabilities Prioritization of Urgency of Needs for Services (PUNS)
## Summary of Total and Active PUNS By Zip Code
## Updated 03/07/19

| Zip Code | | Active PUNS | Total PUNS | |
|---|---|---|---|---|
| 60949 | Ludlow | 3 | 4 | |
| 61801 | Urbana | 45 | 87 | |
| 61802 | Urbana | 57 | 108 | |
| 61815 | Bondville (PO Box) | 1 | 1 | |
| 61816 | Broadlands | 2 | 3 | |
| 61820 | Champaign | 41 | 83 | |
| 61821 | Champaign | 86 | 178 | |
| 61822 | Champaign | 50 | 99 | |
| 61840 | Dewey | 0 | 2 | |
| 61843 | Fisher | 10 | 12 | |
| 61845 | Foosland | 1 | 1 | |
| 61847 | Gifford | 1 | 1 | |
| 61849 | Homer | 0 | 5 | |
| 61851 | Ivesdale | 1 | 1 | |
| 61852 | Longview | 1 | 1 | |
| 61853 | Mahomet | 39 | 64 | |
| 61859 | Ogden | 5 | 12 | |
| 61862 | Penfield | 1 | 2 | |
| 61863 | Pesotum | 1 | 2 | |
| 61864 | Philo | 5 | 10 | |
| 61866 | Rantoul | 31 | 84 | |
| 61871 | Royal (PO Box) | -- | -- | no data on website |
| 61872 | Sadorus | 2 | 2 | |
| 61873 | St. Joseph | 14 | 25 | |
| 61874 | Savoy | 7 | 12 | |
| 61875 | Seymour | 2 | 3 | |
| 61877 | Sidney | 5 | 10 | |
| 61878 | Thomasboro | 0 | 2 | |
| 61880 | Tolono | 9 | 29 | |
| Total | | 420 | 843 | |

http://www.dhs.state.il.us/OneNetLibrary/27897/documents/DD%20Reports/PUNS/PUNSbyZipallandactivects05102016.pdf

**Summary of PUNS - Total of All Clients by ISC Agency (Including closed records)**
**Updated 03/07/19**

| ISC Agency | Individual Count | % of Total PUNS | Estimated Total Census for Agency | Estimated % of IL Census |
|---|---|---|---|---|
| CCRPC Total* | 1,028** | 1.88% | 244,880 | 1.90% |
| **ISC Agency** | **Individual Count** | **% of Total PUNS** | **Estimated Total Census for Agency** | **Estimated % of IL Census** |
| CCRPC Active* | 454** | 2.33% | 244,880 | 1.90% |

*Totals include Ford & Iroquois Counties

**Increase

http://www.dhs.state.il.us/page.aspx?item=56039

Stephanie Howard-Gallo
Operations and Compliance Coordinator

# Staff Report--March 2019 Board Meeting

## SUMMARY OF ACTIVITY:

### Contract Compliance:

We had a few compliance issues that were resolved quickly and no payments were withheld.

### Audits:

United Cerebral Palsy—Land of Lincoln (UCP) has not yet submitted their audit. Payments for February and March have been withheld. We have reached out to them by email and phone, but have received no response.

### Anti-Stigma Efforts/Alliance for Inclusion and Respect (AIR)/Ebertfest:

Our relationship with Crossroads Corner Consignment did not work out. The good news is that International Galleries at Lincoln Square has welcomed us! We thank International Galleries for giving us an opportunity to elevate the message of inclusion and respect. Preston N. Lord will be featured the month of March with his pastel and charcoal drawings. Water color paintings and greeting cards by Izabela Rayski will be featured the month of April. We will continue with a new artist every month for as long as International Galleries will host us. Artists are still participating in the Urbana "Market IN the Square" on Saturdays; however, we will not be participating in the outdoor market during the summer.

On Saturday, April 13th, artists that are interested in showing/selling their work outside of Ebertfest will have an opportunity to do so from 11 a.m. until 6 p.m. We are organizing what we need to accommodate them. Vicki Tolf from DSC and Nancy Carter from NAMI do a great deal of work to help with this show. We have 15 artists/artist groups interested in participating in this event. We believe we are about at capacity at this point.

### Other:

- Preparing meeting materials for CCMHB/CCDDB regular meetings and study sessions/presentations.
- Composing minutes for the meetings.
- Applications review.
- Annual Report organization.

**Champaign County CILA Facilities**

FY18 Revenues and Expenditures as of 02/28/19

| **Revenue** | | **FY18** |
|---|---|---|
| From Mental Health Board | $ | 50,000.00 |
| From Developmental Disabilities Board | $ | 50,000.00 |
| Rent | $ | 22,440.12 |
| Other Misc Revenue | $ | 3,585.25 |
| **TOTAL** | **$** | **126,025.37** |

| **Expenditure** | | **FY18** |
|---|---|---|
| Mortgage Principal | $ | 49,750.32 |
| Mortgage Interest | $ | 17,230.37 |
| Professional Fees | $ | 6,000.00 |
| Utilities | $ | 866.76 |
| Building/Landscaping Maintenance | $ | 14,341.72 |
| Building Improvements | $ | 12,045.00 |
| Other Services | $ | 36.00 |
| **TOTAL** | **$** | **100,270.17** |

**Champaign County Mental Health Board**

FY18 Revenues and Expenditures as of 02/28/19

| Revenue | Q4 | YTD | Budget | % of Budget |
|---|---|---|---|---|
| Property Tax Distributions | $ 133,828.19 | $ 4,619,386.49 | $ 4,661,225.00 | 99.10% |
| From Developmental Disabilities Board | $ 56,892.55 | $ 310,782.55 | $ 338,515.00 | 91.81% |
| Gifts & Donations | $ 0.00 | $ 21,612.73 | $ 20,000.00 | 108.06% |
| Other Misc Revenue | $ 35,258.20 | $ 71,772.93 | $ 500.00 | >100% |
| **TOTAL** | **$ 225,978.94** | **$ 5,023,554.70** | **$ 5,020,240.00** | **100.07%** |

| Expenditure | Q4 | YTD | Budget | % of Budget |
|---|---|---|---|---|
| Personnel | $ 152,202.63 | $ 522,073.19 | $ 538,373.00 | 96.97% |
| Commodities | $ 3,767.53 | $ 10,048.50 | $ 20,983.00 | 47.89% |
| Contributions & Grants | $ 935,456.00 | $ 3,681,870.00 | $ 3,947,244.00 | 93.28% |
| Professional Fees | $ 75,766.76 | $ 283,276.81 | $ 300,000.00 | 94.43% |
| Transfer to CILA Fund | $ - | $ 50,000.00 | $ 50,000.00 | 100.00% |
| Other Services | $ 42,103.23 | $ 127,561.52 | $ 163,640.00 | 77.95% |
| **TOTAL** | **$ 1,209,296.15** | **$ 4,674,830.02** | **$ 5,020,240.00** | **93.12%** |

**Champaign County Developmental Disability Board**

FY18 Revenues and Expenditures as of 02/28/19

| Revenue | Q4 | YTD | Budget | % of Budget |
|---|---|---|---|---|
| Property Tax Distributions | $ 111,620.89 | $ 3,852,926.01 | $ 3,887,208.00 | 99.12% |
| From Mental Health Board | $ 6,778.87 | $ 6,778.87 | $ 8,000.00 | 84.74% |
| Other Misc Revenue | $ 13,833.72 | $ 30,470.08 | $ 300.00 | >100% |
| **TOTAL** | **$ 132,233.48** | **$ 3,890,174.96** | **$ 3,895,508.00** | **99.86%** |

| Expenditure | Q4 | YTD | Budget | % of Budget |
|---|---|---|---|---|
| Contributions & Grants | $ 827,403.00 | $ 3,308,448.00 | $ 3,506,993.00 | 94.34% |
| Professional Fees | $ 56,892.55 | $ 310,782.55 | $ 338,515.00 | 91.81% |
| Transfer to CILA Fund | $ - | $ 50,000.00 | $ 50,000.00 | 100.00% |
| **TOTAL** | **$ 884,295.55** | **$ 3,669,230.55** | **$ 3,895,508.00** | **94.19%** |

**March 2019 Monthly Staff Report- Shandra Summerville**
**Cultural and Linguistic Competence Coordinator**

## Agency Cultural and Linguistic Competence (CLC) Technical Assistance, Monitoring, Support and Training for CCMHB/DDB Funded Agencies

**DREAAM Academy-** I met with Tracy Dace about CLC Activities and talked to him about the support services that I offer funded agencies. We discussed ways he will be able to receive assistance with CLC Plan Development, annual training, and ways to expand family engagement.

**Family Service Center of Champaign County-** The Self-Help Center's Biennial Conference, "Collaboration in Times of Need" will take place on Friday, May 3, 2019 at the Round Barn Banquet Centre in Champaign. Registration will begin very soon please visit: http://selfhelp.famservcc.org/ for additional information.

## CLC Coordinator Direct Service Activities:

### FY 2020 CLC Plan Review:

I have been reviewing the CLC Plans for all the organizations that submitted applications. There will be one summary for each organization provided with the program summaries to review. If you have any questions about what you are reviewing, please feel free to contact me.

### Youth Mental Health First Aid Training:

I am going to renew my certification for Mental Health First Aid that will include Adult Rural and Higher Education. Derrick Saunders of Clark County reached out to me from Mental Health First Aid USA. He is a member of the 708 Board in Clark County and is a Mental Health First Aid Instructor. He has trained over 900 people and has partner with us to expand capacity in Champaign County. This will be no cost to our board. I have been in contact with the student group Stomp Out Stigma, on the campus of the University of Illinois at Urbana-Champaign. The student group is interested in getting students trained to be Mental Health First Aiders.

### Georgetown Leadership Academy: Increasing Cultural Diversity and Cultural and Linguistic Competence in Networks Supporting Individuals with Intellectual and Developmental Disabilities:

I will have my final coaching call with Professor Tawara Goode from the National Center for Cultural Competence next month. I will attend the Learning Series on March 14; the session will hear stories from other Leadership Academy Alumni and how they are implementing leadership in CLC in their communities.

**ACMHAI** -I will attend the March Children's Behavioral Health Committee Call. There will be a quarterly meeting April 11 &12.

**Monthly Training Series-** I attended Bookkeeping 101 on March 7, 2019. This workshop was helpful for organizations to learn basics about bookkeeping for Non-Profit organizations.

## Anti-Stigma Activities/Community Collaborations and Partnerships

### Alliance for Inclusion and Respect-

We hosted a meeting on February 26th with some of the members of the Alliance for Inclusion and respect. We reviewed the information that was going to be in the Ebert Fest Program and the different slides that will be featured on the screen.
The Art Show will be held on Saturday, April 13, 2019 in front of the Virginia Theatre from 11am-6pm. Additional information will be available on the AIR Website.

### Ebert Festival 2019

I am working with Urbana High School to finalize the details about how show our sponsored film at Urbana High School. Initial contact was made in August. I am working with the administration to finalize the details.

### Disability Resource Expo –

I met with Jim Mayer and Barb Bressner about the volunteer coordination for the expo. We are on the final stretch to recruit volunteers. We are looking for people with the ability to lift heavy items and help with the tear down of the Expo. If you know of any groups that are willing to help tear down at the end of the expo, that would be helpful.

### Illinois Public Media Community Advisory Committee (CAC)

I have attended 3 meetings on behalf of the Community Advisory Board. I also spoke with the community engagement coordinator about promoting the disAbility Resource Expo. I also recruited additional volunteers from the committee for the Expo.

**C-HEARTS African American Story Telling Project:** This is a group of interdisciplinary scholars and community members exploring community healing through story telling. We meet twice per month to discuss ways to expand the project. We are partnering with DREAAM Academy to begin working with families to expand the story telling project to engage families that are receiving support in the community.

**United Way ECL(Emerging Community Leaders) Alumni Committee:** I was selected to be part of the Emerging Community Leaders Alumni Committee. The purpose of this committee to engage upcoming leaders about not for profit organizations. I was a 2013 ECL Graduate and because of my work in building better boards and cross cultural and community involvement. I was invited to be a mentor upcoming ECL groups.