CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

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

Champaign County Developmental Disabilities Board (CCDDB) AGENDA

Wednesday, March 18, 2020, 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 Report – Lynn Canfield **(pages 3-28)**
7. Approval of CCDDB Board Meeting Minutes* **(pages 29-33)**
   Minutes from 02/19/20 are included. Action is requested.
8. Expenditure Lists* **(pages 34-39)**
   The January and February "Expenditure Approval Lists" are included in the packet. Action is requested.
9. New Business
   A. Mini-Grant Update and Requests* **(pages 40-42)**
      A Decision Memorandum offers updates and presents two recipient requests for reconsideration of components of their awards. Action is requested.
   B. Star Tribune Article **(pages 43-46)**
      For information only
   C. DSC Letter **(pages 47)**
      A letter from DSC CEO, Danielle Matthews, requesting approval to use CCDDB Community Employment funds as a match for their Donated Funds Initiative (DFI Title XX) is included for information only.

D. Board Direction

For Board discussion on Planning and funding. No action is requested.

E. Successes and Other Agency Information

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

10. Old Business

A. CCDDB and CCMHB Schedules and CCDDB Timeline **(pages 48-51)**

B. Acronyms and Glossary **(pages 52-59)**

A list of commonly used acronyms is included for information.

11. CCMHB Input

12. Staff Reports **(pages 60-69)**

For information are reports from Kim Bowdry, Stephanie Howard Gallo, Shandra Summerville and Chris Wilson.

13. Board Announcements

14. Adjournment

**Board action requested*

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

BRIEFING MEMORANDUM

DATE: March 18, 2020
TO: Members, Champaign County Mental Health Board (CCMHB), Champaign County Developmental Disabilities Board (CCDDB), Champaign County Board (CCB), and Association of Community Mental Health Authorities of Illinois (ACMHAI)
FROM: Lynn Canfield, Executive Director, CCMHB/CCDDB
RE: Legislative and Policy Conferences of National Association of Counties (NACO) and National Association of Behavioral Health and Developmental Disabilities Directors (NACHBDD)

Background

From February 29 through March 4, I attended Legislative and Policy Conferences of National Association of Counties (NACo) and National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) in Washington, DC. As NACBHDD's liaison to the NACo Health Policy Steering Committee and Vice Chair of Behavioral Health Subcommittee, I participated in related meetings. The following notes may be of interest to members of the CCDDB, CCMHB, CCB, and ACMHAI.

NACo Health Steering Committee, Joint Subcommittee Meeting

"Call to Order and Welcome"

- **Hon. Phil Serna, Supervisor, Sacramento County, CA** on our role in influencing federal policy for the benefit of our communities' residents: health promotion; disease and injury prevention; inequities; social determinants; long term care for the aged and people with Intellectual/Developmental Disabilities (I/DD).
- **Introductions of Vice Chairs, Subcommittee Chairs and Vice Chairs, and NACo staff/lobbyist Blaire Bryant,** followed by introductions of all present.

"Health and Human Services & Justice Workshop Overview"

- **Kirsty Fontaine, Health Program Manager, NACo:** partnering with Aetna on two-year Healthy Communities Challenge (to prevent chronic disease and improve health equity), with Johnson Foundation (looking at intersection of housing and health), and with Hilton Foundation (webinar on vaping policies); Healthy Counties Initiative advancing health equity and public/private partnerships, economic development tied to health outcomes.
- **Rashida Brown, Associate Program Director for Children Youth and Families, NACo**: Pritzker Children's Initiative (early learning/early childhood investments) evolved from Past President Brooks' Serving the Underserved initiative, with technical assistance (TA) to eight counties (including Champaign); developing a white paper on prenatal to 3; launched Counties for Kids, Prenatal to 3 (for county boards), Getting Started guidebook (for agency directors) with best practices and strategies; conference session on Expanding Services for Infants and Children (financing strategies); initiative with the ECM Foundation on career readiness opportunities for recent graduates, connecting counties to other systems.

"Suicide: Local Strategies for Tackling a National Epidemic"

BROOKENS ADMINISTRATIVE CENTER • 1776 E. WASHINGTON STREET • URBANA, ILLINOIS 61802
PHONE (217) 367-5703 • FAX (217) 367-5741

Suicide is one of ten leading causes of death in the US, and the second leading cause of death among youth 10 to 24. National rates of suicide for all populations have increased exponentially, rising 30% in half of states since 1999... a strain on local communities and systems of care, as suicide and nonfatal self-directed violence result in an estimated $69 billion in combined medical and work loss costs. Solutions must be as multi-faceted and diverse as the causes and begin at the county level. This panel discussed policy options for suicide prevention and examples of programs implemented that can be adapted in both urban and rural settings.

- **Commissioner Helen Stone, Chatham County, GA** introduced the speakers. Rural and youth suicide rates dramatically increased, overall increase of 60%. Emotional toll and financial impact, 24% of medical and work loss cost of fatal injuries. Not caused by any single factor; at least half of those who die by suicide do not have a diagnosed Mental Illness (MI).
- **Dr. Christopher Jones, Associate Director, Office of Strategy and Innovation, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention**: Increases since 1999, prior to which the definitions were different. Among those 10-34, it's second to overdose as cause of death; for 35-54 yo, 4th leading cause; in older groups, cancer and heart disease start having a greater impact. In 2018, 10.7m reported thoughts of suicide, 3.3m made a plan, and 1.4m attempted suicide; about the same number of deaths as opioid overdose; other parallels with opioid use disorder (OUD) in emergency room visits and reports of use. Demographic and geographic variation in suicide deaths help us understand who is burdened in our communities. Risk extends beyond mental health: relationship problem 42%; substance use 28%; job/financial problem 16%; recent or coming crisis 29%; physical health 22%; criminal legal problem 9%; and loss of housing 4%; along with mental illness, Adverse Childhood Experiences (ACEs), lack of connectedness, loss, stigma, personal/family history of suicide, barriers to care access, and availability of lethal means.
- Promote comprehensive suicide prevention using data advancements (emergency department (ED) syndromic data, innovative real-time social media to identify communities at risk, etc.), tailor and target the interventions, and monitor their impact. Roadmap: strengthen economic supports, strengthen access and delivery of suicide care, create protective environments, promote connectedness, teach coping and problem-solving, identify and support people at risk, lessen harms, and prevent future risk. Funding announcement is coming, through state health depts, with recognition that action is at the local level. See https://cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf for the public health holistic approach.
- **Dr. Anita Everett, Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA)**: This year, suicide deaths exceed opioid related deaths. A number of things happen before a suicide attempt; some communities have much higher rates than others. Several resources are available: Suicide Prevention Resource Center; National Suicide Prevention Lifeline; Service Members, Veterans, and their Families Technical Assistance (SMVF TA) Center's Governor's and Mayor's Challenges; several competitive, scored grant opportunities; and materials on the "SAMHSA store" section of their website.
- 4 pillars (with strategies from basic to best) to bring Crisis Services into 21st century, focus on the person:
  Someone to talk to (911 lifeline, call line with local knowledge, local call line with text and follow up);
  A place to go (general ED, ED with behavioral health capacity, crisis center);
  Someone to come to them (police/sheriff, trained law enforcement, mobile crisis unit); and
  Assured safe landing (natural supports, follow up after healthcare, clear accountable system).
- Use community data to target high risk communities; some counties have reversed their high suicide rates, so we look to them for solutions; use big data; several grants focus on counties, with good impact, but not sustainable after the grant goes away; veterans' suicide prevention through the mayor/gov challenge; Zero Suicide has a website with types of services and strategies; healthcare system makes a big difference; data from community Mental Health Centers (MHCs) in TN show success in reducing rates through Zero Suicide (includes flagging high risk folks). Train professionals (general, specialty, and other professionals).
- **Ms. Carol Moehrle, RN, BSN, District Director, North Central District Health Department, ID**: "Suicide in the United States" includes mapping of data from 2005-2015; stressors in rural communities include financial strain and economic stagnation, lack of access to health and behavioral healthcare, isolation (social, person, physical), and accessibility, availability, and acceptability of mental health (MH) care services, plus workforce issues.
- What Causes Rural Despair? MH disorders, history of childhood trauma, poverty and generational poverty, drug and alcohol abuse, chronic pain, and higher access to lethal means.
- Changing the Trajectory: improving access to service (more than half of counties don't have a behavioral health provider though they do have a public health dept); expand telehealth and tele-behavioral health;

promote suicide prevention efforts; support universal screening and access; strengthen surveillance and data collection. Use screening tools and hard handoffs of those who score high risk. Awareness - data, education, events and outreach, lethal means; Prevention – Question, Persuade, and Refer (QPR) training, Applied Suicide Intervention Skills Training (ASIST), Zero Suicide, Sources of Strength; and Support – Crisis Centers, Crisis & Recovery Centers, Mini Crisis Centers, Support Groups, Speakers and Champions, and behavioral health (BH) professionals.

- **Questions:** Webinar on Mental Health First Aid (MHFA) to provide training, to close the gap in BH vs public health? QPR can be online; extension units at land grant universities doing MHFA; lots of Crisis Intervention Training; United States Department of Agriculture (USDA) resources for BH; telemedicine; training and recruitment of people in rural areas to do this work; public health departments in every county due to 9-11. How do we have this conversation without increasing the # of suicide, given the impact of celebrity suicides? The stigma is very important, as are myths such as that talking about it will increase it; MHFA shares the message of what can be done to help early, works well in schools; de-intensifying the impact of secretive suicide thoughts; impact of sensationalism – media have been given guidelines but don't always follow. Info/materials on a partnership to provide better intervention, with correctional and law enforcement who deal with mental illness (MI), substance use disorder (SUD), suicide, and homelessness. USDA grants to land grants are under-utilized; if you receive one, SAMHSA will extend the use; a funding opportunity opens soon. In a growing rural area, where this has been swept under the rug but has a lot of interest from citizens, how to overcome the stigma just to assemble a summit to strategize best interventions? First raise awareness; sometimes everyone is doing the work but not coordinated, so a summit helps and should include partners such as Housing Authority, economic development, mental health providers, and more. Many technical packages are available to serve as a framework; set the expectation that a two-day meeting won't solve the problem; understand how the systems interact; make it a planning summit; get onsite technical assistance (TA). Scope of practice is hard for legislators to expand: physician assistants (PAs) and nurse practitioners (NPs) are moving into this space slowly; suicide is broader than healthcare. Health impacts should be considered in all policies, e.g., the built environment has road expansion but narrow sidewalks, front doors open the wrong way, all impacting our ability to connect to others, while a sense of community is a protective factor. Did the data include veterans? Yes. Many federal efforts beyond Veterans Affairs and facilities (VAs), including the peer veteran-to-veteran strategy.

"Maximizing Resources and Minimizing the Community Impacts of Rural Hospital Closures"

Counties support over 900 hospitals and annually invest nearly $83 billion in community health and hospital facilities. While hospitals are often the economic drivers of rural communities, 166 rural hospitals have closed since 2010, and 21% of rural hospitals are at risk of closing. Discussion of policy solutions and innovations at the federal and local level that help communities mitigate the challenges of rural health care providers and hospitals and ensure their continued ability to provide safe, high quality care to their residents.

- **Commissioner Gloria Whisenhunt, NC**: impact of hospital closures significant, poor health outcomes.
- **Ms. Sarah Young, Deputy Director, Policy Research Division, Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration:** "Researching Rural Hospital Closures" has several initiatives, recently Rural Community Opioids Response Team. Three main definitions of 'rural' come from Census, FORHP, and Office of Management and Budget (OMB) and don't exactly match. 57m rural residents are 18% of US population; 80% of land area is rural. High health disparities, especially in life expectancy, with consistent trend of decline. Rural Hospital Closures and Financial Distress are tracked to understand causes and consequences; one result is a predictive map; another is map of gaps in safety net provider distribution. Opportunities and resources include programs run through states, State Offices of Rural Health, direct support to hospitals (in persistent poverty counties); new opportunity through Rural EMS training and equipment grant through SAMHSA (open until March 30); upcoming funding opportunities (many on three year cycles, so plan ahead); Health Resources and Services Administration (HRSA)- funded information resources Rural Health Research Gateway and Rural Health Information Hub (run by librarians); HRSA funded Telehealth Resource Centers; FORHP Weekly Announcements (newsletter). syoung2@hrsa.gov.
- **Ms. Neleen Rubin, Consultant, Bipartisan Policy Center:** pull together stakeholders to develop solutions. A report on 7 midwest states, "Reinventing Rural Health Care," was completed in 2018; then convened a Rural Health Task Force to develop proposals to address hospital closures and improve access to rural health care; report due in April 2020, with legislators as target audience, will offer policy solutions

focused on stabilizing and transforming infrastructure, transforming provider payment and delivery systems, ensuring adequate workforce, and increasing use of telehealth.

- What are near-term solutions? What are long-term sustainability models? Refining policy proposals with broad stakeholder and task force input. Examples of quick actions: Medicare sequestration cuts keep the reimbursement below actual cost, should be at 103 or 104%; encourage Health and Human Services (HHS) to look at rules and update; take a look at each of the categories of hospital and see where permanent designations would be helpful. Visited 7 states to understand long-term fixes: use different models of care to address local needs, such as more outpatient/ER model, critical access cost-based, include flexible funding for non-medical supports (food security, transportation, health literacy), and test new models (global budget, managed to best suit community needs). See bipartisanpolicy.org or contact neleen@rubinhealthpolicy.com.
- **Mr. Nick Uehlecke, Advisor, U.S. Department of Health and Human Services,** on his own views of the issues: working with those who actually deliver services helps us effect policies. President and Secretary have declared rural health care as one of the biggest priorities this year; task force focuses on four points - infrastructure, technology, workforce, health disparities. Ability to seek treatment outside the ED (not equipped to handle or treat to stability) and addressing maternal health shortages are both critical. Several federal agencies impact healthcare; collaborate with Housing, Education, e.g. Conversations with USDA, which is the fourth largest bank in the world, include broadband infrastructure, also with FCC on billions of dollars' worth of grants to do this. Reimbursement structure doesn't allow many critical telehealth services, so policy work is needed as well. Recognition of cyclical impact of low reimbursement rates. Structured under a one size fits all system, the solution has appeared to be more money, but the systems also need to be different. Empower the individual areas to wrap funding into best approaches for their patients (e.g., pay EMTs to transport people to other providers). Contact Nicholas.Uehlecke@hhs.gov.
- **Hon. Tracey Johnson, Commissioner, Washington County, NC:** 12,800 ppl in her county; county hospital had been a 24-bed accredited facility with excellent service, serving the region, but was gradually diminished through various policy and payment pressures, came out of bankruptcy in 2013; in 2018, a whistleblower reported insurance not being paid though deducted from payroll, so they went into bankruptcy again; hospital closed; instead ran three trucks and transport trucks daily for a 1,000 mile area. Reopened the hospital on May 1, 2019. traceyj204@gmail.com
- **Questions:** How to expand the rural workforce? Training our own people and those who want to live and work in rural communities – a residency and development program funds hospitals to start rural-focused residencies; workforce also includes nurses, IT, paramedics, etc. What were major contributors to the rising costs, that put the Washington County hospital out of business? Increased costs plus non-payment, lots of indigent patients for whom no money was coming back; new hospitals get bigger reimbursements than older ones, making it worth it for them to build a new one; cost was too much, and hospital owes the county back taxes as well; NC doesn't have expanded Medicaid. Regarding mental health and dental care, HHS takes this issue very seriously (e.g., for kidney care, patients cannot have oral infection), looks to lift restrictions to holistic health care. Community health centers depend heavily on Medicaid – equity in pay is a real issue, so how do we braid other funding? Proposals to address that directly and also to use telehealth and expanded practice, more on the hospital side than on the community health center side; healthcare economics challenging for all in rural areas, with aging patients, aging buildings, declining populations, higher rates of uninsured and underinsured, and high deductible health plans; another HRSA project is Rural Health Collaboration Guide; frequently siloed.

NACo Health Steering Committee, Policy Coordinating Committee

Call to Order, Chair's Remarks and Introductions (Around the Room)

Hon. Phil Serna, Supervisor, Sacramento County, CA introduced Kirsty Fontaine and Blaire Bryant, NACo staff, Nick Macchione, FL, the HSC Vice Chairs, and subcommittee leadership. No questions prior to resolutions discussion. Review of procedures for considering resolutions.

"Health Resolutions Received Within 30 Day Deadline"

Policy resolutions are generally single-purpose documents addressing a specific issue or piece of legislation. Resolutions draw attention to a topic of current concern, clarify parts of the broadly worded platform or set policy in areas not covered by the platform. These resolutions are valid until NACo's 2020 Annual Conference.

- Proposed Interim Policy Resolution on New Restrictions on State and Local Flexibility to Finance the Non-Federal Share of Medicaid. Sponsor: Los Angeles County, CA Board of Supervisors; Clay Jenkins, Judge, Dallas County, TX. Judge Jenkins explained the background: 2019 Medicaid Fiscal Accountability Regulation (MFAR) includes very technical changes to Medicaid which would significantly impact counties' safety nets, if unable to draw down the federal match, services and access will reduce. Reaffirm our commitment to the partnership between counties and Medicaid. Commissioner Preckwinkle spoke in support. What was CMS' rationale? Better management of Medicaid program and oversight of how states and local gov'ts are managing it, in order to control spending; this mechanism may be an overstep. Why doesn't the resolution name MFAR? To speak to principles rather than specific rules; a block grant per capita cap would also be restrictive. In counties without this responsibility, how do states use it? Counties without county hospitals still have safety net responsibility, impacted by state-level cuts. Passed (will be forwarded to NACo Board.)
- Proposed Interim Resolution on Declaring Racism as a Public Health Crisis. Sponsor: Dennis Deer, Commissioner, Cook County, IL. *Withdrawn from consideration prior to this meeting, at the sponsor's request due to death in the family; it will be taken up in summer.*
- Proposed Interim Resolution to Increase Resources for Suicide Prevention. Sponsor: Helen Stone, Commissioner, Chatham County, GA. Overview, correction of typo, mention of SB2626 and 2628 (do not disrupt benefits for pre-trial detainees). Various edits were considered; praise for the resolution, review of its origins. Amended to broaden beyond Serious Mental Illness (SMI), given that some risk has other origins. The amended version passed.
- Proposed Interim Resolution on FDA Regulations of CBD and Other Cannabinoids. Sponsor: Ron Manderscheid, Executive Director, NACHBDD and National Association of Rural Mental Health (NARMH). Background: proliferation of products but no info about ingredients, no standards for efficacy or risk, FDA has a very slow process; increase the pace of approval and set up a process for reviewing other over-the-counter products for safety, purity, and efficacy. Passed.
- Proposed Interim Resolution Supporting an Amendment to the Federally Supported Health Centers Assistance Act Clarifying that County Mental Health and Behavioral Health Treatments Involving Court Ordered Patients are Covered by the Federal Torts Claim Act. Sponsor: The Association of Oregon Counties. Commissioner Bosevich: counties are the boards of health and most operate Federally Qualified Health Centers (FQHCs), have encountered an issue: a judge ordered someone into treatment at the FQHC; the person had a psychotic incident and murdered someone; the county was held responsible and is now suing the federal government on the issue of defending against such tort claims. This proposal ask to fix two areas of the law, clarifying that FQHCs offer behavioral services and shifting the source of potential remedies from counties to federal government. Passed.
- Proposed Interim Resolution on Addressing Community Violence as a Public Health Issue, cosponsored with Justice Committee. Susan Harden, Mecklenberg County, NC: holistic response; firearm deaths are 75% of homicide deaths in US; advocate for data collection on community violence offenders and firearm related deaths and for funding to tackle root causes, engaging with neighborhoods, local business, other stakeholders. Support for the resolution. Violence was in the platform already but not declaring community violence as a public health issue. Friendly amendment to add language about related deaths. Passed.

"Emergency Resolutions"

"Emergency" resolutions are federal legislative or regulatory matters that could not have been foreseen 30 days prior to the conference. Steering committees receiving emergency resolutions may consider them only if two-thirds of the steering committee members present vote to review them.

- Proposed Emergency Resolution Supporting Urgent Congressional Action for COVID-19 Response and Protecting Local Public Health Funding. Sponsor Derek Young, Councilmember Pierce County, WA. First US death today, in Seattle; need immediate action; the amount appropriated for Centers for Disease Control (CDC) is not adequate, and many public health departments have not recovered from economic downturn; put together with National Association of County and City Health Officials (NACCHO) who have a similar proposal now to Congress. 2/3 vote of the members supported discussion. Friendly amendment to add a clause requesting that Department of Defense (DOD) maintain jurisdiction over cases within their health system if there is adequate capacity to treat and contain the risk, due to the burden and risk to local governments. Two days ago there was a change in the communication process regarding COVID-19 (can't pass along info, which now all has to go through the Vice President's office, adding a great deal of time) –

another friendly amendment to the policy statement, to use the longstanding communication process in previous public health emergencies. The amended version carried. Now the friendly amendment, to use "Expanding" rather than "Protecting" and include counties among other units of government; support for the resolution. Motion carried. Thanks to the member who brought this matter.

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

- **Blaire Bryant, Associate Legislative Director, Health, NACo:**
- Key Accomplishments of 2019, some continuing: total repeal of the Cadillac tax - raising taxes on this would have harmed counties as employers; promoting MH and SUD treatment and criminal justice reform, through SB 2626 and 2628, president's budget request, NACO and National Sheriff's Association (NSA) joint task force report; met with all congressional committees to bring awareness to these issues and got the two bills introduced, hopeful for bipartisan support; working on companion legislation for the House; two lines in the president's budget supportive of provisions in SUPPORT Act allow continuation of benefits for six months and suspend the Medicaid Institutions for Mental Diseases (IMD) exclusion; task force report published, plus legal strategy asking whether IMD exclusion is a violation of the 5th and 14th amendments.
- Other priorities: advance legislation and administrative changes that will enhance counties' ability to provide services to prevent suicide; protect the Medicaid partnerships and contest work requirements; provide targeted funding and administrative changes to help counties combat addition and its effects. "Opioids in Appalachia" report has guidance which applies to all counties.
- Additional priorities: coronavirus (CDC conversation at tomorrow's session); invest in health care services and supports for older adults – very close to reauthorization of the Older Americans Act; ensure federal funding for and protect the integrity of key health safety net programs – big push to get these reauthorized.
- Thank you to the committee – this was a big year for policy, for our voice at the federal level.

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

- **Rodney Whitlock, McDermott + Consulting:** not much gets done in an election year; doing more depends on other policies.
- First example is surprise billing (e.g., thought it was in network but it was not) addressed in two bills, not very different and with room for compromise; some providers will lose out under any type of surprise billing arrangement, which may be hard for congress to act on in election year. If done, this impacts how much can be done for extenders, Delivery System Reform Incentive Payments (DSRIP), etc. Second issue is prescription drugs, which may go over well and be a bipartisan effort, if both sides recognize the problem and choose to show accomplishment to their constituents. Making community health centers permanent could be another. Possibly on opioids or prescription drug cures – but only non-controversial bills without much heft.
- With MFAR, the Centers for Medicare and Medicaid Services (CMS) is saying to counties and states that these strategies are 'sketchy', though it is how systems have been in place; this could be very disruptive to the way states fund programs and work with local partners, causing state and local tax increases to make the match. MFAR may be pushed prior to Memorial Day, or to after the election, or to go into effect later, causing state legislatures to come back to session to respond. If MFAR stays as is, significant changes in our work; push back against it should not be about transparency; negotiate net neutral cost as a last resort.
- COVID-19 has the potential to impact everything we're doing, taking our attention away from primary responsibilities. Show the value of public health, to do our jobs well, demonstrate clearly to constituents why the work we do matters (legislation, funding, systems, front line), in fact as critical resources. rwhitlock@mcdermottplus.com
- **Questions**: Medicaid work requirements? This has lost every time it's come up, as nowhere in the rules do we see "work" defined as a health benefit. It's different to treat with supports for employment and toward financial independence/away from entitlements. Health should not be political, but our local governments are increasingly divided, so how to heal from local up? Local govts with role in healthcare are constantly showing the value (economic, etc), and care is local, coverage different from treatment; MH is a bipartisan issue with passionate champions on both sides. Human Trafficking Task Force? No information yet.
- **Other Business**? More news – 2 new confirmed cases of COVID-19 (where the person died) plus 27 with symptoms, shutting down schools in WA. Communities lack the resources to respond quickly enough. Restricting travel for employees. A call to action, to use our excellent public health system as designed.

NACo Healthy Counties Advisory Board Meeting

Community health is strongly correlated with and dependent on the conditions in which residents live, work, and play. Counties are leading the charge to integrate health-based decision-making throughout various sectors. County peers and experts discussed using the social determinants of health to guide their work in creating innovative multi-sector approaches to health issues.

"Healthy Counties Strategic Priorities"

- **Mary Jo McGuire, Commissioner, Ramsey County, MN** recognized former chair and vice chairs. Parks Open Space & Trails (POST) is now a subcommittee of this committee. Review of our charge: create and sustain healthy counties by supporting collaboration and sharing innovative approaches to pressing health issues; identify priorities and ensure that county officials receive timely information to make appropriate health decisions for their counties; focus on public-private partnerships in local health delivery; access to and coordination of care for vulnerable populations. Review of previous programming: connecting and leveraging opportunities, addressing health disparities, linking with the justice system. Last year, we brainstormed to identify topic areas, which included food and nutrition, outreach, aging, maternal/child health, adolescence/youth, homeless population, social determinants of health, and more. Theme of health across the lifespan, "Living your Best Life" using the lens of equity. Consider a forum in NC in 2021. "Blue zones" about aging in a healthy way.
- **Brainstorming/Comments:** focus on Adverse Childhood Experiences (ACEs); reach out to National Association of Boards of Health to collaborate on policy positions; addiction and mental health; farmer suicide; healthy school lunches; trauma response and care (esp children impacted by gun violence); frame every area in a positive way, since we're not a policy setting committee; sleep deprivation as a public health crisis; climate change and the environment; prevention services, including healthy food for children; social isolation; overreliance on electronic devices; mortality in very young black children; time poverty.

"The Case for Health-Based Decision Making in Economics and Infrastructure"

Subject matter experts on the benefits of investing in infrastructure, particularly recreational spaces, to bring increased economic investment to communities. Insights from the report, "Equitable Development and Urban Park Space" with issues of place and infrastructure.

- **Mychal Cohen, Research Associate, Urban Institute:** affordable housing, neighborhood initiatives, community development. "Equitable Development Planning – Lessons Learned from the 11th St. Bridge Park" is a project in DC using development to create equity. These structures and processes can be adapted for parks planning. An old commuter bridge connected Wards 6 and 8, with plan for transforming the infrastructure to create a public park with cultural space, vendor space, learning space, etc. Project timeline includes predicting the effects (long before construction) on the surrounding community.
- Goals: Health: improve public health disparities. Environment: re-engage residents with the Anacostia River. Economic: serve as an anchor for inclusive economic opportunity. Families living east of the Bridge Park face more pressure to cover typical expenses like food, housing, and transportation; they are more rent-burdened than other district residents, will experience major population change/growth in the coming years, so this investment should not add to gentrification and displacement, rapid change that wouldn't serve long-term residents.
- Lessons: Start Early: in 2014, asking what equity would look like, how to drive more resources to long-term residents, over 100 engagement meetings toward a plan which was then used to engage more community members and partners. Engage Community and Partners: housing (wealth creation vs preservation) to engage with low income renters and create a community land trust, homebuyers' club, and tenants' rights workshops; workforce development training (e.g., construction); small business enterprise; and in response to cultural displacement, arts and culture space. Community-Driven Programming. Also important was a Community Leadership Empowerment Workshop to guide people to advocate for their interest. Iterate: when you understand an element is missing, be open to changing your plans. Developed logic models for all programs, thinking through how to measure (e.g., for Housing, where things had changed during the process, including timeline and expectation of leveraging city properties), identifying tangible metrics. Measure and Track Your Work: including structural barriers for people of color, leveraging Urban-Greater DC's research and resources (policing, housing, health and human services, buildings) and providing regular updates of national data sources like Census, summarizing at multiple

geographical levels; tracked parcels owned by the city to target the community land trust, articulate ongoing challenges (e.g., ownership is impossible for some). Good data, and we can communicate results but not necessarily impact on equity overall. New opportunities to leverage data, quantify economic impact, and institutionalize continuous improvement processes. See https://bbardc.org/equitytools/ and https://greaterdc.urban.org/ and https://apps.urban.org/features/dc-equity-indicators/ and https://nationalequityatlas.org/

- **Questions:** Fears of gentrification? People were anxious about displacement, divided responses among long-term homeowners and long-term renters, lots of diversity within the community which is seen as a monolith by outsiders. Composition of the Community Land Trust Board? Not specific opportunity zone funding for this project. Timeline for managing expectations esp for those excited early on and frustrated later? Be cognizant of how people feel when being studied, who never hear back from those doing the research or engagement, so build in touchpoints, interim steps, bringing people together through events or opportunities. Efforts to maintain the makeup of neighborhoods? Engaged with tenant organizers around preserving their buildings, and to take advantage of option to purchase; creating more affordable housing. Concerted efforts toward gentrification and pushing people out, but commissioners do not have power over real estate investors and rates to prevent it, so will home ownership be a thing of the past for millennials of color? Disparities between generations may be used for marketing, and millennials are interested in home ownership but may not be able to, so create other opportunities, make renting a sustainable practice to avoid harming future opportunities; appreciate the student loan burden on millennials.

NACBHDD Board Meeting

"Brief Updates"

- **Ron Manderscheid, DC** told us about the art in the room and the artist who created it.
- Prepare for COVID-19: operate your programs virtually; consider the impact on ppl with behavioral health or DD. National Association of Independent Schools' briefing on the changes needed. Impact on workers during crisis in that some will be unable to function or will accomplish very little, some will overwork and burnt out, and some will continue as they have. Suburbs of Portland. CDC presentation at NACo - we don't know much about it yet; prediction of vaccination within a year.
- "Under the Microscope" topics related to healthcare: if Medicaid block grants and fixed amount per client, within 5 years, you can fall behind financially by 25-30%; more frequent SSDI/SSI disability reviews mean to save $, but 35% of cases are due to MI/SUD and stay on much longer than those related to agency.
- NACo Legislative and Policy Conference resolution to protect the non-federal match of Medicaid (e.g., oppose MFAR) was passed along with other resolutions (see above).
- Tuesday Hill Briefing continues the work from 2019 to expand federal participation in Medicaid to include those incarcerated in city and county jails. Collaboration with National Sheriff's Association.

"NACBHDD Committee Reports"

- **President's Report, Bob Sheehan, MI:** evaluation of Executive Director, plans for this year, discuss frequency of committee meetings and need for staff support, sustainability of leadership.
- **Treasurer's Report, David Weden, TX**: some funds left from the Decarceration Initiative will be used and proposed deficit will be covered by this; outcomes initiative is included in the budget as well. The 2019 budget and balance sheet and 2020 budget passed.
- **Directors of State Association Committee, Cherryl Ramirez, OR**: planned conference agenda since September; as ad hoc legislative committee, proposed priorities; and listed awards for legislative reception. By-laws have outdated or inconsistent language; draft revisions will be reviewed in July and voted on in November, might also review terms and membership categories. Need new chair, may meet quarterly.
- **Behavioral Health/Decarceration, Lynn Canfield, IL**: based on outcomes white paper, outcomes survey is complete and pilot project being planned; quarterly webinars on state's Medicaid systems launched (MI in Jan, CA in April); beginning to absorb work of the Justice Committee and Decarceration Initiative.
- **I/DD, Sarah Jane Owens, OR**: each year we define 5 priorities; discussion of managed care; monitoring proposed changes such as block granting. Update on SB3220 and HR5443 (revision to 1915c waiver to ensure access to Direct Support Professionals (DSPs) for ppl with I/DD while in acute care in hospitals), sponsored by Portman & Gillibrand; also interested in a bill which adds DSP to work classifications and a bill regarding DSP wages. Planning for this summer's I/DD summit with topics on workforce efforts, peer

support, Medicaid and payer partnerships, and housing; change in the workforce at all levels; update on the MI/DD survey results; Maria Walker will take over the committee July 1; possible change in committee structure or schedule. Motion to support and write a letter of support for SB 3220 and HR5443 was seconded and was passed.

- **Communications, Rene Hurtado, TX**: changed meeting time to add members (second Thursdays, AM); focus on website and PR initiative with improved aesthetics and member-only access to articles. Neche Nelson added there were technical problems due to unsupported platform; it will be offline and rebuilt with tabs and new design and content; the portal manages memberships for NACBHDD and NARMH as well.
- **NARMH, David Weden, TX**: rebuilt website in a more current and editable platform; August 2019 conference in Santa Fe had over 300 people, in partnership with Technical Transfer Centers; 2020 conference in Portland, kicking off rural MH initiatives, possible international attendees. White House fellow working with Secretary Azar on most common causes of death (including rural suicide) to look at gaps in care and solutions such as MHFA, broadband, licensure, and Medicare. Partnering with National Council on their Hill day in June.
- **Dr. Manderscheid** – I/DD summit on July 19 and NACBHDD meeting July 20 and 21 in Orlando, FL, may be affected by COVID-19. Regarding outcomes project, Phase One was the paper, and Phase Two is the survey for which we are examining results, to see who is doing what and set a benchmark. Phase Three will be a pilot project possibly through state associations, selecting three states where all counties will use common benchmarks/tools, defining a period to implement, then collecting and reporting on data. Still moving toward value-based purchasing, so we want to have viable benchmarks. Regarding the decarceration project, we moved from two clusters of counties and to working with a state (KS) on convening counties and stakeholders to identify 2 priorities- regional crisis response centers and Medicaid expansion, which later fell through due to getting into other legislation; next how to build the necessary data-sharing platform/dashboard; will have a similar meeting in 2020 in a different state. In the early phases of planning another Hill Briefing on I/DD, to continue pushing for the initiatives brought in the 2019 Hill Briefing on transition age youth, under the Mental Health Liaison group. Suggest we follow the Babbin House Gov Tax Act (TX) HR838 and SB265 – examining whether the behavioral health threat assessment tool developed after the Reagan assassination attempt can be used to assess for school shooters.

"Brief State Updates"

How are states using Medicaid for justice-involved persons?
How are states using Medicaid to prevent incarceration of persons with behavioral health and I/DD conditions?
How is your state using Medicaid or other funds to address the opioid crisis?

- TEXAS: again in a state of flux, with Medicaid director leaving in May, ED leaving in two weeks, and the need to be negotiating waiver milestones (or payments will be reduced). Opioid initiatives delayed by contracting problems; responsibility for Medication Assisted Treatment (MAT) deferred through a University; procurement problems and lawsuits related to inconsistencies in scoring. For mental health, 14 'in lieu of' services are to be discussed with CMS, looking at 1115 waivers and Healthy Adult Opportunity waiver, which might not happen for political reasons; commissioners leaving by design, and decisions about health and human services very political right now.
- OREGON: after five years, submitted an SUD 1115 waiver with IMD exclusion and other good things like Medicaid reimbursable peer services (though some peers not excited due to the reporting requirements); using other funds for MAT and Naloxone. Remove legislative barriers to treatment for co-occurring disorders (includes I/DD); bill to provide match for Certified Community Behavioral Health Center (CCBHC) demo for the period it would be extended; all bills are stalled due to all walking out due to Cap & Trade bill, and the session ends on March 8.
- MICHIGAN: northern region community mental health (CMH) applied for liquor tax funds to put a case manager/counselor in the jail to provide services, reconnect benefits, and create discharge plans (two jails); part of the Stepping Up Initiative, moving toward data collection, with TA provided by Wayne State University, looking at Crisis Intervention Team (CIT) and crisis centers. Elsewhere a CMH uses the liquor tax in partnership with a non-profit to offer MAT in the jail, and upon discharge eligible for opioid health home (based on VT model); also a behavioral health home saved Medicaid (managed care and fee for service) $366 per member/month and an additional $100 in second year. With behavioral health staff in the jail, less impact of the limitations on data sharing; the positive impact of housing vs that Medicaid reimburses treatment only.

- VIRGINIA: deaths in jails have created focus on services in jail settings; working on Medicaid expansion. First time in 26 years, VA has a Democratic governor, house, and senate, now taking on gun laws (longstanding dichotomy between calls for MH reform and gun laws). New commissioner at Dept of BH/DD has only worked in private hospitals, is now completely absorbed in general assembly and doesn't understand the community systems yet. Department of Justice (DOJ) settlement agreement includes over 200 process and outcome measures, and integrity of data not going well so there will be more measures – due to exit the agreement next year. VA in a behavioral health redesign process, looking at the whole Medicaid plan with an already revamped SUD system, team of over 160, goals for comprehensive approach to services, filling in service gaps, and statewide expansion of successful programs.
- NEW YORK: last waiver rejected, doomed from the start. Both chambers and governor are Democratic, and some things are coming about, but learning lessons from bail reform - people get out before they can be connected to treatment, increasing the need for community-based care. Governor blames the counties for Medicaid excesses and trying to get the counties to pay more, but the counties are limited by law in the portion they can use for this. Impact of low wages for front line staff – got a 0.1% increase last year so they want a 3% for 5 years (fast food pays better at this point). $50K in Allegany for opioid can only be used for suboxone treatment in the jails.
- ILLINOIS: Opioid Response for 2020 – crisis hotline 24/7 getting lots of hits (mostly males in Chicago); Rx monitoring program but a burdensome process; public awareness initiatives; Good Samaritan Act is on the books but enforced differently around the state; 27 counties have student athlete pain management programs; expansion of services; MAT in 90% of counties; 3 recovery homes; correctional facility based MAT (naltrexone); Rush in Chicago is screening all patients; service enhancement for pregnant women; Oxford House model; expanded Naloxone use. Executive Order to address racial disparities, with $4.1m, because OUD rose in Black and Hispanic populations; extra money for related (needle exchange); #1 in tax revenue in first month from recreational marijuana. Locally, pushing out the info. Also 20% of marijuana licensing revenue for human services and 25% for the R3 communities (Champaign is one).
- MARYLAND: shooting in Annapolis a couple of years ago fit federal definition for public health crisis, moving to new interventions; federal opioid money for MAT in jails, using peers to walk folks from jail to community (many located in EDs); manpower vs cost of living, esp in this area. State law for crisis centers within 20 years; tried to extend services for 30 days post release, but it failed; put anything and everything which can be classified as medical into the fee for service (FFS) Medicaid and use state money to fund case managers to get folks eligible. Waiver for 30 days for SUD services; trauma informed assessments, CIT, and MHFA training for all. MH and suicide threats in schools; not much for alcohol and cocaine treatment.

NACBHDD Reception, with recognition award for Arapahoe County Commissioner Nancy Sharpe for her work with NACO and partners on improving health and behavioral healthcare for those who are incarcerated in county jails. Followed by discussion of "The Shake-Up" with the documentary's director Ben Altenberg.

NACBHDD Legislative and Policy Conference, "Building Resilience Amidst Rapid System Change"

"Welcome, Introductions, Overview of Agenda"

- **Bob Sheehan, MI,** NACBHDD Board President: praise for the conference and agenda.
- **David Weden, TX,** NARMH Board President: initiatives on rural mental health with English-speaking countries, with White House fellow, and partnering with National Council on Hill day.
- **Ron Manderscheid, DC,** NACBHDD Executive Director: Cosmos Club logistics; letter from Dr. McCance-Katz on using block grants for ppl who are incarcerated is very important, because if it can be done with block grants, it can be done with Medicaid. Review of agenda and recent newsletters (legislative priorities). Very special guest today is Teddi Fine who has written our newsletters and more for ten years.

"County and State Response to Mass Shootings: Report from El Paso and Dayton"

- **Kyle Kessler, KS** introduced the topic and panel. Each of our communities has had a mass shooting incident. Importance of a vibrant, functional safety net system. County officials and sheriffs see the value

of supporting behavioral health. Trauma response also depends on your neighboring providers. Crisis communications can be more effective if you plan and practice (and communicate in 27 words or less).

- **Rene Hurtado, El Paso, TX**: the August 2019 Walmart event was the 7th deadliest shooting in US history, racially motivated, and changed the community. Response continues today. Rene handled the media messages: first facebook message went out immediately with crisis contact info. Partners at Office of Emergency Mgt helped put together strategies, identifying who needed help, getting the voice of those community members most effected (includes faith based). Broadcast spots "El Paso Strong" - one with crisis line and MHFA #s and the other with testimonials, in English and Spanish, pushed out through social media with broadcast media support. Another community collaboration was through fundraising events, then deciding who would receive help (looking through their records to determine who needed it), along with financial planners. Media management mostly positive, as they know local media, but a few tough situations with national media. Careful to avoid 2nd amendment and border wall comments, focus on care.
- **Kristi Daugherty El Paso, TX**: right after the 911 calls, 2 of the therapists who respond with police calls did crowd control in the parking lot; then staff were deployed to various sites (also have staff working in the jail); immediate behavioral health support for the first responders, the families in the hospitals, 911 operators, important that trust and relationships had been established ahead of time. Another critical partner is victim services/advocates, with Family Information Centers. Able to manage the first 72 hours and get things organized; on day 4, brought in other supports but did have to push back against state authorities telling them what they needed. Managing volunteers was a full-time job. Strategic with use of neighboring supports; as a border community, also had to support Mexican citizens with bilingual counselors from other parts of TX, transitioning these for weeks at a time (here the state was very helpful and coordinated these). Afterwards, mandated some time off (paid and not deducted from benefit time), and brought in lots of checks and supports for staff; including at six-month anniversary. Community recovery center was up within four days (board gave approval for all). United Way ran the Family Assistance Center. Know your role and don't overextend yourself. Tragedy doesn't bring out the best in people (e.g., ppl seeing the influx of money), a challenge to prioritizing. Hold your breath and jump in. The shooter was brought into the jail, where their staff had to assess and interact with him; media wanted to ask questions, need to protect the staff from the media and impacts of the work. Did not put anyone in front of a camera for a week. Used a partner psychiatrist to do the interviews, to protect their own psychiatrist, who worked with the shooter.
- **Helen Jones-Kelley, Montgomery Cty, OH**: started brewing in May, with a KKK rally on courthouse square, same day as 15 devastating tornados, and coalesced over the summer to the August 4 mass shooting in the entertainment district. Law enforcement showed up in minutes. Received a call immediately, as these relationships had been built in regard to post-tornado efforts. Ppl looking for their loved ones needed immediate support, as did law enforcement and other crisis responders (we don't have enough of them). Managing the secondary trauma through a fully trained cadre is so important. Regarding neighboring networks, Dayton has many neighboring states and communities, highway access, so there was a need for coordination; also had to tell the state that they knew what they needed and would ask for help when ready. Good support from crisis responders from other counties. Internal communications also created through collaboration and run almost immediately after the crisis; behavioral health staff shouldering most of it, so they needed downtime, brought in their own families to volunteer and be together, and had many supportive events to keep the team moving. Re social media and external communications, learn from other communities; mayor and state director very helpful; used "Dayton Strong" to frame message that resonates; MHFA is a good response for those who want to 'do something' and be helpful. Ran the Family Assistance Center, used relationships to get necessary records from other departments, became the lead in modeling the responses. Remain clear-headed about political aspects, be strategic about charitable donations and existing resources because media swoop in to get the story while you're trying to support families in safe space. Some victims of such tragedies travel the country to these scenes, adding to the chaos. Media overuse of "mental illness" to describe everything bad that happens; moved the narrative toward protecting children from impacts of gun violence, to win people over rather than alienate them on the 2nd amendment issue. Also need equity conversations and training so that those effected can actually use the help.
- **Joseph Parks, DC, Medical Director, National Council for Behavioral Health**: in the wake of such events, ppl live at the bottom of their brains. Panelists' responses were so good, asking people what they needed, meeting them where they're at, accommodating those who needed 'something to do' to feel helpful, and staying focused, rather than administering MH assessments. Broad public health cultural interventions emphasizing connection (as opposed to data such as # new cases of PTSD). Keep it local for as long as possible. Stress debriefing should not be done with a large group of strangers, better for a small

group who've worked together for twenty years. National Council released "Mass Violence in America" – useful for pre-planning, includes talking point on MI and shootings. We have not been as serious about this as about other public health crises (e.g., plane crashes, which are about as frequent); need a standard definition of mass violence, clarity of standards for the role of MI, and standard reporting system. Policy position: if we were serious, we'd have something similar to the National Transportation Safety Board.

- Asked the panel about subsequent actions toward improving the response if it happens again. In OH: anti-stigma efforts; embedding lessons into other systems, e.g. YMCA yoga instructors are all trained in MHFA; using BH funds to give Y passes to all families living in the areas of these crises, to emphasize wellness; offered gun locks at no charge (manufacturers even donated many). In TX: non-traditional supports to train; trauma and self-care, talking about MH instead of MI as a community; for future, conversations about working together, and MH provider has authored the disaster preparedness plan; local trauma councils didn't include behavioral health providers, now central, training all in MHFA. Many gun owners with MI will agree to let a family member hold their guns when they become symptomatic.
- Other ways to engage the community early: threat assessment and management teams to gather info, not a one time but ongoing law enforcement care management. No firm evidence supports a specific gun restriction; however, a manual designed for ppl transporting guns across the states had 8 categories of possible gun laws, which researchers used to quantify restrictions and compare with incidents, giving mild-moderate evidence that overall restrictions do have an impact on lowering incidents. Regarding the on again and off again assault weapon ban, the rate of mass violence steadily increased during and past a ten year ban. In the 17 states with extreme risk protection orders (DV, e.g.) extended to non-spousal situations, there is clear evidence that they reduce suicide by firearm; mass shootings are comparatively rare, so it's harder to identify an impact like that.

"PANEL: State and County Progress on Medicaid"

- **Kana Enomoto, McKinsey** chaired the panel, introduced the panelists. McKinsey has a Center with goal to make big advancements in historically under-invested areas for the benefit of society: SUD, MH, Rural Health, Social Determinants, and Maternal Health. Work on the payor and health systems sides. Invests over $9m/year into analytics, supports Shatterproof in their development and execution of national strategy to reduce stigma around OUD. Behavioral health theory of change; public sector does better at delivering evidence-based care than the commercial side does, so take those lessons from Medicaid to private plans.
- **Josh Rubin, Health Management Associates:** think back to Dorothea Dix and see the increase in rate of change, tremendous increase in government investment (then regulation), emphasis on bringing service delivery system into communication with other systems and to integrate behavioral and primary care, all coupled with increasing complexity. We have Medicaided the BH service delivery system, move to Value Based Payments (VBP), while the people making state level decisions may not realize the implications, huge impact on service delivery. Managed Care (MC) plans to take more responsibility for the social determinants, so they will eventually look to the state for those funds as well; Medicaid system is becoming the vehicle for funding many things not traditionally seen as behavioral health services. Biggest impact on quality of care, driving performance metrics into how we care for people, requires a very robust data infrastructure; systems are collectively purchasing these data warehouses; the demands of data are having unintended consequences on providers. Because BH has spent the last 50 years with one foot in medical and one foot in social services, they do know social determinants, but the systems do not use a common language or collaborate naturally – the BH system can create coherence, help meet the needs of ppl where they are. Funding should flow to that work.
- **David Weden, TX** looking at CCBHC potential, but not an expansion state; only 40% of those served have coverage, so how to make a diagnosis-based eligibility so that those with SMI are covered? If not an option by April, there will be additional cuts, and meanwhile, turnover in leadership threatens this progress. For telehealth, working with the state to get codes converted. Another bill was passed to look at 'in lieu of' services, to count toward medical loss ratio; initial list of 14 BH services submitted, among them Assertive Community Treatment (ACT) and respite residential. Pilot to carve in transportation to the Managed Care Organization (MCO) contracts, adding Uber; still educating MCOs on needs of this population. Integration of services based on where a person is and what's important to them; many types of integration currently. Working with the 13-14 CCBHC sites which kept their certification and were built into the state's strategic plan, on more certification within the next few years, all required to do some sort of VBP (sometimes very simple measures), often following the MCO measures. Results in regular data sharing and meetings to

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discuss trends and enhancement of care based on the population analysis. 1115 waiver has helped advance the data points. As we work through these, also saving money in juvenile and adult justice systems. When working with health and human services commission, track Medicaid savings separately (silos still exist).

- **Michelle Cabrera, CA:** 13m beneficiaries in Medical; communities of color are overrepresented in Medical but also are majority population; carve-outs for disabilities; a change in administration shifts from local control to a whole new approach, including implementation of ACEs screening in primary care, and moving from an admin perspective to beneficiary-focus, lots of programmatic changes which were long overdue. Managed care final rule implemented, to pre-paid plan, with network adequacy standards that include network capacity certifications of such high bar (esp for specialty mental health plans) imposed not through law but in a powerpoint presentation and overlaid on a workforce shortage. Off-book-to-Medicaid (crisis continuum, e.g.) costs complicate things even more, as there is so much more safety net than Medicaid pays. 1115 waiver has been the vehicle, but to create budget neutrality, they pulled in systems no longer an option; now mgd care moving into 1115 alongside behavioral health plans; developing a new strategy, moving away from 1115 and toward 1915b. Waiver renewal effort around CalAIM has positive elements: redefining medical necessity for children and adults (pre-diagnosis, through a problem list) plus payment reform. Also integration of specialty mental health and drug plan to have one plan, tackling issues such as 'in lieu of' services, bringing together the pilots which worked; enhanced care management may be slightly oversold. Push to pay for housing itself rather than navigation to housing (when there isn't enough housing). Stronger contractual relationships and partnerships, better data and data systems.
- **Bob Sheehan, MI** a managed care state since 1997 but managed by CMHs which also serve as providers, organizers of care, community conveners. Moving to VBPs, a year-long training by folks who've done it. 2m ppl on Healthy Michigan, same benefit as traditional Medicaid (MAT services almost everywhere, with counseling component) and adds an Autism benefit ($300m). In the middle of all the good news, released a paper regarding the perfect storm from 2014, when capitation rates began to fall behind the demand, rates were cut, the guarantee of cost neutrality (cut general fund), and no risk reserve (which was guaranteed but didn't happen). Fiscal fragility. Market is there, so there's pressure to push back, hopeful about public/private partnership, to serve as social safety net on the Medicaid side with private physical healthcare, and offer the benefit to those with SUD, SMI, and kids with SED. Move to real integration of care and then build the payment systems behind it; some patients want care integrated with housing, some want it coordinated with school or foster care; paying for outcomes vs capitated or case rate (which frees the practitioner to do the social determinants and case mgt most effectively and individualized); private sector part of our work is real, and there are for profit orgs who believe in this work; a concern about gov't not being responsive to issues when they've contracted out to mgd care; real-time clinical data difficult between systems, even when clients want it; population health interchanges help where claims into electronic health records (HER) don't.
- **Questions**: What's the most important thing members can do to prepare for the coming changes in Medicaid? Answers: David Weden – data, understand the measures, speak the same language as the MCOs, understand actual cost prior to setting up VBPs. Bob Sheehan – we aren't just weather predictors but also have an impact on what happens; BH is a holistic, ecological view on humans, and we can't lose that core ethical base. Michelle Cabrera – our duty is to explain why some theories don't match up with experience; some double speak from medical (stigma) requires us to push back and educate; also fix 42 CFR. Josh Rubin – danger of going back to the medical model, so we should 'behavioral health-ize' the medical system to see more funding flow this way (we spend twice as much on healthcare as other countries). Commercial claims data show 25% of ppl with behavioral health account for 60% of healthcare costs, but less than 15% of healthcare costs are for BH care. Counties have lifted up Early Psychosis programs, which are being used by private insurers, but they're not paying counties for that. What have counties used the CCBHC funding for? Answers: whole care coordination; data infrastructure and service expansion (workforce); seeing people more quickly; less concern about diagnosis and more focus on need.

"Key Developments in the Medicaid and Medicare Programs"

- **Lynn Canfield, IL Chair**, introduced the speakers and topics.
- **Kirsten Beronio, National Association for Behavioral Healthcare** (formerly with CMS) gave a brief overview of Medicaid, including an important new benefit in Medicare. 1115 demonstrations in SUD and SMI to improve access to continuum of care; enable federal financial participation (the 'Medicaid match') for services in IMDs. There is overlap between these two initiatives. Also encouraging states to build community care, assessing services capacity and crisis services (recent CMS guidance, regarding hours,

credentials, standards). In crisis service settings, screen for comorbid conditions and follow up in 72 hours; licensing and accreditation rules; quarterly updates by states; expectations that states improve care coordination and use of assessment tools.

- 2 states plus DC have the SMI/SED demonstrations; several have applied for the SUD. 30-day limit on inpatient due to advocates' strong concern about drawing money away from community-based care. See Medicaid.gov under "Federal Policy Guidance" and 1115 state demonstrations.
- Ongoing work to implement the SUPPORT Act: to cover SUD treatment in IMDs, through State Plans; exception for pregnant and post-partum women with SUD; extension of enhanced match for health home benefit for SUD, at 90% match for 10 months; CCBHC extension for the 8 pilot states, and the health home demo covers those services as well. $48m to 15 states to assess SUD treatment needs and provider capacity; 5 of them will later be selected for implementation grants. Expect additional guidance on Medicaid coverage for housing supports and more. Definition of Qualified Residential Treatment Program for youth with SED. President's budget includes some language on IMD exclusion (more in the SAMHSA session below) and to extend benefits to pregnant and post-partum ppl one year.
- **Lindsey Browning, National Association of Medicaid Directors**: NAMD represents state and territorial Medicaid Directors, facilitates peer support and shared data, advances legislative priorities at the federal level. Medicaid is the largest item in state budgets, covers 1 in 4 ppl in the US, and is transforming from pay for volume (fee for service) to pay for value.
- Continuum of Care and Community Capacity: barriers in inpatient services due to IMD exclusion, with possible solutions through the 'in lieu of' option in managed care and using waivers to lift IMD (partial); lack of capacity to deliver services, so they send people to other states or just don't provide the care. A Kaiser budget survey found that 43 states were doing something along these lines. Still talking about integration of Primary and Behavioral Healthcare, at various levels, a marathon rather than a sprint.
- Value Based Payment (VBP) and Social Determinants: incentivizing positive changes, social supports beyond treatment; improvements for children in foster care.
- Direction of 1115s includes the new Healthy Adult Opportunity waivers (block grants, including to close formularies and expand coverage to childless adults, but states will be agreeing to take on great financial risk); for SMI waivers, most states are still assessing. North Carolina has a Social Determinant of Health waiver. Other factors to consider are the requirement for budget neutrality, increased expectations for monitoring and evaluation, and reserving 1115 for true experimentation.
- Two other federal happenings: focus on program integrity and oversight regarding what can be used for match – the proposed MFAR would impact local match more drastically than intended, beyond fixing the oversight problems; eligibility and payment – need to balance people's entitlement to services with program integrity. Continue partnering, there is much left to do to eliminate silos.
- **Ryan Howe, Center for Medicare and Medicaid Services**: CMS employs 6,000 people; Medicare work is carried out by contractors. How this work influences our systems: under Medicare FFS, very specifically defined categories don't give the authority to pay for the most appropriate and best treatment, only what is defined; much valuable care is outside of these categories. Make sure the foundation of this shift toward paying for value is right, with baseline rates. It matters what you count in that rate; pay for care management, behavioral health integration (e.g., through physician or licensed clinical social worker benefits, some services are not included).
- Recognize the costs through the coding system, e.g., Collaborative Care Model didn't need to be tested so much as to be implemented; CMS is interested in feedback on the rates and the rules, with a lot of faith in that model of care. Provisions for telehealth for SUD, broadly, under Medicare (doesn't have to be rural), and a patient's home can be an eligible site.
- Another effort is to include methadone in MAT (enacted very quickly under the SUPPORT Act) – a challenge to develop the coding where Medicare payment will be first. Also a challenge to stabilize payment in areas where needed; enrollment process is difficult – how to report services and get paid.
- **Comments and questions**: Regarding the Collaborative Care Model, whether changes to the rule are needed or just some time to be implemented broadly, it's too early to declare victory. Is there a code for "Professional Care"? Within FFS, recognition that care delivery models have changed over time; payment rules changed to pay for interprofessional consultations. Psychiatrists opt out of Medicare most often, and the state agencies are trying to address that. How does MFAR address states' practices? States recognized the need for cleaning it up, for contributing the appropriate share, but the proposed rule is more far-reaching than expected. On the very acute end, non-Medicaid patients' needs must be addressed, stressing providers and making it difficult to improve care; if the best use of the funding doesn't appear in the rules,

how does the payor have leverage? Building community capacity is fundamental; trying to shift to the value-focus will be easier after chipping away at the IMD exclusion. This is a very hard situation at the state level, and federal CMS was trying to address it broadly, with visibility to outcomes, to better understand states' outcomes, then to the managed care organizations.

"Introduction and Overview of the Mental Health Technology Transfer Centers (MHTTCs)"

- **David Weden, TX, Chair** introduced the speaker and topic.
- **Heather Gotham, PhD, Stanford University**: Technology Transfer is about disseminating evidence-based practices (EBPs) and accelerating their adoption. All of the technology transfer centers (TTC) are about developing and strengthening workforce for SUD and MH. Each TTC network includes 13 centers. Network Coordinating Office (leadership, support, coordination, training infrastructure); National Focus Area Centers (experts on specific populations); Regional Centers (training and TA to provider systems, collaborating with SAMHSA). A five-year project with fairly lean funding. www.mhttcnetwork.org.
- How Training and TA are provided: yearly work plans through needs assessments, advisory boards, and input from key stakeholders. Centers consider the spread of services, intensity, flexibility in response to emerging needs; implementation science informs the strategies (context and what is needed to move an EBP forward, implementation specific to the need, maximize impact on service delivery systems). List of the MHTTCs' areas of focus, events and products, online courses at www.HealtheKnowledge.org, recently includes Cognitive Behavioral Therapy (CBT) for psychosis, with continuing education units (CEUs).
- Examples of what the National Focus Area Centers are up to: one for Hispanic and Latino and the other for American Indian and Alaska Native, often working with members of these communities directly as well as those providing services to them.
- Examples of SMI initiatives: early psychosis learning collaborative; CBT for psychosis intensive project, and enhanced illness treatment.
- School Mental Health Initiative offers supplemental funding, 300 trainings and events in first year, reaching 10,500 participants, addressing issues like how to reach all students even if there's only one counselor. National School MH Curriculum: Guidance and Best Practices for States, Districts, and Schools. New release "Supporting Student Mental Health: Resources to Prepare Educators" with classroom-based strategies offered in a two-hour training.
- Cross-Network and Cross-TTC Collaboration: facilitating a culture of BH in Hispanic and Latino communities. SAMHSA website on Practitioner Training also describes this work; this is a huge shift in the way SAMHSA provides TA, new resources coming in September. Find yours at www.mhttcnetwork.org but you can ask questions about others which may have developed the resources you're looking for.
- **Comments and questions**: wonderful if the 17 states with large Native populations would collaborate to remove barriers to care. It would be great to establish a National Focus Area Center for Black/African American people.

"Progress on Addressing Workforce Issues"

- **Cherryl Ramirez, OR:** who has a sufficient BH workforce? Much distress regarding recruitment and retention. Welcome your novel approaches.
- **Angela Beck, PhD, University of MI** provided a Center Summary: since 2015, part of HRSA's Health Workforce Research Center Network, guided by Consortium model, with primary research themes of workforce data quality, supply/demand/distribution, worker characteristics and practice settings, workforce development, scopes of practice, service delivery and reimbursement; maps of locations of SUD treatment facilities (more on the east coast and in metro areas of Midwest) and sites offering buprenorphine treatment. Primary Care physicians as frontline rural providers of BH treatment, more confident in handling lower complexity disorders (depression, anxiety, ADHD) and less confident with SUD, bipolar, and SMI; rural providers tended to have more confidence in these areas, which could be explained by higher prevalence in those areas or by higher selection of primary care by folks with these conditions. Recruitment and retention study: interviews with ppl from 47 states, finding that more data on effectiveness is needed to communicate to state policymakers; interventions to improve the situation include financial incentives (loan repayment, tax credit), education and training, and practice-oriented tactics (expansion, e.g.); these findings led to a toolkit for action, with funding mechanisms, state regulatory suggestions, potential public/private partnerships. Telehealth also came up regularly, as a broad topic (video conferencing, teleprescribing, telemonitoring, and asynchronous); found varying levels of telehealth authorization in state

regulations, with some disconnect, and each state had different components; this patchwork nature could be inhibiting growth of telehealth. Scope of practice is an ongoing discussion, should be modernized to account for health care transformation and prioritize patients - see paper in the New England Journal of Medicine, with a podcast. Continue to explore the issues; don't equate head count to capacity; move away from provider/population ratios and think about capacity holistically (demand side too); more focus on needs and wants of patients over the preferences of individual professions.
www.behavioralhealthworkforce.org and ajbeck@umich.edu and jesbuche@umich.edu

- State Panel on Workforce Issues:
- **Robert Sheehan, MI** referred to another study on workforce shortage, from Community Mental Health Association of Michigan. Ratios aren't helpful but are stunning: 25 counties in MI have no psychiatrist; at ¼ of national ratio of child psychiatrists; tend to be around academic centers but not in rural areas. MIDOCS program improves # of residencies and $75,000 in student debt forgiveness for each practitioner. Two methods: loan repayment and residency together; dating (which gets residents to stay in the area). Practice change: MC3 is a collaborative care model including primary care providers and child psychiatrist, paired with the public CMH consultant assigned to primary care practices; often a social worker can help the primary figure out that it's not a psychiatric medication issue but a treatment issue. CareConnect is about how to expand this beyond the initial site. When you can educate primary care providers, the # of times they call for consult drops. Wages are barely above minimum wage now, except in the unionized shops. Turnover rate at 37%, and in some sites closer to 100%; think of the impact on patients of interrupting this intimate care; almost 18% of staff will not come back to the field; 45% refuse additional work; clients have more complex conditions. Section 1009 Report (2016) recommended immediate actions (wages, benefits, make the job look like a career) and long-range solutions, but the cost of small raises across the board is multi-millions. Charts comparing the volume of care of direct service versus clinical services and prescribing services. Money is the issue.
- **Cherryl Ramirez, OR** similar thoughts on the roles of DSP, psychiatrist, primary care. In response to # psychiatrists who've retired, Kansas has added this residency to the loan repayment program, adding licensure to the regulatory board, implementing a Masters of Social Work (MSW) program in 3 more campuses. In OR, value of peers and qualified mental health associates (QMHAs), with Associates or Bachelors degrees, and unlicensed Masters level practitioners; a 2015 report recommended certification rather than licensing, more opportunities for variance; 2017 legislation to require certification for unlicensed workforce failed, but adding QMHAs and qualified mental health professionals (QMHPs) could be certified (see mhacbo.org) with exams online; so far this is working, and many have been registered and certified; they also put together a code of ethics and more; fewer complaints about them than about licensed professionals. Four other things happening in OR: SUD 1115 waiver application includes peers as Medicaid provider type; BH workforce legislation waiting (higher rates and more training); BH advisory council with recommendations to go into governor's budget request next year; and version of TreatFirst (ala New Mexico) to reduce administrative burden for providers, may need state plan amendment.
- **Comments**: Are other states dealing with Medicaid Mgd Care final rule workforce clash, esp provider ratios? Yes. If you want info about it, see TreatFirst.org. Data can be helpful: in IA, 99% of providers had vacancy, and 83% of DSPs are eligible for SNAP, housing vouchers, so states are paying for it one way or the other. OR Health Sciences program for Nursing in Eastern OR will start a psychiatric NP program, paying for their education – have other states paid for Masters? National Health Corps pays back after licensing. Pre-Reagan, there were federal programs to pay for the education upfront. In TX, a successful project with University of TX where local Mental Health Authorities can certify providers, who can then bill Medicaid, so now this certification is taught at the University. Seven states have expanded prescribing.

"Progress on Suicide Prevention"

- **David Coe, VA,** introduced the topic and speakers. Family struggles with MH and suicide; David's father took his life last year, after struggling to provide care for David's brother.
- **Richard McKeon, PhD, Chief of Suicide Prevention Branch, SAMHSA**: over 48,000 deaths by suicide in 2018, compare with 46,000 opioid overdose deaths; 1.4m attempts/year by adults; over 10m seriously consider it each year. Opportunities for change, assisting others, need strong state engagement in prevention, alignment between state and federal.
- "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action" guides all the work, done by many federal departments – HHS, VA, DOD, DOJ, DHS, DOT, (within HHS are SAMHSA, NIMH, CDC, Indian Health Services, HRSA, AHRQ, ACL, OSG), FCC, Federal Working Group for

Suicide Prevention, National Action Alliance for Suicide Prevention. List of SAMHSA Programs, Efforts, and Initiatives, including tribal behavioral health, National Suicide Prevention Lifeline, crisis center follow-up grants. Longer-term impact on Youth Suicide Mortality: greater impact in rural areas by 20%; sustained impact after consecutive years of programming (after the funding ended, focus on youth suicide dissipated).

- CDC "Vital Signs: Righting the Course in the US" showed increases across the states, other than NV which started with a very high rate; now almost all counties can access the county-level data; work is needed to bring states, cities, counties into alignment regarding use of these data. Can also track this use of 70% of emergency departments in the US: for those seen in ED for suicide attempt, suicide mortality was 56.8x greater than matched population; for those seen for suicidal ideation, suicide mortality was 31.4x higher; external cause mortality was also elevated, particularly accidental overdose; 3.2% of adults who report an attempt will die by suicide within a year; increased ED visits for suicide for youth and adults – we know that what needs to be done in EDs is universal screening, safety planning, and follow-up calls; the dilemma is no one is paying for the calls. Perhaps a third of suicide decedents accessed care prior to death, but few are included in data.
- Recommended standard care after inpatient and ED discharge. The Zero Suicide Movement. England has already done this, with significant decline in suicide and increase in MH care. VA major effort to reduce veteran suicide; now VA and SAMHSA are collaborating on Mayor's and Governor's Challenge. Crisis intercept mapping in some states. Crisis services an important SAMHSA priority ($35m increase in president's budget for block grants and 3.5% set aside for suicide prevention). Need to make this a more coherent system; guidelines for callers at imminent risk; calls to the lifeline play an important role in reducing the risk.
- CrisisNow model is the "Air Traffic Control" model for crisis call center and hub. Ubiquitous and inexpensive technology is changing every other industry; hopeful that with '988', we move toward a more coordinated and effective MH system. It's time for a national MH Emergency Medical Services (EMS) system. See http://crisisnow.com
- **Laura Evans, Program Director for Policy, National Suicide Prevention Lifeline**: "Scaling Up Crisis Call Center Services and in the Context of National Crisis Services" with Lifeline Mission (est in 2005 through SAMHSA), not one giant call center but rather a network of independently operated, independently funded local and state call centers, sharing best practices and routing calls. Most don't receive any state or local funding to take routed calls. Routing: caller uses the widely shared # 1-800-273-TALK; caller presses 1 for veterans crisis line, presses 2 for Spanish, or does not press and is then routed to local crisis center; if local center unable to answer, the call is routed to national backup network. Local center better because of intimate knowledge of the community. Less than 2% of calls require emergency response or involuntary commitment; the majority can be part of a safe plan. Callers more likely to be assessed and show reductions in distress by the end of the call. Members Centers are also disseminators of best practices, clinical information shared with other stakeholders. Callers in MH crisis deserve to have calls answered, quickly, with linkages to local services, with responses in accordance with best possible standards, and within a system of care that ensures backup centers. Call volume is increasing beyond capacity. IL is one state with very low in-state answer rates (i.e., 33% or less are answered by local call centers); lots of states and communities have their own crisis lines, but Lifeline's number is very widely promoted and well-known. '988' now proposed because it is easier to remember; may also de-stigmatize calling for help. Capacity Keys: variety of funding options needed, best suited to responding to local crisis call center needs; every state's MH needs are unique. levans@vibrant.org
- **Questions:** text to 988? Need to make 988 operational within 18 months, so it's not immediate; FCC asked for input regarding the option for text; Crisis Text Line (a private non-profit) weighed in on that; Lifeline has a chat and phone but not text; VA line has all three. TTC Networks provide some training and TA on suicide prevention – what kinds of scale up to turn the focus from suicide to MH crisis? Centers respond to a range of crisis situations already; 25-30% of calls to Lifeline are actively suicidal, but Lifeline is meant to get those calls back to local systems; numerous other reasons for crisis which would lead people to call; appropriations for Lifeline tripled in last two years but not meeting the need; encouraging companies like Vibrant to work with county behavioral health authorities; up to now there hasn't been a single BH home. Educational outreach? Looking at each state's approach; grant program for communities around veteran suicide prevention; coordinate so that people are aware of the major initiatives and don't compete with each other. Need more help in going from the state level to the community level.

"Federal Initiatives to Address Substance Use and Mental Disorders: An Update from SAMHSA"

- **Elinore McCance-Katz, MD, Assistant Secretary for Mental Health and Substance Use, SAMHSA, USDHHS:** overview on MI and SUD in the US, a very sizable issue; 48m adults met diagnostic criteria for MI, 19m for SUD, and 9m both. SAMHSA has a major role in federal service delivery, must be responsive to the needs of these Americans. Guidance from Congress through legislation and appropriations: 21st Century Cures Act, SUPPORT Act. Major issues: opioids, rise of other illicit substances (marijuana, meth); prevention needs; SMI needs (identify it early to minimize harm); suicide prevention education; parity issues (access to care, practitioner availability); surveillance and data collection issues (to inform policy and determine effectiveness of programs).
- Opioids Crisis Update is Priority #1. Combatting it with: $1.5b grants for prevention, treatment, and recovery services for SUD, $50m set aside for tribes and 15% for states hardest hit, MAT, directed TA and training, Naloxone distribution and first responder training ($54m); MAT Prescription Drug and Opioid Addiction (PDOA) program to assist with OUD pharmacology implementation ($89m); pregnant and post-partum women's residential and outpatient services ($32m); Criminal Justice (CJ) programs with MAT ($89m drug courts); building communities of recovery (coaches and peers – also increased budget); Drug Abuse Warning Network ($10m); Substance Abuse prevention and treatment block grants to states ($1.86b); Drug Addiction Treatment Act waiver expanded to other specialties such as clinical nurse specialist, nurse anesthetists, nurse midwives, with increased patient caseload to 100 after training and approval, option to increase to 275 after a year (extra reporting has been d/c'd), and over 111,000 trained/waivered so far. Collaboration with USDA on supplementing the Extension programs and increasing rural recovery housing – a huge gap, with DEA on telehealth regulations, with OCR on rules such as Health Insurance Portability and Accountability Act (HIPAA) 42 CFR Part 2, with NIDA/NIH on what works best in communities, and with HIS on native communities. Prescription Pain Reliever and Heroin Misuse – 10.3m ppl (significant drop since 2017, in all age groups); heroin use disorder (very big drop among young adults). Treatment gains in # receiving MAT pharmacotherapy; SAMHSA won't fund abstinence only programs. Very large increases in Naloxone prescriptions have reversed overdose deaths. New Programs: Comprehensive Opioid Recovery Centers; Emergency Departments Alternatives to Opioids; Treatment Recovery Workforce Support; Peer Recovery Support TA Center. Other initiatives from 2019: alignment of 42 CFR Part 2 with HIPAA (congressional statutory action would be required for full alignment; with permission, SUD treatment info can now be in the medical section of records); Mandatory Oral Fluid Guidelines for drug testing; Recovery Housing guidelines; expanded efforts to address marijuana, as alarming data on its health risks come in; research on the impact on children of parental use; states are starting to identify it as a treatment for OUD, but evidence doesn't support this.
- Addressing SMI and Severe Emotional Disturbance (SED) in Children, Priority #2. Major increases in budget this year to $1.68b, for MH Block grant ($722m), CMHI ($125m), Infant and Early Childhood ($7m), Project AWARE ($102m), National Child Traumatic Stress Initiative ($69m), Transitional Age Youth ($29m), Suicide Prevention (Lifeline, Zero Suicide, and Prevention Resource Center), and MH Awareness Training and CIT ($23m). Increases for CCBHCs/integrated care ($200m, for the 24 states with planning grants), CJ diversion from incarceration to treatment ($6.3m), Assertive Community Treatment ($7m), Assisted Outpatient and Minority Fellowship Treatment. Addressing the key issue of incarceration of those with SMI: too many do not get treatment and become involved with justice, often on minor offenses; there are no regulatory barriers to services related to justice – block grant can pay for it; form relationships with community providers while in jail; competency restoration = treatment addresses a significant psychosocial stressor. School-based MH services; best practices in crisis intervention, advocacy for psychiatric advance directives; funding a phone app; implementation of mental disorders prevalence study; advocating to congress for '988'.
- Substance Abuse Prevention is Priority #3, with stable funding. Focus on tobacco use and vaping, public education and awareness programs on many topics, and more. Startling increase in marijuana use during pregnancy with many poor outcomes for children; SAMHA did many things in response (some listed above, plus samhsa.gov/marijuana) and then saw a significant drop in 2018, too early to know if the drop was sustained in 2019; comparison of women who use marijuana with those who don't, on a number of risks. Stimulant use increased since 2016, very difficult problem, as psychosocial interventions are challenging due to cognitive impact.

- Priority #4 is Improving Data Collection, Analysis, Dissemination, and Program and Policy Evaluation. To get a more accurate estimate of prevalence, surveys will now include ppl hard to reach, such as those incarcerated. Program eval to ensure that programs are addressing the problems they're meant to. National Survey on Drug Use and Health has new questions on use of medication to treat OUD, use of kratom, vaping, DSM-5, rapid analysis and release of data to the public. Launch of FindTreatment.gov. Reinstitution of the Drug Abuse Warning Network, as meth is a big issue.
- Strengthening Healthcare Practitioner Training and Education, Priority #5: expansion of the Technology Transfer Centers, Provider's Clinical Support System - Universities (embedding training into undergraduate level for future practitioners), Pain and Addiction Care education (pushing for test questions on SUD), evidence-based resource center. New: Family Support TTC. The regional TTCs collaborate. Trained over 70k healthcare practitioners last year. Credentialled peer providers as an integral component of comprehensive care. More TA resources.
- **Questions and comments**: In NM, practice supports, peers within clinical settings, and tools like Project ECHO have helped prescribers do what is needed - did block grant funding covering SUD for those incarcerated include SAMHSA? No, just MI. What's happening with National Outcome Measures? Still there, just added to it. Can we use it locally? Working toward that with new leadership. VA using peer recovery specialists, but how to pay for it? Hasn't been a lot of data on the impact of these supports, working on that; CCBHCs showing good results, and they must use peers.

"Systems of Care (SOC) for Children"

- **Lynn Canfield, IL,** introduced the topic and speakers, framing with brief comments on Champaign County's System of Care and Trauma Informed Care efforts. (Panelist Amy Starin was a Principal Investigator in the Access Initiative cooperative agreement.)
- **Denise Sulzbach, JD, Deputy Director, the TA Network, The Institute for Innovation & Implementation, University of MD School of Social Work:**
- SOC incorporates a broad, flexible array of effective services/supports for a defined population, organized into a coordinated network, with care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, has supportive policy and management infrastructure, is data-driven.
- A set of values and principles provide an organizing framework for systems reform on behalf of children, youth, and families. These are: family-driven and youth-guided; home and community based; strengths-based and individualized; coordinated across providers and systems; trauma-informed; toward health equity through cultural and linguistic competency (CLC); connected to natural helping networks; resiliency- and recovery-oriented; data-driven, and quality and outcomes oriented.
- Shared Population of Focus: categorical system reforms take MH, child welfare, JJ, education separately; non-categorical reforms place the shared population at the center of the systems and connect them. SOC alternative to high cost strategies of the separate systems - child welfare's residential treatment, Medicaid's inpatient/ED, juvenile justice's detention, and special education's out of school placements. Transformation focus is at policy, management, community, and frontline practice levels.
- SOC as Systems Reform Initiatives: move from fragmented to coordinated service delivery; from categorical programs/funding to blended resources; from limited resources to a comprehensive service array; from reactive, crisis-oriented to a focus on prevention and early intervention; focus on deep-end, restrictive to least restrictive settings; from children/youth out of home to within families; from centralized authority to community-based ownership; and from foster dependency to building on strengths and resiliency. Frontline Practice Shifts include from control by professionals to partnerships with families/youth; from multiple case managers and service plans to one care coordinator and a single individualized child and family plan; from deficits focused to strengths focused; CLC; etc.
- The high Medicaid costs for children are in mental health, for adults physical health. Co-morbid physical health conditions are low among children in Medicaid using BH care; though high prevalence of asthma. See https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/ Use of psychotropic meds increasing, higher by 29% compared with low use of BH services, nearly half of these children didn't receive services.
- Opportunities for states to improve quality: expand access; implement clinically informed oversight and monitoring; establish data-sharing agreements. Also working with states on care for LGBTQ+ youth.
- Special Projects: Quality Collaborative on Use of Psychotropic Medication in Youth in Residential Treatment Facilities (9 teams across the country); Intensive In-Home Behavioral Health Treatment (to

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define evidence-based standards at practitioner, organizational, and system levels); and Family First Prevention Services Act, which makes major changes in the use of Title IV-E funding to allow for prevention services and lower the need for congregate care. Family First is a cross-systems intervention online portal.

- Many learning communities, e.g., Clinical High Risk and Early Psychosis, CLC, Early Childhood, Family Leadership, Rural MH, SOC Leadership, Tribal SOCs, Young Adult Services and Supports, Youth with Co-occuring SU/MHD, and Youth Leadership. Connect through https://theinstitute.myabsorb.com/; subscribe to SAMHSA's TA telegram at tatelegram@ssw.umaryland.edu; see www.chcs.org and theinstitute.umaryland.edu/2020traininginstitutes. Contact dsulzbach@ssw.umaryland.edu
- **Lauren Fischman, Child Welfare Program Specialist, Office on Child Abuse and Neglect, Children's Bureau, US Department of Health and Human Services:** overview of the Children's Bureau and its role, information on funding focused on enhancing the development of trauma-informed child welfare services, and resources available to child welfare agencies to support efforts to become more trauma informed.
- Since 1912, the Children's Bureau has tackled pressing social issues such as infant and maternal mortality, child labor, orphanages, delinquency and juvenile courts, abused and neglected children, and foster care. Improve outcomes in safety, permanency, and well-being, through a continuum of family support and child welfare services, prevention of child abuse and neglect, child protective services, family preservation and support, foster care and kinship care, adoption, independent living/transition support and services for older youth, work with the courts, and interagency collaboration. Provides national leadership in the child welfare system by: interpreting federal laws; providing guidance through policy, funding for programs, training and TA, and research and demonstration projects; monitoring implementation of federal laws/policies; and establishing the system's primary goals of safety, permanency, well-being.
- Strategies to strengthen families: change focus to preventing maltreatment and unnecessary placements; prioritize the importance of families (keep children in their communities and schools, foster parents help support birth parents); focus on well-being of children and their parents (addressing trauma and avoiding additional trauma); build the capacity of communities to support their children and families; and develop and support a healthy and stable child welfare workforce. The Office on Child Abuse and Neglect was created in 1996, a focal point for HHS on abuse and neglect, interagency collaboration and coordination, special initiatives, and prevention activities; offers formula grants, discretionary grants (DV, housing, regional partnerships), support for research and evaluation projects, and TA.
- Trauma Informed Child Welfare Services: all involved recognize and respond to the impact of traumatic stress on those who have contact with the child welfare system; not a discrete task – involves the day-to-day work of the system as a whole; programs and agencies infuse and sustain trauma awareness and skills, act in collaboration, and facilitate and support recovery and resiliency; better able to address children's safety, permanency, and well-being needs; more children receive trauma screening, assessment, and evidence based treatment they need; grant funding, training, and TA for development/enhancement of trauma-informed child welfare systems.
- Children's Justice Act Grant Program provides $17m in formula grants to states to improve handling of cases, esp child sexual abuse and exploitation, in a manner that limits additional trauma to the child victim; focus on systems-level reform and improvement; https://www.acf.hhs.gov/cb/resource/childrens-justice-act. Increased complexity of cases necessitates enhanced training for multidisciplinary professionals: in CA, training on trauma-informed care and brain science; in IA, trauma-informed SOC workshops and assessments; in OK, cross-training for multi-disciplinary team (MDT) members on trauma reduction during investigation; in many states, training for legal/judicial on impact of trauma and harm reduction.
- Children's Bureau Discretionary Grants: most recent, promoting well-being and adoption after trauma. Resources produced by grantees: The Connecticut Collaborative on Effective Practices for Trauma (CONCEPT); Rady Hospital/Chadwick Center; and Southwest Michigan Children's Trauma Assessment Center. Additional trauma-focused resources: ACF Resource Guide to Trauma-Informed Human Services; Developing a Trauma-Informed Child Welfare System; Review of Trauma-Informed Initiatives at the Systems Level; Trauma-Informed Approaches: Connecting Research, Policy, and Practice to Build Resilience in Children and Families; Children's Bureau 2019/2020 Prevention Resource Guide; Child Welfare Capacity Building Collaborative; Child Welfare Information Gateway; Trauma-Informed Practice Page. Contact Lauren.Fischman@acf.hhs.gov
- **Amy Starin, PhD, LCSW, Senior Program Officer for Mental Health at the Illinois Children's Healthcare Foundation:** IL Children's Healthcare Foundation was founded 2002, with a statewide focus

including oral health, mental health, other; to increase access to effective mental healthcare for children, integrated care. Uses the Georgetown Implementation Assessment, Family Resource Developer.

- Phase One, 2010 to 2017: invested $2.8m in four communities to focus on MH screening in pediatric & school settings (systems sustained services, juvenile justice reductions), with comprehensive school screening process. Phase Two from 2018-2025: $2.3m in five communities to focus on CASSP principles toward 11 targeted outcomes. Phase Three adds 10 communities.
- Outcomes from Phase One: significant, measured integration of child-serving system partners; MH screening routine in pediatric practices and schools; MH services initially grant funded are sustained by the medical and school systems; youth/families in MH care doubled while juvenile arrests reduced by half; built policy and advocacy capacity; project director roles not sustained; integration scores decreased.
- Phase Two requires communities to have a local funder sustain the project director role as part of the application and at the planning and implementation table; funders might be United Way, Community Mental Health Board directors, local foundations, or public health departments. Goals of Phase Two: measurable impact on the integration of service providers; improvement in children's functioning, including school participation and academic success; strengthened parenting practices and caregiver/child relationships; early identification; reduction in unmet basic needs of families; reduction in caregiver stress and parental depression; increased capacity to provide families with evidence-based clinical interventions; increased parent/caregiver/youth peer-provided services and leadership; effective use of outcomes data to inform operations and changes in the system, including sharing data between provider systems. Analysis of costs and benefits of project; development of well-prepared MH workforce. Contact amystarin@ilchf.org
- **Lisa DeVivo, IL, Executive Director of Oak Park, IL Township Community Mental Health Board** on the "Health Home Hub Initiative: Building a School-Based Children's Mental Health System of Care" (Oak Park MHB and DePaul University and Oak Park School District 97).
- The 2018 Oak Park-River Forest Community Health Plan priorities include behavioral health services and disparities for youth and families. Data sources were Illinois State Board of Education (ISBE), Illinois Youth Survey, key stakeholder, SupportU, and academic performance. Six key areas of need emerged: anxiety, depression, electronic addiction, access to child psychiatry and neuropsychology, home visits for "opportunity gap" families, and executive functioning training for parents and students. 12-week curriculum with 120 children (4-weeks to assess), visits to centers where Black and Brown children gather, data sharing, and care coordinator.
- RFP released in December 2018, with $100,000 for a pilot project, with the MHB paying for up to six months of planning and costs related to startup and oversight; once services were underway, the project would be cofunded by MHB, Medicaid, and private insurance; school support services and space were in-kind; MHB and foundation partners purchased a closed loop referral website to serve as the hub for referrals and linkages to other community organizations; separate funds were provided to SOC partners to utilize one system; MHB committed early on to fund all expenses and staff time not billable to other payors; MHB and the school district reviewed 8 proposals; in May 2019, DePaul University "Mindful Middle-Schoolers: Resiliency Skills for Anxiety, Depression, and Executive Functioning" was selected.
- **Questions and Comments:** Importance of role of CLC. How do you communicate to the public about the real value of flexible funding, including the value of asking people what they need and doing it? Many resources have been developed and are available online.

"Discussion of 2020 NACBHDD Legislative Agenda"

- **Ron Manderscheid** with overview.
- **Bob Sheehan, MI** on positions supported by the board and membership.
- **Jonah Cunningham, Trust for America's Health** https://www.tfah.org
- *(I attended the Hill Briefing rather than this session.)*

Capitol Hill Briefing: "The Intersection of Health and Justice: A Look Inside County Jails"

A briefing on how counties can work with federal partners to strengthen health care in our local justice systems. Co-sponsored by Grand Challenges for Social Work, National Association for Social Workers, NACBHDD, NACo, American Academy of Social Work and Social Welfare, and National Association of Sheriffs.

- **Senator Bill Cassidy, LA**: background on this and earlier efforts to improve health care services for justice-involved ppl and to reduce # of ppl with MI in jails; continuity of care is better for people and systems, disease prevention even better (a long-time priority of his). Focus on Senate Bills 2628 and 2626.
- **Senator Jeff Merkley, OR**: SB 2626 allows a person in custody and pending charges to continue receiving coverage, whether Medicare, CHIP, or VA benefit until they've had due process and conviction. Undue hardship, financial and human impact on counties and ppl, disrupting the person's care and contributing to recidivism related to untreated MI or SUD (and so a public safety consideration). This is also a justice issue in that those who can afford bail continue their health benefits but those who cannot are penalized before adjudication, by interruption or termination of care even though presumed innocent.
- **Sheriff Greg Champagne, St. Charles Parish, LA**: high incidence of MI/SUD among the country's jails.
- **Commissioner Nancy Sharpe, Arapahoe County, CO**: the needs of those incarcerated and the costs to all public systems are not fully captured in our data, so true prevalence and costs may be much greater.
- **Ed Zackery, Director, Veterans Service Officer, Medina County, OH**: connecting our efforts.
- Focus is on support for SB 2626 (and 2628); congressional staff asked for other federal actions which would be helpful; passing the 42 CFR 2 change in the Senate is also important.
- **Questions** from congressional staffers included an interest in other strategies for improving community behavioral health and reducing incarceration; focus on support for SB2626 and IMD exclusion. For video, https://www.naco.org/resources/video/capitol-hill-briefing-intersection-health-and-justice-look-inside-county-jails. Contact Blaire Bryant at bbryant@naco.org.

Capitol Hill Reception with Awards

Presenting awards to James Carroll, Director of the US Office of National Drug Control Policy, US Senators Paul Tonko, NY and Debbie Stabenow, MI, and several congressional staffpersons.

"State Panel: Progress Report on CCBHCs"

- **Cherryl Ramirez, OR** introduced the topic and panelists. Update on the extension (for those currently or planning to do Certified Community Behavioral Health Clinics (CCBHC): on May 22 congress will take up this and a few other health related bills and funding package which includes FQHCs; the two year package will begin in December, and 11 states will be added; it looks positive for these. Each panelist reported on progress, plans for sustainability, and lessons learned, as each state's CCBHC plan is a little different.
- **Jinny Palen, MN Association of Community MH Programs** on "Future Directions of Health Care: Integration, Payment, Delivery Innovations." Status update on the demonstration so far: 2018 congressional appropriation; 2019 state statute changed by legislature; in June, CMS approved the 1115 waiver with 12-month extension bridge to State Plan Amendment (SPA); and now the proposed extension. The statute changes provided clarity and flexibility for peer services, added Licensed Alcohol and Drug Abuse Counselor/SUD services in the model, developed a payment methodology under Medicaid and toward dual certification between FQHCs, rural health clinics, and CCBHCs. The SPA establishes state-based payment system, MN specific quality bonus program. Started with 6 pilot sites which served an additional 17K ppl in the first 20 months and showed good outcomes. Evolving an integrated model with behavioral health at the forefront, addressing health disparities, health care reform, payment reform, and regulatory changes. Near Future: add occupational therapy, registered nurse visits, and care coordination as a core service; clinicians are involved in decisions about changes to assessment tools and other guidelines. More Future Considerations: piloting tablets and telemedicine expansion; designing integrated care pathways with hospital partners; more CMHCs and FQHCs are interested in being certified as CCBHCs; and integration with value-based care.
- **Janice Garceau, Deschutes County Health Services, OR**: ahead of the game and ready to do this work, so the lift was around increased use of evidence-based screening for every person seen. Implemented April 2017. Overarching goals: improve screening; increase access; improve outcomes for veterans, older adults, SMI and other vulnerable clients; and improve payment for community MH programs, to cover the un/underinsured. Already had primary care in many, and added at all locations; increased collaboration between BH and physical health (PH); improved clinical screening; increased access to services for veterans and un/underinsured; increased peer services to improve engagement; prospective payment to help with non-billable service costs; and improved safety planning and monitoring for suicide risk. Data charts on 9 key metrics, many of which are process measures rather than outcomes measures, with a process/checklist focus, not really preparing ~~well for the~~ future of this project. Outcomes include 287 new

clients/month, 107% increase in veterans with high needs and risk (low median income = $10,800, so not people who would have been served in the private sector), and 3.4% decrease in PHQ9 depression scoring.

- Current status is uncertain. Federal funding continued three times; state match impacted by budget and concerns about increased cost, variable outcomes, and low understanding about the goals of CCBHC. Important to think about who is served: many with high risk who would have been served in inpatient settings; the savings associated with higher use of community services may not be seen for a few years. Oregon CMHPs relinquished state general fund dollars to participate in match and continue CCBHC. What's at stake for the County: 25% of budget, loss of staff, loss of services, and loss of momentum for county behavioral health. Janice.garceau@deschutes.org
- **Susan Loughery, NJ**: History of NJ CCBHCs. 7 original sites have all continued, and 4 became extension grantees, plus 2 new agencies. These 9 agencies span the state, work collaboratively with Human Services. Challenges: Workforce considerations, licensing/regulations, silos precluding integration, payment system conflicts (e.g., how to introduce this model of integration in a system already integrated under Medicaid), conflicts with designated screening laws (so introducing the community crisis screening), capturing units and showing outcomes, MAT continuation. Tremendous impact seen in year one data.
- Initial Successes: 17,851 clients served, almost 2k receiving SUD treatment services, high volume of services provided, so that not only are more ppl are coming in but more are staying engaged in services; implications to services and communities; hub and spoke model really makes a difference.
- **Richard Edley, PhD, Rehabilitation & Community Providers Association, PA**: turning off the federal funding and winding down the project. Concerns: federal funding gap, piecemeal extensions, sustainability beyond demonstration, expansion statewide to other providers (of which there are many), outcomes and learning from 2 year demo, and expansion to other states. On the other hand, it became an interesting debate, strong support on both sides, and with only one senator blocking the extension (concerned that we don't know enough about the program to expand it). Outcomes: no one expected mass/longitudinal outcomes but did expect integration and additional services, which the providers could speak to; the big question is what happens when federal funding ends, as happened in PA. Now the 6 CCBHCs are called Integrated Community Wellness Centers, using the state's performance measures and data reporting, BH-MCO measures, payment through the state's Medicaid plan, and built in with actuarially-sound rates. Additional issues: the gap between federal and this new funding (6 months) was not clearly going to have retroactive payment; managed care funding, rates, and rate structure; timing of the ramp-up of new program and winding down of CCBHC, staff cuts, service provision, and consideration of the Commonwealth-Provider partnership (e.g., Dept Human Services told providers they were in it together but those individuals are long gone; new leadership says the providers knew this was a risk but took it anyway.) Summary and Next Steps: PA did not end the program, choosing sustainability, still a federal match but rejecting millions in federal funds, providers absorbing the 6-months losses, movement in state reporting and tracking only. Going through the MCOs means lower rates.
- **Questions and Comments**: Ready for Value Based Payment system? PA not at the win-win stage yet. NJ not fully ready for managed care carve-in (need to maximize codes for all provider types needs, hard to get to the cost of a bundle until flexible provider costs are identified), but there is a tremendous financial pressure. MN had to put all the daily encounter payments through managed care, and operationally not sure how the MCOs will differentiate payments for CCBHCs from other; MN has always been a carve-in state for mental health services. OR has Coordinated Care Organizations, each differently positioned to do VBPs, some just getting started; complex when differing with your MCO; some of those served are not Medicaid enrollees and have significant MH needs – how to incentivize service to all under that model. After the demo, will you need to change regulations, contracts, etc.? Yes in OR, would love to see the day when state rules align with federal; if serious about treating MI as a health condition, we have to get our model closer to how healthcare operates (e.g. list of MI rules is four times longer than for healthcare, an anachronistic model with rigidity), may need to be driven by changes in federal law. PA may need changes in practice as well as regulatory, not related to CCBHC moving in; regarding VBPs, tendency to take a portion of the already low rates and hold that for incentive rather than truly providing additional $. MN system is also rigid and cumbersome; CCBHC model has brought lots of new information; those certified now should not have to meet the many other standards as well. NJ has worked on taking the siloed definitions and creating a framework for integrated care regulations; challenge is on the payor side in carve-in; so much is based on unique community needs, infrastructure, and resources, so aligning across all the diverse geographic areas will be a challenge. NM applied for the one-year and got it, sought an alternative for it through 1115 (BH health home) ~~to~~ integrate with primary care in a cost-based

reimbursement system; next year we'd like to have states present on integrated health home. How hard was it to convince states to put $ forward, and how hard to serve the uninsured, and will it be spread to other providers beyond the initial sites? In MN, it was seen as important so there wasn't much opposition or concern, just how to fit in the growing HHS budget; MN is a Medicaid expansion state, very concerned about the uninsured, not likely to be lost in the state plan, but interested in which direction CMS will ask them to go (whether state plan rule or CCBHC extension) and what that means financially. PA saw this coming. Biggest success and biggest challenge? NJ: a very limited provider pool, but the CCBHCs led this; requirements for backup medical director and services were a big problem too, with no start-up funds vs the cost of that expertise, which is still rising; continues to develop. MN: making it a permanent benefit; ensuring that the model evolves to what is needed for MN rather than the box it came in; and keep challenging the state to implement it that way rather than siloing it as another nice MH program. PA: individuals working in human services not moving forward, hope to move back to it. OR: the challenges first - an enormous lift, lots of additional work for staff but not necessarily easy to share the vision (what clinicians care about is the clients), and not finding in the state a true partner; successes – served many who would not otherwise have been served, and did it well – this mattered to the staff and to the people served and was the whole point of the project.

"Improving Cultural and Linguistic Competency for I/DD and Behavioral Health Care"

- **Sarah Jane Owens, OR** introduced the topic and speaker. CLC webinar emphasized that service planning often lacks input on what a person wants related to their culture/family.
- **Vivian Jackson, National Center for Cultural Competence, Georgetown University, DC**: CLC in the I/DD world; MI is a community of practice state, working to embed diversity and CLC in the state's system; Leadership Academy offered an intensive training on what it takes to promote this work.
- Setting the frame: "My House" emphasizes asking the individual. The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (not new, just not being done) Section 5: "specific efforts must be made to ensure that individuals with DD from racial and ethnic minority backgrounds and their families enjoy increased and meaningful opportunities"; recognition of prevalence, traditionally underserved populations, inequitable treatment; definitions of unserved and underserved. SAMHSA Tip 59: Improving Cultural Competence: CLC definition, general requirements in the CCBHC requirements, which include family centered care related to culture and other specific needs. Title VI – Civil Rights Act of 1964 described language access; if there is a federal penny for the service, there is an obligation to communicate in the language comfortable for the person.
- CLC framework: language in these acts is sometimes 'race & ethnicity,' sometimes 'culture.' Culture is learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. Culture is an integrated pattern of human behavior. An Iceberg Concept of Culture: what's below the water may be body language, how we think of ourselves, gender roles within families, ranking in social status, with the surface being language, how I dance, color of my skin. Cultural factors that influence diversity among individuals and groups: internal factors (racial identity, tribal affiliation, nationality, acculturation/assimilation, political orientation, religion and spiritual values, etc.) inform the tensions of the space we are in. Intersectionality: experience ourselves as the stepchildren of the system – have to think about MI, DD, and more, and while we have this space in the world we have to advocate for, there is cultural diversity within each of these groups; adding layers to our experience of the world (race, DD, SUD, for example); people are struggling with all the '-isms.'
- CLC at all levels: At organizational level, value diversity, conduct self-assessment, manage the dynamics of difference, institutionalize cultural knowledge of the whole organization, and adapt to diversity. Linguistic Competence is the capacity of an organization and its personnel to communicate effectively with all. Creating the organizational infrastructure: core functions (what we do); human resources & staff development (who we are); fiscal resources & allocation (where the money goes); collaboration and community engagement; and contracts. What we do, the service functions: think about internal policies, clear about CLC, need and asset assessment, partnership with individuals and families, adaptation of services and supports, address barriers, use data and research (are you seeing disparities in any of the data sets?) Who we are, Human Resources & Staff Development: diverse workforce, training and professional development, position descriptions (is there an expectation of cross-cultural work for all?) and performance evaluations (is there a measure for positive cross-cultural work?), linguistic competence (who on our team needs to be bilingual/bicultural?), and anti-discrimination policies. Where the money goes, fiscal resources & allocation: adequate funding for appropriate services and support (it takes time to develop the

relationships, money to establish the language access resources, should be part of rates discussions); economic development of the community (investment in communities of color and unserved, by the work that you do – who are your vendors?) Who our partners are, collaboration and community engagement: diverse individuals and families; self-advocacy groups, including for diverse groups. Whom we entrust to deliver services and supports, contracts: needs and asset assessment; experience with community engagement; ability to deliver appropriate services and interventions; workforce knowledgeable and skilled with service population; staff development; experience with individuals and/or family members as staff; capacity to collaborate with them and informal networks; experience and capacity to conduct culturally based advocacy; collaboration with local and or national TA resources; and policies to assure accountability. To be effective, honor diversity within ethnic or racial groups. National Center for Cultural Competence has a CLC assessment tool for healthcare, one for I/DD, one for family-run orgs. Encourage focus groups, input from collaborators/stakeholders, to get a fuller picture. An individual piece too.

- Leadership Role in advancing and sustaining CLC: orchestrating the change process, opportunities to leverage change, use of influence, managing diversity, confronting racism and other isms, addressing personal and institutional resistance to change. Important to the organization's future, essential to implementing the core functions, integral to achieving diversity and equity. Leadership for policy change requires clarity in values and principles, prescribed and proscribed practices for codification, engagement of culturally diverse stakeholders, and establishment of accountability processes.
- Your analysis: consider your own setting, the change you want to see, the benefits and complications of that change, strengths, and challenges, Small group discussions and then sharing of one thing that came out for each. Think through accomplishments to date and next steps to take the org to another level. Even CA has room for growth. Ripple effects toward sustainable change. What House will you Build for Me?
- **Questions and Comments**: assessment tools online, but sometimes the focus on spending is not helpful – are there tools for helping marginalized communities that do not include spending as a measure? Yes, measures related to how ppl live their lives (what does a good life look like?); ppl tell us what matters to them. If you ask "satisfied with services" and you're offering only one thing, the answer will be yes, but we should ask among options. Purchase of service spending is not the way to look at disparities. http://nccc.georgetown.edu and cultural@georgetown.edu for more information.

"Status of the State and County Opioid Settlements"

- **Bob Sheehan, MI** introduced the speaker, who leads the ADM board, now in the funding role after being in the provider role. Summit County is one of the plaintiffs in the suit.
- **Jerry Craig, MSSA, LISW, County of Summit Alcohol, Drug Addiction & Mental Health (ADM) Services Board, OH** www.admboard.org with an inside perspective, background on the agency and context (responsible for planning, funding, and monitoring, and evaluating services for people with addictions and/or mental illness – OH Revised Code Mandate). Supplemental & safety net services – things not on the Medicaid menu, such as 24-hour crisis center and services; not providing direct services but rather contracting with agencies and drawing down for services. Summit County pop 541,228; board's $46m budget is 11% federal, 12% state, and 77% local property tax. Best positioned to invest any funds gained through opioid settlement to abate the harm.
- Timeline on the Opiate Lawsuit: happened later than it should have, with 20-30 overdoses per night in Akron in summer 2016, followed by public outcry; governor did not declare state of emergency, but attorney general filed the lawsuit in May 2017. The complaint brought together many parties, with 11 manufacturers and 3 distributers as named offenders; framed as abatement of a public nuisance, alleges that the companies freely distributed opioids into Summit County, grossly misrepresented the risks of long-term use of those drugs for persons with chronic pain, and distributors failed to properly monitor suspicious orders of those prescription drugs, all of which contributed to the current epidemic. Major milestones in 2018, Opiate Leadership Council, System Mapping (gaps analysis), data from federal gov't tracking medications movement around the community (had tried to avoid releasing these data, but release was allowed to include and exclude defendants based on these data), Bellwether designation for Summit and Cuyahoga Counties, ADM joins lawsuit. In 2019, Addictions Leadership White Paper. State wanted to control the funds rather than allow at the county level; anything carved out early would impact their ability to get $ later on, so filed injunction to slow it down. Judge did not see it as appropriate. Motions filed against the judge and with higher courts also failed.
- October 21, global settlement is $215m to be distributed to the two counties, with a negotiated split (62/38) based on population and overdose rates; one part of the settlement only to Summit county; must be used to

abate the nuisance and can't supplant other funds (no capital expenditures); half to legal and expenses; and distribution on two tracks (meds & funding, but not likely able to use all the meds). Medication Settlement is approx. $9m in meds, most time-limited, and parameters of distribution vary (treatment agencies, hospitals, jails & prisons, distributors – private and state central pharmacy, takeaway). Cash – approx. $54m, Opiate Abatement Advisory Council (ADM board has a seat among many on this council), a portion into a community foundation in order to sustain services over a long term, with stakeholder group (diverse representation of community including families and those with lived experience) to make recommendations for programs, subject to County Council approval. Akron is the home of AA, so the community values abstinence and has pushed back against MAT (stigma).

- **Early Lessons:** investments managed by health district vs BH authority (political processes, planning roles), logistics of medication (Medicaid, parameters unrealistic), state assisting to inform their own settlement talks. Factors informing where the funds should go are rates of prevalence, deaths per capita, and similar. Uses only data collected by the federal gov't. Subsequent legal action, using the template from this settlement: must be spent on OUD treatment, can use for retroactive costs; endow a trust to fight OUD and fund treatment; Franklin County itself would comprise one of the regional councils. Now a national settlement shares some of these features. An amicus brief asking that some endowment dollars address co-occurring MI and underlying causes. Address the needs of children orphaned by ODs and the grandparents now raising them. craigg@admboard.org
- **Questions and comments:** Assuming that a larger % of those affecting have private coverage – what are the commercial insurers doing to support their members and sustain these efforts? Working at the community provider level, but it seems ppl use their insurance up very quickly; cottage industry emerged to take advantage of insurance payments and then turn ppl back to community care, so build out the continuum of community services; private insurance has not been at the table for these discussions. Thank you for the frankness and level of detail.

Closing Comments from NACBHDD President and Executive Director

Thanks for the programming, high level of detail and relevance to our work, which helps us see where the country is going. More of out colleagues in the field should come! The peer exchange here is impossible to match. Announcement of summer meeting, July 19-21, 2020, and next Legislative and Policy meeting, Feb 21- 23, 2021.

7

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

Minutes—February 19, 2020

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

8:00 a.m.

MEMBERS PRESENT: Gail Kennedy, Georgiana Schuster, Anne Robin

STAFF PRESENT: Kim Bowdry, Chris Wilson, Lynn Canfield, Shandra Summerville, Mark Driscoll

STAFF EXCUSED: Stephanie Howard-Gallo

OTHERS PRESENT: Katie Harmon, CCRPC; Annette Becherer, Heather Levingston, Sarah Perry, Scott Burner, Laura Bennett, Danielle Matthews, Patty Walters, DSC; Kyla Woods, SpringHealth; Kaitlyn Puzey, CU Able; Becca Obuchowski, Hannah Sheets, Community Choices; Mel Liong, PACE.

CALL TO ORDER:

Dr. Kennedy, Secretary, called the meeting to order at 8:02 a.m.

ROLL CALL:

Roll call was taken and a quorum was present.

APPROVAL OF AGENDA:

MOTION: Dr. Anne Robin moved to approve the agenda. Ms. Georgiana Schuster seconded the motion. A voice vote was taken, and the motion was passed.

CITIZEN INPUT / PUBLIC PARTICIPATION:

None.

PRESIDENT'S COMMENTS:

None.

EXECUTIVE DIRECTOR'S COMMENTS:
Announcement of upcoming Expo. Watching introduced (state) legislation which would increase I/DD provider rates. Announcement of webinar on the HCBS Statewide Transition Plan. Review of today's agenda items.

APPROVAL OF CCDDB MINUTES:

Minutes from the January 22, 2020 meeting were included in the Board packet.

MOTION: Dr. Anne Robin moved to approve the CCDDB minutes from January 22, 2020. Ms. Georgiana Schuster seconded the motion. A voice vote was taken, and the motion was passed.

NEW BUSINESS:

Mini-Grant Update and Requests:
A Decision Memorandum regarding progress on agreements and purchases, along with requests from award recipients, was included in the packet.
Requests for Board Action:

- **Applicants #5 and #6** are young twin brothers with different disability-related needs. Purchase of television and shower fixture have already been very helpful, per correspondence from their mother. When credit card balance becomes available, we will purchase jacuzzi and basketball hoops. The approved award includes purchase of materials for projects which would support safety and health, but without funding for installation, these are not possible. The family is considering alternative solutions which would be cost neutral, but at the time of writing, a specific request has not been made.
- **Applicant #12** was awarded $2,000 of $5,000 toward purchase of a bike trailer but is unable to pay remaining amount. The applicant cannot ride a bicycle and participate in family bike activities; the trailer would allow him to be included on rides with family and friends. Family has requested that the board consider fully funding the original request. Budget Impact: increases total expenditures by **$2,090.52**.
- **Applicant #32's** father would like reconsideration of the original request for a Teera Trike Rover i8 Tandem with IPS, as the approved single trike bike does not meet applicant's need. Budget Impact: increases total expenditures by **$1,754.87**.
- **Applicant #44** is a young person whose weight has become a medical concern; other support needs were addressed in the application. His father asks the Board to reconsider the full original request ($4,880) in order to include BowFlex and speech therapy. The approval was $1,840 to cover cost of Camp New Hope camp and respite weekends.

Budget Impact: increases total expenditures by **$2,000** for speech therapy and **$1,040** for Bowflex.

- **Applicant #46** has purchased orthopedic shoes, from a list of multiple items. Recipient requests purchase of Planet Fitness or Vision Fitness membership (depending on staff negotiation of payment) rather than the approved karate school and uniform, weight machine, and bike. Budget Impact: **cost neutral.**

If all requests for reconsideration were awarded, the additional expenditures would total **$6,885.39.** Purchases have been completed for $1,090 less than planned, and an amount greater than $5,800 was not reallocated, so that these requests are affordable if deemed appropriate.

MOTION: Ms. Georgiana Schuster moved to approve full purchase of bike trailer, as originally requested by Applicant #12. Dr. Anne Robin seconded the motion. Discussion of request and of review committee recommendation. A roll call vote was taken, and the motion passed.

MOTION: Dr. Anne Robin moved to approve purchase of Teera Trike Rover i8Tandem with IPS, as originally requested by Applicant #32, in place of the approved item. Ms. Georgiana Schuster seconded the motion. Discussion of this request; follow-up will include confirmation that the item is being used and that it meets the applicant's needs. A roll call vote was taken, and the motion passed.

MOTION: Dr. Anne Robin moved to approve request from Applicant #44 for funding of original request as described above. Ms. Georgiana Schuster seconded the motion. Discussion of this request; similar to the concern about the previous request and whether this is what the individual wants, more information is requested. A roll call vote was taken, and the board unanimously voted to request more information.

MOTION: Dr. Anne Robin moved to approve request from Applicant #46 to purchase gym membership rather than the previously approved karate school and uniform, weight machine, and bike. Ms. Georgiana Schuster seconded the motion. Discussion of this request; follow-up will include confirmation that the item is being used and that it meets the applicant's needs. A roll call vote was taken, and the motion passed.

Mid-Year Progress Report:
Katie Harmon, Community Services Program Manager with the CCRPC, reported on the newly funded portion of the Decision Support Person Centered Planning program. A copy of her presentation was distributed. Board members were given the opportunity to ask questions.

SpringHealth Behavior Health and Integrated Care:
Kyla Wood, Behavior Clinician, provided a presentation on behavior services offered in Champaign County. Board members and audience members were given the opportunity to ask questions.

Carle Foundation Property Tax Case Ruling:
A memorandum from the Champaign County Deputy Director of Finance was included in the packet for information only.

PY2021 Applications for Funding:
A list of applications by priority for PY2021 funding for I/DD programs was included in the Board packet.

Board Direction:
For this discussion item, Dr. Robin requested staff input. Staff seek Board members' input as to what will be most helpful in the review of applications for funding and the coming decision process. Board members may give that feedback individually, as many options are available.

Update on Illinois DHS-DDD:
Included in the packet, for information only, was a presentation from the Director of the Illinois Department of Human Services Division of Developmental Disabilities and the portion of the proposed State Transition Plan which relates to DD waiver programs.

Successes and Other Agency Information:
Representatives from DSC, Community Choices, and CU Able shared success stories. Annette Becherer, DSC announced The Crow @ 110 is hosting an Open House on March 7, 2020 from 3:00 p.m. – 5:00 p.m. Becca Obuchowski, Community Choices shared that two participants in the Community Choices Customized Employment program recently found jobs and that Community Choices is holding its Strategic Planning event on February 27, 2020. Kaitlyn Puzey, CU Able shared that the CU Able Good 360 program with Walmart is going very well. This program is coordinated through CU Able website/Facebook page.

OLD BUSINESS:

Agency PY2020 2nd Quarter Program Activity Reports:
Second Quarter reports were included in the packet for information only.

Combined Agency PY2020 2nd Quarter Service Data:
Second Quarter I/DD hours of direct service reported in all funded programs was included in the Board packet.

CCDDB and CCMHB Schedules and CCDDB Timeline:
Copies of the CCDDB and CCMHB meeting schedules and the CCDDB allocation timeline were included in the packet for information only.

Acronyms and Glossary:
A list of useful acronyms was included for information only.

CCMHB Input:

Lynn Canfield reported that the CCMHB meeting tonight has a similar agenda plus an item on financial assurances and supports for funded agencies.

STAFF REPORTS:

Reports from Kim Bowdry and Shandra Summerville were included in the packet for review.

BOARD ANNOUNCEMENTS:

None.

OTHER BUSINESS – CLOSED SESSION:

MOTION: Dr. Kennedy moved to go into closed session pursuant to 5 ILCS 120/2(c)(11) to consider litigation which is pending against or on behalf of Champaign County, and litigation that is probable or imminent against or on behalf of Champaign County, and that the following parties remain present: Executive Director Lynn Canfield and Associate Director Kim Bowdry. Dr. Anne Robin seconded. The motion passed, and the Board went into closed session at 9:40AM.

The Board came out of closed session at 9:48 a.m.

MOTION: Ms. Georgiana Schuster moved to come out of closed session and return to open session. Dr. Anne Robin seconded. A roll call vote was taken. Dr. Robin, Dr. Kennedy, and Ms. Schuster were present, and the vote was unanimous.

ADJOURNMENT:

The meeting adjourned at 9:49 a.m.

Respectfully
Submitted by: Lynn Canfield and Kim Bowdry
CCMHB/CCDDB Staff

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

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 108 DEVLPMNTL DISABILITY FUND												
*** DEPT NO. 050 DEVLMNTL DISABILITY BOARD												
90	CHAMPAIGN COUNTY TREASURER MENT HLTH BD FND 090											
		2/06/20	04	VR	108- 26		604053	2/12/20	108-050-533.07-00	PROFESSIONAL SERVICES	FEB ADMIN FEE	32,997.00
											VENDOR TOTAL	32,997.00 *
104	CHAMPAIGN COUNTY TREASURER HEAD START FUND 104											
		2/06/20	04	VR	108- 20		604055	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB SOC/EMOT DEV SV	2,033.00
											VENDOR TOTAL	2,033.00 *
161	CHAMPAIGN COUNTY TREASURER REG PLAN COMM FND075											
		2/06/20	04	VR	108- 19		604058	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB DECISION SUPPOR	27,735.00
											VENDOR TOTAL	27,735.00 *
11587	CU ABLE											
		2/06/20	05	VR	108- 22		604100	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB COMM OUTREACH	1,439.00
											VENDOR TOTAL	1,439.00 *
15060	CHAMPAIGN COMMUNITY UNIT SCHOOL DIST #4											
		2/07/20	04	VR	108- 30		604107	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR FEE M HUGHES	60.00
		2/07/20	04	VR	108- 30		604107	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	APR FEE M HUGHES	80.00
		2/07/20	04	VR	108- 30		604107	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAY FEE M HUGHES	80.00
											VENDOR TOTAL	220.00 *
18203	COMMUNITY CHOICE, INC SUITE 419											
		2/06/20	05	VR	108- 23		604125	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB COMMUNITY LIVIN	6,750.00
		2/06/20	05	VR	108- 23		604125	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB CUSTOM EMPLOY	12,066.00
		2/06/20	05	VR	108- 23		604125	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB SELF DETERMINAT	11,500.00
											VENDOR TOTAL	30,316.00 *
22300	DEVELOPMENTAL SERVICES CENTER OF CHAMPAIGN COUNTY INC											
		2/06/20	05	VR	108- 24		604148	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB APARTMENT SVCS	36,896.00

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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												
		2/06/20	05	VR 108-	24		604148	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB CLINICAL SVCS	14,500.00
		2/06/20	05	VR 108-	24		604148	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB COMMUNITY EMPLO	30,114.00
		2/06/20	05	VR 108-	24		604148	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB COMMUNITY FIRST	68,580.00
		2/06/20	05	VR 108-	24		604148	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB CONNECTIONS	7,083.00
		2/06/20	05	VR 108-	24		604148	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB EMPLOYMENT FIRS	6,667.00
		2/06/20	05	VR 108-	24		604148	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB INDIV/FAMILY SU	34,713.00
		2/06/20	05	VR 108-	24		604148	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB SERVICE COORD	35,263.00
											VENDOR TOTAL	233,816.00 *
22816	DOWN SYNDROME NETWORK							ATTN: JEANNE DALY				
35		2/06/20	05	VR 108-	21		604156	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB DOWN SYNDROME	1,250.00
											VENDOR TOTAL	1,250.00 *
32085	HEEL TO TOE, INC.											
		1/27/20	06	VR 108-	13		603855	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INV 5615 1/15	199.00
		2/07/20	04	VR 108-	31		604182	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INV 5621 1/18	240.00
											VENDOR TOTAL	439.00 *
58118	QUILL CORPORATION											
		1/27/20	06	VR 108-	12		603907	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INV 4083755 1/16	1,949.97
											VENDOR TOTAL	1,949.97 *
61780	ROSECRANCE, INC.											
		2/06/20	05	VR 108-	25		604271	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FEB COORD SVC DD/MI	2,929.00
											VENDOR TOTAL	2,929.00 *
78888	VISA CARDMEMBER SERVICE - MENTAL HEALTH AC#4798510049573930											
		1/23/20	05	VR 108-	11		603443	1/24/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 WALMART 1/3	178.00
		1/23/20	05	VR 108-	11		603443	1/24/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 AMAZON 1/7	279.00
		1/23/20	92	VR 108-	102		603443	1/24/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 WALMART 12/27	298.00
		1/28/20	01	VR 108-	17		603957	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 AMAZON 1/22	465.46
		1/28/20	01	VR 108-	17		603957	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 AMAZON 1/20	279.99

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												
		1/28/20	01	VR	108- 17		603957	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 AMAZON 1/20	289.99
		1/29/20	01	VR	108- 18		603957	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 AMAZON 1/27	648.98
		1/29/20	01	VR	108- 18		603957	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 SAILFIN 1/27	235.98
		1/29/20	01	VR	108- 18		603957	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 AMAZON 1/25	43.40
		1/29/20	01	VR	108- 18		603957	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 BEST BUY 1/24	1,629.97
		2/04/20	02	VR	108- 28		604332	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 AMAZON 1/31	597.99
		2/07/20	04	VR	108- 29		604332	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 WALMART 2/4	359.22
											VENDOR TOTAL	5,305.98 *
79125	WALK EASY, INC.											
		1/27/20	06	VR	108- 15		603964	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INV 256126 1/22	157.95
											VENDOR TOTAL	157.95 *
609900	DALY, ANN											
		2/07/20	06	VR	108- 32		604373	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	REIM BEST BUY 1/5	599.00
		2/07/20	06	VR	108- 32		604373	2/12/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	REIM BEST BUY 1/30	699.99
											VENDOR TOTAL	1,298.99 *
645115	WATERS, DEBORAH											
		1/27/20	06	VR	108- 14		604036	1/31/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INV 2 1/22	2,000.00
											VENDOR TOTAL	2,000.00 *
										DEVLMNTL DISABILITY BOARD	DEPARTMENT TOTAL	343,886.89 *
										DEVLPMNTL DISABILITY FUND	FUND TOTAL	343,886.89 *
											REPORT TOTAL *****	759,756.49 *

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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												
*** DEPT NO. 050 DEVLMNTL DISABILITY BOARD												
90	CHAMPAIGN COUNTY TREASURER								MENT HLTH BD FND 090			
		3/03/20	04	VR	108- 47		605261	3/09/20	108-050-533.07-00	PROFESSIONAL SERVICES	MAR ADMIN FEE	32,997.00
											VENDOR TOTAL	32,997.00 *
104	CHAMPAIGN COUNTY TREASURER								HEAD START FUND 104			
		3/03/20	04	VR	108- 41		605262	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR SOC/EMOT DEV SV	2,033.00
											VENDOR TOTAL	2,033.00 *
161	CHAMPAIGN COUNTY TREASURER								REG PLAN COMM FND075			
		3/03/20	04	VR	108- 40		605265	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR DECISION SUPPOR	27,735.00
											VENDOR TOTAL	27,735.00 *
220	4 PAWS FOR ABILITY											
		3/03/20	05	VR	108- 38		605271	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	TERRY MANK DON. 2/2	2,500.00
											VENDOR TOTAL	2,500.00 *
1200	ADAPTIVEMALL.COM, LLC											
		3/03/20	04	VR	108- 27	4143	4649	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INV K86675 2/25	2,277.90
											VENDOR TOTAL	2,277.90 *
5350	AUTISM-PRODUCTS.COM								#106-552			
		3/03/20	04	VR	108- 16	4134	605296	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INV 361760 1/31	341.11
											VENDOR TOTAL	341.11 *
11587	CU ABLE											
		3/02/20	03	VR	108- 43		605308	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR COMM OUTREACH	1,439.00
											VENDOR TOTAL	1,439.00 *
18203	COMMUNITY CHOICES, INC								SUITE 419			
		3/02/20	03	VR	108- 44		605327	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR COMMUNITY LIVIN	6,750.00

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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											
	3/02/20	03	VR 108-	44		605327	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR CUSTOM EMPLOY	12,066.00
	3/02/20	03	VR 108-	44		605327	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR SELF DETERMINAT	11,500.00
										VENDOR TOTAL	30,316.00 *
22300	DEVELOPMENTAL SERVICES CENTER OF						CHAMPAIGN COUNTY INC				
	3/02/20	03	VR 108-	45		605345	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR APARTMENT SVCS	36,896.00
	3/02/20	03	VR 108-	45		605345	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR CLINICAL SVCS	14,500.00
	3/02/20	03	VR 108-	45		605345	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR COMMUNITY EMPLO	30,114.00
	3/02/20	03	VR 108-	45		605345	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR COMMUNITY FIRST	65,560.00
	3/02/20	03	VR 108-	45		605345	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR CONNECTIONS	7,083.00
	3/02/20	03	VR 108-	45		605345	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR EMPLOYMENT FIRS	6,667.00
	3/02/20	03	VR 108-	45		605345	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR INDIV/FAMILY SU	34,713.00
	3/02/20	03	VR 108-	45		605345	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR SERVICE COORD	35,263.00
										VENDOR TOTAL	230,796.00 *
22816	DOWN SYNDROME NETWORK						ATTN: JEANNE DALY				
	3/02/20	03	VR 108-	42		605350	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR DOWN SYNDROME	1,250.00
										VENDOR TOTAL	1,250.00 *
54930	PERSONS ASSUMING CONTROL OF THEIR						ENVIROMENT, INC				
	3/03/20	04	VR 108-	7		605425	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	JAN CONSUMER CONTRO	1,976.00
										VENDOR TOTAL	1,976.00 *
58118	QUILL CORPORATION										
	3/03/20	05	VR 108-	39		605429	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INV 4590043 2/6	798.99
	3/03/20	05	VR 108-	39		605429	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INV 4600855 2/6	329.99
										VENDOR TOTAL	1,128.98 *
61780	ROSECRANCE, INC.										
	3/02/20	03	VR 108-	46		605438	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	MAR COORD SVC DD/MI	2,929.00
										VENDOR TOTAL	2,929.00 *

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CHAMPAIGN COUNTY

EXPENDITURE APPROVAL LIST

3/09/20

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											
61890	RUSSELL'S FITNESS										
	3/06/20	03	VR 108-	48		605440	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INV 11380 3/5	2,999.88
										VENDOR TOTAL	2,999.88 *
69371	STEPHENS FAMILY YMCA										
	2/18/20	10	VR 108-	34		604727	2/21/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	2016037 HERRERA 2/1	1,062.00
										VENDOR TOTAL	1,062.00 *
78888	VISA CARDMEMBER SERVICE - MENTAL HEALTH AC#4798510049573930										
	2/19/20	06	VR 108-	33		604749	2/21/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 WALMART 2/5	149.00
	2/19/20	06	VR 108-	35		604749	2/21/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 TARGET 2/14	309.99
	2/19/20	06	VR 108-	35		604749	2/21/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 TARGET 2/14	94.99
	2/19/20	06	VR 108-	35		604749	2/21/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 WALMART 2/13	106.90
	2/19/20	06	VR 108-	35		604749	2/21/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 WALMART 2/13	787.48
	2/26/20	01	VR 108-	36		605213	2/28/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 TARGET 2/15	65.99
	2/26/20	01	VR 108-	36		605213	2/28/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 AMAZON 2/15	297.38
	3/03/20	05	VR 108-	37		605487	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 APPLE 2/22	999.00
	3/03/20	05	VR 108-	37		605487	3/09/20	108-050-533.92-00	CONTRIBUTIONS & GRANTS	3930 APPLE 2/21	200.00
										VENDOR TOTAL	3,010.73 *
									DEVLMNTL DISABILITY BOARD	DEPARTMENT TOTAL	344,791.60 *
									DEVLPMNTL DISABILITY FUND	FUND TOTAL	344,791.60 *
										REPORT TOTAL *****	742,419.89 *

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CHAMPAIGN COUNTY MENTAL HEALTH BOARD 9.A.

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

DECISION MEMORANDUM

DATE: March 18, 2020
TO: Members, Champaign County Developmental Disabilities Board (CCDDB)
FROM: Kim Bowdry, Lynn Canfield
SUBJECT: Mini-Grant Update and Requests

Background:

Agency Program Year 2019 service data provided a very detailed profile of how Champaign County residents utilize services. They also revealed a number of people eligible for but not receiving state or county-funded services. In addition, funds originally allocated to two agency contracts became available. Subsequently, CCDDB developed an individual 'mini-grant' opportunity for these potentially underserved residents with I/DD to request specific assistance to support their needs.

For many years, CCDDB prioritized Flexible Funding to meet people's needs with individualized, person-centered planning and innovations which may reduce reliance on services, often unavailable due to greater demand than capacity. A similar approach has been in place for many years in the state's Medicaid-waiver funded Home Based Support program, which also funds specific assistance as related to individual need.

In December, after defining and implementing a public grant process, the CCDDB approved funding for 37 requests, with total awards of $62,508. For those who accepted the award and determining specific purchases with CCDDB staff; to date all but 4 agreements are fully executed, and purchasing is more than half completed. Some people did not accept the approved award, and others asked for changes within the awarded amount. Three reconsideration requests were approved in February, and more information was needed for a decision about the fourth. This and an additional request are summarized below for action by the Board.

Proposed Outcomes Survey:

All successful applicants who agreed to the approved purchases also agreed to provide the CCDDB with outcome information by 6 months after completion of the purchase. Possibly through electronic and paper versions and in person, CCDDB staff will seek input:

> Selecting one from the five-point scale - "strongly agree"/ "agree"/ "neutral"/ "disagree"/ "strongly disagree" - evaluate the following statements:
> 1. The item(s) which were purchased were helpful to me.
> 2. The items(s) were helpful in the way I had hoped.
> 3. The items(s) were helpful in an unexpected way.
> 4. The process, from application through purchase, was a positive experience.
>
> Comment on how this purchased worked out for you. (comment answer)

If the survey is simple, we hope for a higher return rate and comparable data. We appreciate the value of commentary and have discovered that some family care-providers give enthusiastic

feedback, though it may be trickier to organize as data. In addition, the board has requested more detailed information about the outcomes in those cases where equipment was purchased; as a result, other feedback may be needed.

Requests for Board Action:

- **Applicant #35** was previously approved for the Black Card membership at Planet Fitness. Unfortunately, the Black Card, which would have met her needs, is not available, as Planet Fitness is only offering the Classic membership as an option to be paid for in advance. The Classic membership is not an appropriate option, as the young lady does not function well in places with strangers unless someone she knows is there with her. As a solution, and because her mother can support her using them at home, an elliptical and Exercise Bike Dual Trainer are requested in place of gym membership. Budget Impact: **cost neutral.**

- **Applicant #44** is a young person whose weight has become a medical concern; other support needs were addressed in the application. The original approval was $1,840 to cover cost of Camp New Hope camp and respite weekends. His father requested reconsideration of the full original request ($4,880) in order to include BowFlex and speech therapy. The CCDDB requested more information about use of the BowFlex, prior to making a decision. Subsequent to conversation with CCDDB staff and through email, his father reports:

> "Thanks very much for getting back to us. I would be happy to add any information that I can that would help with this process. [X] is 21 and severely autistic. He would have great difficulty in speaking for himself but on his behalf, I will do what I can. I am his legal guardian and just trying to get him as much help as possible. Twice a week now through the school he is being taken to the local gym where he is using a very similar device to the bowflex. He does like the work outs but the sensory overload in a loud and busy place can be way too much for him. He is very heavy right now and needs the bowflex at home where he can use it on the daily. This will most definitely be used and used well. Once school lets out, he will be aged out and until he gets funding from the PUNS program he will be in need of every opportunity that we can give him. I worry about him getting heavier once school ends and diabetes does run in the family. I really dont want that for him as he has way too much in his way already. I broke my neck and have been recovering from spinal surgeries and I have limited ability to get him moving myself and this bowflex would really help him get his conditioning in at home.
>
> Another activity that I would love to have considered is a pass for the indoor aquatic center in Urbana. [X] does the Tom Jones challenger baseball program which he is aging out of this year and all kinds of special olympics as well. He would love to go to the aquatic center and this would help him very much as well. An annual pass for an adult non resident is $299. He loves to swim all year and will be in need of a new outlet once school lets out and he is no longer getting assistance from their programs.
>
> Lastly for the speech therapy, his severe autism does limit his ability to communicate dramatically. We definitely need some outside help for him as school is letting out and he will no longer have access to any speech therapy. I want him to be a productive citizen and work and participate in the community. To do this he will need much speech therapy and training. Any help in obtaining at home therapy and training would be greatly appreciated.

Thanks again for your time and consideration and know that we will use these all for his benefit and they will definitely not go to waste.

Best regards and have a great week. Looking forward to hearing back from you."

Budget Impact: increases total expenditures by **$2,000** for speech therapy and **$1,040** for Bowflex.

Decision Section:

Motion to approve request from Applicant **#35** to purchase an Elliptical and Exercise Bike Dual Trainer rather than the previously approved gym membership.

Approved _______
Denied _________
Modified ________
More information is requested ________

Motion to approve request from Applicant **#44** for funding of original request as described above.

Approved _______
Denied _________
Modified ________
More information is requested ________

9.B.

With Self-Direction, People With Disabilities Gain Control

by Chris Serres, Star Tribune/TNS | March 10, 2020

MENOMONIE, Wis. — A decade ago, Lori Sabby-Lemke was working two jobs while caring alone for her teenage son Dustin, who was born with a severe form of cerebral palsy.

She was tired, lonely and broke.

Dustin's only means of mobility — a rusted, wheelchair-accessible minivan with holes in the floorboards — sat idle in the weeds outside her mobile home because she had no money to fix it. Worse, her insurance company repeatedly denied requests for more supports to care for Dustin at home.

Then, in the fall of 2010, a social worker told Sabby-Lemke of a new state program that could change everything. It was called IRIS and it was designed to give people like Dustin power over their lives. For the first time, the family would control their own medical budget. Equipment and services that once seemed unattainable — such as a wheelchair-accessible bathroom and a working van — suddenly were within reach.

"It felt like we had emerged from the darkness and into the light," Sabby-Lemke said.

With IRIS (Include, Respect, I Self-Direct), Wisconsin became one of the first states in the nation to adopt a model known as self-directed Medicaid benefits. The controversial move shifted the balance of power away from insurers and government bureaucrats, and empowered individuals to make their own choices.

Today, Wisconsin leads the nation in most measures of promoting independence and quality of life among people with disabilities. Fully 33 percent of Wisconsin residents with intellectual and developmental disabilities report directing their own Medicaid services — nearly three times the national average, according to a 2018 national survey.

"The IRIS program is the best thing that ever happened in this state," said Patti Rood, of Elk Mound, Wis., whose adult son is enrolled in the program. "It's living proof that, when you trust people to make their own decisions, they live richer and fuller lives."

So far, Wisconsin's fervor for self-direction hasn't spread west across the border. In Minnesota, county case managers and large service providers still dictate major decisions for people with disabilities, consigning thousands to isolating group homes rather than independent lives in the community. In Minnesota, only 8 percent of people with intellectual and developmental disabilities report directing their own services, among the lowest rates in the nation.

Officials at the Minnesota Department of Human Services (DHS) pointed to data showing a steady rise in the percentage of Minnesotans on Medicaid choosing to direct their own services, in part because of a staffing shortage among providers. Self-direction will probably grow in popularity

as the state embarks on a multi-year effort to simplify and streamline its complex system of Medicaid benefits, known as "waivers," said Alex Bartolic, disability services director at the DHS.

•••

The movement that Wisconsin embraced is built on a radically simple concept: That people with disabilities will lead happier and more fulfilling lives when they're in control.

It appeared on the national scene in the late 1990s, with an experiment known as "cash and counseling" that allowed Medicaid recipients to receive a fixed monthly sum to hire their own caregivers, rather than have the government pay residential facilities many times more to care for them.

One national study found that people in the program were nearly 20 percentage points more likely than others on Medicaid to say they were satisfied with their lives and were less likely to have health problems or accidents related to their care.

Wisconsin's version of the strategy went statewide in 2008. The state organized a broad network of specially trained social workers, known as IRIS consultants, who make house visits and advise people on how to use their funds. People with more physical disabilities can spend their IRIS funds on home nursing services and specialized medical equipment, such as mechanical ceiling lifts or wheelchair ramps, that help them avoid costly institutional care. Decisions are made swiftly because there is less interference from counties and providers.

When Rood needed a new stroller for her growing son, Richie, who has spastic quadriplegia, she simply submitted a handwritten request with a doctor's note to her IRIS consultant. Within a month, a new stroller arrived on the doorstep of her mobile home in western Wisconsin.

"The bureaucratic red tape that you would expect in a government program is pretty much nonexistent," Rood said.

Today, nearly 22,000 Wisconsin adults with disabilities participate in IRIS. The program is so popular that, when former Gov. Scott Walker proposed a change that would effectively have eliminated the program, hundreds of families launched a grassroots campaign to block the effort.

The popularity of IRIS may explain Wisconsin's low use of costly facilities. Only 10 percent of Wisconsin residents with intellectual and developmental disabilities live in group homes, about a quarter of Minnesota's rate.

•••

Kathryn Burish felt a surge of excitement as she paced the living room of her apartment in a suburb of Milwaukee.

It was a Friday evening and Burish had big plans. Her three closest friends since childhood were going to a play and then a night on the town before returning to her place for their annual pre-

Christmas slumber party. There would be gifts, dancing in her living room, and then a large pancake-and-eggs breakfast.

Burish, who is 23 and has Down syndrome, was already dressed up in her most elegant plaid scarf and long skirt.

"I sometimes feel like the luckiest person in the world. I get to choose how I want to live and whom I want to live with."

Such a night would not have been possible without IRIS. Five years ago, Burish's parents enrolled her in IRIS and directed most of her annual budget toward help with daily living skills, such as cooking and managing a budget. Much of the rest went toward job training and transportation, which helped her keep a job as a medical records clerk.

Today, she lives in her own apartment and requires only a few hours of caregiver support each week. Many weekends, Burish and her "three amigos" can be seen promenading through the Milwaukee Makers Market, a bustling arts and crafts fair.

"The beauty of IRIS is that Kathryn can now do what any other hip, 23-year-old woman would want to do with her life," said her mother, Julie Burish.

Still, the rising costs of IRIS have alarmed some Wisconsin legislators. Its outlays have swelled along with its enrollment, from $277 million in 2014 to $622 million in 2018. Critics have pointed to reports of people using IRIS dollars for trampolines and extravagant vacations.

But a recent analysis found that monthly Medicaid expenditures by IRIS participants were 15 percent less, on average, than spending by participants in Wisconsin's alternative, a managed-care program known as Family Care. In 2018, IRIS enrollees spent $2,845 per month, while Family Care enrollees spent $3,268, according to state records.

Far from being extravagant spenders, families in the IRIS program consistently underspend their allocated budgets by 10 to 15 percent, state data shows. And overall, Wisconsin spends significantly less through Medicaid waivers than most states. The state paid $26,700 per waiver recipient in 2017, compared with $33,900 in Minnesota, federal data shows.

"Families are used to squeezing every last dime out of their budgets," said Matthew Bogenschutz, an expert on self-direction at Virginia Commonwealth University. "They carry that same fiscal discipline forward with their use of public funds."

•••

Snow flurries and a biting wind were blowing over the wooded hills outside Menomonie when Sabby-Lemke rolled Dustin onto the back porch of her mobile home. With the help of a portable lift paid for by IRIS, she and her husband, Tom Lemke, gently lowered Dustin's 180-pound frame into a hot tub. As he sank into the steaming water, Dustin let out a squeal of delight and a grin spread over his chiseled face.

The swirling hot water soothes Dustin's chronic muscle pain and spastic limbs, conditions related to his cerebral palsy. With letters of support from his doctors, the IRIS program paid for the mechanical lift and one-third of the cost of the hot tub. "It's been a godsend," Sabby-Lemke said. "The pain and the spasticity just melts away."

The impact of IRIS is visible everywhere in the Sabby-Lemke home. Dustin's shower is wheelchair-accessible, and a mechanical ceiling lift helps transfer him in and out of bed. In the family's garage is a futuristic, all-terrain wheelchair that enables Dustin to join his family on hikes and trips to the lake. And there is a van out front with a power entry ramp — and a working engine.

All told, the equipment has cost Wisconsin's Medicaid program about $100,000, and it has allowed Dustin to live at home and avoid years of costly care in a group home or other institutional setting.

"This program is what enabled this family to stay together, which is the most important benefit in my book," said Sabby-Lemke, as her family gathered for supper one evening. "After all, if you've got people around you that love you, what more do you need in life?"

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Discover Self Community

9.C.

1304 W. Bradley Avenue
Champaign, IL 61821
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f (217) 356-9851

www.dsc-illinois.org

February 20, 2020

Lynn Canfield
Executive Director
Champaign County Developmental Disabilities Board
Champaign County Mental Health Board
1776 E. Washington Street
Urbana, IL 61802

Dear Lynn,

We were notified last week from United Way that we were not selected to move forward with our Community Employment grant for the next two year grant cycle. The loss of this funding not only has a direct impact on our Community Employment program but we have always listed the United Way grant money as a match for our Donated Funds Initiative (DFI Title XX). We are requesting to use the Champaign County Developmental Disabilities Board (CCCDDB) Community Employment grant dollars as the match for state funding to minimize any additional loss in funding starting July 1, 2020. If you have any questions or need further information, please let us know.

As always, thank you for your continued support of Champaign County, DSC and its mission.

Sincerely,

Danielle Matthews
CEO
Developmental Services Center

CCDDB 2019-2020 Meeting Schedule

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

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)

July 15, 2020 – Lyle Shields Room (4PM) – *off cycle, different time*

August 19, 2020 – Lyle Shields Room (8AM) - *tentative*

September 23, 2020 – Lyle Shields Room (8AM)

October 21, 2020 – John Dimit Conference Room (8AM)

November 18, 2020 – John Dimit Conference Room (8AM)

December 16, 2020 – Lyle Shields Room (8AM) - *tentative*

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--5:45 p.m.
Brookens Administrative Center
Lyle Shields Room
1776 E. Washington St., Urbana, IL (unless noted otherwise)

January 22, 2020
February 19, 2020
February 26, 2020 – Study Session
March 18, 2020
~~March 25, 2020 – Study Session~~ - Cancelled
April 22, 2020
April 29, 2020 – Study Session
May 13, 2020 – Study Session
May 20, 2020
June 17, 2020
July 15, 2020 – off cycle
September 23, 2020
October 21, 2020
November 18, 2020
December 16, 2020 - tentative

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

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DRAFT July 2019 to December 2020 Meeting Schedule with Subject and Allocation Timeline, and moving into PY2022 process

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 5:45PM. Included are tentative dates for steps in the funding allocation process for Program Year 2021 (July 1, 2019 – June 30, 2020) and deadlines related to 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)** Approve Three Year Plan with One Year Objectives Allocation Decision Support – PY21 Allocation Criteria
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)**
01/03/20	*CCMHB/CCDDB Online System opens for Agency Registration and Applications for PY21 Funding.*
01/22/20	**Regular Board Meeting (Lyle Shields Room)**
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 (Lyle Shields Room)** List of Requests for PY21 Funding

03/18/20	**Regular Board Meeting (Lyle Shields Room)**
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 (Lyle Shields Room)** 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 (Lyle Shields Room)** Allocation Decisions; Authorize Contracts for PY2021
06/17/20	**Regular Board Meeting (Lyle Shields Room)**
06/24/20	*PY21 Contracts completed/First Payment Authorized*
07/15/20	**Regular Board Meeting at 4:00PM (Lyle Shields Room)** *– off cycle and different time* Election of Officers; Approve FY2021 Draft Budget
08/19/20	**Regular Board Meeting (Lyle Shields Room) - *tentative***
08/28/20	*Agency PY2020 Fourth Quarter Reports, CLC Progress Reports, and Annual Performance Measures Reports Due*
09/23/20	**Regular Board Meeting (Lyle Shields Room)**
10/21/20	**Regular Board Meeting (Dimit Conference Room)** Draft Three Year Plan 2019-2021 with 2021 Objectives Release Draft Program Year 2022 Allocation Criteria
10/28/20	*Agency Independent Audits, Reviews, or Compilations Due*
10/30/20	*Agency PY2021 First Quarter Reports Due*
11/18/20	**Regular Board Meeting (Dimit Conference Room)** Approve Three Year Plan with One Year Objectives Allocation Decision Support – PY22 Allocation Criteria
12/11/20	*Public Notice to be published on or before this date, giving at least 21-day notice of application period.*
12/16/20	**Regular Board Meeting (Lyle Shields Room) - *tentative***

10.B.

Agency and Program acronyms

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

Glossary of Other Terms and Acronyms

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

AAC – Augmentative and Alternative Communication

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

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

ACA – Affordable Care Act

ACMHAI – Association of Community Mental Health Authorities of Illinois

ADA – Americans with Disabilities Act

ADD – Attention Deficit Disorder

ADHD – Attention Deficit/Hyperactivity Disorder

ADL – Activities of Daily Living

ASD – Autism Spectrum Disorder

ASL – American Sign Language

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

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

BD – Behavior Disorder

BSP – Behavior Support Plan

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

CARF- Council on Accreditation of Rehabilitation Facilities

CC – Champaign County

CDS – Community Day Services, formerly "Developmental Training"

CFC – Child and Family Connections Agency

CFCM – Conflict Free Case Management

C-GAF – Children's Global Assessment of Functioning

CILA – Community Integrated Living Arrangement

CLC – Cultural and Linguistic Competence

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

CNA – Certified Nursing Assistant

COTA – Certified Occupational Therapy Assistant

CP – Cerebral Palsy

CQL – Council on Quality and Leadership

CSEs - Community Service Events. A category of service measurement on the Part II Utilization form. Activity to be performed should also be described in the Part I Program Plan form-Utilization section. It relates to the number of public events (including mass media and articles), consultations with community groups and/or caregivers, classroom presentations, and small group workshops to promote a program or educate the community. Activity (meetings) directly related to planning such events may also be counted here. Actual direct service to clientele is counted elsewhere.

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

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

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

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

DD – Developmental Disability

DDD – Division of Developmental Disabilities

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

DHS – (Illinois) Department of Human Services

DOJ – (US) Department of Justice

DRS – (Illinois) Division of Rehabilitation Services

DSM – Diagnostic Statistical Manual.

DSP – Direct Support Professional

DT – Developmental Training, now "Community Day Services"

DT – Developmental Therapy, Developmental Therapist

Dx – Diagnosis

ED – Emotional Disorder

EI – Early Intervention

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

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

ED – Emergency Department

ER – Emergency Room

FAPE – Free and Appropriate Public Education

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

FOIA – Freedom of Information Act.

FQHC – Federally Qualified Health Center

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

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

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

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

HCBS – Home and Community Based Services

HI – Hearing Impairment or Health Impairment

Hx – History

ICAP – Inventory for Client and Agency Planning

ICDD – Illinois Council for Developmental Disabilities

ICFDD – Intermediate Care Facility for the Developmentally Disabled

ID – Intellectual Disability

IDEA – Individuals with Disabilities Education Act

IDOC – Illinois Department of Corrections

IDPH – Illinois Department of Public Health

IDT – Interdisciplinary Team

IEP – Individualized Education Plan

IFSP – Individualized Family Service Plan

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

Illinois Administrative Code Section 600.400: Certified Local Health Department Code Public Health Practice Standards. The essential elements of IPLAN are:

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

I&R – Information and Referral

ISBE – Illinois State Board of Education

ISC – Independent Service Coordination

ISP – Individual Service Plan, Individual Success Plan

ISSA – Independent Service & Support Advocacy

LCPC – Licensed Clinical Professional Counselor

LCSW – Licensed Clinical Social Worker

LD – Learning Disability

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

LPC – Licensed Professional Counselor

LPN – Licensed Practical Nurse

MCO – Managed Care Organization

MDC – Multidisciplinary Conference

MDT – Multidisciplinary Team

MH – Mental Health

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

MI – Mental Illness

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

MSW – Master of Social Work

NCI – National Core Indicators

NOS – Not Otherwise Specified

NTPC -- NON - Treatment Plan Clients. Persons engaged in a given quarter with case records but no treatment plan. May include: recipients of material assistance, non-responsive outreach cases, cases closed before a plan was written because the client did not want further service beyond first few contacts, or cases assessed for another agency. It is a category of service measurement, providing an actual number of those served in the prior program year and a projection for the coming program year on the Part II utilization form. The actual activity to be performed should also be described in the Part I Program Form, Utilization section. Similar to TPCs, they may be divided into two groups: New TPCS – first contact within any quarter of the plan year; Continuing NTPCs - those served before the first day of July and actively receiving services within the first quarter of the new program year. The first quarter of the program year is the only quarter in which Continuing NTPCs are reported.

OMA – Open Meetings Act.

OT – Occupational Therapy, Occupational Therapist

OTR – Registered Occupational Therapist

PAS – Pre-Admission Screening

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

PCI – Parent Child Interaction groups.

PCP – Person Centered Planning, Primary Care Physician

PDD – Pervasive Developmental Disorders

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

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

PSH – Permanent Supportive Housing

PT – Physical Therapy, Physical Therapist

PTSD – Post-Traumatic Stress Disorder

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

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

QIDP – Qualified Intellectual Disabilities Professional

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

RCCSEC – Rural Champaign County Special Education Cooperative

RD – Registered Dietician

RN – Registered Nurse

RT – Recreational Therapy, Recreational Therapist

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

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

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

SEDS – Social Emotional Development Specialist

SEL – Social Emotional Learning

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

SH – Supportive Housing

SIB – Self-Injurious Behavior

SIB-R – Scales of Independent Behavior-Revised

SLI – Speech/Language Impairment

SLP – Speech Language Pathologist

SPD – Sensory Processing Disorder

SSA – Social Security Administration

SSDI – Social Security Disability Insurance

SSI – Supplemental Security Income

SST – Support Services Team

SUD – Substance Use Disorder

SW – Social Worker

TIC – Trauma Informed Care

TPC – Transition Planning Committee

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

VI – Visual Impairment

VR – Vocational Rehabilitation

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

WIOA – Workforce Innovation and Opportunity Act

Kim Bowdry, Associate Director for Intellectual & Developmental Disabilities
Staff Report – March 2020

CCDDB: PY2021 funding applications are currently being reviewed and program summaries are being developed for the April Board Packet. All applications have been sent to the Independent Application Reviewer.

After review of PY20 2nd Quarter reports, I am working with two agencies to clarify some details in their reports.

After review of their audit, it was discovered that excess revenue is to be returned to the CCDDB from PACE. A letter was sent to the agency requesting the return of those funds. I worked with the PACE Administration & Finance Assistant to secure repayment of the excess revenue.

CCDDB Mini-Grant: I continue to work with Mini-grant awardees and their families to determine the specific/priority items that should be purchased. I continue to work with several vendors to secure W-9s and quotes for Purchase Orders to be developed by the Financial Manager.

In one instance, an item was ordered and had to be returned to the vendor due to an incorrect fit. This item was returned and reordered in the correct size. I have also made a few mini-grant deliveries to families who are unable or have had a difficult time making it into the office to pick up their items.

Learning Opportunities: "Bookkeeping 101 for Non-Profit Programs" was held on March 5, 2020. Twenty-five people registered to attend the workshop and 12 were present for the workshop. Bookkeeping 102, also presented by John Brusveen, is scheduled for April 2, 2020.

I created the sign-in sheets and evaluation forms for Bookkeeping 101 and Bookkeeping 102. Bookkeeping 101 evaluations were compiled and I created the online invitation for Bookkeeping 102.

I have started reaching out for presenters for upcoming workshops.

MHDDAC: I participated in the monthly meeting of the MHDDAC.

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

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

Disability Resource Expo: I participated in a Steering Committee meeting and a Children's Room committee meeting for the 13th Annual Disability Resource Expo. The Expo is scheduled for Saturday, March 28, 2020 from 9:00 am until 2:00 pm at The Vineyard Church. I have also been ordering prized and other supplies for the Expo, including gift baskets, Children's Room prized, as well as items to improve accessibility of the Expo.

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

Other activities: I participated in the following webinars: *Hacking the Science of Your ADHD Brain: 5 Secrets to Productivity; Keeping the Community in HCBS Funded Services: Understanding and Commenting on the Statewide Transition Plan; Marijuana and the ADHD Brain: How to Identify and Treat Cannabis Use Disorder in Teens and Young Adults; How to Become an Executive Function Detective: Solving Middle and High School Problems with Your ADHD Teen; The Fundamentals of Respite Care; ADHD and Food Dyes, Nutrition, and Supplements: The Latest Science On What Dietary Changes Improve (or Worsen) Symptoms; March*

Community of Practice Webinar Confirmation; Understanding the New ADHD Guidelines: A Parent's Guide to the Latest Standards for Diagnosing and Treating Children.

I also participated in a grant review meeting with CCMHB and United Way staff.

I participated in the March meeting of the Transition Planning Committee.

Community Coalition Race Relations Subcommittee: I participated in the March meeting of the Race Relations Subcommittee. I also attended and took notes at Youth Race Talks events.

Prioritization of Urgency of Needs for Services (PUNS) Summary Reports: 1,247 PUNS selection letters were mailed out by the Illinois Department of Human Services Division of Developmental Disabilities (IDHS-DDD) in late August. 33 PUNS Selection letters were mailed to people in Champaign County.

13 of 33 people have received an award letter Home Based Services (HBS) and 2 people's packet for HBS has been submitted to IDHS-DDD. 1 person has been awarded CILA funding. The remaining people are working with CCRPC ISC to complete the PAS process, 3 are awaiting a specific CILA provider/geographic location, 11 are still gathering required documents/awaiting Medicaid approval, 2 are undecided on funding choice, 1 has moved out of the area.

23 PUNS Preselection letters were mailed to residents of Champaign County for an upcoming 2020 PUNS Selection.

Updated "PUNS Summary by County and Selection Detail for Champaign County" and the "Division of Developmental Disabilities Prioritization of Urgency of Needs for Services (PUNS) Summary of Total and Active PUNS by Zip Code" reports are attached. IDHS posted updated versions on March 9, 2020. These documents detail the number of Champaign County residents enrolled in the PUNS database.

Division of Developmental Disabilities

Prioritization of Urgency of Needs for Services (PUNS)

Summary By County and Selection Detail

March 09, 2020

County: Champaign

Reason for PUNS or PUNS Update	**932**
New	47
Annual Update	319
Change of Category (Seeking Service or Planning for Services)	23
Change of Service Needs (more or less) - unchanged category (Seeking Service or Planning for Services)	18
Person is fully served or is not requesting any supports within the next five (5) years	223
Moved to another state, close PUNS	23
Person withdraws, close PUNS	26
Deceased	17
Individual Stayed in ICF/DD	1
Individual Moved to ICF/DD	2
Individual Determined Clinically Ineligible	6
Unable to locate	49
Submitted in error	2
Other, close PUNS	176
CHANGE OF CATEGORY (Seeking Service or Planning for Services)	**433**
PLANNING FOR SERVICES	**151**
EXISTING SUPPORTS AND SERVICES	**388**
Respite Supports (24 Hour)	10
Respite Supports (<24 hour)	13
Behavioral Supports (includes behavioral intervention, therapy and counseling)	148
Physical Therapy	47
Occupational Therapy	104
Speech Therapy	131
Education	181
Assistive Technology	47
Homemaker/Chore Services	6
Adaptions to Home or Vehicle	4
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.)	44
Medical Equipment/Supplies	32
Nursing Services in the Home, Provided Intermittently	4
Other Individual Supports	161
TRANPORTATION	**425**
Transportation (include trip/mileage reimbursement)	118
Other Transportation Service	279
Senior Adult Day Services	1
Developmental Training	87
"Regular Work"/Sheltered Employment	69
Supported Employment	88
Vocational and Educational Programs Funded By the Division of Rehabilitation Services	61
Other Day Supports (e.g. volunteering, community experience)	26
RESIDENTIAL SUPPORTS	**82**
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	2
Skilled Nursing Facility/Pediatrics (SNF/PED)	5
Supported Living Arrangement	7

Division of Developmental Disabilities

Prioritization of Urgency of Needs for Services (PUNS)

Summary By County and Selection Detail

March 09, 2020

Community Living Facility	1
Shelter Care/Board Home	1
Nusing Home	1
Children's Residential Services	4
Child Care Institutions (Including Residential Schools)	9
Other Residential Support (including homeless shelters)	13
SUPPORTS NEEDED	**398**
Personal Support (includes habilitation, personal care and intermittent respite services)	349
Respite Supports (24 hours or greater)	19
Behavioral Supports (includes behavioral intervention, therapy and counseling)	147
Physical Therapy	41
Occupational Therapy	74
Speech Therapy	90
Assistive Technology	48
Adaptations to Home or Vehicle	18
Nursing Services in the Home, Provided Intermittently	5
Other Individual Supports	84
TRANSPORTATION NEEDED	**351**
Transportation (include trip/mileage reimbursement)	289
Other Transportation Service	317
VOCATIONAL OR OTHER STRUCTURED ACTIVITIES	**275**
Support to work at home (e.g., self employment or earning at home)	4
Support to work in the community	240
Support to engage in work/activities in a disability setting	93
Attendance at activity center for seniors	3
RESIDENTIAL SUPPORTS NEEDED	**115**
Out-of-home residential services with less than 24-hour supports	57
Out-of-home residential services with 24-hour supports	67

Total PUNS: 56,650

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

Division of Developmental Disabilities Prioritization of Urgency of Needs for Services (PUNS)
Summary of Total and Active PUNS by Zip Code
Updated 03/09/20

Zip Code		Active PUNS	Total PUNS	
60949	Ludlow	1	3	
61801	Urbana	34	83	
61802	Urbana	62	123	
61815	Bondville (PO Box)	1	1	
61816	Broadlands	2	3	
61820	Champaign	44	90	
61821	Champaign	79	184	
61822	Champaign	54	105	
61826	Champaign	0	1	
61840	Dewey	0	2	
61843	Fisher	7	11	
61845	Foosland	1	1	
61847	Gifford	1	1	
61849	Homer	0	5	
61851	Ivesdale	1	2	
61852	Longview	1	1	
61853	Mahomet	34	68	
61859	Ogden	4	13	
61862	Penfield	1	2	
61863	Pesotum	1	2	
61864	Philo	3	11	
61866	Rantoul	29	86	
61871	Royal (PO Box)	--	--	no data
61872	Sadorus	2	2	
61873	St. Joseph	14	26	
61874	Savoy	9	16	
61875	Seymour	2	3	
61877	Sidney	4	10	
61878	Thomasboro	0	2	
61880	Tolono	8	26	
Total		**399**	**883**	

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

Stephanie Howard-Gallo

Operations and Compliance Coordinator Staff Report –

March 2020 Board Meeting

SUMMARY OF ACTIVITY:

I was off on medical leave the month of February and returned to work part time on March 2.

County Operations:
On March 5, 2020 at Brookens Administrative Center, I attended a county-wide department heads meeting to discuss continuity of operations should Coronavirus infections become widespread.

Audits:
As previously reported, Promise Healthcare and CU Area Project (CCMHB funded) did not submit audits by their extended due date. Payments have been withheld.

Compliance:
2nd Quarter financial and program reports for all funded programs were due at the end of January. In my absence, Kim Bowdry, Mark Driscoll, and Chris Wilson handled 2nd quarter reporting non-compliance issues.

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 in Urbana 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 and the artists.

In March, NAMI artists are being featured at the gallery. In April, we have a new artist that has agreed to represent the Alliance and support our mission. Laura Anne Welle creates paintings, drawings and mixed media.

We will continue with a new artist/group of artists 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. Please support this awesome local business by doing some shopping or having custom framing done!

Barb Bressner is organizing AIR artists to show at the Market IN the Square (Lincoln Square in Urbana on most Saturdays from 8 a.m. until 1 p.m.) during the winter/spring months. The current schedule is as follows:

Mar. 14	Melanie McGhiey
Mar. 21	TBD
Mar. 28	No Market
Apr. 4	Swann Care Center
Apr. 11	TBD
Apr. 18	Circle of Friends
Apr. 25	Carol Bradford

On **Saturday, April 18th,** Alliance artists that are interested in showing/selling their work outside of Ebertfest will have an opportunity to do so from 11 a.m. until 8 p.m. We are organizing what we need to accommodate them. Vicki Tolf from DSC and Nancy Carter from NAMI do a great deal of work to help us with this show and offer support to artists. We currently have 14 artists/artist groups interested in participating in this event.

Other:

- I prepared meeting materials for the March CCMHB/CCDDB meetings.

2020 March 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

Funding Applications FY21:

I am reviewing the CLC Plans and summarizing feedback. The summaries will be included in the Program Summaries.

Family Services Center: I attended the Self- Help Advisory Meeting. The Spring Conference will be held on Friday, April 24, 2020 9:00am. The Spring workshop will be about Mindfulness.

GROW Illinois: I spoke with the staff members of GROW about additional improvements to the FY20 CLC Plan after the submission of the 2nd quarter report.

Cunningham Children's Home: I attended a cultural competence training at Cunningham Children's Home. Therapeutic Benefits of Humor: with Clients & in the Workplace (Mark Sanders-Presenter). This workshop talked about ways to keep hope through humor in workplace settings.

Don Moyer's Boys and Girls Club: Members of the Illinois Family and Youth Alliance reached out to get feedback about activities and planning for Children's Mental Health Awareness Week May 3-9, 2020.

CLC Coordinator Direct Service Activities

Mental Health First Aid Training: I competed Mental Health First Aid for Adults on February 21st and 28th. There were 25 people that attended this class. This was in partnership with the School of Social Work and the Community Learning Lab Students from the fall semester.

We will offer Mental Health First Aid for Youth on May 15th and May 22nd 9:00-1:30pm. This class will be offered to anyone that would like to attend and will be held at Brookens in the Jeanie Putnam Room. **For additional information please email shandra@ccmhb.org.**

Upcoming Trainings:

Mental Health First Aid Summit for Instructors. This will be a training for instructors to learn about best practices and tips on how to be an effective instructor. It will be in Austin, TX on April 4, 2020.

Anti-Stigma Activities/Community Collaborations and Partnerships

Disability Resource Expo: I attended the Expo Steering Committee Meeting on March 3, 2020. We are still looking for Volunteers. If you are interested in volunteering at the Expo please

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contact Shandra Summerville: shandra@ccmhb.org or you can go to disAbility Expo site and volunteer directly. http://www.disabilityresourceexpo.org/volunteer/

AIR- Alliance for Inclusion and Respect: I convened the AIR Meeting with the partners for the Ebert Film Festival and The AIR Art Show on February 25th. Please save the date for the AIR Art Show Saturday April 18th, 2020. I have started the planning for the Student Film presentation at Urbana High School. Details should be finalized within the next few weeks.

C-HEARTS African American Story Telling Project: I attended two meetings for C-HEARTS this month. On February 24, I attended a meeting with representation from CUAP (Champaign Urbana Area Project), Bruce Nesbit African American Cultural Center, C-U Trauma and Resilience, and Krannert Art Center. This meeting was the follow-up about the storytelling project and opportunities to bring the training Emancipation Circles to the community.

On March 3, 2020 we had our regular meeting. We discussed the partnership to bring the Emotional Emancipation Circles Training to Champaign-Urbana in early May.

Champaign County Mental Health Board
FY19 Revenues and Expenditures as of 02/28/20

Revenue	Q4	YTD	Budget	% of Budget
Property Tax Distributions	$ 1,420,121.81	$ 4,826,752.78	$ 5,001,938.00	96.50%
From Developmental Disabilities Board	$ 127,884.84	$ 409,174.84	$ 337,555.00	121.22%
Gifts & Donations	$ 350.00	$ 18,981.00	$ 20,000.00	94.91%
Other Misc Revenue	$ 10,824.19	$ 174,978.46	$ 45,000.00	>100%
TOTAL	**$ 1,559,180.84**	**$ 5,429,887.08**	**$ 5,404,493.00**	**100.47%**

Expenditure	Q4	YTD	Budget	% of Budget
Personnel	$ 144,808.95	$ 517,053.28	$ 542,252.00	95.35%
Commodities	$ 3,887.10	$ 11,147.00	$ 17,600.00	63.34%
Contributions & Grants	$ 683,909.00	$ 3,993,282.50	$ 4,347,815.00	91.85%
Professional Fees	$ 23,788.00	$ 158,061.61	$ 235,000.00	67.26%
Transfer to CILA Fund	$ -	$ 300,000.00	$ 50,000.00	>100%
Other Services	$ 149,498.59	$ 234,819.84	$ 211,826.00	110.86%
TOTAL	**$ 1,005,891.64**	**$ 5,214,364.23**	**$ 5,404,493.00**	**96.48%**

Champaign County Developmental Disability Board
FY19 Revenues and Expenditures as of 02/28/20

Revenue	Q4	YTD	Budget	% of Budget
Property Tax Distributions	$ 1,174,978.41	$ 3,993,551.97	$ 4,174,033.00	95.68%
From Mental Health Board	$ 6,504.85	$ 106,504.85	$ 8,000.00	1331.31%
Other Misc Revenue	$ 18,432.63	$ 36,052.82	$ 15,000.00	240.35%
TOTAL	**$ 1,199,915.89**	**$ 4,136,109.64**	**$ 4,197,033.00**	**98.55%**

Expenditure	Q4	YTD	Budget	% of Budget
Contributions & Grants	$ 593,156.00	$ 3,445,272.00	$ 3,809,479.00	90.44%
Professional Fees	$ 28,129.00	$ 309,419.00	$ 337,554.00	91.67%
Transfer to CILA Fund	$ -	$ 50,000.00	$ 50,000.00	100.00%
Other Services	$ 100,000.00	$ 100,000.00	$ -	>100%
TOTAL	**$ 621,285.00**	**$ 3,904,691.00**	**$ 4,197,033.00**	**93.03%**