Champaign County Developmental Disabilities Board (CCDDB) Meeting Agenda
Wednesday, March 20, 2024, 9:00 AM

This meeting will be held in person at the Shields-Carter Room of the Brookens Administrative Building, 1776 East Washington Street, Urbana, IL 61802
Members of the public may attend in person or watch the meeting live through this link: https://us02web.zoom.us/j/81559124557 Meeting ID: 815 5912 4557

I. **Call to order**
II. **Roll call**
III. **Approval of Agenda***
IV. **CCDDB and CCMHB Schedules, CCDDB Timeline** (pages 3-7) *No action is needed.*
V. **CCDDB Acronyms and Glossary** (pages 8-15) *No action is needed.*
VI. **Citizen Input/Public Participation** *All are welcome to attend the Board's meeting to observe and to offer thoughts during this time. The Chair may limit public participation to 5 minutes per person and/or 20 minutes total.*
VII. **Chairperson's Comments – Ms. Vicki Niswander**
VIII. **Executive Director's Comments – Lynn Canfield**
IX. **Approval of CCDDB Board Meeting Minutes** (pages 16-19)*
Minutes from the CCDDB's regular meeting on 2/21/24 are included for approval. Action is requested.
X. **Vendor Invoice Lists** (pages 20-25)*
Action is requested to accept the "Vendor Invoice Lists" and place them on file.
XI. **Staff Report** (pages 26-58)
Included for information only is a conference report from Lynn Canfield. Other reports are deferred due to the review of agency requests for funding.
XII. **New Business**
    a) **PY2025 Funding Requests** (page 59)
    A list of agency requests for I/DD funding is included to support Board questions. Agencies applying for these funds are encouraged to answer Board questions.
    b) **PY2023 I/DD Service Activity Data** (pages 60-76)
    Included for information only is a memorandum summarizing individual level claims data reported for PY23 I/DD contracts.
XIII. **Old Business**
    a) **Evaluation Capacity Building Project**

Representatives of the UIUC Family Resiliency Center ECB team will provide an oral update. No action is requested.

b) **Expo Report** (pages 77 and 78)
For information only are postcards announcing the October 26th event.

XIV. Successes and Other Agency Information
The Chair reserves the authority to limit individual agency representative participation to 5 minutes and/or total time to 20 minutes.

XV. County Board Input

XVI. Champaign County Mental Health Board Input

XVII. Board Announcements and Input

XVIII. Other Business - Review of Closed Session Minutes*
Board staff and attorneys request that the Board continue to maintain as closed the minutes of closed sessions held 2/19/2020, 2/26/20, and 2/23/2022, which have been distributed for review.

For discussion, the Board may "move to executive session, exception 5 ILCS 120/2(c)(11) of the Open Meetings Act, to review status of minutes of prior closed session meetings, and that the following individuals remain present: members of the Champaign County Developmental Disabilities Board, Executive Director Canfield, and Associate Director Kim Bowdry."

If this motion is approved, those authorized will move to Brookens Meeting Room 3 for roll call and discussion. When the closed session discussion ends, they will move back to the Shields Carter Room, for a motion to return to Open Session and new roll call.

Once the Open Session is re-established, the recommended action to take might be: "motion to accept the February 19, 2020, February 26, 2020, and February 23, 2022 closed session minutes as presented (or revised), to continue maintaining them as closed, and to destroy the recordings of the meetings."

XIX. Adjournment

** Board action is requested.*

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

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CCDDB 2024 Meeting Schedule

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

January 17, 2024 – Shields-Carter Room
February 21, 2024 – Shields-Carter Room
March 20, 2024 – Shields-Carter Room
March 27, 2024 5:45PM – Shields-Carter Room – *joint study session with the CCMHB*
April 17, 2024 – Shields-Carter Room
May 22, 2024 – Shields-Carter Room
June 12, 2024 – Shields-Carter Room *(off cycle)*
July 17, 2024 – Shields-Carter Room
August 21, 2024 – Shields-Carter Room - *tentative*
September 18, 2024 – Shields-Carter Room
September 25, 2024 5:45PM – Shields-Carter Room – *joint study session with the CCMHB*
October 16, 2024 5:45PM – Shields-Carter Room – *joint meeting with the CCMHB*
October 23, 2024 – Shields-Carter Room
November 20, 2024 – Shields-Carter Room
December 18, 2024 – Shields-Carter Room – *tentative*

This schedule is subject to change due to unforeseen circumstances.

Please email stephanie@ccmhb.org to confirm meetings or to request alternative format documents, language access, or other accommodation needed to participate.
All meetings and study sessions include time for members of the public to address the Board.
Meetings are posted in advance and recorded and archived at
http://www.co.champaign.il.us/mhbddb/DDBMeetingDocs.php

Public Input: All are welcome to attend the Board's meetings, whether virtually or in person, to observe and to offer thoughts during the "Public Participation" period of the meeting. For support to participate in a meeting, let us know how we might help by emailing stephanie@ccmhb.org. If the time of the meeting is not convenient, you may still communicate with the Board by emailing stephanie@ccmhb.org any written comments which you would like us to read to the Board during the meeting. Your feedback is appreciated but be aware that the time for each person's comments may be limited to five minutes.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CCMHB 2024 Meeting Schedule

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

January 17, 2024 – Shields-Carter Room
January 24, 2024 – *Study Session* - Shields-Carter Room
February 21, 2024 – Shields-Carter Room
~~**February 28, 2024** – *Study Session* Shields-Carter Room~~ *CANCELLED*
March 20, 2024 – Shields-Carter Room
March 27, 2024 – *Joint Study Session w CCDDB* - Shields-Carter
April 17, 2024 – Shields-Carter Room
April 24, 2024 – *Study Session* - Shields-Carter Room
May 15, 2024 – *Study Session* - Shields-Carter Room
May 22, 2024 – Shields-Carter Room
June 12, 2024 – Shields-Carter Room (*off cycle)*
July 17, 2024 – Shields-Carter Room
August 21, 2024 – Shields-Carter Room - *tentative*
September 18, 2024 – Shields-Carter Room
September 25, 2024 – *Joint Study Session w CCDDB* - Shields-Carter
October 16, 2024 – *Joint Meeting w CCDDB* - Shields-Carter
October 23, 2024 – Shields-Carter Room
November 20, 2024 – Shields-Carter Room
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This schedule is subject to change due to unforeseen circumstances.

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Meetings are archived at http://www.co.champaign.il.us/mhbddb/MHBMeetingDocs.php

Public Input: All meetings and study sessions include time for members of the public to address the Board. All are welcome to attend meetings, whether using the Zoom options or in person, to observe and to offer thoughts during "Public Participation". For support to participate, let us know how we might help by emailing stephanie@ccmhb.org. If the time of the meeting is not convenient, you may still communicate with the Board by emailing stephanie@ccmhb.org any written comments which you would like us to read to the Board during the meeting. Your feedback is appreciated but be aware that the time for each person's comments may be limited to five minutes.

IMPORTANT DATES

2023-24 Meeting Schedule with Subjects, Agency and Staff Deadlines, and PY25 Allocation Timeline

This schedule offers dates and subject matter of meetings of the Champaign County Developmental Disabilities Board. Included are tentative dates for steps in the funding process for PY25 and deadlines related to PY23 and PY24 agency contracts. Subjects are not exclusive to any given meeting, as other matters requiring Board attention may be addressed. Study sessions may be scheduled on topics raised at meetings or by staff, or in conjunction with the CCMHB. **Regular meetings are held at 9AM; joint study sessions and meetings at 5:45PM; dates and times are subject to change and may be confirmed with Board staff.**

12/1/23	*Public Notice of Funding Availability to be published by this date, giving at least 21-day notice of application period.*
12/20/23	**Regular Board Meeting** (off cycle) - *tentative*
12/22/23	*Online System opens for Applications for PY2025 Funding*
12/31/23	*Agency Independent Audits, Reviews, or Compilations due*
1/17/24	**Regular Board Meeting**
1/26/24	*Agency PY24 2nd Quarter and CLC progress reports due*
2/12/24	*Deadline for submission of applications for PY25 funding (Online system will not accept any forms after 4:30PM)*
2/21/24	**Regular Board Meeting** Discuss list of PY25 Applications, Review Process
3/20/24	**Regular Board Meeting** Discussion of PY25 Funding Requests
3/27/24	**Joint Study Session OR Joint MEETING with CCMHB** (5:45PM)
4/10/24	*Program summaries released to Board, posted online with CCDDB April 17 meeting agenda and packet*

4/17/24	**Regular Board Meeting** Board Review, Staff Summaries of Funding Requests
4/26/24	*Agency PY2024 3rd Quarter Reports due*
5/15/24	*Allocation recommendations released to Board, posted online with CCDDB May 22 board meeting packet*
5/22/24	**Regular Board Meeting** Allocation Decisions; Authorize Contracts for PY25
6/1/24	*For contracts with a PY24-PY25 term, all updated PY25 forms should be completed and submitted by this date.*
6/12/24	**Regular Board Meeting** *(off cycle)* Draft FY2025 Budget
6/18/24	*Deadline for agency application/contract revisions* *Deadline for agency letters of engagement w/ CPA firms*
6/21/24	*PY2025 agency contracts completed.*
6/30/24	*Agency Independent Audits, Reviews, or Compilations due (only applies to those with calendar FY, check contract)*
7/17/24	**Regular Board Meeting**
8/21/24	**Regular Board Meeting -** *tentative*
8/30/24	*Agency PY2024 4th Quarter reports, CLC progress reports, and Annual Performance Measure Reports due*
9/18/24	**Regular Board Meeting** Community Needs Assessment Report Draft Three Year Plan 2025-27 with 2025 Objectives Approve Draft FY2025 Budgets
9/25/24	**Joint Study Session with CCMHB** (5:45PM)
10/16/24	**Joint Meeting with CCMHB** (5:45PM)

	I/DD Special Initiatives
10/23/24	**Regular Board Meeting** DRAFT Program Year 2026 Allocation Criteria
10/23/24	*Agency PY2025 First Quarter Reports due*
11/20/24	**Regular Board Meeting** Approve Three Year Plan with One Year Objectives Approve PY26 Allocation Criteria
11/29/24	*Public Notice of Funding Availability to be published by date, giving at least 21-day notice of application period.*
12/18/24	**Regular Board Meeting**– *tentative*
12/20/24	*Online system opens for applications for PY26 funding.*
12/30/24	*Agency Independent Audits, Reviews, Compilations due.*

Agency and Program acronyms commonly used by the CCDDB

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
CUAN – Champaign-Urbana Autism Network
DSC - Developmental Services Center
DSN – Down Syndrome Network
IAG – Individual Advocacy Group
ISC – Independent Service Coordination Unit
FDC – Family Development Center
PACE – Persons Assuming Control of their Environment, Inc.
PCMHC – Piatt County Mental Health Center
RCI – Rosecrance Central Illinois
RPC – Champaign County Regional Planning Commission

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

IDHS – Illinois Department of Human Services

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

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

NACO – National Association of Counties

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

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

Minutes February 21, 2024

This meeting was held at the Brookens Administrative Center
1776 E. Washington St., Urbana, IL 61802
and with remote access via Zoom.

9:00 a.m.

MEMBERS PRESENT:	Kim Fisher, Susan Fowler, Vicki Niswander, Anne Robin, Georgiana Schuster
STAFF PRESENT:	Kim Bowdry, Lynn Canfield, Shandra Summerville, Stephanie Howard-Gallo, Chris Wilson
OTHERS PRESENT:	Laura Bennett, Sarah Perry, Danielle Matthews, Patty Walters, Heather Levingston, DSC; Becca Obuchowski, Hannah Sheets, Community Choices; Angela Yost, Jessica McCann, Tiara Richardson, CCRPC; Michelle Ingram, Bill Kubaitis, Mel Liong, Paula Vanier, PACE; Nancy Uchtmann, Respite Task Force of Illinois; Leah Taylor, Champaign County Board; Stephanie Sloane, Rachel Jackson, Evaluation Capacity Building Project

CALL TO ORDER:

CCDDB Vice-President Georgiana Schuster called the meeting to order at 9:03 a.m.

ROLL CALL:

Roll call was taken, and a quorum was present. CCDDB member Vicki Niswander requested to attend remotely due to illness. In compliance with the CCDDB By-Laws a motion was requested by Ms. Schuster to allow her remote attendance.

MOTION: Dr. Fowler moved to allow remote attendance for Vicki Niswander for this meeting due to illness. Dr. Fisher seconded the motion. All CCDDB members voted aye and the motion passed.

APPROVAL OF AGENDA:

An agenda was available for review and approved by a unanimous vote.

CCDDB and CCMHB SCHEDULES/TIMELINES:

Updated copies of CCDDB and CCMHB meeting schedules and CCDDB allocation timeline were included in the packet.

ACRONYMS and GLOSSARY:

A list of commonly used acronyms was included for information.

CITIZEN INPUT/PUBLIC PARTICIPATION:

Ms. Nancy Uchtmann from the Illinois Respite Task Force spoke regarding her concerns with the lack of developmental disability caregivers.

PRESIDENT'S COMMENTS:

None.

EXECUTIVE DIRECTOR'S COMMENTS:

Director Canfield provided a brief report on the national conferences she attended. A written report from her will be presented at a future meeting.

She reviewed the agenda.

APPROVAL OF MINUTES:

Minutes from the 1/17/2024 board meeting were included in the packet.

MOTION: Dr. Fisher moved to approve the minutes from the 1/17/24 CCDDB meeting. Dr. Fowler seconded the motion. A voice vote was taken. The motion passed.

VENDOR INVOICE LIST:

The Vendor Invoice List was included in the Board packet.

MOTION: Dr. Fisher moved to accept the Vendor Invoice List as presented in the packet. Dr. Robin seconded the motion. A voice vote was taken, and the motion passed unanimously.

STAFF REPORTS:

Staff reports were included in the packet.

NEW BUSINESS:

Mid-Year Progress Reports:
Becca Obuchowski from Community Choices presented mid-year findings on the Transportation and Staff Retention programs.

Angela Yost from the Regional Planning Commission presented on the Dual Diagnosis program and Person-Centered Planning survey.

Board members were given an opportunity to ask questions following the presentations.

PY2025 Applications for Funding:
A list of applications submitted by the February 12, 2024 deadline was included in the Board packet. The review process was discussed by Board members at length.

Draft Revised Travel Policy:
A Decision Memorandum presented a final draft of the CCDDB-CCMHB Travel and Business Expense Policy for review.

MOTION: Dr. Fisher moved to accept the final draft of the CCDDB-CCMHB Travel and Business Expense Policy. Ms. Niswander seconded the motion. A vote was taken and the motion passed unanimously.

OLD BUSINESS:
Evaluation Capacity Building Project:
Rachel Jackson and Stephanie Sloan provided a verbal update on the project.

Expo Update:
Save the Date Flyers for 2024 and an updated financial summary on the 2023 event were included in the packet.

2nd Quarter Program Service Reports:
Reports were included in the packet.

2nd Quarter Program Claims Data:
Reports were included in the packet.

211 4th Quarter 2024 Reports:
An activity report from October 1 through December 31, 2023 was included in the packet.

SUCCESSES AND AGENCY INFORMATION:

Updates were provided by Patty Walters and Sarah Perry from DSC; and Bill Kubaitus, Mel Liong, and Paula Vanier from PACE;

COUNTY BOARD INPUT:

None.

CCMHB INPUT:

The CCMHB will meet this evening with similar agenda items.

BOARD ANNOUNCEMENTS AND INPUT:

None.

ADJOURNMENT:

The meeting adjourned at 11:03a.m.

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

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

Champaign County, IL

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
1 CHAMPAIGN COUNTY TREASURER										
Feb'24 DD24-078		02/01/2024	020224A	28995	36,148.00	36,148.00	02/29/2024	INV	PD	DD24-078 Decision Supp
CHECK DATE: 02/02/2024										
10146 COMMUNITY CHOICES, INC										
Feb'24 DD24-075		02/01/2024	020224A	29033	14,708.00	14,708.00	02/29/2024	INV	PD	DD24-075 Self-Determin
CHECK DATE: 02/02/2024										
Feb'24 DD24-076		02/01/2024	020224A	29033	2,833.00	2,833.00	02/29/2024	INV	PD	DD24-076 Staff Recruit
CHECK DATE: 02/02/2024										
Feb'24 DD24-077		02/01/2024	020224A	29033	10,499.00	10,499.00	02/29/2024	INV	PD	DD24-077 Transportatio
CHECK DATE: 02/02/2024										
Feb'24 DD24-090		02/01/2024	020224A	29033	16,500.00	16,500.00	02/29/2024	INV	PD	DD24-090 Inclusive Com
CHECK DATE: 02/02/2024										
Feb'24 DD24-095		02/01/2024	020224A	29033	18,875.00	18,875.00	02/29/2024	INV	PD	DD24-095 Customized Em
CHECK DATE: 02/02/2024										
Jan'24 DD24-075		01/01/2024	020224A	29033	14,708.00	14,708.00	01/31/2024	INV	PD	DD24-075 Self-Determin
CHECK DATE: 02/02/2024										
Jan'24 DD24-076		01/01/2024	020224A	29033	2,833.00	2,833.00	01/31/2024	INV	PD	DD24-076 Staff Recruit
CHECK DATE: 02/02/2024										
Jan'24 DD24-077		01/01/2024	020224A	29033	10,499.00	10,499.00	01/31/2024	INV	PD	DD24-077 Transportatio
CHECK DATE: 02/02/2024										
Jan'24 DD24-090		01/01/2024	020224A	29033	16,500.00	16,500.00	01/31/2024	INV	PD	DD24-090 Inclusive Com
CHECK DATE: 02/02/2024										
Jan'24 DD24-095		01/01/2024	020224A	29033	18,875.00	18,875.00	01/31/2024	INV	PD	DD24-095 Customized Em
CHECK DATE: 02/02/2024										
					126,830.00					
10170 DEVELOPMENTAL SERVICES CENTER OF										
Feb'24 DD23-086		02/01/2024	020224A	29043	18,958.00	18,958.00	02/29/2024	INV	PD	DD23-086 Workforce Dev
CHECK DATE: 02/02/2024										
Feb'24 DD24-081		02/01/2024	020224A	29043	47,123.00	47,123.00	02/29/2024	INV	PD	DD24-081 Community Liv
CHECK DATE: 02/02/2024										
Feb'24 DD24-082		02/01/2024	020224A	29043	74,170.00	74,170.00	02/29/2024	INV	PD	DD24-082 Community Fir
CHECK DATE: 02/02/2024										
Feb'24 DD24-083		02/01/2024	020224A	29043	41,340.00	41,340.00	02/29/2024	INV	PD	DD24-083 Service Coord
CHECK DATE: 02/02/2024										

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
Feb'24 DD24-084		02/01/2024	020224A	29043	20,083.00	20,083.00	02/29/2024	INV	PD	DD24-084 Clinical Serv
CHECK DATE: 02/02/2024										
Feb'24 DD24-085		02/01/2024	020224A	29043	7,508.00	7,508.00	02/29/2024	INV	PD	DD24-085 Employment Fi
CHECK DATE: 02/02/2024										
Feb'24 DD24-091		02/01/2024	020224A	29043	38,300.00	38,300.00	02/29/2024	INV	PD	DD24-091 Community Emp
CHECK DATE: 02/02/2024										
Feb'24 DD24-092		02/01/2024	020224A	29043	8,866.00	8,866.00	02/29/2024	INV	PD	DD24-092 Connections
CHECK DATE: 02/02/2024										
Jan'24 DD24-082		01/01/2024	020224A	29043	74,170.00	74,170.00	01/31/2024	INV	PD	DD24-082 Community Fir
CHECK DATE: 02/02/2024										
20 INVOICES					493,496.00					

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

ACCOUNT DETAIL HISTORY FOR 2024 02 TO 2024 02

ORG / OBJECT / PROJ / YR/PR / JNL / EFF DATE / SRC / REF1 / REF2 / REF3 / CHECK # / OB	AMOUNT	NET LEDGER BALANCE
21000100 502001 PROFESSIONAL SERVICES		
24/02 121 02/09/24 GEN	35,447.00	35,447.00
Feb DDB Feb DDB Admin Fee		
LEDGER BALANCES --- DEBITS: 35,447.00 CREDITS: .00 NET:		35,447.00
21000100 502025 CONTRIBUTIONS & GRANTS		
24/02 7 02/01/24 API 000001 DD24-078 56493 28995	36,148.00	36,148.00
W 020224A Feb'24 DD24-078 Decision Suppo CCT		
24/02 7 02/01/24 API 010146 DD24-095 56505 29033	18,875.00	55,023.00
W 020224A Feb'24 DD24-095 Customized Emp COMMUNITY CHOICES, I		
24/02 7 02/01/24 API 010146 DD24-090 56506 29033	16,500.00	71,523.00
W 020224A Feb'24 DD24-090 Inclusive Comm COMMUNITY CHOICES, I		
24/02 7 02/01/24 API 010146 DD24-076 56508 29033	2,833.00	74,356.00
W 020224A Feb'24 DD24-076 Staff Recruitm COMMUNITY CHOICES, I		
24/02 7 02/01/24 API 010146 DD24-075 56511 29033	14,708.00	89,064.00
W 020224A Feb'24 DD24-075 Self-Determina COMMUNITY CHOICES, I		
24/02 7 02/01/24 API 010146 DD24-077 56512 29033	10,499.00	99,563.00
W 020224A Feb'24 DD24-077 Transportation COMMUNITY CHOICES, I		
24/02 7 02/01/24 API 010170 DD24-084 56513 29043	20,083.00	119,646.00
W 020224A Feb'24 DD24-084 Clinical Servi DEVELOPMENTAL SERVIC		
24/02 7 02/01/24 API 010170 DD24-091 56514 29043	38,300.00	157,946.00
W 020224A Feb'24 DD24-091 Community Empl DEVELOPMENTAL SERVIC		
24/02 7 02/01/24 API 010170 DD24-082 56517 29043	74,170.00	232,116.00
W 020224A Feb'24 DD24-082 Community Firs DEVELOPMENTAL SERVIC		
24/02 7 02/01/24 API 010170 DD24-081 56519 29043	47,123.00	279,239.00
W 020224A Feb'24 DD24-081 Community Livi DEVELOPMENTAL SERVIC		
24/02 7 02/01/24 API 010170 DD24-092 56520 29043	8,866.00	288,105.00
W 020224A Feb'24 DD24-092 Connections DEVELOPMENTAL SERVIC		
24/02 7 02/01/24 API 010170 DD24-085 56521 29043	7,508.00	295,613.00
W 020224A Feb'24 DD24-085 Employment Fir DEVELOPMENTAL SERVIC		
24/02 7 02/01/24 API 010170 DD24-083 56522 29043	41,340.00	336,953.00
W 020224A Feb'24 DD24-083 Service Coordi DEVELOPMENTAL SERVIC		
24/02 7 02/01/24 API 010170 DD23-086 56523 29043	18,958.00	355,911.00
W 020224A Feb'24 DD23-086 Workforce Deve DEVELOPMENTAL SERVIC		

ACCOUNT DETAIL HISTORY FOR 2024 02 TO 2024 02

ORG / YR/PR	OBJECT / JNL	PROJ / EFF DATE	SRC	REF1	REF2	REF3	CHECK #	OB	AMOUNT	NET LEDGER BALANCE
LEDGER BALANCES --- DEBITS:					355,911.00	CREDITS:		.00	NET:	355,911.00
GRAND TOTAL --- DEBITS:					391,358.00	CREDITS:		.00	NET:	391,358.00

15 Records printed

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Champaign County, IL

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	PAID AMOUNT	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
10170 DEVELOPMENTAL SERVICES CENTER OF										
Feb'24 IDDSI24-080		02/01/2024	020224A	29043	20,833.00	20,833.00	02/29/2024	INV	PD	IDDSI24-080 Individual
CHECK DATE: 02/02/2024										
10424 PERSONS ASSUMING CONTROL OF THEIR ENVIRONMENT INC.										
Feb'24 IDDSI24-079		02/01/2024	020224A	29086	3,000.00	3,000.00	02/29/2024	INV	PD	IDDSI24-079 Consumer C
CHECK DATE: 02/02/2024										
Jan'24 IDDSI24-079		01/01/2024	020224A	29086	3,000.00	3,000.00	01/31/2024	INV	PD	IDDSI24-079 Consumer C
CHECK DATE: 02/02/2024										
		3 INVOICES			26,833.00					

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ACCOUNT DETAIL HISTORY FOR 2024 02 TO 2024 02

ORG / YR/PR	OBJECT / JNL	PROJ / EFF DATE	SRC	REF1	REF2	REF3	CHECK #	OB	AMOUNT	NET LEDGER BALANCE
21000096	502025	CONTRIBUTIONS & GRANTS								
24/02	7	02/01/24	API	010170	IDDSI24-80	56524	29043		20,833.00	20,833.00
	W 020224A	Feb'24 IDDSI24-080 Individual			DEVELOPMENTAL SERVIC					
24/02	7	02/01/24	API	010424	IDDSI24-79	56525	29086		3,000.00	23,833.00
	W 020224A	Feb'24 IDDSI24-079 Consumer Co			PERSONS ASSUMING CON					
LEDGER BALANCES --- DEBITS:		23,833.00	CREDITS:		.00	NET:				23,833.00
GRAND TOTAL --- DEBITS:		23,833.00	CREDITS:		.00	NET:				23,833.00

2 Records printed

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Briefing Memorandum

To: Champaign County Executive; Members, Champaign County Board;
Members, Champaign County Mental Health Board (CCMHB);
Members, Champaign County Developmental Disabilities Board (CCDDB); and
Members, Association of Community Mental Health Authorities of Illinois
From: Lynn Canfield, Executive Director, CCMHB/CCDDB
Date: March 20, 2024
Re: Legislative and Policy Conferences of National Association of Counties (NACO) and National Association of Behavioral Health and Developmental Disabilities Directors (NACBHDD)

From February 10 through February 15, 2024, I attended the annual Legislative and Policy Conferences of National Association of Counties (NACO) and National Association of County Behavioral Health and Developmental Disabilities Directors (NACBHDD). Following are my notes from conference sessions, committee meetings, a board meeting, and a congressional briefing.

NACo Legislative & Policy Conference

Conference information is also online here, including remarks by President Joe Biden, Health and Human Services Secretary Xavier Becerra, and Agriculture Secretary Tom Vilsack. Videos and highlights are here. All resolutions approved at the conference can be found at this link. For more information on NACo Legislative and Policy work, see NACO's federal policy priorities and, in particular, those related to mental and behavioral health and policy briefs for all areas, five of which are from the Health Steering Committee. I serve on this committee as well as the Healthy Counties Advisory and Resilient Counties Advisory groups.

Health Steering Committee (HSC) Joint Subcommittee Meeting

Call to Order and Welcome - Hon. Helen Stone, Commissioner, Chatham County, GA, and Committee Chair**.** HSC is one of ten policy setting committees for NACo, to influence national decisions which affect counties. Our work relates to public health, wellness, finance and delivery systems, services for uninsured and underinsured, equity, special populations, etc. Introduction of leadership, including the four subcommittees working on issues between these meetings. Introduction of Blaire Bryant, NACo staff.

Eduardo Cisneros, Acting Principal Deputy Director of Intergovernmental and External Affairs at the U.S. Department of Health and Human Services (HHS)**.** Was on the White House COVID response team until a week ago. HHS can receive texts! Looking forward to continued partnership with county leaders, on mental health, maternal health, substance use disorders, and more, to strengthen our work in 2024 toward shared goals. Eduardo.Cisneros@hhs.gov and U.S. Department of Health and Human Services Office of Intergovernmental & External Affairs (IEA) Webpage

Keynote Address: Pioneering Innovations in Health Equity and Social Determinants of Health through ARPA-H

Synopsis: *The Advanced Research Projects Agency for Health (ARPA-H) is a federal agency that fosters impactful research to drive biomedical and health breakthroughs, delivering transformative, sustainable,*

and equitable health solutions… addressing social determinants of health and … employing innovative strategies to tackle health disparities with the help of local governments.

Dr. Jen Roberts, Resilient Systems Mission Office Director, ARPA-H:
Also previously at the White House, as Director of Health Technologies. ARPA-H is one of the newest departments, focused on accelerating solutions to health problems, acknowledging SDOH.
Mission: Accelerate better health outcomes for everyone. DRPA puts money into possible solutions quickly, failing fast, de-risking strategies for other organizations, leading to successes such as GPS. ARPA-H is based on this approach, trying new things to learn if they're possible, getting what's possible in the lab into the hands of orgs which can implement, taking small successes and scaling them up for all US populations. Two upcoming programs are HEROES and PARADIGM.

The ARPA Model at Work for Health: defining how, who, and what; attributes that support the mission are radical change, autonomy, and term limits; bring on new experts for 3-6 years, either in emerging technology or new problem space.

Initial Mission Focus Areas: health science futures (what's technically possible), scalable solutions (reaching everyone quickly), proactive health (keeping people from being patients), resilient systems (building integrated healthcare systems); further investment in these areas will generate asymmetrical benefits to the health ecosystem.

Upcoming program, HEROES. What if we moved from a sick care system to a system that truly rewards better health? Preventive health care is not working for many Americans, despite massive spending. Health care outcomes: currently, health care orgs don't have financial incentives for prevention; in future, HEROES rewards fixing early warning signs to deliver better outcomes for all people, incentivized pre-negotiated payments. HEROES outcome toolkit: outcome selected for maximum impact on health disparities; geographic inclusion of every person in the area; site and performer selection (those with worse than national average performance and a plan to reach all people.) Will select two outcomes from these: to reduce stroke/cardiac events, alcohol misuse, opioid overdose, and negative maternal outcomes. HEROES regional teams will include investors, outcome buyers (could be local govt), and health accelerators (those actually doing the work). Proposers Day is Feb 13-14.

PARADIGM's mission is to solve rural America's critical health challenges by revolutionizing access to hospital level care – lung cancer rates and mortality are higher in rural areas, as are cervical and colorectal cancers, with maternal mortality twice as high. Program envisions a multipurpose care delivery platform that acts as a force multiplier. High-tech, advanced care. Mobile CT scanner, e.g. Contact ARPA-H

Resources:
Advanced Research Projects Agency for Health (ARPA-H)
Learn More About the Health Care Rewards to Achieve Improved Outcomes (HEROES) Project
Learn More About the Platform Accelerating Rural Access to Distributed and Integrated Medical Care
NACo Blog: White House releases playbook to address the social determinants of health

Panel Discussion:
Leveraging Medicaid to Enhance Housing Stability

Synopsis: *The connection between housing conditions and health outcomes is well recognized. As there is an increasing focus at the federal level to address social determinants of health (SDOH), Medicaid programs are partnering with housing authorities at the state and local level to bridge the service gap*

between housing and health. This collaboration aims to provide supportive housing assistance to beneficiaries by covering the cost of services related to housing that also promote health and integration into the community. These services include help with finding and securing housing, and making modifications to the home when individuals are transitioning from an institutional setting to a community environment… overview of how federal agencies such as HUD and CMS are partnering to improve housing and health outcomes through service coordination… spotlight on how a local government is putting these regulatory flexibilities in action to serve residents.

Hon. Tarenia Carthan, Commissioner, Douglas County, GA, Subcommittee Chair, Medicaid Subcommittee, introduced the topic and panelists.

Dr. Richard Cho, Senior Advisor for Housing and Services, HUD:
Medicaid and homelessness efforts are converging on common populations and needs: people with complex health needs exacerbated by homelessness, and people who are homeless with chronic health conditions including chronic homelessness. Leading to a common policy solution, Medicaid covered housing related supports plus. Understanding supportive services needs of people experiencing homelessness: housing or rental assistance (all), housing search and navigation (most), connections and coordination with existing community-based services (many), ongoing wraparound services (some), and assistance engaging through outreach (a few). Acknowledging the impact of traumatic experiences, including with the 'system'; hard to rebuild trust.

Permanent Supportive Housing is a proven intervention to address housing and health (numerous studies find it cost-effective with good human outcomes). Services include individualized, 'high touch' case management services that support tenancy and coordinate connection to other needed clinical and supportive services; mobile interdisciplinary team plus housing vouchers. Traditional low funding, but continuum of care HUD grants nearly $2b, of which $200m for supportive services. Emergency Solutions grants fund shelter and outreach. SAMHSA funds PATH and outreach limited to those with MH needs.

Medicaid Coverage of Housing-Related Services and Supports: not ongoing room and board, supportive services, home modifications, basic needs, etc. Medicaid expansion increased these opportunities, now covering low-income adults and families. Can states use Medicaid for the housing related services? Federal Actions: 2013 research papers; 2015 CMS guidance; 2016 CMS launched the Medicaid Innovation Accelerator Program; 2021 CMSH SDOH guidance, incorporating housing related services.

Dr. Jessica Lee, Chief Medical Officer, Center for Medicaid and CHIP Services, CMS:
Direct clinical strategies for Medicaid and CHIP. Recent CMS activities to support Health Related Social Needs: streamlining options through a number of CMS programs - State Plan authorities, 1915 waivers, ILOS, 1115 demonstration waivers, CHIP Health Service Initiatives. 8 states now have 1115 waivers to address HRSN. Advancing equity by addressing HRSN: care delivery, quality measurement (big data this year), and coverage of clinically appropriate HRSN interventions (short term upstream interventions); school-based services (a $50m NOFO out right now); transportation (for street medicine, e.g.)

Published framework of services and supports; Housing Example provides a roadmap for states to apply for demonstrations appropriate to their states, explains what each CMS authority is. Detail on 1115 demonstrations: covered services (must be medically appropriate – housing, nutrition, case management) and must be integrated with existing social services; service delivery; fiscal policy (can't be more than 15%, budget neutrality, and state spending must be maintained or increased to avoid supplantation); and related requirements (reimbursement rates for primary, behavioral and OBGYN but be at least 80% of Medicare rates and systematic monitoring of quality). CMS programming covers the lifespan, but quality information to drive improvement need to be aligned.

Dr. Cho gave examples:
Massachusetts – case management and wraparound supports for those experiencing homelessness, expanded from just managed care recipients to including one time transition costs, etc.
Oregon (new) - rent and temp housing for up to 6 months, housing navigation, transition costs, etc.
Coordinating federal programs for housing and health is complex. Barriers include need for cross-sector cross-program knowledge; differences in population definitions, eligibility criteria; confusion regarding how funds can be blended; resource limitations. Outreach – pre-tenancy supports - ongoing tenancy supports and services. HHS and HUD selecting several states to receive intensive federal implementation support.16 applied. (IL is not one of the recipients.) Also facilitating peer to peer learning for states.

Resources:
NACo Policy Brief: Protect the Federal-State-Local Partnership for Medicaid
HUD Continuum of Care Program: includes nearly $2 billion for permanent supportive housing, of which over $200 million is for supportive services.
HUD's Emergency Solutions Grant: can fund homeless outreach and housing navigation, but not ongoing tenancy sustaining services.
SAMHSA Grants & SAMHSA's PATH program is the primary federal formula grant program that funds homeless outreach, limited to people with mental health needs
CMCS Informational Bulletin describing the ways that states can address HRSN in Medicaid and CHIP authorities, and framework of HRSN services and supports that CMS considers allowable.
ASPE Report: Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts
HHS and HUD Partnership: Advancing Community Living Through Coordination Between Housing and Voluntary Community Services

Federal Agency Partner in Health:
USDA Resources for Rural Communities

Synopsis: *The United States Department of Agriculture (USDA) plays a vital role in bolstering rural health care access through its Rural Development programs, which include funding for the construction and expansion of healthcare facilities in underserved areas. Additionally, the USDA provides financial assistance and grants to rural communities to enhance telemedicine infrastructure, connecting residents to crucial medical services despite geographical challenges. In this partner spotlight, members of the Health Steering Committee will learn about the resources and opportunities offered by the USDA to improve health outcomes in rural communities.*

Kellie Kubena, Rural Health Liaison, USDA:
Farm Production and Conservation; Food, Nutrition, and Consumer Services; Food Safety; Marketing and Regulatory programs; Natural Resources. Within Rural Development: Innovation Center; Rural Housing Service; Rural Business and Cooperative Service; and Rural Utilities Service.

The Rural Health Liaison is a newer position, created by the 2018 Farm Bill, to collaborate and coordinate across the department and with HHS and other departments, sharing data about rural health. Recent accomplishments: MH Awareness Month Workshop Series; inventory of resources and products. Advancing Racial Justice, Equity, Opportunity, and Rural Prosperity. Key priorities: addressing climate change and environmental justice; advancing racial justice, place-based equity, and opportunity; and creating more and better market opportunities.

Single & Multi-Family Housing programs, water & environmental programs, community facility programs (very popular – lower death rates from COVID in communities using these programs), business and cooperative programs, and more. Community Development: Rural Placemaking Toolkit; Strategic Economic and Community Development (set-aside funding); Creating Opportunities through Rural Engagement (measuring engagement); Rural Partners Network (10 states + Puerto Rico, technical assistance to identify projects and access funds). Workforce Development: the rural workforce innovation network, just coordination and collaboration with lots of workshops and webinars (grants 101 training.)

Beyond Rural Development: USDA Support for Rural Health; grant program for agriculture at the community level – community gardens; National Agricultural Library. Ideas for Moving Forward: factors affecting mental health among farmers, tools to best support people, national suicide prevention strategy, maternal health pilot project with HRSA, and rural hospitals. Rural data gateway allows you to map USDA investments. kellie.kubena@usda.gov

Resources:
USDA's Rural Development – Federal Funding Opportunities
Community Facilities Programs offer fixed rate, low- cost direct loans, loan guarantees and grants to develop or improve essential public services and facilities in communities across rural America.
Telecom Programs: expand broadband through grants and loans.
Distance Learning and Telemedicine Grant
Rural Economic Development Loan and Grant Program (REDLG)
Rural Placemaking Toolkit
Strategic Economic and Community Development
Rural Partners Network
Rural Workforce Innovation Network

Health Steering Committee Business Meeting

Call to Order and Welcome - Helen Stone introduced leadership and staff, process, and agenda.
Hon. Kevin Anderson, Hennepin County, MN led the discussion. Resolution sponsors provided overview and answered questions from the committee (then members move, second, discuss, vote). The committee approved all of the proposed interim resolutions, and some were discussed at length.

Interim Health Policy 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. Resolutions and platform changes are valid until NACo's 2024 Annual Conference.

• Proposed Interim Resolution in Support of Federal Funding for Doula and Social Support Services and Training
Hon. Donna Miller, Cook County, IL. 2021 was the worst year for US maternal mortality, far worse rates for African American and Hispanic mothers. Value of doulas and patient centered care, but only 6% of mothers use them. Supports certification, community-based workforce, technical assistance for Medicaid reimbursement, extension of Medicaid post-partum coverage, address racial disparities. Commissioner Randall commented that Black women are not listened to, a greater factor than any other in the disparate outcomes. Passed.

• Proposed Interim Resolution in Support of Federal Funding for Social Media Safety Education and Training (cross claimed by the Human Services and Education Committee)
Hon. Donna Miller, Cook County, IL. Response to the US Surgeon General warning on increased concerns about the impact of social media on youth mental health. Additionally, social media is used to facilitate cyberbullying, privacy invasion, fraud, human trafficking, sexual harassment/predation, sale of illegal narcotics, hate, misinformation. The costs of these harms to our communities are significant, esp compared to prevention education. During discussion, a proposed amendment to strike "and misinformation" from line 14 – the amendment was moved, seconded, and during discussion amended to change to "and misinformation made to appear factual" – this change to the amendment was not accepted. The original amendment was further discussed. Another amendment to the amendment was presented – change "misinformation" to "disinformation." This friendly amendment was accepted, seconded. The friendly amendment passed. The proposed resolution as amended then passed.

• Proposed Interim Resolution on Tricare Reimbursement Adequacy
Hon. Janet Sinclair, Island County, WA. Largest per capita number of veterans in the state, with a rural hospital at risk since closure of Naval hospital due to low (26%) reimbursement rates. Puts the whole population at risk. Passed.

• Proposed Interim Resolution on Enhancing the Mental Health Parity and Addiction Equity Act of 2008
Hon. Laurie Trager, Lane County, OR. OR ranks 49th in mental health care. Operational needs not met with state and local tax funds, and a more robust payer mix is needed (limited to Medicaid). Commercial insurance doesn't cover many of the new and necessary services. NACo's Mental Health Commission has focused on this, among their four priority areas. Amendment proposed and seconded, to add "Tricare," was passed. Support for the amended Resolution passed.

• Proposed Interim Resolution on Ensuring Timely Death Certificate Signatures by U.S. Department of Veterans Affairs Clinicians
Hon. Julie Jepson, Anoka County, MN. Huge impact on benefits to families. Has full support of Veterans subcommittee and International Society of Coroners and Medical Examiners. Friendly amendment was made in Executive Committee, strengthening the final sentence of the "Proposed Policy" statement. The amended language passed. Support for the resolution as amended also passed.

• Proposed Interim Resolution on Studying the Relationship Between VA Benefits and Veteran Suicide Prevention
Dir. James Zinner, Dept of Veterans and Military Service, CA. 4x as many veterans passed from suicide as were lost in the War on Terror. Vets impacted by justice system or homelessness are even more likely to die by suicide. Passed.

• Proposed Interim Resolution on Support for Hepatitis C Elimination Initiative
Grace Phillips, General Counsel for the NM Association of Counties. Prevalence in correctional facilities, treatment not very effective in the past, but now an 8-12 week antiviral with high 90% success rate – an opportunity to eliminate a very serious disease within five years, with huge financial and human benefits. Accelerate development of testing, fund treatment, expand outreach. Passed.

• Proposed Interim Resolution on Securing Reimbursement for Rural Emergency Medical Services (Cross claimed from the Agriculture and Rural Affairs Committee)
Data from the public health emergency waiver showed great savings as a result of reimbursement for Rural EMS. An amendment was proposed to add "and Urban," leading to discussion of the message and the process and loss of rural healthcare. The amendment passed, and the resolution as amended passed.

• Proposed Interim Resolution on Strengthening and Sustaining the Healthcare Workforce in the US

Cook County, IL. Postsecondary and high school careers education, scholarship, publicly funded medical systems 'pipelines' for healthcare careers. Amended to add "and fund any mandatory increases." Amendment failed. Another amendment, "and encourage language access planning in the workforce development programs." Amended passed. Lots of discussion. Resolution passed.

Cross-Jurisdictional Resolutions ***(two, see above)***
… resolutions are initially referred to a primary steering committee. However, other steering committees can claim a resolution if the policy issue is relevant to other steering committee's issue areas.
Emergency Resolutions – *none*

Advancing Responsible AI Policy: A Collaborative Approach with the Silicon Valley Leadership Group

Synopsis: *The Silicon Valley Leadership Group, a CA-based business association, will join the committee to discuss how technology companies are working with local governments to advance responsible AI policy. The discussion will also delve into the specific policies being considered in the healthcare sector.*

Dr. Nadia Anderson, Chief of Staff and Strategy, Silicon Valley Leadership Group (SVLG):
SVLG serves as the nation's most effective and dynamic business association representing the innovation economy and its ecosystem. Over 200 members, including tech, non-profits, startups, hospitals, etc.
AI presents lots of unknown unknowns. When machines perform tasks and behaviors like an intelligent human; large quantities of data are processed, patterns recognized, and tasks performed. Biased data leads to biased outcomes. AI is limited in its ability to think, requires human input.

Institute for California AI Policy (ICAP), as we are the fourth industrial revolution; CA early to introduce policy around AI and seek ways to leverage the technology for social good. Collaboration and capacity building - public policy, strategic partnerships, and coalition building. AI policy and the Health Sector: Governor Newsom Executive Order on generative AI; legislation and regulatory action on AI; hospitals innovation and exploring AI. Start early when it comes to outreach and engagement. nanderson@svlg.org

Resources:
SLVG Responsible AI
Institute for California Artificial Intelligence Policy (I-CAP)
Governor Newsome's Executive Order on Generative AI
Policy Updates:
House Launches Bipartisan Taskforce on Artificial Intelligence
Watch Hearing from the Senate Finance Committee: Artificial Intelligence and Healthcare: Promise & Pitfalls

Keynote Address: Updates on Congressional Mental Health Policy Advancement

Synopsis:*… Congressional policy staff to discuss policy provisions that address the committee's mental health priorities in legislative packages under consideration in the Senate.*

Charlotte Kaye Rock, Health Policy Advisor, Senate Finance Committee (Minority)

Senate Finance Committee has a long history with MH/SUD funding. Last congress, 5 bipartisan working groups, including parity, children/young people, telehealth, etc. led to expansion of CCBHC, Medicaid coverage for juveniles pre-release, access through telehealth, and integration of crisis care.

Marielle Kress, Senior Health Policy Advisor, Senate Finance Committee (Majority)
This congress also focuses on behavioral health crisis, especially youth. ARPA creation of mobile crisis service in Medicaid and enhanced federal funding; SAFER Communities Act includes a set of policies making it easier for schools to pay for Medicaid services; pretrial detention coverage; MAT coverage. Currently trying to marry the house package and marked up senate package, with focus on the entire continuum of behavioral health care and emphasis on people coming out of incarceration. A number of Medicare telehealth flexibilities will expire at the end of this year (e.g., don't need in person visit to access care); want to keep some, also expand and make permanent the mobile crisis flexibilities.

Lauren Battle, Health Policy Advisor, Senator Laphonza Butler (D-CA)
Also served as advisor to the HELP committee. SUPPORT Act focuses on prevention, treatment, and recovery of SUD, especially OUD; school-based services; loan repayment program for workforce; training; support for ACES; others which fall under HHS. SUPPORT Act reauthorization package, plus new items, through HELP committee, continues funding for most and increases a few. Language to improve access to addiction supports and peer supports. Still talking through these toward a combined package. 2022 was another record-breaking year for overdose. Other areas of interest: young people struggled prior to the pandemic, compounded by isolation and loss of parents/caregivers; implications of social media on young people, esp girls; AI as opportunity and threat to health and behavioral health. Impact of community and interpersonal violence another focus.

Resources:
United States Senate Committee on Finance
United States Senate Committee on Health, Education, Labor, and Pensions
S.3393 - SUPPORT for Patients and Communities Reauthorization Act
H.R.4531 - Support for Patients and Communities Reauthorization Act
S.3430 - Better Mental Health Care, Lower-Cost Drugs, and Extenders Act of 2023

2024 Legislative Preview & Open Discussion

Synopsis: *The committee will close out the meeting with an overview of the committee's policy priorities, policy wins from the past year, and key legislation to watch in the coming year.*

Blaire Bryant, Legislative Director, Health:
Need to get reauthorization in the first quarter, maybe through an omnibus; need to responsibly steward AI in healthcare (congress and CMS regulatory side); health equity also a policy priority, lots of partnerships across federal agencies.

Briefs on each of the policy pillars (workforce, amending the exclusionary policies, crisis response and its infrastructure, parity) identified by the Mental Health Commission; collaboration of NACO and NACBHDD on brief on the IMD exclusion and how it creates barriers to care.

Headwinds due to it being an election year, but tailwinds as these have become Congressional priorities.

Resources:
NACo Blog: Congress work to reauthorize behavioral and mental health programs in SUPPORT Act

NACo Resource: Top 10 County Policy Priorities for Behavioral Health Reform
NACo Blog: Congress introduces Local 9-8-8 Response Act of 2023 to improve mental healthcare access

Illinois State Association of Counties (ISACo) Networking Dinner

ISACo is sponsoring 7 interim policy resolutions to be taken up by NACO's board:
- Building Community through Multi-County "Good Food for All" Initiatives;
- (support for) FY 2025 Appropriations for the US Department of Housing and Urban Development;
- (support for) HOME Reauthorization;
- (support for) Federal Funding for Doula and Social Support Services and Training;
- (support for) Strengthening and Sustaining the Healthcare Workforce in the US;
- (support for) Federal Funding for Social Media Safety Education and Training;
- (support for) High-Speed Rail Funding.

Resilient Counties Advisory Board Breakfast

Synopsis: *Since 2022, the private sector has announced $372 billion in clean energy investments. These investments are expected to result in 107 new utility-scale clean energy manufacturing facilities, 40,780 new jobs and $4.4 billion in financial savings for over 24 million customers served by utilities generating clean power. The U.S. Department of Energy requires that community benefit measures be attached to each new public-private installation. This segment will provide an overview of federal requirements and examples of place-based benefits.*

Opening Remarks - Hon. Frank Williams, Commissioner, Brunswick County, NC, introduced board members and NACo staff. Overview of capacity to withstand many types of disaster event. RCAB meets monthly, focus on economic development aligned with hazardous mgt, cybersecurity, volatile insurance industry, seniors, frontline staff.

Ms. Kate Gordon, Former Senior Advisor to Secretary Jennifer Granholm at US Dept of Energy: Two decades of geopolitical, economic, and climate shocks have led to the political will for transition planning and implementation. COVID underscored inadequacies (supply chain, e.g.) Energy transition is at the center of this transitiom. Moving toward a "just transition" from place-neutral modeling and technology to place-based, people-based approach. Elements of collaborative place-based impact investing/core for success, using systems approach to recognize and address historic inequity and build toward long-term change.

Community Benefit Agreements (CBA) are legal agreements between community groups and energy developers that stipulate the benefits an energy developer agrees to fund or furnish, in exchange for community support of a project.

Defining Place: Justice40 disadvantaged communities, with specific geographic or demographic criteria, such as being underinvested or greatly harmed (e.g., coal and power plant communities). What does it take to pull a community back from job loss, etc? Policy priorities for a place-based energy transition (planning, remediation and reclamation, investing in new tech). Bills, 3 of them bipartisan: ARP; Bipartisan Infrastructure Law; CHIPS and Science Act; and Inflation Reduction Act (tax credits, etc.)

Who's to say this will be good for the community? Hence, ensuring communities benefit from federal investment: DOE Community Benefits Plan approach. Elements are workforce and community engagement, good jobs, DEI and accessibility, and Justice 40 (40% of benefits accrue to disadvantaged communities.) CBPs are about 20% of the overall score of grant and loan application, a new requirement to all Funding Opportunity Announcements and Loan Program Office negotiations. Process of funding. Justice40 doesn't mean that all the projects need to be in places harmed by industry. Policy priorities: decrease energy burden and environmental exposure and burdens; increase parity through access to low-cost capital, enterprise creations, clean energy jobs, job pipelines and training, energy resiliency and democracy. Good jobs in the CBP: above average wages and benefits, free and fair chance to join union, e.g. Unions narrow racial wealth gaps.

Resource: Presentation slide deck

Maximizing the Community Benefits of Clean Energy Investments

Synopsis: *This panel discussion will focus on how county government can maximize the benefits and minimize the risks of clean energy investments for local communities. Speakers will discuss best practices aimed at ensuring the equitable distribution of jobs and fostering development in historically underinvested communities.*
Moderator: Hon. Heather Kimball, Council Chair, Hawai'i County, Hawai'i
Speakers: Ms. Kate Gordon, Former Senior Advisor to Secretary Jennifer Granholm at U.S. Department of Energy; Ms. Kristen Granier, Director of Federal Infrastructure Policy at Entergy and member of NACo's corporate partner Edison Electric Institute (EEI).

Social justice implications of energy transition; equity issues; also ensure mutual benefit to the utility, local govt, and customer. Entergy works with power companies in several Southern states, does power and light for about 3m people, many energy-burdened, offers low rates and is well-positioned to go after some of these programs. Bringing workforce development experts into the planning, along with experts about the community. Disadvantaged communities suffer more even in brief outages.

Creation of family-supporting jobs. Where counties are involved (for land use issues, especially), these projects are more successful. Engaging in the conversation early to get the commitment helps: what do the construction and long-term jobs look like; use technical college; community meetings; etc. On the ground these projects are not siloed. Not just building a stronger grid, building stronger and more resilient communities – ask what people need to be more successful; it could be childcare, literacy programs, career center, union engagement and commitments. Set up community meetings with all sorts of orgs.

Lessons learned: from a utility perspective, lots of engineers who were set in their ways about standing up and budgeting projects needed to become more flexible to match the approach (setting milestones, e.g.); recidivism and expungement; thinking about these programs in a new way and conveying to colleagues; with more competition in the utility industry, we need to be more thoughtful and community-centric. Not a great focus on displaced worker training or workforce housing or affordable housing. Housing is a climate issue. Very important to bring the climate community into the discussion of housing. Rethinking affordable – what does it cost a person to live in a place?

Need to create/revise policy to do so much of this: e.g., many low-income families don't own their homes so they can't do solar. To keep the solar industry alive, the tax credits need to come back. Home Energy rebate program goes straight to states then consumers, toward utility affordability. If it goes to a landlord, there are stipulations (can't kick the renter out for two years), allowing energy flexibility for both owners

and renters. Regarding energy-burden, the national standard is 6% of household budget. ALICE households may not be quite energy-distressed or burdened, but income-limited, gaps for which there are targeted resources such as LIHEAP. Concern about loss of ag land. Some ag land is being lost anyway (water-sensitive) and so can be repurposed, but the biggest cause of loss of ag land is sprawl. Maps showing designations help. Capacity around the grids is another issue, fighting development to those perfect locations for battery storage. A shortage of power system engineers, as the workforce has lost out to computer engineering. Without grid capacity, some wind power has to be let go.

Healthy Counties Advisory Board Lunch Meeting
Leveraging Data Collection to Address the Social Determinants of Health

Welcome and Opening Remarks, Hon. Tarryl Clark – Board of Commissioners, Stearns County, MN and Mary Jo McGuire, NACo President
Moderator: Richard Leadbeater, Global Manager: State/Provincial Government Industry Solutions and Government Trade Associations, Esri
Speakers: Hon. Mary Alford, Commissioner, Alachua County, FL; Ms. Sharmane Anderson, Deputy County Administrator, Clarendon County, SC; Hon. Orlando Trainer, Supervisor, Oktibbeha County, MS
Synopsis:*… how county leaders can address social drivers of health to improve community health and well-being and the underlying social needs of their residents. A national expert will join a panel of county leaders to share best practice approaches and strategies promoting data collection, surveying, and geospatial mapping, which can be useful in understanding the unique contexts and needs of communities, customizing interventions and preparing for future challenges.*
Slides and resources*:* *HCAB Lunch NACo Leg 2024.zip*

Richard Leadbeater:
The many elements of GIS include data, spatial analysis, apps, maps. GIS as an enabling framework – using data on photos taken in locations, a community can understand tourism from other countries. Policy is a geography problem. Knowing what data is available; broadband a critical infrastructure that supports effective economic growth, education, workforce development, telehealth, and more. Strong broadband is a requirement for cities to compete in the global economy and provide equitable opportunities for their residents. Libraries' data on use of broadband by people in their parking lot showed which communities needed better broadband access, and this data (which told you where you SHOULD spend money) took 15 minutes to gather. Esri Living Atlas applications were all built off of free data.

Mary Alford on Mapping Inequity in Alachua County FL:
Many rural roads have not had maintenance in over 20 years. To understand where to focus on road repair, used census data maps (HUD Qualified Census Tracts) on 50% of FPL, then 189% FPL and then from realtors - bottom 20% residential improvement values with a 1320 food buffer. This showed them where they needed to make equitable investments. Then foodshed mapping in a 15-county area; helpful during COVID and still under development; food programs (better access to fresh produce, e.g.) in specific areas. Finally, Climate Migration mapping as part of climate vulnerability analysis, many floods, population growth at an astronomical rate, where will people go over the next 40 years? Overlaying this migration map over the poverty map may show who will be displaced.

Sharmane Anderson, Clarendon County, SC:
A data walk, combined with state agencies and county organizations, to compare county data with the entire state – 15th for poverty, a food dessert and a health dessert; used info from the Coroner to learn who's been most effected (men – so they created a men's health expo) and causes (transportation

shortage); also concerned about youth; no health care access; not so much about throwing money at the situation but educating the public and bringing services to them.

Orlando Trainer, Oktibbeha County, MS:
Studied residents' individual data and shared it back with them (without recommendations); educating people about how important it is to fill out surveys, including census, so that good decisions can be made based on accurate data.

What's the one piece of data which would have made your process faster and better?
Mapping of affordable housing and nearby amenities.
Data on rural residents and their access to transportation (how can you have public meetings for them?)
Info on healthcare and how data directs resources.
Who do you have to fire to get this done? Myself.
Those NOT collecting COVID data… SC Coroner asks surviving family members about healthcare and issues prior to death, leading to usable data.

Breakout Discussion
1. How are you using data to address the social drivers of health and wellbeing of your community?
2. If your county experiencing any challenges to data collection (e.g., across agencies, community-level data, basic health info)?
    a. If so, what is your county doing to address those challenges (i.e., privacy concerns, lack of leadership, guidance and resources/tools)?
3. Are you making data actionable to address health disparities in your county? If so, what best practice approaches are you using?
4. Is your county integrating or using data by location to understand the unique needs of communities based on their geography? If so, tell us more about your county's efforts.
    a. Are you using GIS mapping and technology for these purposes? Please share.
    b. What has and has not been working? What is needed to improve your efforts?
    c. Are there any lessons learned from your efforts? What would you do differently? What strategies would you keep?
5. Other takeaways/misc.

Report Outs and Meeting Close
Hon. Tarryl Clark – Board of Commissioners, Stearns County, MN
NACo Staff Contact: Rashida Brown, Program Director – Health and Human Services, rbrown@naco.org

NACBHDD Spring Board Meeting

Opening, Overview of Agenda, and Introductions - Kyle Kessler, NACBHDD Chair.
Representatives from Texas, Utah, Oregon, Kansas, Virginia, Michigan, Iowa, Illinois, Netsmart, and College for Behavioral Health.

Presentation of 2024 Board Books - Jonah Cunningham, NACBHDD CEO and Netsmart
The Creative Act: A Way of Being – Rick Rubin
NeuroTribes: the Legacy of Autism and the Future of Neurodiversity – Steve Silberman

Overview of Netsmart - Dave Kishler and Julie Ingram and Brook Jobes. Programs relevant to our organizations and mission: population health management and data across systems; public and private

sector; technology to support care coordination; federal legislative advocacy (selective – applicable to our clients, e.g., final rule on 42 CFR Part 2.) Request for support for sharing certain data from behavioral health system to law enforcement, corrections, and other justice. This is in the area of their care coordination and population health management solutions. Also working on cross county processes. Similar issues with data sharing across systems on behalf of the unhoused. Chair Kessler expressed gratitude from the membership, segued to the meeting agenda.

Update from the President/CEO - Jonah Cunningham

- Year Ahead. Goals for 2024 are Empower NACBHDD Community; Pursue NACBHDD Policy Platform; Membership Recruitment, Retainment, and Refinement.
  Three board meetings – Feb 13, July 12-14 in Tampa, November 21 virtual.
  Joint projects: technical policy advisor to NACo's Mental Health Commission; LA County Joint Project; and Sozosei Project on Crisis Response.
  Membership Push with 2024 Goal of 2 new state association members and 2 association leader or county/regional authority members, future goal staff.
- Policy Updates. Shift to Campaign Politics: conventional wisdom is that congress does the bare minimum, but congress currently working on Child Tax Credit, Immigration/Foreign Aid, FY24/25 funding (bills due this spring and fall), and the SUPPORT Act (SUD, but house and senate each have a passed version which now need to be aligned); monitor the Chevron lawsuit and impact on future regulations (currently the agency with rulemaking would have precedence) and the congressional review act (ability to overturn executive orders made within last period of administration).
- Strategic Planning. Goal is to map the next three years, important due to our diversity and many priorities; 12 month staff-driven process with help from Chris Wimbush (pro-bono), relying on an advisory group of board members. Identify core operating questions (why do people join NACBHDD and what do they enjoy); recruitment of the advisory board; surveying members.
- Comments from Chair Kessler, seeking feedback from others.

NACBHDD Policy Platform and Projects - Makana Meyer

- NACO/NACBHDD Projects. Collocation with NACo allows for some focused approach on projects such as Sozosei Project, a series of briefs with examples of how local leaders operate – county elected officials, I/DD directors, rural and frontier county leaders, law enforcement, behavioral health directors and judges; LA County commissioned to produce three educational documents – IMD exclusion, crisis response (early April), and behavioral health workforce (June). For the IMD exclusion, cases include LA County (construction costs levied on county for multiple buildings compared to physical health rehab centers) and Washington County (people with compromising health needs can't be placed in residential care due to behavioral health diagnosis), highlighting the undue burden on counties. This is an equity grounded report, to be presented at Hill Briefing today.
- 2024 Policy Platform. A clear platform reflective of members' priorities and projects. The process started with member polls, discussion of priorities in committee meetings, and resulted in:
  Strengthen the Behavioral Health and I/DD Workforce.
  Advancing Equity.
  Comprehensive Crisis Response.
  System Sustainability.
  Member discussion of these categories and the priority statements which follow each.

Committee and Affiliate Reports

- President - Kyle Kessler, KS
  Executive Committee reviewed Jonah's performance; direction and tone are different and match the tone of what our orgs want; positive use of NACo offices, with staff building on those relationships; exceptional rating, salary increases. Innovation in behavioral health announcement feels too new to be announced, states might not be ready (feels like CMS taking a little back from SAMHSA).

- I/DD - Annie Uetz, IA
  New to the committee, would like to see it grow from 5 or so regular attendees. The messaging brief related to the committee's work and was well-received.
- Behavioral Health and Justice - Lynn Canfield, IL
  Update on most recent meeting (topic Care Courts), Makana's contributions. Through NACo Health Policy Steering Committee, we support relevant interim resolutions. Attended Resilient Counties Advisory Board and Healthy Counties Advisory Board meetings.
- DSAC – In Bob Sheehan's absence, Kyle Kessler, Jonah Cunningham, and Makana Meyer
  Hard to get the group back together. COVID seems to have put years on people's lives. Need federal policy initiatives led by the state association directors, who are all busy and need a reason to be on the call. Bifurcated agenda to have NACBHDD updates and a more directed policy discussion/peer environment. Poll got interesting responses, esp housing. Good for sharing policy, outcomes, data, etc. This group has the best opportunity to be micro and macro, esp with more states represented.
- Communications and Policy – Rene Hurtado, TX
  Will be reactivating from hiatus. Looking at what the communications toolbox needs to look like; staff have streamlined some media and will continue with significant efforts.
- NARMH – Shauna Reitmeier, MN
  In Shauna's absence, Jonah said they're partnering with Vital on their conference, which will be in Tuscaloosa this year, Alaska next year. NACBHDD members have some benefits with NARMH. They've also rolled up into the association management system.

Treasurer Report – Rene Hurtado, TX
- Jonah reviewed the reports. Trilogy relationship needed to be modified, may end. Projected increase in interest income, rolled into some high interest CDs and savings accounts to increase. Grants and contracts with NACo, some of which end this year. Corporate partnerships to stay flat or increase. Memberships increase. In Expenses: new professional development (Sozosei in April, grantwriting class); workshops/conference; changing rental agreement with NACo (they're asking for a 12 year commitment, will have room to grow), NACO handles payroll and benefits; legal expenses (last year review of personnel handbook and bylaws); software subscription (Glueup). Year-end position better but will be adjusted by NACO charges. Still a great financial position. Subscriptions/publications lower due to cancelling those not used and revamping (now Health Affairs, etc.) We did have three authors, reduced, now switching some of the functions around.
- Mike Deal moved to approve financial reports, Cherryl Ramirez seconded. Approved by voice vote.

Bylaw Revisions – Jonah Cunningham
- Discussed at November mtg, subsequent revisions; written in such a way that the board could be 150 people, lack of clarity on how to get on the board, no mention of NARMH seat, outdated provisions.
- Update Membership Criteria to include 'safety net'; clarify affiliate membership with NARMH; membership on rolling basis rather than calendar year.
- Currently 20 people are on the board; the revision is 20 seats for the full state members, plus another 5 seats which would have staggered terms.
- Nathan Strait moved to accept the revised bylaws, Lisa Williams seconded. Approved by voice vote.

Dues Increase for Affiliate and State Association and Cap for 100% States – Jonah Cunningham
- Dues not adjusted for a few years. Should not be growing for its own sake; fairly priced but to expand the community as appropriate. Payment plan option.
- Three types of members: affiliates (not fully BH and I/DD, e.g., law enforcement) currently at $600, to increase to $2,000; 100% state associations (calculated as the number of counties, population of each, plus state association fee) – a capped fee of $45,000 for these; standalone state associations (not quite 100%) had three different rate structures, including partial, so renaming to 'association leader' organizations and changing the fee from $720 to $1000. Renaming local authority membership to

'county or regional authority' and eliminating partial state association memberships. Discussion of the changes and possible impacts (including increased NACBHDD revenue). Targeting some larger counties for the county memberships. Value of the conference and other NACBHDD meetings and products. Some planning for next time. Clarification of 'affiliate' (NACo and NARMH) and 'associate' (the other entities which had been covered under 'affiliate' such as non BH and IDD orgs). Edit '2020 census' to 'most recent census'. Another proposed change was from '100% state association' to 'complete state association.' We can approve the dues language and structure, and staff can edit these items prior to publishing.

- Lynn Canfield moved to adopt the revised dues and membership structure. Annie Uetz seconded. No additional discussion. Approved by voice vote.

Nomination of Dennis Grantham for Emeritus Membership – Jonah Cunningham

- Communications budget cut. Dennis has been involved since 2010 and has written for NACBHDD since 2014, an invaluable resource regarding prior work. Recognizing him at the conference, so a nice gesture to nominate him for this emeritus membership.
- Lisa Williams moved, Cherryl Ramirez seconded, and the motion passed by voice vote.

Overview of Conference– Jonah Cunningham

- Hill Briefing, target dates for 2025 conference, keynote will join virtually, topics.

Joint Lunch with NARMH

Special Guest Kellie Kubena, Rural Health Liaison, USDA

Capitol Briefing, NACBHDD & NACo National Commission on Mental Health and Wellbeing

County Leadership in Mental Health: Overcoming Barriers for Equitable Care Access

Synopsis: *The Institution of Mental Disease (IMD) Exclusion limits Medicaid reimbursement, creating barriers to mental health care. This rule restricts federal funding for certain behavioral health facilities, exacerbating patient inequity and administrative burdens. This discussion will elevate the challenges faced by local communities due to this policy, while exploring reforms that could enhance treatment capacity and promote equitable access.*

Moderator: Hon. Helen Stone, Chatham County, GA - offered background, introduced speakers, and moderated the subsequent discussion.

Speakers: Jonah Cunningham; Gabrielle de la Gueronniere, VP of Health & Justice Policy, Legal Action Center; Connie D. Draxler, Acting Chief Deputy Director, LA County Dept of Mental Health.

Jonah Cunningham gave an overview of the IMD rule and history, current issues, and three broad possible solutions, which include repealing the whole rule.

Connie Draxler described the CA system, which still has some state hospitals. LA County and Dept of MH focus on these, the need to expand acute, subacute, and long-term care, and outreach to the unhoused. Few residential facilities and losing more. Few providers are willing to operate MH treatment sites, as facilities for 16 or fewer (IMD limit) are cost prohibitive. Many counties don't have the luxury of county

land on which to develop 'villages' of continuum of care (from 24 hour to 18-month lengths of stay), with separate buildings to qualify for the Medicaid reimbursement. Also can't have multiple providers in the same building, as regulations separate populations which are trying to share a building; when seeking 3 separate providers to serve in one place, they've had NO applicants. IMD applies also to freestanding acute psychiatric hospitals and behavioral health rehabilitation centers. Waivers don't go far enough.

Gabrielle de la Gueronniere: since the ACA, lots of activity around IMD and access to care, in a continuum and regardless of health needs. The IMD is old, with lots of interpretation over the years. A lot can be done through regulations and guidance, i.e., CMS. It promotes deinstitutionalization (MH), while there is a different but also difficult history of SUD care. Because it involves spending federal money, very slow to offer states flexibility. Now it creates barriers to access to the high level of care people seek across the country. 37 states have a waiver (partial) for SUD IMDs, and 14 more await approval, but all are time-limited arrangements and required to be budget neutral. The CURES Act required guidance around adult SMI and youth SED, to improve access to residential mental health care. 12 states have approved waivers for this, and 8 others await approval. Managed care can pay for clinically appropriate services in IMDs, limited to 15 days. MH waivers can go up to 30 days and SUD up to 60. State Plan amendments are another option, to cover care for up to 30 days; expired but could be made permanent in the SUPPORT Act, and only 2 states have used this flexibility so far. Also focus on evaluation.

Discussion: risk of returning to institutional care at the expense of the rest of the continuum of care; assault weapons and increased violence; whether local funds could be used to restore institutional care in specific communities; low likelihood of legislative fixes as opposed to the regulatory solutions.

NACBHDD Legislative & Policy Conference

Keynote, Workforce, and Medicaid

Slides from the Day's Sessions

Kyle Kessler, NACBHDD Board Chair: opening remarks, agenda, and updates. In human services, we may not relish the wins as much as we should due to the gravity of the losses and our need to correct, to get to the core of what we do and improve service delivery in our communities.
Jonah Cunningham, NACBHDD CEO: housekeeping; we have 8 or 9 federal agency reps coming to talk to us, so feel free to engage them in discussion; focus on building community and empowering the membership; thanks to sponsors.
Holly Salazar, CEO of CBHL: support leaders to discuss challenges and innovations in small group dialogues; leadership development through immersion. Four primary areas: membership activities (leadership conversations, critical conversations, webinars on innovations); workforce issues and solutions (collab with NatCon, steering committee and working groups); equity-grounded leadership; global collaboration 'Global Leadership Exchange' on behalf of SAMSHA.

Keynote Speaker: **Tom Coderre,** Principal Deputy Assistant Secretary of SAMHSA.
Tom Coderre in recovery himself. It's a long-term chronic condition, not acute.
Strengthening the behavioral health workforce is the ubiquitous topic.

SAMHSA's 2023-2026 Priorities: preventing SU and Overdose; enhancing access to suicide prevention and MH services; promoting resilience and emotional health for children, youth, and families; integrating behavioral and physical healthcare; and strengthening the BH workforce.

Guiding Principles: commitment to data and evidence; equity; trauma-informed approaches; recovery.
Workforce Goals: recruit, train, and retain diverse, qualified individuals; professional development to improve competencies; increase access to providers to reduce barriers to continuum of care.

Shortage started before COVID, already projected to become deep, compounded by COVID and burnout plus higher prevalence and worsening symptoms of SUD and depression resulting from pandemic.
Fellowship Programs: HBCU centers of excellence; minority fellowship program (SAMHSA has asked congress to expand this program to the LGBTQIA+ community); prevention fellowship program.
Rural EMS Program, for underserved areas managing higher prevalence; using emergency approach to expand access to needed services; trains EMS providers in MH and SUD care.

Expand availability of peers through National Model Standards for Peer Support Certification: designed to accelerate universal adoption, recognition, and integration of the peer workforce; strengthens the foundation set by the peer workforce; standards for training (includes reciprocity between states), examination, formal education, background checks, formal work experience, recovery, costs and fees, etc.

Professional Development: Evidence Based Practice Resource Center, with topics: Addressing Burnout in the Behavioral Health Workforce through Organizational Strategies Evidence Based Guide; Peer Support Servies in Crisis Care Advisory; Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings Practical Guide.

50 Training and Technical Assistance Centers: The Peer Recovery Center of Excellence; Service Mental Illness Adviser; Mental Health Technology Transfer Centers. Training millions of people through these.

Increasing Access to Providers and Reducing Barriers to Services through addressing regulatory barriers (e.g., making some telehealth permanent). New actions to treat addiction and save lives: updated regulation governing opioid treatment programs; approved federal grant funding to purchase Xylazine test strips; and overdose prevention and response toolkit (e.g., overdose reversal meds beyond Naloxone.)

Strengthening the Crisis Care Workforce: integrate 988 Lifeline with 911 and mobile crisis response services; increase access to SU crisis counselors; identify best practices; disseminate materials for awareness and training.

Office of Recovery, est within SAMHSA in 2023, supports the power of the peer workforce, addressing some regulatory barriers. Also programs to focus on rural communities.
www.samhsa.gov/grants and www.samhsa.gov/988toolkit and www.samhsa.gov/resource-search/ebp

Workforce Panel:
The Next Generation of Behavioral Health

Synopsis: *As the behavioral health and I/DD fields continue to face a workforce shortage it is critical that we support the next generation of leaders…*
Moderator: Makana Meyer
Speakers: D'Wayne James, Minority Fellowship Program Doctoral Fellow; Jaiden Moore, Center for Rural Behavioral Health at Mankato; Morgan Ramsey, Former Johnson County Intern

Why this field?
Jaiden Moore chose BH due to personal experience and observation, while working in medical records, of how great the needs are; had not been aware of the needs and the field while in high school. She is now

80 days away from getting her MSW. Morgan Ramsey also became interested due to personal experience and a teen-led prevention team, then student government (destigmatizing from that platform), and then experience through Johnson County Kansas. Dwayne James is a 3rd year doctoral student at Howard. His journey of discovery started in college, being the first of his family to attend college and out of town, exploring financial aid put him in a very dark space. Cultural barrier to seeing a social worker turned into an opportunity to shift his perspective; he shared that with others and then shifted his own studies to social work, now focused on recruitment of African American men to the field.

Barriers?
Jaiden noted absence of scholarships to pursue post-grad; 600 hours in unpaid internship so working other jobs; also takes an emotional toll. Morgan was not academically motivated, didn't know how to get involved or later how to balance her own mental health with demands of school (and to overcome worry about that.) For Dwayne, it was around dispelling stigma including around social work, which many only know as child protective services (traumatizing for many); communication through church, social media. Jaiden - trauma very high in rural communities, along with very long periods of time on wait list for more intensive services and then long travel time to provider appointments. Morgan was involved with Tim DeWeese's teen-led suicide prevention "Zero Reasons Why" program and became an intern, which later turned into an intern program for other students; academia not well tailored to self-care; ideal educational situation was when her studies combined with personal values and interest, more motivating. D'wayne - to understand Black male connections, they engage with the community, and other factors, to fill the gaps; to recruit people to a system which has harmed them, large scale changes must be made – not reinventing the wheel, but relying on trauma-informed practices, improving sensitivity to the needs, and cultural competency/humility. To increase interest in this workforce, speak to high school students; important to start younger, teaching about the professions as well as how to use various services. Personal narratives help destigmatize.

What would you have liked to learn earlier, knowing what you know now?
Keep your options open.
Meeting people where they're at, going beyond posters seeking young people. You're going to be okay. Others are feeling the same things.
Social media feed can include good resources, but we may not be hooked by them since we're so used to consuming the feed. How can we be more effective in reaching people? Social media has changed how we use information, so marketing is limited, requiring more authentic in person outreach.

Big changes that would get more people into the workforce or make conditions better for you?
Scholarships or grants would remove a huge barrier; compare the cost of six years of school with the likely income later.
Workshops for emotional regulation, engaging in the schools.
Continuing support for education, as people may be afraid that they can't live a quality life.

Legislative Panel

Synopsis: *Congress has been instrumental in creating a time of transformation for behavioral health. From the expansion of Certified Community Behavioral Health Clinics (CCBCHs) to the establishment of 988, a nationwide behavioral health crisis line, the legislative branch has been critical in this moment. Join us as we hear from lead staffers for the newly established Senate Mental Health Caucus and the House Mental Health Caucus.*
Moderator: Jonah C. Cunningham

Speakers: Gray Rixey, Legislative Aide, Office of Senator Tillis; Garrett Daniel, Legislative Assistant, Office of Senator Tillis; Joseph Ciccone**,** Deputy Chief of Staff & Legislative Director, Congresswoman Grace F. Napolitano (CA-31)

Grace Napolitano's priority has been the House Mental Health Caucus for two decades. It shares information on bills, programs, and new rules, to make sure funding reaches constituent districts, and holds roundtables to hear efforts of the federal agencies. The Senate MH Caucus will educate staff about gaps and challenges and be a conduit to constituents. The don't get through Education meetings without talking about mental health and are struck by lack of communication about funding opportunities for constituents, especially small communities. These resources need to be continued and expanded.

Bipartisan caucus: Senate caucuses are less active, so we'd like to be more active through this partnership, leveraging the current 33 members, many in leadership roles. The House has a lot of caucuses, helping bring credibility to issues, pointing to what's going on and outside stakeholders, very excited to see that the Senate has an MH caucus; can identify legislative champions and also point to policy work.

As Congresswoman Napolitano prepares to retire, finding new leaders, esp for children's mental health (house has passed it many times, but the senate has not) and 988 funding. Congress is behind on everything they need to do. Focus will be on the SAFER Communities Act, the single biggest investment in MH, with once in a generation funding, which needs to prove itself to make the model permanent. National expansion of the CCBHC model and impact on cost of care and outcomes, preserving hospital capacity and keeping it resilient. Political, policy, and budget dynamics will make it hard to get things completed this year. IMD session yesterday, in person or virtual MH services in schools, gaps in care in underserved areas. Staff need to hear from those doing the work in communities (e.g., email staff working on specific bills, as well as local reps.) Anecdotal data and relationship to national or state data, reinforcing it. Ask for briefing on an issue of concern.

Challenges for established and new caucus? Funding for FY24 still needs to be figured out, especially since they've been working so hard to increase MH funding in recent years. Suspension calendar includes non-controversial items which can pass with 2/3 support; how to make them aware of bills that can be supported, remind them of things on the calendar.

Co-chairs of house MH caucus will be announced soon. 8 months behind on FY24, last week should have started FY25 planning, so what happens in March will determine the rest of the year. Outside the funding conversation, identify policy changes which can be made on the agency side without legislation; focus on programmatic opportunities. Senate will be in recess for a large majority of the year.

$9bn in SAFER Communities Act for CCBHCs. Mental health is apolitical; need to continue destigmatizing mental health conditions, improve pipeline to careers and ability for all to recognize the need for help. $500m to increase the MH workforce, $50m for extracurricular orgs. Tighten up the efficiency in getting that funding out; communicating with DOJ and DOE and HHS, and political differences are not impacting most of this work. Where to draw the line in giving the agencies the flexibility to do what's best but also some sense of ownership by Congress.

Folks 'on the ground' need to know that the funding exists. Congressional staff have a local MH consortium (police, etc,), another avenue to bring in agency leadership. Information sharing on grant opportunities. Takes a long time to change a law, keep pushing. SAFER Communities Act could have revised criteria in order to adapt to effective innovations.

Discussion: administrative burden related to Medicaid; expansion of existing structures for 24/7 access (school, e.g.); CCBHC model is transformational and hopefully not impacted by shifts in party power; staff talk across party lines – lots of traffic.

Medicaid Presentation Panel #1: Opportunity for Creativity in Waiver Use

Synopsis: *Medicaid programs vary widely by state. A main driver of this diversity is the use of waivers which can be used to expand coverage, modify delivery systems, and restructure financing and other program elements. This panel will provide an overview of waivers, including 1115 Demonstration Waivers, recent developments, and their ramifications for behavioral health and I/DD.*
Moderator: David Weden, Vice Chair of NACBHDD, reminded us to think of the movie "Yes Day" when parents were encouraged to say yes. We have the option to use 1115 waivers. Texas has $350m new federal dollars into the community mental health system through these.
Speakers: Blaire Bryant, Legislative Director, Health, National Association of Counties (NACo); Kevin Martone, Executive Director, TAC; Cherryl Ramirez, Executive Director, Association of Oregon Community Mental Health Programs; Elissa Feld, Director of Policy, County Behavioral Health Directors Association, CA.

Blaire Bryant, NACo:
History of 1115 waivers: 1970s - experimenting with nominal cost sharing; 1990s - transition from fee for service to capitated managed care; 2012 - expanded coverage and other delivery system reforms; 2020 - restrict eligibility through work requirements and cap financing, reforms which were mostly repealed by Biden administration; and 2023 -reduce disparities and address health related social needs.

Current waiver opportunities include IMD SUD services (most popular, with 37 states having them, including Illinois, and 4 awaiting approval); IMD MH services (12 states have them and 8 await approval); QRTPS (cover residential treatment for children in foster care); and Behavioral Health and Other Community Based Benefit Solutions (23 states, including Illinois, with 10 awaiting approval. Reentry waivers another opportunity for those leaving incarceration, reconnecting with their Medicaid benefits in order to continue care; in 2023 the waiver option opened that allows youth in reentry to start Medicaid case management in the 30 days prior to release, along with some screening services, allows states the option to offer Medicaid covered services to pre-adjudicated youth. Also in 2023, approval of expanded reentry waiver for adults (e.g., CA) to allow continuity of care, up to 90 days prior to release. 1115 waivers are a state option, generally unrelated to expansion status, time-limited and subject to change based on the administration. Most IMD waivers/QRTP waivers have length of stay requirements. Waiver opportunities can be decided by Congress and/or the Administration. bbryant@naco.org

Kevin Martone, Technical Assistance Collaborative, Inc (TAC):
Medicaid can be overwhelming. Health Related Social needs (HRSN) are individuals' unmet, adverse social conditions that contribute to poor health outcomes.

CMS supports states in addressing HRSN through coverage of clinically appropriate and evidence-based HRSN interventions, care delivery transformations including improvements in data sharing, and performance measurement to create accountability for HRSN screening and connecting to needed supports as part of successful care management. States can address HRSN through a variety of Medicaid authorities, including state plans, 1915 waivers, managed care, and 1115 demonstrations.

At the Point in Time survey this year, those unhoused and living on streets who have SMI or SUD and may have been unhoused for years should be our focus. CMS informational bulletins discuss what they'll pay for through 1115 waivers. Housing navigation and supports were not covered, but CMS is now approving them as well as some rental assistance. There is a shortage on the HUD side too. CMS will pay for up to 6 months, in the hope of transition to longer term housing. Lots of implementation challenges. Can even include medically necessary home accessibility modifications and remediation services, one time transition and moving costs, etc.

Housing and Services Partnership Accelerator program working with 9 states on TA (federal funding). Alignment of care, addressing the social determinants of health (SDOH), through another program "Innovations in Behavioral Health".

Engage in conversations with housing and homeless systems. Lack of integrated care is a significant issue. Foundational challenges include workforce, rates, funding models, infrastructure, best practices, training. Medicaid can't do it all. Systems should be clear about who pays for what and should strive for maximum coordination. Developing the policy and plan at the system level is hard, but implementation is REALLY hard.

Cherryl Ramirez on Oregon's current 1115 waiver:
Prior to 2012, making OR's system more flexible became the parameters of the Coordinated Care Organizations (managed care) experiment. Current 1115 goal is to advance health equity: ensuring people can maintain their health coverage, improving health outcomes, etc. New benefits in effect: continuous enrollment for children up to age 6; 2-year enrollment for everyone else; HRSNs for housing, nutrition, climate-related needs, and outreach and engagement; coverage to age 26. HRSNs are very case management-like.

CMS approved infrastructure grants for Medicaid to pay for these types of service. Starting in March, this can pay for humidifiers, heaters, generators, air conditioners, and air filtration, though there must be a climate emergency (e.g., extreme heat, fires). Severe homelessness crisis all along the West Coast. Can pay for ramps, railings, household goods, getting IDs, working with landlords, transportation. Nutrition counseling and education, three meals a day for up to six months, fruit and vegetable prescriptions up to six months, and more. Transition populations are the hardest: adults and youth discharged from an IMD; adults and youth released from incarceration; people who are homeless or at risk of becoming homeless. Would cover transition services and limited Medicaid 90 days prerelease for adults and for youth, and full Medicaid benefits for pretrial detainees. The Carceral Project will plan that implementation.

Elissa Feld on California's Specialty Behavioral Health System:
Realigned to counties from state, due to a series of budget shortfalls, funded by licensing fees and sales tax and other.

CA was among the first to take advantage of the SUD waiver, using the drawdown to subsidize services for the uninsured and underinsured. Justice Involved Initiative (2023), an 1115 waiver to allow targeted in-reach services 90 days prior to release from custody, to ensure continuity of coverage. Still working through hiccups, such as bringing in all the partners (e.g., resistance from sheriff depts); Medicaid enrollment and screening for pre-release services, including BH, requirement to provide MAT for OUS and AUD, and reentry care management.

BH-CONNECT is their 1115 SMI/SED demonstration in progress, very ambitious; expands community-based services, bundled rate, using state plan amendment to add 6 services (ACT, supported employment, FEP care, etc.) to get these higher level services in place in order to avoid having only IMDs to send people to. Statewide incentive programs to improve quality, outcomes, and coordination across systems

and to add child welfare focused initiatives to improve outcomes and long and short-term workforce investments for Medi-Cal specialty behavioral health. Expanded Continuum of Services, Investment Opportunities, and Cross-sector Collaboration. Challenges will include costs, workforce, and implementation fatigue.

Takeaways per panelist:
Don't get lost in the weeds of 1115 waivers; think about what your systems should look like, focus on what you want, and work with your partners to get it done.
Understand that Medicaid flexibilities are increasing over the years, so ride the wave; make CMS aware of gaps in systems; and because waivers are not permanent, be an advocate.
Learn from California, with 90-Day In-Reach policy guidance developed with all partners.
System problems beyond these need to be addressed.
Get letters to state Medicaid directors; use CMS website info on current efforts to model.

Medicaid Presentation Panel #2: Redetermination

Synopsis: *During the COVID-19 pandemic, Congress required Medicaid disenrollments to stop. Primarily due to this continuous enrollment requirement over 94 million people enrolled in Medicaid or CHIP. Since the continuous enrollment requirement expired in April 2023 over 13 million Medicaid enrollees have been removed from the program. This panel will discuss state experiences for Medicaid redetermination, its ramifications for the future of the program, and other developments.*
Moderator: Mike Deal, UT
Speakers: Jinny Palen, Executive Director, Minnesota Association of Community Mental Health Programs (MACMHP); Allie Gardner, Senior Research Associate at Georgetown University Health Policy Institute's Center for Children and Families; Mary Rumbaugh, Behavioral Health Director for Clackamus County, OR

Pandemic-related flexibilities such as continuous Medicaid enrollment have stopped. Headlines from 2023: 1 in 3 people dropped from Utah Medicaid, enrollment lower than in other states, many didn't try to renew their coverage.

Jinny Palen on Medicaid Re-enrollment in Minnesota:
MN had Medicaid expansion in 2010. Basic Health Plan through MinnesotaCare (200% of Federal Poverty Level). MN was one of two states to adopt a basic health plan. Medical Assistance 133% FPL or 278% pregnant people. CHIP (275% children). State-based Health Insurance Exchange is MHSure.

MN uses a state-regulated, county-administered system for all public programs.

MN response to the unwinding: there were over 360k people on Medical Assistance and MinnesotaCare (over .15m MN residents) so1 in 4 MNs insured through MN public insurance. Continuous MA enrollment for children, also continuing telehealth.
Are people falling through the cracks, esp in communities of color? Tracking to mitigate disparities.

Allie Gardner on Medicaid Unwinding: What Has Happened and Where Do We Go?
All states have restarted renewal process and subsequent terminations. Some have completed unwinding, finishing renewals for individuals flagged as ineligible, though regular renewals still need to be completed. At least 56% of Medicaid population pre-unwinding has been through the renewal process, some have data available only through November.

Appeals spike during the unwinding; the process has gone wrong in many places and many ways, revealing how many Medicaid systems were not operating properly, dating all the way back to the ACA and resulting in half a million children losing benefits unjustly.

Who is experiencing disruptions in coverage? Parents in non-expansion states may not have any affordable coverage options once they lose coverage. More than 3.53m children have lost coverage; due to income eligibility disparities, parents may not realize their children are still eligible. Individuals disenrolled for procedural reasons have 90-day reconsideration period, but that can still result in gaps in coverage and delays in needed care. As a result, individuals may experience disruptions to ongoing treatments of timely care, even if they are still eligible for coverage.

Positive trends: Medicaid's role as a safety net; some flagged as ineligible are retaining coverage; states are seeking CMS flexibilities and improving their systems; continuing and increasing transparency result in earlier data; adoption of policies that promote continuity.

Concerns: lots of procedural disenrollments; low rates; issues with notices, call centers and mail delays; parents unclear on children's eligibility; slow response on corrective action; not seeing coverage transitions corresponding with level of disenrollments.

Where do we go from here? Timelines for completing the unwinding are unknown. Increase funding for education/communication with enrollees. Double down on outreach and education. Use lessons learned for longer term systems fixes and adopting best practices. Identify policies to reduce barriers to coverage and promote continuity of coverage.

Mary Rumbaugh on Clackamus County, OR:
The third largest county, with population 420k, and 100k people on Medicaid, a mix of urban and rural. OR redetermination numbers encouraging: 1.35m ppl needed to be renewed; slowed the process down to get it right. 1,067,187 renewals completed by January 2024, for 85% benefits continuing, 13% ending, less than 2% reduced. An automated renewal process, so folks got notice it was going to happen, with info about actions to take. CMS offered flexibility around how to do this, and OR took advantage of that, e.g., made it easier to correct errors in address.

Discussion: Urban and rural divide has impacts such as the mail slower in rural, which can impact people's ability to maintain coverage; people denied for procedural reasons won't be known for a while (the fall), but seeing some spikes as people realize they've lost coverage and then reapply; shocking to see that children who've lost Medicaid are NOT transitioning to CHIP as expected. OR slowed it down enough to be thoughtful, do analysis, and be all hands on deck, working from the heart with effective communication from the top down. MN's IT infrastructure system had not been updated for over two decades, a huge barrier, but the state did the best they could with resources they did have; improvements we didn't know we needed until now will be the silver lining. Move to compliance with standard practice, per CMS, and advocating for more standards. CMS is also overwhelmed trying just to get to the baseline of regs equal to a proposed rule right now, related to disability and other statuses with more difficult standards, to be revised to be less difficult.

I presented an award to **Dennis Grantham** and announced his designation as an Emeritus Member.

Executive Coaching: Upgrade Critical Thinking Skills with Style

Synopsis:*… through the framework provided by the* ***Kirton Adaption-Innovation Inventory****… explore different styles of generating ideas, implementing solutions, and whether a person embraces or changes the structure… move your team from seeming trapped in mediocrity to producing outstanding results.*
Speaker: Anne E. Collier, MPP, JD, PCC, Chief Executive Officer, Aruida

Anne Collier is a former tax lawyer but daunted by all the Medicaid details.
Creativity, critical thinking skills, recognize cognitive diversity, harness different thinking styles.
Specifics of thinking styles (brainstorming, implementation of ideas, working with rules).
Critical thinking – intentional systemic standards (assessing, adjusting, adapting, improving), scrutinization (assumptions, biases, perspectives). Think about your thinking.

Harness cognitive diversity. We all go to work to solve Problem A, but Problem B happens (e.g., frustration with others due to differences). Style matters. Different ways of thinking. Consider when dealing with a new problem, working with others, what does problem solving look like when it's working well, and what are the annoyances? Adaptive (solve problems within the structure) vs Innovative (shake things up). How do you prefer to solve problems, within a consensually agreed upon structure or with less structure? Creativity is the generation of a novel idea. Level of personal creativity versus Style: style is not related to how clever a person is.

Most people are in the middle between adaptive and innovative; to get change, the middle needs to be on board. Coping takes a lot of energy. The more time you spend on activities or with people far outside of your problem-solving style, the more you get into ulcer territory. To improve critical thinking skills, expose yourself to diverse styles and people in other fields. Be curious. Use the coaching model to get from current situation to goal: establish focus, brainstorm options, create action plan, remove obstacles, and review and commit; then follow up. Most problems we solve are very complex. Different styles don't equal lack of ability. Arudia Leadership & Management Academia – anne@arudia.com.

Continuum of Care, Social Determinants of Health, and Federal Partners

Slides from the Day's Sessions

David Weden, Vice Chair, NACBHDD, introduced the agenda, asked that we keep the shooting victims in our thoughts, reviewed yesterday's discussions, especially the Medicaid unwinding.

Jordan Grossman, Health Resources and Services Agency (HRSA) Deputy Administrator:
HRSA is working to expand access to behavioral health services. Traditional focus on primary care. Integration of care is a top priority. Breadth of reach: National Service Corps, Federal Office of Rural Health, Maternal Health, etc. A unique opportunity to reach large segments of the population and improve BH. Also a workforce development program.

Health centers serve 30m ppl in the US, have expanded into schools including with mental health services; $25m last year into essential services, which had to include MH. Health Centers now serve over a million children. Only ¼ of health centers are equipped to meet behavioral health needs, so making it a required service now and getting them the funding for it so that the first layer of BH services are part of what people can do there (with dental, primary, etc.) Annual and multi-year funding have both expired, so currently on temporary increases and working closely with Congress to make sure Health Centers can add this to their services. Vital to many communities, especially as these centers treat everyone, regardless of ability to pay. Also reduce stigma and improve outcomes.

To expand and diversify the workforce, programs to increase professional and paraprofessional, across the spectrum. Training and placement in areas of shortage. Increase access to and quality of care. Other programs provide loan repayment and scholarship in shortage areas, such as the National Health Service Corps Program, with financial assistance for education in exchange for a few years of service in areas of shortage or areas hard hit by behavioral health threats. Data show that a few years after their commitment is over, the vast majority of providers stay in those areas.

To improve healthcare access for those with I/DD (and others), $8m into training, to ensure equitable access to treatment for all, which is a particularly tough issue for those with I/DD. Also funding LEND and Developmental Pediatric programs – interdisciplinary leadership related to those children most likely to have developmental disability, including autism.

At the patient level, investments toward low barrier, open door. National Maternal Mental Health Hotline was launched in 2022 (English, Spanish, and 24/7), serving over 27k people so far. Expanded Pediatric Mental Health Care program, state-based with teleconsultation and training for pediatricians, to increase their comfort level with these issues and integrate into their practice and technical assistance when beyond comfort level. Reaching 46 states now.

In rural areas, programs offer solutions tailored to local communities, e.g., infant exposure to opioids. Workforce program grantees are required to partner with those with lived experience.

Coordination mechanisms allow closer work with SAMHSA and other agencies. Last year, they issued a shared bulletin on braiding funding for improving youth mental health.

Crisis and Continuum of Care
Panel: BH and I/DD

Synopsis: *Crisis response efforts require coordination between behavioral health care, emergency services, law enforcement, and other sectors. The importance of these services has amplified since the launch of 9-8-8 in the Summer of 2022 along with the establishment of Medicaid waivers for crisis response and the expansion of the Certified Community Behavioral Health Clinic (CCBHC) program. Panelists will discuss the impact, infrastructure, and future of local crisis services.*
Moderator: Shauna Reitmeier
Speakers: Crista Taylor, President and CEO, Behavioral Health System Baltimore (BHSB); Hannah Wesolowski, Chief Advocacy Officer, NAMI; John Palmeri, MD, MHA, Deputy Director, 988 and Behavioral Health Crisis Coordinating Office, SAMHSA; Billina Shaw, MD, MPH, FAPA, FASAM, Senior Medical Advisor, Center for Mental Health Services, SAMHSA

Crista Taylor on BHSB:
Operates in Baltimore City but is run by the state. Crisis response follows the SAMHSA model, someone to call, someone to respond, and somewhere to go. The Central Maryland Partnership secured funding from 17 hospitals, federal, state and local funds, and private philanthropy, developed crisis response standards, convened all partners, 988 regional call center (a 3 provider partnership), developed call matrix for dispatch, 34 clinics adopted open access scheduling for same or next appointments, used technology to enhance services, engagement and outreach (ambassadors program), built statewide coalition to advocate for sustainable funding, funded assessment for peer respite implementation, developed multistakeholder oversight, and some items specific to 911.

988 in the context of Baltimore. Have the first consent decree which holds the City responsible for building out a crisis network, due to previous unfair practices toward people in crisis or with disabilities. Lessons learned: meaningfully engage with the community; people like the word helpline more than crisis line; emphasize confidentiality and offer hope (as providers can perpetuate stigma); creativity needed to design the 988 campaigns, which should be done with the community.

Marketing for Change, e.g. "Moving from Crisis to Hope" has behavioral insights: normalize help-seeking, lower the stakes of engagement, focus on what people want to feel right now, help people know what to expect if they call.

Need a dedicated revenue source. A 988 trust fund is in place, and over $17m has been allocated so far but not enough. Advocating for a 988 telecom fee ($0.25/month fee) – 83% of Marylanders agree and 63% strongly agree, across parties and age groups and regions; there is a 911 equivalent.

Challenges: geo-routing, shifting the response to reduce criminalization (policies at all levels), politics, egos, building trust among partners, effectively integrating data into accountability.

Opportunities: define values together and communicate them directly and often; engage meaningfully and regularly with the community; partner with local leaderships (electeds PLUS community); coordinate across systems; think broader than just crisis services; leverage your work force through partnership; promote the least police response possible but talk openly about safety; regionalize where you can; embrace technology; continuously use your data for improvement; sustainably resource the services needed for someone calling 988 (all payors and payors blind to the person.) 988 has the power to transform the system. Crista.taylor@bhsbaltimore.org and www.BHSBaltimore.org

Hannah Wesolowski, NAMI:
Prioritized a Reimagine Crisis Response campaign. 988 is an entry point to a reimagined crisis system. NAMI is sustaining momentum to see this vision through, same as SAMHSA model. Alignment of crisis services toward common goals (care in the least restrictive and least costly setting).

Equity and Crisis Response: 85% want a MH response to someone experiencing a mental health, drug, or suicide crisis, not a police response; this result is even higher among Black and LGBTQIA+ citizens.

Dr. Billina Shaw, Substance Abuse and Mental Health Services Administration (SAMHSA):
Block grant funds for states. Transformation Transfer Initiative, such as the Samish Indian Nation "Native and Strong Lifeline" in the state of Washington. A report to Congress, "Ring the Alarm: the Crisis of Black Youth Suicide" was recently followed with "Still Ringing the Alarm," prompting the Black Youth Suicide Prevention Initiative, stigma reduction, policy academies, 8 states to continue the work. Community Crisis Response Partnerships (CCRP) grants with main goal of diverting people from law enforcement, enhanced FMAP, tribal grantees.

GAINS Center through Policy Research Associates, an early diversion grant program ($8m in PY23, 25 grantees receiving 330k/year for 4 years, strong focus on Intercept Zero, mainly funds co-responder services.) Through relationship with Dept of Defense, Service Members, Veterans and their Families TA Center also does the SIMS mapping project. Crisis Mapping for Counties Policy Academy to develop goals and objectives for local teams, looked at geographic diversity to identify those pilot communities.

Children's Mental Health Initiatives grant program with $130m in appropriations for FY23 focused on youth 0-21 with SED and their families, Systems of Care (SOC) approach, up to $1m per year for 4 years.

There are more than 500 Certified Community Behavioral Health Centers (CCBHCs) nationwide, across 46 states, DC, Guam, and PR. Hoping to expand to additional states. 2023 CCBHC Criteria Crisis-Related Updates to make sure guidance is consistent.

Dr. John Palmeri, SAMHSA:
SAMHSA Goals: 1- Strengthening and Expanding the 988 Suicide & Crisis Lifeline; 2- Transforming America's BH Crisis System (best practices, data collection, workforce, financial sustainability).

FY24 priorities: expanding access and connecting people to local support through geo-routing; building awareness and trust through earned and paid media; ensuring quality service through training, data collection and evaluation; strengthening partner engagement to disseminate practice recommendations, promote service access and sustainability.

988 social media awareness campaign.

Panel discussion based on questions: embedding equity rather than doing something separately, and serving youth should be the same; people with I/DD deserve the services to be appropriate to them; standards for training police include the CIT model in use by many counties and endorsed by NAMI (which provided the initial seed money), then handoff to a trained officer, some states require it; determining a structured tool to dispatch calls appropriately; also review police policies and training curricula and debrief.

Crisis and Continuum of Care
Partners Panel: Federal-State-Local Connection

Synopsis**:** *Collaboration is imperative for improving access to behavioral health and I/DD services. NACBBHDD partners will share the vision and mission of their respective organizations, building an image of the landscape of work being done in behavioral health and I/DD within various interest groups.*
Moderator: David Weden
Speakers: AJ Walker, MPA, Policy Director, National Association of State Mental Health Program Directors (NASMHPD); Mary Sowers, Executive Director, National Association of State Directors of Developmental Disabilities Services (NASDDDS); Rob Morrison, Executive Director, National Association of State Alcohol and Drug Abuse Directors (NASADAD).

Mary Sowers on NASDDDS:
The nation struggles to provide MH services for people with I/DD, brain injury, and other cognitive disabilities. People with complex needs stretch the systems of care. Lawsuits relate to care occurring in multiple states. Lack of expertise, resources.

"Link Center" leading partners are NASDDDS, NADD, and NASMHPD with six other partners, people with lived experience, and universities. Emerged over time with SAMHSA-convened roundtable series in 2019 with a cohort of states to identify promising practices. Link Center goals are systems change, DSW and clinical capacity (diverse workforce), and service access (person centered, culturally and linguistically appropriate MH services and community supports). Lens on DEI: steering committee 100% with lived experience; shared learning groups; resource development and dissemination. Lens on CQI: project management evaluation, expert contributors, website. Outcomes are effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs and practices, preferred language, etc.

Rob Morrison of NASADAD:
(computer issues here) updates; a ten-state learning community to look at tools for workforce development, such as curricula, who would use them, getting people excited to be a line counselor.

AJ Walker on NASMHPD:
Past collaboration around MH and IDD. Effective services for children, summit in 2014, white paper "Interagency Planning for Youth with Co-occurring I/DD and MH Disorders," and in 2015 and 2017, Transformation Transfer Initiative grants focused on MH/IDD in 5 states and DC.

NASMHPD State Policy Academy on Children's Behavioral Health Policy Convening, on children with complex behavioral health needs and their families, to continue the dialog and find solutions. RFI on MH and SUD needs in higher ed. Other priorities are 988, SAMHSA CSR TTAC, SAMHA guidelines to expand crisis systems, and advocacy for crisis to include addressing SUD and IDD. Children's Services to build prevention and early intervention efforts. Peer Support and Recovery. Workforce.

For 2024, continue focus on 988 for youth, which may need to look different than for adults. With federal agencies collaborating more, leverage at state and local levels, elevating the needs of people with MH and I/DD. Use data to describe workforce strengthening efforts; Oregon invests state dollars into workforce; connecting with universities to show the core function of support linked to providers; NIAAA has a tool that offers CEUs to educate physicians, physician assistants, and others around alcohol, incentivizes using the tool. Even in OR, funds do not usually cover the state projects, setting providers up for failure. Need to continue paying community-based providers adequate salaries; state leadership wants it all done yesterday and doesn't always see the progress and the good which is occurring. Need to refocus on appropriate caseload size now that everyone has a workforce shortage/crisis. Don't have an infrastructure for this crisis continuum, so are we willing to increase Medicaid investments in our states, maybe lifting up the CCBHCs? This is an opportunity; CMS is working on all at once; we don't want to take 10 years to build up 988. In states really committed to necessary investments, there's recognition of the cost savings, including human and trauma.

Regarding inclusion of peers with lived experience, what are the tables we are invited to and how will we know that the same barriers will not then exclude us? A peer support bill is currently in Ways and Means. As you roll out peer support, develop clear training for clinicians on how to work with peer support.

Lunch conversation with John Chambliss, Policy Advisor/Office of Senator Alex Padilla:
What to expect from the Senate Mental Health Caucus. Use the caucus to communicate with constituents regarding all the good moves made by the administration which can be used in our communities. Support for workforce and 988. Data-driven legislation can be bipartisan. If meeting with staffers or members of Congress, best approach is to show the impact to their state, of what's already out there and working. Know that behavioral health bills will touch a broad array of people, despite how each may be focused.

Partners in Progress #1:
Traditional Federal Partners

Synopsis: *Impactful policy hinges on cross sectional relationships, especially those spanning between local and federal authorities. By understanding federal efforts in relation to behavioral health and I/DD policy, local providers better utilize available support systems. This panel will feature traditional federal partners focused on behavioral health and I/DD.*
Moderator: Jonah C. Cunningham

Speakers: Dr. Anita Everett, M.D. DFAPA, Director, the Center for Mental Health Services (CMHS), SAMHSA; Dr. Judy Qualters, PhD, MPH, Director, Division of Injury Prevention, CDC; Kirsten Beronio, Senior Policy Advisor, CMS; Jennifer Johnson, Deputy Commissioner, Administration on Disabilities, ACL; Julie Lunstead, Policy Advisor, HRSA.

Dr. Anita Everett on Substance Abuse and Mental Health Services Administration (SAMHSA):
Primarily working through grants, useful for 'start up' of a line of services or supports which may be sustained by other resources. After Senator Stabenow retires, need a new champion for CCBHCs and funds to support the buildup of these. Over 60 years ago, the Community Mental Health Act was signed into law, and CCBHCs are the most transformative, moving from hospitals to community care. Current inconsistent access across the country is unfair, and CCBHCs create a more level playing field.

Kids' online health and safety: addressed through the Center of Excellence on Social Media and Youth MH; co-chairing a task force with Dept of Commerce; technical assistance center by American Academy of Pediatrics, which already had a robust and user-friendly website, now designed to give an expert answer back to a specific answer entered by a parent or other user.

Upcoming Policy Academies, working meetings of teams from state or local govt. Black Youth Suicide in May (had one last year too), and Local Behavioral Health Crisis Mapping in April. Time to listen to national experts, make a local plan, and discuss. Mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

Dr. Judith Qualters on Centers for Disease Control and Prevention (CDC):
Comprehensive public health approach to suicide prevention, funding to bring in 7 new states or districts (includes IL), and funding 4 tribal orgs.

Provisional Data, Health Equity, and Infographics are now on the CDC's web-based Injury Statistics Query and Reporting System (WISQARS). Trying to get data out faster. Strengthening Capacity in Suicide Prevention for Local Health Departments. Continue TA, learning communities, evaluate effectiveness, deliver a webinar.

Suicide Cluster Guidance is a new resource to be released soon, with background and rationale, community assessment and investigation recommendations, and community response recommendations (in 3 MMWRs, Feb 29). What to do with a suspected cluster.

2024 National Strategy for Suicide Prevention (National Strategy) and Action Plan, coming out by April, includes advances in the science of prevention and prevention/treatment of risk, continuum around 988, attention to the role of social media, health equity, and interaction of suicide and SUD. The first time a strategy is accompanied by an Action Plan – more than 20 agencies across 5 departments.

Kirsten Beronio on Centers for Medicare & Medicaid Services (CMS):
Medicaid and CHIP focus on school-based services, CCBHC demonstration, crisis response services, improving transitions from jails and prisons, and parity request for comments. Recent provisions in 2022 on youth MH, CMS updated claiming guide on school-based services. Website has webinars and info on states' activities. Current NOFO to help states improve coverage of these and expand to IEP services.

CCBHC overview and history, recently proposed updates to the prospective payment guidance with new options for states on reimbursing for crisis services. 10 states will be added every two years for four-year demonstrations. Applications due in March for selection of the next new cohort.

Transition from jails/prisons to communities: improve transitions; guidance around the new 1115 waiver authority for prerelease between 30 and 90 days, minimum benefits (case management, MAT, 30-day supply of Rx meds), 2 states approved (CA and WA), and at least 15 more have expressed interest.

Jennifer Johnson on Administration for Community Living:
Part of HHS, focused on services for older adults and ppl with disabilities, who thrive when empowered to make their own decisions. Being valued alongside ppl without disabilities. Administration on Disabilities funds state Councils for DD, Protection and Advocacy agencies, and university centers. Learn about how people choose to live their lives, the work really happens at the local level.

With partners, making sure that focus on mental health efforts doesn't exclude folks who have disabilities. Currently a great focus on cooccurring MI and DD. Biggest barriers have been the silos between these systems, so several initiatives work to support greater collaboration. Also funding the Link Center on policy development, service design and coordination, resources around that and for individuals, families, providers, and policy makers. Also working with SAMHSA on training for 988 staff and policy academy on 988 crisis prevention services this spring. About one third of children in child welfare may have co-occurring disabilities. Website with information on disability resources for state and local areas.

Caring infrastructure work, for both paid direct support professionals and unpaid family caregivers in Home and Community Based Services. Over 53m family caregivers currently fill gaps. National Workforce Strategy Center supports states and local communities on this, has a website with resources, offers TA to partnerships across systems.

Regarding affordable accessible housing in communities, partnering with HUD on a Housing and Services resource center. Inclusive housing strategies for people with I/DD (webinar). Rapid housing for a number of states using Medicaid flexibilities through 1115 or 1915i waivers, to overcome challenges related to payment models, eligibility, and data alignment.

Big data gaps regarding people with I/DD, data desserts for those with MI and DD, especially in child welfare, emergency depts, and jails/prisons. Working on better data on health and prevalence. Also working on the HCBS settings rule and alternatives to guardianship.

Julie Lunstead on Health Resource Services Administration (HRSA) Behavioral Health Initiatives:
Providing care to the country's highest need groups. Health Center Program, BH workforce programs, maternal and child health programs, etc. HRSA-funded health centers serve communities by meeting them where they are, with school-based services, community partnerships and events, community sites, mobile units, in person and virtual care, medical services, etc. Behavioral health needs increased dramatically in last few years; responding in different ways, especially virtual visits. 98% of centers currently provide BH services, but all have wait lists. Expanding access through school-based service sites, with increased funding; $25m in 2022, and 77 new sites in 2023 (also $25m).

HHS Workforce Strategic Plan goals and objectives: several workforce development programs with financial incentives and trying to increase diversity and get providers into areas with low access.

Primary Care Training and enhancement, language and disability access, focused on people with I/DD but also people with low English. Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) program to address SDOHs, people with lived experience/self-advocates are part of this. Developmental Behavioral Pediatrics (DBP) program.

Family to Family Health Information Centers: training about children with special needs, staffed by parents of children with special needs.

Pediatric MH Care Access program: to address the gap in pediatric and adolescent psychiatry; un through the state; offers consult line for pediatricians to speak with psychiatrists on handling mental health issues.

Rural Communities Opioid Response Program: direct funding and TA to rural areas to improve access to BH care, including SUD/OUD prevention, treatment, and recovery. Over $80m in 39 states.
Maternal MH also a crisis being addressed, with a hotline. jlunstead@hrsa.gov

Regarding health homes, federal match for better care coordination related to MH or SUD. CCBHC is a heavy lift for rural areas, but health home benefit is still available and a good option to improve access.

Guidance released during this session, partnership between CMS and SAMHSA on options for structuring payments in CCBHC, including adequate payment for crisis services, so by splitting it out, a higher match for mobile crisis, e.g.

Collaboration across all of these agencies, to increase provider participation, to reduce demand; also work on maternal MH and school-based MH, a very high point in federal agency collaboration. Also working across government agencies to get the message out about 988 and formative research around it; about suicide prevention and behavioral change. Hard to sustain over time. Because Congress directed joint efforts around CCBHC and evaluation, everyone brings their best expertise to the table. Next on TA center and building the continuum. Also working together on youth, what to do to hold the child and their family. Hopefully moving out of the crisis space and into the prevention space.

Partners in Progress #2:
New Partners

Synopsis: *Impactful policy hinges on cross sectional relationships, especially those spanning between local and federal authorities. By understanding federal efforts in relation to behavioral health and I/DD policy, local providers better utilize available support systems. This panel will feature traditional federal partners focused on behavioral health and I/DD.*
Moderator: Makana Meyer
Speakers: Tamara Telles, Rural Health Fellow, USDA; Richard S. Cho, Ph.D., Senior Advisor for Housing and Services, HUD; Susan Wilschke, Associate Commissioner for the Office of Research, Demonstration, and Employment Support (ORDES), Social Security Administration

Tamara Telles on US Dept of Agriculture's Rural Health Resources and BH and I/DD:
Overview of Rural Development, within USDA, at the Innovation Center, on Rural Housing Services, Rural Business and Cooperative Service, and Rural Utility Service. Website has links to open funding announcements. Farm Bill every 5 years; in 2018 created the Rural Health Liaison, who was appointed in March 2022; many accomplishments since then.

Rural Development programs contribute to creating better conditions by touching all of the social determinants of health. Over 70 financial assistance programs (loans and grants) for a variety of rural applications that impact a community's health, including communities, health care, broadband, business. Essential community facilities offer fixed-rate, low-cost loans, loan guarantees, and grants to develop or improve essential public services and facilities.

Expanding broadband with telecoms programs, distance learning, and telemedicine grants, programs also to purchase or support devices and use. Rural Placemaking Toolkit, strategic economic and community

development, creating opportunities through rural engagement, and rural partners network. Other supports for rural behavioral health include farm and ranch stress assistance network, cooperative extension and 4H, WIC, SNAP-Ed, etc.

Ideas for moving forward: exploring factors affecting farmers and the interventions which are successful, equipping USDA staff with tools to best support customers; participate in updating National Suicide Prevention Strategy and others.

Susan Wilschke on Social Security Disability Programs and Mental Health:
Overview of SSDI and SSI, which use the same definition of disability: as of December 2022, 7.6m disabled workers received SSDI, 2m dependents, 29% had primary diagnosis of mental impairment; 5.2m SSI recipients under age 65, 62% had primary diagnosis of mental impairment (22% of children autism).

Work incentives and employment supports for those entering the workforce for the first time or reentering. Moving from benefit dependency to independence: Ticket to Work, Trial Work Period, etc. Supported Employment Demonstration to test whether employment services provided along with integrated BH and social services can increase labor force participation and reduce SSI/SSDI participation. MH was the primary or secondary impairment on initial claims, services provided through community MH agencies in 30 sites. Highlights – treatment group members had higher employment rates, worked more weeks and earned more than control group members. No differences in SSDI/SSI allowance rates. Most had had low access to resources, emphasizing the need for coordination of services.

Promoting Readiness of Minors in SSI (PROMISE): with US Dept of Ed, HHS, DOL, the SSA testing improved provision and coordination of services to promote education and employment outcomes resulting in long-term reductions in a child's reliance on SSI. Two sites increased youth's employment rates, and three increased their income. No programs reduced payment amounts.

Opportunities for Collaboration: third party assistance https://ssa.gov/thirdparty/ to help people facing barriers across benefits; Ticket to Work pays providers for outcomes, additional funding for supported employment, works with many types of organizations. https://choosework.ssa.gov – over 400 employment networks and State Voc Rehab agencies provide a variety of employment services. Protection and Advocacy for beneficiaries of Social Security provide legal support and advocacy. Participate as an Employment Network.

Interventional Cooperative Agreement Program (ICAP): allows SSA to enter into cooperative agreements to collaborate with states, private foundations, and other non -federal groups who have the interest and ability to identify, operate, and evaluate interventional research projects related to the programs. Yearly competition, up to $3m funding opportunity, 5-year project period to conduct intervention and evaluation. Projects support SSA priorities including employment, outreach, and application assistance. https://ssa.gov/disabilityresearch/icap.html All of SSA research is on https://ssa.gov/disabilityresearch – see the tabs for completed research projects.

CMS push for EVV is tough. Monthly calls with rural health leaders, so she will bring this up to find out what tools and information could close the gap. As people lose Medicaid due to being put in the wrong bucket (TANF rather than ADB, for example), they lose their supports – how can we prevent this? SSA is talking with CMS about this.

Richard Cho on Housing and Urban Development:
Strengthening partnerships between public health and housing programs, to meet the needs of people with complex health needs and disabilities; integrating health and behavioral health care with housing; using HOMES as a platform for better health and mental health.

As housing inspections resumed (paused during pandemic), impacts of the pandemic became clear, especially how isolation and loneliness impact health. In one state, 20 public housing authorities raised issues, and at the top were MH and SUD needs of residents. Also heard from providers of senior housing about isolation. More resources for connections to care as well as for housing assistance.

While HUD are not behavioral health experts, they have a responsibility to connect to experts, hence these new partnerships, identifying federal collaboration to meet these health and housing needs and to connect the sectors, and to address the intersection of homelessness and mental health. Webinar series, messaging campaigns, trauma-informed care, recognizing signs of MI, crisis response. Housing crisis can trigger emotional distress, so MHFA training for housing professionals (HUD and Senior).

Also no community is immune to impacts of OUD epidemic, despite overdose reversal medications, about which public housing eligibility requirements are misinterpreted, leading to loss of HUD assisted housing. To counter this effect, new guidance was issued, as well as a joint letter with SAMHSA to make Naloxone available in HUD assisted settings.

Resolving homelessness by access to housing will resolve some BH concerns, but a subset of people with MI and SUD are chronically living outside, and the story is more complex than that. Stresses, trauma, interpersonal violence, and sleep disturbance associated with homelessness all exacerbate and create MI and SUD, some substance use being a coping mechanism.

HUD works to help the public recognize the value of models like permanent supportive housing, tenant vouchers linked to services, Housing First. It's almost impossible to treat the symptoms while people are unhoused and facing ongoing triggers. Treatment First approaches often mean treatment only, but Housing First is never Housing Only. Treatment and recovery start with home, but we need resources for all. More housing vouchers in the last 3 years than in 20 years. Largest Continuum of Care grants, 12% increase in homelessness assistance funding over the previous year. Lack of funding for supportive services has hampered finding and keeping stable housing. Of the CoC funding, 2/3 goes to housing support (rental assistance, e.g.), which means they can't spend that on services to stabilize folks. Intensive case management, housing navigation services, moving costs and application fees and security deposits, and up to 6 months' rent can be paid through Medicaid innovations. States are realizing that housing is part of health care and beginning to take advantage of Medicaid flexibilities. 8 states and DC will partner through the Accelerator Program (not IL), with implementation TA, peer to peer learning on how to design these benefits and authorize their use, then take them into proof points to serve as models. Also partnering to implement CCBHCs to meet needs of people in public housing, to extend regulatory waivers, and more.

CCDDB and CCMHB I/DD Funding Requests for PY2025

uly 1, 2024 thru June 30, 2025

Agency	Program Name	Current Approved Contract Amounts DDB PY24 Original	DDB PY24 Amended	PY24 IDDSI	PY24 MHB	Requests PY25 all 3 funds	% chang	Primary/Secondary Reviewer	
Priority: Self-Advocacy									
CU Autism Network	Community Outreach Program	**$79,132**	**n/a**			**$0**	n/a	n/a	
CU Autism Network	CUAN Planning Seed Grant	**$65,217**	**n/a**			**$0**	n/a	n/a	
Priority: Linkage and Coordination									
CCRPC - Community Services	Decision Support PCP	**$433,777**	**n/a**			**$418,845**	-3%	KF/SF	
DSC	Service Coordination	**$496,080**	**n/a**			**$520,500**	5%	SF/VN	
Priority: Home Life									
Community Choices, Inc.	Inclusive Community Support (formerly Community Li	**$198,000**	**n/a**			**$213,000**	8%	GS/VN	
DSC	Community Living (formerly Apartment Services)	**$565,480**	**n/a**			**$615,000**	9%	AR/GS	
Priority: Personal Life									
Community Choices, Inc.	Transportation Support	**$76,221**	**$117,697**			**$171,000**	45%*	VN/KF	*PY24 $119,500 prorated to $117,697
DSC	Clinical Services	**$241,000**	**n/a**			**$260,000**	8%	SF/AR	
DSC (IDDSI PY24)	Individual & Family Support			**$250,000**		**$308,000**	23%	GS/SF	
PACE (IDDSI PY24)	Consumer Control in Personal Support			**$36,000**		**$45,972**	28%	AR/VN	
Priority: Work Life									
Community Choices, Inc.	Customized Employment	**$226,500**	**n/a**			**$239,500**	6%	KF/GS	
DSC	Community Employment	**$459,606**	**n/a**			**$500,000**	9%	GS/KF	
DSC/Community Choices	Employment First	**$90,100**	**n/a**			**$98,500**	9%	VN/SF	
Priority: Community Life									
Community Choices, Inc.	Self-Determination Support	**$176,500**	**n/a**			**$213,500**	21%	AR/KF	
DSC	Community First	**$890,042**	**n/a**			**$950,000**	7%	SF/VN	
DSC	Connections	**$106,400**	**n/a**			**$115,000**	8%	KF/AR	
CCRPC	Community Life Short Term Assistance - NEW	**n/a**	**n/a**			**$232,033**	n/a	VN (and MHB Chair)	
Priority: Strengthening the I/DD Workforce									
Community Choices	Staff Recruitment and Retention	**$34,000**	**n/a**			**$34,000**	n/a	2 year - no review	
DSC	Workforce Development and Retention	**$227,500**	**n/a**			**$244,000**	7%	GS/AR	
Priority: Young Children and their Families (CCMHB focus)									
DSC	Family Development				**$656,174**	**$656,174**	n/a	2 year - no review	
CC Head Start/Early Head Start	Early Childhood Mental Health Svs (MH & DD)				**$149,666**	***$241,135***		SF/GS	
CU Early	CU Early				**$4,043**	**$16,145**	299.3%*	AR/KF	*PY24 to PY25 not greatly increased
	(amounts listed are for DD portion of MHB contracts)				-	-			
	TOTAL	**$4,365,555**	**$41,476**	**$286,000**	**$809,883**	**$6,092,304**			
		DDB Original	*DDB Addition*	*IDDSI Tota*	*MHB total*				
		total PY2024 = $5,502,914				*total PY2025 requests, to all three funds and including multi year*			
						MHB amount will be $913,454 or $889,119 depending on levy growth.			
						$241,135 or $216,800- DD portion of Head Start. Remainder to IDDSI?			

Briefing Memorandum

DATE: March 20, 2024
TO: Members, Champaign County Developmental Disabilities Board (CCDDB) and Champaign County Mental Health Board (CCMHB)
FROM: Kim Bowdry, Associate Director for I/DD
SUBJECT: Program Year 2023 Service Activity Data

Background

During PY2018, CCDDB staff implemented a new data collection system for programs serving people with I/DD. Funded programs began entering service claims into the Online Reporting System for the types of services provided to people served. Since this implementation, agencies have continued providing a higher level of detail about client specific service activities than before.

Prior to PY2021 reporting categories were changed at the request of a CCDDB member. New service categories were meant to provide details on a client's presence with staff during the time entered as a claim and where the service activity took place. These new claims were entered as 'With Person Served' or 'On Behalf of Person Served.' Both new service options could be associated with one of the following place options, 'Off Site (in the community or client home)' or 'On Site (at an agency facility)'. At this time units of service were changed from quarter hour entries to full hour entries. Although full hours of service may give an appearance of over service in some cases, it provides a more accurate description of service and was also meant to prevent agency staff from spending as much time entering claims. This way of reporting also provides a clearer representation of services provided by CCDDB funded programs than before PY2018.

CCDDB Funded Program Information

'Utilization Summaries for PY2023 CCDDB and CCMHB I/DD Programs' is attached for reference. This document was included in the October 18, 2023 CCDDB packet. Programs listed below reported service activity data for specific people served. PY2023 totals are listed by program.

CCRPC

- Decision Support Person Centered Planning served 320 people for a total of 3,280 hours, with total payments of $323,550.

Community Choices

- Community Employment served 51 people for a total of 3,741 hours, with total payments of $217,500.
- Inclusive Community Support served 32 people for a total of 2,103 hours, with total payments of $193,874.

DSC

- Clinical Services served 58 people for a total of 1,140 hours, with total payments of $184,000, $22,924 of which was returned as unspent revenue.
- Community Employment served 92 people for a total of 6,989 hours, with total payments of $435,000, of which $24,013 was returned as unspent revenue.
- Community First served 40 people for a total of 27,408 hours, with total payments of $847,658.
- Community Living served 76 people for a total of 12,023 hours, with total payments of $536,000, of which $10,261 was returned as unspent revenue.
- Connections served 25 people for a total of 1,216 hours, with total payments of $95,000.
- Individual and Family Support served 34 people for a total of 8,714 hours, with total payments of $390,000. $54, 893 was returned as unspent revenue.
- Service Coordination served 248 people for a total of 5,866 hours, with total payments of $468,000, of which $68,859 was returned as unspent revenue.

PACE

- Consumer Control in Personal Support registered 34 PSWs, with total audited payments of $27,367. The program also matched 12 Personal Support Workers (PSWs) to people with I/DD seeking PSWs.

As in past years, some programs did not report client level data as claims in the Online Reporting System. These programs, including support groups and another, are listed below. One program serves a significant number of Non-Treatment Plan Clients and does not report client level data on these services. For the programs below, this information can be found in the attached 'Utilization Summaries for PY2023 CCDDB and CCMHB I/DD Programs' document.

Community Choices

- Self-Determination Support, $171,000

DSC

- Employment First, $85,000. $1,877 was returned as unspent revenue.

Programs and People with Service Level Data

- Of the programs reporting on specific individuals and service activities, we learn that there were **571 unduplicated adults or older children** and **908 young children.**
- Of the unduplicated adults and older children served during PY2023, **33% had state waiver funding as well, an increase of 7% from PY2023 related to billing restrictions through IDHS-DDD HBS program.**

- Of the unduplicated adults and older children served during PY2023, **67% had DDB/MHB funding only**.
- An individual may receive services from more than one agency and more than one program within a single agency. All adult TPCs in CCDDB funded programs should also be enrolled in CCRPC's Decision Support PCP program, receiving Conflict Free Case Management, or be enrolled in Medicaid waiver funded services. There was **no** overlap of adults, older children, or young children served between agencies with similar programs.
    - 410 (352 in PY2022) people were served by **one agency only**;
    - 154 (150 in PY2022) people were served by two agencies; and
    - 4 (2 in PY2022) people were served by three agencies.
    - 335 (307 in PY2022) people were served in **one program only**;
    - 118 (94 in PY2022) people were served in two programs;
    - 54 (50 in PY2022) people were served in three programs;
    - 36 (26 in PY2022) people were served in four programs;
    - 12 (17 in PY2022) people were served in five programs;
    - 11 (9 in PY2022) people were served in six programs; and
    - 2 people were (1 in PY2022) served in seven programs.

Profiles of People Receiving Services from Multiple Programs

Involvement with multiple agencies and multiple programs is often appropriate for each individual person's service needs and preferences. The need or preference for multiple agencies and/or program involvement should be documented in each person's person-centered plan. Below is a summary of agency and program involvement during PY2023.

- Of the **4 people served by three agencies**:
    - Three were served by CCRPC Decision Support PCP, Community Choices, and DSC. One person was served by CCRPC, DSC, and he worked with PACE to hire a PSW.
- Two people served in **seven programs** were served by CCRPC Decision Support PCP, DSC Clinical, Community Employment, Community First, Community Living, Connections, and Service Coordination with CCDDB funding only.
- Of the **11 people served in six programs**:
    - 5 people were served by CCRPC Decision Support PCP and DSC Clinical Services, Community First, Community Living, Connections, and Service Coordination, with CCDDB funding only;
    - 1 person was served by CCRPC, Community Choices Customized Employment (closed in August 2022), and DSC Community Employment (opened in September 2022), Community First, Community Living, and Service Coordination.
    - 1 person was served by CCRPC and DSC Clinical, Community Employment, Community First, Community Living, Connections, and Service Coordination;
    - 1 person was served by CCRPC and DSC Clinical, Community Employment, Community First, Connections, and Service Coordination, CCDDB funding only; and

- 3 people served by CCRPC Decision Support PCP, DSC Community Employment, Community First, Community Living, Connections, and Service Coordination.

- Of the **12 people served in five programs**:
  - 12 had CCDDB funding only;
  - 12 were served by CCRPC Decision Support PCP;
  - 1 was also served by Community Choices Customized Employment, DSC Community First, Connections, and Service Coordination;
  - 1 was also served by DSC Community Employment, Community First, Connections, and Service Coordination;
  - 2 were also served by DSC Community First, Community Living, Connections, and Service Coordination;
  - 1 was also served by DSC Clinical, Community First, Connections, and Service Coordination;
  - 1 was also served by DSC Clinical, Community Living, Individual and Family Support, and Service Coordination;
  - 1 was also served by DSC Community Employment, Community Living, Individual and Family Support, and Service Coordination;
  - 2 were served by DSC Clinical, Community Employment, Community Living, and Service Coordination;
  - 2 were also served by DSC Community Employment, Community First, Individual and Family Support, and Service Coordination; and
  - 1 was also served by DSC Community Employment, Community First, Community Living, and Service Coordination.

Samples of Total Hours of Services by Program

Client level data can be found below. This data exhibits how people with I/DD in Champaign County utilized the programs funded by the CCDDB for PY2023.

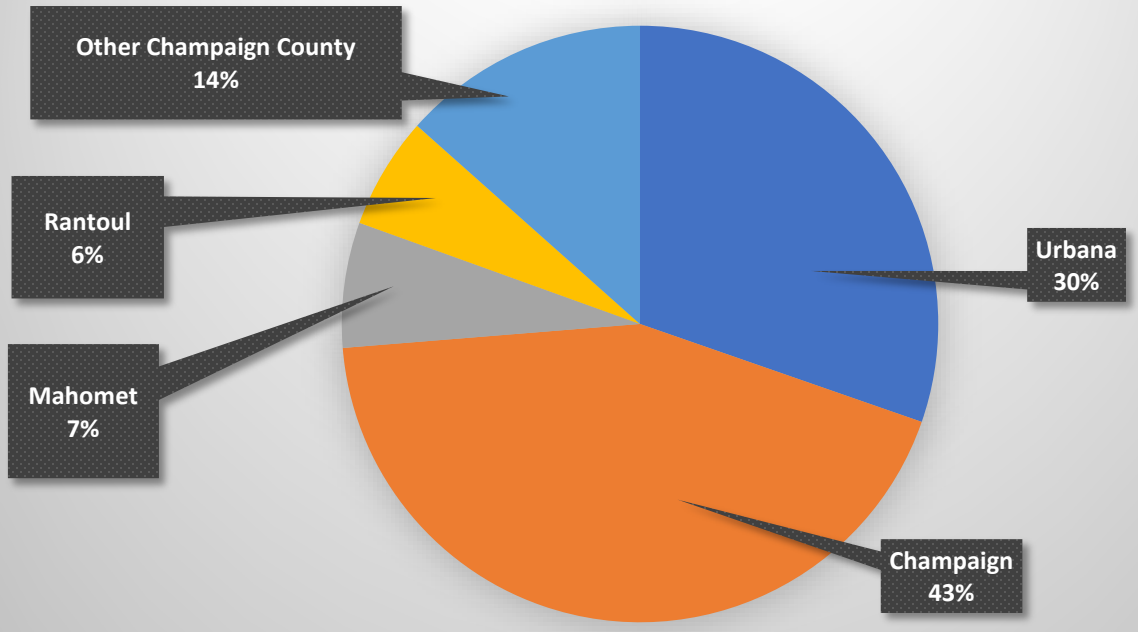
- Person A participated in **6 programs, 2 agencies**:
  - 29 hours of service from CCRPC Decision Support PCP, 1% of total program hours;
  - 21 hours of service from DSC Clinical Services, 2% of total program hours;
  - 293 hours of service from DSC Community First, 1% of total program hours;
  - 385 hours of service from DSC Community Living, 3% of total program hours;
  - 83 hours of service from DSC Connections, 7% of total program hours; and
  - 25 hours of service from DSC Service Coordination, <1% of total program hours.
- Person B participated in **6 programs, 2 agencies**:
  - 15 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
  - 40 hours of service from DSC Clinical Services, 4% of total program hours;
  - 1,195 hours of service from DSC Community First, 4% of total program hours;
  - 1,290 hours of service from DSC Community Living, 11% of total program hours;
  - 44 hours of service from DSC Connections, 4% of total program hours; and
  - 43 hours of service from DSC Service Coordination, 1% of total program hours.

- Person C participated in **5 programs, 3 agencies**:
  - 7 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
  - 3 hours of service from Community Choices Customized Employment, <1% of total program hours;
  - 517 hours of service from DSC Community First, 2% of total program hours;
  - 39 hours of service from DSC Connections, 3% of total program hours; and
  - 15 hours of service from DSC Service Coordination, <1% of total program hours.
- Person D participated in **3 programs, 2 agencies**:
  - 5 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
  - 81 hours of service from DSC Community Living, 1% of total program hours; and
  - 25 hours of service from DSC Service Coordination, <1% of total program hours.
- Person E participated in **2 programs, 2 agencies**:
  - 30 hours of service from DSC Service Coordination, 1% of total program hours and
  - 1 hour of service from PACE Consumer Control in Personal Support. This person had 1 Successful Match with a PSW from the PACE registry during PY23.
  - This person also receives services through IDHS-DDD Home Based Services.
- Person F participated in **3 programs, 2 agencies**:
  - 4 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
  - 134 hours of service from Community Choices Customized Employment, 2% of total program hours; and
  - 35 hours of service from Community Choices Inclusive Community Support, 6% of total program hours.
- Person G participated in **1 program, 1 agency**:
  - 11 hours of service from CCRPC Decision Support PCP, <1% of total program hours.
- Person H participated in **2 programs, 2 agencies**:
  - 19 hours of service from CCRPC Decision Support PCP, 1% of total program hours;
  - 6 hours of service from DSC Service Coordination, <1% of total program hours.
- Person I participated in **4 programs, 2 agencies**:
  - 5 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
  - 150 hours of service from DSC Community Employment, 2% of total program hours;
  - 476 hours of service from DSC Community First, 2% of total program hours; and
  - 4 hours of service from DSC Service Coordination, <1% of total program hours.
- Person J participated in **2 programs, 2 agencies**:
  - 14 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
  - 5 hours of service from Community Choices Customized Employment, <1% of total program hours.

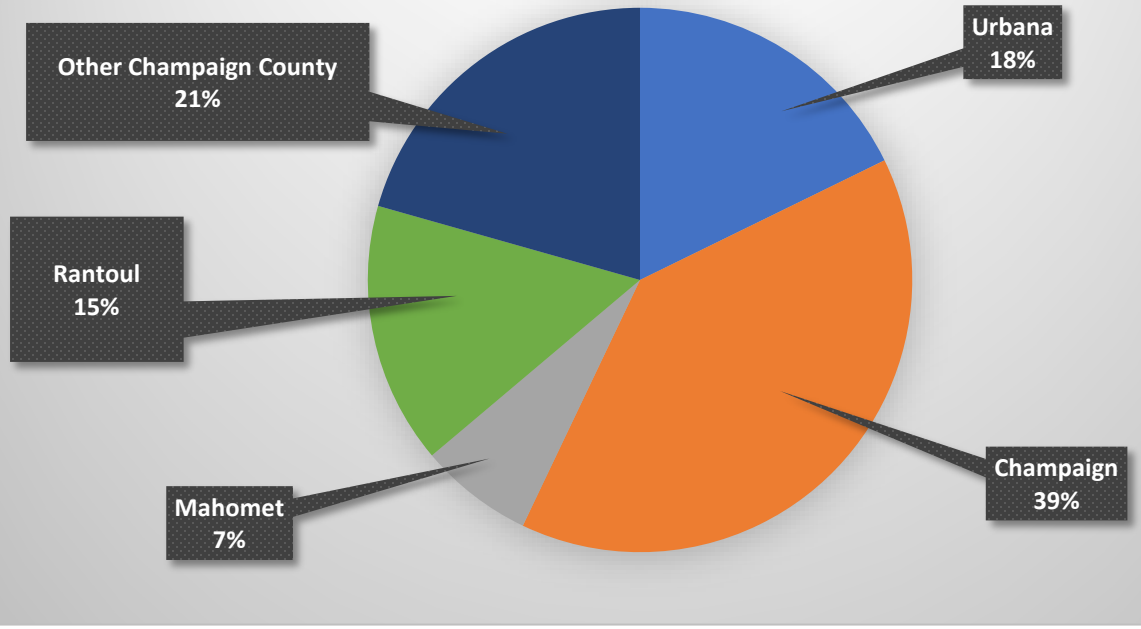
Characteristics of People Served through CCDDB and CCMHB I/DD Funding for PY2023

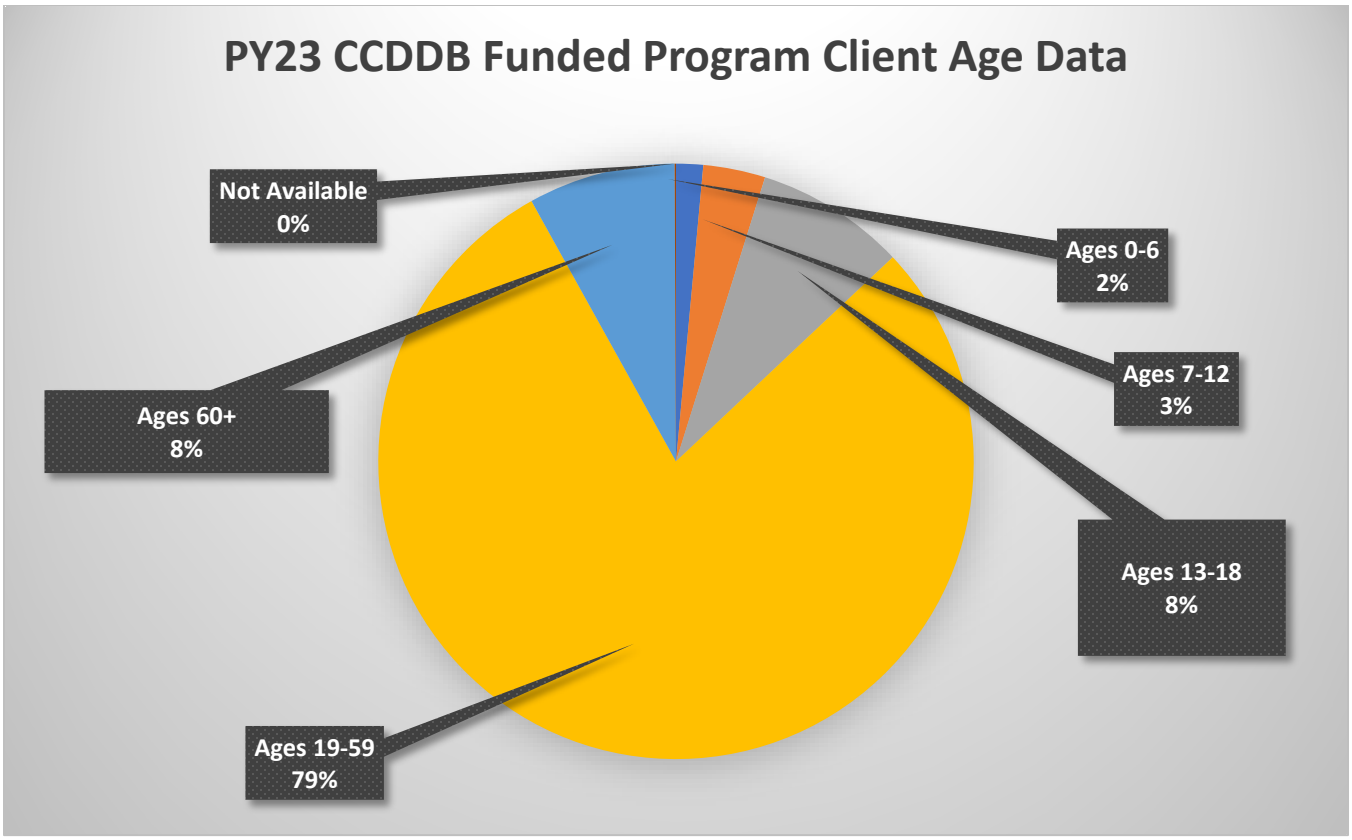
Included below are charts of aggregate agency service data per demographic category and residency, total hours of service by program, and total hours of service by type.

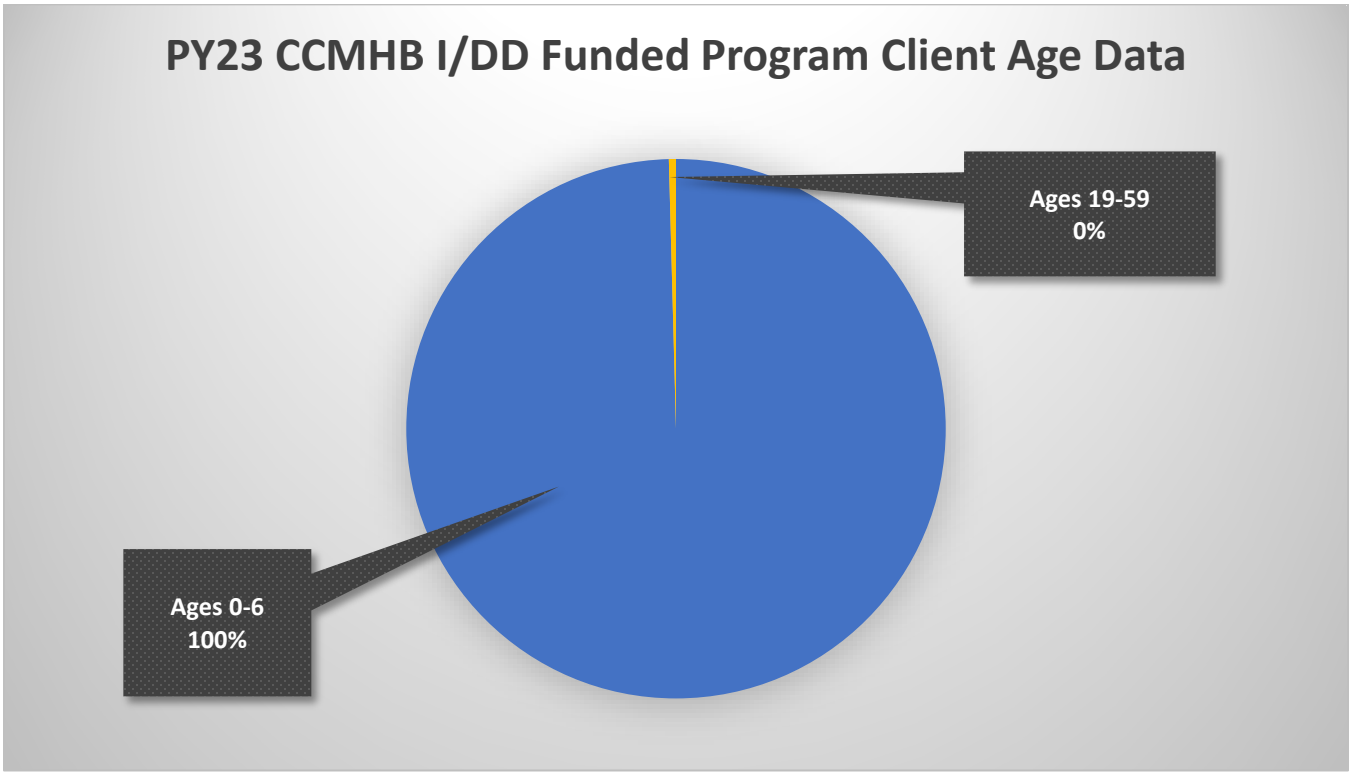
PY23 CCDDB Funded Program Client Zip Code Data

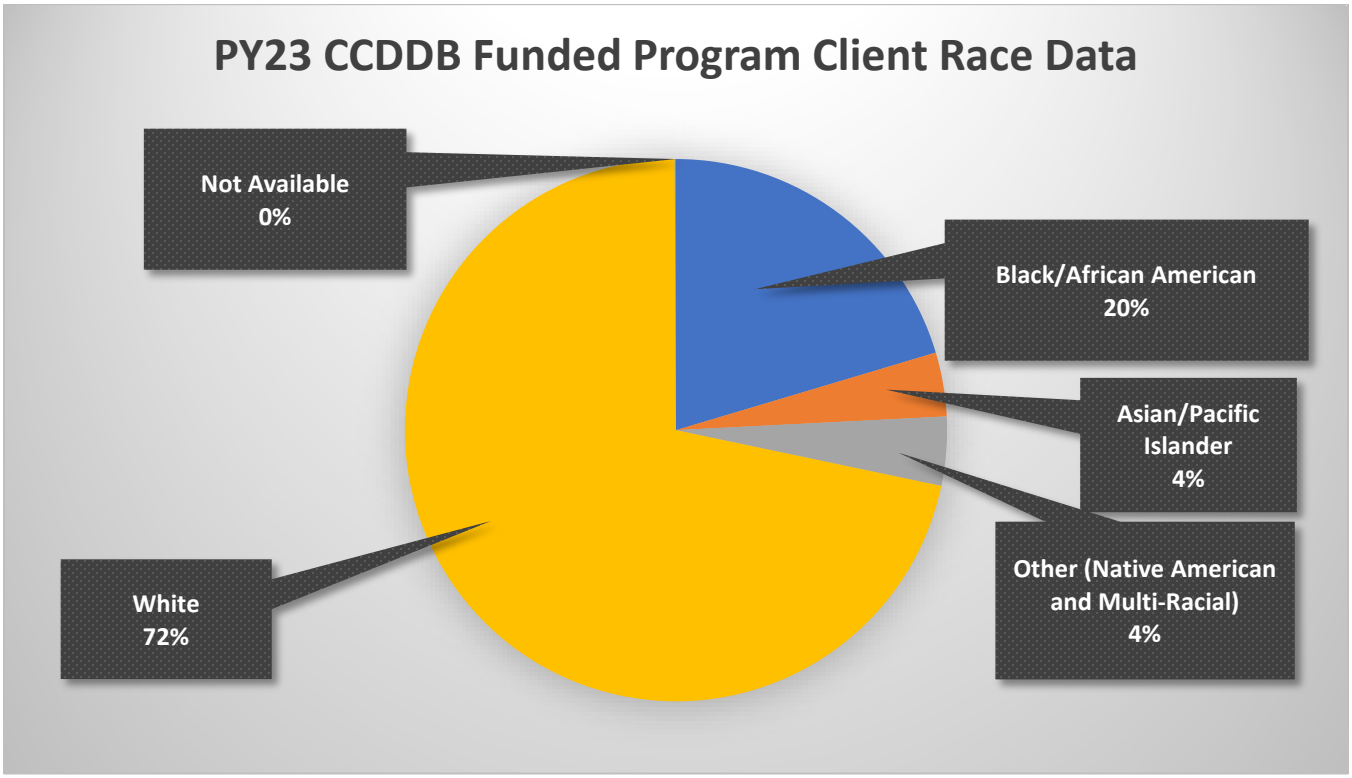


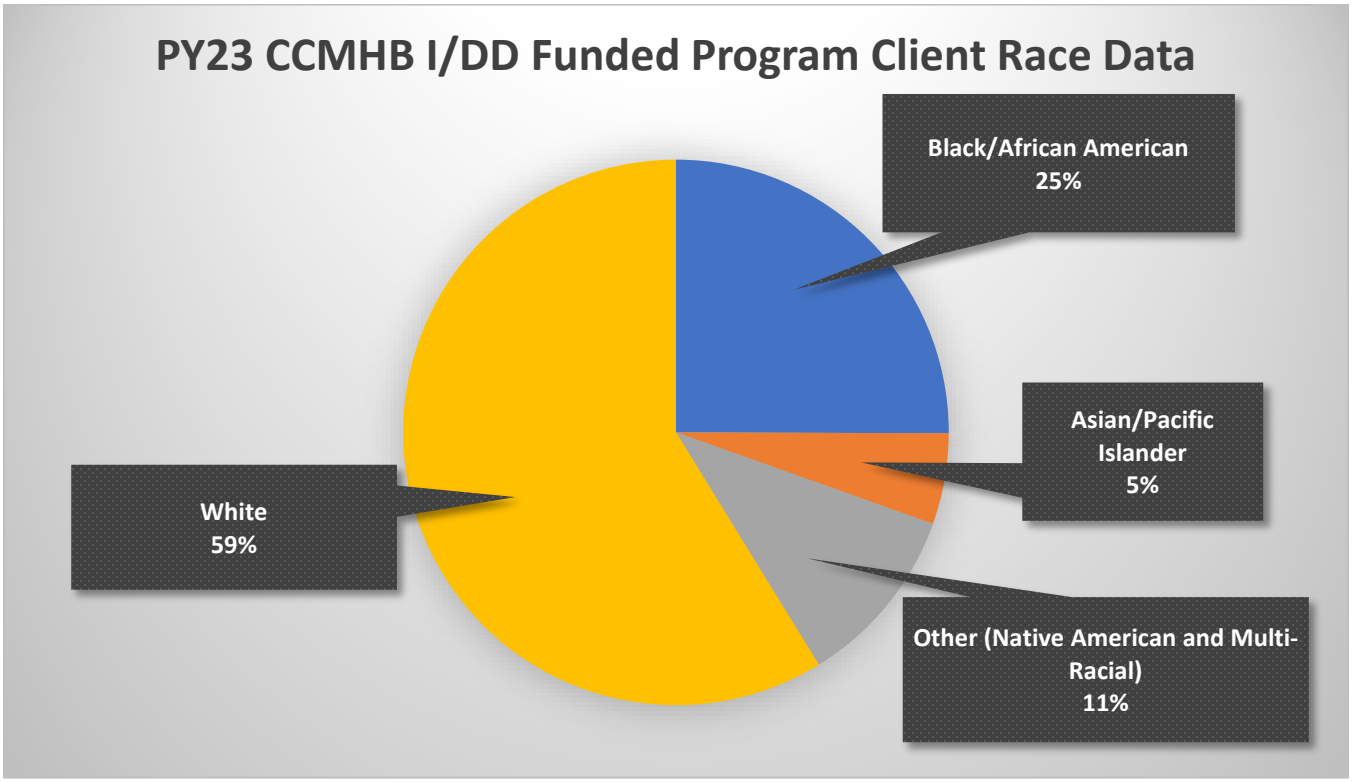
PY23 CCMHB I/DD Funded Program Client Zip Code Data

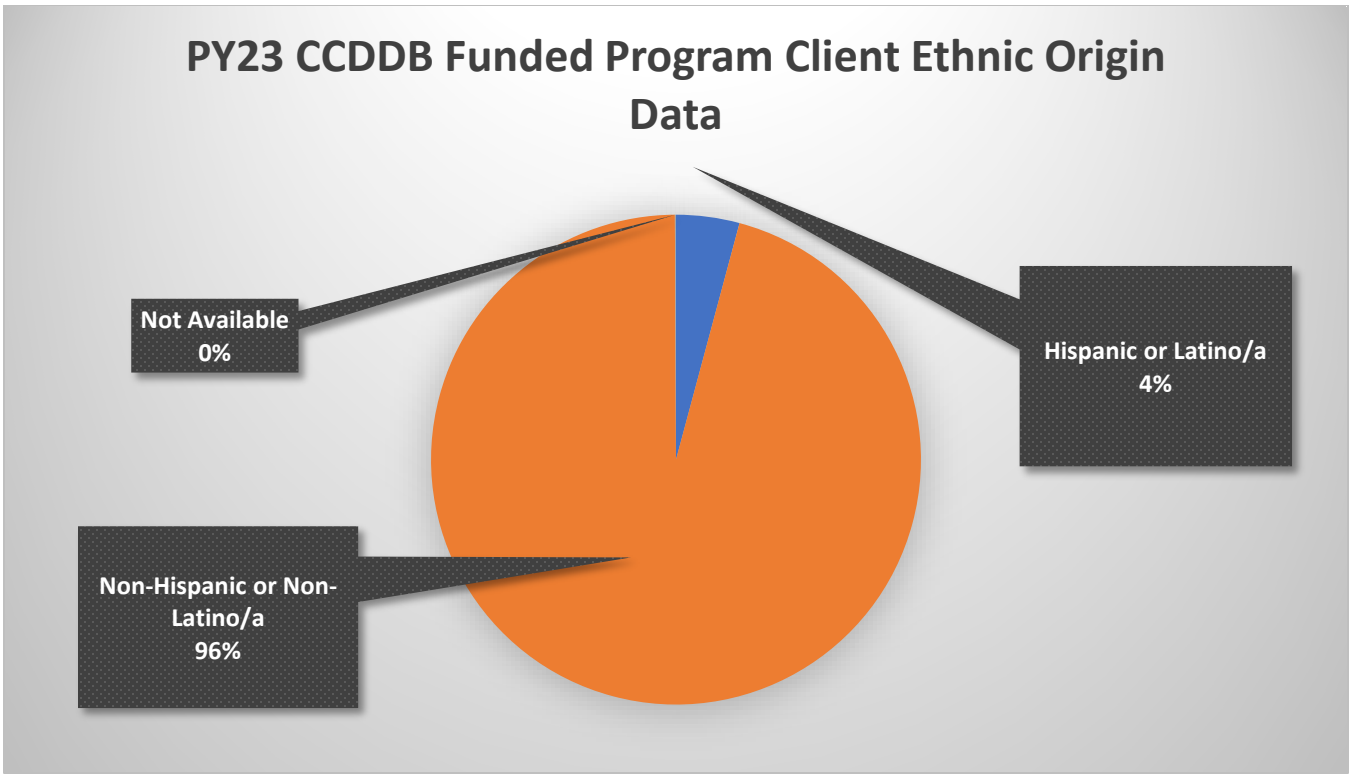


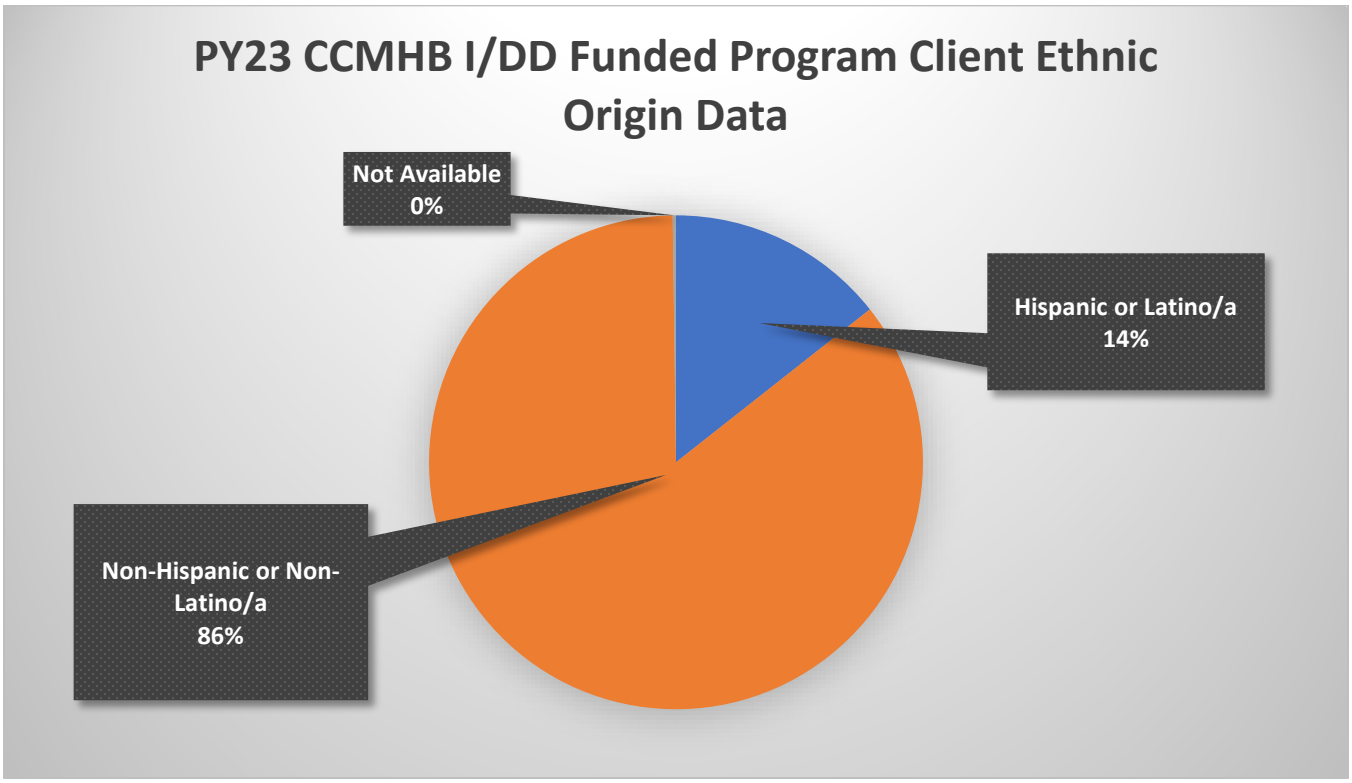

PY23 CCDDB Funded Program Client Age Data
Not Available
0%
Ages 0-6
2%
Ages 7-12
3%
Ages 13-18
8%
Ages 19-59
79%
Ages 60+
8%


PY23 CCMHB I/DD Funded Program Client Age Data
Ages 19-59
0%
Ages 0-6
100%

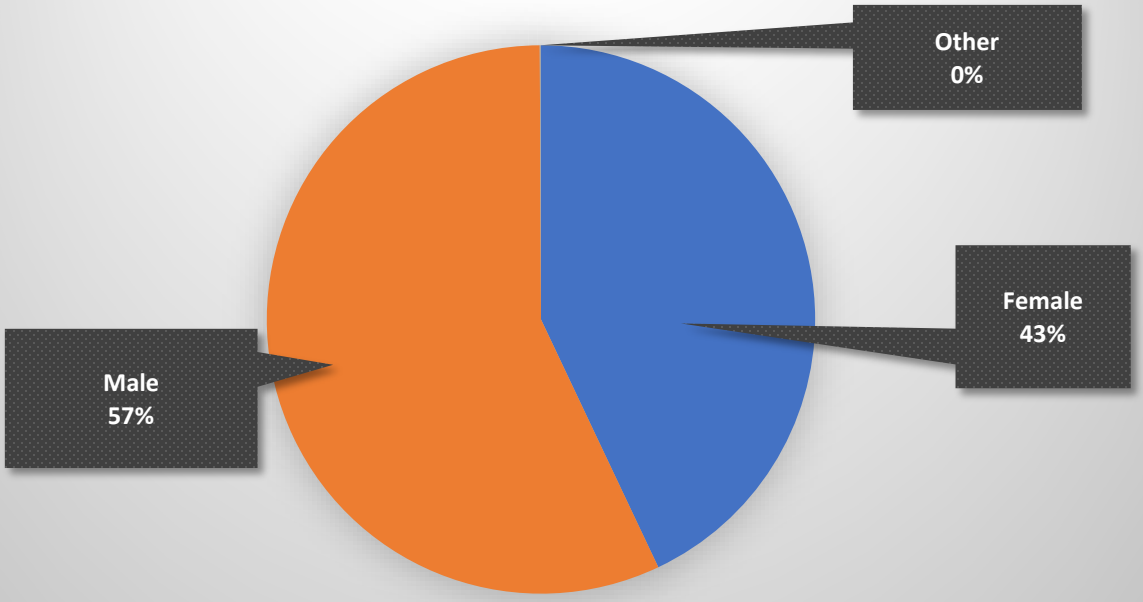

PY23 CCDDB Funded Program Client Race Data
Not Available
0%
Black/African American
20%
Asian/Pacific
Islander
4%
Other (Native American
and Multi-Racial)
4%
White
72%


PY23 CCMHB I/DD Funded Program Client Race Data
Black/African American
25%
Asian/Pacific
Islander
5%
White
59%
Other (Native American and Multi-
Racial)
11%

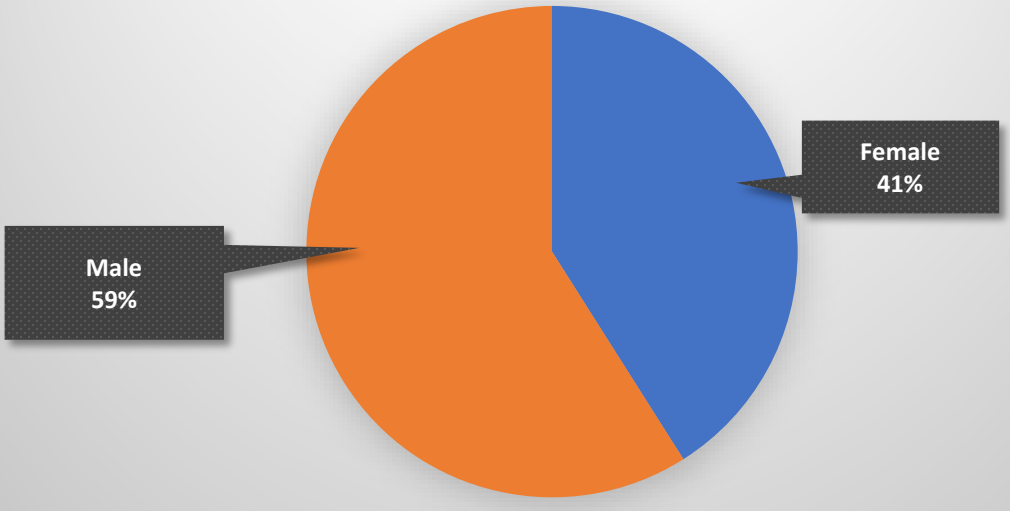

PY23 CCDDB Funded Program Client Ethnic Origin Data
Not Available 0%
Hispanic or Latino/a 4%
Non-Hispanic or Non-Latino/a 96%

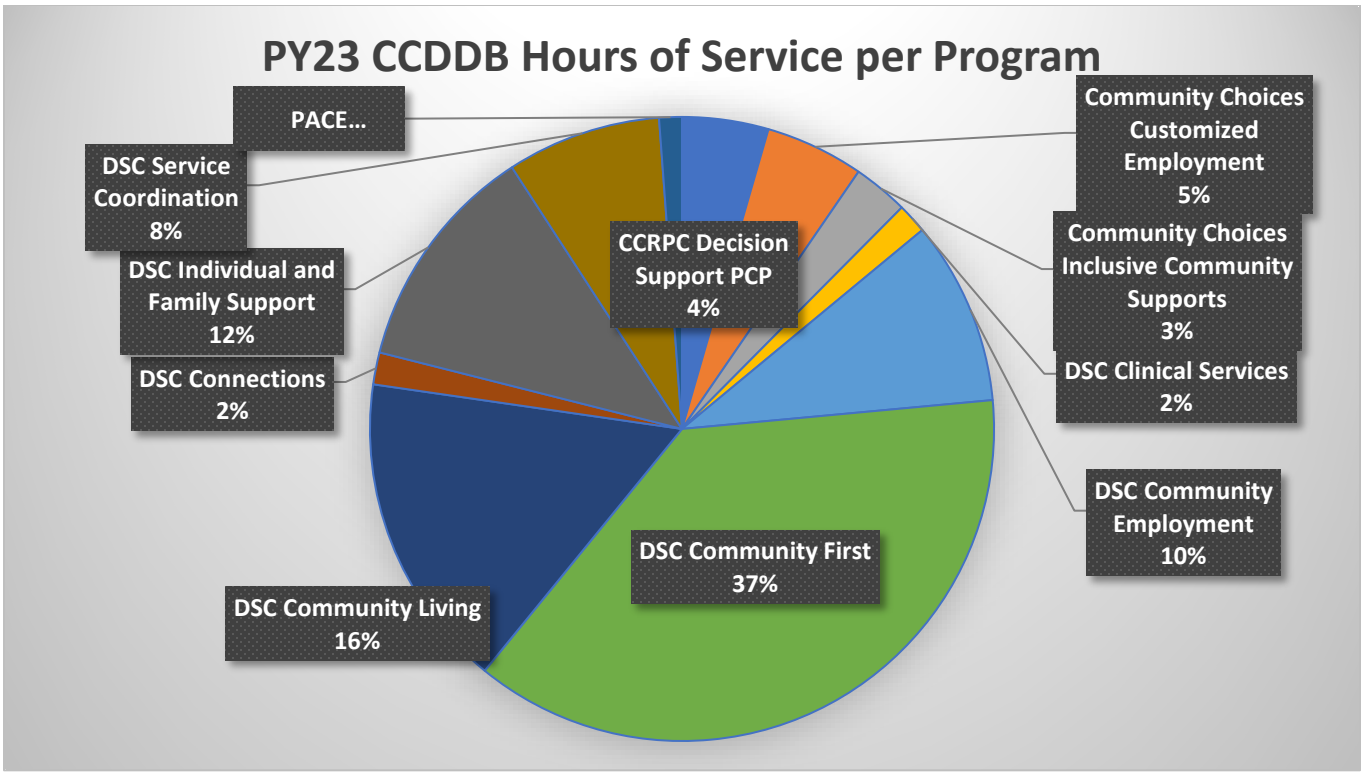

PY23 CCMHB I/DD Funded Program Client Ethnic Origin Data
Not Available 0%
Hispanic or Latino/a 14%
Non-Hispanic or Non-Latino/a 86%

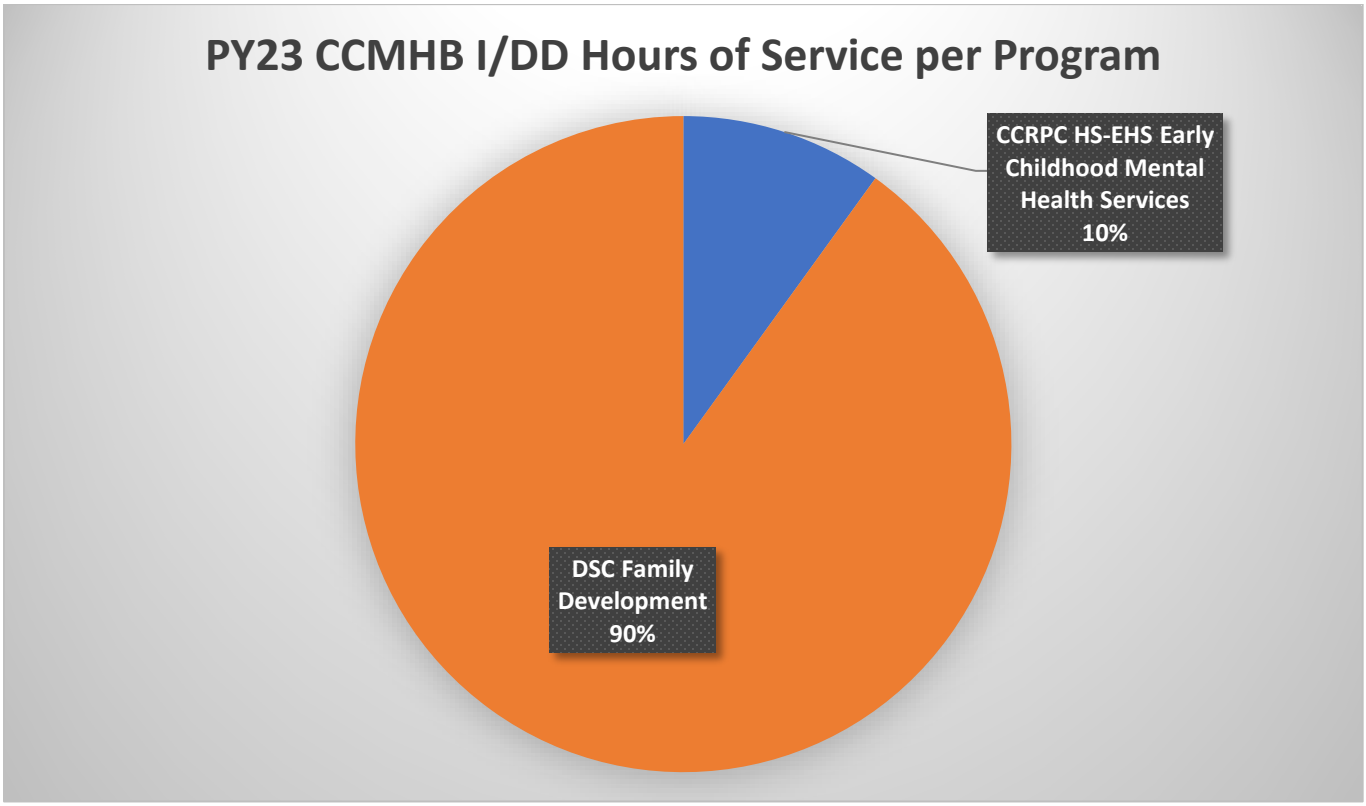
PY23 CCDDB Funded Program Client Gender Data

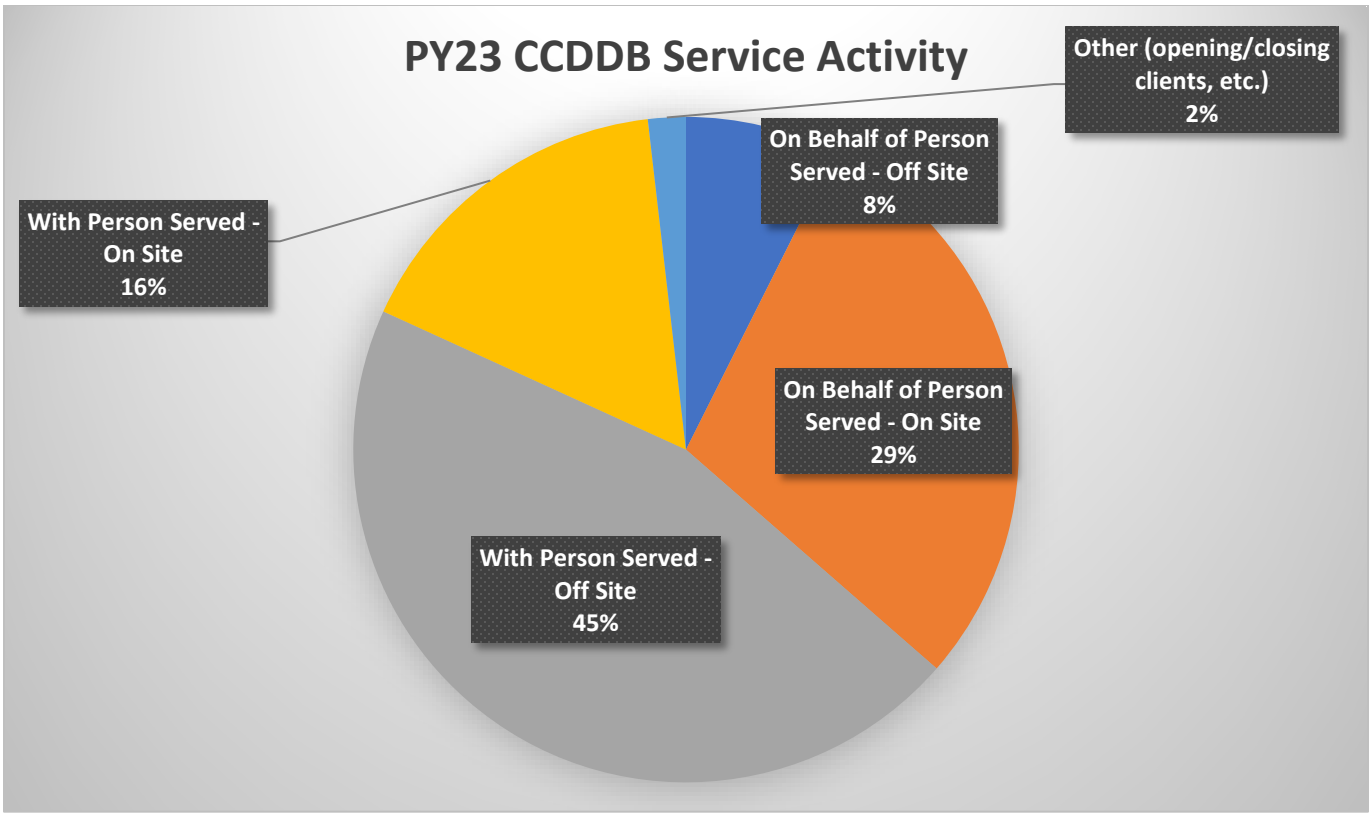


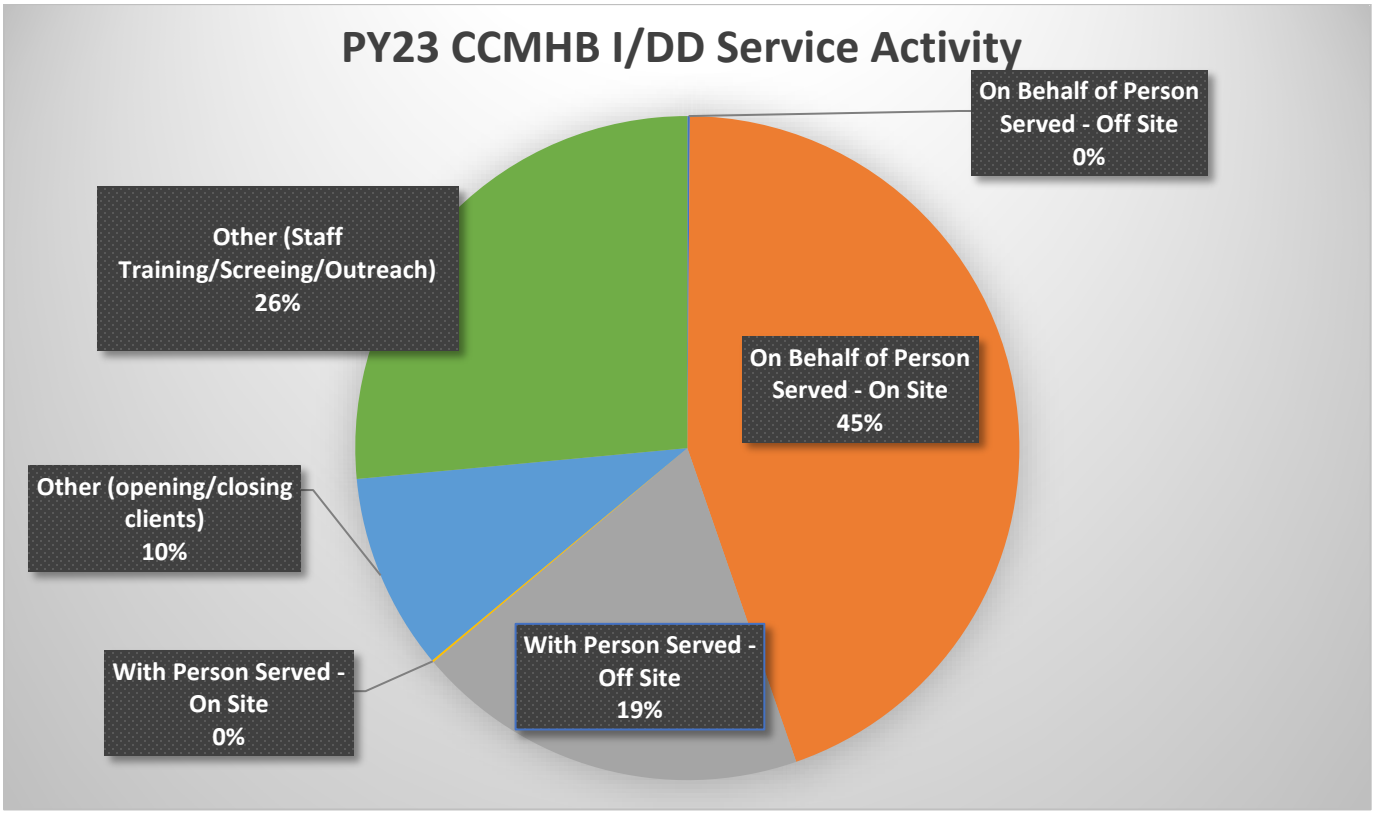
PY23 CCMHB I/DD Funded Program Client Gender Data




PY23 CCDDB Hours of Service per Program
PACE…
DSC Service Coordination 8%
DSC Individual and Family Support 12%
DSC Connections 2%
CCRPC Decision Support PCP 4%
Community Choices Customized Employment 5%
Community Choices Inclusive Community Supports 3%
DSC Clinical Services 2%
DSC Community Employment 10%
DSC Community First 37%
DSC Community Living 16%


PY23 CCMHB I/DD Hours of Service per Program
CCRPC HS-EHS Early Childhood Mental Health Services 10%
DSC Family Development 90%


PY23 CCDDB Service Activity
Other (opening/closing clients, etc.) 2%
On Behalf of Person Served - Off Site 8%
With Person Served - On Site 16%
On Behalf of Person Served - On Site 29%
With Person Served - Off Site 45%


PY23 CCMHB I/DD Service Activity
On Behalf of Person Served - Off Site 0%
Other (Staff Training/Screeing/Outreach) 26%
On Behalf of Person Served - On Site 45%
Other (opening/closing clients) 10%
With Person Served - Off Site 19%
With Person Served - On Site 0%

Utilization Summaries for PY2023 CCDDB and CCMHB I/DD Programs

Detail on each program's performance toward defined consumer outcomes during the funding year of July 1, 2022 to June 30, 2023 is available at http://ccmhddbrds.org, among downloadable public files toward the bottom of the page. The document is titled "CCDDB PY23 Performance Outcome Reports."

TPC = Treatment Plan Client
NTPC = Non-Treatment Plan Client
CSE = Community Service Event
SC = Service Contact or Screening Contact
Other, as defined in individual program contract

Priority: Self-Advocacy

There were no applications under the Self-Advocacy priority in PY2023.

Priority: Linkage and Coordination

Champaign County Regional Planning Commission Community Services

Decision Support Person Centered Planning $323,550

Services: ISC staff assess persons who are eligible for and may or may not be receiving IDHS-DDD waiver funding and who have not yet been assessed for service preferences. Transition Consultants assist people/families in conflict free transition planning. Extensive outreach, preference assessment, and person-centered planning services for Champaign County residents with I/DD who do not yet have Medicaid-waiver funding. Consultation and transition planning for people with I/DD nearing graduation from secondary education. Conflict free person-centered planning and case management services, using DHS' Discovery and Personal Plan tools currently utilized by ISC agencies throughout Illinois for those who do have Medicaid waiver funding. Case management provided to PUNS enrolled people who are dually diagnosed. **Utilization targets:** 320 TPC, 200 NTPC, 300 SC, 50 CSE. **Utilization actual:** 320 TPC, 429 NTPC, 698 SC, 27 CSE.

DSC **Service Coordination** $468,000

Services: Serves children and adults with I/DD who request support to enhance or maintain their highest level of independence in the community, at work, and in their home. Focusing on the hopes, dreams, and aspirations serves as the basis of planning and outcomes for that person. With each person as the center of their team, Case Coordinators work closely with all members of each person's team assuring the most person–centered and effective coordination. **Utilization targets:** 280 TPC, 36 NTPC, 70 SC, 2 CSE. **Utilization actual:** 248 TPC, 31 NTPC, 24 SC, 4 CSE.

Priority: Home Life

Community Choices **Inclusive Community Support** (formerly Community Living) $193,874

Services: Housing, skills, connections, resource coordination, benefits and budget management, health, daily life coordination, and comprehensive HBS administration. Services chosen after an in-depth planning process. Family-Driven Support: planning process for self-directed community living. Sustained Community Supports (ala carte): choice of specific services and support in any of the domains on a short- or long-term basis. Sustained Community Supports (full coordination): people looking for in-depth support for daily living can choose to participate in most, or all, of the service domains. Program Design: Support will be provided by a team and up to 5 times per week. Optional Personal Development Classes available to participants and other members. **Utilization targets:** 30 TPC, 15 NTPCs, 4 CSE, 3539 SC, 4100 Other (direct support hours). **Utilization actual:** 32 TPC, 20 NTPC, 9 CSE, 1930 SC, 2392 Other (direct support hours).

DSC **Community Living** $536,000

Services: Program supports people to live their best life enjoying independence, community engagement, and self-sufficiency. Staff provide individualized training, support, and advocacy. Program supports people with their health and wellness, accessing their community, and provides varied financial supports. Emergency Response is available to support those needing assistance after hours and on the weekends. **Utilization targets:** 64 TPC, 6 SC. **Utilization actual:** 76 TPC, 15 SC.

Priority: Personal Life and Resilience

DSC **Clinical Services** $184,000

Services: Provides clinical supports and services to children and adults with I/DD. Consultants under contract include one Licensed Clinical Psychologist, two Licensed Clinical Social Workers, three Licensed Clinical Professional Counselors, two Licensed Professional Counselors, and one Psychiatrist. Consultants meet with people at their private practice, at the person's home or DSC locations. People schedule their appointments or receive support from family and/or DSC staff members for scheduling and transportation. **Utilization targets:** 59 TPC, 6 NTPC, 10 SC, 2 CSE. **Utilization actual:** 58 TPC, 2 NTPC, 15 SC, 4 CSE.

DSC **Individual & Family Support** $390,000

Services: Program services children and adults with I/DD with significant behavioral, medical, or support needs and reflects expressed needs of people/families. Program offers community activities such as social, recreational, educational, volunteering opportunities either 1:1 or with peers. The program offers primary caregivers scheduled and emergency support. Program provides more flexible/less restrictive, individualized support than state funded programs. Financial support has afforded families to benefit from extended breaks such as camps, after-school programs, and summer camps with specialized support. All provide temporary relief to primary caregivers while providing a dual benefit for their loved one outside the family home. **Utilization targets:** 19 TPC, 27 NTPC, 8 SC, 2 CSE. **Utilization actual:** 11 TPC, 29 NTPC, 15 SC, 4 CSE.

PACE, Inc. **Consumer Control in Personal Support** $27,367

Services: Personal Support Worker (PSW) recruitment and orientation, focused on Independent Living Philosophy, Consumer Control, and the tasks of being a PSW. Personal Assistant (PA)/PSW Registry can be sorted by; location, time of day, services needed, and other information which allows consumers to get the PSW that best matches their needs. Service is designed to ensure maximum potential in matching person with I/DD and PSW to work long-term towards achieving their respective goals. **Utilization targets:** 30 NTPC, 200 SC, 15 CSE, and 6 Other (Successful PSW matches). **Utilization actual:** 34 NTPC, 315 SC, 28 CSE, and 12 Other (Successful PSW matches). ***Note – NTPC counts updated to reflect New NTPCs only for PY23. Original publishing included New and Continuing NTPCs.**

Priority: Work Life

Community Choices **Customized Employment** $217,500

Services: Focus on individualizing relationships between employees and employers resulting in mutually beneficial relationships. Discovery identifies strengths, needs and desires of people seeking employment. Job Matching identifies employers and learns about needs and meeting those needs through customized employment. Short-term Support develops accommodations, support, and provides limited job coaching. Long-term Support provides support to maintain and expand employment. Increased Support Model Development proposes to develop a program design to ensure more people with I/DD can work inclusively in our community. Supported Experiences for First Time Job Seekers provides classroom and intensive job-shadowing at two local businesses in structured 12-week program for first-time job seekers and others seeking additional experiences. **Utilization targets:** 40 TPC, 2200 SC, 4 CSE, 3220 Other (direct support hours). **Utilization actual:** 51 TPC, 2707 SC, 8 CSE, 3706 Other (direct support hours).

DSC **Community Employment** $435,000

Services: Assists people to find and maintain jobs. Discovery process: employment plan development; interviews with the person and others; daily observation; exploration of job interests; encourage/support volunteer opportunities. Resume or portfolio development: interview preparation and support; contact with potential employers; soft skills education and practice. Application process/follow-up: traditional and non-traditional approaches to interviewing/hiring. Job orientation, skill acquisition including transportation, mastery of specific job responsibilities, potential accommodations, adaptive tools, development of natural supports, foster relationship with supervisor and coworkers. Job coaching: advocacy, development of self-advocacy skills, identification of potential new responsibilities or promotions, monitoring work environment for potential risks to job security; identifying and facilitating natural supports. Supported Employment: establish volunteer/work options for all people including those with significant support needs; support niches for a small group of people within local businesses. **Utilization targets:** 70 TPC, 2 CSE, 15 SC. **Utilization actual:** 92 TPC, 5 CSE, 20 SC.

DSC with Community Choices **Employment First** $85,000

Services: Training emphasizes person-centered, customized, community-based services and cutting-edge employment practices to include employment readiness and leading to experience in areas of volunteerism, supported employment, and customized employment. Continued outreach and incentive for businesses, promoting inclusion and prioritizing employment for people with I/DD. Advocacy and ongoing dialogue with representatives and policymakers of various state agencies to further employment opportunities for those with developmental disabilities. New Employer Directory which will reflect/promote businesses identified as inclusive and will be made available in a variety of formats. **Utilization targets:** 25 CSE. **Utilization actual:** 61 CSE.

Priority: Community Life and Relationships

Community Choices **Self Determination Support** $171,000

Services: Family Support & Education: educating families on the service system, helping them support each other, and advocating for improved services through public quarterly meetings and individual family consultation. Leadership & Self-Advocacy: Leadership Classes and an Advocacy Board. Building Community: options for adults with I/DD to become engaged with others through clubs and community opportunities. Scaffolded Supports: Opportunities for adults with I/DD to participate in opportunities available in their community, with ongoing intermittent support from CC staff, including half-day small group social opportunities, support to attend a park district class, or community cooking class. **Utilization targets:** 180 NTPC, 2759 SC, 4 CSE, 1953 Other (direct support hours). **Utilization actual:** 183 NTPC, 2861 SC, 12 CSE, 2035.5 Other (direct support hours).

DSC **Community First** $847,658

Services: For people with IDD interested in community-focused activities, a variety of offerings ranging from partial to full day options may include classes/offerings for educational opportunities hosted onsite and in community, with expanded social connections and involvement. Community connection through participation in self-advocacy, recreational activities, social events, educational groups, volunteering, and other areas of interest to enhance personal fulfillment. Program supports people with a wide range of interests, abilities, and needs, with people choosing from a diverse menu of activities, over 27 options. Program is committed to personalized support based on person's individual interests and needs. **Utilization targets:** 50 TPC, 50 NTPC, 5 SC, 2 CSE. **Utilization actual:** 40 TPC, 93 NTPC, 24 SC, 5 CSE.

DSC **Connections** $95,000

Services: Community-based alternative encouraging personal exploration and participation in the arts/artistic expression, promoting life enrichment and alternative employment. Introduces and supports people to experience a creative outlet, promote self-expression, and profit from products they create/produce. Encourages people to be creative and offers a welcoming venue for a variety of events. Groups and classes vary and are based on the interests and requests of program participants. Program hosts on-site events to promote collaboration and a venue for like-minded community artists. **Utilization targets:** 25 TPC, 12 NTPC, 5 CSE. **Utilization actual:** 25 TPC, 25 NTPC, 7 CSE.

Priority: Young Children and their Families

Champaign County Regional Planning Commission Head Start/Early Head Start

Early Childhood Mental Health Services $149,666 (CCMHB)

Services: Seeks to identify and address social-emotional concerns in the early childhood period, as well as to promote mental health among all Head Start children. The social-emotional portion of the program focuses on aiding the development of self-regulation, problem solving skills, emotional literacy, empathy, and appropriate social skills. Accomplishments in these areas will affect a child's ability to play, love, learn and work within the home, school, and other environments. All fit together to form the foundation of a mentally healthy person. **Utilization targets:** 90 TPC, 380 NTPC, 5 CSE, 3,000 SC, 12 Other (workshops,

trainings, professional development efforts with staff and parents). **Utilization actual:** 129 TPC, 362 NTPC, 5 CSE, 3,235 SC, 11 Other (workshops, trainings, professional development efforts with staff and parents).

DSC **Family Development** $596,522 (CCMHB)

Services: Serves children birth to five years, with or at risk of developmental disabilities and their families. FD responds to needs with culturally responsive, innovative, evidence-based services. Early detection and prompt, appropriate intervention can improve developmental outcomes for children with delays and disabilities and children living in at-risk environments. Family-centered intervention maximizes the gifts and capacities of families to provide responsive intervention within familiar routines and environments. **Utilization targets:** 655 TPC, 200 SC, 15 CSE. **Utilization actual:** 872 TPC, 272 SC, 25 CSE.

A FAMILY FRIENDLY EVENT!

15TH ANNUAL DISABILITY RESOURCE EXPO

People with disabilities, families, friends, caregivers, all are welcome...

SEE YOU THERE!!!

77

SATURDAY, OCTOBER 26
OPEN 11:00AM - 4:00PM

DISABILITY RESOURCE EXPO
Reaching Out For Answers

Market Place Mall
2000 N Neil St, Champaign

¡Un evento familiar!

15TH exposición anual de recursos para la discapacidad

Personas con discapacidad, familias, amigos, cuidadores, todos son bienvenidos...
NOS VEMOS ALLÍ

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Sábado 26 de Octubre del 2024
11 am – 4 pm

DISABILITY RESOURCE EXPO
Reaching Out For Answers

Market Place Mall
2000 N Neil St, Champaign