CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

REMEMBER this meeting is being audio recorded. Please speak clearly into the microphone during the meeting.

Champaign County Mental Health Board (CCMHB)

WEDNESDAY, March 20, 2019

Brookens Administrative Center, Lyle Shields Room
1776 E. Washington St. Urbana, IL
5:30 p.m.

1. Call to Order

2. Roll Call

3. Citizen Input/Public Participation
   The CCMHB reserves the authority to limit individual public participation to 5 minutes and limit total time to 20 minutes.

4. Approval of Agenda*

5. President's Comments

6. New Business

   A. CCMHB FY 2018 Annual Report* **(Pages 3-31)**
   The FY18 Annual Report is included in the Board packet for review and approval. Action is requested.

   B. Liaison Assignment Update
   Board discussion of liaison assignments

   C. Application Review Process **(Pages 32-33)**
   Briefing memorandum presents an overview of the review process and timeline.

   D. Amendment Report **(Page 34)**
   Briefing Memorandum on contract amendments issued included in the packet for information only.

E. Update on Legislative and Policy Conferences
(Pages 35-53)
A Briefing Memorandum is in the packet

7. Agency Information
The CCMHB reserves the authority to limit individual agency participation to 5 minutes and limit total time to 20 minutes.

8. Old Business

A. Agency Acronym List and Glossary **(Pages 54-63)**
List of agency and program name acronyms and glossary of terms is included in the packet.

B. Schedules & Allocation Process Timeline **(Pages 64-67)**
Updated copies of meeting schedules and allocation timeline are included in the packet.

9. CCDDB Information

10. Approval of CCMHB February 20, 2019 and February 27, 2019 Minutes* **(Pages 68-73)** *Minutes are included. Action is requested.*

11. Executive Director's Report

12. Staff Reports **(Pages 74-87)**
Staff reports from Mark Driscoll, Kim Bowdry, Shandra Summerville, Stephanie Howard-Gallo, and Chris Wilson are included for review.

13. Financial Report* **(pages 88-95)**
A copy of the Expenditure Approval List is included in the packet for action.

14. Board to Board Reports

15. Board Announcements

16. Adjournment

Board action

6.A.

Champaign County Mental Health Board

In fulfillment of our responsibilities under the Community Mental Health Act, the Champaign County Mental Health Board (CCMHB) presents the following documents for public review:

The CCMHB's Annual Report provides an accounting to the citizens of Champaign County of the CCMHB's activities and expenditures during the period of January 1, 2018 through December 31, 2018.

The CCMHB's Three-Year Plan for the period January 1, 2016 through December 31, 2018 presents the CCMHB's goals for development of Champaign County's system of community mental health, intellectual and developmental disabilities, and substance use disorder services and facilities, with One-Year Objectives for January 1, 2018 through December 31, 2018.

Any questions or comments regarding the CCMHB's activities or the county's behavioral health and developmental disability services can be directed to the Champaign County Mental Health Board; 1776 E. Washington; Urbana, IL 61802; phone (217) 367-5703, fax (217) 367-5741.

Champaign County Mental Health Board

Fiscal Year 2018 Annual Report & Three-Year Plan 2016-2018

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LISTING OF 2018 BOARD MEMBERS AND STAFF

BOARD MEMBERS

Dr. Susan Fowler
(President)

Ms. Elaine Palencia
(Vice President)

Dr. Thom Moore

Ms. Judi O'Connor

Dr. Julian Rappaport

Dr. Anne Robin

Ms. Margaret White

Mr. Kyle Patterson

Mr. Joseph Omo-Osagie

STAFF

Lynn Canfield
Executive Director

Kim Bowdry
Associate Director for Intellectual and Developmental Disabilities

Mark J. Driscoll
Associate Director for Mental Health & Substance Use Disorder Services

Stephanie Howard-Gallo
Operations & Compliance Coordinator

Shandra Summerville
Cultural & Linguistic Competence Coordinator

Chris Wilson
Financial Manager

2018 was a year filled with funding decisions and study sessions. The Board was supported greatly by Lynn Canfield, Executive Director as well as the talented staff of the Mental Health and Developmental Disabilities Board. The staff continues work on the county's behalf to ensure that services for mental health and developmental disabilities are available and increasing in innovation. Board members are appointed to serve for four years and each year we extend thanks to those whose terms have ended. We much appreciated the perspective of Dr. Anne Robin, a local physician, who completed her term on the Board. Ms. Judi O'Connor was reappointed for a second term, and Ms. Jane Sprandel, agreed to serve a term and has joined the Board. We will have the potential of three new board appointments for 2020. Elections conducted in February 2019 bring a change in leadership. Ms. Margaret White assumes the role of President, and Mr. Kyle Patterson will be Vice-President. Appreciation is expressed to Ms. Elaine Palencia for her two years as Vice-President.

We are starting the year with a new plan three year-plan, which the staff developed based on information gained from surveys conducted with community members and planning meetings with the Board. For a second year in a row, we have a state budget and a healthy county fund. The Board in FY2018 received $4,611,577 as part of the county property tax levy and awarded $4,222,179 to social service agencies for the period 7/1/2018-6/30/2019. This was the second year that the award process was conducted by assigning each board member to serve as a primary or secondary reviewer of 9-10 original applications, and to discuss those reports in study sessions and board meetings. This provided Board members and staff the opportunity to identify questions for agency response prior to voting on the allocations. Staff provided guidance to the board in terms of fiscal recommendations, and the Board provided input to staff on the merits of each application. The process proceeded smoothly and will be repeated again this year for the FY 20 allocations. While many ongoing programs continued to be funded, we saw the discontinuation of one program (Parenting with Love and Limits) and the development of several new programs, including: Rosecrance Recovery Home for treatment of substance use, a new program for housing and employment services from Cunningham Children's Home, Rattle the Stars, a youth suicide prevention program, and Mental Health Services for very young children through Head Start/Early Head Start.

I am pleased to present the Champaign County Mental Health Board 2019 Annual Report. The Annual Report includes information on the Boards finances, funding allocated to a wide range of programs, service data reported by funded programs for the term of the contract, and various charts presenting data on individuals served and funding allocations.

Respectfully, Susan Fowler, PhD

CCMHB President, 2018

SECTION I: Financial Reports and Service Data

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

ANNUAL FINANCIAL REPORT

1/1/18 - 12/31/18

	2017	2018
Beginning of the Year Fund Balance	$ 2,527,902	$ 2,842,704
REVENUE		
General Property Taxes	$ 4,415,651	$ 4,611,577
Back Taxes, Mobile Home Tax & Payment in Lieu of Taxes	9,698	7,809
Local Government Revenue		
Champ County Developmental Disabilities Board	287,697	310,783
Interest Earnings	18,473	41,818
Gifts and Donations	5,225	21,613
Miscellaneous	117,195	29,955
TOTAL REVENUE	$ 4,853,939	$ 5,023,555
EXPENDITURES		
Administration & Operating Expenses:		
Personnel	$ 449,220	$ 522,073
Commodities	6,263	10,049
Services	432,828	404,059
Interfund Transfers*	57,288	56,779
Capital Outlay	-	-
Sub-Total	$ 945,599	$ 992,960
Grants and Contributions:		
Program	3,593,538	3,648,188
Capital	-	-
Sub-Total	$ 3,593,538	$ 3,648,188
TOTAL EXPENDITURES	$ 4,539,137	$ 4,641,148
Fund Balance at the End of the Fiscal Year	$ 2,842,704	$ 3,225,111

*to CILA fund and to CCDDB fund for share of revenue from Expo donations and miscellaneous

CHAMPAIGN COUNTY CILA FACILITIES

ANNUAL FINANCIAL REPORT

1/1/18 - 12/31/18

REVENUE	2017	2018
From Mental Health Board	$ 50,000.00	$ 50,000.00
From Developmental Disabilities Board	$ 50,000.00	$ 50,000.00
Rent	$ 21,600.00	$ 22,440.12
Other Misc Revenue	$ 1,633.86	$ 3,585.25
TOTAL REVENUE	$ 123,233.86	$ 126,025.37

EXPENDITURES		
Mortgage Principal	$ 49,750.32	$ 49,750.32
Mortgage Interest	$ 19,199.10	$ 17,230.37
Commodities	$ 46.21	$ -
Professional Fees	$ 6,000.00	$ 6,000.00
Utilities	$ 675.93	$ 866.76
Building/Landscaping Maintenance	$ 7,574.79	$ 14,341.72
Building Improvements	$ -	$ 12,045.00
Other Services	$ 351.62	$ 36.00
TOTAL EXPENDITURES	$ 83,597.97	$ 100,270.17

CHAMPAIGN COUNTY MENTAL HEALTH BOARD
PROGRAM ALLOCATIONS -- FY2017
01/01/2017 - 12/31/17

AGENCY/PROGRAM	TOTAL PAID
CHAMPAIGN COUNTY CHILDREN'S ADVOCACY CENTER	**37,080.00**
CHAMPAIGN COUNTY REGIONAL PLANNING COMMISSION	
Youth Assessment Center	51,170.00
Headstart - Social/Emotional Disabilities*	55,645.00
Justice Diversion (6 months)	31,374.00
Agency Total	**138,189.00**
CHAMPAIGN URBANA AREA PROJECT	
CU Neighborhood Champions	19,597.00
TRUCE	75,000.00
Agency Total	**94,597.00**
COMMUNITY CHOICES	
Self Determination*	83,002.00
Community Living (6 months)*	31,500.00
Customized Employment (6 months)*	35,002.00
Agency Total	**149,504.00**
COMMUNITY FOUNDATION	
DREAAM HOUSE (6 months)	**28,998.00**
COMMUNITY SERVICE CENTER OF NORTHERN CHAMPAIGN COUNTY	
Resource Connection	**65,944.00**
COURAGE CONNECTION	
Courage Connection	**66,948.00**
CRISIS NURSERY	
Beyond Blue - Rural	**70,000.00**
DEVELOPMENTAL SERVICES CENTER	
Individual & Family Support*	**390,038.00**
DON MOYER BOYS & GIRLS CLUB	
Community Coalition Summer Youth Programs	107,000.00
CU Change	100,000.00
Youth and Family Organization (6 months)	160,000.00
Agency Total	**367,000.00**
EAST CENTRAL ILLINOIS REFUGEE ASSISTANCE CENTER	
Family Support and Strengthening	**22,000.00**
FAMILY SERVICE	
Self Help Center	28,676.00
Family Counseling (6 months)	9,998.00
Counseling (6 months)	12,498.00
Senior Counseling and Advocacy	142,337.00
Agency Total	**193,509.00**
FIRST FOLLOWERS	
Peer Mentoring for Re-entry	**44,596.00**

CHAMPAIGN COUNTY MENTAL HEALTH BOARD
PROGRAM ALLOCATIONS -- FY2017
01/01/2017 - 12/31/17

AGENCY/PROGRAM	TOTAL PAID
GROW IN ILLINOIS	
Peer Support (6 months)	**10,002.00**
MAHOMET AREA YOUTH CLUB	
Members Matter	12,000.00
BLAST	15,000.00
Agency Total	**27,000.00**
PRAIRIE CENTER HEALTH SYSTEMS now ROSECRANCE	
Fresh Start	76,002.00
Parenting with Love and Limits - Extended Care	300,660.00
Return Excess Revenue - PLL Extended Care	*(8,898.00)*
Prevention	58,247.00
Specialty Courts	201,024.00
CJ Substance Abuse Treatment	10,450.00
Youth Services	37,500.00
Agency Total	**674,985.00**
PROMISE HEALTHCARE	
Mental Health Services	222,000.00
Wellness/Justice	58,000.00
Agency Total	**280,000.00**
RAPE ADVOCACY COUNSELING EDUCATION SERVICES	
Counseling	17,050.00
Return Excess Revenue - Counseling	*(92.25)*
Agency Total	**16,957.75**
ROSECRANCE	
Criminal Justice	283,122.00
Crisis, Access, Benefits & Engagement	241,718.00
Early Childhood (4 months)	25,000.00
Parenting with Love and Limits - Front End Services	263,652.00
TIMES Center (6 months)	35,002.00
Transitional Housing (6 months)	7,002.00
Agency Total	**855,496.00**
UNITED CEREBRAL PALSY LAND OF LINCOLN	
Vocational Training (6 months)	**25,944.00**
UP CENTER OF CHAMPAIGN COUNTY	
Children/Family/Youth Program	**19,000.00**
URBANA NEIGHBORHOOD CONNECTION	
Community Study Center	**15,750.00**
GRAND TOTAL	**3,593,537.75**

* Programs for people with ID/DD, per Intergovernmental Agreement with the Champaign County Developmental Disabilities Board

Service Totals – Brief Narrative of What the Service Categories Represent

The Champaign County Mental Health Board funds a wide range of services through local human service providers of varying size and sophistication. The CCMHB invests in services that range from helping mothers and families with newborn babies into early childhood to supporting youth through adolescence and young adulthood to assisting adults and families dealing with life's challenges to helping the elderly with activities of daily living. The not for profit and government agencies that provide services with CCMHB funds range from small agencies with only a few employees and volunteers to large multi-million dollar agencies with over a hundred employees. Descriptions of the service activities supported in current and previous years are available at http://www.co.champaign.il.us/MHBDDB/PublicDocuments.php and http://ccmhddbrds.org.

Regardless of their size, agencies are required to report on services delivered using four categories. Those categories must be broad enough to provide a certain amount of flexibility to account for how and to whom the programs delivered services. The four categories are Community Service Event (CSE), Service Contact (SC), Non-Treatment Plan Client (NTPC), and Treatment Plan Client (TPC). Each agency is allowed to define within each category what will be reported. Definitions of CSEs and SCs relate to types of activities. Definitions of TPCs and NTPCs relate to who has been served and require a certain level of documentation associated with the service. Some programs may only report under one of the categories, others may report on all four. Which and how many categories an agency reports activity under depends on the services provided by the program.

Community Service Events (CSEs) can be public events, work associated with a news interview or newspaper article, consultations with community groups and caregivers, classroom presentations, and small group workshops and training to promote a program or educate the community. Meetings directly related to planning such events may also be counted here. Examples are the Family Service Self-Help Center planning and hosting of a self-help conference or newsletters published by the East Central Illinois Refugee Mutual Assistance Center.

A Service Contact (SC), also referred to as a screening contact or service encounter, represents the number of times a program has contact with consumers. Sometimes this can be someone who is being served by the program. Or it can be sharing of information, fielding a call about services, or doing an initial screenings or assessment. An example of a service contact would be the volume of calls answered by the Crisis Line at Rosecrance.

A Non-Treatment Plan Client (NTPC) is someone to whom services are provided and there is a record of the service but does not extend to a clinical level where a treatment plan is necessary or where one would be done but does not get completed. An example is a person who comes into the domestic violence shelter at Courage Connection but leaves within a few days before fully engaging in services.

A Treatment Plan Client (TPC) has traditionally meant people engaged in services where an assessment and treatment plan have been completed and case records are maintained. This applies to agencies such as Promise Healthcare, Rosecrance Central Illinois, and others. It can also represent an individual receiving a higher level of care within the spectrum of services provided within a program.

Most contracts are funded as grants while a few are paid on a fee for service basis. Those operating on a fee for service basis have additional detail included in the table. Fee for service detail includes number and type of units of service the program delivered to clients.

Utilization Summaries for FY2018 CCMHB Funded Programs

Detail on each program's performance toward defined consumer outcomes during the funding year of July 1, 2017 to June 30, 2018 is available at http://ccmhddbrds.org, among downloadable public files toward the bottom of the page. The relevant document is titled "CCMHB FY18 Performance Outcome Reports."

Priority: Intellectual/Developmental Disabilities (Collaboration with CCDDB)

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

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

Community Choices **Self Determination Support** $96,000

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

Community Choices **Community Living** $63,000

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

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

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

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

This annual investment pays for mortgage and property management costs of two of the three local small group homes run by Individual Advocacy Group, which was selected in 2014 through an RFP process to provide services to people with I/DD living in MHB/DDB owned-homes. **Utilization:** 7 TPCs with staffing

ratios from 1:4 to 2:3 and a choice between IAG 'Flexible Day Experience' and community day programs run by other local providers.

Priority: System of Care for Youth and Families

Champaign Urbana Area Project

CU Neighborhood Champions $20,000

Services: Designed to increase community understanding of trauma and expand community capacity to implement trauma-informed practices and procedures. The goals of this effort are: addressing the needs of those impacted by trauma and violence, and also creating more supportive and healed communities. Accomplished through training community members, focusing on youth leaders and elder helpers, and educating the community about trauma and trauma-informed practices to support the creation of community-based trauma response teams. **Utilization actual:** 6 TPC, 13 NTPC, 60 SC, 64 CSE, Other 380.

Community Foundation – DREAAM House

DREAAM House $58,000

Services: Prevention and early intervention program for boys, aimed at cultivating academic excellence and social emotional health. Designed to increase positive outcomes (academic achievement, self-efficacy, social mobility) and decrease negative outcomes (suspensions, low educational performance, violence). Evidence-informed components: 1) day-long summer program, 2) 5-day week, after-school program, 3) school-based mentoring, 4) Saturday athletic activities, and 5) family engagement and training. Embedded in each component is social emotional learning and behavioral health instruction to foster transfer of skills from DREAAM House to school to home. **Utilization actual:** 79 TPC, 0 NTPC, 187 SC, 13 CSE.

Don Moyer Boys & Girls Club **CU Change** $100,000

Services: Seeks to impact under resourced youth with potential for high school graduation by providing group and individual support, counseling, life skills training, and exposure to positive cultural and healthy life choices. Program emphasizes academic support, community engagement, interactive, hands on learning experiences and exposure to positive life alternatives. Goals are to assist youth with navigating obstacles to success in the school environment, increase positive peer and community involvement and develop a positive future plan. **Utilization actual:** 52 TPC, 42 NTPC, 601 SC, 38 CSE.

Don Moyer Boys & Girls Club **Summer Youth Initiative** $107,000

Services: Services and supports provided by specialized providers, through subcontract to Don Moyer Boys and Girls Club, to engage Champaign County's youth in a range of positive summer programming: strengthening academics; developing employment skills and opportunities; athletics; music and arts instruction; etc. With oversight by the Champaign Community Coalition, reinforces System of Care principles and values particularly relevant to system-involved youth impacted with emotional and environmental challenges. **Utilization actual:** 879 NTPC, 0 SC, 60 CSE.

Don Moyer Boys & Girls Club **Youth & Family Services** $160,000

Services: Family-driven, youth-guided services for/with families and children experiencing mental health and/or emotional challenges, supports at home, in school, and in the community for optimal recovery.

Partnering with caregivers to provide the best-fit, most comprehensive services and supports possible. Peer-driven support from those with lived experiences and challenges, educational opportunities to make informed decisions, and technical support to help navigate complicated systems for the best possible outcomes for you and your family. **Utilization actual:** 39 TPC, 19 NTPC, 779 SC, 62 CSE.

Mahomet Area Youth Club **Bulldogs Learn & Succeed Together (BLAST)** $15,000

Services: Programming for students K-12 includes enrichment activities, academic help, and cultural and community-based programming. MAYC partnered with Mahomet Seymour Schools District in this endeavor for several reasons: it allows the use of district facilities, providing a safe and structured environment, where children participate in activities in their own school community, additional contact with teachers, school staff, social workers, and guidance counselors, specialized learning spaces (including computer labs, gyms, music and art rooms), access to a variety of caring community volunteers, and most importantly, an inclusive environment that brings students from all economic backgrounds together. The B.L.A.S.T program is open to all students, but specifically target low income and/or struggling students and make the program available at no cost. **Utilization actual:** 4 TPC, 511 NTPC, 3015 SC, 630 CSE.

Mahomet Area Youth Club **MAYC Members Matter!** $12,000

Services: Programming for students K-12 includes enrichment activities, academic help, and cultural and community-based programming with CCMHB funds targeted to MAYC's Junior High Club and summer programming. Partnered with Mahomet Seymour Schools to allow for the use of district facilities, provide a safe and structured environment, participation in activities in school community, additional contact with teachers, school staff, social workers, and guidance counselors, specialized learning spaces, access to caring community volunteers, and an inclusive environment bringing students from all economic backgrounds together. **Utilization actual:** 5 TPC, 199 NTPC, 2334 SC, 192 CSE.

The UP Center of Champaign County **Children, Youth & Families Program** $19,000

Services: Serves LGBTQ adolescents aged 11-18; LGBTQ families; and children dealing with issues related to the stigmatization of their gender and sexual identifications and identities. Services include provision of social-emotional supports; non-clinical crisis intervention; case management referrals, risk reduction strategies; strengths development; community-building events; and management of adult volunteers within this program. Program provides a weekly adolescent non-clinical support group. **Utilization actual:** 2 TPC, 24 NTPC, 67 SC, 31 CSE.

Urbana Neighborhood Connections **Community Study Center** $19,500

Services: Empowerment zone where youth benefit from productive year-round academic, recreational, and social-emotional supplements. Study Center provides opportunity to engage school aged youth in non-traditional, practical intervention and prevention approaches for addressing difficulties. In individual and group activities facilitated/supervised by program staff and volunteers, participants can process feelings in a secure and supportive environment. **Utilization actual:** 257 NTPC.

Priority: Behavioral Health Supports for Those with Justice Involvement (Community, Youth, Adult, and/or Victims)

Champaign County Children's Advocacy Center (CAC)
Children's Advocacy $37,080

Services: Promoting healing and justice for children/youth who have been sexually abused. The CAC provides: a family-friendly initial investigative interview site; supportive services for the child and non-offending family promoting healing; and abuse investigation coordination. While most of the young people served are victims of sexual abuse, CAC services are also provided to those children/youth who are victims of severe physical abuse and to victims of child trafficking. Trauma inflicted by these crimes is deep, with the right help the young person can begin to heal. **Utilization actual:** 231 TPC, 46 NTPC, 224 SC, 18 CSE.

Champaign County Regional Planning Commission – Social Services
Justice Diversion Program (JPD) $62,755

Services: Primary connection point for case management and services for persons who have Rantoul Police Department (RPD) Crisis Intervention Team (CIT) and/ or domestic contacts. The goal of JPD case management services is to reduce calls for crisis intervention or domestic offenses by connecting residents to services to help clients develop and implement plans to become successful and productive members of the community. The JDP will also strive to develop additional community resources and access to services in Rantoul. **Utilization actual:** 31 TPC, 278 NTPC, 352 SC, 58 CSE. (278 referrals, 77 suicide threats.)

Champaign County Regional Planning Commission – Social Services
Youth Assessment Center (YAC) $76,350

Services: Screens youth for risk factors and links youth/families to supports and restorative community services. Provides an alternative to prosecution for youth involved in delinquent activity. Case managers, using Trauma Informed Care and Balanced and Restorative Justice (BARJ) principles, screen juvenile offenders referred to the YAC to identify issues that might have influenced the offense and link youth to services to address the underlying issues. Focused on helping youth be resilient, resourceful, responsible and contributing members of society. **Utilization actual:** 61 TPC, 19 NTPC, 46 SC, 57 CSE.

Champaign Urbana Area Project **TRUCE** $75,000

Services: Addresses gun violence preventively from a public health perspective. Under this approach, first posited by the epidemiologist creator of "Cease Fire" at the University of Chicago Gary Slutkin, the spread of violence is likened to the spread of an infectious disease and it should be treated in much the same way: go after the most infected, and stop it at its source. TRUCE engages the community in reducing violence by: 1) interrupting the transmission of the violence; 2) reducing the risk of the highest risk; and 3) changing community norms. **Utilization actual:** 0 TPC, 3 NTPC, 12 SC, 88 CSE, Other 3.

Courage Connection **Courage Connection** $66,948

Services: A family's immediate safety is intimately connected to their long-term success. A community's stability is threatened when any family is in danger. Courage Connection's purpose is to help victims and survivors of domestic violence rebuild their lives through advocacy, housing, counseling, court advocacy, self-empowerment, community engagement, and community collaborations. **Utilization actual:** 442 TPC, 109 NTPC, 537 SC, 167 CSE.

First Followers **Peer Mentoring for Re-entry** $59,754

Services: Mission is building strong and peaceful communities by providing support and guidance to the formerly incarcerated, their loved ones, and the community. Offers assistance in job searches, accessing housing and identification as well as emotional support to assist people during the transition from incarceration to the community. In addition, First Followers carry out advocacy work aimed at reducing the stigma associated with felony convictions and attempt to open doors of opportunity for those with a criminal background. **Utilization actual:** 15 TPC, 91 NTPC, 21 SC, 7 CSE.

Prairie Center Health Systems/Rosecrance Central Illinois
CJ Substance Use Treatment $10,600

Services: Supports Champaign County adults briefly incarcerated at Champaign County Correctional Center. Coordinates services with Correctional Healthcare Companies, Rosecrance, and other agencies providing services within the jail. Case manager provides the GAIN Short Screen, brief intervention using Motivational Interviewing techniques, treatment referral, and case management to adults at Champaign County jail. Follow-up after jail release includes to coordinate services to assist with engagement in treatment at Prairie Center. **Utilization actual:** 4 TPC, 97 NTPC, 5 SC, Other =204 hours.

Prairie Center Health Systems/Rosecrance Central Illinois **Fresh Start** $77,000

Services: The Champaign Community Coalition's C-U Fresh Start initiative is aimed at addressing the root cause of the violence, customized for our community, involving a 3-pillar approach – Community, Law Enforcement, and a Case Manager. Identifies and focuses on core offenders with history of violent, gun-related behaviors, offering an alternative to violence. The CCMHB funding supports the case manager who provides intensive case management to offenders, assisting with accessing services, such as medical, dental, behavioral health, to address immediate personal or family issues, and overcome barriers to employment, housing, education. **Utilization actual:** 13 TPC, 11 NTPC, 4 SC, 150 CSE, 24 Other.

Prairie Center Health Systems/Rosecrance Central Illinois
PLL Extended Care $300,660 *(during 2018, merged with Rosecrance contract for PLL Front End)*

Services: An evidence-based family education, skill building, and therapeutic intervention model which has demonstrated effectiveness in significantly reducing aggressive behaviors, depression, attention deficit disorder problems, externalizing problems and substance use in youth while reducing recidivism and improving family communication. After an assessment, parents and youth attend six group sessions, held one evening a week for six weeks, and receive individual family coaching sessions. Program targets specific risk and protective factors related to delinquency and other emotional and behavioral problems. **Utilization actual:** Totals include PLL Front End activity due to mid-year merger of the two PLL Providers and consolidation of the PLL Programs. 61 TPC, 208 SC.

Prairie Center Health Systems/Rosecrance Central Illinois **Specialty Courts** $203,000

Services: People sentenced to Champaign County Drug Court receive substance use disorders assessment, individualized treatment planning, individual counseling sessions, and a wide array of education and therapeutic groups. Case manager provides intensive case management to connect the clients to overcome barriers to treatment, such as access to food, clothing, medical and dental services, mental health treatment, employment, housing, education, transportation, and childcare. **Utilization actual:** 88 TPC, 1802 SC, 6 CSE, Other 73 hours assessment, 640 hours case management, 9,046.75 hours counseling. "Other" represents services funded by other sources leveraged through CCMHB support for non-billable activities crucial to the operation of the Specialty Court.

Prairie Center Health Systems/Rosecrance Central Illinois **Youth Services** $75,000

Services: Early intervention and outpatient substance use disorder treatment services at Urbana facility and Champaign County schools. Assessment performed to determine the severity of each individual's illness and to screen for medical and mental health disorders. An individualized treatment plan is then created, building on strengths and needs. Developed with a counselor assigned to each client, treatment plans provide those seeking care and help with the ongoing treatment and support needed to build a strong and lasting recovery foundation. **Utilization actual:** 76 TPC, 28 NTPC, 88 SC, 39.5 (hrs in presentations) CSE, Other = 1385 hours billed to other funders.

Rape Advocacy, Counseling & Education Services **Counseling and Crisis** $18,600

Services: Rape Advocacy, Counseling & Education Services (RACES) is the only agency charged with providing comprehensive services to victims of sexual assault in Champaign County. Provides trauma-informed counseling, 24-hour crisis hotline, in-person advocacy at hospital Emergency Departments, and at meetings with law enforcement or Courthouse. CCMHB funding supports RACES' prevention education to thousands of local children and adults per year, and conduct community events to further the aim to create a world free of sexual violence. **Utilization actual:** 8664 (# attending) SC, 214 CSE, Other = 23 media contacts.

Rosecrance Champaign-Urbana/Rosecrance Central Illinois **Criminal Justice** $300,265

Services: Problem Solving Courts (Drug Court) clients and other adults involved with criminal justice system screened at the Champaign County Jail receive, as appropriate, mental health assessment, substance abuse assessment, Moral Reconation Therapy and Anger Management group counseling, case management, individual and/or intensive outpatient substance abuse treatment, and linkage to additional supports as needed in the community. A subcontract with Champaign County Health Care Consumers augments services to those clients in need of obtaining and/or retaining necessary healthcare insurance and other essential benefits. **Utilization actual:** 141 TPC, 257 NTPC, Other = 134 group sessions.

Rosecrance Champaign-Urbana/Rosecrance Central Illinois

Crisis, Access, & Benefits $228,002

Services: A 24-hour program that including Crisis Team and Crisis Line. Clinicians provide immediate intervention by responding to crisis line calls and conducting crisis assessments throughout Champaign County. The Crisis Team works closely with the hospitals, local police, the University and other local social service programs. Offers access services including information, triage, screening, assessment and referral for consumers and other members of the community. **Utilization actual:** 954 NTPC, 3946 SC (crisis calls), 20 CSE; Crisis team contacts are not a subset of crisis calls. Other = 306 benefits applications (includes those subcontracted through CC Healthcare Consumers).

Rosecrance Champaign-Urbana/Rosecrance Central Illinois

PLL Front End $282,663 *(during 2018, combined with PCHS/RCI PLL Extended Care contract)*

Services: PLL provides multi-family group therapy and family therapy sessions for youth who are involved with the juvenile justice system and/or are having behavioral concerns at home, school or in the community. PLL is a short term evidenced based practice that draws on structural and strategic family therapy theory to improve overall family functioning and reduce recidivism. **Utilization actual:** See PLL Extended Care for utilization data.

Rosecrance Champaign-Urbana/Rosecrance Central Illinois **Transition Housing CJ** $14,000

Services: TIMES Center provides transitional housing and supportive services to homeless men in Champaign County. The program offers an opportunity to obtain behavioral health treatment, build financial security, increase coping and independent living skills, expand recreational interests, and discharge into a self-sufficient housing situation in the community. Comprised of 20 beds in 10, 2 room units, residents are responsible to pay 30% of their monthly income to a maximum of $150/month in program fees. **Utilization actual:** 47 TPC, 24 NTPC, 4432 SC.

Priority: Innovative Practices to Support Access to Core Services

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Family Service of Champaign County **Self-Help Center** $28,428

Services: Information about and referral to local support groups. Provides assistance to develop new support groups and maintaining and strengthening existing groups. Program maintains a database of Champaign County support groups, national groups, and groups in formation. Information is available online and in printed directory and specialized support group listings. Provides consultation services, workshops, conferences, educational packets and maintains a lending library of resource materials. **Utilization actual:** 334 CSE.

Family Service of Champaign County **Senior Counseling & Advocacy** $142,337

Services: Program offers services in the home or in the community to Champaign County seniors and their families. Caseworkers assist with needs and challenges faced by seniors, including grief, anxiety, depression, isolation, other mental health issues, family concerns, neglect, abuse, exploitation and need for services or benefits acquisition. Program assists seniors providing care for adult children with disabilities and adults with disabilities age 18-59 experiencing abuse, neglect or financial exploitation. **Utilization actual:** 272 TPC, 1083 NTPC, 8518 SC, Other = 145 caregivers.

GROW in Illinois **Peer Support** $20,000

Services: Mutual-help; peer to peer 12-step program provides weekly support groups for mental health sufferers of all races and genders. GROW compliments the work of professional providers by connecting people with others in similar situations and empowering participants to do that part which they can and must be doing for themselves and with one another. While professional providers offer diagnosis and treatment, consumer-providers offer essential rehabilitation and prevention services because of firsthand experience with the recovery process. **Utilization actual:** 90 NTPC, 586 SC, 6 CSE.

United Cerebral Palsy Land of Lincoln **Vocational Training and Support** $51,885

Services: Vocational support services to people with behavioral health conditions, ages 18-55, in Champaign County. Services include extended job coaching and case management to people currently employed as well as vocational training and job development to people seeking employment or improvement of skills. Job coaching/support services allow people to continue working in their community, receive promotions, and have the opportunity to increase hours. **Utilization actual:** 16 TPC, 50 SC, 28 CSE, Other = 1095 hours contact with clients.

Priority: Other - Renewal

Community Service Center of Northern Champaign County **Resource Connection** $66,596

Services: A multi-service program aimed at assisting residents of northern Champaign County with basic needs and to connect them with mental health and other social services. The program serves as a satellite site for various human service agencies providing mental health, physical health, energy assistance, and related social services. We also have an emergency food pantry, provide prescription assistance, clothing and shelter coordination, and similar services for over 1,700 households in northern Champaign County. **Utilization actual:** 1441 NTPC, 5833 SC, 20 CSE, Other = 2574 contacts with other agencies using CSCNCC as a satellite site.

Crisis Nursery **Beyond Blue – Champaign County** $70,000

Services: Serves mothers who have or are at risk of developing perinatal/postnatal depression (PD), targeting mothers who demonstrated risk factors for PD and are pregnant or have a child under age one. Individual and group support and education to facilitate healthy parent-child engagement. Research suggests that 10-20% of mothers suffer from PD, nearly half are undiagnosed. Beyond Blue addresses risk

factors that lead to emotional disturbances and multiagency and system involvement in children. The program also works to increase awareness of PD and reduce stigma. **Utilization actual:** 32 TPC, 105 NTPC, 963 SC, 205 CSE, Other = 4077 hours of in-kind/respite care.

East Central IL Refugee Mutual Assistance Center **Family Support and Strengthening** $25,000

Services: Support and strengthen refugee and immigrant families transitioning and adjusting to American culture and expectations. Provides orientation, information/referral, counseling, translation/interpretation services, culturally appropriate educational workshops, and help accessing entitlement programs. Bi-monthly newsletter, and assistance to refugee/immigrant mutual support groups. Staff speaks nine languages and accesses community volunteers to communicate with clients in languages not spoken by staff. **Utilization actual:** 88 CSE, Other = 25.5 hours of workshops.

Family Service of Champaign County **Counseling** $25,000

Services: Affordable, accessible counseling services to families, couples and people of all ages. Clients are given tools and supports to successfully deal with life challenges such as divorce, marital and parent/child conflict, depression, anxiety, abuse, substance abuse/dependency and trauma. Strength-based, client driven services, utilize family and other natural support systems and are respectful of the client's values, beliefs, traditions, customs and personal preferences. **Utilization actual:** 38 TPC, 4 NTPC.

Prairie Center Health Systems/Rosecrance Central Illinois **Prevention Services** $58,247

Services: Uses an evidence-based life skills and drug education curriculum for Champaign County students. Programs available for preschool through high school with emphasis on middle school students. Sessions on health risks associated with the use of alcohol, tobacco and other drugs. Life skills sessions may include instruction on and discussion of refusal skills, self-esteem, communicating with parents, and related social issues. The prevention team are active members of several anti-drug and anti-violence community-wide coalitions working to reduce youth substance abuse levels. **Utilization actual:** 1357 CSE.

Promise Healthcare **Promise Healthcare Wellness and Justice** $58,000

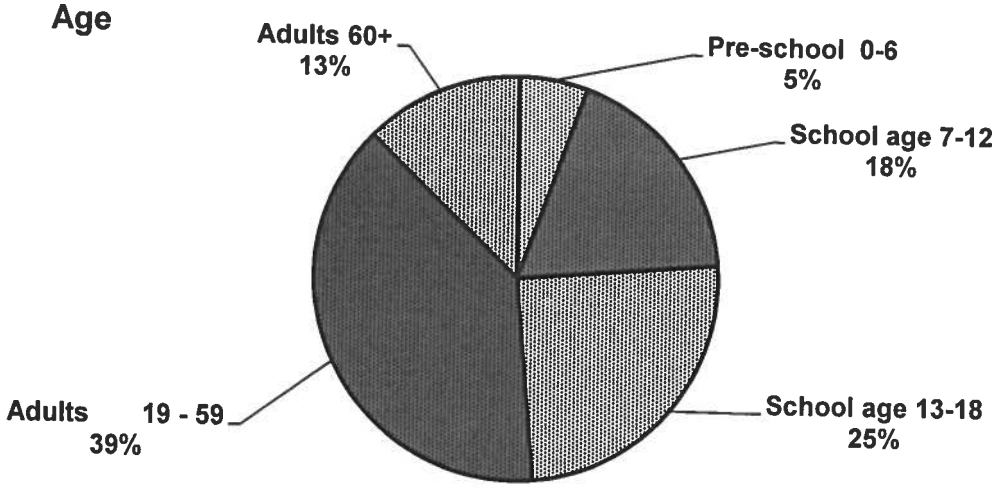
Services: Provides support, case management, and benefit enrollment for patients with non-clinical barriers to achieving optimum medical and mental health. Targets hundreds of patients who have a mental health diagnosis and a chronic medical condition and those at risk of or have had a justice system encounter. Coordinators work with patients to remove barriers from reaching optimum medical and mental health. Program facilitates care at satellite location, and supports collaborations with other agencies, and community outreach. **Utilization actual:** 60 TPC, 209 NTPC, 250 SC, 12 CSE, Other = 2094 enrolled in healthcare coverage.

Promise Healthcare **Mental Health Services with Promise** $222,000

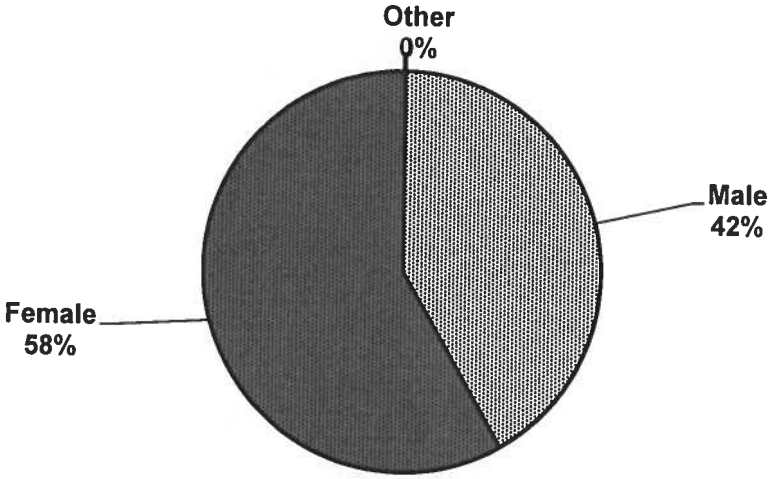
Services: Promise Healthcare provides on-site mental health services to achieve the integration of medical and behavioral health care as supported by both the National Council for Community Behavioral Healthcare and the National Association of Community Health Centers. Mental health and medical providers regularly collaborate, make referrals, and even walk a patient down the hall to meet with a therapist. Patients receive mental illness treatment through counselor, psychiatrist or primary care provider. **Utilization actual:** Counseling Services: 357 TPC, 36 NTPC, 2149 SC, Psychiatric Services: 1918 in psychiatric practice, 1217 getting psych meds through primary care, 8672 psychiatric service encounters, 12 lunch and learn sessions.

DEMOGRAPHIC AND RESIDENCY DATA FOR PERSONS SERVED IN PY2018

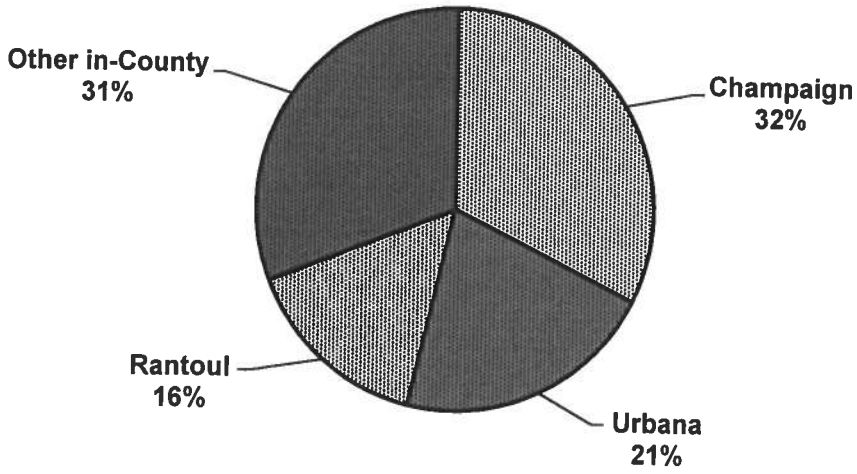
Age



Gender

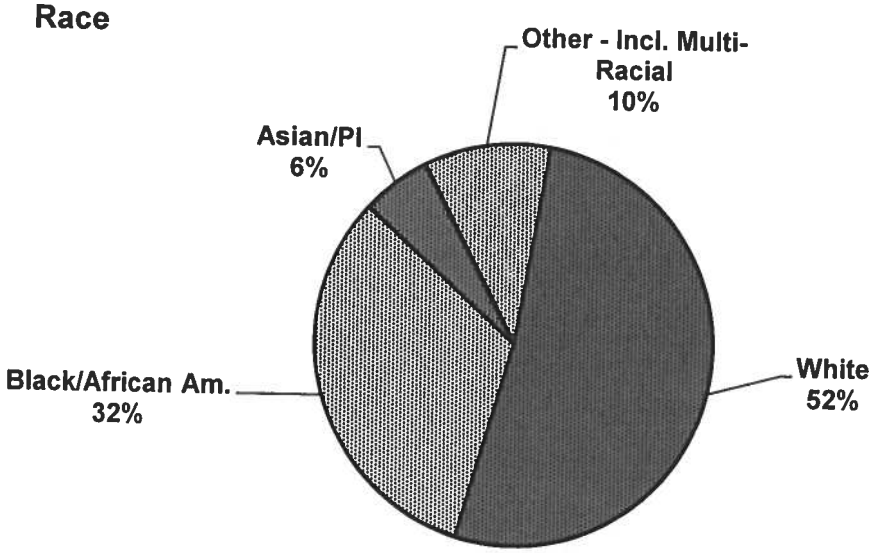


Residency

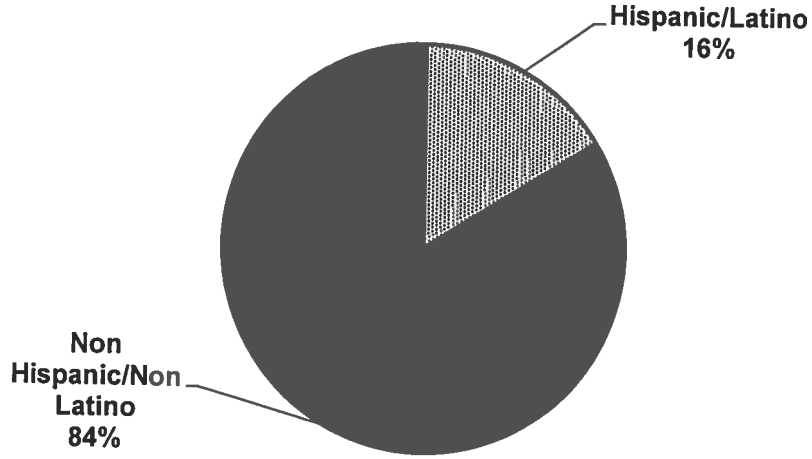


DEMOGRAPHIC AND RESIDENCY DATA FOR PERSONS SERVED IN PY2018

Race

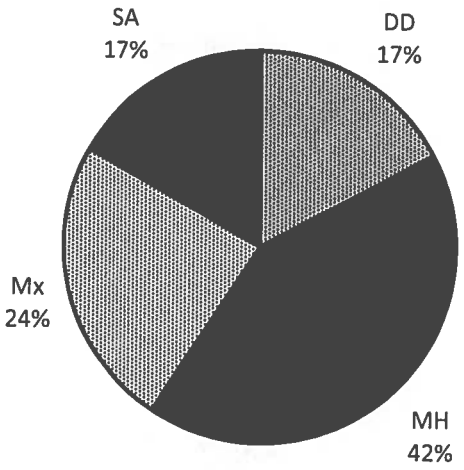


Ethnic Origin

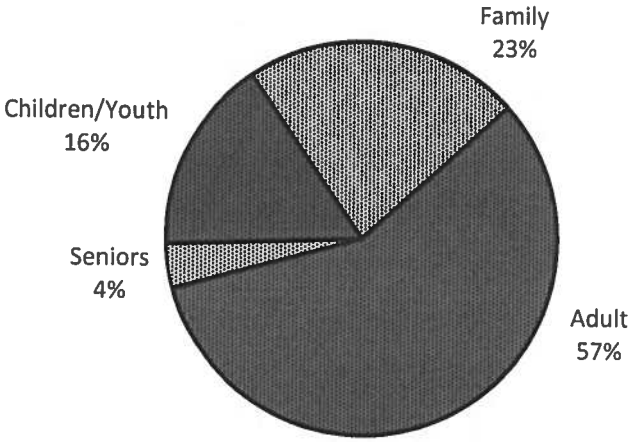


FUNDING BY SECTOR, POPULATION, SERVICE IN PROGRAM YEAR 2018 (PY18)

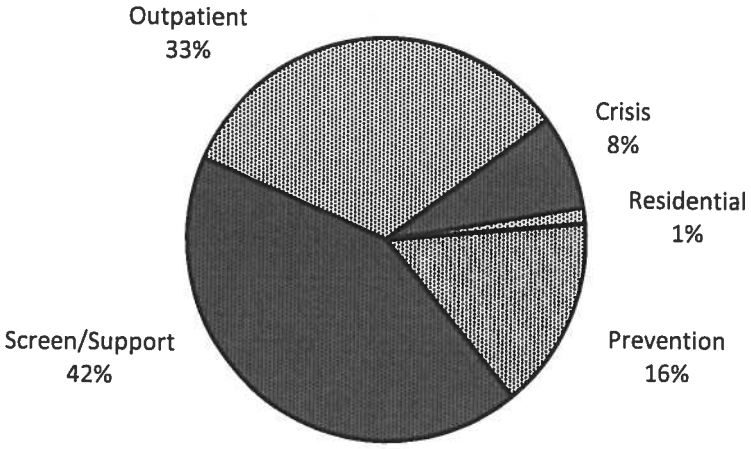
CCMHB PY18 Appropriation by Community Mental Health Sector



CCMHB PY18 Appropriation by Target Population



CCMHB PY2018 Appropriation by Type of Service



SECTION II: Three-Year Plan 2016-2018
with FY 2018 One-Year Objectives

CHAMPAIGN COUNTY MENTAL HEALTH BOARD
THREE-YEAR PLAN
FOR

FISCAL YEARS 2019 - 2021
(1/1/19 – 12/31/2021)

WITH
ONE YEAR OBJECTIVES
FOR

FISCAL YEAR 2019
(1/1/19 – 12/31/19)

25

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

WHEREAS, the Champaign County Mental Health Board has been established under Illinois Revised Statutes (405 ILCS – 20/Section 0.1 et. seq.) in order to "construct, repair, operate, maintain and regulate community mental health facilities to provide mental health services as defined by the local community mental health board, including services for, persons with a developmental disability or substance use disorder, for residents thereof and/or to contract therefor..."

WHEREAS, the Champaign County Mental Health Board is required by the Community Mental Health Act to prepare a one- and three-year plan for a program of community mental health services and facilities;

THEREFORE, the Champaign County Mental Health Board does hereby adopt the following Mission Statement and Statement of Purposes to guide the development of the mental health plan for Champaign County:

MISSION STATEMENT

The mission of the CCMHB is the promotion of a local system of services for the prevention and treatment of mental or emotional, intellectual or developmental, and substance abuse disorders, in accordance with the assessed priorities of the citizens of Champaign County.

STATEMENT OF PURPOSES

1. To plan, coordinate, evaluate and allocate funds for the comprehensive local system of mental health, intellectual and developmental disabilities, and substance use disorder services for Champaign County.

2. To promote family-friendly community support networks for the at-risk, underserved and general populations of Champaign County.

3. To increase support for the local system of services from public and private sources.

4. To further develop the systematic exchange of information about local services and needs between the public/private service systems and the CCMHB.

In order to accomplish these purposes, the Champaign County Mental Health Board must collaborate with the public and private sectors in providing the resources necessary for the effective functioning of the community mental health system.

SYSTEMS OF CARE

Goal #1: Support a continuum of services to improve the quality of life experienced by individuals with mental or emotional disorders, substance use disorders, or intellectual and/or developmental disabilities and their families residing in Champaign County.

Objective #1: Expand use of evidence informed, evidence based, best practice, recommended, and promising practice models appropriate to the presenting need in an effort to improve outcomes for individuals across the lifespan and for their families and supporters. (Allocation Priority/Criteria Objective)

Objective #2: Promote wellness for people with mental illnesses, substance use disorders, intellectual and/or developmental disabilities to prevent and reduce early mortality, through support services including access to services addressing basic needs, enrollment in benefit plans and coordinated access to primary care. (Allocation Priority/Criteria Objective)

Objective #3: In light of potential congressional or presidential actions on the Affordable Care Act and Medicaid expansion, support development or expansion of residential and employment supports for persons with behavioral health diagnosis not supported through expansion of Medicaid or the Affordable Care Act. (Allocation Priority/Criteria Objective)

Objective #4: Support broad based community efforts to prevent opiate overdoses and expand treatment options. (Allocation Priority/Criteria Objective)

Objective #5: Build resiliency and support recovery e.g. Peer Supports, outside of a therapeutic environment. (Allocation Priority/Criteria Objective)

Objective #6: Build evaluation capacity of contracted providers utilizing expertise of evaluators from the Department of Psychology at the University of Illinois to further positive outcomes of those engaging in funded services. (Policy Objective)

Goal #2: Sustain commitment to addressing health disparities experienced by underrepresented and diverse populations.

Objective #1: Support culturally responsive and family driven support networks for underrepresented populations, underserved populations, and general populations of Champaign County. (Allocation Priority/Criteria Objective)

Objective #2: Provide technical assistance in support of continuous improvement of cultural and linguistic competence plans to meet the needs of the population served. (Collaboration/Coordination Objective)

Objective #3: Encourage providers and other community-based organizations to allocate resources to provide training, seek technical assistance, and pursue other professional development activities for staff and governing or advisory boards to advance cultural and linguistic competence. (Allocation Priority/Criteria Objective)

Objective #4: Use the Culturally and Linguistically Appropriate Services Standards (CLAS) as a blueprint to strengthen funded agencies' Cultural and Linguistic Competence. (Policy Objective)

Objective #5: Where families and communities are disproportionately impacted by incarceration, encourage the development of social networks and improved access to resources. (Policy Objective)

Objective #6: Address the needs of residents of rural areas and encourage greater engagement by community-based organizations. (Policy Objective)

Goal #3: Improve consumer access to and engagement in services.

Objective #1: Encourage development of collaborative agreements between providers to increase or maintain access and coordination of services for consumers throughout Champaign County. (Collaboration/Coordination Objective)

Objective #2: Participate in various coordinating councils whose missions align with the needs of the populations of interest to the Board with the intent of strengthening coordination between providers in the delivery of services. (Collaboration/Coordination Objective)

Objective #3: Explore at the Board level potential for collaboration on issues of mutual interest with the C-U Public Health District and the Champaign County Board of Health. (Collaboration/Coordination Objective)

Objective #4: Engage with CUPHD, United Way, Carle Foundation Hospital, and OSF in the collaborative planning process for the next Community Health Improvement Plan. (Collaboration/Coordination Objective)

Objective #5: Increase awareness of community services and access to information on when, where, and how to apply for services. (Collaboration/Coordination Objective)

Goal #4: Continue the collaborative working relationship with the Champaign County Board for Care and Treatment of Persons with a Developmental Disability (CCDDB).

Objective #1: Coordinate integration, alignment, and allocation of resources with the CCDDB to ensure the efficacious use of resources within the intellectual/developmental disability (I/DD) service and support continuum. (Allocation Priority/Criteria Objective)

Objective #2: Assess alternative service strategies that empower people with I/DD and increase access to integrated settings as exemplified by the collaborative approach to the Employment First Act. (Policy Objective)

Objective #3: With the CCDDB, continue financial commitment to community-based housing for people with I/DD from Champaign County and as part of that sustained commitment, review the Community Integrated Living Arrangement (CILA) fund and recommend any changes. (Allocation Priority/Criteria Objective)

Objective #4: Collaborate with the Champaign County Board for the Care and Treatment of Persons with a Developmental Disability on promoting inclusion and respect for people with I/DD. (Collaboration/Coordination Objective)

MULTI-AGENCY INVOLVED YOUTH AND FAMILIES

Goal #5: Building on progress achieved through the six Year Cooperative Agreement between the Federal Substance Abuse and Mental Health Services Administration (SAMHSA), the Illinois Department of Human Services (IDHS), and the Champaign County Mental Health Board (CCMHB), sustain the SAMHSA/IDHS system of care model.

Objective #1: Support the efforts of the Champaign Community Coalition and other system of care initiatives. (Collaboration/Coordination Objective)

Objective #2: Sustain support of Champaign County family-run organizations that incorporate family-driven and youth-guided principles in use of peer support specialists, and other peer-to-peer supports to assist multi-system involved youth and their families (Allocation Priority/Criteria Objective)

Objective #3: Assess the impact of community violence on the children and youth whose families and neighborhoods are most impacted and where indicated, encourage the development of appropriate supports as prevention and early intervention strategies. (Policy Objective)

Objective #4: Promote and support those targeted interventions that specifically address historical trauma experienced by African American and other minority youth disproportionately impacted in multiple systems. (Allocation Priority/Criteria Objective)

Objective #5: Sustain commitment to trauma-informed, family-driven, youth-guided, and culturally responsive systems. (Policy Objective)

CRIMINAL JUSTICE AND MENTAL HEALTH SYSTEM COLLABORATION

Goal #6: Divert from the criminal justice system, as appropriate, persons with behavioral health needs or intellectual/developmental disabilities.

Objective #1: Continue involvement in the Crisis Intervention Team Steering Committee in support of increased collaboration between law enforcement and crisis service providers on implementing mobile crisis response in the community. (Collaboration/Coordination Objective)

Objective #2: Sustain efforts to engage persons with behavioral health diagnoses re-entering the community from jail or prison or with recent involvement with the criminal justice system, in treatment and other support services such as the Champaign County Problem Solving Court and reentry services. (Allocation Priority/Criteria Objective)

Objective #3: Support integrated planning and service coordination for adults involved in the criminal justice system through participation in the Champaign County Reentry Council or similar body to address needs identified in the Sequential Intercept Map gaps analysis. (Collaboration/Coordination Objective)

Objective #4: Through the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD), in its partnership with the National Association of Counties (NACo,) pursue opportunities for technical assistance and support through collaborative and mentorship opportunities aimed at improving outcomes for those with behavioral health needs and justice system involvement. (Collaboration/Coordination Objective)

Goal #7: In conjunction with the Champaign County Sheriff's Office and other community stakeholders pursue a continuum of services as an alternative to incarceration and/or overutilization of local Emergency Departments for persons with behavioral health needs or developmental disabilities.

Objective #1: Support initiatives providing housing and employment supports for persons with a mental illness, substance use disorder, and/or intellectual and developmental disabilities through the Champaign County Continuum of Care or other local collaboration. (Allocation Priority/Criteria Objective)

Objective #2: Identify options for developing jail diversion services to provide behavioral health assessments, crisis stabilization and detoxification from alcohol and/or other substances as may be necessary to serve Champaign County. (Collaboration/Coordination Objective)

Goal #8: Support interventions for youth who have juvenile justice system involvement to reduce contact with law enforcement or prevent deeper penetration into the system.

Objective #1: Support continued implementation of the Parenting with Love and Limits (PLL) program based on positive evaluation and feedback from community partners and stakeholders, or as appropriate, an acceptable alternative. (Allocation Priority/Criteria Objective)

Objective #2: Through participation on the Youth Assessment Center Advisory Board advocate for community and education-based interventions contributing to positive youth development and decision-making. (Collaboration/Coordination Objective)

Objective #3: Through participation and engagement in the Champaign Community Coalition and other community focused initiatives, promote and encourage multi-system collaborative approaches for prevention and reduction of youth violence. (Collaboration/Coordination Objective)

Objective #4: Utilize the principles from "Models for Change" to reduce the disproportionate minority contact with law-enforcement and involvement with the juvenile justice system. (Policy Objective)

COMMUNITY ENGAGEMENT & ADVOCACY

Goal #9: Address the need for acceptance, inclusion and respect associated with a person's or family members' mental illness, substance use disorder, intellectual and/or developmental disability through broad based community education efforts to increase community acceptance and positive self-image.

Objective #1: Continue support for and involvement in efforts to challenge stigma and discrimination, the disABILITY Resource Expo: Reaching Out for Answers, National Children's Mental Health Awareness Day, and other related community education events. (Collaboration/Coordination Objective)

Objective #2: Promote substance use disorder prevention initiatives as a community education tool targeting youth and young adults. (Collaboration/Coordination Objective)

Objective #3: Participate in behavioral health community education initiatives, such as National Depression Screening Day, to encourage individuals to be screened and seek further assistance where indicated. (Collaboration/Coordination Objective)

Objective #4: Encourage and support efforts to more fully integrate people with behavioral health disorders and/or intellectual and/or developmental disabilities into community life in Champaign County. (Allocation Priority/Criteria Objective)

Goal #10: Engage with other local, state, and federal stakeholders on emerging issues.

Objective #1: Monitor implementation of state Medicaid Plan amendments, 1115 waiver pilot projects, and use of Managed Care Organizations to implement the expansion of Medicaid by the State of Illinois and advocate through active participation in the Association of Community Mental Health Authorities of Illinois (ACMHAI) and other statewide associations and advocacy groups. (Collaboration/Coordination Objective)

Objective #2: Track state implementation of class action suit settlements involving persons with intellectual and/or developmental disabilities or mental illness, e.g. Ligas vs. Hamos Consent Decree and Williams vs. Quinn Consent Decree, and advocate for the allocation of state resources sufficient to meet needs of clients returning to home communities or seeking fuller integration in their communities. (Policy Objective)

Objective #3: Maintain active participation in the National Association of County Behavioral Health and Developmental Disability Directors (NACHBBD), National Association of Counties (NACo), and like-minded national organizations, to monitor activities and advocate at the federal level. (Collaboration/Coordination Objective)

BRIEFING MEMORANDUM

DATE: March 20, 2019
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Lynn Canfield, Mark Driscoll
SUBJECT: Application Review Process

Background: Two years ago, the CCMHB instituted a new review process for evaluating agency applications. Last year, a few minor modifications were made in response to what we learned about which activities require more time in order to accommodate fuller board discussion of: alignment of applications to identified priorities; the relationship between the programs, for the sake of the most balanced, coordinated, effective local system; affordability of the final set of contracts; and contract considerations to be addressed through special provision or contract negotiation.

At present, staff is reviewing each application and preparing program summaries. Last year, the release and discussion of program summaries was organized by priority. Program summary booklets will be compiled for each priority. Our intent is to follow the same process this year.

Important Dates:

April 10 is the staff deadline for program summaries to be made available to the board and public. They will be posted online along with the board packet for the following week's meeting, and paper copies of the board packet will go out that afternoon.

April 17 is a regular meeting of the CCMHB, with some business and action items. The main focus of this meeting will be on review of agency applications. This board discussion is supported by the staff program summaries.

April 24 is a study session of the CCMHB, for the purpose of continued board discussion of agency applications.

May 1 is a study session of the CCMHB, for the purpose of continued board discussion of agency applications.

May 8 is the staff deadline for recommendations to the board about allocations for the Program Year 2020. A decision memorandum, along with the board packet for the following week's study session, will be posted online and paper copies mailed out.

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May 15 is a study session of the CCMHB, for board discussion of allocations of funding for Program Year 2020.

May 22 is a regular meeting of the CCMHB, at which the goal is to finalize decisions about allocation of funding for Program Year 2020.

Following the final board decisions, staff have a goal of completing contract negotiations by June. This would allow a month for preparation of contracts by board staff, completion of any required revisions by agency staff, and full execution by all parties so that July payments may be authorized in a timely fashion.

Expectations of the Process:

Throughout the review and decision process, staff are available to work with board members. It has been our experience that these conversations are very helpful to our own program summary and recommendation processes. The timelines above are intended to support the board's mission of allocating funding for the benefit of the community, but they are not required.

6.D.

BRIEFING MEMORANDUM

TO: Members, Champaign County Mental Health Board
FROM: Mark Driscoll, Associate Director
DATE: March 20, 2019
RE: Contract Amendment Report

The Funding Guidelines include a section on contract amendments. The section gives the Executive Director authority to review and act on amendments, the Board President and the Executive Director discretion to bring amendments to the Board for action, while further stipulating certain requests must have Board approval. Regardless of the process applied to executing the amendment, the Board is to be informed of all contract amendments. To that end, the following amendments have been executed under the authority granted to the Executive Director:

The following amendments were issued following Board action at the February 20, 2019 meeting.

Rosecrance Central Illinois (RCI) contract amendment – Terminates Parenting with Love and Limits contract. Amendment has been issued, but not fully executed.

Savannah Family Institute Parenting with Love and Limits Center of Excellence Agreement contract amendment – Terminates Center of Excellence Agreement contract that licenses the PLL model for use by authorized providers in Champaign County. Amendment has been issued, but not fully executed.

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6.E.

BRIEFING MEMORANDUM

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

Background

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

NACo Health Steering Committee, Joint Subcommittee Meeting

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

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

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

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

"Medicaid Waivers: An Overview of Current Opportunities"

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

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

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

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

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

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

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

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

NACo Health Steering Committee, Policy Coordinating Committee

"NACo Programming of Interest to Health Policy Steering Committee"

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

"Health Resolutions Received Within 30 Day Deadline"

Policy resolutions are generally single-purpose documents addressing a specific issue or piece of legislation. Resolutions draw attention to a topic of current concern, clarify parts of the broadly worded platform or set policy in areas not covered by the platform. These resolutions are valid until NACo's 2019 Annual Conference.

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

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

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

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

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

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

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

"Healthy County Advisory Board Meeting"

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

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

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

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

"County Cannabis Roundtable"

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

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

NACBHDD Board Meeting

"Committee Reports"

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

"Review Progress on NACBHDD Strategic Directions"

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

"State Updates"

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

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

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

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

NACBHDD Legislative and Policy Conference

"Progress on Medicaid"

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

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

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

"Solving Workforce Issues at the State Level"

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

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

"Key Developments in the Medicaid Program"

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

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

"State Brain Drain"

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

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

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

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

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

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

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

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

"Discussion of 2019 NACBHDD Legislative Agenda"

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

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

"Value Purchasing for I/DD Services"

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

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

"Working with the Justice Community"

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

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

"National Update on Suicide and Suicide Prevention"

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

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

NACO Data-Driven Justice Initiative Sessions

"Reimagining County Behavioral Health Crisis Response Systems and Policies"

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

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

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

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

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

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

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

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

Agency and Program acronyms

BLAST – Bulldogs Learning and Succeeding Together. A Mahomet Area Youth Club program.

CAC - Children's Advocacy Center

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

CDS – Court Diversion Services, a program of the Regional Planning Commission.

CN - Crisis Nursery

CSCNCC - Community Service Center of Northern Champaign County, may also appear as CSC

Courage Connection – agency previously known as The Center for Women in Transition

DMBGC - Don Moyer Boys & Girls Club

DSC - Developmental Services Center

ECIRMAC – East Central Illinois Refugee Mutual Assistance Center

ECMHD - Early Childhood Mental Health and Development, a program of Rosecrance Champaign/Urbana

FDC – Family Development Center

FS - Family Service of Champaign County

FN - Frances Nelson previously known as Frances Nelson Health Center Health Center. Healthcare facility operated by Promise Healthcare

GAP – Girls Advocacy Program, a program component of the Psychological Service Center.

MAYC - Mahomet Area Youth Club

MRT – Moral Reconation Therapy, a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning.

PEARLS - Program to Encourage Active Rewarding Lives

~~PCHS - Prairie Center Health Systems~~

PHC – Promise Healthcare

PSC - Psychological Services Center (University of Illinois)

RAC or ECIRMAC – East Central Illinois Refugee Mutual Assistance Center

RACES – Rape Advocacy, Counseling, and Education Services

RCI – Rosecrance Central Illinois

RPC – Champaign County Regional Planning Commission

TIMES Center – Transitional Initiative Men's Emergency Shelter Center, a program of Rosecrance Champaign/Urbana

UCP – United Cerebral Palsy

UNCC – Urbana Neighborhood Community Connections Center

UP Center – Uniting in Pride Center

UW – United Way of Champaign County

YAC – Youth Assessment Center. Screening and Assessment Center developed by the Champaign County Regional Planning Commission-Social Services Division with Quarter Cent funding.

Glossary of Other Terms and Acronyms

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

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

ACA – Affordable Care Act

ACMHAI – Association of Community Mental Health Authorities of Illinois

ANSA – Adult Needs and Strengths Assessment

APN – Advance Practice Nurse

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

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

ASD – Autism Spectrum Disorder

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

ATOD – Alcohol, Tobacco and Other Drugs

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

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.

CBCL – Child Behavior Checklist.

CC – Champaign County

CCBoH – Champaign County Board of Health

C-GAF – Children's Global Assessment of Functioning

CILA – Community Integrated Living Arrangement

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

CLC – Cultural and Linguistic Competence

CLST – Casey Life Skills Tool

CQL – Council on Equality and Leadership

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

CSEs - Community Service Events. Is a category of service measurement on the Part II utilization form and the actual activity to be performed should also be described in the Part I Program Performance Measures-Utilization section of the application/program plan. 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.

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

CY – Contract Year, runs from July to following June. For example CY08 is July 1, 2007 to June 30, 2008. (Also may be referred to as Program Year – PY). Most contract 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. FY07

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

DASA – Division of Alcoholism and Substance Abuse in the Illinois Department of Human Services.

DCFS – Illinois Department of Children and Family Services.

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

DD – Developmental Disability

DFI – Donated Funds Initiative, source of matching funds for some CCMHB funded contracts. The Illinois Department of Human Services administers the DFI Program funded with federal Title XX Social Services Block Grant. The DFI is a

"match" program meaning community based agencies must match the DFI funding with locally generated funds. The required local match is 25 percent of the total DFI award.

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

DHS – Illinois Department of Human Services

DMHARS – Division of Mental Health and Addiction Recovery Services. This is the new division at the Department of Human Services that brings together the Division of Alcohol and Substance Abuse and the Division of Mental Health.

DSM – Diagnostic Statistical Manual.

DSP – Direct Support Professional

DT – Developmental Training

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.

ER – Emergency Room

FACES – Family Adaptability and Chesion Evaluation Scale

FAST – Family Assessment Tool

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, for the county runs from December to following November. Changing in 2015 to January through December.

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.

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

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

HRSA – Health Resources and Services Administration. The agency is housed within the federal Department of Health and Human Resources and has responsibility for Federally Qualified Health Centers.

ICADV – Illinois Coalition Against Domestic Violence

ICASA – Illinois Coalition Against Sexual Assault

ICDVP - Illinois Certified Domestic Violence Professional

ICFDD – Intermediate Care Facility for the Developmentally Disabled

ICJIA - Illinois Criminal Justice Authority

ID – Intellectual Disability

IDOC – Illinois Department of Corrections

I&R – Information and Referral

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.

ISC – Independent Service Coordination

ISP – Individual Service Plan

ISSA – Independent Service & Support Advocacy

JDC – Juvenile Detention Center

JJ – Juvenile Justice

JJPD – Juvenile Justice Post Detention

LCPC – Licensed Clinical Professional Counselor

LCSW – Licensed Clinical Social Worker

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

LPC – Licensed Professional Counselor

MAYSI – Massachusetts Youth Screening Instrument. All youth entering the JDC are screened with this tool.

MDT – Multi-Disciplinary Team

MH – Mental Health.

MHP - Mental Health Professional. Rule 132 term. Typically refers to a bachelors level staff providing services under the supervision of a QMHP.

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

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

NMT – Neurodevelopmental Model of Therapeutics

NTPC -- NON - Treatment Plan Clients – This is a new client engaged in a given quarter with case records but no treatment plan - includes: 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

application/program plan and the actual activity to be performed should also be described in the Part I Program Performance Measures-Utilization section of the application. Similar to TPCs, they may be divided into two groups – Continuing NTPCs - clients without treatment plans served before the first day of July and actively receiving services within the first quarter of the new program year. The first quarter of the program year is the only quarter in which this data is reported. Essentially it is a case carried from one program year into the next. The other is New TPCs that is the number of new clients in a given quarter of the program year.

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

OMA – Open Meetings Act.

OUD/SUD – Opioid Use Disorder/Substance Use Disorder

PAS – Pre-Admission Screening

PCI – Parent Child Interaction groups.

PCP – Person Centered Planning

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

PLL – Parenting with Love and Limits. Evidenced based program providing group and family therapy targeting youth/families involved in juvenile justice system.

PPSP – Parent Peer Support Partner

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 individuals' classification of need may be emergency, critical or planning.

PY – Program Year, runs from July to following June. For example PY08 is July 1, 2007 to June 30, 2008. (Also may be referred to as Contract Year – CY and is often the Agency Fiscal Year)

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

QIDP – Qualified Intellectual Disabilities Professional

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

SA – Substance Abuse

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.

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

SCs - Service Contacts/Screening Contacts. This is the number of phone and face-to-face contacts with consumers who may or may not have open cases in the program. It 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 utilization form of the application/program plan and the actual activity to be performed should also be described in the Part I Program Performance Measures-Utilization section of the application.

Seeking Safety - a present-focused treatment for clients with a history of trauma and substance abuse.

SEDS – Social Emotional Development Specialist

SEL – Social Emotional Learning

SFI – Savannah Family Institute. Manages the Parenting with Love and Limits (PLL) model.

SUD – Substance Use Disorder

TALKS - TALKS Mentoring (Transferring A Little Knowledge Systematically)

TPCs - Treatment Plan Clients – This is the number of 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 of the application/program plan and the actual activity to be performed should also be described in the Part I Program Performance Measures-Utilization section of the application. Treatment Plan Clients may be divided into two groups – Continuing TPCs - clients with treatment plans written prior to the first day of July and actively receiving services within the first quarter of the new program year. The first quarter of the program year is the only quarter in which this data is reported. Essentially it is a case carried from one program year into the next. The other is New TPCs that is the number of new clients with treatment plans written in a given quarter of the program year.

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.

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

YASI – Youth Assessment and Screening Instrument. Instrument assesses risks, needs, and protective factors in youth. Instrument is used in Champaign County by the Youth Assessment Center, Juvenile Detention Center, and Parenting with Love and Limits programs.

8.B.

CCMHB 2019 Meeting Schedule

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

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

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

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

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

8/31/18	*Agency PY2018 Fourth Quarter and Year End Reports Due*
9/12/18	**Study Session** U of I Program Evaluation Presentation
9/26/18	**Regular Board Meeting** Draft Three Year Plan 2019-2021 with FY19 Objectives
10/17/18	**Regular Board Meeting** Draft Program Year 2020 (PY20) Allocation Criteria Community Coalition Summer Initiatives Report
10/24/18	**Study Session** – Mental Health Crisis Services
10/26/18	*Agency PY2019 First Quarter Reports Due*
10/31/18	*Agency Independent Audits Due*
11/14/18	**Regular Board Meeting** Approve Three Year Plan with One Year Objectives Allocation Decision Support – PY20 Allocation Criteria
11/28/18	**Study Session** (John Dimit Room) – Housing/MI/SUD/DD
12/12/18	*Public Notice to be published on or before this date, giving at least 21-day notice of application period.*
~~12/19/18~~	~~**Regular Board Meeting**~~ *cancelled*
01/04/19	*CCMHB/CCDDB Online System opens for Agency Registration and Applications for PY20 Funding.*

1/23/19	**Regular Board Meeting** Election of Officers
1/25/19	*Agency PY2019 Second Quarter Reports Due*
1/30/19	**Study Session**
2/8/19	*Agency deadline for submission of applications for PY2020 funding. Online system will not accept forms after 4:30PM.*
2/12/19	*List of Requests for PY2020 Funding assembled*
2/20/19	**Regular Board Meeting** Assignment of Board Members to Review Proposals
2/27/19	**Study Session**
3/20/19	**Regular Board Meeting** 2018 Annual Report
3/27/19	**Study Session**
4/10/10	*Program summaries released to Board, copies posted online with CCMHB April 17, 2019 meeting agenda*
4/17/19	**Regular Board Meeting** Program Summaries Review and Discussion
4/24/19	**Study Session** Program Summaries Review and Discussion
4/26/19	*Agency PY2019 Third Quarter Reports Due*
5/8/19	*Allocation recommendations released to Board, copies posted online with CCMHB May 15, 2018 meeting agenda*
5/15/19	**Study Session** Allocation Recommendations
5/22/19	**Regular Board Meeting** Allocation Decisions Authorize Contracts for PY2020
6/19/19	**Regular Board Meeting** Approve FY2020 Draft Budget
6/27/19	*PY2020 Contracts completed/First Payment Authorized*

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

CCDDB 2019 Meeting Schedule

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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CHAMPAIGN COUNTY MENTAL HEALTH BOARD
BOARD MEETING

Minutes—February 20, 2019

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

5:30 p.m.

MEMBERS PRESENT:	Susan Fowler, Judi O'Connor, Joseph Omo-Osagie, Elaine Palencia, Kyle Patterson, Jane Sprandel
MEMBERS EXCUSED:	Thom Moore, Julian Rappaport, Margaret White
STAFF PRESENT:	Lynn Canfield, Mark Driscoll, Stephanie Howard-Gallo, Shandra Summerville
OTHERS PRESENT:	Juli Kartel, Rosecrance; Autumn Daniels, Courage Connection; Danielle Matthews, DSC; Elise Belknap, Lisa Benson, Regional Planning Commission (RPC); Andy Kulczycki, Community Service Center of Northern Champaign County (CSCNCC); Abdulhakeem Salaam, First Followers (FF); Angie Adams Martin, Cunningham Children's Home (CCH)

CALL TO ORDER:

Dr. Fowler called the meeting to order at 5:30 p.m.

ROLL CALL:

Roll call was taken and a quorum was present.

CITIZEN INPUT / PUBLIC PARTICIPATION:

None.

APPROVAL OF AGENDA:

The agenda was in the Board packet. Board members approved the document.

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PRESIDENT'S COMMENTS:

Dr. Fowler stated she appreciated the opportunity to serve as Board president. An election of new officers is on the agenda.

NEW BUSINESS:

Election of Officers:

MOTION: Ms. O'Connor moved to nominate Margaret White for CCMHB President. Ms. Palencia seconded the motion. A voice vote was taken and all members present vote aye. The motion passed.

MOTION: Mr. Omo-Osagie nominated Kyle Patterson for CCMHB Vice-President. Ms. Palencia seconded the motion. A voice vote was taken and all members present voted aye. The motion passed.

(Mr. Patterson presided over the remainder of the meeting.)

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

MOTION: Dr. Fowler moved to authorize the Executive Director to take action in order to accomplish early payoff of the CILA loan for two houses. Ms. O'Connor seconded the motion. A roll call vote was taken. The motion passed unanimously.

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

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

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

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

PY2020 Application List:
A list of applicants and amount requested by program was included in the Board packet. Ms. Canfield reviewed the application process and timeline with Board members.

Parenting with Love and Limits (PLL) Contract:
A Decision Memorandum on the status of the PLL program and a written request from Rosecrance to terminate the contract due to lack of staff was included in the Board packet.

MOTION: Ms. O'Connor moved to terminate the Rosecrance Parenting with Love and Limits contract #19-034. Ms. Palencia seconded the motion. A roll call vote was taken. All members voted aye and the motion passed unanimously.

MOTION: Dr. Fowler moved to terminate the Savannah Family Institute Center of Excellence Agreement contract #19-048. Ms. O'Connor seconded the motion. A roll call vote was taken. All members voted aye and the motion passed unanimously.

Agency Information:
None.

OLD BUSINESS:

Schedules and Allocation Process Timeline:
An updated copy of the meeting schedule and allocation timeline was distributed for information only.

CCDDB INFO:

The CCDDB met earlier in the day. The CCDDB approved the early payoff of the CILA mortgage and the NACO Achievement Award.

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APPROVAL OF MINUTES:

Minutes from the November 14, November 28, and January 23 meetings were included in the Board packet for review.

MOTION: Dr. Fowler moved to approve the meeting minutes from November 14, November 28 and January 23. Ms. Palencia seconded the motion. A voice vote was taken and the motion passed.

EXECUTIVE DIRECTOR'S COMMENTS:

Ms. Lynn Canfield provided a brief review of current activities.

STAFF REPORTS:

Staff reports from Mark Driscoll, Kim Bowdry, Shandra Summerville, and Stephanie Howard-Gallo were included in the packet for review.

FINANCIAL REPORT:

A copy of the Expenditure Approval List was included in the Board packet for action.

MOTION: Ms. O'Connor moved to approve the Expenditure Approval List as present in the Board packet. Ms. Sprandel seconded the motion. A voice vote was taken and the motion passed unanimously.

BOARD ANNOUNCEMENTS:

None.

ADJOURNMENT:

The meeting adjourned at 6:25 p.m.

Respectfully
Submitted by: Stephanie Howard-Gallo
CCMHB/CCDDB Staff

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

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CHAMPAIGN COUNTY MENTAL HEALTH BOARD
STUDY SESSION

Minutes—February 27, 2019

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

5:30 p.m.

MEMBERS PRESENT:	Susan Fowler, Judi O'Connor, Joe Omo-Osagie, Elaine Palencia, Kyle Patterson, Jane Sprandel, Margaret White
MEMBERS EXCUSED:	Thom Moore, Julian Rappaport
STAFF PRESENT:	Lynn Canfield, Mark Driscoll, Stephanie Howard-Gallo, Shandra Summerville
OTHERS PRESENT:	Juli Kartel, Rosecrance Inc.; Brandi Granse, Elise Belknap, Jonathon Westfield, Regional Planning Commission (RPC); Nicole Sikore, DSC; Angie Adams Martin, Angie Berlauski-Pierce, Cunningham Children's Home (CCH); Kim Bryan, Rattle the Stars

CALL TO ORDER:

Ms. Margaret White called the meeting to order at 5:30 p.m.

ROLL CALL:

Roll call was taken and a quorum was present.

CITIZEN INPUT / PUBLIC PARTICIPATION:

None.

APPROVAL OF AGENDA:

The agenda was approved.

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PRESIDENT'S COMMENTS:

None.

STUDY SESSION: CY2019 New Funded Programs:

Cunningham Children's Home—ECHO Program:

Head Start—Early Childhood Mental Health Services:

Rattle the Stars—Youth Suicide Prevention Education:

Representatives presented on their respective roles in the programs and provided a brief overview of their organization. They discussed services, coordination and collaboration. Board members were given an opportunity to ask questions following the presentation.

BOARD ANNOUNCEMENTS:
ADJOURNMENT:

The meeting adjourned at 6:55 p.m.

Respectfully
Submitted by: Stephanie Howard-Gallo
CCMHB/CCDDB Staff

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

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Mark Driscoll
Associate Director for Mental Health & Substance Abuse Services

Staff Report – March 20, 2019 Board Meeting

Summary of Activity

PY2020 Program Summaries: Preparation of program summaries has started in earnest. With 61 application submitted between the two Boards we have much work a head of us. As you will find as you do your own reviews, some additional sections have been added to the program side of the application. This includes new questions on coordination, collaboration, evidence-based practices, inclusion, and more detail on outcome measures. As appropriate, staff comments are being inserted into the program summaries foreshadowing final comments and observations posted in the allocation priorities and criteria section. One change in approach I have made is to not pose questions but simply identify missing information or a lack of clarity in an application.

PY19 Contract Activity: The PLL amendments terminating contracts have been drafted and sent to Rosecrance and Savannah Family Institute. While the amendments have not been returned yet, Rosecrance has sent a check for the excess revenue accrued from underbilling the advance payments.

Lynn and I along with State's Attorney Julia Reitz also participated in a conference call with Savannah Family Institute. Dr. Sells who developed the model had requested the call. While he hopes that PLL will return to Champaign County someday, he expressed deep appreciation to the Board and Peter Tracy for having taken a chance on him and the PLL model as Champaign County was an early adopter of the model.

A site visit on the Rosecrance Fresh Start program was completed in late February. The program met expectations for documentation of reported activity for the periods selected for review. I was pleased to meet the new case manager as I had not had the opportunity since she started in last August.

CCMHB Annual Report: My contribution to the FY2018 annual report was the charts on allocation of funds across various domains: sector, population, and service. Also took the opportunity to align the format of the demographic charts with the allocation charts. This makes for a more uniform presentation of the charted data. The service descriptions and utilization data are the work product of Lynn and Kim with some limited input from me. These changes make for a significant improvement to the presentation of the Annual Report. As has been past practice, a section of the report includes the Three-Year Plan.

Criminal Justice – Mental Health: Attended monthly meetings of the Reentry Council Executive Committee and full Reentry Council. At the Council meeting, monthly data reports were presented as was the mid-year report to be submitted to the County Board. A number of housekeeping details associated with the Council Bylaws were also addressed. The Crisis Intervention Team Steering Committee (CIT-SC) met in March too. The majority of the meeting was spent reviewing the CIT data report which led to a discussion of what targeted interventions are available for "super utilizers."

Other Activity: Recap of various meetings I was involved in since my last report.

- Regular monthly meeting of Mental Health Developmental Disabilities Agencies Council. The Council is comprised primarily of CCMHB and CCDB funded agencies. Dr. Aber from the Program Evaluation Team gave an update on engagement with the targeted programs, participation in the logic model workshops, and utilization of the consultation bank. The Council also discussed the recently passed minimum wage increase. And agencies shared information on upcoming events or other activities of interest.
- Attended the Champaign County Department Heads meeting on Lynn's behalf. The February meeting overlapped with the CCDDB meeting. Most of the discussion at the meeting regarded updates to various county policies.
- The Rantoul Service Providers group is meeting on a regular monthly basis now. Meetings are led by the Champaign County Regional Planning Commission Justice Diversion Services (JSD) Program. Plans are being made to use a website to post information on community resources and links to providers webpages. Printed information would also be available. Research into unmet needs and most frequently requested services will be presented at the next meeting.
- At the Child and Adolescent Local Area Network meeting, Jonathon Westfield presented on the Youth Assessment Center (YAC) and efforts to pilot Moral Reconation Therapy groups for youth. The YAC plans to expand the groups with the start of the new contract year.
- CUPHD hosted focus groups facilitated by the Illinois Criminal Justice Information Authority. The topic extended beyond criminal justice into a general assessment of services available, collaboration and coordination between providers, access and capacity of programs and services, and community education of available services.
- The United Way Community Impact Committee had an update on several off-cycle funding requests, the beginning of a strategic planning process, health building block data (health is one of the three priority areas for UW funding), and results of mid-cycle reports among other topics.
- Continuum of Service Providers to the Homeless: Among a range of topics addressed at the meeting was the FY20 Emergency Solutions Grant (ESG) opportunity from the Illinois Department of Human Services. Available to Champaign County is approximately $138,000. An initial request from the Continuum for providers to submit a notice of intent to apply through the Continuum for these funds was issued in late February. That only two providers responded with requests totaling less than the pool of funds available was discussed at the March meeting. The deadline for the notice of intent was extended to March 12th. Proposals totaling the full amount available are expected by the new deadline.

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

Program Summaries: I have started reviewing CCDDB FY20 Applications for funding and completing program summaries on those applications. Twenty CCDDB applications were submitted and will be reviewed. Stephanie Howard-Gallo will be assisting me in the review process and Lynn Canfield and Chris Wilson will be completing a review of the financial sections of each application.

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

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

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

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

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

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

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

PUNS Selection & Reports: The Illinois Department of Human Services-Division of Developmental Disabilities selected fifteen people from Champaign County from the PUNS database in June 2018. Seven of those 15 people have received award letters - six for Home

Based Services (HBS) and one for CILA. Three people have refused services. Five people continue to work with a CCRPC ISC to complete the pre-admission screening (PAS) process.

Attached is the updated PUNS Summary by County and Selection Detail for Champaign County. I have also included the Division of Developmental Disabilities Prioritization of Urgency of Needs for Services (PUNS) Summary of Total and Active PUNS By Zip Code and the Summary of PUNS - Total of All Clients by ISC Agency (Including closed records).

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

March 07, 2019

County: Champaign

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

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

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

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

Division of Developmental Disabilities
Prioritization of Urgency of Needs for Services (PUNS)
Summary By County and Selection Detail
March 07, 2019

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

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

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

EXISTING SUPPORTS AND SERVICES

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

TRANPORTATION

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

RESIDENTIAL SUPPORTS

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

Division of Developmental Disabilities
Prioritization of Urgency of Needs for Services (PUNS)
Summary By County and Selection Detail
March 07, 2019

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

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

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

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

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

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

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

*Totals include Ford & Iroquois Counties

**Increase

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

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

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

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

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

CLC Coordinator Direct Service Activities:

FY 2020 CLC Plan Review:

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

Youth Mental Health First Aid Training:

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

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

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

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

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

Anti-Stigma Activities/Community Collaborations and Partnerships

Alliance for Inclusion and Respect-

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

Ebert Festival 2019

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

Disability Resource Expo –

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

Illinois Public Media Community Advisory Committee (CAC)

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

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

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

Stephanie Howard-Gallo
Operations and Compliance Coordinator

Staff Report--March 2019 Board Meeting

SUMMARY OF ACTIVITY:

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

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

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

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

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

Champaign County CILA Facilities

FY18 Revenues and Expenditures as of 02/28/19

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

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

Champaign County Mental Health Board

FY18 Revenues and Expenditures as of 02/28/19

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

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

3

Champaign County Developmental Disability Board

FY18 Revenues and Expenditures as of 02/28/19

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

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

CHAMPAIGN COUNTY

EXPENDITURE APPROVAL LIST

2/13/19 PAGE 1

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
*** DEPT NO. 053 MENTAL HEALTH BOARD												
12	CHAMPAIGN COUNTY TREASURER								POSTAGE REIMBURSEMNT			
		1/10/19	80	VR	53- 468		586502	1/11/19	090-053-522.06-00	POSTAGE, UPS, FED EXPRESS	DEC POSTAGE	20.83
											VENDOR TOTAL	20.83 *
25	CHAMPAIGN COUNTY TREASURER								RENT-GENERAL CORP			
		2/04/19	02	VR	53- 65		587699	2/13/19	090-053-533.50-00	FACILITY/OFFICE RENTALS	FEB OFFICE RENT	1,775.97
											VENDOR TOTAL	1,775.97 *
41	CHAMPAIGN COUNTY TREASURER								HEALTH INSUR FND 620			
		1/18/19	02	VR	620- 9		587091	1/25/19	090-053-513.06-00	EMPLOYEE HEALTH/LIFE INS	JAN HI, LI, & ADMIN	3,805.80
											VENDOR TOTAL	3,805.80 *
88	CHAMPAIGN COUNTY TREASURER								I.M.R.F. FUND 088			
		1/10/19	81	VR	88- 70		586508	1/11/19	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 1/4 PR	1,130.88
		2/06/19	04	VR	88- 4		587706	2/13/19	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 1/18 P/R	830.59
		2/05/19	80	VR	88- 73		587707	2/13/19	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 1/18 P/R FY18	69.15
											VENDOR TOTAL	2,030.62 *
96	CHAMPAIGN COUNTY TREASURER								T & A ADVANCES			
		1/09/19	02	VR	53- 31		586509	1/11/19	090-053-533.89-00	PUBLIC RELATIONS	TD 3223 12/26 URBAN	140.00
		2/12/19	02	VR	53- 66		587709	2/13/19	090-053-533.89-00	PUBLIC RELATIONS	TD 3248 URBANA BUSI	240.00
											VENDOR TOTAL	380.00 *
104	CHAMPAIGN COUNTY TREASURER								HEAD START FUND 104			
		2/04/19	02	VR	53- 42		587710	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB EARLY CHILD MH	7,510.00
		2/04/19	02	VR	53- 42		587710	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB SOC/EMOT DEV	6,133.00
											VENDOR TOTAL	13,643.00 *
161	CHAMPAIGN COUNTY TREASURER								REG PLAN COMM FND075			
		2/04/19	02	VR	53- 43		587713	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB JUSTICE SYS DIV	5,422.00

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
		2/04/19	02	VR	53- 43		587713	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB YOUTH ASSMT CTR	6,362.00
											VENDOR TOTAL	11,784.00 *
176	CHAMPAIGN COUNTY TREASURER								SELF-FUND INS FND476			
		1/09/19	80	VR	119- 92		586515	1/11/19	090-053-513.04-00	WORKERS' COMPENSATION INS	WORK CMP 12/7, 21 P	171.20
		2/05/19	01	VR	119- 7		587714	2/13/19	090-053-513.04-00	WORKERS' COMPENSATION INS	WK CMP 1/4,18 PR	95.88
		2/05/19	80	VR	119- 94		587715	2/13/19	090-053-513.04-00	WORKERS' COMPENSATION INS	WK CMP 1/4,18PR FY1	136.43
											VENDOR TOTAL	403.51 *
179	CHAMPAIGN COUNTY TREASURER								CHLD ADVC CTR FND679			
		2/04/19	02	VR	53- 41		587717	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CAC	3,979.00
											VENDOR TOTAL	3,979.00 *
188	CHAMPAIGN COUNTY TREASURER								SOCIAL SECUR FUND188			
		1/10/19	81	VR	188- 114		586517	1/11/19	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 1/4 P/R	1,461.35
		2/06/19	04	VR	188- 7		587718	2/13/19	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 1/18 P/R	1,073.32
		2/05/19	80	VR	188- 117		587719	2/13/19	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 1/18 P/R FY18	89.35
											VENDOR TOTAL	2,624.02 *
8552	BLUE DRAGON SIGNS											
		2/04/19	01	VR	53- 37		587738	2/13/19	090-053-533.98-00	DISABILITY EXPO	INV 1045 1/18	181.90
											VENDOR TOTAL	181.90 *
18230	COMMUNITY SERVICE CENTER OF NORTHERN								CHAMPAIGN COUNTY			
		2/04/19	02	VR	53- 45		587768	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB RESOURCE CONNEC	5,550.00
											VENDOR TOTAL	5,550.00 *
18430	CONSOLIDATED COMMUNICATIONS											
		2/01/19	04	VR	28- 1		587771	2/13/19	090-053-533.33-00	TELEPHONE SERVICE	2173843776/0 1/1	30.14
											VENDOR TOTAL	30.14 *
19260	COURAGE CONNECTION											
		2/04/19	02	VR	53- 46		587778	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB COURAGE CONNECT	10,583.00
											VENDOR TOTAL	10,583.00 *

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
19346	CRISIS NURSERY											
		2/04/19	02	VR	53- 47		587780	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB BEYOND BLUE	6,250.00
											VENDOR TOTAL	6,250.00 *
20271	CUNNINGHAM CHILDREN'S HOME											
		2/04/19	02	VR	53- 48		587781	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB ECHO HOUSING/EM	7,500.00
											VENDOR TOTAL	7,500.00 *
22300	DEVELOPMENTAL SERVICES CENTER OF CHAMPAIGN COUNTY INC											
		2/04/19	02	VR	53- 49		587786	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB FAM DEV CENTER	46,856.00
											VENDOR TOTAL	46,856.00 *
22730	DON MOYER BOYS & GIRLS CLUB											
		2/04/19	02	VR	53- 50		587787	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CU CHANGE	8,333.00
		2/04/19	02	VR	53- 50		587787	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB YOUTH/FAMILY SV	13,333.00
											VENDOR TOTAL	21,666.00 *
22870	DREAAM HOUSE											
		2/04/19	02	VR	53- 51		587789	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB DREAAM	6,666.00
											VENDOR TOTAL	6,666.00 *
24095	EMK CONSULTING LLC											
		1/09/19	02	VR	53- 33		586556	1/11/19	090-053-533.07-00	PROFESSIONAL SERVICES	INV 310 12/29	2,144.00
		1/09/19	02	VR	53- 33		586556	1/11/19	090-053-533.07-00	PROFESSIONAL SERVICES	INV 311 12/29	1,059.11
											VENDOR TOTAL	3,203.11 *
24215	EAST CNTRL IL REFUGEE MUTUAL ASSIST CTR											
		2/04/19	02	VR	53- 52		587793	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB FAM SUP/STRENGT	4,019.00
											VENDOR TOTAL	4,019.00 *
26000	FAMILY SERVICE OF CHAMPAIGN COUNTY GRANTS											
		2/04/19	02	VR	53- 53		587796	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB COUNSELING	2,083.00

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
		2/04/19	02 VR	53-	53		587796	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB SELF HELP CENTE	2,410.00
		2/04/19	02 VR	53-	53		587796	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB SENIOR CNSL/ADV	11,861.00
											VENDOR TOTAL	16,354.00 *
26760	FIRST FOLLOWERS											
		2/04/19	02 VR	53-	54		587799	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB PEER MNTR REENT	5,833.00
											VENDOR TOTAL	5,833.00 *
27970	FREDERICK & HAGLE											
		1/14/19	95 VR	53-	473		586820	1/18/19	090-053-533.07-00	PROFESSIONAL SERVICES	CONSULT 12/18-1/2	733.00
											VENDOR TOTAL	733.00 *
30550	GROW IN ILLINOIS											
		2/04/19	02 VR	53-	55		587808	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB PEER SUPPORT	1,667.00
											VENDOR TOTAL	1,667.00 *
44570	MAHOMET AREA YOUTH CLUB											
		2/04/19	02 VR	53-	56		587841	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB BLAST	1,250.00
		2/04/19	02 VR	53-	56		587841	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB MEMBERS MATTER	1,500.00
											VENDOR TOTAL	2,750.00 *
50106	NATL ASSC OF CNTY BEHAVRL HLTH & DEV DIS SUITE 400											
		1/16/19	02 VR	53-	34		586864	1/18/19	090-053-533.93-00	DUES AND LICENSES	2019 NACBHDD DUES	900.00
											VENDOR TOTAL	900.00 *
51600	NEWS GAZETTE											
		1/14/19	90 VR	53-	474		3455	1/18/19	090-053-533.70-00	LEGAL NOTICES,ADVERTISING	7084 1398014 12/12	97.02
											VENDOR TOTAL	97.02 *
54650	PEPSI COLA CHAMPAIGN-URBANA BOTTLING											
		1/14/19	95 VR	53-	476		586880	1/18/19	090-053-522.02-00	OFFICE SUPPLIES	INV 81108280 12/21	18.60
		1/16/19	01 VR	53-	35		586880	1/18/19	090-053-522.02-00	OFFICE SUPPLIES	INV 81108420 1/7	13.12
											VENDOR TOTAL	31.72 *

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
57196	PROMISE HEALTHCARE											
		2/04/19	02	VR	53- 57		587868	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB MENTAL HLTH SVC	20,525.00
		2/04/19	02	VR	53- 57		587868	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB WELLNESS	4,833.00
											VENDOR TOTAL	25,358.00 *
58118	QUILL CORPORATION											
		1/09/19	90	VR	53- 471		586615	1/11/19	090-053-522.44-00	EQUIPMENT LESS THAN $5000	INV 3442107 12/12	588.36
		1/09/19	90	VR	53- 471		586615	1/11/19	090-053-522.02-00	OFFICE SUPPLIES	INV 3453167 12/12	26.47
		1/09/19	90	VR	53- 471		586615	1/11/19	090-053-522.04-00	COPIER SUPPLIES	INV 3453167 12/12	129.40
		1/09/19	90	VR	53- 471		586615	1/11/19	090-053-522.02-00	OFFICE SUPPLIES	INV 3554920 12/17	4.42
		1/09/19	90	VR	53- 471		586615	1/11/19	090-053-522.02-00	OFFICE SUPPLIES	INV 3563936 12/17	385.47
		1/09/19	90	VR	53- 471		586615	1/11/19	090-053-522.44-00	EQUIPMENT LESS THAN $5000	INV 3594264 12/18	299.99
		1/09/19	90	VR	53- 471		586615	1/11/19	090-053-522.02-00	OFFICE SUPPLIES	INV 3563936 12/18	2.21-
		1/09/19	90	VR	53- 471		586615	1/11/19	090-053-522.02-00	OFFICE SUPPLIES	INV 3643198 12/19	2.21
		1/09/19	90	VR	53- 471		586615	1/11/19	090-053-522.44-00	EQUIPMENT LESS THAN $5000	INV 3661362 12/20	51.99
		1/09/19	90	VR	53- 471		586615	1/11/19	090-053-522.02-00	OFFICE SUPPLIES	INV 3512281 12/14	14.69
											VENDOR TOTAL	1,500.79 *
59434	RAPE, ADVOCACY, COUNSELING & EDUC SRVCS SUITE 211											
		2/04/19	02	VR	53- 58		587874	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB SEX VIOL PREV/E	1,550.00
											VENDOR TOTAL	1,550.00 *
59472	RATTLE THE STARS											
		2/04/19	02	VR	53- 59		587875	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB YTH SUIC PREV/E	4,541.00
											VENDOR TOTAL	4,541.00 *
61780	ROSECRANCE, INC.											
		2/04/19	02	VR	53- 60		587886	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CRIMNL JUSTC PS	28,220.00
		2/04/19	02	VR	53- 60		587886	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CRIS/ACCSS/BENF	21,286.00
		2/04/19	02	VR	53- 60		587886	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB FRESH START	6,609.00
		2/04/19	02	VR	53- 60		587886	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB PREVENTION SVCS	5,000.00
		2/04/19	02	VR	53- 60		587886	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB RECOVERY HOME	16,666.00

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
		2/04/19	02 VR	53-	60		587886	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB SPECIALTY COURT	16,916.00
											VENDOR TOTAL	94,697.00 *
74550	TROPHYTIME, INC.											
		1/09/19	02 VR	53-	32		586636	1/11/19	090-053-522.02-00	OFFICE SUPPLIES	INV 127614 1/3	9.65
											VENDOR TOTAL	9.65 *
76867	UNIV OF IL SPONSORED PROG & RESEARCH ADM											
		2/04/19	02 VR	53-	64		587911	2/13/19	090-053-533.07-00	PROFESSIONAL SERVICES	FEB MHB19-039 CONSL	4,444.00
											VENDOR TOTAL	4,444.00 *
76916	UNIVERSITY OF IL FOUNDATION-EBERTFEST 119 GREGORY, MC462											
		2/04/19	01 VR	53-	39		3538	2/13/19	090-053-533.89-00	PUBLIC RELATIONS	EBERTFEST SPONS FY1	15,000.00
											VENDOR TOTAL	15,000.00 *
77280	UP CENTER OF CHAMPAIGN COUNTY											
		2/04/19	02 VR	53-	62		587916	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CHLD/YTH/FAM PR	1,535.00
											VENDOR TOTAL	1,535.00 *
78120	URBANA NEIGHBORHOOD CONNECTION CENTER											
		2/04/19	02 VR	53-	63		587920	2/13/19	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB COMM STUDY CNTR	1,625.00
											VENDOR TOTAL	1,625.00 *
78888	VISA CARDMEMBER SERVICE - MENTAL HEALTH AC#4798510049573930											
		1/28/19	90 VR	53-	479		587515	1/31/19	090-053-522.01-00	STATIONERY & PRINTING	3930 MOO.COM 12/18	17.98-
		1/28/19	90 VR	53-	479		587515	1/31/19	090-053-522.44-00	EQUIPMENT LESS THAN $5000	3930 BEST BUY 12/21	39.99-
		1/28/19	90 VR	53-	479		587515	1/31/19	090-053-522.03-00	BOOKS,PERIODICALS & MAN.	3930 NADD 12/12	79.95
		1/28/19	90 VR	53-	479		587515	1/31/19	090-053-522.44-00	EQUIPMENT LESS THAN $5000	3930 BEST BUY 12/12	39.99
		1/28/19	90 VR	53-	479		587515	1/31/19	090-053-533.18-00	NON-EMPLOYEE TRAINING,SEM	3930 MEIJER 12/12	33.61
		1/28/19	90 VR	53-	479		587515	1/31/19	090-053-533.18-00	NON-EMPLOYEE TRAINING,SEM	3930 NACO 12/19	490.00
		1/28/19	90 VR	53-	479		587515	1/31/19	090-053-533.18-00	NON-EMPLOYEE TRAINING,SEM	3930 MEIJER 12/19	26.63
		1/28/19	90 VR	53-	479		587515	1/31/19	090-053-522.44-00	EQUIPMENT LESS THAN $5000	3930 AMAZON 12/22	68.36

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
		1/28/19	90	VR 53-	479		587515	1/31/19	090-053-533.18-00	NON-EMPLOYEE TRAINING,SEM	3930 MEIJER 12/27	25.06
		1/29/19	04	VR 53-	40		587515	1/31/19	090-053-533.42-00	EQUIPMENT MAINTENANCE	3930 MICROSOFT 1/7	210.38
		1/29/19	04	VR 53-	40		587515	1/31/19	090-053-533.18-00	NON-EMPLOYEE TRAINING,SEM	3930 AMERICN AIR 1/	269.00
		1/29/19	04	VR 53-	40		587515	1/31/19	090-053-533.18-00	NON-EMPLOYEE TRAINING,SEM	3930 TRAVEL INS 1/9	22.75
		1/29/19	04	VR 53-	40		587515	1/31/19	090-053-522.06-00	POSTAGE, UPS, FED EXPRESS	3930 USPS 1/7	23.70
											VENDOR TOTAL	1,231.46 *
81610	XEROX CORPORATION											
		1/14/19	95	VR 53-	475		586941	1/18/19	090-053-533.85-00	PHOTOCOPY SERVICES	INV 157283738 11/3	246.29
		1/14/19	95	VR 53-	475		586941	1/18/19	090-053-533.85-00	PHOTOCOPY SERVICES	INV 157283739 11/3	39.60
		2/06/19	90	VR 53-	480		587946	2/13/19	090-053-533.85-00	PHOTOCOPY SERVICES	INV 158224708 1/3	246.29
		2/06/19	90	VR 53-	480		587946	2/13/19	090-053-533.85-00	PHOTOCOPY SERVICES	INV 158224709 1/3	39.60
											VENDOR TOTAL	571.78 *
602572	BOWDRY, KIM									MENTAL HEALTH BOARD		
		1/09/19	90	VR 53-	472		586657	1/11/19	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	124.6 MIL 11/1-12/1	67.91
		1/09/19	90	VR 53-	472		586657	1/11/19	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	PARKING 12/14	2.25
		1/09/19	90	VR 53-	472		586657	1/11/19	090-053-533.18-00	NON-EMPLOYEE TRAINING,SEM	REIM COPIES CEU 12/	31.50
											VENDOR TOTAL	101.66 *
604568	CANFIELD, LYNN									MENTAL HEALTH BOARD		
		1/09/19	90	VR 53-	469		586659	1/11/19	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	119 MILE 11/7-12/27	64.86
		1/09/19	90	VR 53-	469		586659	1/11/19	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	PARKING 11/7-12/27	18.00
											VENDOR TOTAL	82.86 *
611802	DRISCOLL, MARK									MENTAL HEALTH		
		1/09/19	90	VR 53-	470		586662	1/11/19	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	142 MILE 11/1-12/19	77.39
		1/09/19	90	VR 53-	470		586662	1/11/19	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	PARKING 11/1-12/19	1.25
											VENDOR TOTAL	78.64 *
641810	SUMMERVILLE, SHANDRA A									MENTAL HEALTH BOARD		
		2/06/19	90	VR 53-	477		588010	2/13/19	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	54 MILE 11/6-12/18	29.43

CHAMPAIGN COUNTY

EXPENDITURE APPROVAL LIST

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
		2/06/19	90	VR	53- 477		588010	2/13/19	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	PARKING 11/27-12/18	6.00
											VENDOR TOTAL	35.43 *
										MENTAL HEALTH BOARD	DEPARTMENT TOTAL	333,679.91 *
										MENTAL HEALTH	FUND TOTAL	333,679.91 *