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

Champaign County Developmental Disabilities Board (CCDDB) AGENDA

Wednesday, October 23, 2019, 8AM
Brookens Administrative Building
1776 E. Washington St., Urbana, IL 61802
Lyle Shields Meeting Room

(Members of the Champaign County Mental Health Board are invited to sit in as special guests)

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 Comments – Lynn Canfield
7. Approval of CCDDB Board Meeting Minutes* **(pages 4-7)**
   Minutes from 09/18/19 are included. Action is requested.
8. Financial Information* **(pages 8-9)**
   A copy of the claims report is included in the packet. Action is requested.
9. New Business
   A. CCMHB & CCDDB Travel Regulations* **(pages 10-30)**
      A Decision Memorandum on the CCMHB & CCDDB Travel Policy and the Champaign County Travel Policy is included in the packet. Both travel policies are included for reference as well. Action is requested.
   B. Building Evaluation Capacity Presentation

The University of Illinois Evaluation Capacity Team will provide a short update on their previous work and the work they will do with the targeted CCDDB funded programs.

C. Independent Service Coordination PUNS Presentation **(pages 31-52)**
Katie Harmon, Program Manager will provide a brief presentation on the PUNS Database and PUNS process. A copy of the PY2019 Preference Assessment Results is also included for information only.

D. Envision Unlimited **(pages 53-54)**
Shawnaci Schroeder, Central Illinois Respite Director will provide a brief overview of the respite services being offered in Champaign County through Envision Unlimited.

E. Illinois Respite Coalition **(pages 55-57)**
Tina Yurik, Director will provide a brief overview of the respite services that Illinois Respite Coalition offers in Champaign County.

F. Board Direction
For board discussion of planning and funding. No action is requested.

G. 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. Mini-Grant Process* **(pages 58-60)**
A Decision Memorandum on the Mini-Grant Process is included in the packet. Action is requested.

B. Utilization Summaries for PY2019 **(pages 61-65)**
The results of all CCDDB and CCMHB I/DD Programs are included for information only.

C. Meeting Schedules **(pages 66-69)**
Copies of CCDDB and CCMHB meeting schedules and CCDDB allocation process timeline are included in the packet for information.

D. Acronyms **(pages 70-77)**
A list of commonly used acronyms is included for information.

11. CCMHB Input

12. Staff Reports **(pages 78-135)**

    For information are reports from Kim Bowdry (PUNS data attached), Lynn Canfield (on conference sessions), Stephanie Howard-Gallo, Shandra Summerville (with attachments), and Chris Wilson (third quarter report).

13. Board Announcements
14. Adjournment

**Board action requested*

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

Minutes –September 18, 2019

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

DRAFT

8:00 a.m.

MEMBERS PRESENT:	William Gingold, Gail Kennedy, Anne Robin, Sue Suter, Deb Ruesch
STAFF PRESENT:	Kim Bowdry, Lynn Canfield, Mark Driscoll, Shandra Summerville, Chris Wilson
OTHERS PRESENT:	Danielle Matthews, Patty Walters, Heather Livingston, DSC; Becca Obuchowski, Community Choices; Julienne Wilde, Pat Gerth, United Cerebral Palsy (UCP); Katie Harmon, Regional Planning Commission (RPC); Kathy Kessler, Rosecrance; Mel Liong, PACE; Willard Benison, United Cerebral Palsy (UCP)

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.

DRAFT

APPROVAL OF AGENDA:

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

CITIZEN INPUT:

None.

PRESIDENT'S COMMENTS:

None.

EXECUTIVE DIRECTOR'S COMMENTS:

A written report was included in the packet.

APPROVAL OF CCDDB MINUTES:

Minutes from June 26, 2019 and July 10, 2019 were included in the Board packet.

MOTION: Dr. Robin moved to approve the CCDDB minutes from June 26, 2019 and July 10, 2019. Ms. Ruesch seconded the motion. A voice vote was taken and the motion was passed.

FINANCIAL INFORMATION:

A copy of the claims report for two months was included in the Board packet for review and approval.

MOTION: Ms. Ruesch moved to accept the claims report as presented. Ms. Suter seconded the motion. A voice vote was taken and the motion passed.

NEW BUSINESS:

CCDDB Mini-Grant:
A Decision Memorandum detailing the rationale and process for the administration of the CCDDB Mini-Grant was included in the packet for review and action. Board members discussed marketing strategies. Dr. Gingold suggested the requirement of a letter of support be removed from the document. Dr. Gingold asked for a brief report on PUNS and how it works?

MOTION: Dr. Gingold moved to approve the Executive Director and CCDDB staff to implement a mini-grant process as described in the memorandum and the application form, with revisions as discussed at the meeting. Dr. Robin seconded. A vote was taken and all members voted in approval of the motion.

Draft CCDDB Three-Year Plan with FY2020 Objectives:
A Briefing Memorandum on the Draft CCDDB Three-Year Plan with FY2020 Objectives was included in the Board packet. Service providers and other stakeholders will have an opportunity

to provide input and a revised draft will be presented for approval at a later date. Dr. Gingold mentioned one of a few suggestions, which he will share directly with the staff.

CCDDB Allocation Priorities and Decision Support Criteria:
A Briefing Memorandum on FY2020 CCDDB Allocation Priorities and Decision Support Criteria was included in the Board packet. Service providers and other stakeholders will have an opportunity to provide input and a revised draft will be presented for approval at a later date.

Building Evaluation Capacity:
"A Final Report on Building Evaluation Capacity for Programs Funded by the CCMHB Year 4" written by Mark Aber, Nicole Allen, Chelsea Birchmier, and Markera Jones was included in the packet. Dr. Gingold would like the authors to make a presentation to the CCDDB.

Board Direction:
No comments:

Successes and Agency Information:
CU Able, DSC, Community Choices, and Regional Planning Commission and PACE reported on recent activities within their agencies.

Ms. Suter asked for a presentation from the new respite provider for our region, Envision.

OLD BUSINESS:

Revised CCDDB FY2020 Draft Budgets:
A Decision Memorandum on FY2020 CCDDB and CILA Draft Budgets were included in the Board packet. Additional budget documents were included for information only.

MOTION: Ms. Ruesch moved to approve the CCDDB Budget included in the Board packet, with anticipated revenues and expenditures of $4,373,905. Ms. Suter seconded the motion. A vote was taken and all members voted aye. The motion passed.

MOTION: Ms. Ruesch moved to approve the 2020 CILA Fund Budget included in the Board packet, with anticipated revenues and expenditures of $76,000. Dr. Robin seconded the motion. A vote was taken and all members voted aye. The motion passed.

Agency PY2019 4th Quarter Program Reports:
Reports were included in the Board packet for review.

PY2019 Service Data Reporting:
Reports were included in the Board packet for review. These reports were mistakenly described as fourth quarter only, but this was full year data.

Meeting Schedules:
CCDDB and CCMHB meeting schedules were included in the packet for information only. Patty Walters from DSC asked about the topics of upcoming study sessions. The CCDDB will consider whether to join the CCMHB October 30th Study Session discussion of priorities; the CCMHB will see a draft of the CCDDB PY2021 Priorities document and may have comments, questions, suggestions.

CCMHB Input:
The CCMHB will meet later in the day.

STAFF REPORTS:

Reports from Lynn Canfield, Kim Bowdry, Stephanie Howard-Gallo, Shandra Summerville, and Chris Wilson were included in the packet for review.

BOARD ANNOUNCEMENTS:

None.

ADJOURNMENT:

The meeting adjourned at 9:11 a.m.
Respectfully Submitted by: Stephanie Howard-Gallo

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

(8)

CHAMPAIGN COUNTY

EXPENDITURE APPROVAL LIST

10/07/19 PAGE 7

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					
		9/27/19	09	VR 108-	83		598280	9/30/19	108-050-533.07-00	PROFESSIONAL SERVICES	OCT ADMIN FEE	28,129.00	
											VENDOR TOTAL	28,129.00	*
104	CHAMPAIGN COUNTY TREASURER							HEAD START FUND 104					
		9/27/19	09	VR 108-	75		598281	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT SOC/EMOT DEV SV	2,033.00	
											VENDOR TOTAL	2,033.00	*
161	CHAMPAIGN COUNTY TREASURER							REG PLAN COMM FND075					
		9/27/19	09	VR 108-	74		598283	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT DECISION SUPPOR	27,735.00	
											VENDOR TOTAL	27,735.00	*
11587	CU ABLE												
		9/27/19	07	VR 108-	77		598317	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT COMM OUTREACH	1,439.00	
											VENDOR TOTAL	1,439.00	*
18203	COMMUNITY CHOICE, INC							SUITE 419					
		9/27/19	07	VR 108-	78		598333	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT COMMUNITY LIVIN	6,750.00	
		9/27/19	07	VR 108-	78		598333	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT CUSTOM EMPLOY	8,241.00	
		9/27/19	07	VR 108-	78		598333	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT SELF DETERMINAT	11,500.00	
											VENDOR TOTAL	26,491.00	*
22300	DEVELOPMENTAL SERVICES CENTER OF							CHAMPAIGN COUNTY INC					
		9/27/19	07	VR 108-	79		598350	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT APARTMENT SVCS	36,896.00	
		9/27/19	07	VR 108-	79		598350	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT CLINICAL SVCS	14,500.00	
		9/27/19	07	VR 108-	79		598350	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT COMMUNITY EMPLO	30,114.00	
		9/27/19	07	VR 108-	79		598350	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT COMMUNITY FIRST	68,580.00	
		9/27/19	07	VR 108-	79		598350	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT CONNECTIONS	7,083.00	
		9/27/19	07	VR 108-	79		598350	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT EMPLOYMENT FIRS	6,667.00	
		9/27/19	07	VR 108-	79		598350	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT INDIV/FAMILY SU	34,713.00	

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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												
		9/27/19	07	VR 108-	79		598350	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT SERVICE COORD	35,263.00
											VENDOR TOTAL	233,816.00 *
22816	DOWN SYNDROME NETWORK											
		9/27/19	07	VR 108-	76		598355	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT DOWN SYNDROME	1,250.00
											VENDOR TOTAL	1,250.00 *
54930	PERSONS ASSUMING CONTROL OF THEIR ENVIROMENT, INC											
		9/27/19	07	VR 108-	80		598430	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT CONSUMER CONTRO	1,976.00
											VENDOR TOTAL	1,976.00 *
61780	ROSECRANCE, INC.											
		9/27/19	07	VR 108-	81		598442	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT COORD SVC DD/MI	2,929.00
											VENDOR TOTAL	2,929.00 *
76107	UNITED CEREBRAL PALSY LAND OF LINCOLN											
		9/27/19	07	VR 108-	82		598466	9/30/19	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT VOCATIONAL SVC	5,000.00
											VENDOR TOTAL	5,000.00 *
										DEVLMNTL DISABILITY BOARD	DEPARTMENT TOTAL	330,798.00 *
										DEVLPMNTL DISABILITY FUND	FUND TOTAL	330,798.00 *
											REPORT TOTAL *****	720,389.98 *

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CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

DECISION MEMORANDUM

DATE: October 23, 2019
TO: Members, Champaign County Developmental Disabilities Board (CCDDB)
FROM: Lynn Canfield
SUBJECT: Travel Regulations

Overview:

The Champaign County Executive and State's Attorney's Office Civil Division developed a set of revised policies with input from Department Heads. The revised Travel Policy have been reviewed and adopted by the Champaign County Board. According to the Community Mental Health Act, 405 ILCS 20/3e, Ch. 91 1/2, par. 303e, Section 3e., (k) (2)(c), the CCMHB has the duty and power "to employ, establish compensation for, and set policies for its personnel, including legal counsel, as may be necessary to carry out the purposes of this Act and prescribe the duties thereof." Through an intergovernmental agreement with the CCDDB, oversight of administration is shared. The guidelines developed for other County employees are an appropriate framework for CCMHB/CCDDB staff. Some provisions of the Travel Regulations also apply to Board members.

The recently established Champaign County Travel Regulations are attached for reference, along with a draft of CCMHB/CCDDB Travel Regulations.

The proposed CCMHB/CCDDB Travel Regulations vary from those of the County by:

- no access to County vehicles;
- additional restrictions on business meals;
- additional detail on the calculation of meal per diems;
- lower threshold requirement for receipts;
- timeliness of reimbursement requests (less frequent than County);
- authority for supervision, discipline, and approvals for staff and board members.

Differences are highlighted in the attached DRAFT version. These variations from the new County policy relate to the special nature of the business of the CCMHB and CCDDB, with staff and Board travel being relatively small portions of CCMHB and CCDDB budgeted expenses, and with oversight requirements. Provisions are generally aligned with the revised Champaign County Travel Regulations.

Proposed Action:

Review and approval or revision of the proposed CCMHB/CCDDB Travel Regulations will ensure that administration of the funds and oversight of employees are consistent with the standards established for other Champaign County government and appropriate to the purposes of the CCMHB and CCDDB. If revisions are required by one Board, the full revised draft of relevant policy or policies will be brought back to each Board for approval at their next regular meeting. The next regular meeting of the CCMHB is October 23, 2019, so if the CCMHB require revisions to any version of draft approved/revised by the CCDDB on this date, the new draft will be presented to the CCDDB again on November 20.

In the approved version of Travel Regulations, the word "DRAFT" and all highlights will be removed, and the effective date added.

Budget Impact:

The policy under consideration does not have a direct impact on budgets. Clear guidelines regarding the reimbursement of expenses incurred by staff and board members allow for the completion of board business within approved budgets and protect the interests of the CCMHB, CCDDB, their employees, and the County. This policy mirrors that of Champaign County, within the context of applicable state and federal laws.

Decision Section:

Motion to approve the attached draft CCMHB/CCDDB Travel Regulations, pending approval by the CCMHB:

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

DRAFT TRAVEL REGULATIONS
CHAMPAIGN COUNTY MENTAL HEALTH BOARD AND CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY, ILLINOIS

ARTICLE I. APPLICABILITY AND POLICY

APPLICABILITY: These Travel Regulations apply to all employees and appointed board members of the Champaign County Mental Health Board (CCMHB) and the Champaign County Developmental Disabilities Board (CCDDB). These regulations do not apply to members of advisory boards or committees, or other persons who are not employed by the CCMHB or CCDDB, except as provided in Article X, A and B. Appropriations for travel must be in the appropriate budget prior to travel.

Established by referendum in 1972, through the Illinois Community Mental Health Act (405 ILCS 20/3e), the CCMHB has the authority "to employ, establish compensation for, and set policies for its personnel, including legal counsel, as may be necessary to carry out the purposes of this Act and prescribe the duties thereof." The CCMHB and CCDDB have an Intergovernmental Agreement which defines the sharing of oversight and costs of administration of the funds under their control. The following provisions fulfill these obligations and align with the Champaign County, Illinois Travel Regulations.

PURPOSE: The purpose of the Regulations is to ensure that the Champaign County Mental Health Board (CCMHB) and Champaign County Developmental Disabilities Board (CCDDB)'s appointed officials and employees who travel on official business will be treated fairly and reimbursed at rates which are reasonable, consistent with actual, necessary costs, and which will ensure the promotion of economy in County government. The purpose is not to create any additional source of income beyond the Official's or Employee's compensation. Reimbursement from Champaign County Mental Health Board or Champaign County Developmental Disabilities Board funds for entertainment expenses is not allowed for any Officials or Employees.

EFFECTIVE DATE: These Regulations are to be effective upon approval by both boards.

ARTICLE II. AUTHORITY TO TRAVEL

A. The Champaign County Mental Health Board and Champaign County Developmental Disabilities Board, through their budgets, shall be responsible for maintaining control of travel for officials and employees which will provide for

the efficient and economical conduct of CCMHB and CCDDB business, both within and outside the County.

B. Appropriation for trips planned during the budget year shall be obtained as part of the approved CCMHB and CCDDB budgets. Additional appropriations may be added by budget amendment, subject to CCMHB/CCDDB and Champaign County Board approval, or by budget transfer. Transfers within the same category are allowed.

C. All travel shall be approved by a Board Officer or the Executive Director, prior to the beginning of travel. Said approval may be oral, but where requested, same can be in writing.

D. As a courtesy, summary reports of travel for Conferences and Instruction and Schooling may be reported to Executive Director, or in the case of travel of the Executive Director, to the CCMHB and CCDDB. Such summary reports are not a requirement for reimbursement of expenses.

ARTICLE III. ALLOWABLE TRANSPORTATION EXPENSES

A. Governing Regulations

1. All travel shall be by the most direct route.

2. All travel shall be by the most economical mode of transportation available, considering travel, time, costs, and work requirements.

B. Use of Public Transportation

1. The full cost of public transportation is recoverable if it is the chosen mode of transportation in view of Article III; A, 1 and 2.

C. Use of Personal Vehicle

1. When the use of a privately-owned vehicle is necessary or desirable in consideration of the CCMHB and CCDDB travel policy and expenditures, it may be used at the reimbursement rate given in the current year IRS provision for determination of mileage for business expenses.

2. When the use of public transportation is a reasonable alternative to the use of a personal vehicle, the mileage payment shall not exceed the cost of travel by public transportation.

3. Mileage will be payable to only one of two or more individuals traveling in the same vehicle. The names of all travelers shall be listed on the travel

voucher, along with a travel log that indicates date, purpose of trip, and total mileage.

4. No mileage payments are allowed for employees to attend CCMHB or CCDDB meetings which are held in the same building as staff offices. Members and Officers of the CCMHB or CCDDB are allowed reimbursement for expenses related to fulfilling their duties as Board members, consistent with state Statute, "for payment for the ordinary and contingent expenses of the board."

D. Fly Local Policy

1. When making air travel decisions, consideration will always be first given to flying in and out of Willard Airport (CMI).

2. In determination of the overall expense of air travel on behalf of the CCMHB and CCDDB, the following will all be considered in making air travel decisions:
   i. Costs of employee time spent in travel;
   ii. Travel reimbursement to another airport;
   iii. Parking fees;
   iv. Time savings of getting through security at CMI versus other airports.

ARTICLE IV. ALLOWABLE EXPENSES

A. Meal Expense

1. When traveling outside Champaign County, reimbursement for meals and tips shall be allowed, in accordance with Internal Revenue Service per diem meal allowances as published annually for all cities within the continental United States. On a 'travel day,' the per diem rates are based on the destination rather than the location in which the meal was purchased. In January, the Auditor's Office will provide staff with a chart of the breakfast, lunch, and dinner reimbursement allowed within each per diem category for the calendar year.

   Receipts for individual meals need not be submitted (unless charged to a county credit card), but a travel log must be submitted in accordance with IRS regulations, which substantiates the business purpose (meeting type, seminar, or conference title), the travel dates, the applicable meals to be reimbursed for each day, and the place (city).

2. Meals and tips will not be reimbursed if the cost of meals for seminars or official meetings is included in the registration fee. A copy of the meeting

brochure should be submitted with the travel log at the time of request for reimbursement.

3. Within Champaign County, meals and tips may be reimbursed for Officials and Employees attending meetings, conferences, and seminars, if the attendance at the meeting, conference, or seminar is required by the Board Officer(s) or Executive Director, and if the meeting, conference, or seminar, includes a meal for which the employee is expected to pay. The same limits apply as noted in Article IV, Section A, Items 1 and 2.

4. Alcoholic beverages are excluded from reimbursement.

5. Any exceptions to the above shall be presented in a letter to the Board Officers and Executive Director for approval.

B. Lodging

1. Actual lodging expense will be reimbursed, with the understanding that:

    a. The person traveling will always seek, and use, when available, the "government economy" room rate offered by the hotel.

    b. When the "government economy" rate is not available, and a convention is the reason for the trip, the person will be reimbursed only in terms of the lowest two levels of convention lodging rates, unless such accommodations are not available to the person making the trip.

2. Receipts are required to be submitted with travel vouchers to support accommodation expenses claimed.

ARTICLE V. ALLOWABLE MISCELLANEOUS EXPENSES

A. The following are items that may be reimbursed by the CCMHB and CCDDB under miscellaneous expenses, if authorized by the Executive Director:

1. Taxicab fares or rideshare costs (where a hotel limousine is available, it is to be used).
2. Limousine fares, i.e. hotel limousine.
3. City transit (if used instead of taxicab or limousine).
4. Parking fees.
5. Bridge, road and tunnel tolls.
6. Registration fees.
7. Storage of baggage.
8. Hire of room for official business (when appropriate).

9. Car rentals (when appropriate).
10. Tips for parking attendants and baggage handling.
11. Internet access, if required for work activities and not provided with cost of hotel or conference.

B. Any miscellaneous expense OVER $20.00 shall be accompanied by a receipt.

ARTICLE VI. EXCEPTIONS TO TRAVEL REGULATIONS

A. Any Exceptions

1. Any exception to the above regulations - whether it is an estimate of the cost of travel, meals, or lodging if expenses have not been incurred or a receipt of the cost of the travel, meals, or lodging if the expenses have already been incurred - shall be presented in a letter submitted to the Board Officers and Executive Director for approval.

ARTICLE VII. APPROVAL OF TRAVEL EXPENSES FOR MEMBERS OF THE CHAMPAIGN COUNTY MENTAL HEALTH BOARD AND CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD

A. Approval of expenses. Expenses for travel, meals, and lodging of any member of the CCMHB or CCDDB may be approved by an Officer of the respective Board.

B. Documentation of expenses. Before an expense for travel, meals, or lodging may be approved for any member of either Board, the following minimum documentation must first be submitted, in writing, to the Board Officers and Executive Director:
   a. An estimate of the cost of travel, meals, or lodging if expenses have not been incurred, or a receipt of the cost of the travel, meals, or lodging if the expenses have already been incurred;
   b. The name of the individual who received or is requesting the travel, meal, or lodging expense; and
   c. The date or dates and nature of the official business in which the travel, meal, or lodging expense was or will be expended.

C. All documents and information submitted under this Section are public records subject to disclosure under the Freedom of Information Act.

ARTICLE VIII. PREPARATION OF A TRAVEL VOUCHER

A. All claims for the reimbursement of traveling expenditures shall be submitted within sixty (60) days of the last date of travel on a CCMHB/CCDDB voucher and shall be itemized in accordance with the regulations. If an employee or board member is unable to meet this deadline, earliest possible submission will ensure accurate and timely reimbursement.

B. Each year, there shall be an exception period to the sixty-day standard for submission of travel receipts with regard to travel occurring up to December 31st, the last day of the fiscal year. All requests for reimbursement of travel expenses incurred up to December 31st of each year should be submitted to the Auditor's Office by the deadline established by the Auditor for submission of payments to allow payment out of the appropriate fiscal year expenditure budget. If the completed voucher is not submitted in that time frame, the Auditor's Office will not pay the reimbursement.

C. In all instances, travel vouchers shall be supported by receipts for public transportation, lodging, and all other miscellaneous items in excess, individually, of $20.00.

D. Individuals submitting travel vouchers are personally responsible for the accuracy and propriety of said vouchers. Any misrepresentation shall be grounds for disciplinary or legal action.

E. In order to avoid unnecessary paperwork, cash advances are to be issued for travel only when the trip is outside Champaign County and involves an overnight stay; otherwise reimbursements for travel shall be made through the accounts payable system and not by issuing advances.

ARTICLE IX. OTHER EXPENSE GUIDELINES

A. Items Billed Directly. No requests for reimbursement shall be made for items of expenditure, in connection with travel, that are billed directly to the CCMHB/CCDDB. Travel expense items billed to a credit card should accompany an appropriately signed and completed voucher for reimbursement.

B. Business Meals & Expenses. Business meals are not often appropriate to the nature of the Boards' business; approval should be obtained prior to the expense being incurred. If approved, the cost of the Board member's or employee's meal is subject to meal allowance limitations, but the cost of a guest's meal is not.

With prior approval, business breakfasts, lunches and dinners shall:

1. Be in accord with IRS per diem meal allowances as published annually, for county employees.

2. Have documentation of the nature of the business and expenses incurred, attached to the reimbursement voucher submitted.

C. All reimbursement is subject to budget limitations.

D. With prior approval, reimbursement is allowed for the purchase of refreshments or meals for meetings, conferences, and seminars hosted by the CCMHB or

CCDDB. However, every effort should be made to complete such purchases in advance rather than through reimbursement to staff or Board members.

D. Reimbursement will be made for travel expenses of job applicants while in Champaign County for interviewing purposes. This can include transportation, hotel, meals and other allowable expenses. Total expenses are set by the Board Officers or designees for each job search, but other County limitations will not apply. Job applicants should be advised in advance that the Internal Revenue Service requires that we have documentation for reimbursed expenses.

   A Search Committee may invite employees, CCMHB/CCDDB members, and other public local officials to eat meals with or attend receptions for job applicants, subject to the total search expense limitation. Specific meal allowances per person will not apply to such meals.

ARTICLE X. PROSPECT AND APPOINTEE TRAVEL

A. Upon the request of the CCMHB and CCDDB, a prospect for a position may be reimbursed for reasonable travel expenses incurred in coming to CCMHB and CCDDB offices or meeting rooms for interviews.

B. Upon request of the CCMHB and CCDDB to travel to the County to conduct official business prior to employment, an individual appointed by the CCMHB/CCDDB or the County to an authorized position may be reimbursed for travel expenses, within the reimbursement guidelines of this policy.

ARTICLE XI. CREDIT CARDS

A credit card may be issued to the CCMHB/CCDDB Executive Director or designee for the efficient operation of the department in regard to charging and payment of business expenses including air fares, lodging, car rental, hotels, other ground transportation, meals, and other miscellaneous expenses that cannot be conveniently paid for by other means. Regulations on the use of credit cards issued by Champaign County government are defined in Champaign County Travel Regulations, where "department" includes the CCMHB/CCDDB, and "department head" includes the Executive Director of the CCMHB/CCDDB:

A. *"ELIGIBILITY – Champaign County business credit cards may be issued to department heads, for allowable use by that department.*

B. *"POLICY – Champaign County credit cards are issued for the convenience of department heads and their designees. Champaign County credit cards are for business related purchases only.*

C. *"PROCEDURES –*

1. *Purchasing Limits – All Champaign County departments issued credit cards, are authorized to utilize Champaign County business credit cards for purchases of up to $5,000 for travel arrangements in compliance with the Champaign County Travel Policy. Purchases of all other goods and/or services, up to $5,000, that can be made more conveniently through the use of the credit card are also authorized if made in compliance with the Champaign County Purchasing Policy.*
2. *Tax Exempt Status – Champaign County Department Heads are also required to ensure that vendors are made aware of and provided with Champaign County tax exemption information whenever applicable.*
3. *Receipts - Receipts for all purchases made on Champaign County business credit cards are to be submitted to the Department Head or his/her designee as soon as practicable after the charge is made; and receipts for all purchases made on Champaign County business credit cards are to be submitted to the Auditor's Office with the monthly payment requisition for reconciliation with account statements.*
4. *Examples of Allowable Use – Champaign County business credit cards may be used for, but not limited to the following:*
    i. *Hotel expenses*
    ii. *Conference Registration*
    iii. *Business meals*
    iv. *Car rentals and fuel*
    v. *Supplies and equipment which can be more conveniently purchased through a credit card and whereby tax exempt purchases can be accomplished."*

ARTICLE XII. ADVISORY BOARDS AND COMMITTEES

A. Board committees having a budget included as part of the CCMHB or CCDDB operating expense may be entitled to include a travel item in their budgets, subject to revenue limitations. Members of such committees shall be reimbursed for approved travel expenses in accordance with the provisions contained in these regulations.

B. Members of advisory boards, committees, or other groups of private citizens which have no board, committee, or group-budget subject to CCMHB or CCDDB support are not covered by these regulations and shall not be reimbursed for travel expenses by the CCMHB or CCDDB unless specifically authorized by the CCMHB or CCDDB, by the recommendation of the respective Board Officer(s) and Executive Director.

ARTICLE XIII. FOR CHAMPAIGN COUNTY MENTAL HEALTH BOARD AND CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD MEMBERS ONLY

A. Members and Officers of the CCMHB and CCDDB are allowed mileage payments to attend committee meetings, subcommittee meetings, and any other meetings they attend in fulfilling their duties.

ARTICLE XIV. APPROPRIATE BUDGET LINE ITEMS FOR TRAVEL EXPENSES

The following line items are to be used for the charging of travel expenses. The proper account should be used for travel-related expenses, based on the descriptions below:

533.12 JOB-REQUIRED TRAVEL – Reimbursement will be made for travel expenses as a result of performing mandatory, job-required duties. Mileage will be paid for the use of personal vehicles for business trips inside the County when such trips are a normal part of getting the job done.

Reimbursement may be made for trips outside the County which are required by the individual's job. This can include mileage, public transportation, meals, hotel, registration and other expenses as allowed by the travel policy.

533.95 CONFERENCE & SCHOOLING – Reimbursement may be made for travel expenses related to attending a conference, seminar, or workshop which employees have the option to attend. This can include mileage, public transportation, meals, hotel, registration and other expenses as allowed by the travel policy.

Reimbursement may be made for expenses (registration/tuition, books) incurred by an employee while attending educational courses for the improvement of their job performance. If the approved course is out of the County, other allowable expenses may be reimbursed: transportation, hotel, and meals. All such expenses should be charged to 533.95.

Some employees may be required to attend classes or workshops in order to maintain their job status. Employees generally have the option to attend courses from a list of several. This is properly considered schooling and should NOT be charged to 533.12 Job Required Travel.

NOTE: Restrictions set forth in the Travel Regulations apply.

ARTICLE XV. MISUSE OF CHAMPAIGN COUNTY MENTAL HEALTH BOARD AND CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD TRAVEL POLICY

Any misrepresentation or misuse of this policy shall be grounds for disciplinary and/or criminal or civil liability.

TRAVEL REGULATIONS
CHAMPAIGN COUNTY, ILLINOIS
ESTABLISHED PURSUANT TO
CHAMPAIGN COUNTY ORDINANCE NO.

ARTICLE I. APPLICABILITY AND POLICY

APPLICABILITY: These Travel Regulations apply to all Elected Officials, Appointed Officials and Employees of the County of Champaign, regardless of source of funds. Mental Health is specifically excluded from this policy. These regulations do not apply to members of advisory boards or committees or other persons who are not employed financially by the County, except as provided in Article X, A and B. Appropriations for travel must be in appropriate County budgets prior to travel.

POLICY: The purpose of the Regulations is to insure that Elected and Appointed Officials and Employees who travel on official business will be treated fairly and reimbursed at rates which are reasonable, consistent with actual, necessary costs, and which will insure the promotion of economy in County government. The purpose is not to create any additional source of income beyond the Official's or Employee's compensation. Reimbursement of entertainment expenses is not allowed for any Elected or Appointed Officials, or for any Employees of the County.

EFFECTIVE DATE: These Regulations are to be effective October 19, 2018.

ARTICLE II. AUTHORITY TO TRAVEL

A. The County Board, through its budget system, shall be responsible for maintaining a system for control of travel for officials and employees which will provide for the efficient and economical conduct of the County's business, both within and outside the County.

B. Prior authorization for all trips planned during the budget year shall be obtained as part of the approved budget for each department. If appropriations are depleted from all travel line items during the budget year, an additional appropriate sum may be added by budget amendment or transfer for unanticipated trips, subject to County Board approval. Transfers within the same category are allowed.

C. All travel shall be approved by either Appointed or Elected Officials, as department heads, prior to the beginning of travel. Said approval may be oral, but where requested, same can be in writing.

D. As a courtesy, summary reports of travel for Conferences and Instruction and Schooling may be reported to the relevant Department Head, or in the case of

travel of a Department Head to the County Board. Such summary reports are not a requirement for reimbursement of expenses.

ARTICLE III. ALLOWABLE TRANSPORTATION EXPENSES

A. Governing Regulations

1. All travel shall be by the most direct route.

2. All travel shall be by the most economical mode of transportation available, considering travel, time, costs, and work requirements.

3. County owned vehicles shall be used whenever possible.

B. Use of Public Transportation

1. The full cost of public transportation is recoverable if it is the chosen mode of transportation in view of Article III; A, 1 and 2.

C. Use of Personal Vehicle

1. When the use of a privately owned vehicle is necessary or desirable in consideration of the County's travel policy and expenditures, it may be used at the reimbursement rate given in the current year IRS provision for determination of mileage for business expenses.

2. When the use of public transportation is a reasonable alternative to the use of a personal vehicle, the mileage payment shall not exceed the cost of travel by public transportation.

3. Mileage will be payable to only one of two or more individuals traveling in the same vehicle. The names of all travelers and their employing department shall be listed on the travel voucher, along with a travel log that indicates date, purpose of trip, and total mileage.

4. No mileage payments are allowed for Elected or Appointed departments to attend committee meetings, subcommittee meetings and County Board meetings. The County Board Chair and County Board members are allowed mileage payments to attend committee meetings, subcommittee meetings, any other meetings they attend in fulfilling their duties as County Board Members, and County Board meetings.

D. Fly Local Policy

1. When making air travel decisions for Champaign County and its employees, consideration will always be first given to flying in and out of CMI.

2. In determination of the overall expense of air travel on behalf of the County, the following will all be considered in making air travel decisions for the County:
    i. Costs of employee time spent in travel;
    ii. Travel reimbursement to another airport;
    iii. Parking fees;
    iv. Time savings of getting through security at CMI versus other airports.

ARTICLE IV. ALLOWABLE LIVING EXPENSES

A. Meal Expense

1. When traveling outside Champaign County, reimbursement for meals and tips shall be allowed, in accordance with Internal Revenue Service per diem meal allowances as published annually for all cities within the continental United States. In January, the Auditor's Office will provide departments with a chart of the breakfast, lunch, and dinner reimbursement allowed within each per diem category for the calendar year.

   Receipts for individual meals need not be submitted, but a travel log must be submitted in accordance with IRS regulations, which substantiates the business purpose (meeting type, seminar or conference title), the travel dates, the applicable meals to be reimbursed for each day, and the place (city).

2. Meals and tips will not be reimbursed, if the cost of meals for seminars or official meetings is included in the registration fee. A copy of the meeting brochure should be submitted with the travel log at the time of request for reimbursement.

3. Within Champaign County, meals and tips may be reimbursed for Officials and Employees attending meetings, conferences and seminars, if the attendance at the meeting, conference or seminar is required by the Department Head and if the meeting, conference or seminar, includes a meal for which the employee is expected to pay. The same limits apply as noted in Article IV. Section A, Items 1 and 2.

4. Alcoholic beverages are excluded from reimbursement.

5. Any exceptions to the above shall be presented in a letter to the Policy, Personnel and Appointments Committee for approval.

B. Lodging

1. Actual lodging expense will be reimbursed, with the understanding that:

    a. The person traveling will always seek, and use, when available, the "government economy" room rate offered by the hotel.

    b. When the "government economy" rate is not available, and a convention is the reason for the trip, the person will be reimbursed only in terms of the lowest two levels of convention lodging rates, unless such accommodations are not available to the person making the trip.

2. Receipts are required to be submitted with travel vouchers to support accommodation expenses claimed.

ARTICLE V. ALLOWANCE MISCELLANEOUS EXPENSES

A. The following are items that may be reimbursed by the County under Miscellaneous Expenses, if authorized by the affected elected official/department head:

1. Taxicab fares (where a hotel limousine is available, it is to be used).
2. Limousine fares, i.e. hotel limousine.
3. City transit (if used instead of taxicab or limousine).
4. Parking fees.
5. Bridge, road and tunnel tolls.
6. Registration fees.
7. Storage of baggage.
8. Hire of room for official business (when appropriate).
9. Car rentals (when appropriate).
10. Tips for parking attendants and baggage handling.

B. Any miscellaneous expense OVER $40.00 shall be accompanied by a receipt.

ARTICLE VI. EXCEPTIONS TO TRAVEL REGULATIONS

A. Any Exceptions

1. Any exception to the above regulations; whether it is an estimate of the cost of travel, meals, or lodging if expenses have not been incurred or a receipt of the cost of the travel, meals, or lodging if the expenses have already been incurred; shall be presented in a letter submitted to the Policy, Personnel and Appointments Committee for approval and recommendation for approval by the County Board which must be documented with a roll call vote.

ARTICLE VII. APPROVAL OF TRAVEL EXPENSES FOR MEMBERS OF THE COUNTY BOARD

A. Approval of expenses. Expenses for travel, meals, and lodging of any member of the County Board may only be approved by roll call vote at an open meeting of the County Board.

B. Documentation of expenses. Before an expense for travel, meals, or lodging may be approved for any member of the County Board, the following minimum documentation must first be submitted, in writing, to the County Board:
   a. An estimate of the cost of travel, meals, or lodging if expenses have not been incurred or a receipt of the cost of the travel, meals, or lodging if the expenses have already been incurred;
   b. The name of the individual who received or is requesting the travel, meal, or lodging expense;
   c. The job title or office of the individual who received or is requesting the travel, meal, or lodging expense; and
   d. The date or dates and nature of the official business in which the travel, meal, or lodging expense was or will be expended.

C. All documents and information submitted under this Section are public records subject to disclosure under the Freedom of Information Act.

ARTICLE VIII. PREPARATION OF A TRAVEL VOUCHER

A. All claims for the reimbursement of traveling expenditures shall be submitted within sixty (60) days of the last date of travel on a County voucher and shall be itemized in accordance with the regulations. If an employee is unable to meet the specified deadline of within sixty days of the last date of travel, the employee will not receive reimbursement.

B. Each year, there shall be an exception period to the sixty day requirement for submission of travel receipts with regard to travel occurring up to December 31st, the last day of the fiscal year. All requests for reimbursement of travel expenses incurred in the month of December of each year should be submitted to the Auditor's Office by the deadline established by the Auditor for submission of payments to allow payment out of the appropriate fiscal year expenditure budget. If the payment is not submitted in that time frame, the Auditor's Office will not pay the reimbursement.

C. In all instances, travel vouchers shall be supported by receipts for public transportation, lodging, and all other miscellaneous items in excess, individually, of $20.00.

D. Individuals submitting travel vouchers are personally responsible for the accuracy and propriety of said vouchers. Any misrepresentation shall be grounds for disciplinary or legal action.

E. In order to avoid unnecessary paperwork, cash advances are to be issued for travel only when the trip is outside Champaign County and involves an overnight stay, otherwise reimbursements for travel shall be made through the accounts payable system and not by issuing advances.

ARTICLE IX. OTHER EXPENSE GUIDELINES

A. Items Billed Directly. No requests for reimbursement shall be made for items of expenditure, in connection with travel, that are billed directly to the County. Travel expense items billed to a credit card should accompany an appropriately signed and completed County voucher for reimbursement.

B. Business Meals & Expenses. Business breakfasts, lunches and dinners, for both County employee and appropriate guest, which are involved in the course of conducting County business shall be termed a legitimate expenditure for County Officials, Employees and appropriate County guests.

Example: A County employee pays for his own lunch and that of an architect working on space needs for the county. BOTH lunches would be charged to 533.84. (The cost of the employee's lunch is subject to meal allowance limitations; the cost of the guest's meal is not.)

Business breakfasts, lunches and dinners shall:

1. Be in accord with IRS per diem meal allowances as published annually, for county employees.

2. Have documentation of the nature of the business and expenses incurred, attached to the reimbursement voucher submitted.

C. All reimbursement is subject to budget limitations.

D. Reimbursement will be made for travel expenses of job applicants while in Champaign County for interviewing purposes. This can include transportation, hotel, meals and other allowable expenses. Total expenses are set by the Policy Personnel and Appointments Committee for each job search, but other County limitations will not apply. Job applicants should be advised in advance that the Internal Revenue Service requires that we have documentation for reimbursed expenses.

The Search Committee may invite County employees, County Board members, and other public local officials to eat meals with, or attend receptions for, job applicants, subject to the total search expense limitation. Specific meal allowances per person will not apply to such meals.

ARTICLE X. PROSPECT AND APPOINTEE TRAVEL

A. Upon the request of the County, a prospect for a position in County government may be reimbursed for reasonable travel expenses incurred in coming to County office buildings for interviews.

B. Upon request of the County to travel to the County to conduct official business prior to employment, an individual appointed by the County to an authorized position may be reimbursed for travel expenses, within the reimbursement guidelines of this policy.

ARTICLE XI. CREDIT CARDS

A credit card may be obtained by a County department for the efficient operation of the department in regard to charging and payment of business expenses including air fares, lodging, car rental, hotels, other ground transportation, meals, and other miscellaneous expenses that cannot be conveniently paid for by other means.

A. ELIGIBILITY – Champaign County business credit cards may be issued to department heads, for allowable use by that department.

B. POLICY – Champaign County credit cards are issued for the convenience of department heads and their designees. Champaign County credit cards are for business related purchases only.

C. PROCEDURES –

1. Purchasing Limits – All Champaign County departments issued credit cards, are authorized to utilize Champaign County business credit cards

for purchases of up to $5,000 for travel arrangements in compliance with the Champaign County Travel Policy. Purchases of all other goods and/or services, up to $5,000, that can be made more conveniently through the use of the credit card are also authorized if made in compliance with the Champaign County Purchasing Policy.

2. Tax Exempt Status – Champaign County Department Heads are also required to ensure that vendors are made aware of and provided with Champaign County tax exemption information whenever applicable.
3. Receipts - Receipts for all purchases made on Champaign County business credit cards are to be submitted to the Department Head or his/her designee as soon as practicable after the charge is made; and receipts for all purchases made on Champaign County business credit cards are to be submitted to the Auditor's Office with the monthly payment requisition for reconciliation with account statements.
4. Examples of Allowable Use – Champaign County business credit cards may be used for, but not limited to the following:
    i. Hotel expenses
    ii. Conference Registration
    iii. Business meals
    iv. Car rentals and fuel
    v. Supplies and equipment which can be more conveniently purchased through a credit card and whereby tax exempt purchases can be accomplished.

ARTICLE XII. ADVISORY BOARDS AND COMMITTEES

A. Boards and committees having a budget included as part of the County operating expense, are entitled to include a travel item in their budgets, subject to County revenue limitations. Members of such boards and committees shall be reimbursed for approved travel expenses in accordance with the provisions contained in these regulations.

B. Members of advisory boards, committees, or other groups of private citizens which have no board, committee, or group-budget subject to County support, are not covered by these regulations and shall not be reimbursed for travel expenses by the County unless specifically authorized by the County Board, by the recommendation of the Policy, Personnel and Appointments Committee.

ARTICLE XIII. FOR COUNTY BOARD MEMBERS ONLY

A. County Board members shall be paid one per diem daily for meetings attended, whether local or outside Urbana, in accordance with County Board regulations and except where such per diem payment is expressly forbidden by state law. The per diem shall be in addition to approved travel allowance for transportation, meals, and other miscellaneous accompanying expenses.

B. The County Board Chair and County Board members are allowed mileage payments to attend committee meetings, subcommittee meetings, any other meetings they attend in fulfilling their duties as County Board Members, and County Board meetings.

ARTICLE XIV. APPROPRIATE BUDGET LINE ITEMS FOR TRAVEL EXPENSES

The following line items are to be used for the charging of travel expenses. The proper account should be used for travel-related expenses, based on the descriptions below:

533.12 JOB-REQUIRED TRAVEL – Reimbursement will be made for travel expenses as a result of performing mandatory, job-required duties. Mileage will be paid for the use of personal vehicles for business trips inside the County when such trips are a normal part of getting the job done.

Examples: - Viewing property – Assessor's Office
- Inspecting county roads – Highway Department
- Delivering reports, etc. – Coroner

Reimbursement may be made for trips outside the County which are required by the individual's job. This can include mileage, public transportation, meals, hotel, registration and other expenses as allowed by the travel policy.

Examples: - Transporting prisoners – Correctional Center
- Meeting with IDOT officials in Paris, IL – Highway
- Attendance at UCCI Meetings – County Board

533.95 CONFERENCE & SCHOOLING – Reimbursement may be made for travel expenses related to attending a conference, seminar, or workshop which employees have the option to attend. This can include mileage, public transportation, meals, hotel, registration and other expenses as allowed by the travel policy.

Examples: – National Association of County Officials Annual Conference
- American Payroll Association Annual IRS Up-Date

- County Clerk/Recorder Zone meetings
- Total Quality Management Two-Day Seminar

(If the zone meeting is in Champaign County, the meal will not be reimbursed, unless part of the meeting fee. If the TQM seminar is in Champaign/Urbana, tuition and books will be reimbursed, but meals and mileage will not be.)

Reimbursement may be made for expenses (registration/tuition, books) incurred by an employee while attending educational courses for the improvement of their job performance. If the approved course is out of the County, other allowable expenses may be reimbursed; transportation, hotel, and meals. All such expenses should be charged to 533.95.

Examples: - IN-COUNTY: Parkland College business writing class, University of Illinois accounting class

- OUT-OF-COUNTY: Danville Community College workshop on Microsoft Windows

Some employees are required to attend classes or workshops in order to maintain their job status. Employees generally have the option to attend courses from a list of several. This is properly considered schooling and should NOT be charged to 533.12 Job Required Travel.

Examples – Property Assessment Institute classes, for Board of Review members or Supervisor of Assessment employees, to maintain CIAO designation.
- Coroner's classes to satisfy 24-hr annual schooling requirement.

NOTE: Restrictions set forth in the Travel Policy apply.

ARTICLE XV. MISUSE OF CHAMPAIGN COUNTY TRAVEL POLICY

Any misrepresentation or misuse of this policy shall be grounds for disciplinary and/or criminal or civil liability.

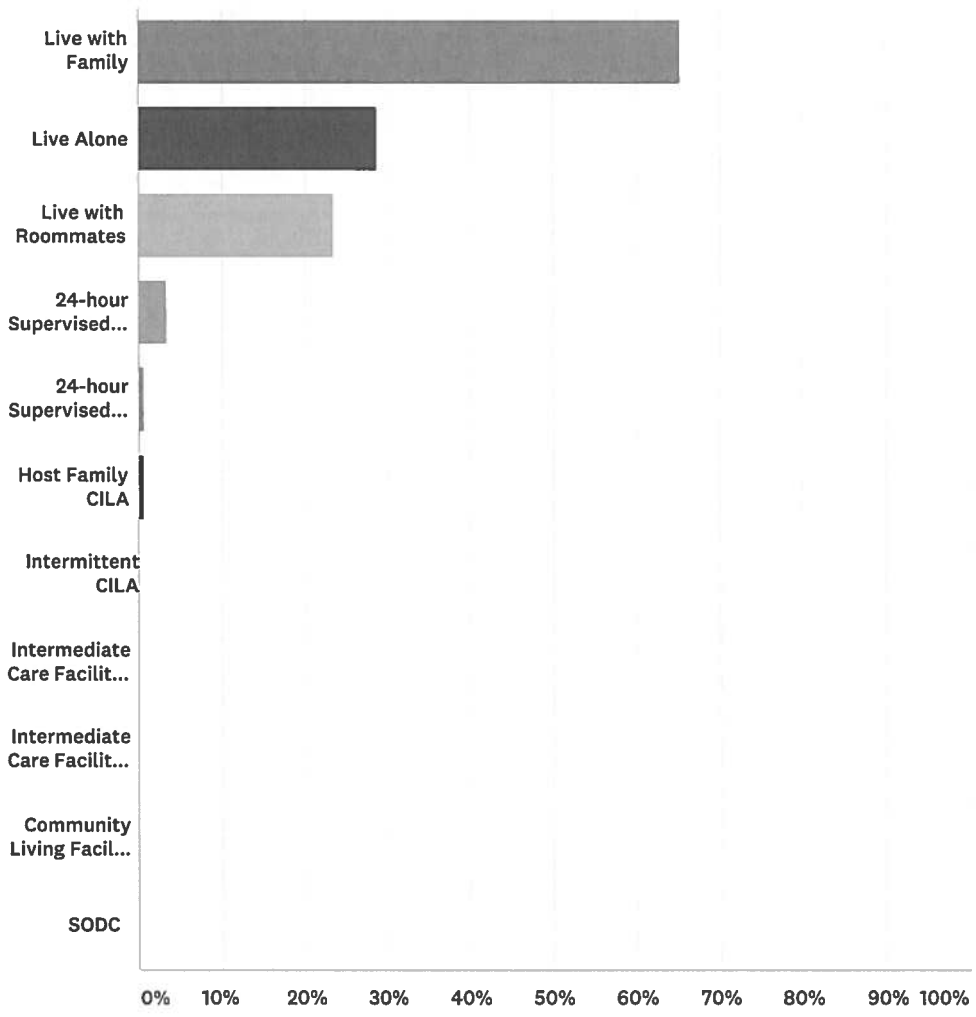
(9, C,)

Q1 Personal Background and Social Summary (Provide a one-paragraph overview of the individual including a brief summary of the person's background, skills, and abilities, personal likes and dislikes current and future vision/hopes, relationships with family members and support staff) - Answers documented and on file.

Answered: 150 Skipped: 4

Q2 What is your preferred living arrangement?

Answered: 153 Skipped: 1

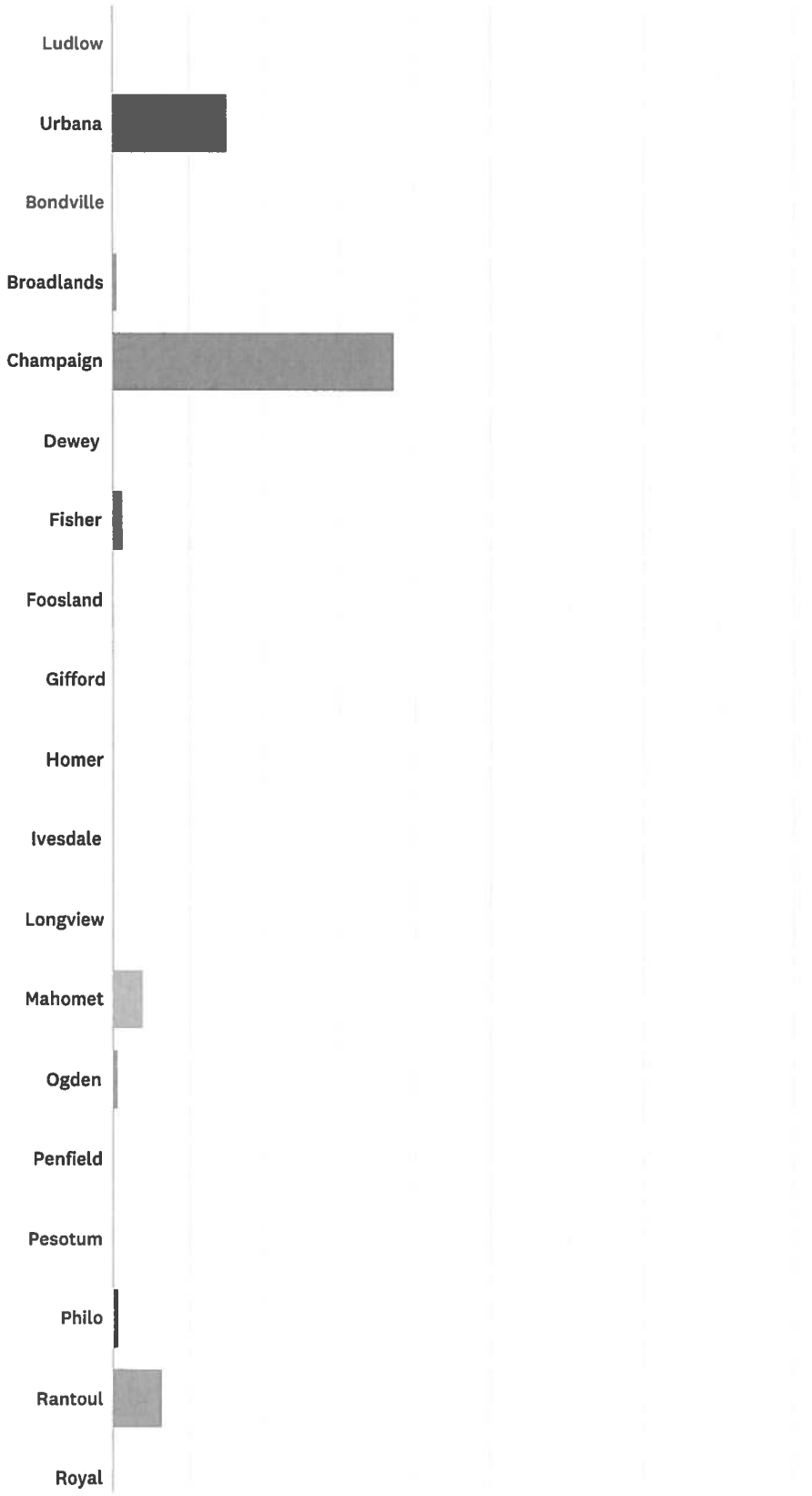


ANSWER CHOICES	RESPONSES	
Live with Family	65.36%	100
Live Alone	28.76%	44
Live with Roommates	23.53%	36
24-hour Supervised Group Home (CILA) - Single Bedroom	3.27%	5
24-hour Supervised Group Home (CILA) - Shared Bedroom	0.65%	1
Host Family CILA	0.65%	1
Intermittent CILA	0.00%	0
Intermediate Care Facility (ICF/DD)	0.00%	0
Intermediate Care Facility (ICF/DD)	0.00%	0
Community Living Facility (CLF)	0.00%	0

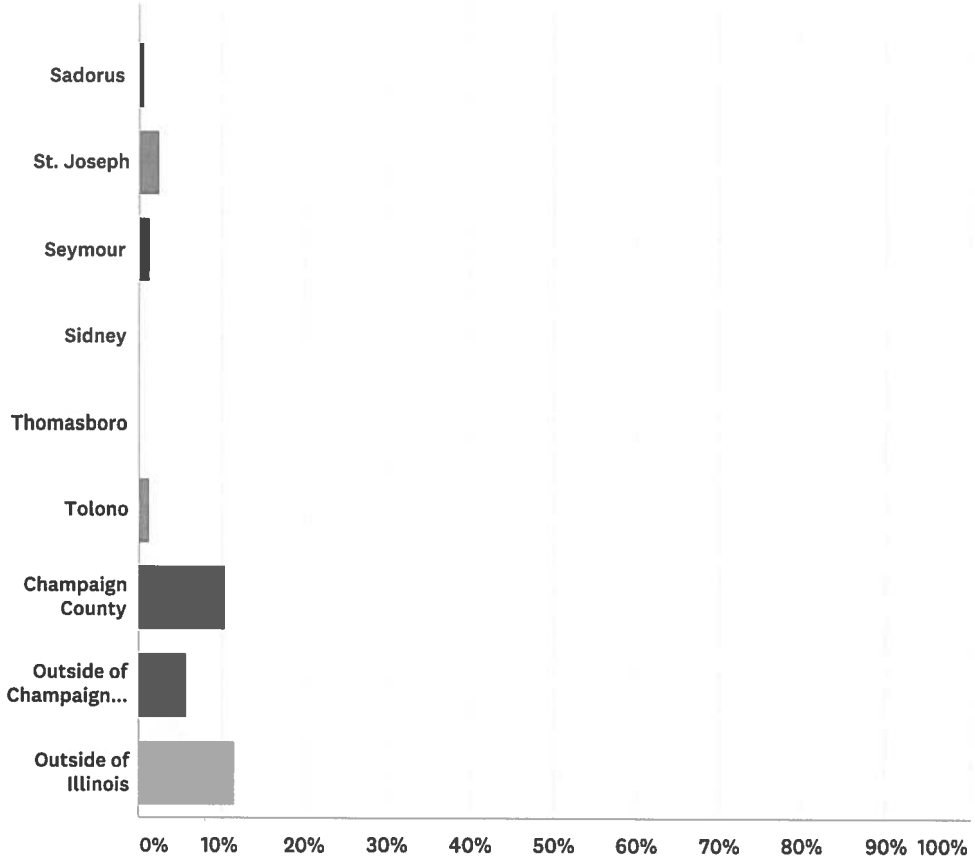
SODC	0.00%	0
Total Respondents: 153		

Q3 Where do you want to live? (City, county, or geographic region)

Answered: 153 Skipped: 1



ISC - Preference Assessment

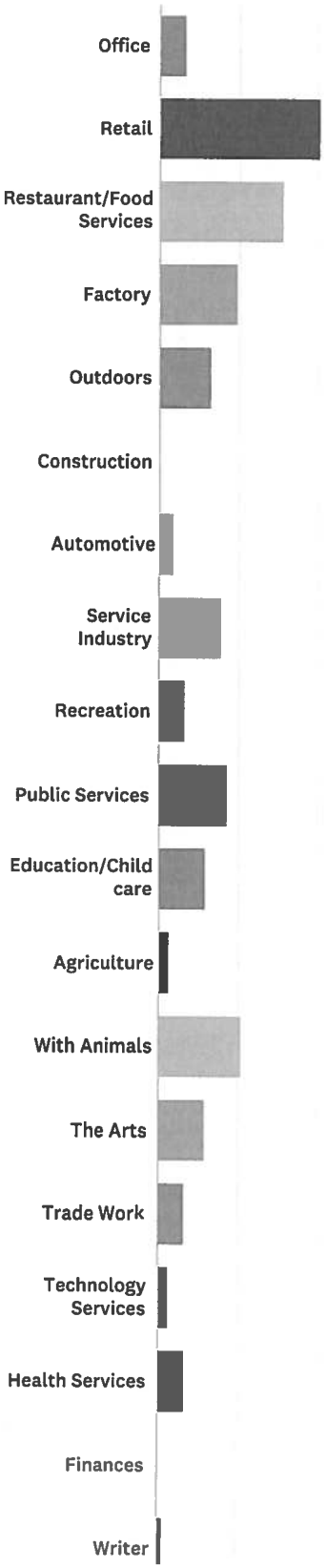


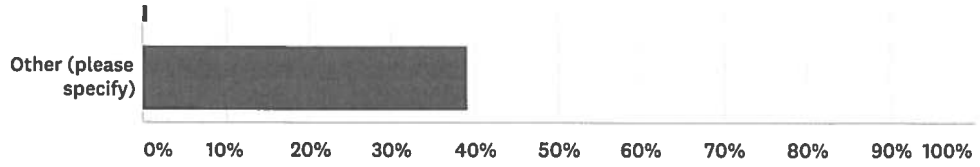
ANSWER CHOICES	RESPONSES	
Ludlow	0.00%	0
Urbana	15.03%	23
Bondville	0.00%	0
Broadlands	0.65%	1
Champaign	37.25%	57
Dewey	0.00%	0
Fisher	1.31%	2
Foosland	0.00%	0
Gifford	0.00%	0
Homer	0.00%	0
Ivesdale	0.00%	0
Longview	0.00%	0
Mahomet	3.92%	6
Ogden	0.65%	1
Penfield	0.00%	0
Pesotum	0.00%	0

Philo	0.65%	1
Rantoul	6.54%	10
Royal	0.00%	0
Sadorus	0.65%	1
St. Joseph	2.61%	4
Seymour	1.31%	2
Sidney	0.00%	0
Thomasboro	0.00%	0
Tolono	1.31%	2
Champaign County	10.46%	16
Outside of Champaign County	5.88%	9
Outside of Illinois	11.76%	18
TOTAL		153

Q4 Employment or Volunteer

Answered: 153 Skipped: 1

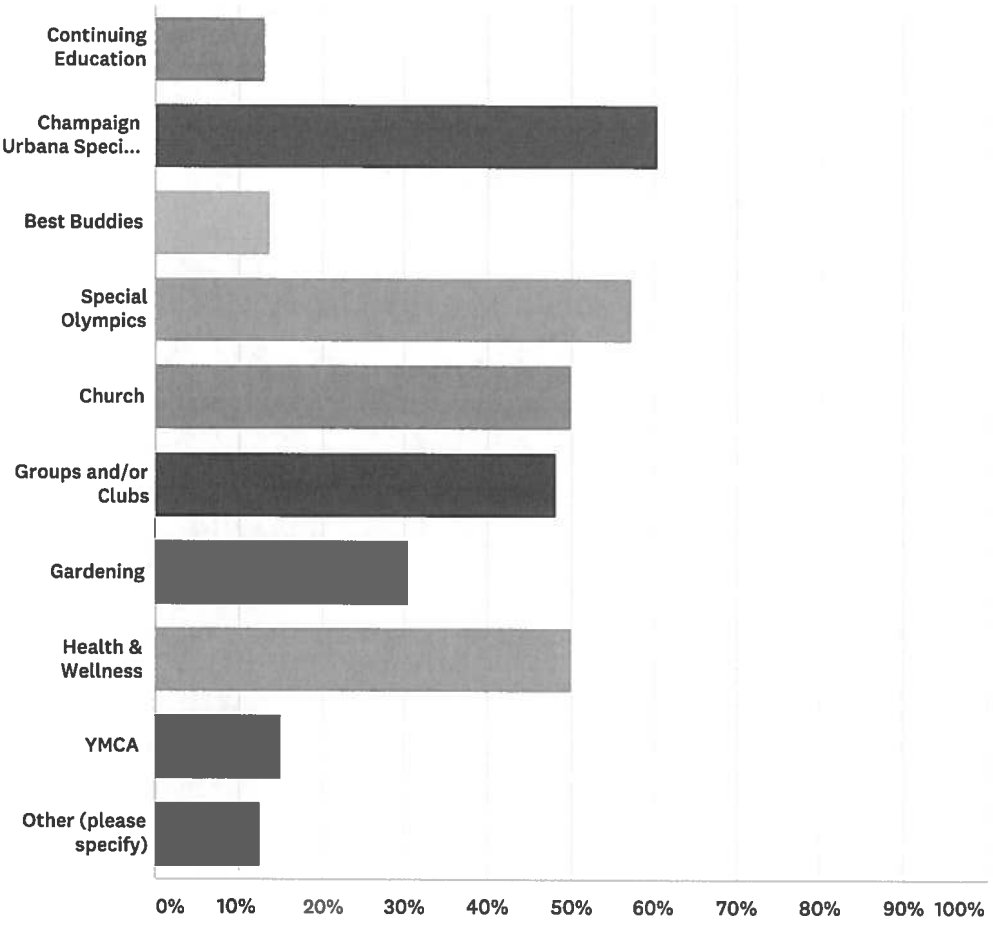




ANSWER CHOICES	RESPONSES	
Office	3.27%	5
Retail	20.26%	31
Restaurant/Food Services	15.69%	24
Factory	9.80%	15
Outdoors	6.54%	10
Construction	0.00%	0
Automotive	1.96%	3
Service Industry	7.84%	12
Recreation	3.27%	5
Public Services	8.50%	13
Education/Childcare	5.88%	9
Agriculture	1.31%	2
With Animals	10.46%	16
The Arts	5.88%	9
Trade Work	3.27%	5
Technology Services	1.31%	2
Health Services	3.27%	5
Finances	0.00%	0
Writer	0.65%	1
Other (please specify)	39.22%	60
Total Respondents: 153		

Q5 Community Opportunities

Answered: 152 Skipped: 2

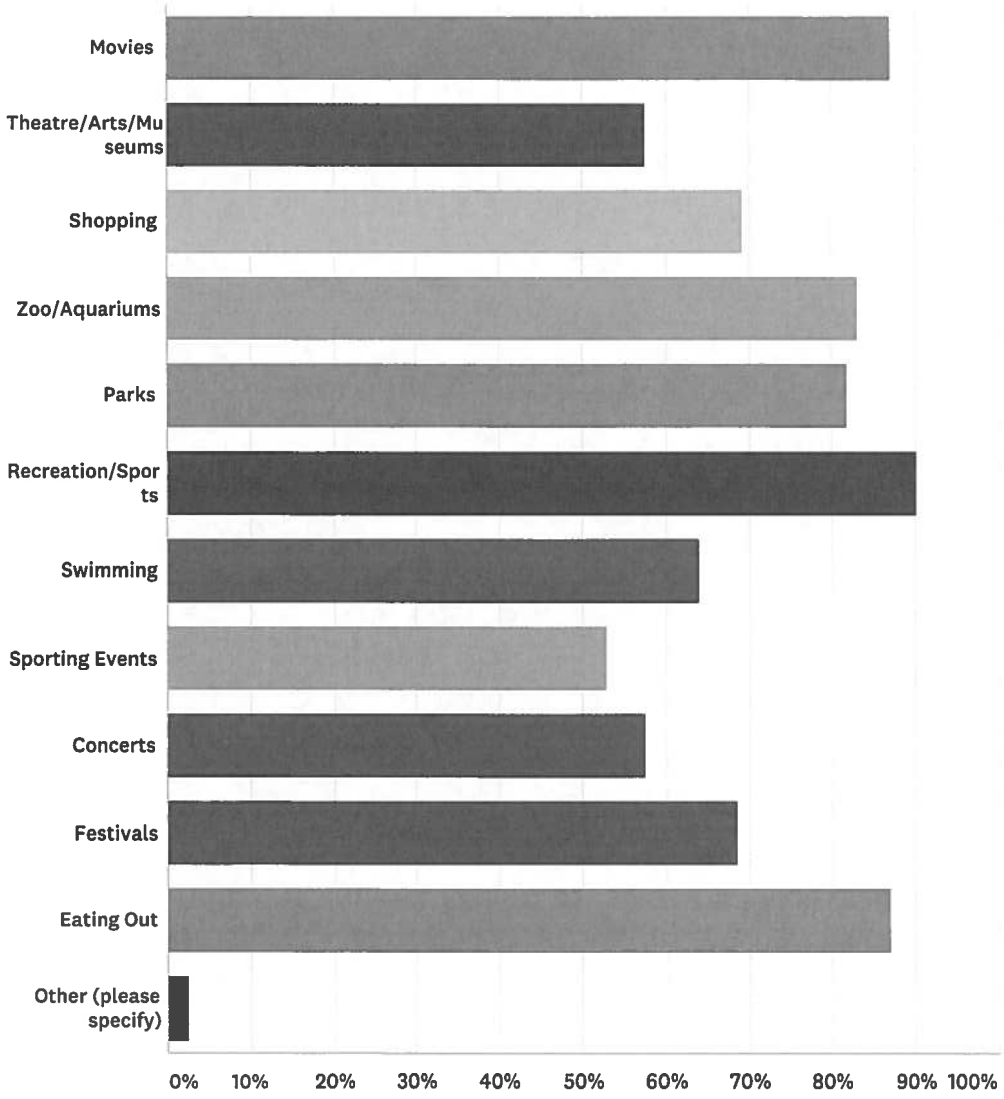


ANSWER CHOICES	RESPONSES	
Continuing Education	13.16%	20
Champaign Urbana Special Recreation (CUSR)	60.53%	92
Best Buddies	13.82%	21
Special Olympics	57.24%	87
Church	50.00%	76
Groups and/or Clubs	48.03%	73
Gardening	30.26%	46
Health & Wellness	50.00%	76
YMCA	15.13%	23
Other (please specify)	12.50%	19

Total Respondents: 152

Q6 Leisure

Answered: 153 Skipped: 1

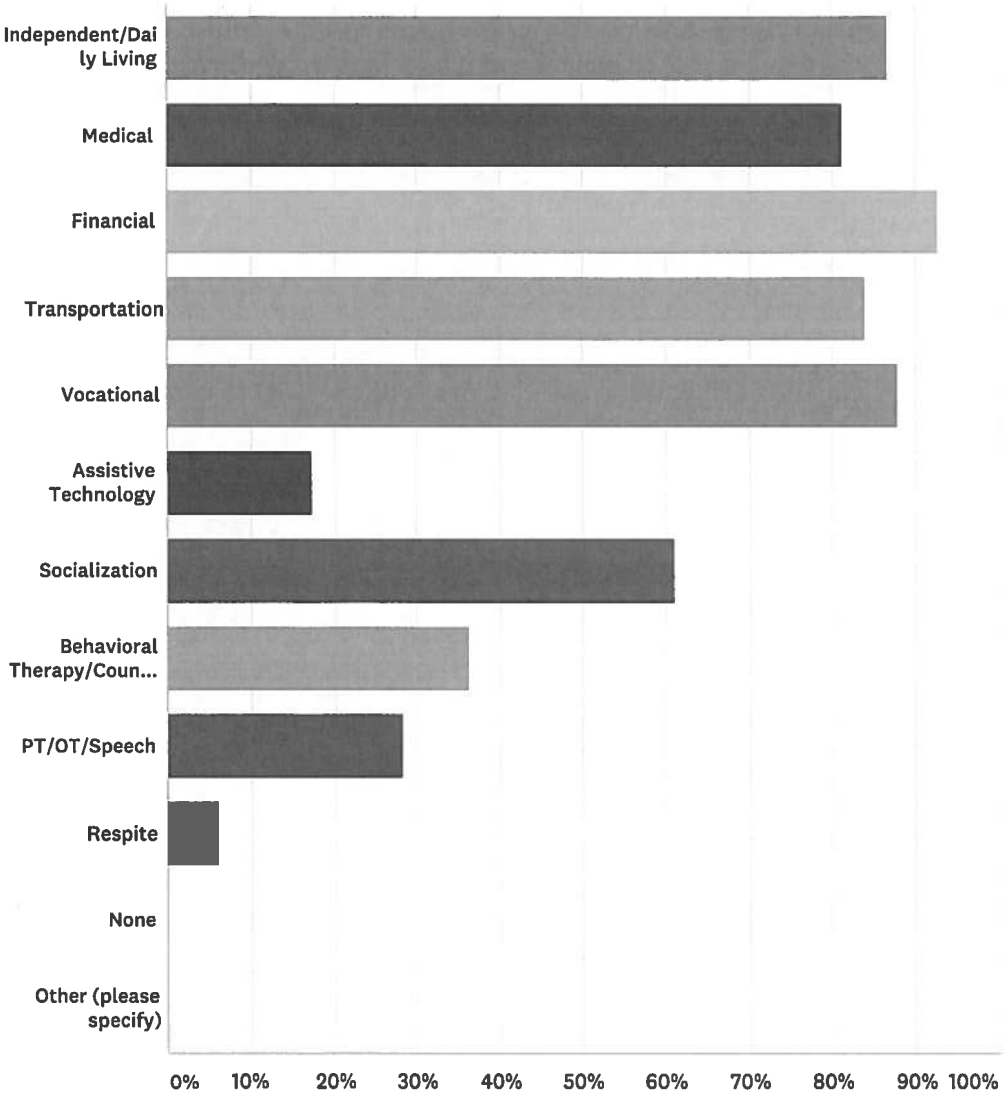


ANSWER CHOICES	RESPONSES	
Movies	86.93%	133
Theatre/Arts/Museums	57.52%	88
Shopping	69.28%	106
Zoo/Aquariums	83.01%	127
Parks	81.70%	125
Recreation/Sports	90.20%	138
Swimming	64.05%	98
Sporting Events	52.94%	81

Concerts	57.52%	88
Festivals	68.63%	105
Eating Out	86.93%	133
Other (please specify)	2.61%	4
Total Respondents: 153		

Q7 What kind of supports do you need?

Answered: 149 Skipped: 5

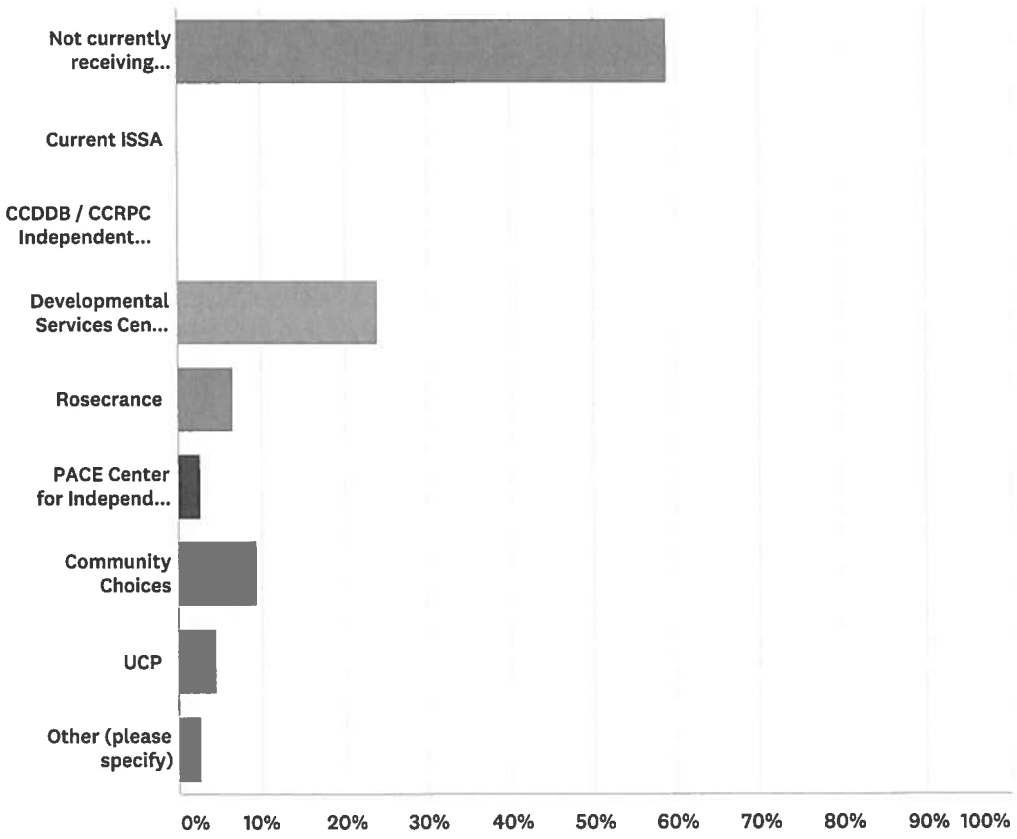


ANSWER CHOICES	RESPONSES	
Independent/Daily Living	86.58%	129
Medical	81.21%	121
Financial	92.62%	138
Transportation	83.89%	125
Vocational	87.92%	131
Assistive Technology	17.45%	26
Socialization	61.07%	91
Behavioral Therapy/Counseling	36.24%	54

PT/OT/Speech	28.19%	42
Respite	6.04%	9
None	0.00%	0
Other (please specify)	0.00%	0
Total Respondents: 149		

Q8 Are you currently receiving case management services? If so, where?

Answered: 149 Skipped: 5



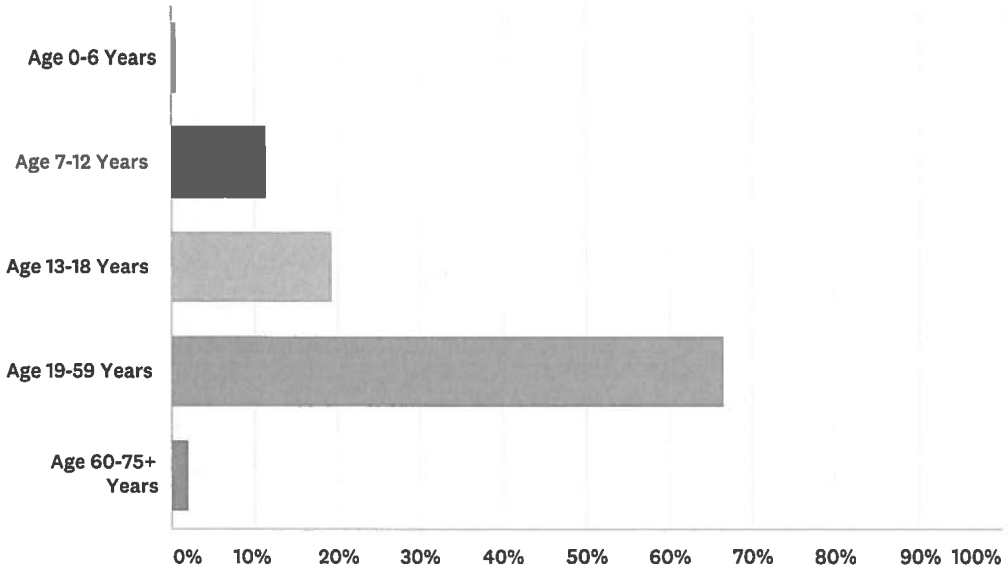
ANSWER CHOICES	RESPONSES	
Not currently receiving services	59.06%	88
Current ISSA	0.00%	0
CCDDB / CCRPC Independent Service Coordination	0.00%	0
Developmental Services Center (DSC)	24.16%	36
Rosecrance	6.71%	10
PACE Center for Independent Living	2.68%	4
Community Choices	9.40%	14
UCP	4.70%	7
Other (please specify)	2.68%	4
Total Respondents: 149		

Q9 Client's Full Name

Answered: 149 Skipped: 5

Q10 Age Group

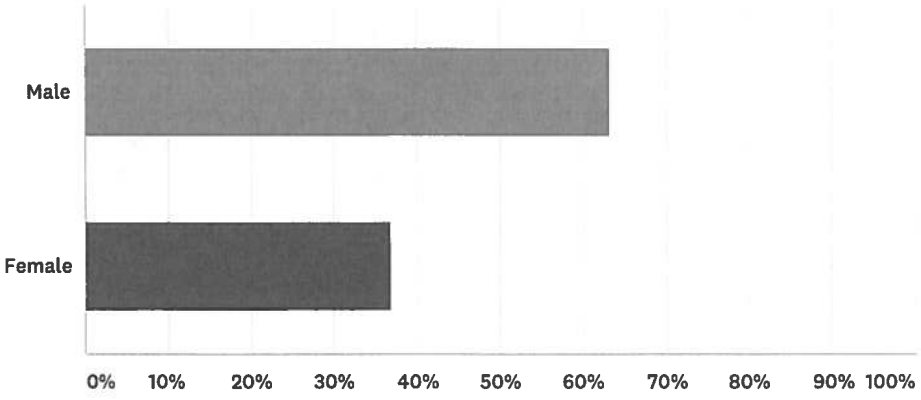
Answered: 149 Skipped: 5



ANSWER CHOICES	RESPONSES	
Age 0-6 Years	0.67%	1
Age 7-12 Years	11.41%	17
Age 13-18 Years	19.46%	29
Age 19-59 Years	66.44%	99
Age 60-75+ Years	2.01%	3
TOTAL		149

Q11 Gender

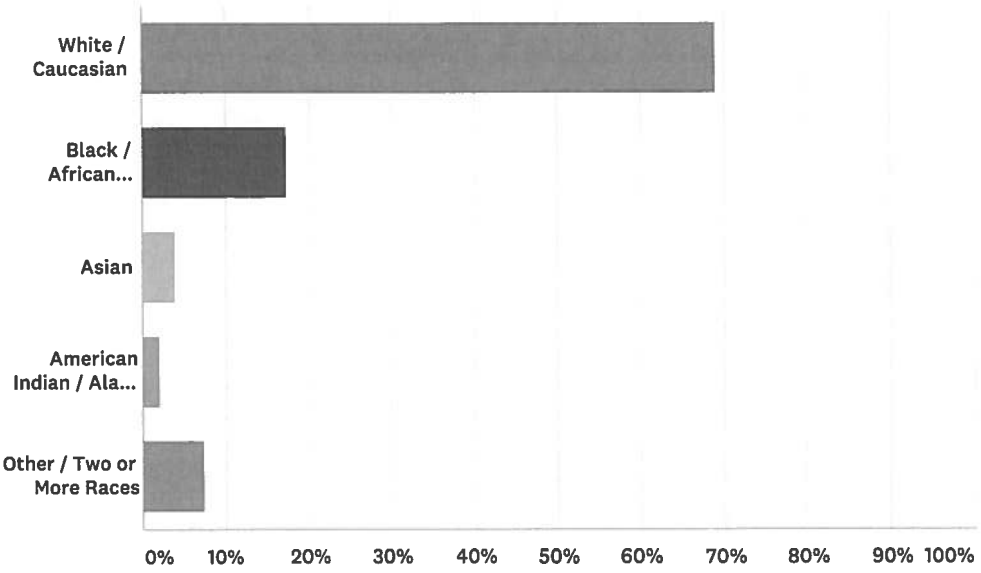
Answered: 149 Skipped: 5



ANSWER CHOICES	RESPONSES	
Male	63.09%	94
Female	36.91%	55
TOTAL		149

Q12 Race

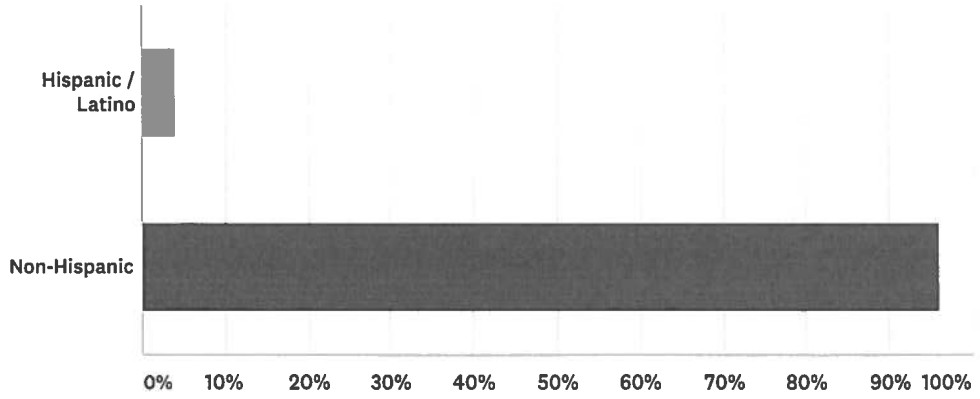
Answered: 149 Skipped: 5



ANSWER CHOICES	RESPONSES	
White / Caucasian	69.13%	103
Black / African American	17.45%	26
Asian	4.03%	6
American Indian / Alaska Native	2.01%	3
Other / Two or More Races	7.38%	11
TOTAL		149

Q13 Ethnicity

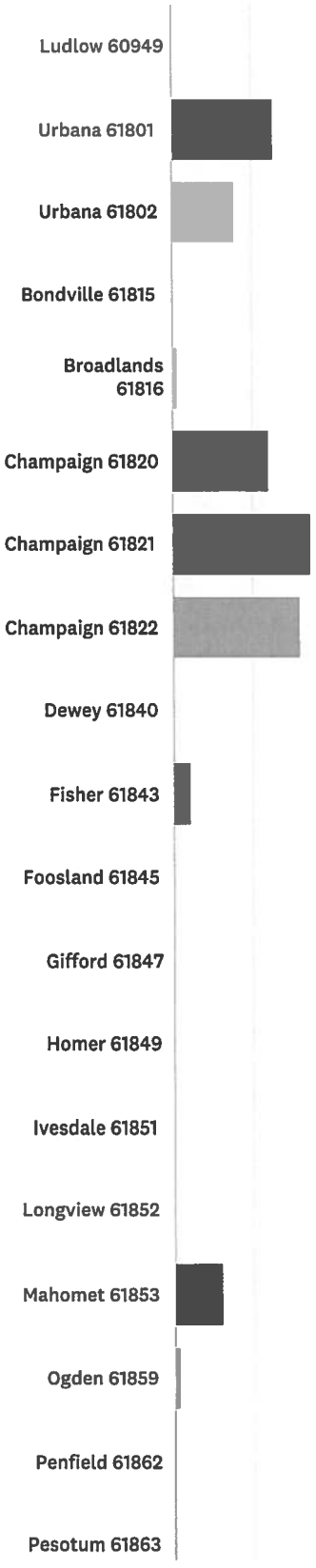
Answered: 149 Skipped: 5

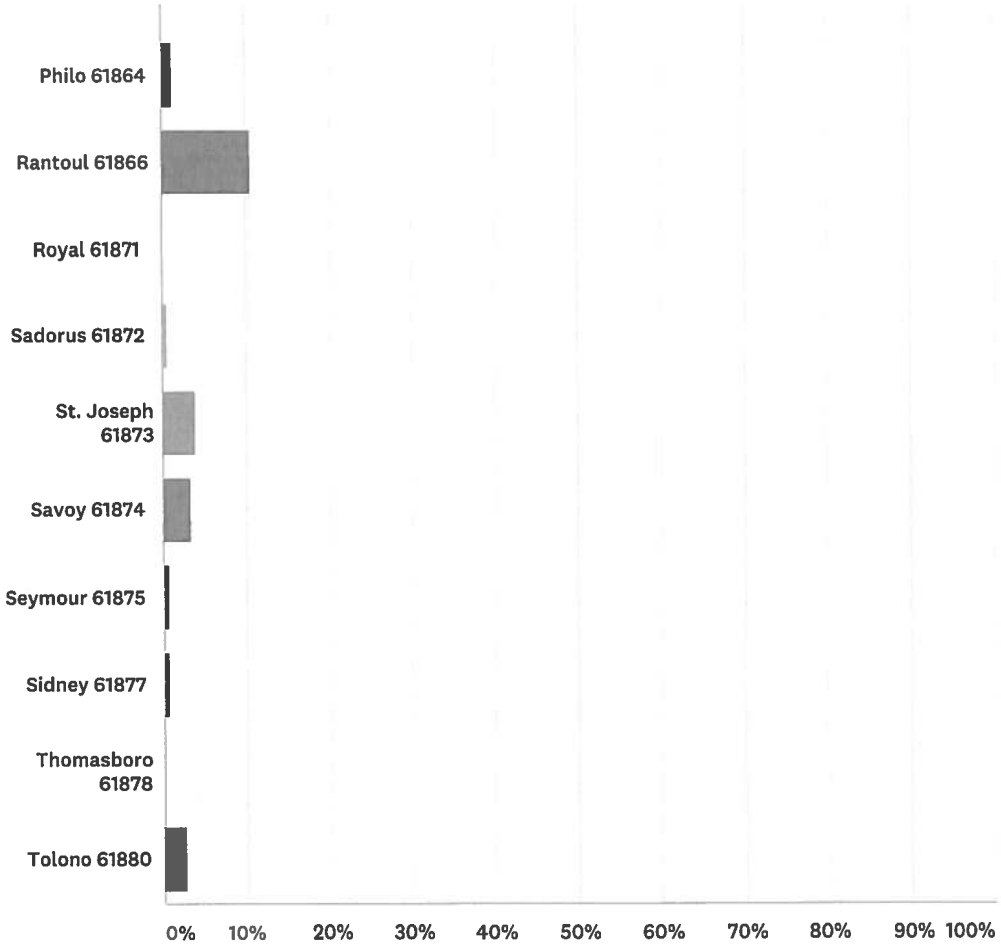


ANSWER CHOICES	RESPONSES	
Hispanic / Latino	4.03%	6
Non-Hispanic	95.97%	143
TOTAL		149

Q14 Zip Code

Answered: 149 Skipped: 5





ANSWER CHOICES	RESPONSES	
Ludlow 60949	0.00%	0
Urbana 61801	12.75%	19
Urbana 61802	8.05%	12
Bondville 61815	0.00%	0
Broadlands 61816	0.67%	1
Champaign 61820	12.08%	18
Champaign 61821	17.45%	26
Champaign 61822	16.11%	24
Dewey 61840	0.00%	0
Fisher 61843	2.01%	3
Foosland 61845	0.00%	0
Gifford 61847	0.00%	0
Homer 61849	0.00%	0
Ivesdale 61851	0.00%	0

Longview 61852	0.00%	0
Mahomet 61853	6.04%	9
Ogden 61859	0.67%	1
Penfield 61862	0.00%	0
Pesotum 61863	0.00%	0
Philo 61864	1.34%	2
Rantoul 61866	10.74%	16
Royal 61871	0.00%	0
Sadorus 61872	0.67%	1
St. Joseph 61873	4.03%	6
Savoy 61874	3.36%	5
Seymour 61875	0.67%	1
Sidney 61877	0.67%	1
Thomasboro 61878	0.00%	0
Tolono 61880	2.68%	4
TOTAL		149

FAQS ABOUT RESPITE WORKERS

How is a respite worker identified?

Typically, families identify the individual that they would like to provide respite for their family member. That individual then receives any required training through Envision Unlimited. Families may be given assistance in identifying a suitable respite worker if requested or necessary.

What are workers' qualifications?

Respite workers must be 18 years of age, able to pass a background check, and willing to participate in any training required by the agency on an annual basis.

"Respite has been key in supporting our family and allowing us to participate in outside activities. We know that our daughter is cared for by a trained and loving individual."

-Pat Singer

Envision Unlimited is a 501(c)(3) nonprofit providing individuals with disabilities a wide array of high quality programs and services that promote choice, independence, and inclusion.

Learn more at **envisionunlimited.org**

envision
UNLIMITED
Choice. Independence. Inclusion.

For additional information or to make a referral, contact our Respite Coordinator at:

773.899.6177
respiteinfo@envisionunlimited.org

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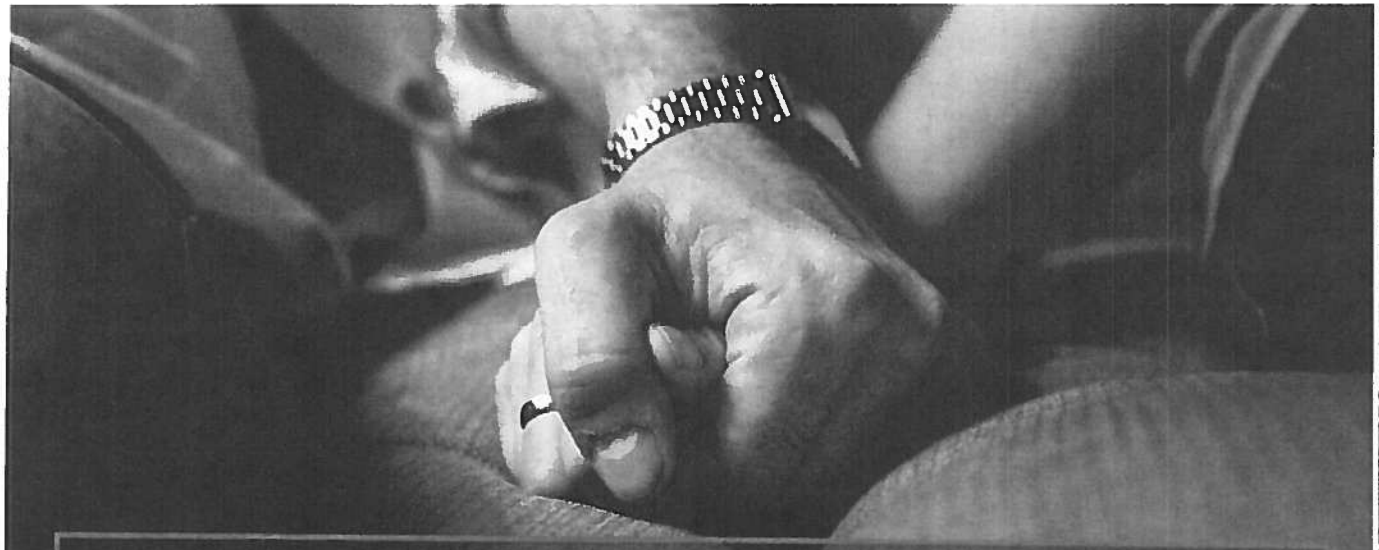
Explore Our

IN-HOME RESPITE PROGRAM



OUR COMMITMENT

Envision Unlimited's Community Living Program provides a variety of residential living arrangements and supports to adults with Intellectual/Developmental Disabilities (IDD).

Services are individualized and person-centered. The intent is to assist each individual to live in the community in a setting most aligned with his/her preferences and those of his/her guardian. In-home respite is prioritized for individuals who are not receiving any other funded service and who are on the PUNS wait list.

WHAT IS IN-HOME RESPITE?

In-home respite is essentially the opportunity for families to have temporary relief from their caregiving roles, thus reducing stress within the family. It provides families with a trained individual who comes into the home to spend time with their family member with a disability. It allows families to engage in necessary daily activities, thus decreasing their feelings of isolation. It provides families with rest and relaxation opportunities. It improves a family's ability to cope with the daily responsibilities of caring for a family member with IDD, and it assists the parent or guardian, if requested, with teaching skills to support their family member.

WHO IS ELIGIBLE?

Any person with a documented developmental disability who requires the presence and support of another person to ensure they are safe.

HOW MANY HOURS PER WEEK/MONTH IS RESPITE AVAILABLE?

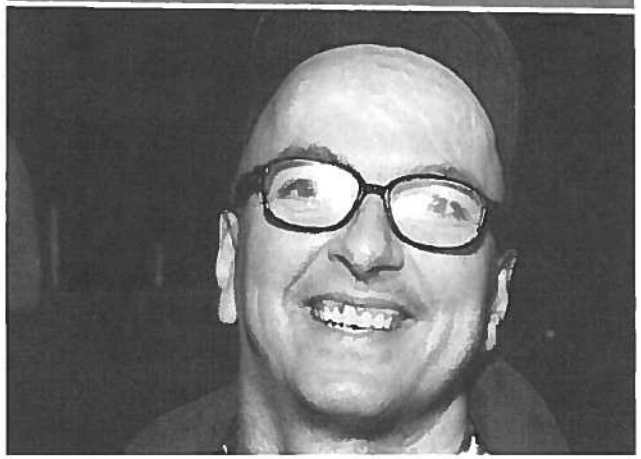
Families generally are eligible to receive up to 180 hours of respite services per year. They may use the hours monthly as they choose and schedule respite services directly with their respite worker.

Is there an application process?

To schedule an in-person appointment to discuss eligibility and complete all necessary paperwork, contact our Respite Coordinator via email at respiteinfo@envisionunlimited.org or by phone at 773.899.6177.

Where are respite services available?

We currently serve the following counties: Adams, Brown, Champaign, Cook, DeWitt, Fulton, Knox, Livingston, Logan, Macon, Mason, McLean, Morgan, Moultrie, Peoria, Pike, Sangamon, Scott, and Tazewell.



(9.E.)

The Illinois Respite Coalition (IRC) is dedicated to increasing public awareness of the importance of "Lifespan Respite," promoting education and training for families and providers of respite services, and advocating support for caregivers by ensuring access to quality respite services for the residents of Illinois.

Additional Agencies and Respite Resources

American Parkinson Disease Association
800.223.2732
Illinois Department of Aging
800.252.8966
National Autism Society
800.328.8476
Illinois Department of Human Services
800.848.6154
Alzheimer's Association
800.272.3900
Eldercare Locater
800.677.1116
Division of Specialized Care for Children (Through UIC)
800.322.3722
National Alliance on Mental Illness
800.950.6264
Caregiver Action Network
202.454.3970
Illinois Department of Children's Services (Child Abuse Hotline)
800.25.ABUSE

IRC Illinois Respite Coalition

(55)

IRC Contact
17314 Kedzie Avenue
Hazel Crest, IL 60429

Phone: 630.207.8479
ilrespitecoalition@gmail.com
illinoisrespitecoalition.org

What is Respite Care?

Respite care provides temporary relief for caregivers from the ongoing responsibility of caring for an individual of any age with special needs who may be at risk of abuse or neglect.

Special needs may include any disabilities, and chronic or terminal, physical, emotional, cognitive or mental health condition requiring ongoing care and supervision, including Alzheimer's disease and children with special needs (eligibility under Lifespan Respite).

Over one million people in the state of Illinois provide unpaid help to family members who have special needs.

It is estimated that if the work of these caregivers had to be duplicated by paid staff, the cost to the state would be $1.3 billion dollars.

Respite care is a gift of time for the caregiver. It alleviates stress and has been shown to improve relationships.

IRC Illinois Respite Coalition

In every community across the state of Illinois, Family members are becoming caregivers for their loved ones.

Emergency Respite Funding

When funding is available, the IRC will provide Emergency Respite Care (ERC) to families experiencing crisis statewide across the lifespan. This funding is allocated to anyone with a disability. The funding, once approved, would be for crisis/ emergency situations. The funding can be used to hire a respite worker that will assist the family with his/ her loved one.

In-Home Respite Program

The Illinois Respite Coalition (IRC) has an In-Home Respite Program that is funded by the Department of Human Services. The IRC offers services to caregivers who have loved ones with intellectual and developmental disabilities, primarily in 14 southern Illinois counties.

Families can receive up to 180 hours of in-home respite care per year through this grant. Families or caregivers can speed up the respite process if they have their own respite worker. However, families without workers will be matched with a trained respite worker. All respite workers will receive training and background checks.

Respite Work Opportunity

Are you interested in becoming a respite worker and gaining hands-on experience working with individuals with disabilities? Consider becoming a respite worker. Hours are flexible, and training will be provided.

*** Individuals on state waivers and/ or receiving respite services through other agencies are not eligible for emergency respite funding.**

IRC Illinois Respite Coalition

The Illinois Respite Coalition (IRC) is dedicated to increasing public awareness of the importance of "Lifespan Respite," promoting education and training for families and providers of respite services, and advocating support for caregivers by ensuring access to quality respite services for the residents of Illinois.

"It is because of people like you and your fine organization that we can say that even in what seems to be the worst of storms, clouds truly do have a silver lining." -Submitted by D.C.

In-Home Respite

The Illinois Respite Coalition will continue our in-home respite services through a DHS funded grant. The IRC will be offering services to caregivers with loved ones with intellectual and developmental disabilities through a trained respite worker. These services are no longer rendered via voucher payment. Instead, families can receive up to 180 hours of in-home respite care per year. Families or caregivers can speed up the respite process if they have their own respite worker. However, families without workers will be matched with a trained respite worker. All respite workers will receive training and background checks.

The primary In-home funded counties are:
Bond, Champaign, Clark, Clinton, Crawford, Cumberland, Dewitt, Edgar, Effingham, Jasper, Macon, Marion, Mason, Moultrie, Richland, Washington

Respite Work Opportunity

Are you interested in becoming a respite worker and gaining hands-on experience working with individuals with disabilities? Consider becoming a respite worker. Hours are flexible, and training will be provided.

For more information about becoming a worker or receiving respite, please email or call us:
Phone: (630)207-8479 *email: ilrespitecoalition@gmail.com*

DECISION MEMORANDUM

DATE: October 23, 2019
TO: Members, Champaign County Developmental Disabilities Board (CCDDB)
FROM: Lynn Canfield, Executive Director
SUBJECT: Review of Individual Mini-Grant Applications

Background:

Given that over 200 Champaign County residents are enrolled in PUNS but likely underserved, receiving no long term supports and services through state-waiver or CCDDB/CCMHB funded programs, the CCDDB has an interest in offering an individual grant opportunity to support identified needs, especially as defined by people with I/DD. Based on needs assessment results, we expect one-time purchases (for equipment, technology, recreation, etc.) to be helpful to many.

At their September 18, 2019 meeting, the CCDDB authorized an individual mini-grant application process. Notification of Funding Availability was made in the News-Gazette on Sunday, September 22, posted on http://ccmhddbrds.org and on our page of the Champaign County website, and distributed to providers, stakeholders, and support networks, some of whom posted on social media. A final draft of the application itself incorporated changes as directed by the Board, was distributed in both paper and electronic format, and was posted on http://ccmhddbrds.org.

The opportunity is available to people who would qualify for but are not receiving a state-waiver service or ongoing CCDDB or CCMHB funded service and who have a need or preference which can be met by one-time specific assistance. Awards cannot be made to family members of a Board or staff member. Applications, submitted by or on behalf of an eligible person, are due by 4:30PM on **November 8, 2019**. These are to be submitted by mail or in person to the CCDDB office.

The CCDDB approved a broad process and timeline: a review committee will review applications from November 12 to December 6. Results will be compared, to arrive at recommendations. Recommendations will be brought to the CCDDB for approval at their meeting on **December 18**. Notification of awards will be made by **December 31, 2019**. Agreements will be finalized in a timely manner and payments issued as appropriate to each individual award.

Recommended Actions:

1. **Establish a committee** to review applications between November 12 and December 6 and develop a set of recommendations for grant awards to be considered by the CCDDB on December 18. Each set of reviewers includes a back-up person who will review with the committee if another is unavailable:

- Two CCDDB/CCMHB staff: Mark Driscoll, Associate Director, and Shandra Summerville, Cultural and Linguistic Competence Coordinator, with Chris Wilson, Financial Manager, as backup.
- Two CCDDB members: Sue Suter and Anne Robin, with Gail Kennedy as backup.
- One Community Member (family advocate): Linda Tortorelli, with Jane Webber as backup.

2. **Prepare applications for review.**

After the November 8 deadline, CCDDB/CCMHB staff who are not serving on the review committee will screen applications for eligibility:

- Kim Bowdry, Associate Director, will confirm residency, PUNS, and service eligibility of all individual mini-grant applicants. If the applicant is not a Champaign County resident, not enrolled in PUNS, or receiving long-term services through the State or County, the application will be marked as ineligible and the reason noted.
- If an applicant is a family member of CCMHB or CCDDB board or staff member, the application will be marked as ineligible and the reason noted.
- If an application is late or substantially incomplete, it will be marked as ineligible and the reason noted.

All applications, including those deemed ineligible, will be copied so that individuals' names and any other identifying information can be redacted. Because these are requests for direct assistance, reviewers will not see the names of individual applicants. A unique, neutral identifier will be assigned to each, and copies of de-identified applications will be distributed to each member of the review committee. Copies of all de-identified applications will be available to all CCDDB members. A summary of ineligible applications and reasons will also be available to board members and review committee.

3. **Review of applications and recommendations for individual awards.**

The review committee may read and consider the set of eligible applications individually and communicate with other reviewers and as a group, preferably in person. A record of deliberations should be kept as support for the final set of grant award recommendations.

By or before December 6, the committee should agree on recommendations for the CCDDB to consider. The total of their allocation recommendations should not exceed $55,640. If the committee has concerns or questions about applications which had been deemed ineligible, the non-review staff will provide explanations. If the committee disagrees with a designation of ineligibility, they may make a recommendation to the CCDDB with rationale for why an exception should be made.

Committee recommendations will be presented in a Decision Memorandum, prepared by non-review staff. The memo will also summarize ineligible applications and the reasons. Applicants will be referred to by the unique, neutral identifier rather than by name. The review committee may offer additional recommendations, such as for next steps or future similar individual grant opportunities. This Decision Memorandum will be included in the packet for the CCDDB's December 18 meeting.

Budget Impact:

Due to an unsuccessful PY2020 contract negotiation, a total of $55,640 is available for allocation of individual mini-grant awards, not changing the 2019 or 2020 CCDDB budgets.

Decision Section:

Motion to approve the Executive Director and CCDDB Staff to implement a mini-grant application review process as described in this memorandum.

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

Utilization Summaries for PY2019 CCDDB and CCMHB I/DD Programs

Detail on each program's performance toward defined consumer outcomes during the funding year of July 1, 2018 to June 30, 2019 is available at http://ccmhddbrds.org, among downloadable public files toward the bottom of the page. The relevant document is titled "CCDDB PY19 Performance Outcome Reports."

Priority: Comprehensive Services and Supports for Young Children

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Champaign County Regional Planning Commission Head Start/Early Head Start
Social Emotional Development Services $73,605 (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:** 70 TPC, 60 NTPC, 20 CSE, 700 SC, 8 Other (newsletter articles, staff training). **Utilization actual:** 67 TPC, 90 NTPC, 31 CSE, 594 SC, 73 Other (newsletter articles, staff training).

Developmental Services Center **Family Development Center** $562,280 (CCMHB)

Services: Serves children birth to five years of age, 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:** 655 TPC, 150 SC, 505 CSE.

Priority: Self-Advocacy and Family Support Organizations

CU Able **CU Able Community Outreach** $15,285

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 providing 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:** 52 TPC, 56 NTPC, 100 SC, 16 CSE. **Utilization actual:** 18 TPC, 22 NTPC, 159 SC, 15 CSE.

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

Services: Support to people with Down Syndrome and their families, providing current DS related information for members, parents, professionals and the general public. DSN reaches out to new parents, providing many networking & social opportunities as well as education, support & connections to local resources. DSN hosts many community awareness events each year, helping to promote inclusion for

individuals with Down syndrome in our community. **Utilization targets:** 145 TPC, 50 NTPC, 20 CSE. **Utilization actual:** 179 TPC, 157 NTPC, 19 CSE.

Community Choices **Self Determination Support** $116,000

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:** 145 NTPC, 1846 SC, 4 CSE, 1256 Other (direct support hours). **Utilization actual:** 162 NTPC, 2210 SC, 8 CSE, 1650 Other (direct support hours).

PACE, Inc. **Opportunities for Independence** $49,000

Services: Serves people with I/DD in an Independent Living Philosophy based program to grow and/or maintain independence. 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:** 30 TPC, 35 NTPC, 125 SC, 25 CSE, and 500 Other (direct support hours). **Utilization actual:** 22 TPC, 57 NTPC, 131 SC, 12 CSE, and 245 Other (direct support hours).

Priority: Linkage and Advocacy for People with I/DD

Champaign County Regional Planning Commission Community Services

Decision Support for CCDDB/Person Centered Planning $119,629

Services: ISC staff continue to assess persons transitioning from other counties who are eligible for and may or may not be receiving DHS waiver funding, who have not yet been assessed for service preferences. Transition Consultants assist people/families in conflict free transition planning. Provides extensive outreach, preference assessment, and person-centered planning services for Champaign County residents with I/DD without waiver funding. Consultation and transition planning provided to people with I/DD (and families) nearing graduation from secondary education. New in 2018: Provides conflict free person-centered planning and case management services, using DHS' Discovery and Personal Plan tools currently utilized by ISC agencies throughout Illinois for those with Medicaid waiver funding. **Utilization targets:** 100 TPC, 150 NTPC, 200 SC, 40 CSE. **Utilization actual:** 184 TPC, 301 NTPC, 462 SC, 59 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 serves 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:** 300 TPC, 36 NTPC, 100 SC, 2 CSE. **Utilization actual:** 273 TPC, 42 NTPC, 75 SC, 2 CSE.

Rosecrance Champaign/Urbana **Coordination of Services – DD/MI** $35,150

Services: Emphasis 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:** 30 TPC, 15 SC, 12 CSE. **Utilization actual:** 8 TPC, 19 SC, 18 CSE.

Priority: Employment Services and Supports

Community Choices **Customized Employment** $87,000

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, 965 SC, 4 CSE, 1325 Other (direct support hours). **Utilization actual:** 33 TPC, 1416 SC, 5 CSE, 1216 Other (direct support hours).

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, 8 SC. **Utilization actual:** 71 TPC, 23 NTPC, 11 CSE, 23 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:** 25 TPC, 10 NTPC, 4 CSE. **Utilization actual:** 27 TPC, 19 NTPC, 5 CSE.

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, 15 CSE. **Utilization actual:** 22 NTPC, 37 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**: 27 TPC,46 SC, 25 CSE.

Priority: Non-Work Community Life and Flexible Support

Developmental Services Center **Apartment Services** $429,861

Services: Supports people with I/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 for those needing assistance after hours and on the weekends. **Utilization targets:** 60 TPC, 5 SC. **Utilization actual:** 56 TPC, 15 SC.

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

Services: Provides clinical supports and services to children and adults with I/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:** 65 TPC, 5 NTPC, 10 SC, 2 CSE. **Utilization actual:** 65 TPC, 6 NTPC, 17 SC, 2 CSE.

Developmental Services Center **Community First** $799,000

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:** 44 TPC, 40 NTPC, 5 SC, 4 CSE. **Utilization actual:** 56 TPC, 128 NTPC, 20 SC, 6 CSE.

Developmental Services Center **Individual & Family Support** $404,428

Services: Program serves children and adults with I/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, 33 NTPC, 5 SC, 2 CSE. **Utilization actual:** 17 TPC, 37 NTPC, 13 SC, 2 CSE.

PACE, Inc. **Consumer Control in Personal Support** (NEW) $21,000

Services: Personal Support Worker (PSW) recruitment and orientation, focused on Independent Living Philosophy, Consumer Control, and the tasks of being a PSW. Personal Assistant/Personal Support Worker Registry can be sorted by; location, time of day, services needed, and other information which allows consumers to get the PSW that best matches their needs. Service is designed to ensure maximum potential in matching person with I/DD and PSW to work long-term towards achieving their respective goals. **Utilization targets:** 150 NTPC, 200 SC, 12 CSE, and 100 Other (direct support hours). **Utilization actual:** 148 NTPC, 157 SC, 10 CSE, and 212 Other (direct support hours).

Priority: Expansion of Independent Community Residential Opportunities

Community Choices **Community Living** $72,500

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, 15 NTPCs, 2 CSE, 1420 SC, 1602 Other (direct support hours). **Utilization actual:** 19 TPC, 18 NTPC, 5 CSE, 1537 SC, 1414 Other (direct support hours).

Individual Advocacy Group, **CILA Expansion** $450,000 (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 I/DD living in MHB/DDB owned-homes. During 2019, the CCMHB contributed a larger share in order to pay off the mortgage loan in full; the CCDDB will continue to transfer $50,000 to this fund each year until their total payments are equal to the CCMHB contribution. **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

CCDDB 2019-2020 Meeting Schedule

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

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

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

October 30, 2019– Lyle Shields Room (5:30PM) - CCMHB Study Session (includes discussion of CCMHB funding of I/DD programs)

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

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

January 22, 2020 – Lyle Shields Room (8AM)

February 19, 2020 – Lyle Shields Room (8AM)

March 18, 2020 – Lyle Shields Room (8AM)

April 22, 2020 – Lyle Shields Room (8AM)

May 20, 2020 – Lyle Shields Room (8AM)

June 17, 2020 – Lyle Shields 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

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

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

CCMHB 2019-2020 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)

September 18, 2019
September 25, 2019 – Study Session
October 23, 2019
October 30, 2019 – Study Session
November 20, 2019
December 18, 2019 (tentative)
January 22, 2020
February 19, 2020
March 18, 2020
April 22, 2020
April 29, 2020 – Study Session
May 13, 2020 – Study Session
May 20, 2020
June 17, 2020

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

DRAFT

July 2019 to June 2020 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 2020. 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 2021 (July 1, 2019 – June 30, 2020) and deadlines related to current (PY2020) agency contracts.

07/10/19	**Regular Board Meeting (Lyle Shields Room)** Election of Officers
08/30/19	*Agency PY2019 Fourth Quarter and Year End Reports Due*
09/18/19	**Regular Board Meeting (Dimit Conference Room)**
10/23/19	**Regular Board Meeting (Dimit Conference Room)** Draft Three Year Plan 2019-2021 with 2020 Objectives Release Draft Program Year 2021 Allocation Criteria
10/25/19	*Agency PY2020 First Quarter Reports Due*
10/28/19	*Agency Independent Audits, Reviews, or Compilations Due*
11/20/19	**Regular Board Meeting (Dimit Conference Room)**
12/08/19	*Public Notice to be published on or before this date, giving at least 21-day notice of application period.*
12/18/19	**Regular Board Meeting (Dimit Conference Room)** Approve Three Year Plan with One Year Objectives Allocation Decision Support – PY21 Allocation Criteria
01/03/20	*CCMHB/CCDDB Online System opens for Agency Registration and Applications for PY21 Funding.*
01/22/20	**Regular Board Meeting**
01/31/20	*Agency PY2020 Second Quarter and CLC Progress Reports Due*
02/07/20	*Agency deadline for submission of applications for PY2021 funding. Online system will not accept forms after 4:30PM.*
02/19/20	**Regular Board Meeting**

List of Requests for PY21 Funding

03/18/20	**Regular Board Meeting**
04/15/20	*Program summaries released to Board, copies posted online with the CCDDB April 22, 2020 Board meeting agenda*
04/22/20	**Regular Board Meeting** Program Summaries Review and Discussion
04/24/20	*Agency PY2020 Third Quarter Reports Due*
05/13/20	*Allocation recommendations released to Board, copies posted online with the CCDDB May 20, 2020 Board meeting agenda.*
05/20/20	**Regular Board Meeting** Allocation Decisions Authorize Contracts for PY2021
06/17/20	**Regular Board Meeting** Approve FY2021 Draft Budget
06/24/20	*PY21 Contracts completed/First Payment Authorized*
08/28/20	*Agency PY2020 Fourth Quarter Reports,* *CLC Plan Progress Reports, and* *Annual Performance Measures Reports Due*
10/28/20	*Agency Independent Audits, Reviews, or Compilations Due*

10.D.

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

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

CCDDB Contracts: Contract negotiations with PACE continued for the Opportunities for Independence contract through July. PACE withdrew from the negotiation process on August 1, 2019. We continue to contract with PACE for the Consumer Control in Personal Support program. UCP was approved for funding at the July 10, 2019 CCDDB meeting.

CCDDB Reporting: I cloned programs in the online claims system so agencies can begin reporting FY20 2nd Quarter claims. I also compiled all of the agency Performance Outcomes Reports into one document. This document can be found in the Downloadable Files section of the Champaign County (Illinois) Mental Health Board (CCMHB) and Developmental Disabilities Board (CCDDB) Registration, Application, and Reporting System site (https://ccmhddbrds.org). PY20 1st Quarter Service Activity Reports are due on October 25, 2019. Programs required to submit the names of program participants who also receive IDHS-DDD waiver funding should occur on or before quarterly report due date deadline.

MHDDAC: I participated in regular meetings of the Mental Health and Developmental Disabilities Agencies Council Meetings. Prior to the meeting all members were presented with an opportunity to complete a survey on the format of the meetings. The survey results were presented and discussed and will shape future meetings.

Site Visits: I conducted site visits with the Rosecrance DD/MI and the CCRPC Decision Support PCP programs. PY20 reports were reviewed. No concerns were noted for either program. My site visit reports are currently in progress.

Respite: I was able to meet with representatives from Envision Unlimited and Illinois Respite Coalition to learn about the respite services that are being offered in Champaign County. Representatives from each agency will be in attendance at the October 23, 2019 CCDDB Meeting.

Learning Opportunities: Raul Almazar, RN, MA presented "Applying Trauma Informed Approaches," a follow-up to his presentation in October 2019, "Trauma Informed Care for Persons with I/DD." Mr. Almazar also presented during an afternoon session for agency directors. The title of the afternoon session was "Organizational Wellness: Creating a Trauma Informed Organization."

In November, Laura Gallagher Watkin is scheduled to present a follow-up to her February 2019 presentation. Ms. Watkin will be presenting, "Social Security Disability and Returning to Work."

Tamela Milan-Alexander, MPPA is scheduled to present, "A Mother's Story: Her Journey in Becoming a Community Advocate," on December 5, 2019. Ms. Milan-Alexander was the lunchtime presenter at the

closing session of the Illinois Public Health Association Conference/Association of Community Mental Health Authorities of Illinois opening session in Springfield in September.

NACBHDD: I participated in monthly I/DD committee calls.

ACMHAI: I participated in the ACMHAI I/DD committee call.

Disability Resource Expo: I participated in the first Steering Committee Meeting for the 13th Annual Disability Resource Expo. The Expo is scheduled for Saturday, March 28, 2019 at The Vineyard Church. The next Expo meeting is scheduled for October 25, 2019. The Steering Committee is seeking new members, please join us on Friday, October 25 at 9:30 at the Brookens Administrative Center in the Lyle Shields Meeting Room.

Other activities: I participated in the following webinars: *ADHD and Executive Functioning Issues, Doors to Wellbeing Peer Specialist Monthly Webinar Series, Time for Bed! Sleep Solutions for the ADHD Brain, What Is ADHD? Everything You Need to Know Before and After an ADHD Diagnosis, and A Parent's Guide to Evaluating and Troubleshooting Your Child's IEP or 504 Plan.*

I participated in the monthly Race Relations planning meetings at the Bahai' Center.

I also attended a planning meetings for the New American Welcome Center.

I attended the Local Interagency Council Meeting. This goal of this meeting was to determine if this meeting should be held on a regular basis as it had previously been done. There was a general consensus amongst the attendees that this meeting is particularly beneficial for providers of Early Intervention Services. The next meeting will be held on October 28, 2019.

Community Learning Lab: I continue to meet with the students from the Community Learning Lab. The students are working to identify and accumulate all electronic resource guides for Champaign County. The United Way, Cunningham Township, and the CCMHB, and Anita Chan from UIUC met to discuss a pilot app or a responsive website using enhanced data from the 2-1-1 PATH website resource list.

PUNS Selection & Reports: PUNS selection letters were mailed out by DHS in late August. The Division of Developmental Disabilities mailed out 1,247 letters, with 33 letters being mailed to people in Champaign County.

The Division of Developmental Disabilities has announced its new Director. Allison Stark, formerly the President and CEO of Orchard Village, a service provider for people with I/DD in Skokie, Illinois, will take over as the Director of the Division on September 23, 2019.

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. These documents were updated by IDHS on October 8, 2019 and give a glimpse into the number of Champaign County residents waiting on the PUNS database for Medicaid waiver funded services.

Division of Developmental Disabilities

Prioritization of Urgency of Needs for Services (PUNS)

Summary By County and Selection Detail

April 15, 2019

County: Champaign

Reason for PUNS or PUNS Update	900
New	54
Annual Update	299
Change of Category (Seeking Service or Planning for Services)	40
Change of Service Needs (more or less) - unchanged category (Seeking Service or Planning for Services)	38
Person is fully served or is not requesting any supports within the next five (5) years	191
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	169
CHANGE OF CATEGORY (Seeking Service or Planning for Services)	**432**
PLANNING FOR SERVICES	**171**
EXISTING SUPPORTS AND SERVICES	**399**
Respite Supports (24 Hour)	10
Respite Supports (<24 hour)	14
Behavioral Supports (includes behavioral intervention, therapy and counseling)	145
Physical Therapy	37
Occupational Therapy	100
Speech Therapy	135
Education	188
Assistive Technology	44
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	143
TRANPORTATION	**465**
Transportation (include trip/mileage reimbursement)	144
Other Transportation Service	301
Senior Adult Day Services	1
Developmental Training	98
"Regular Work"/Sheltered Employment	82
Supported Employment	91
Vocational and Educational Programs Funded By the Division of Rehabilitation Services	70
Other Day Supports (e.g. volunteering, community experience)	31
RESIDENTIAL SUPPORTS	**81**
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
Skilled Nursing Facility/Pediatrics (SNF/PED)	5
Supported Living Arrangement	7

Illinois Department of Human Services

Division of Developmental Disabilities

Prioritization of Urgency of Needs for Services (PUNS)

Summary By County and Selection Detail

October 08, 2019

Shelter Care/Board Home	1
Children's Residential Services	4
Child Care Institutions (Including Residential Schools)	7
Children's Foster Care	1
Other Residential Support (including homeless shelters)	13
SUPPORTS NEEDED	**420**
Personal Support (includes habilitation, personal care and intermittent respite services)	372
Respite Supports (24 hours or greater)	22
Behavioral Supports (includes behavioral intervention, therapy and counseling)	140
Physical Therapy	45
Occupational Therapy	80
Speech Therapy	98
Assistive Technology	55
Adaptations to Home or Vehicle	15
Nursing Services in the Home, Provided Intermittently	4
Other Individual Supports	73
TRANSPORTATION NEEDED	**370**
Transportation (include trip/mileage reimbursement)	313
Other Transportation Service	333
VOCATIONAL OR OTHER STRUCTURED ACTIVITIES	**299**
Support to work at home (e.g., self employment or earning at home)	6
Support to work in the community	262
Support to engage in work/activities in a disability setting	108
Attendance at activity center for seniors	3
RESIDENTIAL SUPPORTS NEEDED	**141**
Out-of-home residential services with less than 24-hour supports	68
Out-of-home residential services with 24-hour supports	84
Total PUNS:	**55,964**

http://www.dhs.state.il.us/OneNetLibrary/27897/documents/DD%20Reports/PUNS/PUNS_Sum_by_Count_and_Selection_Detail_6-10-19.pdf

Division of Developmental Disabilities Prioritization of Urgency of Needs for Services (PUNS)
Summary of Total and Active PUNS by Zip Code

Updated 10/08/19

Zip Code		Active PUNS	Total PUNS	
60949	Ludlow	2	3	
61801	Urbana	40	86	
61802	Urbana	65	116	
61815	Bondville (PO Box)	1	1	
61816	Broadlands	2	3	
61820	Champaign	46	87	
61821	Champaign	89	185	
61822	Champaign	54	102	
61840	Dewey	0	2	
61843	Fisher	10	13	
61845	Foosland	1	1	
61847	Gifford	1	1	
61849	Homer	0	5	
61851	Ivesdale	1	2	
61852	Longview	1	1	
61853	Mahomet	40	65	
61859	Ogden	4	13	
61862	Penfield	1	2	
61863	Pesotum	2	2	
61864	Philo	6	12	
61866	Rantoul	32	87	
61871	Royal (PO Box)	--	--	no data on website
61872	Sadorus	2	2	
61873	St. Joseph	15	26	
61874	Savoy	8	14	
61875	Seymour	2	3	
61877	Sidney	4	10	
61878	Thomasboro	0	2	
61880	Tolono	8	27	
	Total	**437**	**873**	

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

REPORT ON CONFERENCES

DATE: October 23, 2019
TO: Members, Champaign County Mental Health Board (CCMHB), Champaign County Developmental Disabilities Board (CCDDB), Champaign County Executive, Champaign County Board, and Association of Community Mental Health Authorities of Illinois (ACMHAI)
FROM: Lynn Canfield, Executive Director, CCMHB/CCDDB
RE: National Association of Counties (NACO) and National Association of Behavioral Health and Developmental Disabilities Directors (NACHBDD)

Background

I attended conferences of the National Association of Counties (NACo) and the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD), each held in July. As NACBHDD's liaison to NACo's Health Committee and Vice Chair of Behavioral Health Subcommittee, I participated in meetings, related sessions, and an award ceremony. Along with regular sessions of NACBHDD, I attended the Annual Intellectual/Developmental Disabilities Summit for a day of presentations and discussion. The October meeting of NACBHDD featured presenters from Illinois and reports on the association's projects of interest. Notes from all sessions follow, links in electronic version.

NACo Health Steering Committee, Joint Subcommittee Meeting

Increasing Connections to Care in Rural Counties
NACo's Presidential initiative "Connecting the Unconnected" explored innovations such as telemedicine and public private partnerships. Local practitioners and a representative from the White House Office of National Drug Control Policy discussed service delivery models and removing barriers to healthcare access for rural residents.

Kenneth Dahlstedt introduced speakers and topic: 2/3 of counties are rural, combined population of 60m; scarcity of doctors and other providers contributes to higher mortality.

Dr. Charity Breneman, *Former Postdoctoral Research Fellow at Rural & Minority Health Research Center, University of South Carolina (c.b.breneman@gmail.com). Presentation here.* Identification of High-Need Rural Counties to assist in planning; a brief is available at ruralhealthresearch.org. 'Summary measures of health' combines a set of population health indicators from multiple publicly available sources into a single measure. For many small populations, data are missing or limited by aggregating multiple years of data, case deletion, or single imputation methods. Many rural communities don't have safety net providers (rural hospitals or FQHCs), but some are not high need areas, especially if wealthy or close to regional providers. Variable selection is limited to measures available at all. Use County Health Rankings in five domains. Examined infrastructure of 174 counties with no access; rescaled each variable, ranked each of the 174, grouped them into 10 equal intervals, then assigned 1-10; and averaged individual measures for one score. One metric not available in the County Health Rankings was geographic isolation, so they calculated drive times to the nearest safety net provider. Physical Environment, Travel Time (up to 2.5 hours in Wyoming!), and Health Outcomes. Then layered

these variables, narrowing to 36 counties, which met 7 of the criteria, and then to 2 measures. This identifies areas of greatest need for safety net. Limitations: grouping counties can exaggerate the differences between counties with similar values; calculation uses GIS data which change. Value in mapping rural counties that have low access to maternal care or similar.

Ms. Joan Hall, RN, *President, Nevada Rural Hospital Partners Foundation (joan@nrhp.org). Click here for presentation.* Access to Rural Health. Of 6200 US hospitals, 1800 are rural, with fewer critical access hospitals. 46% operate at a loss, 98 have closed since 2010, and 700 are at risk for closure. Closures impact the entire community: patients, community health, primary care, EMS (who are mostly volunteers), community economic impact, and job loss. Safety net – 24/7 access to care through ER, may employ the only physicians in the community, offer some access to specialists. Nevada has 14 rural hospitals; for tertiary care, some residents have a 3-hour drive. Telemedicine is a benefit but problematic due to low bandwidth in some communities, impacting specialty care, hospitalist rounding, stroke care, cardiac care, behavioral health care. Remote monitoring helps, for jails too. Innovations through health care providers: advance practice RNs, PAs, Nurse anesthetists, medical assistants, community health workers, and community paramedicine. Counties should consider: credentialing, esp for employer coverage; housing and homelessness; food insecurity; messaging; bandwidth; impact on EMS; local health authority regulations; and transportation. Medicaid expansion very beneficial for rural hospitals, though reimbursements can be inadequate, and network adequacy still an issue. Regarding workforce development, community paramedicine (mobile integrated health) outcomes, and alignment with FQHCs, second year of HRSA grant for population health management; many residents are eligible for health homes. Use home visits post discharge. Paramedics visit the 'frequent flyers' to do glucose monitoring, safety assessments, etc. and share results back to the doctors. The neediest patients seem to be in low bandwidth areas. VSEE, a mobile telemedicine app, very helpful, used well by law enforcement and youth.

Ms. Betty-Ann Bryce, *Special Advisor/Rural Lead, Public Health Education and Treatment, Office of the National Drug Control Policy (ONDCP) (betty-ann.m.bryce@ondcp.eop.gov). Click here for presentation.* Prevention - reducing the number of first-time illicit drug use and Rx misuse. Treatment and recovery - improve quality, increase access, and reduce barriers. Supply reduction - reduce production and availability of illicit drugs. Rural communities have higher rates of poverty, persistent poverty, and unemployment and less access to transitional and permanent housing. Map of drug overdose deaths in the US, comparison of 2008-2012 and 2013-2017: https://opioidmisusetool.norc.org. Community Assessment Tool, per community (eg. 27.2 to 47.1 drug overdose mortality rate in Cass County, MN). The website also has Socio-demographic and Health Overlays and will be adding overlays for broadband, rural transportation, poverty, and health provider shortage. Recovery is often disconnected from other healthcare, with lack of workforce, facilities, and transportation. 400 HRSA grantees gave feedback culminating in a 50-page report. Increasing connections to SUD care in rural communities means increasing the focus on the socioeconomic challenges that impact the provision of services, increasing focus on all aspects of recovery and not just treatment: employment; education; housing; healthcare and new healthcare models such as teleservices, while long term measures build up the medical provider workforce again, also good for critical needs; mobile services to the community through Specialized Health Service Vehicles, funded through Childrens Health to focus on child needs especially when parents are not readily available to support access; and health care kiosks/carts (vitals can be taken and sent to provider in other location). These are USDA funded innovations to reconnect rural people to services; also broadband development. See https://www.rd.usda.gove/files/RuralResourceGuide.pdf Rural communities are taking the least advantage of innovation grants, whether through SAMHSA, DOJ, DOL, or HRSA. To a question about overlap with county health depts, using mobile

services van/vending machines for naloxone (in NV), though not CDC supported, a rural listserv announces such opportunities. Rural counties may not be accessing these grants because they don't have the capacity to write or administer grants, the Office of National Drug Control Policy won't fund staffing or services but interacts with other federal funding opportunities which would; also looking at a pilot to identify intermediaries and pilot sites to fill these gaps; Office of Rural Health for help with grant-writing process. In Healthy People Objectives for 2020, rural concerns not always well-represented, but our committee could help create that focus. State association directors might also help the smaller communities get grant applications in place.

Exploring Key Safety Net Programs that Matter to Counties

Counties invest heavily in health and well-being, often serving as a safety net for low-income and indigent residents. A number of key safety net programs are up for reauthorization, and continued funding for the programs will be considered in a legislative "extenders" package. From community health centers to Medicaid disproportionate share hospital (DSH) payments, to county hospitals and the 340B drug pricing program, counties seek to maintain funding for and protect the integrity of federal health safety net programs they rely on. Local practitioners and a representative from the Health Resources and Services Administration (HRSA) Region IX office provided an overview of county-administered programs that help provide critical health services to those most in need.

Mr. Mason VanHouweling, *CEO, UMC of Southern NV (mason.vanhouweling@umcsn.com). Click here for presentation.* Offering NV's Highest Level of Care. UMC's history, organizational structure, and key facts: affiliated with UNLV; 4100 employees, 1000 physicians, and 1300 nurses; the only level one trauma center; the only pediatric care center; the only burn care center; the only accredited children's hospital; and the only transplantation hospital in the state. They have 7 primary care locations, 9 urgent care locations, 1 occ med, and 1 HIV/AIDS Wellness Center. Revenue from: Federal Supplementation Payments - UPL (upper payment limit, based on fee for service Medicaid utilization); pass through payments based on Medicaid Managed Care enrollment rather than utilization; DSH Disproportionate Share Payments (DSH) – combination of federal dollars and required contributions from state. Under ACA, DSH allotments were to begin reducing in 2014 but are delayed to begin in 2020 (to 2025). NV's Federal Medical Assistance Percentage is 64.87%. UMC is very busy, with record volumes but declining revenue. 46% of business is Medicaid. Next year they'll see a $15.8m reduction in UPL, $5.9m reduction in MCO enhanced rates, and $3.6m reduction in DSH. Total budget over $500m. Good news regarding DSH cuts; private payors are important since federal payments don't cover actual cost. Each state has its own DSH allotment, distributed to safety net and other.

Ms. Erica Murray, *President and CEO, California Association of Public Hospitals and Health Systems (CAPH) (emurray@caph.org). Click here for presentation.* Advocates in DC persuaded congress to eliminate some DSH cuts; a bill now includes an amendment changing the cuts, as the need continues in Medicaid expansion and non-expansion states. 340B Drug Discount Program overview at https://www.youtube.com/watch?v=ep3jD_u3Uk4. There are only 21 county-run hospitals left in CA ("Public Health Care Systems"); they range in size, primarily rural, and many have strong telemedicine systems. Like UMC they go beyond primary care. 340B requires drug manufacturers participating in Medicaid to give discounts to safety net providers, and it has grown to cover other categories such as rural and children's and critical access hospitals; no cost to taxpayer, federal or state, created solely to allow providers to stretch their resources and do more. The program is working, e.g., comprehensive diabetes care program and another to monitor patients' wellness. Significant threats emerge, even though 340B has done good work: questions about where the savings have gone (no requirement to track that); attempts to limit eligibility; states get drug rebates on other drugs, pitting states against each other. *After the conference, Ms.*

Murray provided more information on how to support the 340B Program at the federal level. Please contact me for that letter.

Ms. Valerie Gallo, *Deputy Regional Administrator, Region IX, Health Resources and Services Administration (vgallo@hrsa.gov). Click here for presentation.* Improve health outcomes and reduce disparities, through innovative programs. Over 3,000 grantees, in 90 programs and services, e.g., Ryan White program, Black Lung, 340B, Organ Transplantation. Just over $11.7b for FY2019. Primary health care (community health center) is the biggest portion, then HIV/AIDS, then health workforce. Health Center program is sometimes the only game in town; these serve 27m ppl, 1 in 12 across the US, 1 in 9 are children, and 1 in 5 rural. Map of 12,000 service delivery sites; telehealth at 44% or 600 of the 1373 health centers, esp helpful for behavioral healthcare. Integrated Care at HRSA health centers (features primary, oral health, MH, SUD prevention and treatment, and more). National Health Service Corps program (over 50,000 health professionals in the communities that need most help, either through loan repayment or scholarships, plus 8400 rural training sites in partnership with academic institutions) announcing grant programs to strengthen the health workforce, including opioid addiction treatment (includes meth and other SUD) and other behavioral health workforce. 15 HRSA regional offices across the country: https://hrsa.gov. To a question about dental and behavioral healthcare provider shortage, there is new funding; many trained in last 2 years. Several large investments related to treatment for opioid and other addictions. Regarding 340B and posting the prices for services, who will compile the drug price info? Rx are so high, resistance from pharmaceutical industry.

Supporting Our Nation's Aging Population at the Local Level: The Health and Human Services Continuum for Older Americans

By 2035, for the first time in our nation's history, the population of adults 65 and older will outnumber children younger than 18. In an effort to meet the needs of our nation's aging population and their caregivers, the reauthorization of the Older Americans Act (OAA) is critical, which expires in September 2019. Since it was signed into law in 1965, OAA has played a pivotal role in the implementation of a nationwide network of community-based services to ensure sustained health, independence, and dignity for America's aging population. Whether it's creating supports for home-based care, building safe and accessible communities for people of all ages or promoting social integration among our aging populations, counties are leveraging local resources to support our nation's older adults. National and local leaders talked about the challenges and benefits of supporting our nation's aging population and what this looks like at the county level. (Due to the luncheon reaching capacity before our meeting ended, Health Steering Committee members were unable to attend, even to listen to the panel.) Watch Here. or https://www.naco.org/resources/video/our-nations-aging-population-local-level

Sandy Markwood, *National Association of Area Agencies on Aging (smarkwood@n4a.org)*
Kristin Dillon, *Senior VP for State and Community Engagement, AARP (KDillon@aarp.org)*
Mary Rumbaugh, *Behavioral Health, Clackamas County, OR (MaryRum@clackamas.us)*
Barry Zimmerman, *Human Services Agency, Ventura Cty CA (Barry.Zimmerman@ventura.org)*

NACO Health Policy Steering Committee Business Meeting

Committee Business: Resolutions

14 resolutions and 1 emergency resolution were considered. Many had passed in previous years and only needed to be re-approved; brief summaries for those. New ones required background from sponsors and discussion. Judge Jenkins reviewed the bylaws: debate the proposed policy but not the background, which

disappears when passed; the proposed policy must have a federal action. All resolutions and platform changes were later adopted by NACo membership and are valid until Annual Conference in July 2020. Final resolutions are here or at https://www.naco.org/sites/default/files/documents/2019-2020%20American%20County%20Platform%20FINAL.pdf

1. Suspend Rather than Terminate Medicaid Coverage for Incarcerated Individuals.
   Urges Congress to pass legislation that: a) amends federal law to prohibit states from terminating eligibility for individuals who are inmates of public institutions or residents of Institutes for Mental Disease based solely on their status as inmates or residents; and b) requires states to establish a process under which an inmate or resident of an Institute for Mental Disease, who continues to meet all applicable eligibility requirements, is placed in a suspended status so that the state does not claim federal financial participation for services the individual receives, but the person remains on the state's rolls as being eligible for Medicaid; and c) once release or discharge from the facility is anticipated, require states to take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that they can begin receiving Medicaid-covered services immediately upon leaving the facility.
   Passed for nearly 10 years, no discussion. Motion carried unanimously.

2. Extend Federal Medicaid Payments to Detainees in County Jails Who Are Pre-Adjudicated.
   Require the federal Medicaid program to contribute federal Medicaid match for health and mental health care that is provided while a pre-adjudicated detainee is actually incarcerated.
   Without this, total cost is borne by counties. No discussion. Motion carried unanimously.

3. Prohibit Insurers from Denying Health Benefits to Pre-Adjudicated Persons.
   Urges the U.S. Department of Health and Human Services (HHS) to prohibit insurers from denying reimbursement under health benefit plans for covered services provided to pre-adjudicated persons in the custody of local supervisory authorities.
   The private insurance version of #2, as people are not eligible for Medicaid during detention. No discussion. Motion carried unanimously.

4. Integrate Mental Health and Addiction Care in Treatment Centers.
   Urges the federal government, specifically, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, Center for Disease Control and Prevention, and Center for Medicare and Medicaid Services, to modify grant, technical assistance and service funding programs that support the development and operation of integrated care in treatment centers to include provision for the integration of mental health and addiction care, including for depression and substance use disorders such as opioid addiction.
   Friendly amendments were made after recent conference call. Many opioid users have untreated depression, so that addiction treatment should also involve addressing the mental health condition; community providers are the focus (not jails). The change was made in order to avoid incentivizing keeping people in jail longer just to receive the care they need. In the background is also the consideration that this not be simply for thirty days but for a treatment period appropriate to the need. Amendments to include addiction care beyond opioid. Motion carried unanimously.

5. Importance of the ACA and Medicaid Expansion.
   Maintain the Medicaid program as a means-tested entitlement and further support provisions in current law that allow for expanded program eligibility and coverage standards. Urges Congress and the administration not to repeal the Medicaid expansion. Maintaining eligibility and coverage under the current program is essential to sustain the strong federal-state-local partnership that underpins our nation's health system.
   No discussion. Motion carried unanimously.

6. National Health Service Corps Loan Repayment Program.
   Urges Congress to amend this loan repayment program and allow county and municipal jails to be eligible for the program. Current law excludes county jails from being designated as health professional shortage areas, and NACo urges Congress to review this designation and allow county and municipal jails to be named health professional shortage areas.
   No discussion. Motion carried unanimously.

7. Funding for Alzheimer's Disease/Other Related Dementias Research, Community Education and Outreach and Caregiver Support.
   Support continuous and increased use of federal funding to support Alzheimer's Disease/ other related dementias research, Alzheimer's community education and outreach, and resources for caregivers, family members, and individuals with Alzheimer's Disease/ other related dementias.
   This resolution is not new, and the need is growing. Friendly amendment to add related dementia. Motion carried unanimously.

8. Immigrant Eligibility for Federal Benefits.
   Oppose specific changes to existing policy that would lead to increases in uncompensated care and shift federal and state costs and the administrative burden to counties, including preventing access to and/or penalizing immigrants for the use of federally-funded health care and public health programs including Medicaid and the Children's Health Insurance Program.
   In response to the change in practice around access to benefits, this resolution continued from last year. Impact on counties is a large cost shift, especially in the 12 states administering their health and human services at county level. Legal non-citizens, undocumented immigrants, and families with dual status; those attempting to attain green cards may be discouraged from using public benefits; counties will be on the hook financially, regardless of legal status. Clarifying the public charge rule changes, impact of immunization, WIC, and SNAP programs. People have disenrolled and failed to use protective programs like these. Motion carried unanimously.

11. Fund the Supporting and Improving Rural EMS Needs Grants.
    Urges Congress to fund Supporting and Improving Rural EMS Needs Act (SIREN) grants at $20 million for FY2020. The SIREN grants will provide funding for rural fire and EMS agencies to recruit personnel, procure emergency medical supplies and provide emergency medical services (EMS) training classes. Only public and nonprofit agencies are eligible to receive these funds.
    Discussed ahead of order due to sponsor's schedule. Chief Singer explained that the SIREN Act was included in last winter's Farm Bill, but no money was appropriated for it. Fund at $20m for the fiscal year. No discussion. Motion carried unanimously.

9. Supporting Local Efforts for Mobile Support Teams.
   Supports legislative efforts at federal and state levels to fully fund and promote mobile support teams within a local health department or local jurisdiction. Urges federal and state matching funds to maximize financial support for local jurisdictions in implementing mobile support teams.
   MST is a critical tool for law enforcement dealing with MI crisis/emergency. With MST, 7% rate of arrest, but without, 21% arrest rate, and then complicated and expensive to deliver MH treatment. Another long-standing resolution, need federal and state funding to do this in all communities. Positive impact in member's community. A friendly amendment to add "or local jurisdiction". Motion carried unanimously.

10. Reducing Disparities in African American Child Deaths.

Supports legislative efforts to fund local initiatives to reduce African American child deaths through collective impact models and targeted, community-based programs to reduce risks.
Phil Serna reported success in Sacramento County. No discussion. Motion carried unanimously.

12. Improve Compliance through Better Regulation in Nursing Homes.
Supports strengthening efforts by the Centers for Medicare and Medicaid Services to improve compliance through collaborative efforts with healthcare providers and stakeholders to reduce administrative burdens, increase effective and efficient conformity with regulations and improve the beneficiary experience by removing regulatory obstacles that diminish the ability to put patients/residents first over paperwork.
Separated into two resolutions to clarify, incorporating suggestions from recent conference call. Focus on CMS collaboration toward more effective care. Goal to strengthen care, not decrease accountability or standards. Changes were read. No discussion. Motion carried unanimously.

13. Supporting Better Staffing in Nursing Homes.
Urges Congress to amend federal law to allow disapproval for nurse aide training programs to be discretionary rather than mandatory and support the Nursing Home Workforce Quality Act.
Review; discretion is with states' licensing authorities. Motion carried unanimously.

14. Support Federal Action to Obtain Better Research on Kratom and to Promote Dissemination of Best Public Health Practices Related to Kratom.
Urges Congress to pass legislation and/or federal agency directives to fund and support efforts to research the health impacts related to the use of kratom. Includes federal action steps to devote the appropriate agency and staff resources to complete both: (1) a review of existing research on kratom in order to provide counties and other local government jurisdictions with immediate guidance on the most appropriate public health best practices related to kratom; and (2) to pursue more comprehensive research on kratom that can inform longer-term public health approaches related to the use of kratom.
Southern Oregon Health and Human Services Committee needs to understand if this is harmful. Background: an herb from Southeast Asia, used in teas, pills, etc. which, if combined with bath salts or weed, can lead to major issues. Legal in all but six states, reported as an herbal supplement, illegal in those states where there was high incidence. Need to investigate the impacts on young brains. Discussion of DEA process, e.g., fentanyl. Motion carried unanimously.

15. Emergency Resolution: Support Amending 42 CFR Part 2 SUD Privacy Rules to Improve Care Coordination
Amend 42 Code of Federal Regulations (CFR) Part 2 (Part 2) privacy provisions to improve care coordination for patients undergoing treatment for SUD by aligning the privacy requirements for SUD patient records as governed by Part 2 with those in HIPAA for medical care. This would permit information sharing between SUD treatment providers, behavioral health providers, and medical care providers for the purposes of health care treatment, payment, and operations, while bolstering efforts to identify high utilizers of public services and hospital emergency departments.
An older resolution which had fallen away, relevant now (moving in Congress): change Part 2 so SUD records can be shared with other providers. No discussion. Motion carried unanimously.

Update on Federal & State Legislation Around Rx Drug Pricing: Why It Matters to Counties
Overview of new legislation aimed at lowering the cost of prescription drugs and a discussion on how dramatic increases in drug pricing has impacted local governments.

Mr. Rodney Whitlock, *Vice President of Health Policy, McDermott Consulting. Click here to read more about the President's Drug Pricing Blueprint.* Very few administrative proposals remaining, and those already passed are low hanging fruit. Potential larger package from Senate Finance Committee. Administration action will continue to be challenged in court. Drug manufacturers continue to innovate, which we want, but how much? Idea of mortgage pricing – over five years, provide the miracle drug. Will we see transparency in pricing? Temper expectations of immediate change, but more engagement. Regarding Medicare pricing, compared to 3 bids in counties, negotiate lowest rate cost but can't prove it, not using real indicators.

Blaire Bryant, *Associate Legislative Director- Health Committee*. A task force of NACo and Sheriff Association members will address the inmate exclusion (costly to counties). For more from the task force, see https://www.naco.org/resources/featured/healthcareinjails; relates to many resolutions. Recognition award for Judge Clay Jenkins for his service to the Health Steering Committee over the last two years.

NACO Healthy Counties Advisory Board Meeting

Members of the Healthy Counties Advisory Board and those interested in joining heard from peers across the nation working to improve health equity in their county. See https://www.naco.org/articles/forge-partnerships-improve-your-county%E2%80%99s-health-equity

Nick Macchione, *Healthy Counties Chair. Director of San Diego Health and Human Services*, introduced Vice Chairs, panelists, and NACo staff. Build capacity to achieve health and success for all counties' residents. Place matters, so Parks & Rec "POST" have joined this committee. Healthy Counties Summit in San Diego considered innovations in health equity. Challenges: safe housing, access to food, Rx costs, child abuse, access to parks. Different access to care for enclaves of racial and ethnic groups; we need each other to achieve equity.

Sig Hutchinson, Wake County Commissioner, "Equity, Diversity, and Inclusion in Parks, Greenways, and Open Space Systems": built environment is the focus; 300 miles of greenways running along stream corridors, with 7000 acres of open space and 70 miles bike trails. The POST committee can advocate for these spaces within Healthy Counties. Regarding inclusion, his commissioner pointed out that bike trails mean 'the white folks are coming' and that she needed better jobs, schools, and affordable housing instead. Physical activity and community building are important social determinants of health. Diversity and inclusion are top priority for parks/rec nationally. Miami River Greenway project had to demonstrate to the Latinx community that this would benefit them; interested when given the example of The Malecon, Havana, Cuba (5 miles and amazing). Wolf River Greenway in Memphis: 'walk for health,' stewardship, and workforce programs. Wake County, NC: downtown area has Walnut Creek Trail in some neglected areas, up to 5000 acre Umstead Park and smaller Dorothea Dix Park; planned soccer stadium and Wetland Center and Beacon Ridge (schools, YMCA, 100 acres with affordable housing, and Hyde Foundation/Walmart suppliers to support active lifestyle by gifting bikes); all of it connects to Neuse River Trail. Opportunity for healing and improved health.

Mark Ridley-Thomas, "What is Health Equity?": 2x risk of asthma for children in poverty, lower life expectancy, other well-known data. How will we know when we've achieved health equity? Everyone has access to what they need for optimal health and well-being, and not just access to health services, but well-considered policies and practices. Center for Health Equity: "A Call to Action: Supporting a Movement for Fair and Just Health Outcomes Action Plan 2018-2023" has priorities for reducing the gap in black/white infant mortality, improving integrated

care access across cultural and clinical settings, and promoting Cultural and Linguistic inclusion. Health inequities based on race and ethnicity. Homelessness is an acute/chronic crisis across the country, exacerbated by longstanding inequities; e.g., in LA, 39% of homeless are African-American, and 1/3 of homeless suffer MI/SUD. Root of the crisis is poverty and an economy which does not lift all boats; many are one crisis from homelessness. Feminization of poverty. LA Cty is 100k units short; voters approved a tax for MH services, rapid rehousing; helping 21,000 people transition from homelessness; need sobering and behavioral health centers, #everyonein.

Kenneth Wilson, *Franklin County, OH*, "Perspectives on health Equity Healthy Counties Initiative Advisory Board Business Meeting": housing is everything, can't have health without it; 54K units short in Franklin County, investing $64m, along with city and private contributions; how to use these partnerships to increase health equity. Charitable pharmacy offers free or low cost Rx. Sliding scale medical and dental services at one clinic. Racial inequities in behavioral health are exacerbated by stigma (e.g., it is wrong to seek help). Outreach through schools. Community Health Improvement Plan started with community assessment, very grass roots, to put together plans that take ALL into account and address other health problems. The Health Equity Lens identified low socio-economic status, those in reentry, LGBTQ, pregnant women, very young children, kindergarten, school children, adolescents, and elderly. Multiple strategies and action steps. Priorities addressmchronic illness, MH and addiction, access to healthcare, and maternal and infant health. https://myfcph.org/health-systems.

Challenges: large unmet housing needs; parks versus screens (Pokemon Go), but technology can make parks more accessible ("10 minutes to park" app). Attendees' future topics: San Diego County Housing First, using a vulnerability index - "who is most likely to die overnight?"; disparities in maternal and infant mortality; wraparound for people in jail with behavioral health needs; shortage of MH and medical providers; gun violence; obesity/diet; the need for crisis stabilization units; and one stop health centers for MI, SUD, and physical health needs.

NACO Healthy Counties Luncheon: Addressing Youth Substance Abuse

Supporting the well-being and development of youth is critical to the future of our counties, states, and nation. In a rapidly changing world, counties must be innovative and strategic preventing substance use and abuse among youth populations. Continue the dynamic conversation begun at NACo's 2019 Legislative Conference to explore best practices and emerging strategies counties are employing to engage and educate youth and discuss new approaches that leverage partnerships and resources.

Nick Macchione introduced officers, talked about the intersection of various committees' work and impact of substance abuse on children. At March Legislative and Policy Conference, started partnership between counties and federal agency. Focus on: public-private partnerships in local health delivery; access to, and coordination of, care for vulnerable populations in the community, including through health services in hospitals, community health centers and county jails, while concentrating on cost-containment strategies; public health and behavioral health programs.

Timothy McCue, *NACO staff*: feedback from members at https://naco.org/topics/health or email tmmcue@naco.org. Healthy Counties is merging with POST (Parks, Open Space, and Trails) for programming to explore the relationships, define strategies for members to conserve, protect, and make available those spaces, describe the benefits of spaces, and provide easy to understand info.

Kirstie Fontaine, *NACO staff*: current CSI health youth substance use work, grant with Hilton Foundation to describe needs, gaps, and opportunities across the country; report to be released.

First (raised at previous meeting): "What are the perceived barriers in creating and sustaining multi-sectorial partnerships in programming?" Responses: failing to recognize the interplay of mental health and stigma (undermines treatment and prevention efforts), mental health awareness and training, taking care of our own MH; not identifying available resources (SAMHSA, CDC 'overdose to action,' CADCA, school boards, faith based communities); not adequately addressing the needs of marginalized and potentially greater risk people (communities of color, low income, veterans, justice-involved); not fully acknowledging the role of family and community in the problem and solution; underestimating the broad nature of substance use; attempting to treat the condition and not the person (social determinants of health/life, ACEs); not including the target population in the development and implementation of solutions (youth advisory boards; incubator for community leaders); inadequate resources, bandwidth, funding.

Second (today's project): "What strategies are being employed to foster a multi-sector approach to youth substance use? How do counties effectively generate collaborative solutions and approaches?" Results of group discussions: trauma-informed care; addressing underlying causes such as two generations of poverty; deployment of targeted survey instruments regionally; MATs (successful with adults); regional in-school SUD prevention for youth funded by liquor tax; treat the root causes, break the cycle; robotics program run through cooperative extension as a diversionary program; SAMHSA Technology/Transfer Centers for Addiction and Mental Health; cooperative extension can access USDA 100 year loans in areas without treatment centers; youth homeless outreach; embedding county workers in schools to link students to behavioral health services; use data to cross-department silos; engagement to influence culture of family systems.

Next: "What does a sustainable solution to youth substance use look like at the county level?"

Health is Local: A Fireside Chat with Dr. Garth Graham

Research has shown that your zip code has a greater impact on your life expectancy than your genetic code. Dr. Garth Graham talked about the social determinants of health affecting our communities' health. We heard from counties who are successfully addressing some of these factors locally.

Dr. Garth Graham, *AETNA*, **George Dunlap**, *Mecklenburg County (NC) Commissioner,* and **Ken Cornell**, *Alachua County (FL) Commissioner*

Alachua County surrounds Gainesville, with U of Florida and medical center, 2 colleges, 3 hospitals; professionals on one side of county, working class and poor on the other. FL not an expansion state; after local referendum "Choices" expired, the remaining money was allocated to preventive primary care at local health dept. Wages haven't kept up; a living wage established for county employees and contractors, and the University (largest employer) followed suit, which lowered turnover/training costs and put money into local economy. Safe housing, using Housing First model; living wage; quality health care and preventive services for those without access; healthy food is now an element of the economic development plan; reduce structural inequities by investing in specific communities (dental screens at child care facility, park and road, county services brought to neighborhood); Children's Trust ballot initiative to bring $7.5m.

Mecklenburg is largest county in NC, borders SC; of 1.1m people, 13% are Hispanic/Latinx, 39% African-American, 41% white; UNC, tech and fortune 500 companies; not an expansion state, hard to provide health care to the large uninsured population. Commissioners concerned about wage gap: priorities include ending racial disparities; no county employee makes less than $15/hr; other employers in the county are following suit, creating upward mobility. County program "Village Heartbeat" asks the community what should be done to ensure ppl have healthy and

productive lives, partners with faith-based and hospital to develop programs; includes a competition among churches, with exercise programs and monitoring 16 weeks, convening to celebrate and acknowledge winners; a scalable model, with growing interest. Living wage has a lot to do with health. Community resource centers throughout the county allow people in a neighborhood to find social services in one place rather than travel around.

"What is scalable nationally?"
Alachua County program teaching gardening/cooking to those in work-release; policy not to destroy or mitigate wetlands (building resiliency in areas prone to flooding), as environment is a buffer for communities during increasingly common severe storm events; hearing about programs as soon as they're developed in order to support and help them be successful.
Mecklenburg's Village Heartbeat: engaging the community includes faith-based – behavior change (run it like a playoff); community health leadership academy is named after a longstanding local public health advocate to add credibility (teach people how to use the computer, to empower them); system change, e.g., neighborhoods display the program logo, every church creates a health and wellness ministry, addressing the way they cook, e.g., and plant gardens for fruit and flowers using coops; and creating walking trails for physical activity, using church gyms, esp for elderly members who benefit from chair aerobics. San Diego County (CA): start with your own culture, resources you already have. Do we understand what we have and what we're doing? Focus on the inequities, not the roles of each involved with planning.

"How do others bring departments together to improve life expectancy and quality of life?"
Mecklenburg example of chair exercises at the churches, and seniors smiling and waking up with less pain; churches keep joining this initiative.
Alachua trained all county employees in MHFA, then all city staff and officials; to stop people from watering their yards, the county stopped watering theirs. Health care is local. Add to health care services, telehealth counseling, wraparound services, and PHACT teams for the justice involved and high utilizers. Palm Beach County example of great impact from a one-cent tax supporting diversion of frequent users.
Regarding transportation, need to be more proactive; meeting more often with hospital leadership to address needs. Mecklenburg "MeckUse" provides high users with housing and wraparound; compelling data about stabilizing them as well as reduced cost to public systems. Michigan example: partners with Lyft to schedule rides to appts for those with transportation issues, lowering appt cancellation rates. Gainesville public transportation to engage Lyft/Uber to reach those who can't get to bus stops.

"What should we do more of in the future?"
Mecklenburg is changing rapidly, needs more of these programs; expand Medicaid to avoid the local burden of costs of uninsured. Alachua has large old and young populations; younger should continue to educate the older about health; Ag community to help feed the elderly. Future of health care in these innovations; many interesting local developments.

Other NACO Sessions of Interest (Annual Meeting and Previous):

Architects of Health & Housing: County Strategies for Promoting Affordable, Safe and Healthy Homes. *Watch Here.*

Sesame Street in Communities: Supporting Children and Families: supporting children's developmental, physical and emotional needs; partnering with counties…to improve outcomes for children and their families; access free online tools and resources. *Watch Here.*

NACo-NSA Health Care and Jails Joint Task Force Town Hall: the Medicaid Inmate Exclusion Policy (MIEP) strips federal health and veterans' benefits from individuals upon admission to jail… leading to increased recidivism. Watch a listening session about NACo and the National Sheriffs' Association Jail Inmate Task Force, focusing on passing legislation to ease or undo the MIEP and reinstate federal health care benefits for non-convicted, justice-involved individuals. *Watch Here.*

Coordinating Health, Human Services and Justice to Improve Outcomes. *Watch Here.*

Connecting the Unconnected Through 211 And Other Centralized Call Centers. *Read More.*

NACBHDD Annual I/DD Summit

The summit was attended by representatives of Optum, Benchmark Human Services (operating in three states), Texas, DC, Iowa, Nevada, Oregon, Illinois, and Missouri. Discussions may be very well timed due to federal 'tweaking' of relevant rules. As we develop crisis centers, don't forget this population.

> **Kristen Daugherty**, *CEO, Emergence Health Network,* shared an example of crisis response with CIT in El Paso, in conjunction with Tarrant County's team in to make it affordable, and certified under them.

I/DD Session 1: Addressing Difficult Co-Occurring Mental Health and I/DDs: The START Model
START is a research-based model serving people, aged 6 and up, who have I/DD and co-occurring behavioral health conditions; a comprehensive model of services and system linkage that optimizes independence, treatment, and community living. 1.5-2.5% of people in US have I/DD; MH conditions are 2-3x higher than general population, seen as 'challenging behaviors' and also challenging for service systems. Goal is not to remake MH and I/DD services, but to provide a framework enabling them to work together to serve this small population's special needs. See iod.unh.edu/projects/center-start-services.

> **Jill Hinton**, *Clinical Director of the Center for START Services, UNH Institute on Disability/UCED:*
>
> START offers timely access: providers with expertise define the problem so that service matches needs. Build consensus about different providers' roles and how they work together; cost effective; recipient satisfied with services; services meet objectively established goals and change with the individual's needs; listening and mutual respect in the system.
>
> Systems Linkage Approach: enrich the system, resources allocated to promote linkages and to fill service gaps, services provided across systems, expertise improves capacity, outreach is key, develop a common language. Core START elements: trained linkage coordinators; linkage at local, state, national levels; consultation, service evaluations; trainings; 24/7 crisis support; planned therapeutic resources (respite), emergency (respite), expertise as members of core team; national center for excellence; data driven, evidence informed practices (SIRS).
>
> Examples of implementation per state and how Center for START Services supports them. Some linkages are not possible, e.g., if there is no neurologist or psychiatrist in the community. Caseload for START coordinators (Masters Level) is 20-30. Average length of service is 15-20 months. START Assessments and Training Tools: multimodal consult teams, Clinical Education Teams (similar to ECHO), a START Plan for each person enrolled, CSCPs, Comprehensive Service Evaluations for difficult cases (to get those who are stuck in the system unstuck), SIRS,

Systemic Analysis, practice groups across the county, PLCs. For people enrolled in START, 24-hour Community Based Crisis Response: collaborates with any first responders available, inpatient units, mobile crisis teams, ERs. MH crisis teams not always responsive or confident with this population, so partner with rather than replace them.

START resource options at times of crisis: consider the best place and type of supports needed in first 72 hours home/as a guest at START Resource Center (or other stabilization center); for in-home therapeutic coaching, define goals/objectives. In-home therapeutic coaching (crisis) assistance, with Coordinator, Clinical Director. In-home therapeutic coaching (planned): skill building for provider, follow up to prevent need for crisis services, support to implement plans, outreach to monitor and modify plans, training, transitional support. Resource Center (formerly Respite Center): ranch, single bedrooms, open floor plan, safe, welcoming, low sensory room, color coded rooms, chalk board for positive statements, yard, green space, removed from road. Crisis Stabilization and Assessment, up to 30 days: safe environment, linkage and system support, diagnostic clarification, med review, psychological and social review, assessment of problem, structured programming, hospital diversion/prevention. Half of the beds are for this, half are for Planned Supports, 3-5 days: keep families together, practice new strategies, transition from more restrictive settings, develop new skills, ongoing assessment to ensure stability, medication changes/modifications, familiarity to ensure safety net, supporting families and systems in crisis. Coordinator stays involved, learns more, takes it back to community for their work with people. Core Concepts: tertiary care, biopsychosocial approach, positive psychology, evidence-informed.

Special 6-8 week learning collaboratives, to which MH counselors are invited. States moving into integrated care models/integrated funding may see great savings from systems perspective (preventive education, social determinants of health). Public Health Model & START: Primary Intervention (effective strategies), Secondary Intervention (improved supports), Tertiary Intervention (accurate response). Potential impact of intervention increases with primary and required intensity of intervention increases with tertiary. NC and VA average cost per START recipient per year is $12,000. Higher in CA and NY. Also consider cost impact/savings elsewhere. START uses a separate case rate (like ACT), since it's not an ongoing service.

30-40% of those with I/DD have co-occurring MI. But some are treated and not in crisis, maybe 5-10% of the total need START. Biopsychosocial Model Engel, 1977; medical factors (genetic disorders, diabetes, sleep irregularities, constipation, GI, infections, seizure disorders, physical pain, vision/hearing changes, med side effects and drug toxicities) and very high incidence of undiagnosed medical conditions. START is a mental health program for people with I/DD, prevents 70-80% hospitalizations.

Discussion: MCOs and challenges, changing the values of the system, building up the workforce, promoting and training on START or similar models to support the shift. Make use of university programs, e.g., dental school services and rounds by nursing students in El Paso, clinicians at UNLV. The SIRS (START Information Reporting System) database has service outcome feedback and more. Psychiatric Hospitalization among START participants is more likely for those who have milder ID, diagnosis of schizophrenia and higher aberrant behavior scores, and are Black/African American. Study Goals on aberrant behavior checklist, family satisfaction with MH services increased, hospital and ED visits greatly reduced.

Implications: START National Research Consortium (largest database of this kind in the world); options to join the START network, have a certified team that meets the fidelity (certified START clinical team, program based on the model), or START network provider. SKILL is a

similar model. Optum is comparing the two and can share the comparison. States may be developing their own.

I/DD Session 2: SPARK Initiative Examines Issues in Self-Determination, Self-Directed Services

The SPARK Initiative, a consortium of 25 organizations was launched in 2016 to address service issues and challenges for specific populations. The first was on justice involvement, the second, in 2017, on I/DD. Next, the "I/DD Provider Survey on Self-Directed Services and Supports" on five broad areas. With no single source on self-determination, a draft white paper is a focus for the four workgroups; this will be shared with us.

Mike Hammond, *Optum and previous KS State Association Director,* **Caitlin Bailey**, *Director of Research and Evaluation, National Leadership Consortium on Developmental Disabilities/University of DE, and* **Cory Gilden**, *Doctoral Student and Research Assistant, University of DE:*

Survey on Self-Directed Services: adults with I/DD have control of budget and spending, living situation, agency and people who facilitate services, interests and goals, schedule, and work. Need not live alone but must have control over their lives, with supports they want/need to be successful. Definitions: self-directed services = personal choice and control over the delivery of waiver and state plan services; self-determination = right to become contributing and valued members of communities and live lives of their own choosing; and person-centered = planning, providing, and organizing services by listening to people. 90% of people with disabilities don't have self-directed services, so a survey was developed to understand barriers, facilitators/facilitating practices, agency practices, value of self-directed services, and demographics. Refined with results of a pilot survey, it included 45 multiple choice questions and 3 short answer response sections, and from April to July 2018 was disseminated to agency sites, social media, listservs, leadership consortia. Usable data came from 475 respondents, of whom 27% were managers, 35% leaders, and 19% DSPs of provider orgs; 70% private non-profits, 83% offering both individual and congregate services. The results:

Barriers to self-directed services (for all agencies) ranked: family factors, then state factors, then community factors (flipped for 'my agency'). Most impactful barriers: state policies/regs/service definitions, then federal, then families' attitude/knowledge. If you could fix just one thing, most selected state policies, then federal policies, then community systems, opportunities, and attitudes. Comments were very familiar!
Facilitators to self-direction: agency leadership, people with I/DD, families. Most impactful facilitators are people with I/DD, provider leadership, then provider policies. For people to feel ready enough to take control of their own services, families can play a big role, if actively seeking a way for their person to take more control. If no family support, in this risk-averse culture, agencies may not push for self-direction. Correlation between desire & capacity to deliver self-directed services.
Agency practices of self-direction: principles included in agency materials, agency provides tools and supports for staff, and agency provides tools and supports for people with I/DD.
Values of self-direction: agency board members and leaders who are supportive led to a higher capacity to deliver the services; several individual values closely related.

Implications for federal and state policymakers and managed care organizations: incentivize self-direction; make sure policies, regs, funding structure, and service definitions enable it; provide technical support to agencies interested in transition to it (MN offered grants). If a self-directed service option is available in state, it is not always supported by regulations and funding.

Implications for provider agencies: learn from those successfully transformed and implementing self-directed services; embed principles into written and unwritten agency policies, practices and training; adopt leadership and management philosophies that align with principles of self-direction (e.g., do DSPs have self-direction and control over their choices?); and make sure employees' beliefs and attitudes align with self-direction.

Implications for families and people with I/DD: learn from ppl with I/DD and families who have successfully transitioned to self-directed services; leverage the power and influence of families and ppl with I/DD to make it a reality. Families were listed as both barriers and facilitators of self-directed services, and many people with I/DD live with families, so it is very important to understand their concerns and include them; many later embrace the change. Discussion of history of institutionalization, risks associated with changes, need for legislative advocacy, deeply held values which delay progress, Medicaid fraud, build assurances to protect people.

Next steps for SPARK Initiative: distribute survey results; launch new information portal, supported by Open Minds, Optum, and NACBHDD at www.MySORCe.org, with best practice information for introducing and supporting self-directed services; distribute the four white papers for states to use as single source; use these lessons as managed care enters these markets. I/DD may be a bit ahead of Mental Health in self-direction. HSRI operates a resource on self-direction, looking for a tool to assess individual budgets; Medicaid would be directed to individuals rather than agencies. Pay for outcomes, holding providers/plans responsible. Federal agencies increasingly support use of the social determinants of health and wraparound, in the hope of driving down the cost of healthcare. For details see www.optum.com\providersurvey.

I/DD Session 3: Polk County, Iowa takes on DSP Workforce Crisis

Polk County, IA is initiating a project to address DSP shortage, starting with frontline supervisor Train the Trainer support, vetted through University of Minnesota.

Maria Walker, *Program Planner, Polk County IA Health Services (MH & DD) presented.*
The Case for Change: IA has lower than 2% unemployment rate, further stress for the I/DD Direct Support Professional workforce. 2017 President's report projects a need for 2.3m DSPs. From national data on turnover, 45-66% annually (DSPs plus similar workers), 77% caregiver shortage overall, and 32% caregiver turnover. National Core Indicators suggest state average turnover rate for DSPs was 44% in 2017. Polk County provider data is even worse, with 40% of turnover in fewer than 6 months, 21% between 6 and 12 months, and vacancy rates at 17.3% for full-time and 8.1% for part-time, increasing overtime costs, mostly covered by middle management. Some providers report 25% vacancy rate.

Medisked survey shows inadequate pay as the primary reason (89%), followed by stress of the work (67%), then low supervisory support/appreciation, then low advancement opportunities. Across the country, the cost of turnover in 2017: 1,276,000 DSPs, at $4,073 to replace, costing $2.3b total, which is roughly $2k per DSP. Medicaid rates are unsustainable living wages; privatized managed care in IA uses tiered rates; tough to advocate for higher wages for this group since there is no Occupational Code just for DSPs.

Project Strategic Direction: of many accredited options, chose the National Association of Direct Support Professionals, due to alignment of their core competencies with CMS; in addition, the Department of Labor recognizes them as the only long-term supports and services competency-based model. Pilot for NADSP: a 3 day "bootcamp" addressing the three core components; a frontline supervisor program, and a train the trainer model; a 2-day program to dive deeper into the competencies, using role playing and youtube videos.

Through one-day strategic planning with leadership from 17 provider agencies; considered 2 train the trainer models; identified as best option and developed the "collaborative model" with technical assistance from New York State Mid-Hudson, allowing for provider input where the "internal model" fits best. Determined that stating with a core group of frontline supervisors would have greatest initial impact. Front Line supervisor training on: 9 tenets of DSP code of ethics; 15 DSP competencies; and 11 frontline supervisor competencies (from U of MN's Institute on Community Integration).

Polk County offers incentive payments of $1k to those who complete the 24hr training and $2k for the 54 hr program, with approved work portfolio; evaluate effectiveness. 11 providers signed up; Polk County contracted with NADSP for the first year of membership, and providers will pay ongoing annual membership; offered Train the Trainer for 2-3 people per organization; NY Collaborative did 1 day onsite, 4 webinars, and 1 onsite wrap-up. Teams working on this curriculum (e.g., motivational interviewing for self-directed services, trauma informed care for DSPs) to submit to NADSP for approval. U of MN will do evaluation (metrics, qualitative and quantitative, including turnover). Paid out initial bonus to previous attendees.

Future: measure the impact of this program on retention, not only of trained supervisory personnel but also of DSPs who benefit from improved supervision and support. Then extend the benefits of training, professionalism, and someday, greater compensation, to DSPs. Create sustainability for trainers, with ongoing TTT training. Analysis by U of MN on return on investment after two years.

Nevada's State of the State I/DD Issues

Rural Regional Center, now under Department of Aging, covers Carson City, Reno, Las Vegas, surrounding, and rural areas.

Roswell Allen, *Administrator, State of NV, includes office of DD, and* **Dr. Christine Moninghoff**, *Director of Psychological Services/Desert Regional Center, NV:*

Overview: Diversity across regions, very different economies (Tesla, gold, etc). In North Las Vegas, can't purchase housing to do residential services; pop concentrated here. Services range from supportive living arrangement dedicated to a person (2hrs a week) to 24/7 group home. Contract with providers around the state, but avg $9.50-$12/hr where people can make $30/hr to dig fence posts in gold mine areas. Respite stipend to families. Self-Directed Family Supports Arrangement for parents ($450/mo) through a fiscal intermediary. Purchase of Service model under a family support model (diapers, Ensure, and other, necessary to remain in home). Another for more intensive needs. Jobs and Day Training in community, through massive providers (Opportunity Village, Easter Seals) and mom & pop agencies (equestrian village, hobby crafts), moving away from sheltered workshops but providers struggle. Voc Rehab for more community-based work. Working on trauma informed care, FAS training, sexual/social education, BCBAs in all three regionals providing ancillary support to providers and collecting data.

Issues: provider capacity (workers stay because they like it but then they get elevated beyond their capacity); medical supports so good that people are living longer and now experiencing early onset dementia, but providers don't know how to manage that, and nursing homes can't deal with DD. CIT training in the 15 northern counties to train law enforcement and corrections, including how to work with those with autism; LCSW clinician rides along with law enforcement, includes check-ins with those likely to be in crisis, in order to avoid the jail/ED/"divert to what?" cycle, and many of these folks do have MI, which has taken a while to educate the system; now rotation from the medical school will include these folks; doctors and

mental health clinicians had not realized that they could work out a way to get info from folks who don't talk. Guardianship concerns vs supported decision making; many private and public guardians have been misinformed about rights; legal supports in southern NV to help; supported decision making allows you to have staff help with decisions. Children's services a big topic across regions, education on who is responsible for placing children. NV has Autism Court, possibly the only one in the country, with a Hearing Master (a psychologist at every hearing, gold standard of testing, recommends to DRC for up to 21 years of age), but Juvenile Court sometimes over-refers folks to DRC; sometimes ppl don't contact DRC until crisis, and then they may not be eligible; MH Courts across the state. One ICF is still open, in southern NV. 48 beds, 40 individuals served, but they look like cottages, with 4 people per home. A cooperative team with MH, meet monthly to discuss shared cases, who takes the lead, and who pays for what.

Eligibility is different from other states, determined by a committee with recommendation from psychologist. Three regional committees, one state level appeal committee. Appeal decisions to Medicaid. Eligibility is also not aligned with school criteria. Family physicians may even determine eligibility without using any formal diagnostic criteria.

Vision: to move toward more intermittent services, more intense supports in community. Providers don't always understand how ppl can be successful without 24/7; avoid putting children into CISLAs; Youth Intensive Supports team in the south working with children very difficult to serve in the community, to keep them out of residential; providers with expertise are asked to do this differently and offer in-home supports. Transforming from workshop to community required working with staff who were also mourning this loss.

Discussion: EVV compliance; Oregon pilot; bandwidth infrastructure; deadline next January, at least to prove attempts to implement and describe barriers; includes family providers, non-traditional services. Host homes in NV. IA and IL are doing more of those, due to other provider capacity issues, some serious concerns with the model. In OR, host homes were eliminated, now coming back for children only. In NV, called Shared Living but looking for provider mentors. In IA workforce capacity program, they've included host home providers as DSPs. Challenges with affordable housing stock in metro areas. States now using SIS find it is easily manipulated, suggesting ICAP was better. Various consent decrees.

NACBHDD Summer Board Meeting

Welcome, Introductions, Announcements

Tom Renfree, *CA and Board President and* **Dr. Ron Manderscheid**, *Director, NACBHDD:* NACo Health Committee resolutions, 4 originating from us: addiction/opioid care; private insurance coverage for pre-adjudicated; Medicaid payments to pre-adjudicated; emergency resolution on 42CFRPart2 (SUD records to primary and MH providers).

NACo and Sheriffs Association initiative to move the Medicaid legislation ahead, to be joined by the District Attorneys Association, expected to move through congress, will be more successful by noting that savings go to community supports around/outside the jail. The 5th Circuit Court of Appeals to argue ACA is unconstitutional, then to supreme court; if ACA eliminated, start over.

Self-direction and self-determination in person centered, integrated care. Behavioral Health Outcomes paper, webinar, pilot to test various outcome measures and build experience with them.

NACBHDD Strategic Directions: Review and Update Current Plan

Discussion resulted in recommendations toward an updated Strategic Plan Document.

Tom Renfree, *CA and Board President*

1. Improve NACBHDD identity. Continue I/DD efforts. Some objectives are completed: Marketing, our role, Mitch's 7Ps paper, possible white paper on role of county data, white paper on priorities.
2. Develop workforce. I/DD discussions do include this focus. Include NACo. Separate out the DSP objective to focus on increased wages/rates. Different from incentivizing psychiatry. Add individual level cross-systems training (SUD/MI/IDD) or as objective under healthcare integration (#5). Four specific I/DD calls to action at last year's congressional briefing. Limitations of telehealth. Focus on the pay aspect of MH/SUD parity. Workforce diversity. Fund sustainable models of care, removing focus on providers and being sensitive to other supports. Peer certification programs; shared experience is peers' greatest impact (co-response model); must avoid professionalizing or pushing peers into their illness. Remain sensitive to new issues.
3. Parity Taskforce. Objectives done; work with state insurance commissioners and state attorneys general. Kennedy Forum's review of each states' parity laws, with model legislation. Look at qualitative violations (e.g., service array insufficiency). Crisis services.
4. Behavioral health and justice involvement. IMD exclusion done, inmate exception in process. Still working on white paper, TA and collaboration with HHS and DOJ. Incorporated I/DD. Healthy Counties Advisory Board at NACo. MATs within jails. CIT trainings. Criminal justice reform. Bexar County recovery setting (must have 120 days clean/sober, including staff!) for folks admitted by virtue of law enforcement, is as effective as Betty Ford Treatment Center.
5. Cross-system. Crisis supports for people with I/DD. Upcoming member survey on I/DD and MI. Housing/job supports as a separate bullet point, esp supportive housing. Acknowledge systems separately. Coordinate with Administration on Community Living. Add focus on children's system, Dept of Education. Build data accountability toward measures.
6. External pressures. Kirsten Barlow did a waiver matrix. Status of ACA. Add a philosophical statement about principles guiding the work. Managed Care partnerships with providers; payor and provider demonstrate value to each other. Medical model not relevant (harmful) to I/DD.

Perspectives on Working with Managed Care

Cherryl Ramirez, *Oregon:* Coordinated Care Organizations. Centene most successful (Eugene to Portland metro, 40% of population), HealthShare, CareOregon. Higher population areas have more than one CCO. Priorities: behavioral health, VBP, social determinants, sustainable cost growth, financial transparency, access to services. Goals per year, savings and downside risk. Excluded from VBP are pharmaceuticals and transportation. The planning role of local MH authorities is to engage in community assessments. No longer delegation of behavioral health benefit from CCO to community MH programs. No limit for BH in global budget, same reimbursement criteria as for physical health; MOUs with counties, metrics change every year (e.g. ED utilization, assessment of child welfare clients, cigarette use, depression screenings, developmental screenings, MH screenings, SBRT.) Was carved out, in last two years, deficit, forcing the idea of true global budget; if the behavioral health system helps with physical health costs, those savings should be reinvested. Opportunity to hold the second CCO accountable. Requirements are redundant to those of the county, so reduce duplication of effort.

Robert Sheehan, *Michigan:* 20 years of managed care, as a benefit carve out. 11 private health plans do fiscal management. MI manages some specific public benefits for four populations (I/DD, e.g.) All MCOs are members of the state association. From 1998-2016, six rebids of the PIHPs. CMHs are constitutionally mandated to run the mental health system; the PIHPs are provider-sponsored plans, creations of county government. Why MI built it this way: in 2002, clarified, in the 1915 waiver, the unique role of county government as integrator. What the system has done to contain costs: non-traditional, whole person approach, high medical loss ratio, whole

person integration efforts. Role of the Public Sector: fiscal control (get the first dollar), public governance, partnership, through many models. In 2016, fought back against language to privatize fully. In pilots, they have to use MI's networks, as the public safety net, maximizing Medicaid. Waiting for the results of a 4-year study to determine whether to take them statewide. Systemic underfunding for five years; acknowledge the impact of the seeds you plant.

Tom Renfree, *California:* Overview of managed behavioral healthcare in CA, a trifurcated managed system. Had been carved out under 1915 waiver and through counties. Medicaid MC plans for mild to moderate MH, with some debate about their success. Counties are responsible for severe MI and all of SUD; now an 1115 to expand DrugMediCal. Discussion with the state on the 2020 waivers includes: carve-in integrated system of care (MI, SUD, physical) with a 2025 goal of a single entity accountable for payment, admin, and oversight (though financial and organizational integration do not guarantee integrated clinical care). County systems have culturally responsible outreach, engagement, resiliency, esp with people who are marginalized and stigmatized. Counties which operate as their own MC plans have effective rehab, reducing costs. Selection of county BH departments led to excellent models of care. An excellent model of public/private partnership emerges: regional fiscal management contracting with several small counties on Drug MediCal expansion; the private company has agreed to take the financial risk; this model is still under development. Risk-based models for adults do not necessarily translate to approaches for youth; counties have found better results, so the question is who should manage the care and how; counties seem to do it well in CA. I/DD is under a separate state department, resulting from an Act that guarantees lifelong services.

Questions/Discussion: *CA had a weak SUD system until the new waiver created Systems of Care, at the same time as ACA and Medicaid expansion. How would those concepts fare as you move ahead?* CA intends to renew the waiver, some talk of putting all under one waiver; expansion of Drug MediCal very beneficial, a whole continuum of care, use ASAM assessment, Medicaid reimbursement across the full range. All counties will opt in. Regional models for the small counties would be a great development. Managed Care experience in MI has been good, allowing them to move past fee for service; as long as the public governance piece stays, there can be great plans; MI leaning toward plans that get along with the counties. CA has some public run health plans for children and moms. KanCare supported by the state association because they knew what they wanted and wanted to forge that relationship: to contain costs, partners must both have successes. Their system has grown from a provider-led plan; expensive friction was created by separating payor and provider functions. Greatest challenge is holding providers accountable for outcomes. If you're not careful, you'll get a health plan that ruins your system. Important not to demonize either partner. OR was supposed to have had a global budget; new contracts are 300 pages long; strength of the required MOUs will have impact. Running a FFS billing system, as opposed to capitated, makes it very hard to pay for social determinants, population health, quality of care. Monopoly in the public system is called a safety net, with benefits we all should have access to. *To control for conflict, other public oversight?* Further discussion of hospitalization, crisis, and values, data sharing across physical health plans, variation state by state.

<u>Payment Reform and Outcomes: Carve Out, Carve In, and Integrated Funding</u>

David Weden, *CFO, Integral Care of Austin, TX, and NARMH President:*
To prepare TX community behavioral health centers for a carve-in to managed care, a Community Center Readiness Guide describes challenges and imperatives providers would face, including: need to welcome change and new technology, enhance clinical capabilities and outcomes, and operate within set rates, in part by boosting productivity and outcomes; understanding of true cost of services; and need to maintain adequate financial reserves to successfully negotiate rates and collect claims. Funding for indigent individuals will remain at

pre-carve in levels. As of January, community centers had received $1.86b in DSRIP (Delivery System Reform Incentive Payments), which will end in September 2021. The funding transition from project-based to provider-based measures and payments when the waiver was renewed. CMS will not be renewing this waiver after 2 years, so it must be taken into managed care; behavioral health will use diagnosis-based eligibility and be in an alternate payment methodology in the CCBHC model. Working with the centers on gap analysis and cost reports, which will inform the transition plan (due in October). TX has 13 managed care regions, covering 254 counties and presenting challenges for some; multiple MCOs within regions, and with so many contracts, it is difficult to do the value-based payments. Data on hospitalizations and savings, negotiation on in-lieu of hosp so that they were using the right language for MCOs; also to get them closer to specialty health homes. HCBS waiver folks were using hospitals frequently and many were homeless (now doing housing vouchers for them). There has been some work on first episode psychosis, mood disorder clinic, drone-delivery of naloxone. Pay for success program, private foundations doing social bond programs/webinars on readiness reviews for communities and TA. If through 1115, with no cap, and diagnosis-based, 100k people with SMI in program.

Kyle Kessler, *Kansas:*
The last three governors had big ideas about behavioral health: carve out, carve in, and value based payments; reducing ED visits; tracking measures per provider (more data for more money); moved away from best practice designations. National Outcomes Measurement System (NOMS) working on VBP and access to data, but until then we'll chart our own course. KS started with the provider sponsored plan and moved away from fee for service, but it went backwards under the next governor, so they went back through claims history and put out allocation findings: disclosing the results (and identifying the providers) was what got people motivated. These systems have a lot of data, but to manage it with an outside vendor cost $5k/month in KS. Provider challenges can be addressed through these data, but publicly funded systems don't have the resources to manage, sometimes even enter, the data needed. Mike Hammond proposed that Optum offer analytics to support VB arrangements, at no cost as this would eventually paid out of projected savings, but this didn't end up happening. For payment reform, you need to know what the costs are and what you can do about them. Co-response crisis services in Johnson County have been funded only by city budget, demonstrating success and moving toward multiple revenue sources. No one is opposed to use of the social determinants of health.

Discussion: Oregon has learned you can't just jump to bundled payments track the right data consistently; CCBHC is an FQHC wrap payment, which the state doesn't like because it's expensive and they're not seeing the outcomes; Dale Jarvis says the savings are in the huge federal match payments they were going to get, acknowledged that Medicaid directors don't like this payment, advised that we see this as a bridge or infusion into a deeply underfunded system to get us to VBP. They have seen improvements in access etc. California moving toward a lot more care in various settings (jail, hospitals, etc) and to make the case that we're generating savings across many settings. Rand studied the "Whatever it takes" model there and identified these savings. Texas used a second crisis system, showed ROI, and county and city funded it. That's how the MediCal program was extended. In TX, working toward a rate that's not site specific.

"Charting the Life Course"
Charting the Life Course (CLC) framework and tools originated with the idea that current I/DD services and supports tend to "surround" the person completely, creating a ring that serves to isolate them from family and community. CLC was developed to break down the isolation by integrating services toward a fuller family and community life. Optum and some states have used this framework, promoting a wider view of resources, taking pressure off of family as they and the individual grow older, while better

structuring supports around family members' commitments. The presenter has a brother with I/DD, 22 years working in this field, and runs a statewide family peer support network.

Michelle 'Sheli' Reynolds, *UM-Kansas City's Institute for Human Development, UCEDD:* Current reality of services and supports: higher demand with lower $, changing workforce, different expectations/values/culture. This framework was created to transform services with values: evolving toward integrated supports and services across contexts of person, family, and community. How do we think of supports in a way that isn't a barrier between people and their families/communities? Our system lingo doesn't match how others talk about life. 1 in 4 people with IDD use formal state services; typically the only source of data, making it hard to create a framework which includes the 75% not known to services, i.e., outside of Medicaid services in home or out of home. 4.7m estimated ppl with DD: 75% no services, 12% or 672k living at home and 11% or 528k in home services. In Missouri, 65% not in state system, 17% in targeted CM.

Core Belief: all ppl and their families have the right to live, love, work, play and pursue their life aspirations in their community. Think about the Family Cycle, which impacts the member's life cycle; family life experience impacts trajectory; family unit impacts individual level characteristics. Supporting the needs of the person and family through Discovery & Navigation, Connecting & Networking, and Goods & Services; change as families and individuals change. Use the social determinants of health domains. Trajectory towards Good Life, a sense of where people are heading in their future. Ppl clear on things they don't want (poverty, poor health, isolation, being treated differently); our role to support them away from those things, to see long-term consequences of choices (exercise vs. watching TV, e.g.) and guide problem-solving.

Life Course framework in practice: combines many similar, e.g., person-centered planning, public health model, self-determination, community integration. Practice level = specific action, policy, procedure to enhance/revise, and tools like educational resources (worksheets). Families have influence, to encourage and challenge the individual to keep looking ahead and working toward goals. Value in "visualizing the positives that help vs. the negatives we don't want" to structure the decision process. Life span is not disconnected stages, siloed by age, but rather each stage influences the next: what are the life stages and experiences we aren't giving ppl with DD throughout their lives which prepare them for the next life transition? What things do you want to experience to help move toward your good life? The integrated nature of each service and support is described as a "STAR." When you map integrated supports around this star, you might see relationships only with parents, a cluster of eligibility-based supports, and nothing in the other sectors. Paid supports do not typically result in lifetime relationships, so build on personal strengths, relationships, eligibility-specific supports, public-private partnerships which foster peer networks, community-based supports, and technology. Make sure those with 24 hr support are not experiencing loneliness, poverty, segregation; watch for burnout among family and friends of those with no paid supports. Transformed, Dr. Reynolds' brother Ben has integrated supports of: many other relationships (through active engagement), creative community-based (firemen where he volunteers, coaches, bus), ipad when alone (family started with giving him five minutes alone at home, with a pet, then added), and list of strengths.

Partnering at every level for system transformation: comprehensive, integrated, and coordinated systems across life domains and stages; universal strategies for supporting Good Lives for ALL (community and society, public/private partnerships, and eligibility specific supports). Examples in IN, MD, etc. National Community of Practice starting. Successes in CT and MI. Prevalence rates: some say 2%, some 5%. Report from U of MN with data from Medicaid, identifying prevalence through a few measures, then per state. My LifeCourse Portfolios for Healthy Living

and Services and Supports. For more about Charting the Life Course, and to examine domains and tools, visit www.lifecoursetools.com.

Panel discussion: **Maria Walker**, *Iowa,* **Michael Hammond**, *Optum*, **Lynn Canfield**, *Illinois, and* **Sarah Jane Owens**, *Oregon*. OR is a Community of Practice state for Life Course, and DD Council is active with it. ISPs must be translated into other languages and then back to English for auditors, so with every new model, a great deal of time is spent incorporating it, leading to system fatigue. Optum and Aetna intend to encourage the CLC framework across all populations, as it's relevant to all. Other topics of discussion: workforce recruitment and retention; technology; our state systems; remote supports; performance measures; capacity building; federal legislation; employment first/workshop closure; doing away with subminimum wage. The DSP workforce crisis initiative of IA with turnover cost data ($2.3b nationally, equal to a $1/hr increase for them) and projected needs; our committee requests affiliation with NADSP; SPARK Initiative work on self-directed services and barriers identified by survey. Also working on barriers to services for people with DD and behavioral health and a white paper on best practices for that population. Interested in state updates, HCBS state transition plans, EVV, legislation, and possible negative impacts of HCBS regulations, such as isolation. System redesign and system underfunding and perpetual lawsuits, resistance from providers and communities, dehumanizing language and practices; values of the culture are anchoring this system.

Strategies for Member Recruitment

Tom Renfree, *CA,* **Rene Hurtado**, *TX, and* **Michael Deal**, *NACBHDD Secretary:*

Of 23 county-oriented states (not FL, TX, and IL), some county systems don't have a role. If a state has 100% county members, 3 can be on this board. Membership resides in the county, while state association of directors would be a member at a very low rate. NACBHDD has added regional memberships and affiliate memberships.

Outreach through personal connections; each member could push for a new state; PA would be a powerful addition. What does association involvement mean? Dialogue with staff, and the L&P conference are highlights. See pieces written by Dennis Grantham (Under the Microscope, Sept 2016) and Bob Sheehan. Develop a bit more through the Communications Committee so that all are ready to go when we have a potential member's attention. Add Hill Briefings The trifold brochure with basic info can be shared. In 2008, PA, OH, MN, IA, WA, NY, MD were all involved, sometimes NJ, NC, FL, and WI, and Cherryl Ramirez invited all of the county-based states to the Carter Center meeting, with highest attendance; calling could be overseen by the Executive Committee and Committee Chairs. States which have fallen away were often due to retirements with successors not following. MN may be reemerging; would be good to have IL, even Cook County. Nacbhdd.org does not compare to the updates and flash of the National Council's site. Membership Committee needs marketing experts; working with Trilogy to get as much free stuff as possible (e.g., first part of newsletter is public, but only members can read the whole thing); member spotlight on the home page will need to be updated. Our newest member says stick to the substance and not the appearance. Updates from members to potential members have greater impact. Send out a teaser, give folks something of greater value after they respond.

Reports from Committee Chairs

State Association Directors: looking for the priorities document to circulate to state directors, recruiting other state directors. Serves as ad hoc policy committee and conference planning; first Friday at 3PM.

Behavioral Health: outcomes paper; next steps are survey of members, toward pilot project on clinical and system outcomes, and development of webinars (esp on topics brought up yesterday).

ID/DD: I/DD summit with presentations on SMART, SPARK Initiative Self-Directed Services, Iowa DSP Workforce project, and NV system. Next step is survey on MI/DD: how our systems respond to folks with MI/DD, gaps in system, where it falls in each state's waiver, etc. Hill Briefing on this issue in May, in support of HR1329 (Medicaid Reentry Act).
Justice: completed the de-carceration pilots, with counties who had done Medicaid expansion and those who had not, also with vast differences in racial diversity. Mid-size counties able to define and address problems, though getting the right people together is hard (behavioral health, health dept, police, sheriffs, correctional facility, community members, folks with MI/SUD/DD). In contract, small counties could define issues but had no capacity to address them, so they decided to get state governments involved, may start with KS due to some small counties being in the pilot (state Medicaid agency and BH agency, and relevant associations). Can we move the agenda for those small counties by engaging state governments? Dr. M was invited to SAMHSA meeting with reps from six state and counties, even IL Lt Gov. Julianna Stratton. Timing is good, with foundation funding also to develop community crisis for small rural/frontier. The committee will merge with Behavioral Health, Tim DeWeese joining, as our liaison to NACO Justice Committee.
Communications: working with Trilogy to expand functionality, searchable by topic. White paper can be updated based on points made during discussion of membership and recruitment needs. This committee can be a resource for other committees. Also looking for members!

NACBHDD Reports

President: strategic plan discussion will be summarized; we are elevated at NACo by Dr. Manderscheid's work, so engage with county commissioners on BH. Current administration is working closely with counties and has a focus on opioid addiction care and even MI, with the message to "fund these services, they improve the safety net and save communities money." Discussion of fall election and candidates. The VP has been on NACo board in last few years, after splitting the duties of the President; liaisons to NACo health and justice committees.
Treasurer: ahead $136K for 2019; good response from corporate sponsors; net worth not changed over a year of balance, some in money market to improve interest income; report approved by.
NARMH: August 26-29 annual meeting in Santa Fe, with a room featuring local artisans; next year, Aug 17-22 in Portland.
Executive Director/Legislation: NACo elected Larry Johnson as second VP. All of our resolutions, and all 14 health committee resolutions, were passed; they'll be lobbying the 42CFRPart 2 resolution soon. Fall meeting in Chicago. Second edition of "Public Mental Health" has two chapters by Dr. M. The first is on MH organization, with criminal justice as the fifth service sector (after specialty, primary, social service, self-help) and not the right solution: if you build the beds, they will fill up, and the longer people are there, the longer they'll stay, with no more capacity. The other chapter = what is public health without mental health strategies and tools. This is a complete reference book, an Oxford University Press book and textbook at Hopkins, available on Amazon. He also has an article in American Journal on Public Health. Questions about Kratom raised at NACO; concerned with CBD (effective with a couple of conditions, epilepsy) which may contain metals or high levels of THC; need FDA research and regulations; Kratom is used to withdraw from opioids.

Behavioral Health in NV: the State and County Perspective

Ariana.saunders@clarkcountyNV.gov for more info.

Ariana Saunders, *Clark County Human Resources:*
NV is 51st in MH rankings; untreated MH more in line with US for youth, a little higher for adults. Due to large unsheltered population, high % of uninsured even though it is a Medicaid expansion state. No public MH system, all state-run clinics and hospitals, so all who are

uninsured go to those. Southern NV ER usage high among those with anxiety and depression, rather than using preventive care.

Ranked #3 in US for unsheltered adults: Point in Time count spiked in 2018, with 50% reporting MI, 54% depression, and 64% MI, depression, or PTSD, up from 47.6% in 2017. Housing is healthcare! Homelessness & co-occuring disorders, against the gap in providers to serve them. Behavioral health in jails: in Carson City, 1/5 inmates receive MH treatment at state facilities; in Clark County, 23% inmates had hx of MI and 25% were on psychotropic med; MH Court is always full, but recidivism post-graduation relates to lack of housing.

State priorities: for adults – CJ diversion, supported housing, ACT, access for crisis and community based treatment; for children/youth – JJ diversion, residential treatment facility capacity and linkage to services, transition age youth services, access to crisis, partial hospitalization, intensive outpatient, day treatment, wraparound, respite, family peer support, and habilitation. Gaps and Needs include crisis intervention and transitional, workforce development, program development at multiple levels, data management and application, services for youth and other special pop, housing and residential beds, adequate Medicaid, and consideration of regional characteristics. Highest in loss of hospital funding; people with severe MI die 30 years earlier than genpop; 7-10 day follow-up is critical; case management not currently through Medicaid.

Advocacy for a stronger system: in 2017, created four regions and four BH regional policy boards, each with 13 members, specific advisory roles, and review of data and data collection standards, plus a Regional BH coordinator serving the policy board and working with local BH providers/coalitions, community stakeholders, local jurisdictions. Previous priorities were: targeted CM, affordable housing, data improvement, Freedom to Heal Act, multi-disciplinary teams, ACT, transportation, specialized funding; priorities for Medicaid expansion and redesign, crisis stabilization, justice diversion and reentry, and workforce development. With no psych ERs, NV relies on crisis stabilization units, 16 or fewer beds; Crisis Now model, but no database to track clients moving through the system. Promoting first episode psychosis strategy. Opening more FQHCs and 'Hub and Spoke' opioid treatment centers. Clark County applies for federal and private funding to bring services. Coordinating across providers to develop database for assurance about the quality of services referred to. Medical services at county hospital. Diversion and reentry are big part; a Stepping Up state with several counties implementing best practices: in Clark Cty, law enforcement assisted diversion, reentry, crisis response team, frequent user data integration, coordinating council, special populations subcommittee, emerging co-occurring condition court; in other counties, MOST and FASTT teams, telehealth in rural jails, and CIT.

Discussion: LA County, CA, moving away from law enforcement to EMS (pre-arrest) taking to sobering centers and the like. Community paramedicine. The vehicle that shows up is MH specific, not a police car, fire, or ambulance.

Brief State Reports, All Participants

Oregon: budgeting model for DD case management (lower this year); implementing EVV today (checking in by phone when contacting folks with DD); issues with not getting paid for the services which keep folks with mental illness out of hospitals; competency to stand trial.

Michigan: incompetent to stand trial are waiting in jail; working to move people into treatment; followed NY model for AOT but with no $. School-based MH increased funding, getting guidance from the state association; small Healthy Michigan program. In 31 states, people move from 'disabled, aged, and blind' Medicaid into expansion (e.g., Healthy MI). Clients have the right to enroll in the program they choose; no spenddown obligation; DAB is the most expensive

rate. In order to make expansion work, they had to show cost savings and cut general fund by 60%, resulting in cuts to important services and too-low rates. Great stuff is happening, but the fiscal threat is real. New governor, building roads, cleaning water, and re-funding schools (add that fourth leg, mental health).

Texas: lots of bills coordinating MH, school. $99m to children's MH initiative (research, telehealth); $80m added to services including crisis; hospital redesign; adding sheriffs as non-voting board advisors; opioid target added to budget (35% of those treated must be in MAT); pairing rural centers to find efficiencies in operations/economies of scale; initiating an I/DD strategic plan as a subset of BH strategic, adding $ for crisis for I/DD. STAR kids program was based on disability not income, now difficulties with other insurance. Prop tax increase of 3.5% for counties and cities but not on healthcare districts.
Kansas: counties are stressed by property tax policy. Similar to Michigan politically, with new governor (school funding, Medicaid expansion, parks/rec, and one other priority). Revenues coming in at a higher rate than 15 years, could lead to larger than helpful backlash. Got health homes, supportive housing codes, more money for state contracts, school MH pilot, and crisis homes/centers; 80% of those in crisis would be eligible for Medicaid if there is expansion. When you advocate for new programs, don't forget to advocate for more state staff to implement them. Nebraska just expanded Medicaid and got 8% rate increase so they'll be recruiting along state lines; Colorado also has expansion.

California: MediCal moving from 1115 waiver into 1915; matching prevalence data with Medicaid enrollment numbers (which the state doesn't give them) to determine how many providers. Failing this, they go straight to sanctions; possibly rolling BH into managed care, holding BH to a different standard than physical health. The Millionaire tax brings in extra money, used to leverage Medicaid as non-federal share, but it's volatile and not aligned with need, and the state uses it to plug gaps. They've pushed back against that money being directed away from BH and toward school nurses and other; BH should be embedded in the schools, so developing a plan to partner and focus on social determinants of health. Early psychosis programs and outcomes important; new state surgeon general, the celebrity inventor of ACES, so improve EPSDT, prevention, in multi-generational approach; juvenile justice; continue working on Drug MediCal expansion (1115); residential not limited by the IMD; can use MediCal as the core with other resources to wrap around it; still cost-based reimbursement; homelessness very high; lack of expertise at policy and leadership levels, as well as other workforce, leaves much to do in terms of education, but there is political momentum and will. The public behavioral health system in CA is worth fighting for, but we're not making people homeless to get services.

Illinois: we have a budget, new legislation, and new projected tax revenues; MHFA trainings/stigma (youth and rural), environmental issues, etc. More info on IL at fall meeting.

NACBHDD Fall Board Meeting

Current Systems in Illinois

Lynn Canfield *and* **Lisa DeVivo**, *IL, introduced the panelists.*
Marvin Lindsay, *Executive Director, Community Behavioral Healthcare Association (IL):*
CBHA has 55 members, including health departments, FQHCs, hospital programs, managed care orgs, ACMHAI, and community-based MI/SUD providers. CBHA tries to organize across siloed state behavioral healthcare authorities, many of which don't even know the others offer funding.

IL has 214 community based mental health centers, 27 community hospitals with psychiatric units, and 7 state operated hospitals. For substance use disorder treatment, there are 1,037 licenses, 469 corporations, 922 sites.

Medicaid Medicare Alignment Initiative. 25% of those in Medicaid have MH needs, making up 50% of total costs. TANF has been a managed care program since the 1980s. IL had 29 MCOs, now down to 6. Between 2009 and 2012, the CMH system was cut by $113m. From 2015 to 2017, the lack of state budget destroyed social service systems. Gaps were filled by local funds, and Equip for Equality took the state to court to force it to pay bills. The transition to managed care was inadequately funded.

New commitment to MH, and lots going on: 1115 waiver and state plan amendments; consent decrees; child welfare to move to managed care for care coordination (DCFS and HFS must work together, as legislators want to get this right). Challenges to value based purchasing: low rates, need $ for infrastructure, workforce shortages, fee for service system. Strengths: knowledgeable, dedicated providers; Illinois Health Practice Alliance working with Centene to increase provider network; a payor and provider partnership. Goal to have all 6 MCOs contract with this group and eventually bring in the FQHCs. Centene's initial strategy was to deny services, which drove up inpatient costs, so now they are spending more on outpatient care.

Scott Block, *Executive Director, McHenry County MH Board, and President of ACMHAI:*
IL is not a county-run system, but has 70 local mental health authorities, referred to as '708 boards' after HB708 (passed 1963) and adding $75m to the service system each year. Communities may also establish '377 boards' for DD care and '553 boards' within Health Departments. McHenry 708 has the largest levy. Some very small funds are governed by volunteers. Structured as government entities; while board members are appointed, the work can become political (property taxes). Most do NOFA and grant funding annually; boards risk supplementing Medicaid or supplanting state obligations, if simply funding what providers want.

ACMHAI (a 501c6) offers organization, direction, for full compliance with statute and relevant laws and for most effective allocation decisions and contracting strategies. Examples of funding. Threats include recent effort by IL Sheriffs Association to direct 20% of funds to sheriff budgets. Managed care may be headed for DD services, taking on an already broken system and adding chaos. Mergers and affiliations of DD providers very likely, to increase service capacity.

Heather O'Donnell, *Senior VP for Public Policy and Advocacy, Thresholds:*
Thresholds operates in Cook and surrounding. While Sheriff Dart refers to Cook County jail as the largest MH facility in IL, it offers the worst kind of treatment. Deinstitutionalization turned out to be re-institutionalization. 22k people in IL are in nursing homes due to MI. Even though concerns are growing, there is no leadership with a clear vision. IL has 2.5m residents with MI, but only 1/3 get treatment; suicide increased by 25% in the last 10 years; addiction is often self-medication of MI.

Medicaid is primary funder, but MI rules were developed in a different era, around team-based treatment and flexibility (because people tend not to come to office settings), but Fee for Service did not fit with that. Challenge now to pay for value, as the regulatory system is suffocating. We keep laying new initiatives over the bad foundation of Medicaid. Rather than delivering care, the focus is on assessment rather than treatment. State regulatory agencies need to fix the system so that we CAN do whole person care, for better care and not just cost impact.

Good things in Cook County: a flexible services housing pool, which funds rental subsidies for those with chronic medical conditions, based on a model from LA, a partnership with hospitals, universities, and providers; develop housing or at least subsidies.

Capacity is limited by Medicaid rates. From Kaiser Foundation: IL MI rates are 38th in the country, 11th in the Midwest, with no increase in 10 years. 27% shortfall costs over reimbursements, so Threshold cannot take new cases; struggling to hire social workers, case managers, therapists, psychiatrists; turnover at 33%. Not bold in what we ask from legislators; it's about what people need in their neighborhoods to be well.

Discussion: NC 1115 waiver on housing, supported by HHS Secretary Azar, for coordination of services; documentation is a workplace burden, true in IL too, the biggest barrier named by providers. Local funders and 708 boards do some Deemed Status reviews (lighter than for non-deemed) and streamlining. CA paperwork reduction effort.

Amy Peterson *and* **Laura Miller**, *Equip For Equality:*
Overview of Protection and Advocacy (private) agencies, with majority federal funding. EFE has 60% federal. 3 class action suits on community integration (Ligas, Williams, and Colbert) and 2 against Department of Corrections (Rasho and case regarding deaf or hard of hearing prisoners).

Many rights flow from living in the community (voting, privacy), and the 1970s were good for people with disabilities. With legal support for deinstitutionalization, states moved toward community-based care through Medicaid waivers. Equal Protection Clause (though weak, lacking evidence of discrimination), Due Process, ADA regulation for most integrated settings, and then Olmstead in 1999, with isolation as the form of discrimination. IL was not making the progress other states were, with 9,000 people in large institutions (3k in SODCs and 6k in private ICFs which are 5x more expensive than CILAs) and many more at home with aging caregivers. In 2004, several groups wrote to Gov Blagojevich, with no answer. Then they partnered with the ACLU, Access Living, and private lawyers. Ligas got class certification in 2006, started with ICFs (no union) but found organized resistance anyway. From 2011-2017, all ICF residents could leave, problems with outreach; 3000 people were selected from the wait list; those in crisis had to be served, not counted in the 3000.

Good news: over 8000 now have services through Ligas. Court Monitor proposed that a study of whether 250 people are getting what's called for in their person centered plans. 630 selections per year (beyond crisis), and then no one waits more than 5 yrs. Slight increase in DSP wages. Bad news: group homes too large, too far away from families; low flexibility in work and day activities; few options for the 'hard to serve'; very low rates; high turnover; crisis services slow. Moved to find IL out of compliance due to quality issues: base rates on actual costs, sufficient to attract employers, plus monitoring tool. Committee on rates, technology, nursing, etc. Final plan due July 2020. Approved rate increase (3.5%) is not adequate and also not approved by CMS.

Williams: 4,500 people in IMDs with no federal match, includes people with MI. Certified class in 2006. 2500 people have moved to community.

Colbert: 16,000 people w/ physical disabilities (some have MI) in Cook County nursing homes; class now combined with Williams; due to the mixed class, various state agencies are involved.

For compliance with HCBS rules (PCP, integrated settings), IL doesn't even have preliminary approval of a State Transition Plan; did approve a position whose role is Olmstead, plus another

to work on Ligas. Discussion: what is special about that 16th bed (IMD exclusion); regarding people with ID and MI, Ligas covers all co-occuring diagnoses.

Update on Mental Health Parity

Tim Clement, *Director of Legislative Development, APA tclement@psych.org:*
The Basics: should be no more restrictive than coverage for other medical care; law passed in 2008, enforced by various entities depending on type of insurance; current problems include complex components of the law (esp federal), state and federal regulators slow to implement and provide guidance. Had been mostly Democratic bills, but bipartisan during 2017-18, focus on transparency and accountability, making sure people are getting what they pay for.

Components of Model Legislation; versions have been developed for all states, in each one's format, at https://www.psychiatry.org/psychiatrists/advocacy/state-affairs/model-parity-legislation In 2018, DC, DE, and TN adopted, and IL adopted everything in the model and more. In 2019, CT, MJ, and MN adopted, and CO adopted everything in the model and more. Many are interested for 2020 (MT, NV, OH, and PA).

Federal Parity Legislation: Behavioral Health Coverage Transparency Act will not pass (no Republican cosponsors); Parity Enforcement Act was voted down along party lines; Mental Health Parity Compliance Act is already in broad Senate package, needs cosponsors from Energy & Commerce, Education & Labor, and Ways & Means committees. Kennedy Forum's "Six Steps" approach. The long-term outlook for compliance: this will take years, complicated law, opioid epidemic raised the profile.

Discussion with Cook County Sheriff's Office

Jane Gubser, *PsyD, Chief of Programs, Cook County Dept of Correction:*
95-98% of detainees are pre-trial, making discharge planning and community reentry tough. With bond reform, 5800 individuals, but many are receiving care for the first time ever. 37% are on MH caseload. A 3-step process for determining security level, then assess medical and mental health need. IL very strict privacy law; housing need is a measure. Assess for level of care needed, not diagnosis-based. Very sick people, but also need to get the buy-in of over 3000 correctional staff. Data focus helps make the case to the Cook County Board. All officers do CIT and advanced MH training. 24/7 CARE line to learn if an inmate has MH issue. Everyone has MH assessment at intake. Now more people are going out on bond, so working with TASC and Parkland and University of Chicago on new models. MAT in jail. Fitness restoration pilots through IL Dept of Human Services. Mental health intensive outpatient treatment, yoga, AA, and more. Nika Jones, LCP, started MH treatment area in an unused space. An alumni component at the MH Transition Treatment Center; participants have even better outcomes, which speaks to the value of connections. What people say is most helpful is feeling heard. Link people to peers or providers from their own areas. Sheriff's Anti-Violence Effort (SAVE) finds those most likely to engage in violence, offers them anger management and resources (not people with MI diagnoses, but 18-24 yo from violent areas), with a trauma-informed approach, calling to check on them.

Discussion: national 988 system for diverting from jail; no more solitary confinement. Asked about funding – all County, no Medicaid. Community connectivity services are through FQHC. Students are critical to the program. State closed 6 of 12 Chicago community mental health facilities. Many with service needs moved to Oak Park.

Serving Individuals with I/DD: A Collaborative Approach to Behavioral Healthcare

Tandra Rutledge, *Director of Business Development,* **Kerry Overbee**, *and* **Amanda Norris**, *School and I/DD Program Liaison, Riveredge Hospital*

IL is 47th among states for community DD care. (See theydeservemore.org for recommendations on DSP wages and stable system.) Hospitals trying to discharge people back to care find programs and group homes closed, changes in CILAs, a very unstable care system, less time in community.

Riveredge is a psychiatric hospital, average care 10 days, longer for those with I/DD; accept Medicaid, Medicare, MCOs, private insurance, self-pay, and some no pay; offer trauma-informed, evidence-based treatment, clinical excellence, and suicide SaferCare; with 210 beds, largest in State, and the only with specialization in MI/DD. Project with IlliniCare for care coordination to decrease readmission of high-risk psych patients; project to lower suicide risk for patients during care transition; great outcomes and quality of care; piloting a partial residential program for people with co-occuring MI and SUD. Data on calls, assessments, inpatient and outpatient admissions – all increasing each year. NAMI peers are onsite 40 hours/week. Peer Recovery Specialist contacts showed positive impact in 90% of satisfaction surveys. Family peer support person leads groups.

IDD/MI conditions: consensus around challenging behaviors (self-injury and aggression, threat of self-harm, could be physical pain or reaction to loss) leading to the calls; data underestimate – 30-35% have a psychiatric disorder, hard to assess and also 'diagnostic overshadowing', with nothing about suicide rates. High comorbidity of Autism Spectrum Disorders, ADHD, schizophrenia/psychosis, bipolar, anxiety, etc.

Developing an I/DD specialization: physical unit dedicated to DD; staff training; need a psychiatrist willing to treat these people (theirs is also the Medical Director); a psychologist is coordinator, brought CPI. Features of I/DD Behavioral Health Program: physical setting, clinical, I/DD specialist; most referrals had come from ERs; better data helps prove medical necessity. Challenges: learning the complex DD system rules; IL's crisis CILAs have a total capacity for 16 people. At admission, guardians have to sign a commitment to post-discharge care plan. Work closely with the state's crisis team (SST). Pro-active approach with agencies and communities. Improving access to care with telepsychiatry, outpatient services, Health Connection Hub (a closed loop referral system built on Aunt Bertha platform), and text support for youth. New project: Pathways, using WRAP, with two agencies' care coordinators for high utilizers.

Meeting of State Association Directors

Cherryl Ramirez, *Chair, and* **Dr. Manderscheid** *led the committee's discussion:*
Topics and speakers for next meeting; all have an interest in Tawara Goode (CLC at Georgetown University) and in IA's requirement to build a children's mental health system; new name for this committee; outreach to other communities, states, and state association directors; developments in community restoration and parity efforts (NM has a model to "Treat First" – Medicaid Director can simply instruct that services are assigned a Z code and pay); next call November 1.

Reports from Committee Chairs

Directors of State Associations Committee: see above
Behavioral Health and Justice: 'meetme' call on Outcomes Paper and pilot, 10/17, regular committee meeting 10/18, and series of webinars on Medicaid in our states, with Bob Sheehan presenting first, on MI.
I/DD: survey on MI/DD still out, next call 10/22, annual summit July 19, 2020.
Communications: updates on website, database upgrade. Large pdfs can be added, so we can share more. Network for Good allows donations on facebook, NARMH is currently using that. Presence on youtube, twitter, facebook, etc and working on creating a conference app.

NACBDD Reports

President: Tom Renfree is looking forward to retirement. Discussion of prevention efforts, Iowa's work on ACEs, and stigma as the most deadly part of MI, keeping people from getting help.
NARMH (National Association for Rural Mental Health): Mountain Plains TTC co-sponsored the fall meeting; next year, August 16 and 17 in Portland on social determinants of health.
Executive Director: upcoming meetings and topics. Decarceration Pilot showed that, because some small rural communities can't do anything about the issues even with a shared understanding, we must work at the state level; will start with KS, meeting with governor and legislators. Outcomes Pilot will be discussed first at the 'meetme' call next week, then NACBHDD survey on outcomes, then a pilot with select counties. Federally, each agency uses their own outcomes and there is no core to the work and no one in charge. Our outcomes white paper is comprehensive, a starting point for us.
Treasurer: update on financials, positive position, report approved.
Election of 2020-2021 officers: slate of nominations proposed, passed; officers elected.

Brief State Reports

Oregon: prevention efforts, MHFA, then suicide postvention, now becoming Alliance to Prevent Suicide. Policy package for legislature. More staff doing prevention work, pushing to extend the CCBHC demo. State DD funding is in a workload model; EVV and centralized case management system implemented; strategic plan addresses CM systems, may be less bureaucracy. Blueprint due at end of year. Sarajane Owens will retire June 30.

Michigan: a good budget, rate increases for the first time in 5 years. Private health insurance companies really want our business but can't come to an agreement. Policy Analysis Unit (Chi Squared) published a paper about the perfect storm of circumstances, including systemic underfunding, which was persuasive. All members use the GAINS SIM. In response to school violence, $30m to add behavioral healthcare workers, then convert these $ to Medicaid; pushing schools to hire community mental health. Incompetent to Stand Trial - many in jails waiting for fitness determination longer than they would have been sentenced (e.g., for misdemeanors), so CMHs could be the home, but counties are responsible for cost of care for those incarcerated. Moving to VBP system with support from the Johnson Foundation.

Illinois: population changes (various causes for loss), language access issues in most communities, aging rural populations and other challenges for farming communities this year, possible new revenue related to cannabis licensing, revenue to be directed to human services and to 9 specific areas of the state with significant racial disparities in juvenile justice and related (Champaign County includes one of these designated areas), MHFA esp in schools.

Virginia: tragic death of behavioral health director. CCBHC-like services without federal demo funding. Not a system of care, so care coordination is needed. Virginia Beach shooting incident PTSD, so a special session was called, rescheduled for after the November elections to avoid political consequences for positions taken. Bigger budget cuts, partial Medicaid expansion. Should VA regionalize? Behavioral health redesign is coming. 84 planning members toward evidence-based practices, diversion/deflection strategies.

Iowa: Director of DHS relieved of his duties, replaced by a younger person from Texas, to reshape the system. Many providers have left, care coordination is reduced. Children's MH initiative launched when the governor's friend lost a child to suicide. Iowa has 4 regions. Stigma is especially deadly in rural communities, but access is also a barrier to care. With 1% unemployment, the state needs immigrants. Efforts to attract young people to the field of MH. Surplus of $280m. Farm Bureau is the biggest influencer; partner with them and support their

members, esp smaller farms; suicide rate is very high in IA; at least need their help to shed the stigma. MI and DD funding is all based on property tax levies which were capped in 1996, at whatever levels they had reached, uneven across the state and now outdated.

Kansas: Johnson County, with University of Chicago Data Science for Social Good, use data from county and schools to predict the 100 people most likely to have contact with law enforcement and instead reach out to them with services, resulting in 30% reduction. Brief MH screen on 100% of people booked, then outreach. Length of jail stay is 3 days, but 81 days for those with SMI, so MH will soon take over providing services in jail. Epidemic of youth suicides (15 last year). Student-led "Zero Reasons Why" storytelling campaign; Youth Council did strategic plan and initiatives; school-funded at first, now supported by AT&T and church. For the first time since 2006, more $ for uninsured/underinsured. Legislative MH initiatives, momentum from a bus tour. 70-80% of Kansans support it (conservative, moderate, and liberal). Losing MH professionals to schools; however, no crisis services are available over the summer for the same children if you don't have community MHCs – need partnerships between MHCs and school districts. Now moving into the workforce development charge.

Texas: speaker and governor on the same page. $455m to renovate state hospitals, partner with MHCs, added $26m for psychiatric beds in private hospitals. Lots of proposed Children's MH bills, a consortium established, to do telehealth consult to schools and MHCs and to develop best practices. Also adding people to do education on MH with universities and other partners. Help for local MH authorities in response to shooting incidents. Filling some gaps, allowing smaller counties to pair up on services and efficiencies, passed 'in lieu; services and some increases for I/DD. Changes to Medicaid, 1115 waiver renewal due, diagnosis based, and proposing full Medicaid benefits. A great CCBHC funding proposal. 16% of Texans are not insured.

California: new governor. Due to a high-profile argument with anti-vaxxers, the director of behavioral health resigned quickly. BH waivers need to be renewed in 2020. Reorganizing (Medicaid services in one place, others in another). Network capacity requirements, with new Provider to Beneficiary ratios imposed, based on prevalence data but a questionable methodology. MHFA for greater than 15% of teachers; working on certification program for Peer Support Specialists for MH and SUD. Homelessness leads to pressure to decrease MH funding in order to build homes. Still a big underground illegal cannabis market, so tax revenues from legal are not as high as anticipated. Those revenues could go to early childhood care and access (governor's initiative) and youth SUD prevention (already the plan, just not much money).

Reports from sponsors: Jeff Cross said the I/DD incarceration initiative has made good progress, support from Napolitano; across the country, people who rely on DD waivers are not getting all treatment needs met, ending up homeless or incarcerated.

Stephanie Howard-Gallo

Operations and Compliance Coordinator Staff Report –

October 2019 Board Meeting

SUMMARY OF ACTIVITY:

Audits:
Audits and financial reviews will be due on October 31, 2019.

Promise Healthcare received an extension for their 2018 audit. Originally their audit was to be completed by June 30, 181 days after the close of the agency's fiscal year. The extension was approved by staff until September 30, 2019. They did not meet the deadline and payments have been withheld. We were informed their audit is expected October 31, 2019.

Compliance:
CU-Area Project (CUAP) has had their payments held because they had missing and incorrect financial reports for the 4th quarter. Payments will be released once they have addressed the issue.

2019 DisABILITY Expo:
I attended an Expo Steering Committee meeting on September 17. The Expo will take place on March 28, 2019 at the Vineyard.

Community Awareness/Anti-Stigma Efforts/Alliance for Inclusion and Respect (AIR):
A Facebook page promotes AIR's mission, members, artists, events, and news articles of interest. I am one of the administrators of the page.

International Galleries at Lincoln Square continues to give AIR artists a space, free of charge, to host monthly artists. I organize the schedule and maintain a relationship with gallery personnel. The October featured artists are painter, Melanie McGhiey; and, the Philo Road Art Crew. The November artists will be a group from the Cunningham Children's Home.

We will continue with a new artist every month for as long as International Galleries (and owner, Bill Mermelstein) will host us. The gallery does not take any percentage of the artist's sales.

Site Visits:
I participated in a site visit with Kim Bowdry at Rosecrance Inc. (Walnut St. clinic) for the MI/DD Coordination of Services program (CCDDB funded) on September 20, 2019. We met with Kathy Kessler to talk about the program and review client files.

Trainings:
I attended a training on "Employment Law Updates" in Peoria, IL at the request of Lynn Canfield. Of particular interest were changes to employment laws once recreational cannabis is legalized in January of 2020.

Other:

- Preparing meeting materials for CCMHB/CCDDB regular meetings and study sessions/presentations.
- Composing minutes from the meetings.
- I attended a portion of the Chaz and Roger Ebert Symposium on September 27, 2019. The symposium, titled "Creating an Inclusive Media and Cinema Ecosystem, had various panels scheduled throughout the day.

2019 October 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

CLC Compliance Check:

I am still reviewing the 4th Quarter Reports for compliance in the following areas

- ***Annual CLC Training***
- ***Board Diversity and Staff Recruitment***
- ***Policies and Practices that have the value of Cultural Competence***
- ***Language Access and Communications***
- ***Actions connecting to the National CLAS Standards***

Most of the Organizations submitted CLC 4th quarter reports for the FY19. The 2 organizations that did not submit their 4th Quarter Reports was because there was a change in leadership, and they did not know how to report on the activities. Moving forward, I will provide support and check in during the quarters to see if the person that is responsible for tracking the progress is still employed and if there are any questions. The reporting for FY 20 in the Second Quarter will be streamlined. The 4th Quarter will still consist of reporting on all the benchmarks achieved in their CLC Plan.

All contract requirements and updated CLC Plans due September 30, 2019 for FY20 were updated and submitted for contract compliance.

RACES- RACES submitted an updated Language Access Plan that was approved by the Board of Directors.

MAYC- (Mahomet Area Youth Club)- MAYC submitted an updated CLC Plan with updated activities to reflect the direction of the New Executive Director. I was asked to do a cultural competence workshop with Jr. High and High School students on December 11, 2019.

CLC Coordinator Direct Service Activities

Mental Health First Aid Training: I completed Mental Health First Aid for Adults on October 4 and October 11. There were 5 participants that completed the class and passed. These were people from the community, one of our funded agencies and students from the University of Illinois at Urbana-Champaign.

On September 10, I convened a meeting with instructors for Mental Health First Aid. There were representatives from Carle, Vermillion County 708 Board, Champaign Unit 4 School District, and Champaign Urbana Public Health. We learned that there are 17 trainers for Mental Health First Aid for Adults in the area and 2 people trained for Youth Mental Health First Aid. A representative from Unit 4 Schools talked about the how much of a challenge it was to fill classes in the Champaign-Urbana Areas and how many classes had to be canceled to due to last

minute cancelations. There was much discussion from Carle how they charge a small fee and how the turnout has been successful in the rural areas. There is a push to provide Mental Health First Aid to Farmers, because of the increased rate of suicide for farmers. We talked about ways to bring another training to Champaign-Urbana so that more people can become instructors. There is funding available from the SAMHSA(Substance Abuse Mental Health Administration) to Mental Health First Aid so it can be a possible consideration if there was coordination on how to apply for the funding. The group agreed to stay connected and meet at least two times each year.

I have a Mental Health First Aid Training for Adults scheduled on November 2nd and November 9th from 9:00-1:30pm at OSF Hospital. Space is limited, and any community member is welcome to attend this training.

Georgetown Leadership Academy: Increasing Cultural Diversity and Cultural and Linguistic Competence in Networks Supporting Individuals with Intellectual and Developmental Disabilities: I had my final coaching call with Tawara Goode. The call was my evaluation call and what I have learned from the Leadership Academy and my vision for leadership in Cultural and Linguistic Competence for people with DD and IDD. I explained that in our community how Language Access is truly a barrier because of the number of translators and interpreters are limited for the size of our county. I also told her that DDB are doing mini grants to support the needs of people that may not be getting access to services that may not be covered through Medicaid. She stated that was a great start and applauded the DDB for their innovative way to create access to resources. She told me that she is presenting on Cultural Competence in Person Center Planning. On October 29, 2019. Here is the information below about the webinar:

> **Cultural Competence: What it Means for Person-Centered Thinking, Planning, & Practice**
> **Tuesday October 29th, 3 to 4:30pm Eastern Time**
> **To register,**
> **visit: https://zoom.us/webinar/register/WN_nDG6DaHHQPWAa569k5tJ9Q**
> **SCHEDULED SPEAKERS INCLUDE…**
> - **Tawara Goode (Director of the Georgetown University Center for Excellence in Developmental Disabilities and NCCC)**
> - **Brenda Liz Munoz (Executive Committee Member, Georgia Council on Developmental Disabilities),**
> - **Christie Carter (Older Adult Program Coordinator at the Milwaukee LGBT Community Center)**
> - **Diana Autin (Co-Director of the SPAN Parent Advocacy Network) and**
> - **Lorraine Davis (member of the Sisseton-Wahpeton Sioux Tribe, and the Founder and Executive Director of the Native American Development Center)**

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

UIUC Community Learning Lab: The CLL Students have formalized their project on the "Barriers to Providing Services in Rural Areas." They created a survey to send to funded agencies to learn about what services are co-located in rural areas. 15 Funded organizations responded to the survey and scheduled individual meetings with the students so they can learn more about what services the organization provides in rural areas. They will provide a report to the Mental Health Board on November 20, 2019 and will give a full presentation on December 5, 2019. All organizations that completed the survey are invited to learn about the findings from their meetings and recommendations moving forward. I will finalize the location for December 5 in December.

Anti-Stigma Activities/Community Collaborations and Partnerships

Alliance for Inclusion and Respect: There was another group that was created so that I can start having direct conversation with the Artists about opportunities and getting feedback from the artists regarding their experience with AIR. World Mental Health Day was held on October 10, 2019. Parkland College will host Depression Awareness Day on October 16, 2019. To stay updated on all the activities please like, The Alliance for Inclusion and Respect on Facebook.

Disability Resource Expo: I attended the Expo Steering Committee Meeting on September 17, 2019. This meeting was an introduction and we will start recruiting for volunteer groups in November. The Volunteer Sign-up will be available on the Expo site again and we will start actively recruiting in January.

C-HEARTS African American Story Telling Project: On October 8, 2019 I attended a meeting with Rep. Carol Ammons and Tracy Parsons about the work of C-HEARTS. I have included the documents in my report about possible legislation to support Emotional Emancipation.

United Way ECL (Emerging Community Leaders) Alumni Committee: The Capstone Presentation was held on September 19. The teams presented their projects. The program will conclude on October 17, 2019. We will start recruiting for the 2020 ECL Classes and look at ways to be intentional about our reach.

National Federation for Children's Mental Health: "Earlier this year NFFCMH conducted a survey of our affiliate family run organizations to learn more about the services they provide and the populations they support. Using results collected from 48 Executive Directors, we created the report linked below to highlight work being done by family run organizations across the country.

This report is a resource NFFCMH will use in conversations with SAMHSA and other funding agents and partners to illustrate the need to provide greater resources so that family run organizations may continue and expand their work. It will also inform our efforts to provide training, technical assistance and other supports to our network.

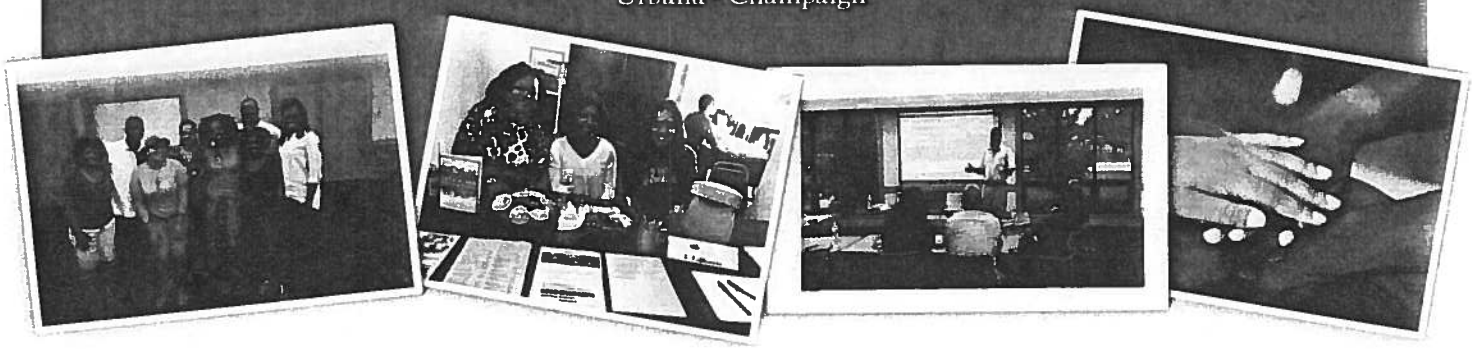
2019 October Monthly Staff Report- Shandra Summerville
Cultural and Linguistic Competence Coordinator

We hope you will take a few minutes to review this valuable information which offers a broad view of the services and supports family run organizations provide nationwide as well as the challenges they face in an ever changing landscape for families, child-serving systems and healthcare providers." The report is included as an attachment so that you can see how the family voice is impacted by the changes in the child serving systems and provide a reference for what we can do locally to support families.

I will be attending the National Conference on November 13-17 in Phoenix, AZ. I will learn about new research and trends that are impacting the families receiving services.

Community Healing & Resistance Through Storytelling (C-HeARTS) Collaborative

N. Chioneso, T. Dace, G. Dagher, R. Gobin, C. Hunter, R. Mendenhall, H. Neville,
H. Radcliffe, R. Robinson, S. Smith, & S. Summerville
Urbana - Champaign

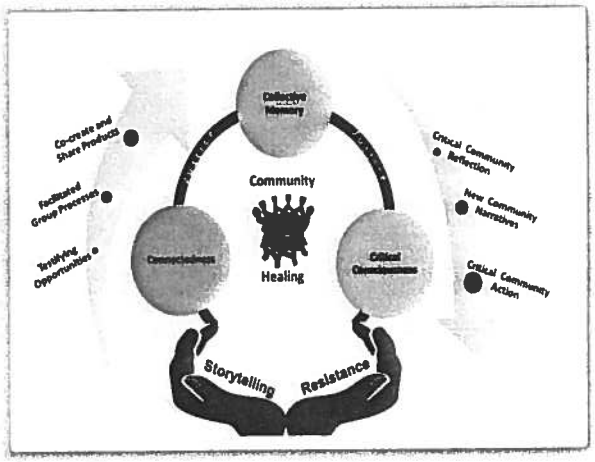


Who is C-HeARTS

C-HeARTS Collaborative is a group of interdisciplinary scholars and community members exploring community healing among African Americans living in Urbana-Champaign.

What are the Goals of C-HeARTS

- Build sustainable partnerships with community members, scholars, and professionals interested in African American community healing.
- Develop a framework of community healing through storytelling and resistance.
- Create and capture the perceptions of community healing through digital storytelling.
- Highlight community members' experiences with racial trauma such as gun violence.



C-HeARTS Framework

What are some C-HeARTS Activities

- Developed culturally relevant community healing framework
- Conducted focus group interviews
- Trained community members to create digital stories & produced 5 digital stories
- Hosted Voices of Community Healing Dialogue
- Facilitated community discussions about healing
- Sponsored talk by national consultant
- Hosted community lunch dialogue with local male community leaders, resulting in the establishment of a book club
- Participated in 2 community mental health fairs
- Assembled healing care packages
- Disseminating findings through community outreach and at least 3 research articles

Healing Care Packages for Community Members Affected by Violence

Policy Brief

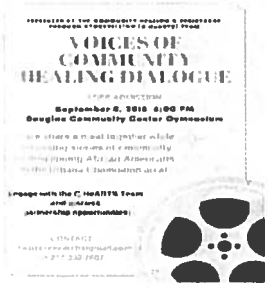
10.19

Community Healing and Resistance through Storytelling (C-HeARTS)

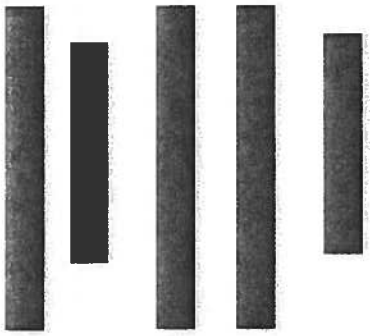
Mendenhall, R. Neville, H., Gobin, R., Smith, S., Hunter, C., Chioneso, N. Summerville, S. & Dace, T., Radcliffe, H., Dagher, G., and Robinson, R.

☎ (217) 972-1635 ✉rubymen@illinois.edu and CIMED-OfficeoftheDean@Illinois.edu

Racial Trauma



Scope of the Problem



Community Healing

Community & University

Policy Implications

400 Years of Racial Inequality

The year 2019 marks four hundred years since whites forcibly brought Africans to Virginia. Four hundred years of racial inequality has created historical trauma that negatively affects the health of Black individuals and where they live, learn, work, play, and worship. Historical trauma involves mass violence, in all its forms, with the goal of killing or wounding a certain group in ways that manifest across generations. Historical trauma creates racial trauma that is defined as real and perceived danger, threats, witnessing harm, humiliating events, and structural barriers (social and economic). Racial trauma is also beyond the control of individuals and emotionally overwhelming (Carter, 2007; Comas-Díaz, 2016). Despite 400 years of racial trauma, Black individuals have engaged in community healing through resistance and storytelling (C-Hearts).

Gun Violence in Champaign-Urbana: C-HeARTS Research Findings

C-HeARTS is an interdisciplinary team that includes community members and has a goal of harnessing the cultural wealth in Black communities to foster community healing. C-HeARTS conducted four focus groups to understand how the Black community in Champaign-Urbana experienced racial trauma and their cultural knowledge about community healing. During the four focus groups conducted, community members consistently expressed a concern about gun violence (GV). According to Christine Herman from WILL Radio, in the past five years, 35 individuals have been killed in Urbana-Champaign.

- → GV is repetitive and numbing and the justice system does not seem to care.
- → The consequences of GV exists within and across generations due to retaliations and children growing up without a parent. One participant stated you might hear, "You killed my cousin, so I'm going to kill your cousin."
- → Participants reported a sense of community stagnation when the same individuals are viewed as the leaders. In addition, there is a sense that over-policing stifles the creativity and imagination of community members.

GV concerns in Champaign-Urbana mirror state and national concerns with close to 40,000 individuals dying from firearm injuries in the U.S. (McLean et al., 2019)

The Role of the Community and University in Community Healing

Participants discussed the need for the village to take the lead in creating solutions and for the university and legislators to be active partners and share resources. The approach must be intergenerational with parents and youth at the table when identifying the problem and solution. Below are the community's recommendations.

"Where Do We Go from Here?" (Dr. King)

- → *Create intergenerational spaces in the community to foster belonging*
- → *Develop leadership pathways for all community participants*
- → *Create events where community members can work with legislators*
- → *Create culturally rich experiences where partners identify problems & create solutions (e.g., art exhibits, STEAM pipeline activities, etc.)*
- → *Fund Ancestry Testing and Return to Ancestral Lands*

APPENDIX 1: Youth Leadership Program

Policy Recommendations

Research show that when Black youth are engaged in civic engagement activities, it fosters their individual development (Sherrod, Tonrney-Purta, & Flanagan, 2010) and the development of the larger community (Watts & Flanagan, 2007). We propose a task force that unites the diverse gun-violence prevention efforts in the Urbana-Champaign community as part of comprehensive Black Youth Leadership Program. The program reflects the C-HeARTS community healing framework due to its focus on (1) connectedness (e.g., mutual interdependence and sense of belonging through activities such as testimonials), (2) collective memory (shared understanding of current or past lived experiences by events such as co-creating digital stories), and (3) critical consciousness (belief in ability to create engage in social change). The below recommendations are priorities in each of the healing areas that we have identified through our engagement with community members and our review of the interdisciplinary research.

Connectedness Policy Priorities

- *Create intergenerational spaces in the community to foster belonging*
- *Fund emancipation healing circles training for local community healers*
- *Implement emancipation healing circles*

Collective Memory Policy Priorities

- *Offer Black history and Black studies short courses and workshops for community members*
- *Fund ancestry testing*
- *Organize and fund return to ancestral lands study trips*

Critical Consciousness Policy Priorities

- *Create events where community members can work with legislators*
- *Support living wage campaign to increase minimum wage*
- *Develop leadership pathways for all community participants*

Potential Partners for Ancestral Lands Project

Civic Engagement in Tanzania. Helen Neville, email: helen.neville1@gmail.com.

Girls Like Me. Founder and Executive Director, Lakeisha Gray-Sewell, email: lgraysewell@gmail.com. Website: http://lakeishagraysewell.com.

The African Kinship Reunion. Reuniting African Families Separated During the Transatlantic Slave Trade. Director, LaKisha David, email: ltdavid2@illinois.edu. Website: https://takir.org/abouttakir/lakishatdavid/.

ACES in Ghana. Christy Lleras, Faculty Director, email: clleras@illinois.edu.

Namibia Project. Rodney Hopson, email: ltdavid2@illinois.edu.

Illinois Abroad and Global Exchange. Website: https://www.studyabroad.illinois.edu/about-us/meet-our-staff/.

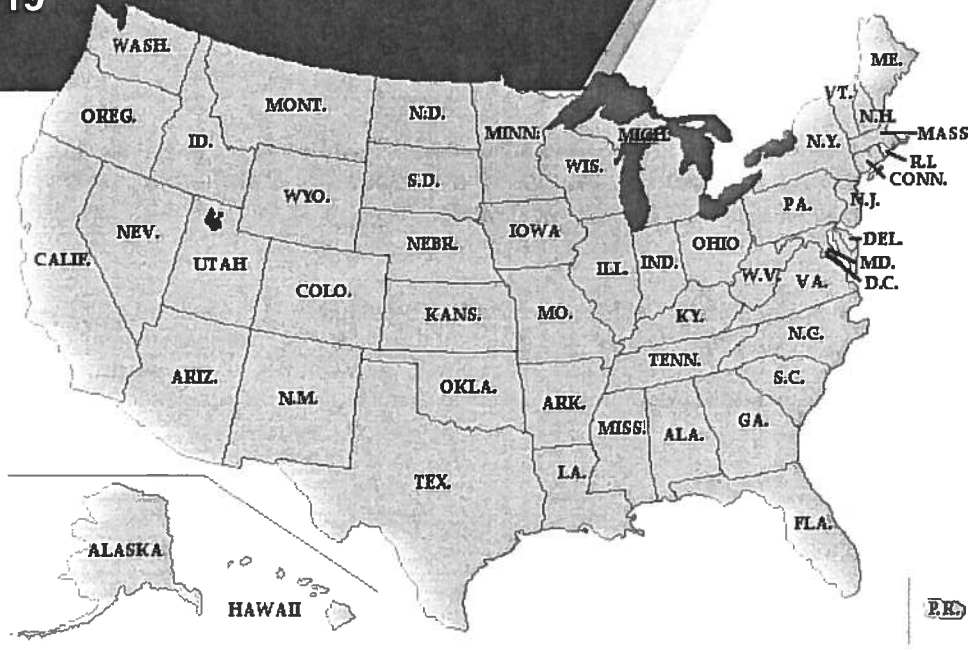
NFFCMH

National Federation of Families
for Children's Mental Health

Family Run Organizations: Nationwide Services and Supports Summary Report

A survey conducted by the National Federation of Families for Children's Mental Health

July 2019



NFFCMH

National Federation of Families for Children's Mental Health

Introduction:

Family-run organizations (FRO) grew out of a dissatisfaction for service delivery systems and a fundamental belief that families are the experts regarding their children's strengths and challenges. Supportive professionals played a huge role in the early years of the family movement and have remained steadfast in their support as these organizations have evolved to meet the needs of a rapidly changing environment. Currently, approximately 125 organizations and partners comprise the National Federation of Families for Children's Mental Health (NFFCMH) nationwide network. These organizations range in size from large, statewide to local, grassroots groups, all of whom play a vital part in their communities.

As the needs of families and their children have evolved, so have the services and supports that are provided by FROs. Diagnostics have improved and have revealed that our children and young people are often more complexly diagnosed than once believed. The drug crises that our communities continue to battle have left their mark on our families and their children and have created a need for expansive supports. As these dynamics have emerged, NFFCMH conducted a survey of FROs to determine how this evolving landscape has affected their focus.

Acknowledgements:

NFFCMH greatly appreciates the family leaders who responded to the survey (listed on the following page). This survey was conducted without the use of any federal or state funds and does not reflect the views, opinions or policies of HHS, SAMHSA, or CMHS.

Adults Pushing Forward, Inc./Young Adults Pushing Forward
Idaho Federation of Families for Children's Mental Health
Allegheny Family Network
Kentucky Partnership for Families and Children, Inc.
ASK Family Services
Keys for Networking
AspireHope NY, Inc.
Maryland Coalition of Families
Camden County Family Support Organization
MIKID (Mentally Ill Kids in Distress)
Champions for Children's Mental Health
Mini Minds Matter
F.A.C.T.
NAMI New Hampshire
Families as Allies
North Carolina Families United
Families CARE
Nebraska Family Support Network
Families Inspiring Families
Nevada PEP
Families Together in New York State
Oregon Family Support Network
Family Involvement Center
Passages Family Support
Family Support Network
Reestablishing the Villiage
Family Support Organization of Bergen County
SPAN Parent Advocacy Network (SPAN)
Family Support Organization of Hunterdon, Somerset and Warren Counties
Texas Family Voice Network
Family Support Organization of Passaic County
Texas Parent to Parent
Federation of Families of Central Florida, Inc.
The Struggle Within, Inc
Federation of Families of Florida, Inc.
The Younger Years and Beyond
Federation of Families of South Carolina
The Youth Mental Health Project
Federation of Families, Miami-Dade Chapter Inc.
Tennessee Voices for Children
Foster & Adoptive Parent Connection
Total Family Care Coalition
Georgia Parent Support Network
UPLIFT
Hawaii Families as Allies
Vermont Federation of Families for Children's Mental Health
HYPED4U Foundation
Wisconsin Family Ties, Inc.

Survey Description:

In March 2019, NFFCMH conducted a seven-question online survey that was sent to 117 FROs. A total of 48 responded to the survey (41% response rate). Questions included both multiple choice and narrative response items. The following report provides a summary of the responses.

Narrative responses are included in this report and are illustrative of the challenges that FROs are facing as they attempt to serve the evolving demographics of family units and the complex child-serving systems that these families are navigating. While this growth can be transformative for an organization, it requires careful planning and management.

Family Run Organizations: Nationwide Services and Supports

Q1: Please indicate which **categories of support** your organization provides, if "lived experience" is required of the parent/family peer supporters who provide the service and if specialized training is provided for them.

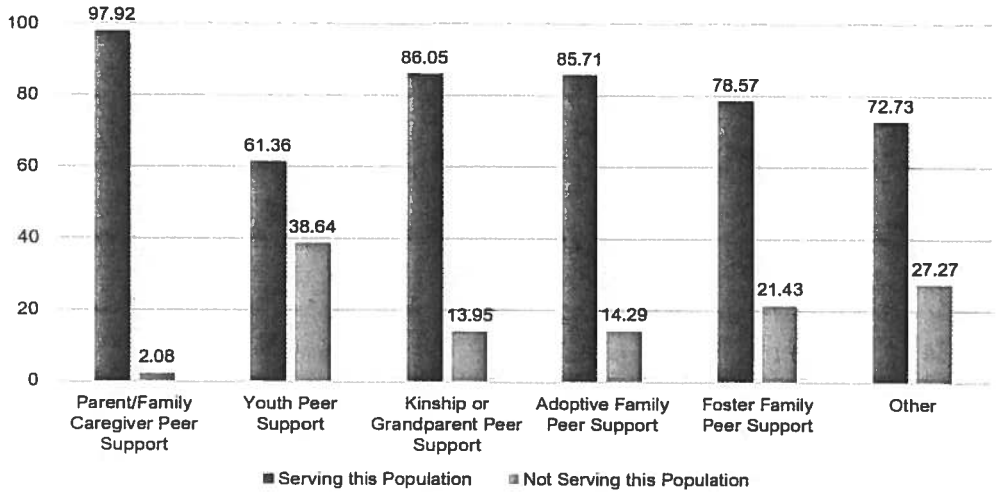


Figure A indicates that, while family peer support is provided by almost every FRO (97.92%) kinship/grandparent, adoptive, and foster family peer support are provided by a large majority of organizations.

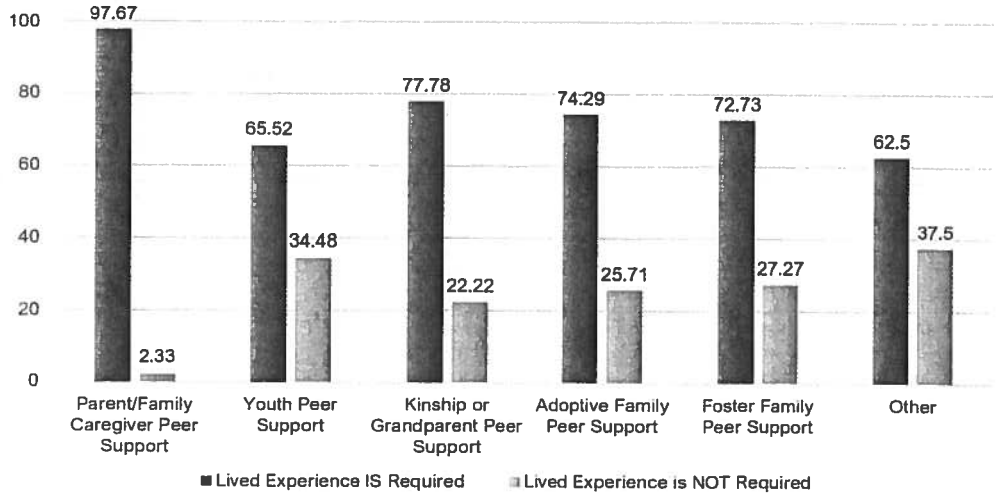


Figure B reveals that, while "lived experience" is an important value across FROs, only 65.5% report that this is a requirement for youth peer support.

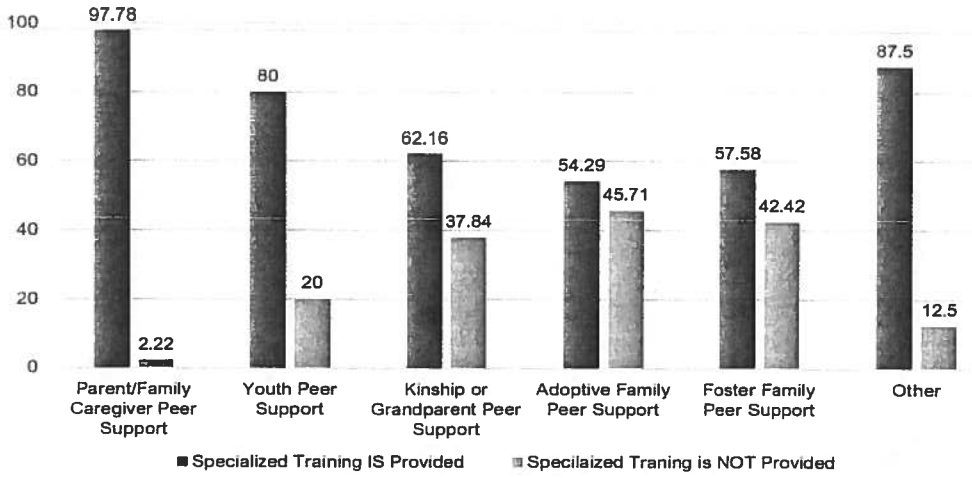


Figure C While it appears that specialized training for kinship, adoptive, and foster family peers is not provided at the same intensity as parent/family peer support, this data may be impacted by the comment shared by Kentucky Partnership for Families and Children "family includes kinship, adoptive and foster."

Please share any additional comments regarding the highlights or challenges related to the support your organization provides in these areas.

Federation of Families of South Carolina - We have affinity groups for grandparents and are working to build kinship caregiver support services.

Oregon Family Support Network - OFSN serves all families in need of support, however, we do not have a formal 'designated' service for foster families or kinship families. We are involved with discussions in our state re: Kinship Family Peer Support.

Families Together New York State - We provide statewide advocacy and information and referral.

MIKID (Mentally Ill Kids in Distress) - Lived experience does not have to be exactly matched. Kinship and Grandparent Support is offered by trained Family Support Partners that may not be Kinship Caregivers or Grandparents.

Families Inspiring Families - We would like to provide Youth Peer Support. We do not have a youth member on our team right now. If we did, the answers would all be YES.

Families CARE – Other: A parent peer support program for parents who have mental/behavioral health challenges themselves and need peer support for their own mental health needs, as well as parenting skills.

Vermont Federation of Families for Children's Mental Health - We may not have specialized funding for all the lived experience categories. We support all families who call our 1-800 line for support, although not all PSP's will have lived experience to match each family member calling.

UPLIFT - We support youth, kinship, and adoptive and foster families via our family support program.

F.A.C.T. - We have Parent Support Partners who support other parents. This includes PSPs who have been foster parents supporting other foster parents. But PSPs are hired because they are parents of a child with a disability, not specifically as a foster parent, etc.

Idaho Federation of Families for Children's Mental Health - Family Peer Support is about to start in Idaho. We will have a consultant role in the process and bring family voice, but not a delivery role in these services. More likely training, support and evaluation.

Foster and Adoptive Parent Connection - I serve both foster and adoptive parents and kinship families.

Federation of Families, Miami-Dade Chapter Inc. - We can only provide Peer Support to families referred to us by the Department of Children and Families that have an open case with them. We don't have funding to provide support to other families outside of this contract.

Mini Minds Matter - Lived experiences dealing with youth mental illness and trauma. Additionally, supporting veterans with mental illness.

Federation of Families of Florida, Inc. - The staff is trained to provide support to all populations.

Family Support Network - Montana annually hosts the Conference for Abuse and Neglect for all providers working with families. The topics are varied and cover a variety of issues facing families.

Families as Allies - Peer support for special health care needs. We are developing training for other areas beyond the core training, but it is not developed yet.

Family Support Organization of Hunterdon, Somerset and Warren Counties - Family Support Partners support the caregiver of the youth involved with CMO services. Lived experience is required. Grandparents, adoptive and foster families are all families that the FSO works with, but partners don't specifically have to be a grandparent or adoptive or foster family themselves. We provide statewide advocacy and information and referral.

Camden County Family Support Organization - We offer youth leadership, but not youth peer support.
SPAN Parent Advocacy Network - Families whose youth are involved in Juvenile Justice or Child Welfare.

Kentucky Partnership for Families and Children, Inc. - Family includes Kinship, Adoptive and Foster.

Federation of Families of Central Florida, Inc. - Kinship/Grandparent/Adoptive/Foster Peer Support lived experience is not required. However, two (2) staff members have lived experience in those areas and are linked with those families.

Texas Family Voice Network - Our focus is developing family leadership across systems, whether it is specifically toward the family leaders or educating the systems on how to work with families within their work.

Wisconsin Family Ties, Inc. - We provide peer support to any primary caregiver; we don't differentiate between the categories specified above. The training is the same, regardless of the population.

Adults Pushing Forward - We have experience with all scenarios and, if not, have training to be able to meet the need.

Q2: Please indicate if your organization provides support to families parenting children involved in each of these **child-serving systems**, and if "lived experience" is required of parent/family peer supporters who provide the service.

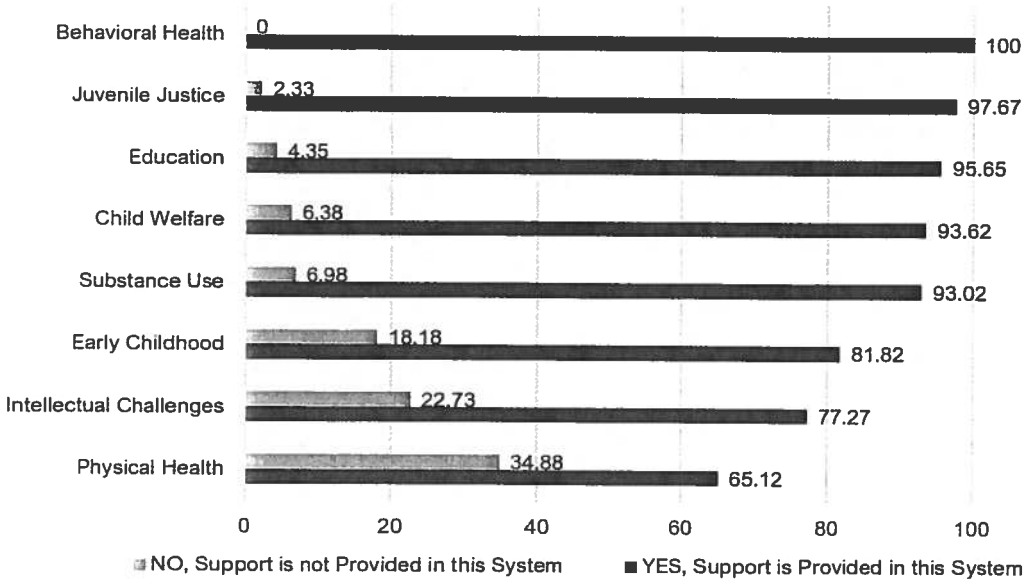


Figure A Over 90% of the FROs responding indicated that they support families and children navigating behavioral health, juvenile justice, education, child welfare and substance use child-serving systems.

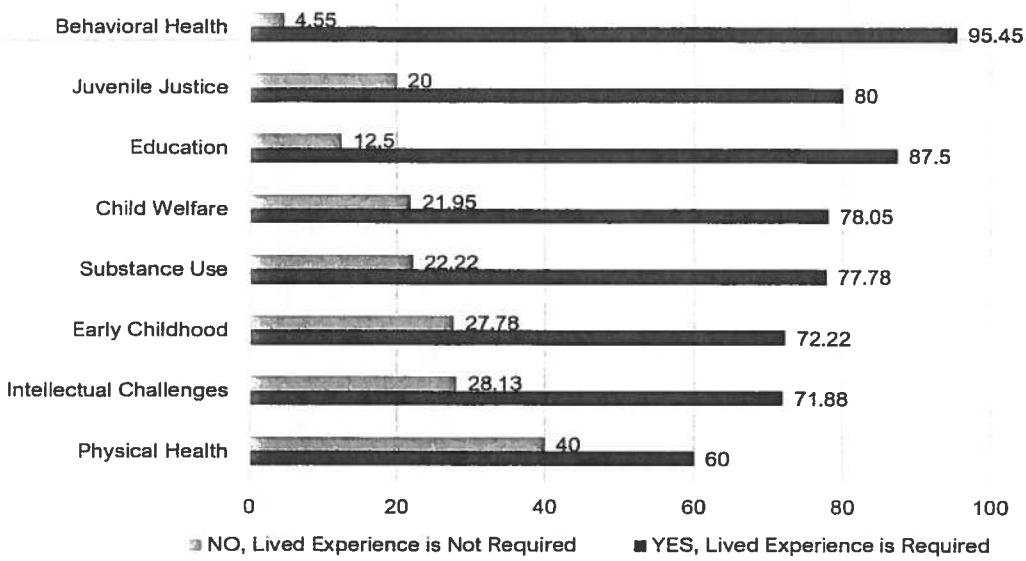


Figure B illustrates that FROs are strongly committed to providing families with support from peers who have navigated the continuum of child-serving systems. As reported, the majority of FROs require system-related lived experience across all child-serving systems.

Please share any additional comments regarding the highlights or challenges related to the support your organization provides in these areas.

Federation of Families of South Carolina - We support families with multiple experiences. We do not have many staff with lived experience in the child welfare system currently, but we do provide support.

Oregon Family Support Network - This is an area where OFSN is currently exploring future development - particularly in the child welfare and early childhood systems.

MIKID (Mentally Ill Kids in Distress) - Lived Experience does not have to be in the system the client family is engaged in. There must be a connection to Medicaid Behavioral Health system in addition to the other systems for us to be able to get paid for our services. Otherwise, we only offer Parent Support Groups and information and referral.

Idaho Federation of Families for Children's Mental Health - We work with youth with intellectual challenges, IF they also have a behavioral health diagnosis.

Vermont Federation of Families for Children's Mental Health - Vermont is a small state. We serve whoever calls us. We may not have funding for every category of peer support; however, we'll serve every family who calls. All our PSP's must have lived experience and are trained, although we cannot ensure a perfect match of lived experience between every family served and PSP.

Families CARE - Ideally, we would have lived experience in all the areas above and specialized training as well.

Foster and Adoptive Parent Connection - Support is for the parents or families for child advocacy.

Mini Minds Matter - Working as a SPED teacher, I deal daily with parents supporting them and their children academically, socially and emotionally.

F.A.C.T. - While specialized training may not be offered in some areas - resource development and communication support and information is offered in all categories.

Family Support Organization of Hunterdon, Somerset and Warren Counties - Family Support Partners must have their own lived experienced, so any of the lived experience categories could qualify them. Example: they may have raised a child with mental health challenges, but not substance use - they are still meeting the criteria to work with those families as well.

The Struggle Within, Inc. - Setting footprint and financial backing.

SPAN Parent Advocacy Network - We have staff who have experienced each of these systems working with families in these areas, but not everyone who supports families in each area is required to have lived experience with EVERY system.

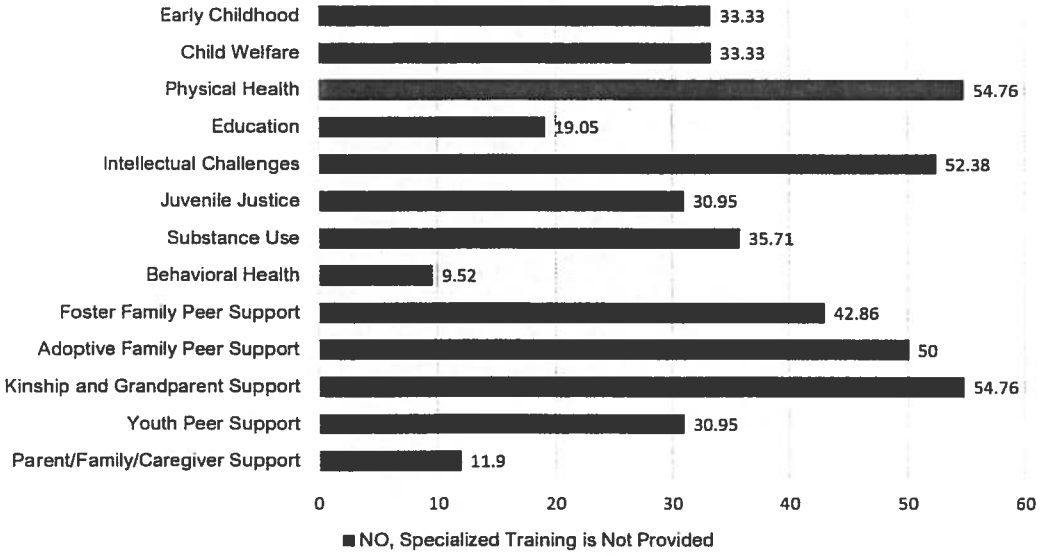
Kentucky Partnership for Families and Children, Inc. - "Behavioral Health" lived experience is the ONLY requirement.

Texas Family Voice Network - Working with families whose children are affected with physical challenges, our focus would be on integrated care including mental health challenges or dual diagnosis. It has been a challenge to identify families with early childhood experiences. The focus has been on mental wellness.

Wisconsin Family Ties, Inc. - We serve any of these, if the child has social, emotional, or behavioral challenges. The lived experience we require is not necessarily in each of the specified systems, although we train our staff in navigating those systems.

Maryland Coalition of Families - Problem gambling.

Q3: Please indicate all the categories where your organization **does NOT currently receive targeted training** that is needed to enhance staff skills and improve support services.



While FROs are providing peer support for a variety of family units and across multiple child-serving systems, 31% - 55% report that they are not currently providing specialized training across 10 child-serving systems. Per the narrative comments, several FROs are in the process of providing or accessing these trainings.

Please share any areas where training is needed that were not mentioned above as well as any additional comments.

Oregon Family Support Network - FRO's serve families in all systems - however the field of family peer support has not yet expanded into these sub-specialty areas of focus.

Families Inspiring Families - We work closely with our region and have access to all kinds of training usually without cost. We have received training in all these areas.

Vermont Families for Children's Mental Health - If we don't offer a standard training on these topics, we know where to request the additional training in our state.

Mini Minds Matter - Peer support.

Family Support Network - Parent engagement, Boundaries.

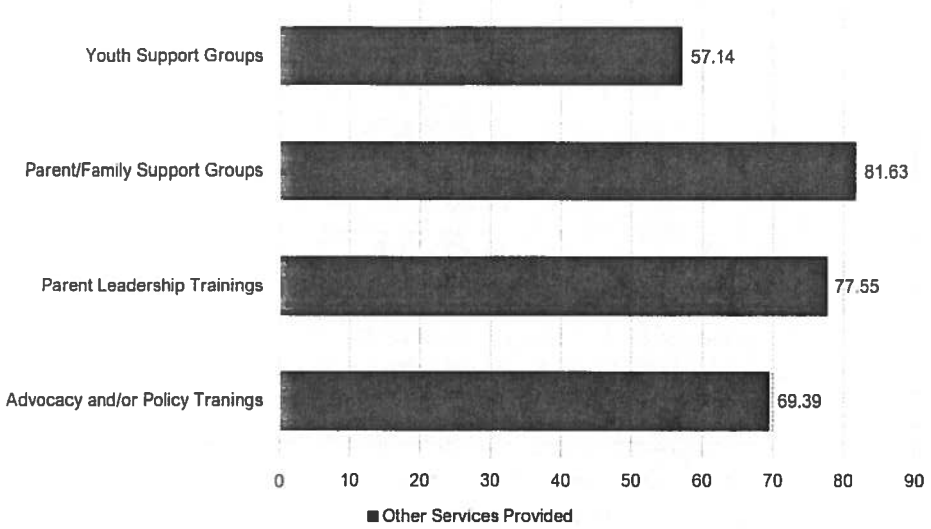
Families as Allies - We are developing these.

Total Family Care Coalition - Trauma.

SPAN Parent Advocacy Network - We are engaged in all the systems above and provide a comprehensive training for all our staff members and volunteers regardless of project or area of focus.

Federation of Families of Central Florida, Inc. - These trainings will be provided in the very near future.

Q4: Beyond Parent/Family Peer Support, please tell us what **other services** your organization provides.



FROs indicate that they are actively involved in several, core areas of support and training for families and youth.

Please share any other services your organization provides.

MIKID (Mentally Ill Kids in Distress) - Specialized services to custodial caregivers of children removed from the caregiver's care by protective services.

Families Inspiring Families - We provide Youth Crisis Response Services to families in crisis.

Families CARE - Family Outreach/Peer activities and events and referral.

Vermont Federation of Families for Children's Mental Health - We no longer offer support groups; we offer workshops on specific topics to existing support groups when requested.

Nebraska Family Support Network - Our staff members serve on committees and workgroups throughout the systems we serve.

Federation of Families, Miami-Dade Chapter, Inc. - Triple P Parenting, Afterschool Program at a middle school, Self Care and Enrichment workshops at our Center.

Federation of Families of Florida, Inc. - Mentoring, Summer Camp, Community Engagement, Community Gardening, Food Pantry, Open Table Faith Model, Coordination of System of Care.

Allegheny Family Network - Employment Specialist and Housing Specialist, Fathers support groups and trainings.

Family Support Network - Parenting classes.

Total Family Care Coalition - Capitol City Youth MOVE

Tennessee Voices for Children - Clinical therapy

Camden County Family Support Organization - Youth Leadership Groups

Kentucky Partnership for Families and Children, Inc. - Youth Leadership Trainings; Youth Peer Support

Federation of Families of Central Florida, Inc. - I.E.P. Trainings, System of Care Trainings, Youth Mental Health First Aid Training, WRAP training, Warmline Support, Monthly Family Educational Mtgs, Self-Care, Saturday Respite

Georgia Parent Support Network - Therapeutic Foster Care

Wisconsin Family Ties, Inc. - Training of child-serving professionals.

ASK Family Services - Youth Peer Support, Youth Move Chapter, SibShops

Adults Pushing Forward - Anger management, grief counseling, shoplifting, job readiness and a few others.

Q5: Please share additional comments regarding the **highlights or challenges** related to the support your organization provide outside of peer support.

MIKID (Mentally Ill Kids in Distress) - MIKID also provides school and community-based Suicide Prevention and Mental Health First Aid that is not funded by anyone in AZ. It is funded by community donations, grants and admin dollars. Families Inspiring Families - Our state recently added Peer Support to the Medicaid menu. The reimbursement does not cover basic cost of service.

Vermont Federation of Families for Children's Mental Health - Training funding is hard to come by and is the first to be cut in hard times. It is hard to get funding to just train families.

Family Support Organization of Passaic County - 1 - We need more help with tangible tip sheets or best practice models for teaming well with care management/wraparound facilitator organizations. 2 - We need not profit management and strategic planning training opportunities to diversify funding and strengthen the organization.

The Struggle Within, Inc. - Receiving financial support and grant writing.

HYPED4U Foundation - Finding affordable space or a building to use on a regular basis to host support groups, classes, and events. Finances are a challenge since the organization depends mostly on donations. We need a grant writer that is affordable. Idaho Federation of Families for Children's Mental Health - We are lacking many mental health services so knowing how to help a family can be challenging because the services and resources needed frequently don't exist.

Foster and Adoptive Parent Connection - Families need childcare services when they attend support groups or training, especially foster, adoptive and kinship where they are the only ones for support.

Nebraska Family Support Network - We are constantly looking for funding.

Mini Minds Matter - Having finances to provide quality trainings and opportunities in the community.

Federation of Families of Florida, Inc. - Funding is always a stretch.

Allegheny Family Network - We provide childcare and bus tickets for our events, trainings and support groups and stipends to parents who share their expertise.

Texas Parent to Parent - Highlights: Training for Medical Residents & Students 4 Conferences a year Challenges: Services to refer families to.

Family Support Network - Ability to hire trained staff and wages and benefits high enough to keep them.

Families as Allies - We do a lot of provider training on family-driven practice and education advocacy.

Total Family Care Coalition - Challenge is always funding and trying to become Medicaid billable.

Family Support Organization of Hunterdon, Somerset and Warren Counties - We must work within a very tight budget, so sometimes that alone is the challenge when there is something we would like to do with our youth who are in our youth partnership.

SPAN Parent Advocacy Network - Never enough money to provide these various types of support. Many varied cultural, racial, ethnic, language groups in our state that require targeted activities, but the end result is amazing! We had our biannual Parent Leadership Conference last Saturday where 320 diverse parent leaders (even dads!) who are leaders in all the systems mentioned above came together to learn, share, etc. Inspirational!

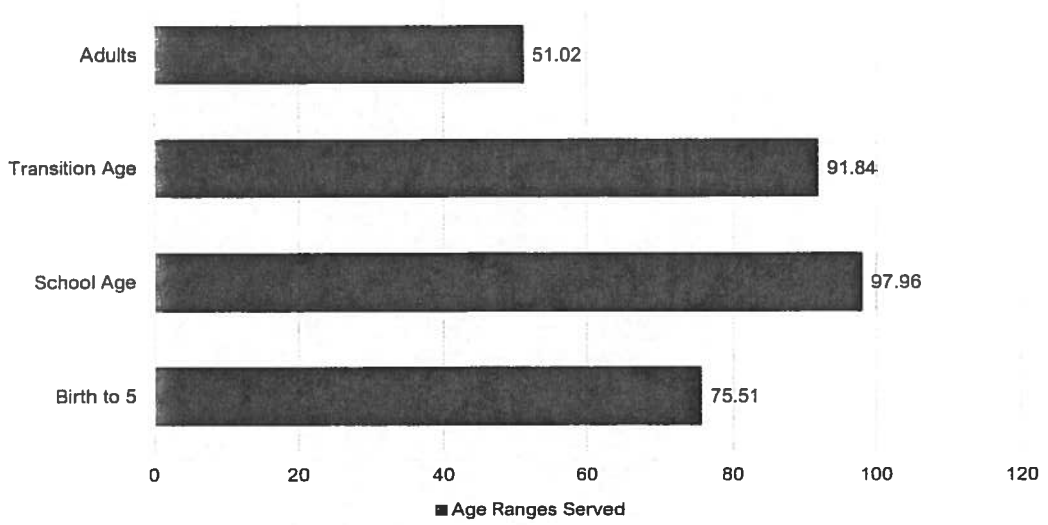
Federation of Families of Central Florida, Inc. - Funding to increase respite.

Georgia Parent Support Network – Funding

NAMI New Hampshire - While we offer a robust array of supports, and have a talented staff and dedicated volunteer pool, need always far exceeds our capacity to fill it. Advocacy is really important, but there are few sustained funding supports for advocacy efforts.

Adults Pushing Forward - Grants are needed to provide free services and supplies on a continual basis.

Q6: Does your organization provide support to families parenting a youth in the following **age ranges**?



Families are receiving support across an increasingly greater age span than previously reported. FROs are now providing support from early childhood through adulthood with the majority of support occurring during school age and transition age. Narrative comments indicate that states have varying definitions "adult", as does Medicaid and states.

Please share any additional comments regarding the highlights or challenges related to the support your organization provides in these areas.

Oregon Family Support Network - Families who are supported in our organization receive support regardless of their child's age.

MIKID (Mentally Ill Kids in Distress) - Adults only up to 25 as part of Transition Age program or a Parent of identified child/youth client in the AZ Medicaid Behavioral Health system.

Families Inspiring Families - For Peer Support we serve youth up to the age of 19. For Youth Crisis Response, we serve youth/families up to the age of 25.

Vermont Federation of Families for Children's Mental Health - We primarily support school age and transition age. Although we are increasingly supporting families with children 0-5 with extreme behavioral challenges.

Family Support Organization of Passaic County - We would do birth to 5, but we don't often receive referrals for this age group.

The Struggle Within, Inc. - Active participation. Accessibility to grant funding to do what I know I can be successful doing.

Federation of Families of Florida, Inc. - We serve the entire family and collaborate with other agencies to assist families.

North Carolina Families United - Young adults up to age 26.

Allegheny Family Network - Only adults up to age 26 if still receiving services and living in their parent's home.

Family Support Network - Long term engagement with families.

Champions for Children's Mental Health - Medicaid serves individuals up to age 21, however, Delaware legislation only allows Medicaid to serve up to age 18.

SPAN Parent Advocacy Network - Families of infants, toddlers, children, youth and young adults – birth to age 26.

Kentucky Partnership for Families and Children, Inc. - Young adults up to age 26.

Federation of Families of Central Florida, Inc. - Up to age 23.

Texas Family Voice Network - Our broad training focus is always in the development of family leaders across systems. We are not a direct service organization. Our emphasis is on the development of family leaders, regardless of the system(s) they are involved in.

NAMI New Hampshire - We don't get many inquiries about birth to 5 – other organizations specialize in that.

Adults Pushing Forward, Inc. - Sometimes transportation.

Q7: As you think about the full range of services your organization provides, are there **additional programs or services** you would like to highlight or additional challenges you would like to include?

Federation of Families of South Carolina - In past couple of years, we've begun providing Wellness Recovery Action Plan (WRAP) trainings to families and youth. I think this can be lucrative for organizations as we've had professionals request that we provide the training.

Oregon Family Support Network - Early Childhood - Supporting parents transitioning from Pre-K services to K-12, Supporting parents who are commercially insured - this has become more limited as funding for direct family peer support has been exclusive to wraparound and other Medicaid services more commonly found in public sector. School-based peer support and Community-based peer support would also provide opportunities for more families to receive support and may decrease the need for higher costing behavioral health services throughout childhood and would certainly improve outcomes for children and families.

Families Together in New York State - Family Peer Advocacy and Youth Peer Advocate training and credentialing.

MIKID (Mentally Ill Kids in Distress) - Higher funding levels in order to pay Peer Supports and other staff wages that are competitive. Walmart, Amazon and many other large employers in our area are paying up to $5 more per hour than we are able to pay for trained Peer Supports and workers that provide direct services to youth.

Families Inspiring Families - We are certified as a Circle of Security parenting facilitator.

Family Support Organization of Passaic County - We would like to do more community awareness and social marketing.

The Struggle Within, Inc. - Transportation and the need to travel and present NFFCMH as a chapter.

F.A.C.T. - We provide Educational Advocacy, are the lead agency for People First St. Charles, and then also have an eligibility specialist to help families get through the Department of Mental Health eligibility process.

Idaho Federation of Families for Children's Mental Health - We do not have parent or youth peer support in Idaho yet (there is limited Family Peer Support that was not rolled out well) which is a challenge when trying to find good family supports. Many of the therapeutic services needed are also not rolled out yet so the CANS identify the needs of the families, but the services are not there to plug them into.

Foster & Adoptive Parent Connection - Webinar support groups are a need, given the circumstance of childcare and transportation issues to identify parents and families' needs. Transitional services for young adults transitioning out of home.

Nebraska Family Support Network - We would like to get some sort of certification as an organization - not sure what other family orgs are doing in this area. Info would be appreciated.

Federation of Families, Miami-Dade Chapter Inc. - We would like to provide peer support to "anyone" walking in through the door of our Youth & Family Center, not just provide the workshops offered at the Center.

Mini Minds Matter - Youth support, family resources and life planning skills.

Allegheny Family Network - We are part of a grant called Steps 2 Connect for supporting the parents of a child that identifies as LGBTQ to help the parent accept the decision of the child promoting safety for at risk youth of suicide. We do research projects with PCORI around family wellness and school.

Family Support Network - Started patient therapy for families and children who have experienced trauma.

Total Family Care Coalition - We are a certified peer recovery provider.

Hawaii Families as Allies - We serve families who are homeless/house less through a partnership with our local family assessment center, a 90-day transitional shelter that works to send families into permanent housing after their stay at the shelter.

Tennessee Voices for Children - We are providing victims assistance, juvenile justice, and school-based services as well.

SPAN Parent Advocacy Network - We have volunteer parents, SPAN Resource Parents, who go through the intensive training that our staff goes through and they provide peer support.

Kentucky Partnership for Families and Children, Inc. - Kentucky Youth MOVE (State Chapter for Youth MOVE National)

Federation of Families of Central Florida, Inc. - MY Life Youth Group has been very successful in Orange, Seminole & Osceola Counties. Great partnership with Magellan Complete Care.

NAMI New Hampshire - There are many areas we would like to add but in particular transition age youth who are justice involved.

ASK Family Services - We are working on partnering with our CMH to begin providing more intentional transition services following the TIP model.

NFFCMH

National Federation of Families
for Children's Mental Health

Summary:

As the data reflects, family-run organizations have significantly expanded their supports to a much broader demographic of families and their children. Many FROs now navigate the breath of child-serving systems and support children, youth and young adults across multiple diagnostic profiles. This evolution is challenging the capacity of FROs to meet the hiring and training needs of an expanding workforce. As this new generation of families looks to the FROs for services and supports, the need to create new partnerships and identify new funding streams is of paramount importance.

Implicit in this evolution is the need for a more heterogeneous mix of family peers to ensure fidelity to the value of "lived experience". As noted in the data, many FROs are currently addressing this challenge while others are struggling to make this shift.

Q7 is particularly instructive as it illustrates the myriad of services and supports that the FROs are providing in an attempt to meet the needs of their communities. This commitment to meeting needs is taxing already limited resources and can overwhelm the capacity of the organization if additional funding and training opportunities are not available. To ensure that this expansion of services and supports to families is successful, the FROs will need strong partnerships with funders, child-serving agencies, and community leaders.

Chris Wilson - Staff report, October 23, 2019

Champaign County Mental Health Board

FY19 Revenues and Expenditures as of 09/30/19

Revenue	Q3	YTD	Budget	% of Budget
Property Tax Distributions	$ 2,284,412.44	$ 3,406,630.97	$ 5,001,938.00	68.11%
From Developmental Disabilities Board	$ 112,516.00	$ 281,290.00	$ 337,555.00	83.33%
Gifts & Donations	$ 60.00	$ 18,631.00	$ 20,000.00	93.16%
Other Misc Revenue	$ 32,010.00	$ 164,154.27	$ 45,000.00	>100%
TOTAL	**$ 2,428,998.44**	**$ 3,870,706.24**	**$ 5,404,493.00**	**71.62%**

Expenditure	Q3	YTD	Budget	% of Budget
Personnel	$ 132,565.44	$ 372,244.33	$ 542,252.00	68.65%
Commodities	$ 1,009.78	$ 7,259.90	$ 17,600.00	41.25%
Contributions & Grants	$ 1,466,226.50	$ 3,309,373.50	$ 4,347,815.00	76.12%
Professional Fees	$ 55,738.00	$ 134,273.61	$ 235,000.00	57.14%
Transfer to CILA Fund	$ -	$ 400,000.00	$ 50,000.00	>100%
Other Services	$ 16,075.49	$ 85,321.25	$ 211,826.00	40.28%
TOTAL	**$ 1,671,615.21**	**$ 4,308,472.59**	**$ 5,404,493.00**	**79.72%**

Champaign County Developmental Disability Board

FY19 Revenues and Expenditures as of 09/30/19

Revenue	Q3	YTD	Budget	% of Budget
Property Tax Distributions	$ 1,890,073.95	$ 2,818,573.56	$ 4,174,033.00	67.53%
From Mental Health Board	$ 100,000.00	$ 100,000.00	$ 8,000.00	1250.00%
Other Misc Revenue	$ 8,955.00	$ 17,620.19	$ 15,000.00	117.47%
TOTAL	**$ 1,999,028.95**	**$ 2,936,193.75**	**$ 4,197,033.00**	**69.96%**

Expenditure	Q3	YTD	Budget	% of Budget
Contributions & Grants	$ 1,197,271.00	$ 2,852,116.00	$ 3,809,479.00	74.87%
Professional Fees	$ 112,516.00	$ 281,290.00	$ 337,554.00	83.33%
Transfer to CILA Fund	$ -	$ 50,000.00	$ 50,000.00	100.00%
TOTAL	**$ 1,309,787.00**	**$ 3,183,406.00**	**$ 4,197,033.00**	**75.85%**