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 18, 2020

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

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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. Executive Director's Comments **(Pages 3-28)**
   Written summary of the NACHBDD Conference is included in the packet.
7. New Business
   A. Youth and Family Peer Support Alliance
      Regina Crider will make a short presentation on the Alliance.
   B. CCMHB FY 2019 Annual Report* **(Pages 29-59)**
      The FY19 Annual Report is included in the Board packet for review and approval. Action is requested.

C. Application Review Process Discussion **(Pages 60-62)**
Briefing memorandum presents an overview of the review process and timeline.

D. Agency Acronym List and Glossary **(Pages 63-73)**
List of agency and program name acronyms and glossary of terms is included in the packet.

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

9. Old Business

E. Family Model Implementation Update **(Page 74)**
Written progress report on the work by Cunningham Children's Home to implement the family model included in the packet for information only.

F. Schedules & Allocation Process Timeline **(Pages 75-79)**
Updated copies of CCMHB and CCDDB meeting schedules and allocation timeline are included in the packet.

10. CCDDB Information

11. Approval of CCMHB Minutes* **(Pages 80-87)**
Minutes from February are included in the Board packet.

12. Staff Reports **(Pages 88-101)**
Written staff reports from Kim Bowdry, Mark Driscoll, Stephanie Howard-Gallo, and Shandra Summerville are included in the packet.

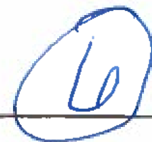
13. Board to Board Reports

14. Expenditure List* **(pages 102-117)**
Copy of the Expenditure List is included in the packet. Action is requested to accept the list as presented.

15. Board Announcements

16. Adjournment

CHAMPAIGN COUNTY MENTAL HEALTH BOARD



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

BRIEFING MEMORANDUM

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

Background

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

NACo Health Steering Committee, Joint Subcommittee Meeting

"Call to Order and Welcome"

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

"Health and Human Services & Justice Workshop Overview"

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

"Suicide: Local Strategies for Tackling a National Epidemic"

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

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

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

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

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

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

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

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

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

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

NACo Health Steering Committee, Policy Coordinating Committee

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

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

"Health Resolutions Received Within 30 Day Deadline"

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

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

"Emergency Resolutions"

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

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

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

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

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

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

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

NACo Healthy Counties Advisory Board Meeting

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

"Healthy Counties Strategic Priorities"

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

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

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

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

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

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

NACBHDD Board Meeting

"Brief Updates"

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

"NACBHDD Committee Reports"

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

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

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

"Brief State Updates"

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

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

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

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

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

"Welcome, Introductions, Overview of Agenda"

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

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

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

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

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

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

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

"PANEL: State and County Progress on Medicaid"

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

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

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

"Key Developments in the Medicaid and Medicare Programs"

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

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

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

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

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

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

"Progress on Addressing Workforce Issues"

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

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

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

"Progress on Suicide Prevention"

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

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

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

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

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

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

"Systems of Care (SOC) for Children"

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

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

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

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

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

"Discussion of 2020 NACBHDD Legislative Agenda"

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

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

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

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

Capitol Hill Reception with Awards

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

"State Panel: Progress Report on CCBHCs"

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

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

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

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

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

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

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

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

"Status of the State and County Opioid Settlements"

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

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

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

Closing Comments from NACBHDD President and Executive Director

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

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

7.B.

DECISION MEMORANDUM

DATE: March 18, 2020
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Lynn Canfield, Stephanie Howard-Gallo
SUBJECT: CCMHB Annual Report for Fiscal Year 2019

Attached for review and approval is the Annual Report for Fiscal Year 2019, January 1 to December 31, 2019. The preparation of the Annual Report is a collaboration among staff members and Board president. Included are a financial accounting of revenue and expenditures, agency program allocations, service activity totals by agency and program (with explanations as introduced in the FY2016 Annual Report), aggregate demographic and residency data, and service sector charts for the past year. The Three-Year Plan (FY 2019 – FY 2021) with One-Year Objectives for FY2020, approved at the November 2019 meeting, is also presented.

The attached document has blank pages omitted that will be inserted prior to distribution. The table of contents may be adjusted to reflect these added pages, but no content will change following approval by the Board.

Decision Section
Motion: Move to approve the Champaign County Mental Health Board Fiscal Year 2019 Annual Report.

_________ Approved
_________ Denied
_________ Modified
_________ Additional Information Needed

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

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

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, 2019 through December 31, 2019.

The CCMHB's Three-Year Plan for the period January 1, 2019 through December 31, 2021 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, 2019 through December 31, 2019.

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 2019 Annual Report & Three-Year Plan 2019-2021

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Section II: Three-Year Plan 2019-2021 20-27
- Three-Year Plan with FY19 Objectives

LISTING OF 2019 BOARD MEMBERS AND STAFF

BOARD MEMBERS

Ms. Margaret White
(President)

Mr. Kyle Patterson
(Vice President)

Dr. Susan Fowler

Dr. Thom Moore

Ms. Judi O'Connor

Mr. Joseph Omo-Osagie

Ms. Elaine Palencia

Dr. Julian Rappaport

Ms. Jane Sprandel

STAFF MEMBERS

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

CCMHB President's Report

As the incoming President, it is my pleasure on behalf of the Champaign County Mental Health Board (CCMHB/Board) to present to the citizens of Champaign County the 2019 Annual Report. The report is statutorily required under the Illinois Community Mental Health Act (405 ILCS 20/). The Board meets the mandated reporting requirements and provides additional information detailing funded services and performance as well as including the Three-Year Plan with objectives for the new year. The following pages include a financial accounting of 2019 expenditures, amounts allocated to community agencies by program, and for the two CILA homes. Detailed descriptions of funded services by program and reported utilization follow and is accompanied by charts aggregating reported service data and the commitment of financial resources by the Board. Closing out the report is the Three-Year Plan with Fiscal Year 2020 Objectives.

While state funding started to stabilize in 2019, agencies continue to struggle in a difficult operating environment. State rates for many services continue to be inadequate. Medicaid and managed care pose enrollment, claims, and other challenges for providers and clients alike. Then there is the competitive employment market compounding existing staff shortages in the developmental disability and behavioral health fields. These are some of the overarching issues confronting providers not only in Champaign County but across the state and nationally. Locally, the cycle of violence perpetuated by youth with guns continues to plague larger communities while rural, small towns lack access to services be it due to the absence of providers, transportation issues, or stigma, all present challenges for the respective communities, stakeholders, and the Board.

Over the last year, the Board has moved to restore a family-based model for addressing needs of youth. Cunningham Children's Home was awarded a grant to complete the planning process in late 2019 and move to implementation in 2020. Another significant achievement is the collaborative effort between the Board and the Champaign County Developmental Disabilities Board to pay off the mortgage of two CILA homes purchased in 2014. In an effort to provide long-standing programs with some security regarding current contracts, the Board approved extending the term of twenty contracts representing 35% of 2019 awards. The amount of funding the Board has awarded to local agencies has continued to increase over the last three years at a rate exceeding that of the property tax levy. For contract year 2019 (7/1/18-6/30/19), the Board awarded $4,201,929, compared to contract year 2020 (7/1/19-6/30/20) awards of $4,562,151. As you will see in the following pages, these funds support services to the very young to the very old, to residents of our large towns and cities to our very small rural communities.

In closing, I want to thank you for your interest in the work of the CCMHB. What has been accomplished would not be possible without the commitment of my fellow volunteer board members, including outgoing members Judi O'Connor and immediate past President Margaret White. I would also like to welcome to the Board, Ms. Kathleen Wirth-Couch and Dr. Jon Paul Youakim.

Respectfully,

Joseph Omo-Osagie
CCMHB President, 2020

SECTION I: Financial Reports and Service Data

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

ANNUAL FINANCIAL REPORT

1/1/19 - 12/31/19

	2018	2019
Beginning of the Year Fund Balance	$ 2,842,704	$ 3,225,111
REVENUE		
General Property Taxes	$ 4,611,577	$ 4,813,598
Back Taxes, Mobile Home Tax & Payment in Lieu of Taxes	7,809	13,155
Local Government Revenue		
Champ County Developmental Disabilities Board	310,783	409,175
Interest Earnings	41,818	45,950
Gifts and Donations	21,613	4,706
Disability Expo	N/A	14,275
Miscellaneous	29,955	129,028
TOTAL REVENUE	$ 5,023,555	$ 5,429,887
EXPENDITURES		
Administration & Operating Expenses:		
Personnel	$ 522,073	$ 517,053
Commodities	10,049	11,147
Services	404,059	286,377
Interfund Transfers*	56,779	406,505
Capital Outlay	-	-
Sub-Total	$ 992,960	$ 1,221,082
Grants and Contributions:		
Program	3,648,188	3,993,283
Capital	-	-
Sub-Total	$ 3,648,188	$ 3,993,283
TOTAL EXPENDITURES	$ 4,641,148	$ 5,214,364
Fund Balance at the End of the Fiscal Year	$ 3,225,111	$ 3,440,634

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

CHAMPAIGN COUNTY MENTAL HEALTH BOARD
PROGRAM ALLOCATIONS -- FY2019
1/1/19 - 12/31/19

AGENCY/PROGRAM	TOTAL PAID
CHAMPAIGN COUNTY CHILDREN'S ADVOCACY CENTER	**50,256.00**
CHAMPAIGN COUNTY CHRISTIAN HEALTH CENTER	
Mental Health Care (6 months)	**6,498.00**
CHAMPAIGN COUNTY HEALTH CARE CONSUMERS	
CHW Outreach and Benefit Enrollment (6 months)	29,646.00
Justice Involved CHW Services & Benefits (6 months)	27,384.00
Agency Total	**57,030.00**
CHAMPAIGN COUNTY REGIONAL PLANNING COMMISSION	
Homeless Services System Coordination (6 months)	23,579.00
Early Childhood Mental Health Services	152,394.00
Youth Assessment Center	76,350.00
Headstart - Social/Emotional Disabilities**	80,607.00
Justice Diversion	70,192.00
Agency Total	**403,122.00**
CHAMPAIGN URBANA AREA PROJECT	
CU Neighborhood Champions (6 months)	25,004.00
TRUCE	50,000.00
Agency Total	**75,004.00**
COMMUNITY SERVICE CENTER OF NORTHER CHAMPAIGN COUNTY	
Resource Connection	**67,094.00**
COURAGE CONNECTION	
Courage Connection	**124,321.00**
CRISIS NURSERY	
Beyond Blue - Rural	**75,000.00**
CUNNINGHAM CHILDREN'S HOME	
ECHO Housing and Employment Support	92,886.00
Parenting Model Planning/Implementation (6 months)	140,472.00
Agency Total	**233,358.00**
DEVELOPMENTAL SERVICES CENTER	
Family Development Center **	**281,144.00**
DON MOYER BOYS & GIRLS CLUB	
CU Neighborhood Champions (6 months)	32,358.00
Community Coalition Summer Youth Programs	107,000.00
CU Change	50,002.00
Youth and Family Organization	80,002.00
Agency Total	**269,362.00**
DREAAM HOUSE	
DREAAM House	**80,000.00**
EAST CENTRAL ILLINOIS REFUGEE ASSISTANCE CENTER	
Family Support and Strengthening	**52,343.00**
FAMILY SERVICE	
Counseling	27,502.00

CHAMPAIGN COUNTY MENTAL HEALTH BOARD
PROGRAM ALLOCATIONS -- FY2019
1/1/19 - 12/31/19

AGENCY/PROGRAM	TOTAL PAID
Self Help Center	28,682.00
Senior Counseling and Advocacy	152,345.00
Agency Total	**208,529.00**
FIRST FOLLOWERS	
Peer Mentoring for Re-entry	**82,498.00**
GROW IN ILLINOIS	
Peer Support (6 months)	**48,614.00**
MAHOMET AREA YOUTH CLUB	
Members Matter	15,000.00
BLAST	18,000.00
Agency Total	**33,000.00**
NATIONAL ALLIANCE ON MENTAL ILLINOIS	
NAMI Champaign County (6 months)	**4,998.00**
PROMISE HEALTHCARE	
Mental Health Services	244,272.00
Wellness/Justice	58,000.00
Agency Total	**302,272.00**
RAPE ADVOCACY COUNSELING EDUCATION SERVICES	
Sexual Violence and Prevention Education	**18,276.00**
RATTLE THE STARS	
Youth Suicide Prevention Education	**54,752.00**
ROSECRANCE	
Criminal Justice PSC	321,495.00
Crisis, Access, Benefits & Engagement	229,700.00
Fresh Start	79,310.00
Prevention Services	60,000.00
Recovery Home	183,326.00
Specialty Courts	203,000.00
Agency Total	**1,076,831.00**
UNITED CEREBRAL PALSY LAND OF LINCOLN	
Vocational Training and Support (6 months)	**21,620.00**
UP CENTER OF CHAMPAIGN COUNTY	
Children/Family/Youth Program	**25,095.00**
URBANA NEIGHBORHOOD CONNECTION	
Community Study Center	**22,500.00**
GRAND TOTAL	**3,673,517.00**

** 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 PY2019 CCMHB Funded Programs

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

Priority: Intellectual/Developmental Disabilities (Collaboration with CCDDB)

Champaign County Regional Planning Commission Head Start/Early Head Start
Social Emotional Development Services $73,605

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:** 67 TPC, 90 NTPC, 31 CSE, 594 SC, 73 Other (newsletter articles, staff training).

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

Services: Program serves children birth to five years old, with or at risk of developmental disabilities, and their families. FDC responds to needs with culturally responsive, innovative, evidence-based services. Early detection and prompt, appropriate intervention can improve developmental outcomes for children with delays and disabilities and children living in at-risk environments. Family-centered intervention maximizes the gifts and capacities of families to provide responsive intervention within familiar routines and environments. **Utilization actual:** 655 TPC, 150 SC, 505 CSE.

Individual Advocacy Group **CILA Expansion** $450,000 (CCMHB and CCDDB)

This annual investment pays for mortgage and property management costs of two of the three local small group homes run by Individual Advocacy Group, which was selected in 2014 through an RFP process to provide services to people with I/DD living in MHB/DDB owned-homes. During 2019, the CCMHB contributed a larger share in order to pay off the mortgage loan in full; the CCDDB will continue to transfer $50,000 into the fund each year until their total payments are equal to the CCMHB contribution. **Utilization:** 7 TPCs with staffing ratios from 1:4 to 2:3 and a choice between IAG 'Flexible Day Experience' and community day programs run by other local providers.

Priority: System of Care for Children, Youth, and Families

Champaign County Children's Advocacy Center (CAC)
Children's Advocacy $47,754

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:** 260 TPC, 44 NTPC, 223 SC, 13 CSE.

Champaign County RPC Head Start/Early Head Start
Early Childhood Mental Health Services (NEW) $90,120

Services: Support from an Early Childhood Mental Health Assistant including: assisting teaching staff and parents in writing individualized social-emotional goals to include in lesson plans for children identified through screening; developing with parents and teaching staff an Individual Success Plan for children who exhibit challenging behaviors; offering teachers social and emotional learning strategies; monitoring children's progress and outcomes; and providing information to families and staff. Also includes facilitating meetings with a child's parent(s) and teaching staff throughout the process of the child receiving services as well as supporting parents and teaching staff with resources, training, coaching, and modeling. **Utilization actual:** 71 TPC, 119 NTPC, 2340 SC, 7 CSE, Other 86.

Champaign Urbana Area Project **CU Neighborhood Champions** $50,000

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:** 17 NTPC, 73 SC, 80 CSE, Other 869.

Champaign Urbana Area Project **TRUCE** $50,000

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:** 3 NTPC, 93 SC, 139 CSE, 20 Other.

Courage Connection **Courage Connection** $127,000

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:** 480 TPC, 110 NTPC, 639 SC, 152 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:** 76 TPC, 43 NTPC, 343 SC, 143 CSE.

Don Moyer Boys & Girls Club **Community Coalition Summer Initiatives** $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. Supports and reinforces System of Care principles and values particularly relevant to system-involved youth impacted with emotional and environmental challenges. **Utilization actual:** 623 NTPC, 12640 SC, 60 CSE.

Don Moyer Boys & Girls Club **Youth and 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:** 19 TPC, 22 NTPC, 332 SC, 38 CSE.

DREAAM House **DREAAM House** $80,000
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:** 91 TPC, 205 SC, 27 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 targets low income and/or struggling students and makes the program available at no cost. **Utilization actual:** 3 TPC, 75 NTPC, 2445 SC, 1152 CSE.

Mahomet Area Youth Club **MAYC Members Matter!** $18,000
Services: Programming for students K-12 includes enrichment activities, academic help, and cultural and community-based 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:** 8 TPC, 185 NTPC, 1709 SC, 200 CSE.

Rosecrance Central Illinois **Parenting with Love & Limits** $16,505 (fee for service billed activity) (program discontinued/contract terminated effective 12/31/18)

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 while reducing recidivism and improving family communication. After an assessment, parents and youth attend six classes, held one evening a week for six weeks. Program targets specific risk and protective factors related to delinquency and other emotional and behavioral problems. **Utilization actual:** Fee For service Billed Activity comprised 170 SCs, comprising 12 intakes, 72.25 hours of family therapy, and 33.75 hours of family centered case management, and 9.5 hours transportation assistance (case management).

Rosecrance Central Illinois **Prevention Services** $60,000

Services: An evidence-based life skills and drug education curriculum for Champaign County students. Programs available for preschool through high school. 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:** 1141 CSE.

UP Center of Champaign County **Children, Youth & Families Program** $18,423

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:** 1 TPC, 29 NTPC, 95 SC, 50 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. Point of contact for information, linkage and referral to community resources. 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:** 344 NTPC.

Priority: Behavioral Health Supports for People with Justice Involvement

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Champaign County Regional Planning Commission – Social Services

Justice Diversion Program (JPD) $65,074

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 criminal recidivism and 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:** 40 TPC, 46 NTPC, 177 SC, 13 CSE.

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

Services: Screens youth for risk factors and links youth/families to support 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 youth referred to the YAC to identify issues that might have influenced an offense and link youth to services to address the identified issues. Focused on helping youth be resilient, resourceful, responsible, and contributing members of society. **Utilization actual:** 38 TPC, 20 NTPC, 40 SC, 60 CSE.

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:** 22 TPC, 30 NTPC.

First Followers **Peer Mentoring for Re-entry** $70,000

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:** 25 TPC, 98 NTPC, 30 SC, 12 CSE.

Rosecrance Central Illinois **Criminal Justice PSC** $338,643

Services: Problem Solving Courts (Drug Court) involved individuals receive a screening at the Champaign County Jail and, 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:** 161 TPC, 256 NTPC, Other = 138 group sessions.

Rosecrance Central Illinois **Fresh Start** $79,310

Services: 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. 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:** 6 TPC, 16 NTPC, 3 SC, 190 CSE, 29 Other.

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:** 48 TPC, 1478 SC, 9 CSE, Other 374 hours assessment, 431 hours case management, 4206 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.

Priority: Innovative Practices and Access to Community Based Behavioral Health Services

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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:** 1357 NTPC, 4268 SC, 20 CSE, Other = 2365 contacts with other agencies using CSCNCC as a satellite site.

Cunningham Children's Home **ECHO (NEW)** $90,000

Services: Program works closely with homeless individuals (or at risk of homelessness) through intensive case management and care coordination geared towards promoting permanent housing and employment and resolving barriers. The Case Manager will accomplish this by taking a holistic approach to supportive services by countering possible barriers to goal stability (e.g., basic needs, child care, physical health, and mental health). Participants will receive weekly services that last until 90 days after obtaining both housing and employment. **Utilization actual:** 45 TPC, 25 NTPC, 592 SC, 20 CSE.

Family Service of Champaign County **Self-Help Center** $28,928

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:** 301 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:** 334 TPC, 392 NTPC, 5924 SC, Other = 134 caregivers.

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

Services: Mutual-help; peer to peer 12-step program provides weekly mental health support groups for those 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:** 49 NTPC, 588 SC, 35 CSE.

Promise Healthcare **Promise Healthcare Wellness** $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. 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:** 284 TPC, 101 NTPC, 1120 SC, 37 CSE, Other = 2283 enrolled in healthcare coverage.

Rattle the Stars **Youth Suicide Prevention Education (NEW)** $54,500

Services: Designed to build skills and improve competence to encourage intervention between peers, and by parents and adults. Covering three core areas for intervention: what to look for to recognize mental illness, mental health crises, and suicidal thoughts; how to intervene by using appropriate and effective communication skills; and accessing necessary resources for professional care. Program is developed from evidence informed models and adheres to best practices suggested by nationally recognized mental health and suicide prevention agencies. **Utilization actual:** 87 CSE.

Rosecrance Central Illinois **Recovery Home (NEW)** $83,330

Services: Therapeutic interventions that facilitate: removal of barriers for safe/supportive housing; 12-Step support involvement; independent living skills; education/vocational skills; identification and use of natural supports; use of community resources; and peer support. Evidence based practices to be used include: 12-Step model and peer support; Level system; Case Management; and Contingency management initiatives. **Utilization actual:** 11 TPC, 93 SC.

United Cerebral Palsy Land of Lincoln **Vocational Training and Support** $43,238

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:** 36 TPC, 40 SC, 21 CSE, Other = 2086 hours contact with clients.

Priority: Other/Renewal

Crisis Nursery **Beyond Blue – Champaign County** $75,000

Services: Serves mothers who have or are at risk of developing perinatal 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:** 31 TPC, 93 NTPC, 503 SC, 320 CSE, Other = 1101 hours of in-kind/respite care.

East Central IL Refugee Mutual Assistance Center
Family Support and Strengthening $48,239

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:** 103 CSE, Other = 31 hours of workshops.

Promise Healthcare **Mental Health Services with Promise** $242,250

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. New in 2018 were the child and adolescent psychiatric services. **Utilization actual:** Counseling Services: 370 TPC, 64 NTPC, 1979 SC. Psychiatric Services: 2072 in psychiatric practice, 1179 getting psych meds through primary care, 8818 psychiatric service encounters, 12 lunch and learn sessions. Pediatric Psyhicatric Services: 163 SC and 83 TPC.

Rape Advocacy, Counseling & Education Services
Sexual Violence Prevention Education $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. Provides prevention education to thousands of local children and adults per year, and holds community events to further the aim to create a

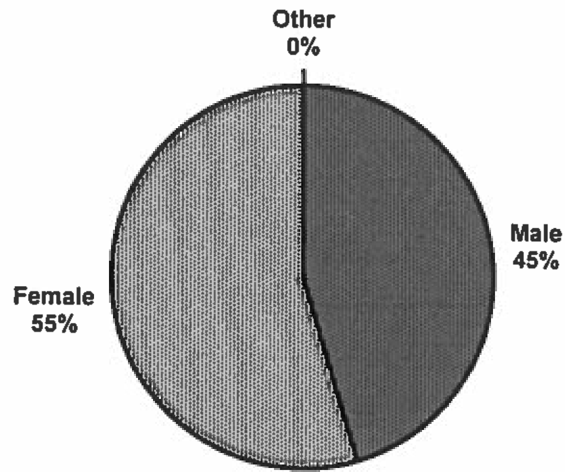
world free of sexual violence. **Utilization actual:** 8986 (# attending) SC, 423 CSE, Other = 13 media contacts.

Rosecrance Central Illinois **Crisis, Access, & Benefits** $255,440

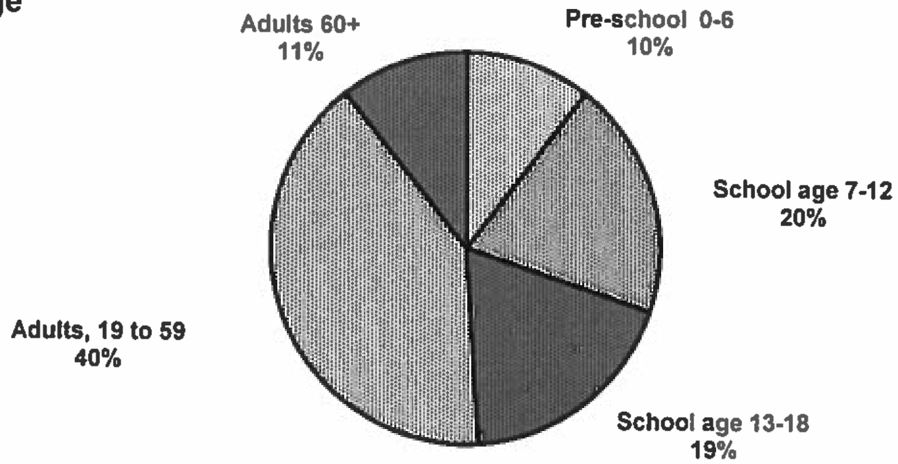
Services: A 24-hour program that including Crisis Team and Crisis Line. Clinicians provide immediate intervention by responding to crisis line calls and conducting crisis assessments throughout Champaign County. The Crisis Team works closely with the hospitals, local police, the University and other local social service programs. Offers access services including information, triage, screening, assessment and referral for consumers and other members of the community. **Utilization actual:** 1060 NTPC (intake screening or mental health assessments), 3175 SC (crisis calls), 21 CSE; Other = 280 benefits applications (includes those subcontracted through CC Healthcare Consumers). Program also reports 1132 Crisis team contacts (not a subset of crisis calls).

Demographic and Residency Data for Persons Served in Program Year 2019

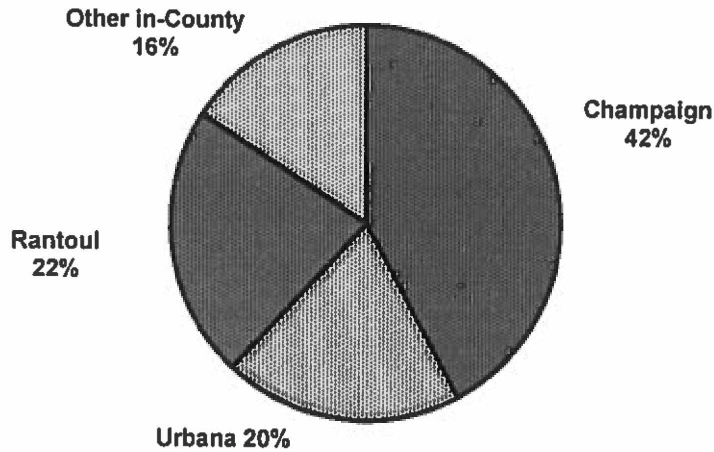
Gender



Age

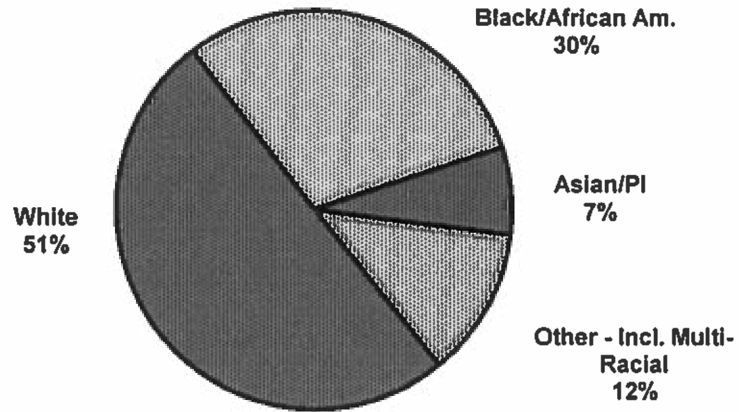


Residency

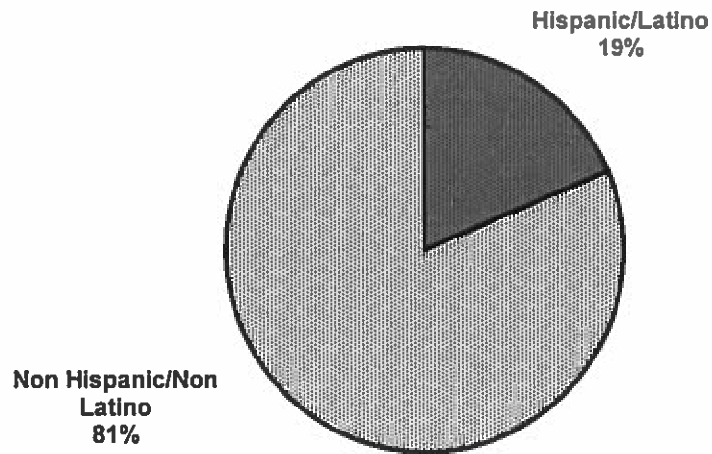


Demographic and Residency Data for Persons Served in Program Year 2019

Race

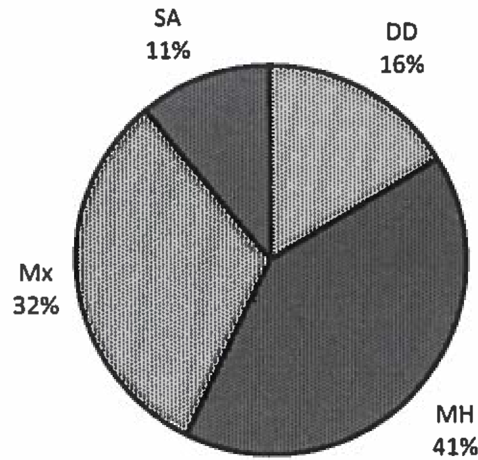


Ethnic Origin

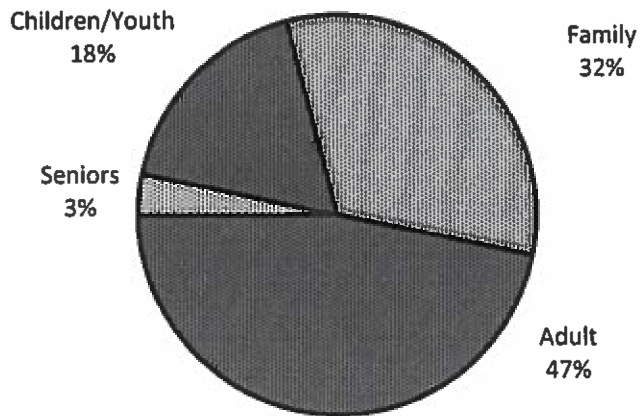


Funding by Sector, Population, and Service in Program Year 2019 (PY19)

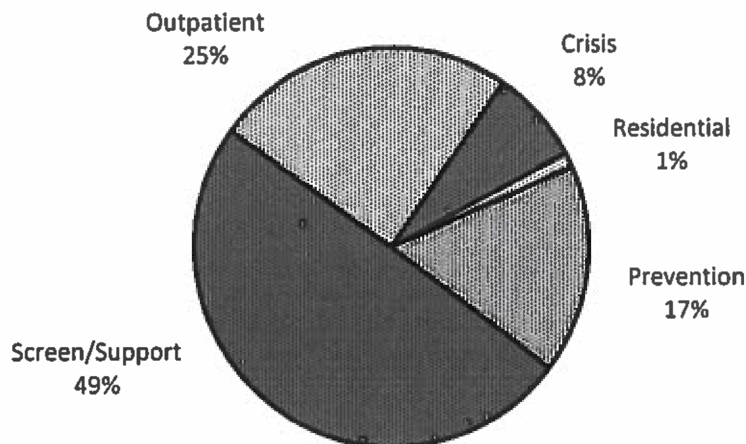
CCMHB PY19 Appropriation by Community Mental Health Sector



CCMHB PY19 Appropriation by Target Population



CCMHB PY19 Appropriation by Type of Service



SECTION II: Three-Year Plan 2019-2021 with FY 2019 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 2020
(1/1/20 – 12/31/20)

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 use 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, or 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: Support development or expansion of residential and employment supports for persons with behavioral health diagnosis not covered under 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 clinical setting. (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)

Objective #7: Increase providers understanding of the value of setting internal goals for advancing program performance outcome evaluation. (Policy Objective)

Objective #8: Support targeted efforts for workforce recruitment and retention initiatives, such as scholarships, loan repayment, and assistance with professional licensure fees, with level of assistance linked to length of service commitment. (Allocation Priority/Criteria 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, provide language access and communication 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)

Objective #6: Explore feasibility of co-locating services in neighborhood community centers to reach underserved and underrepresented populations, including rural areas. (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 building systems that are trauma-informed, family-driven, youth-guided, and culturally responsive. (Policy Objective)

Objective #6: Recognizing alignment with the work of the Community Coalition, Support the goals and objectives of the Illinois Criminal Justice Information Authority "Illinois HEALS (Helping Everyone Access Linked Systems) Action Plan" and support broad based efforts to secure funding as available through Illinois HEALS. (Collaboration/Coordination 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), use and promote 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 planning process to select and implement a model with proven effectiveness engaging youth and families. (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, such as the disABILITY Resource Expo: Reaching Out for Answers, Ebertfest, 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)

Objective #5: Support Mental Health First Aid for Adults and Youth to encourage community members to provide first responder support for people that may be experiencing signs and symptoms of a crisis. (Collaboration/Coordination Objective)

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

Objective #1: Monitor implementation of State Plan amendments, 1115 waiver pilot projects, and Managed Care 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 Consent Decree and Williams 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 (NACHBDD), National Association of Counties (NACo), and like-minded national organizations, to understand trends, best practices, and innovations and to advocate at the federal level. (Collaboration/Coordination Objective)

Objective #4: Monitor State actions to implement terms of the NB vs Norwood Consent Decree to improve access and treatment to children and youth for community based mental health and behavioral health care under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions of the Medicaid Act. (Policy Objective)

Objective #5: Advocate at the state and federal level on the issue of behavioral health and intellectual and developmental disability workforce shortages. (Policy Objective)

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

BRIEFING MEMORANDUM

DATE: March 18, 2020
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Lynn Canfield, Mark Driscoll
SUBJECT: Application Review Process

Background:

Three years ago, the CCMHB instituted a new review process for evaluating agency applications. Minor modifications have been made each year, as we learn which activities require more time or fuller board discussion, such as, alignment of applications to identified priorities, relationships between programs for best coordination and impact, affordability of the final contracts, and contract considerations to be addressed through special provision or negotiation.

During a study session discussion following the PY2020 allocation decision process, Board members considered changing this approach further. One significant result of that discussion was that twenty contracts for agency services were identified as long-standing and were extended by one year, so that fewer would need to submit applications for review this Spring.

Update:

Staff are now reviewing the applications for Program Year 2021 funding and preparing program summaries for each. In 2018 and 2019, discussion of applications was organized by priority, with one booklet of program summaries per priority. This year, the number of applications to be reviewed is decreased due to contracts with a two-year term. In addition, most PY2021 applications are for continuation of current programs, which may streamline review.

As in previous years, board members have been 'assigned' a set of applications to review, as either the primary or secondary reviewer. In this role, each board member leads discussion of specific applications. Some Board questions or concerns may be directed to staff prior to meetings, and others may be posed during the full Board discussion. Staff program summaries will be available to board and public in advance.

Timeline:

April 15 is the deadline for staff program summaries to be made available to the board and public, posted online along with the board packet for the following week's meeting. Paper copies of the board packet will be mailed that afternoon.

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April 22 and April 29 are meetings (or a meeting and a study session) of the CCMHB, with focus on Board review of agency applications, supported by staff program summaries. A regular meeting will include other business and action items.

May 6 is the staff deadline for recommendations to the board about allocations for Program Year 2021. A draft decision memorandum, along with board packet for the following week's study session, will be posted online and paper copies mailed out.

May 13 is a study session of the CCMHB, for board discussion of allocations of funding for Program Year 2021.

May 20 is a regular meeting of the CCMHB, at which the goal is to finalize decisions about allocation of funding for Program Year 2021.

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 and Considerations for 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 helpful to our program summary process and recommendations. The above timeline is intended to support the Board's mission of allocating funds for the benefit of the community, but it may be modified to allow more or less time as needed.

Other considerations:

- A template checklist for (optional) Board use is available (see attached).
- When the 23 program summaries are presented, Board members may have questions for staff or for applicant agency representatives, to be answered as time allows. While Board member questions may be made in writing, any written responses must be brief and in direct response to the Board question.
- It may be helpful to ask agency representatives to attend specific meetings during which their applications are likely to be reviewed.
- The second meeting set aside for Board review is just one week prior to staff deadline for funding recommendations, which may make additional follow-up questions and answers harder to incorporate into that document. As a result, the recommendations memorandum may be revised between the May study session and the May board meeting, or a subsequent board meeting may be required.

CCMHB Application Review Template

Minimal responsiveness:	Y/N	concerns/comments
Are services or supports directly related to mental health, substance use disorder, or I/DD?		
Does the application address how this program will improve the quality of life of those with behavioral health conditions or I/DD?		
Does the application include evidence that other possible funding has been identified and explored and found not available or to have been maximized?		
Does the application provide too much information? Does the application provide enough information? Is the purpose of the funding request clearly stated?		

Priority Categories: check appropriate

Behavioral Health Supports Which Reduce Incarceration __________
Innovative Practices and Access to Behavioral Health Services __________
Systems of Care for Children, Youth, Families __________
Collaboration with CCDDB – Young Children and their Families __________

Overarching Considerations:	Y/N	concerns/comments
Does the program plan narrative reflect CLC work, to engage underserved populations? Does the agency address whether/how rural residents may use the program (if relevant)?		
Inclusion and Anti-Stigma addressed?		
Evidence-based, evidence-informed, recommended, or promising practice/approach?		
Staff qualifications, credentials, specialized training?		
Outcomes?		
Evidence of coordination/collaboration with providers of similar or related services?		
Clear connection between budget and proposed program?		

Other comments:

- Is the amount of funding requested appropriate to the level and type of services to be provided?
- Are there details to be negotiated?
- Is a 2-year award reasonable?

7.D.

Agency and Program acronyms

BBCC – Beyond Blue Champaign County, a program of Crisis Nursery

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

CAC - Children's Advocacy Center

CC – Community Choices

CCCHC – Champaign County Christian Health Center

CCDDB – Champaign County Developmental Disabilities Board

CCHCC – Champaign County Health Care Consumers

CCHS – Champaign County Head Start, a department of the Champaign County 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

CUNC – CU Neighborhood Champions, a program of DMBGC, providing trauma resiliency training and supports to families experiencing or exposed to community violence.

DMBGC - Don Moyer Boys & Girls Club

DSC - Developmental Services Center

ECIRMAC – East Central Illinois Refugee Mutual Assistance Center, also known as The Refugee Center

ECMHS - Early Childhood Mental Health Services, a program of Champaign County Regional Planning Commission Head Start Department

FDC or FD – Family Development Center or simply Family Development, a program of Developmental Services Center

FS - Family Service of Champaign County

FN - Frances Nelson previously known as Frances Nelson Health Center Health Center. The Federally Qualified Health Center operated by Promise Healthcare

MAYC - Mahomet Area Youth Club

PHC – Promise Healthcare

RACES – Rape Advocacy, Counseling, and Education Services

RCI – Rosecrance Central Illinois

RPC – Champaign County Regional Planning Commission

SHC – Self-Help Center, a program of Family Service

UNCC – Urbana Neighborhood Community Connections Center

UP Center – Uniting Pride Center

UW – United Way of Champaign County

YAC – Youth Assessment Center. Screening, Assessment, and Referral 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. A resource best utilized by telephone or text.

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

ATOD – Alcohol, Tobacco and Other Drugs

BJMHS – Brief Jail Mental Health Screen, used by the Champaign County Correctional Facility or jail, to screen adults during the booking process.

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

CHW – Community Health Worker

CILA – Community Integrated Living Arrangement

CIT – Crisis Intervention Team; law enforcement officer trained to respond to calls involving an individual exhibiting behavior 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.

CSPH – Continuum of Service Providers to the Homeless, network of providers and other stakeholders committed to ending homelessness in Champaign County.

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

CY – Contract Year, runs from July to following June. For example CY21 is July 1, 2020 to June 30, 2021. (Also may be referred to as Program Year – PY). Most contracted agencies Fiscal Years are also from July 1 to June 30 and may be interpreted as such when referenced in a Program Summary e.g. FY21

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, may also appear as I/DD Intellectual/ 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 Cohesion 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 the fiscal year is the calendar year. Most agencies are on the state fiscal year that runs July to June. May also be referred to as CY (contract year) or PY (program year).

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.

HUD – federal department of Housing and Urban Development.

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 Information Authority

ID – Intellectual Disability, may also appear as I/DD Intellectual/Developmental 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. The IPLAN is grounded in the core functions of public health and addresses 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

LSI-R:SV – Level of Service – Revised: Short Version. Screening instrument for use within the criminal justice system to determine level of criminogenic risk, needs, responsivity, and service delivery.

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

MCO – Managed Care Organization. Entity under contract with the state to manage healthcare services for persons enrolled in Medicaid.

MCR – Mobile Crisis Response. Previously known as SASS. It is a state program that provides crisis intervention for children, youth, and adults on Medicaid.

MDT – Multi-Disciplinary Team

MH – Mental Health.

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

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

MISA – Co-occurring or dual diagnosis of Mental Illness and Substance Use Disorder

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

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.

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

PEARLS - Program to Encourage Active Rewarding Lives, an evidence-based program available through Family Service's Senior Resource Counseling and Advocacy program

PIT – Point in Time survey to determine the number of persons who are homeless living on the street or in emergency shelters or other temporary housing. The survey is required by HUD and is conducted the end of January.

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.

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.

PWI – Personal Well-being Index

PY – Program Year, runs from July to following June. For example PY21 is July 1, 2020 to June 30, 2021. (Also may be referred to as Contract Year – CY and is often the Agency Fiscal Year)

QCPS – Quarter Cent for Public Safety. May also be referred to as Quarter Cent. These funds support the operation of the Youth Assessment Center.

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. Now referred to as Mobile Crisis Response. Is a state program that provides crisis intervention for children, youth, and adults on Medicaid.

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

SOAR - SSI/SSDI Outreach, Access, and Recovery. Assistance with completing applications for Social Security Disability and Supplemental Income, provided to homeless population

SSPC - Social Skills and Prevention Coaches.

SUD – Substance Use Disorder

TCUDS-V – Texas Christian University Drug Screen, used by the Champaign County Correctional Facility or jail, to screen adults during the booking process.

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.

TPITOS - The Pyramid Infant-Toddler Observation Scale. Used by Champaign County Head Start.

TPOT - Teaching Pyramid Observation Tool. Used by Champaign County Head Start.

TPS – Truce Peace Seekers

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.

9.E.

Cunningham Juvenile Justice Family Program Report
For the CCMHB March 2020 Meeting

We have finalized the name for the program: **'Families Stronger Together'** (FST).

The program currently has 3 staff: the Program Coordinator (.5), a part-time Family Therapist and a part-time Family Support Specialist who would be joining full-time in April as a Therapist. We are in the process of conducting interviews for the other vacant positions.

We have been in contact with Dr. Rachel Liebman who will be conducting the 2 Day ARC Treatment Training in the community. The training will be offered for either the First Day Only (4/23/20) or for Both Days (4/23/20 & 4/24/20. The team also underwent a 4 hour needs assessment consultation with Dr. Liebman last week and have two clinical sessions slated for April. The existing staff is in the process of completing the on-line ARC training, which will enable them to effectively serve clients even before they attend the two day in-person training.

We met with the Youth Assessment Center (YAC) team informing them about the program officially accepting referrals and also consulted with them regarding designing our referral form. YAC and FST staff agreed to streamline the referral process with both program (YAC and FST) staff initially meeting with the family to provide an in-person warm hand-off which will include the assessment.

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

CCMHB 2019-2020 Meeting Schedule

First Wednesday after the third Monday of each month--5:45 p.m.
Brookens Administrative Center
Lyle Shields Room
1776 E. Washington St., Urbana, IL (unless noted otherwise)

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

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

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

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

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

CCDDB 2019-2020 Meeting Schedule

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

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

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

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

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

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

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

June 17, 2020 – Lyle Shields Room (8AM)

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

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

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

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

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

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

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

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

The schedule provides dates and subject matter of meetings of the Champaign County Mental Health Board through June 2020. The subjects are not exclusive to any given meeting, as other matters requiring Board review or action may also be addressed or may replace the subject listed. Study sessions may be scheduled 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 are tentative dates for steps in the funding allocation process for Program Year 2021 (July 1, 2020 – June 30, 2021) and deadlines related to PY2020 agency contracts. **All 2020 meetings are scheduled to begin at 5:45PM; these may be confirmed by contacting Board staff.**

8/30/19	*Agency PY2019 Fourth Quarter and Year End Reports Due*
9/18/19	**Regular Board Meeting** Draft Three Year Plan 2019-2021 with FY20 Objectives
9/25/19	Study Session
10/23/19	**Regular Board Meeting** Draft Program Year 2021 (PY21) Allocation Criteria Community Coalition Summer Initiatives Report
10/25/19	*Agency PY2020 First Quarter Reports Due*
10/28/19	*Agency Independent Audits, Reviews, or Compilations Due*
10/30/19	Study Session
11/20/19	**Regular Board Meeting** Approve Three Year Plan with One Year Objectives Allocation Decision Support – PY21 Allocation Criteria
12/8/19	*Public Notice to be published on or before this date, giving at least 21-day notice of application period.*
12/18/19	**Regular Board Meeting** (tentative)
01/03/20	*CCMHB/CCDDB Online System opens for Agency Registration and Applications for PY21 Funding.*
1/22/20	**Regular Board Meeting** Election of Officers
1/31/20	*Agency PY20 2nd Quarter & CLC Progress Reports due*

2/7/20	*Agency deadline for submission of applications for PY2021 funding. Online system will not accept forms after 4:30PM.*
2/11/20	*List of Requests for PY2021 Funding assembled*
2/19/20	**Regular Board Meeting** Assignment of Board Members to Review Proposals; Mid-year updates on new agency programs
2/26/20	**Study Session** Mid-year updates on new agency programs
3/18/20	**Regular Board Meeting** 2019 Annual Report; Discussion of Liaison Assignments
~~3/25/20~~	**~~Study Session~~ - Cancelled**
4/15/20	*Program summaries released to Board, copies posted online with CCMHB April 22, 2020 meeting agenda*
4/22/20	**Regular Board Meeting** Program Summaries Review and Discussion
4/24/20	*Agency PY2020 3rd Quarter Reports Due*
4/29/20	**Study Session** Program Summaries Review and Discussion
5/6/20	*Allocation recommendations released to Board, copies posted online with CCMHB May 13, 2020 meeting agenda*
5/13/20	**Study Session** Allocation Recommendations
5/20/20	**Regular Board Meeting** Allocation Decisions; Authorize Contracts for PY2021
6/17/20	**Regular Board Meeting**
6/24/20	*PY2021 Contracts completed/First Payment Authorized*
07/15/20	**Regular Board Meeting**– *off cycle and different time* Approve FY2021 Draft Budget
8/28/20	*Agency PY2020 4th Q Reports, CLCP Progress Reports, And Annual Performance Measures Reports due*
09/23/20	**Regular Board Meeting**

10/21/20	**Regular Board Meeting** Draft Three Year Plan 2019-2021 with 2021 Objectives Release Draft Program Year 2022 Allocation Criteria
10/28/20	*Agency Independent Audits, Reviews, or Compilations Due*
10/30/20	*Agency PY2021 First Quarter Reports Due*
11/18/20	**Regular Board Meeting** Approve Three Year Plan with One Year Objectives Allocation Decision Support – PY22 Allocation Criteria
12/11/20	*Public Notice to be published on or before this date, giving at least 21-day notice of application period.*
12/16/20	**Regular Board Meeting - *tentative***

CHAMPAIGN COUNTY MENTAL HEALTH BOARD (CCMHB)
BOARD MEETING

Minutes—February 19, 2020

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

5:45p.m.

MEMBERS PRESENT:	Joseph Omo-Osagie, Elaine Palencia, Kyle Patterson, Julian Rappaport, Jane Sprandel, Kathleen Wirth-Couch, Jon Paul Youakim
STAFF PRESENT:	Lynn Canfield, Mark Driscoll
STAFF EXCUSED:	Stephanie Howard-Gallo, Shandra Summerville, Kim Bowdry, Chris Wilson
OTHERS PRESENT:	Laura Linsday, Courage Connection; Thomas Bates, Lisa Benson CCRPC; Patty Walters, DSC; Natalie Hall, Gail Raney, Rosecrance; Pat Ege, Cunningham; Chris Stohr, GROW; Alison Meanor, NAMI; Claudia Lennhoff, CCHCC; Sara Balgoyen, MAYC.

CALL TO ORDER:

Joseph Omo-Osagie, Board President, called the meeting to order at 5:48 p.m.

ROLL CALL:

Roll call was taken and a quorum was present.

CITIZEN INPUT / PUBLIC PARTICIPATION:

None.

APPROVAL OF AGENDA:

MOTION: Ms. Elaine Palencia moved to approve the agenda. Ms. Jane Sprandel seconded the motion. A voice vote was taken, and the motion was passed.

PRESIDENT'S COMMENTS:

None.

EXECUTIVE DIRECTOR'S COMMENTS:

Announcement of upcoming Expo and Ebertfest activities and film theme (trauma & resiliency). Watching federal legislation related to workforce development, expanded access to behavioral healthcare, and Medicaid and other coverage for those in prisons and jails. Will attend NACO Health Steering Committee and Healthy County meetings and Hill Briefing on healthcare in jails plus NACBHDD legislative and policy conference. Also tracking state legislation which would increase I/DD provider rates.

NEW BUSINESS:

Champaign County Regional Planning Commission Mid-Year Report Presentation:

Coordinator Thomas Bates and Human Services Director Lisa Benson presented on the Homeless Services System Coordination program.

Champaign County Health Care Consumers Mid-Year Report Presentations:

Claudia Lennhoff, Executive Director of CCHCC, presented on two programs, CHW Outreach and Benefit Enrollment and Justice Involved CHW Services and Benefits

PY2021 Applications for Funding:

List of applicants and amounts requested by program was included in the Board packet. Mr. Driscoll gave context. Discussion of board review of applications.

Carle Foundation Property Tax Case Ruling:

A memorandum from the Champaign County Deputy Director of Finance was included in the packet for information only.

Agency Information:

None.

OLD BUSINESS:

Family Model Planning Process:

Written progress report on the work by Cunningham Children's Home to implement the family model was included in the packet for information. Mr. Driscoll shared a handout on the selected model, ARC, and noted that the agency is setting up trainings in this model.

Financial Assurances and Supports:

A Briefing Memorandum on funded agency financial accountability and capacity, copy of Online Registration form completed by agency applicants, and CCMHB Funding Guidelines were included in the packet for information.

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

CCDDB INFORMATION:
Lynn Canfield reported that the CCDDB met this morning with a similar agenda plus an item on the progress of the mini-grant project, with requests for action on specific awards.

APPROVAL OF CCMHB MINUTES:
Minutes from the January 22, 2020 meeting were included in the Board packet.

MOTION: Dr. Julian Rappaport moved to approve the CCMHB minutes from January 22, 2020. Mr. Kyle Patterson seconded the motion. Discussion: add Kathleen Wirth-Couch to list of members present. A voice vote was taken, and the amended motion was passed.

STAFF REPORTS:

Reports from Mark Driscoll, Kim Bowdry. and Shandra Summerville were included in the packet for review. Dr. Rappaport commented that Mr. Driscoll's report is very helpful and in fact the first part of the packet that he reads.

BOARD TO BOARD REPORTS:

Ms. Palencia reported on the most recent meeting of the Champaign County Community Coalition, with listing of school and agency partnerships and CU-Trauma & Resiliency Initiative report on the need for infrastructure to respond to families in crisis; those present were encouraged to attend the Champaign City Council study session on the state grant funded Fresh Start Initiative February 25th.

BOARD ANNOUNCEMENTS:

None.

OTHER BUSINESS – CLOSED SESSION:

MOTION: Mr. Joseph Omo-Osagie moved to go into closed session pursuant to 5 ILCS 120/2(c)(11) to consider litigation which is pending against or on behalf of Champaign County, and litigation that is probable or imminent against or on behalf of Champaign County, and that the following parties remain present: Executive Director Lynn Canfield and Associate Director Mark Driscoll. Mr. Kyle Patterson seconded. A roll

call vote was taken, and the motion passed, and the Board went into closed session at 7:20PM.

The Board came out of closed session at 7:35 p.m.

MOTION: Mr. Kyle Patterson moved to come out of closed session and return to open session. Mr. Joseph Omo-Osagie seconded. A roll call vote was taken, and the motion passed.

ADJOURNMENT:

The meeting adjourned at 7:36p.m.

Respectfully
Submitted by: Lynn Canfield and Mark Driscoll
CCMHB/CCDDB Staff

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

CHAMPAIGN COUNTY MENTAL HEALTH BOARD (CCMHB) STUDY SESSION

Minutes—February 26, 2020

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

5:45p.m.

MEMBERS PRESENT:	Susan Fowler, Joseph Omo-Osagie, Elaine Palencia, Kyle Patterson, Julian Rappaport, Jane Sprandel, Kathleen Wirth-Couch, Jon Paul Youakim
STAFF PRESENT:	Lynn Canfield, Mark Driscoll, Shandra Summerville
STAFF EXCUSED:	Stephanie Howard-Gallo, Kim Bowdry, Chris Wilson
OTHERS PRESENT:	Allison Meanor, NAMI; Jeff Trask, Champaign County Christian Health Center; Gail Raney, Rosecrance; Chris Stohr, GROW in Illinois; Georgiana Schuster, CCDDB and NAMI; Kim Bryan, Rattle the Stars; Joel Fletcher, State's Attorney's Office; Gail Kennedy, CCDDB.

CALL TO ORDER:

Joseph Omo-Osagie, Board President, called the study session to order at 5:50 p.m.

ROLL CALL:

Roll call was taken and a quorum was present.

CITIZEN INPUT / PUBLIC PARTICIPATION:

None.

APPROVAL OF AGENDA:

MOTION: Dr. Susan Fowler moved to approve the agenda. Ms. Jane Sprandel seconded the motion. A voice vote was taken, and the motion was passed.

STUDY SESSION:

Champaign County Christian Health Center – Mental Health Care at CCCHC PY20 Mid-Year Program Report:
CCCHC Director Jeffrey Trask presented on the Mental Health Care program.

NAMI Champaign County PY20 Mid-Year Program Report:
Presentation by Allison Meanor, Director of NAMI Champaign Chapter.

Rattle the Stars – Youth Suicide Prevention Education PY20 Mid-Year Program Report:
Presentation by Kim Bryan, Director of Rattle the Stars.

Rosecrance – Recovery Home PY20 Mid-Year Program Report:
Presentation by Gail Raney, Administrator, Rosecrance Central Illinois.

BOARD ANNOUNCEMENTS:

Mr. Patterson reported that at their recent community board meeting, Rosecrance introduced the new Executive Director, previously at Pavilion and involved with this community.

ADJOURNMENT:

The Study Session adjourned at 7:12 p.m.

Respectfully
Submitted by: Lynn Canfield and Mark Driscoll
CCMHB/CCDDB Staff

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

Special Joint Meeting of the CHAMPAIGN COUNTY MENTAL HEALTH BOARD (CCMHB) and the CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD (CCDDB)

Minutes—February 26, 2020

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

6:45p.m.

MEMBERS PRESENT:	Susan Fowler, Joseph Omo-Osagie, Elaine Palencia, Kyle Patterson, Julian Rappaport, Jane Sprandel, Kathleen Wirth-Couch
STAFF PRESENT:	Lynn Canfield, Mark Driscoll, Shandra Summerville
STAFF EXCUSED:	Stephanie Howard-Gallo, Kim Bowdry, Chris Wilson
OTHERS PRESENT:	Georgiana Schuster, CCDDB; Joel Fletcher, State's Attorney's Office; Gail Kennedy, CCDDB.

CALL TO ORDER:

Joseph Omo-Osagie, Board President, called the special meeting to order at 7:13 p.m.

ROLL CALL:

CCMHB: Roll call was taken and a quorum was present: Susan Fowler, Joseph Omo-Osagie, Elaine Palencia, Kyle Patterson, Julian Rappaport, Jane Sprandel, and Kathleen Wirth-Couch.
CCDDB: Roll call was taken, a quorum was not present: Georgiana Schuster and Gail Kennedy.

CITIZEN INPUT / PUBLIC PARTICIPATION:

None.

APPROVAL OF AGENDA:

MOTION: Ms. Elaine Palencia moved to approve the agenda. Dr. Susan Fowler seconded the motion. A voice vote was taken, and the motion was passed.

BOARD ANNOUNCEMENTS:

None.

OLD BUSINESS – CLOSED SESSION:

MOTION: Mr. Kyle Patterson moved to go into closed session pursuant to 5 ILCS 120/2(c)(11) to consider litigation which is affecting the Champaign County Mental Health Board and the Champaign County Developmental Disabilities Board, and that the following parties remain present: Executive Director Lynn Canfield and Assistant State's Attorney Joel Fletcher and Ms. Georgiana Schuster and Dr. Gail Kennedy. Mr. Joseph Omo-Osagie seconded. Present were: Kyle Patterson, Kathleen Wirth-Couch, Jane Sprandel, Susan Fowler, Elaine Palencia, Julian Rappaport, and Joseph Omo-Osagie. A roll call vote was taken, and the motion passed, and the Board went into closed session at 7:17PM.

The Board came out of closed session at 7:39 p.m.

MOTION: Mr. Joseph Omo-Osagie moved to come out of closed session and return to open session. Ms. Jane Sprandel seconded. Present were: Kathleen Wirth-Couch, Jane Sprandel, Susan Fowler, Elaine Palencia, Julian Rappaport, and Joseph Omo-Osagie. A roll call vote was taken, and the motion passed.

ADJOURNMENT:

The meeting adjourned at 7:40p.m.

Respectfully
Submitted by: Lynn Canfield
CCMHB/CCDDB Staff

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

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

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

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

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

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

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

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

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

I have started reaching out for presenters for upcoming workshops.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Division of Developmental Disabilities

Prioritization of Urgency of Needs for Services (PUNS)

Summary By County and Selection Detail

March 09, 2020

County: Champaign

Item	Count
Reason for PUNS or PUNS Update	**932**
New	47
Annual Update	319
Change of Category (Seeking Service or Planning for Services)	23
Change of Service Needs (more or less) - unchanged category (Seeking Service or Planning for Services)	18
Person is fully served or is not requesting any supports within the next five (5) years	223
Moved to another state, close PUNS	23
Person withdraws, close PUNS	26
Deceased	17
Individual Stayed in ICF/DD	1
Individual Moved to ICF/DD	2
Individual Determined Clinically Ineligible	6
Unable to locate	49
Submitted in error	2
Other, close PUNS	176
CHANGE OF CATEGORY (Seeking Service or Planning for Services)	**433**
PLANNING FOR SERVICES	**151**
EXISTING SUPPORTS AND SERVICES	**388**
Respite Supports (24 Hour)	10
Respite Supports (<24 hour)	13
Behavioral Supports (includes behavioral intervention, therapy and counseling)	148
Physical Therapy	47
Occupational Therapy	104
Speech Therapy	131
Education	181
Assistive Technology	47
Homemaker/Chore Services	6
Adaptions to Home or Vehicle	4
Personal Support under a Home-Based Program, Which Could Be Funded By Developmental Disabilites, Division of Rehabilitation Services or Department on Aging (can include habilitation, personal care, respite, retirement supports, budgeting, etc.)	44
Medical Equipment/Supplies	32
Nursing Services in the Home, Provided Intermittently	4
Other Individual Supports	161
TRANPORTATION	**425**
Transportation (include trip/mileage reimbursement)	118
Other Transportation Service	279
Senior Adult Day Services	1
Developmental Training	87
"Regular Work"/Sheltered Employment	69
Supported Employment	88
Vocational and Educational Programs Funded By the Division of Rehabilitation Services	61
Other Day Supports (e.g. volunteering, community experience)	26
RESIDENTIAL SUPPORTS	**82**
Community Integrated Living Arrangement (CILA)/Family	3
Community Integrated Living Arrangement (CILA)/Intermittent	5
Community Integrated Living Arrangement (CILA)/Host Family	1
Community Integrated Living Arrangement (CILA)/24 Hour	31
Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) 16 or Fewer People	1
Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) 17 or More People	2
Skilled Nursing Facility/Pediatrics (SNF/PED)	5
Supported Living Arrangement	7

Division of Developmental Disabilities

Prioritization of Urgency of Needs for Services (PUNS)

Summary By County and Selection Detail

March 09, 2020

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

Total PUNS: 56,650

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

Division of Developmental Disabilities Prioritization of Urgency of Needs for Services (PUNS)

Summary of Total and Active PUNS by Zip Code

Updated 03/09/20

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

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

Mark Driscoll
Associate Director for Mental Health & Substance Abuse Services

Staff Report – March 18, 2020 Board Meeting

Summary of Activity

PY21 Program Summaries: I have started reading through the full applications and making initial comments and observations on the draft summaries formatted by Lynn. Between the CCMHB and CCDDB, there are over forty applications subject to review. While still a significant number of applications, it is much more manageable than the sixty plus applications we have had to prepare summaries for in the past. The reduced number of applications subject to review by CCMHB can be attributed to the decision last fall to extend the terms through the end of PY21 of twenty current contracts.

CCMHB Annual Report: My contributions to the annual report have been referenced in previous staff reports. Various staff contribute to the final document in one way or another making it a team effort. The final draft of the full report plus the previously approved Three-Year Plan is included in the packet.

Criminal Justice- Mental Health: The Specialty Court Steering Committee, CIT Steering Committee, and the Reentry Council all held meetings the first week of March.

Two important items of note from the Specialty Court Steering Committee: the Administrative Office of the Illinois Courts has certified the Champaign County Drug Court as being in compliance with state standards; and, with Judge Ford's retirement from the bench the end of March, it was announced Judge Randy Rosenbaum will be his permanent replacement.

The CIT Steering Committee was provided data on CIT contacts for 2019 with some comparison to 2017 and 2018 data. Contacts resulting in arrest continue in the range of 5% to 7%. Urbana Police Department continues to meet with Carle Hospital, Rosecrance, and CU At Home regarding the Mobile Crisis Response (MCR) pilot and "one door" behavioral health center. The MCR pilot would have a CIT officer given direct access to a crisis team to respond to the scene during certain shifts. Other announcements included changes to the SNAP (food stamp) eligibility now includes work requirements with some exclusions for persons with a disability while other special populations must submit documentation to qualify for the exclusion. Cunningham Township and others can assist with filing the request for an exclusion. METCAD is updating its address-based premise alert data base. Carle Hospital reported its emergency departments averages 275 to 325 visits a day.

The Reentry Council had a special presentation from Land of Lincoln Legal Aid about a new state funded program they are providing in east central Illinois. It is called "The Fresh Start Project" and provides legal assistance with sealing and expungement of criminal records and also can assist adults reentering the community from jail or prison with housing, credit, or other issues. The program is not affiliated with the Champaign County Community Coalition CU Fresh Start Initiative.

Other Activity: Recap of some monthly meetings attended since my last staff report.

- Community Learning Lab Grant-A-Thon: For the last four year's through the Community Learning Lab, the School of Social Work at the University of Illinois has hosted a day long Grant-A-Thon. The event is billed as giving students an intensive, one-day, hands-on experience in searching for and writing grants for a local community partner. Once again, I was invited to serve on the funders panel to speak about the CCMHB/DDB grant application process.

- Child and Adolescent Local Area Network (LAN): Developmental Services Center was the featured presenter. Covered were adult services as well as those available through the CCMHB funded Family Development Center. Support provided to DSC programs from the CCMHB and CCDDB was mentioned.

- Mental Health Developmental Disabilities Agency Council: The February meeting included a presentation on reaching underserved/undercounted populations as part of the upcoming 2020 Census. The presentation is part of a coordinated effort to engage community partners working with hard to reach populations. Information on the importance of the census and how agencies trusted by traditionally undercounted populations can assist such households with completing the census form was shared with the group. Next months meeting will include a presentation from Life Links, the community mental health center in Coles County on the First Illinois program. Life Links has a contract with the state to provide some services in Champaign County. The Council will hear more about those services and how they can connect clients to them.

- United Way Community Impact Committee (CIC): While the CIC did not meet this month, I am participating on one of the application review panels. My particular panel has been assigned five applications submitted under the "health building block." I have reviewed each of the applications, completed an initial rating as well as prepared some questions for each of the review sessions. The first of the five panel review sessions has been held with the remaining scheduled for the end of the month. I plan to finalize the ratings once the last of panel sessions is completed.

  Let me close by calling your attention to "ALICE in Illinois, A Financial Hardship Study," released March 4, 2020 by United Way of Illinois. ALICE stands for Asset Limited, Income Constrained, Employed. I plan to attend the breakfast meeting United Way of Champaign County is hosting on March 24, 2020, to learn more about the report. The statewide report includes county specific data on the working poor. Attached is the analysis for Champaign County. The full report is here: www.UnitedForAlice.org/Illinois

ALICE IN CHAMPAIGN COUNTY

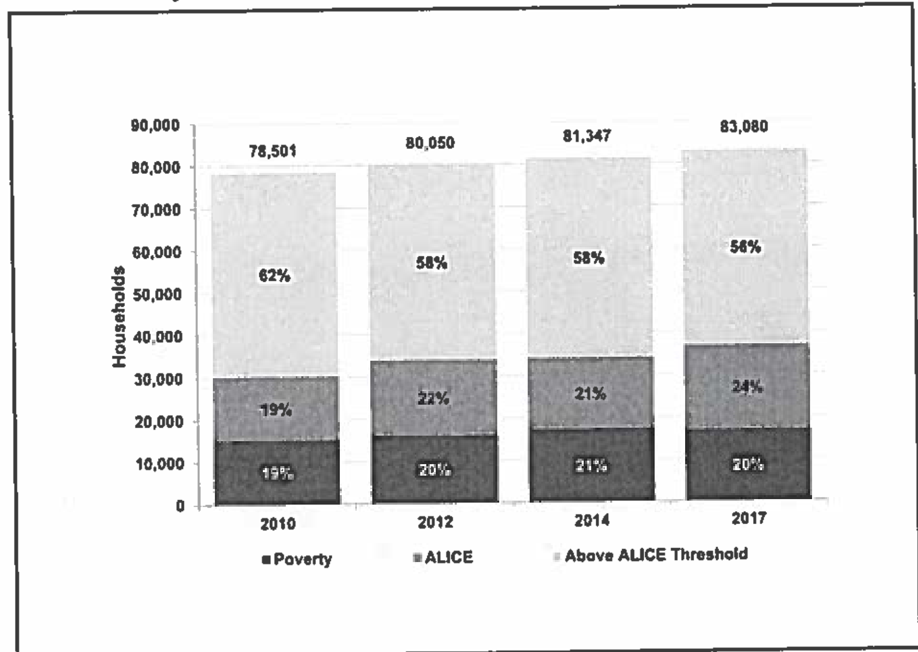
2017 Point-in-Time Data

Population: 209,399 • **Number of Households:** 83,080
Median Household Income: $50,281 (state average: $62,992)
Unemployment Rate: 6.2% (state average: 6.1%)
ALICE Households: 24% (state average: 24%) • **Households in Poverty:** 20% (state average: 12%)

How has the number of ALICE households changed over time?

ALICE is an acronym for Asset Limited, Income Constrained, Employed – households that earn more than the Federal Poverty Level, but less than the basic cost of living for the county (the ALICE Threshold). Combined, the number of ALICE and poverty-level households equals the total population struggling to afford basic needs. The number of households below the ALICE Threshold changes over time; households move in and out of poverty and ALICE status as their circumstances improve or worsen. The recovery, which started in 2010, has been uneven across the state. Conditions have improved for some families, but with rising costs, many still find themselves struggling.

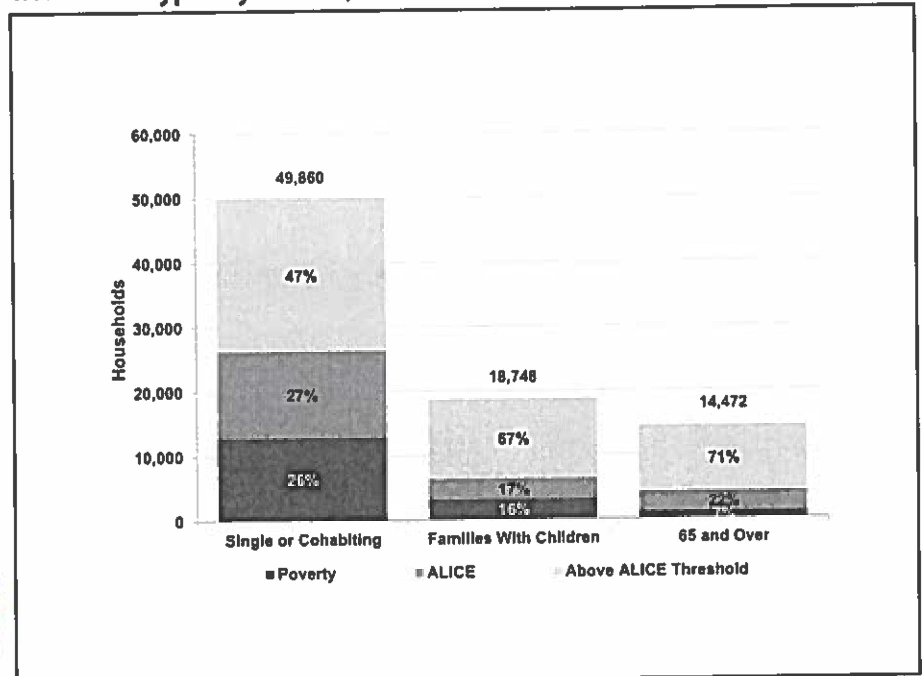
Households by Income, 2010 to 2017



What types of households are struggling?

The way Americans live is changing. There are many different family and living combinations — more than ever before. More adults are living alone, with roommates, or with their parents. Families with children are changing: There are more non-married cohabiting parents, same-sex parents, and blended families with remarried parents. The number of senior households is also increasing. Yet all types of households continue to struggle: ALICE and poverty-level households exist across all of these living arrangements.

Household Types by Income, 2017



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Why do so many households struggle?

The cost of living continues to increase...

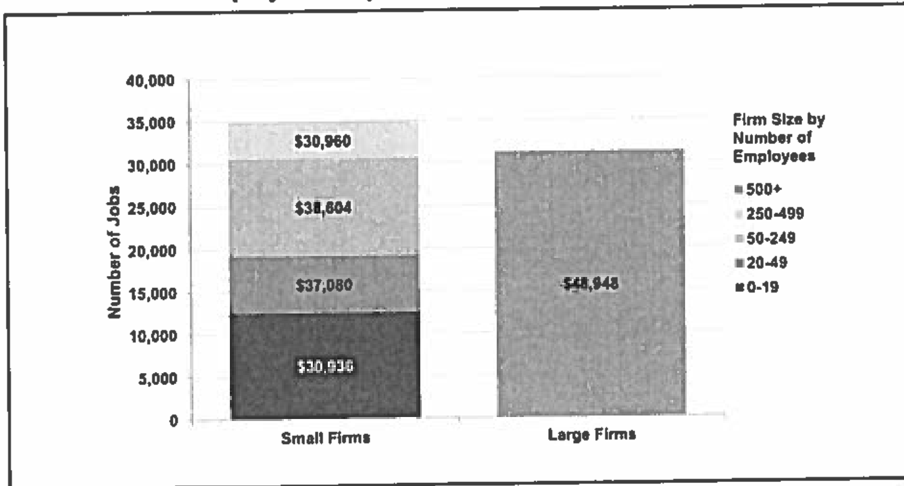
The Household Survival Budget reflects the bare minimum that a household needs to live and work today. It does not include savings for emergencies or future goals like college. In 2017, costs were well above the Federal Poverty Level of $12,060 for a single adult and $24,600 for a family of four. Family costs increased by 28 percent statewide from 2010 to 2017, compared to 12 percent inflation nationally.

Household Survival Budget, Champaign County		
	SINGLE ADULT	2 ADULTS, 1 INFANT, 1 PRESCHOOLER
Monthly Costs		
Housing	$544	$829
Child Care	$–	$1,263
Food	$174	$526
Transportation	$340	$679
Health Care	$162	$689
Technology	$55	$75
Miscellaneous	$150	$458
Taxes	$227	$515
Monthly Total	$1,652	$5,034
ANNUAL TOTAL	$19,824	$60,408
Hourly Wage	*$9.91*	*$30.20*

...and wages lag behind

Employment and wages vary by location; firms generally pay higher wages in areas with a higher cost of living, although those wages still do not always cover basic needs. Employment and wages also vary by firm size: Large firms tend to offer higher wages and more job stability; smaller businesses can account for more jobs overall, especially in rural areas, but may pay less and offer less stability. Medium-size firms pay more but typically employ the fewest workers.

Private-Sector Employment by Firm Size With Average Annual Wages, 2017



Sources: **2017 Point-in-Time Data:** American Community Survey, 2017. **ALICE Demographics:** ALICE Threshold, 2017; American Community Survey, 2017. **Wages:** BLS, 2017. **Budget:** BLS, 2017; Consumer Reports, 2017; HUD, 2017; Illinois Department of Human Services, 2018; IRS, 2017; Tax Foundation, 2017; USDA, 2017.

Champaign County, 2017		
Town	Total HH	% ALICE & Poverty
Bondville	207	47%
Broadlands	150	32%
Champaign	35,590	49%
Fisher	727	37%
Gifford	337	28%
Homer	484	32%
Ivesdale	112	42%
Lake of the Woods CDP	1,056	42%
Ludlow	145	48%
Mahomet	2,943	21%
Ogden	307	33%
Pesotum	210	19%
Philo	544	12%
Rantoul	4,962	49%
Royal	134	28%
Sadorus	150	34%
Savoy	3,492	38%
Seymour CDP	132	60%
Sidney	573	30%
St. Joseph	1,633	30%
Thomasboro	496	41%
Tolono	1,071	24%
Urbana	15,986	59%

Note: Municipal-level data on this page shows 1- or 5-year averages for Incorporated Places. Totals will not match county-level numbers because some places cross county borders, data is not available for the smallest places, and county-level data is often 1-year estimates.

Stephanie Howard-Gallo

Operations and Compliance Coordinator Staff Report –

March 2020 Board Meeting

SUMMARY OF ACTIVITY:

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

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

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

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

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

International Galleries at Lincoln Square in Urbana continues to give AIR artists a space, free of charge, to host monthly artists. I organize the schedule and maintain a relationship with gallery personnel and the artists.

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

We will continue with a new artist/group of artists every month for as long as International Galleries (and owner, Bill Mermelstein) will host us. The gallery does not take any percentage of the artist's sales. Please support this awesome local business by doing some shopping or having custom framing done!

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

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

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

Other:

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

2020 March Monthly Staff Report
Shandra Summerville, Cultural and Linguistic Competence Coordinator

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

Funding Applications FY21:

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

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

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

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

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

CLC Coordinator Direct Service Activities

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

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

Upcoming Trainings:

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

Anti-Stigma Activities/Community Collaborations and Partnerships

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

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

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

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

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

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

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

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

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

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

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

CHAMPAIGN COUNTY

EXPENDITURE APPROVAL LIST

2/12/20

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
*** DEPT NO. 053 MENTAL HEALTH BOARD												
25	CHAMPAIGN COUNTY TREASURER							RENT-GENERAL CORP				
		2/06/20	04	VR	53- 65		604047	2/12/20	090-053-533.50-00	FACILITY/OFFICE RENTALS	FEB OFFICE RENT	1,841.37
											VENDOR TOTAL	1,841.37 *
41	CHAMPAIGN COUNTY TREASURER							HEALTH INSUR FND 620				
		1/27/20	04	VR	620- 4		603769	1/31/20	090-053-513.06-00	EMPLOYEE HEALTH/LIFE INS	JAN HI, LI & ADMIN	3,951.15
											VENDOR TOTAL	3,951.15 *
88	CHAMPAIGN COUNTY TREASURER							I.M.R.F. FUND 088				
		1/27/20	04	VR	88- 1		603773	1/31/20	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 1/3 PR	191.19
		1/27/20	80	VR	88- 50		603773	1/31/20	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 1/3 PR FY19	920.97
		2/04/20	03	VR	88- 2		604051	2/12/20	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 1/17 PR	907.58
		2/07/20	80	VR	88- 51		604052	2/12/20	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 1/17 PR FY19	233.29
		2/04/20	03	VR	88- 4		604052	2/12/20	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 1/31 PR	1,202.36
											VENDOR TOTAL	3,455.39 *
104	CHAMPAIGN COUNTY TREASURER							HEAD START FUND 104				
		2/06/20	04	VR	53- 42		604055	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB EARLY CHILDHD M	17,889.00
		2/06/20	04	VR	53- 42		604055	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB SOC/EMOT DEV SV	7,300.00
											VENDOR TOTAL	25,189.00 *
161	CHAMPAIGN COUNTY TREASURER							REG PLAN COMM FND075				
		2/06/20	04	VR	53- 43		604058	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB HOMELESS COORD	4,464.00
		2/06/20	04	VR	53- 43		604058	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB JUSTICE SYS DIV	6,275.00
		2/06/20	04	VR	53- 43		604058	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB YOUTH ASSMT CTR	6,362.00
											VENDOR TOTAL	17,101.00 *
179	CHAMPAIGN COUNTY TREASURER							CHLD ADVC CTR FND679				
		2/06/20	04	VR	53- 39		604060	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CAC	4,396.00
											VENDOR TOTAL	4,396.00 *

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VENDOR NO	VENDOR NAME / TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH											
188	CHAMPAIGN COUNTY TREASURER						SOCIAL SECUR FUND188				
	1/27/20	04	VR	188- 3		603780	1/31/20	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 1/3 PR	200.09
	1/27/20	80	VR	188- 94		603780	1/31/20	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 1/3 PR FY19	963.79
	2/04/20	03	VR	188- 6		604061	2/12/20	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 1/17 PR	949.81
	2/07/20	80	VR	188- 96		604062	2/12/20	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 1/17 PR FY19	244.15
	2/04/20	03	VR	188- 9		604062	2/12/20	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 1/31 PR	1,258.27
										VENDOR TOTAL	3,616.11 *
4990	ASSN OF COMMUNITY MENTAL HLTH AUTH OF IL % BRIAN EAGAN										
	2/07/20	06	VR	53- 68		604084	2/12/20	090-053-533.93-00	DUES AND LICENSES	INV 1084 1/28 1ST P	8,000.00
										VENDOR TOTAL	8,000.00 *
5780	BP COMPUTER SERVICES										
	1/23/20	92	VR	53- 492		603301	1/24/20	090-053-533.29-00	COMPUTER/INF TCH SERVICES	INV 201907 9/30	250.00
	1/23/20	92	VR	53- 492		603301	1/24/20	090-053-522.44-00	EQUIPMENT LESS THAN $5000	INV 201905 9/30	164.00
	1/23/20	92	VR	53- 492		603301	1/24/20	090-053-522.44-00	EQUIPMENT LESS THAN $5000	INV 201906 9/30	1,434.17
										VENDOR TOTAL	1,848.17 *
8552	BLUE DRAGON SIGNS										
	2/07/20	06	VR	53- 66		604096	2/12/20	090-053-533.98-00	DISABILITY EXPO	INV 1141 2/6	188.35
										VENDOR TOTAL	188.35 *
15123	CHAMPAIGN COUNTY CHAMBER OF COMMERCE										
	1/23/20	02	VR	53- 34		603314	1/24/20	090-053-533.98-00	DISABILITY EXPO	INV 87549 1/2	200.00
										VENDOR TOTAL	200.00 *
15127	CHAMPAIGN COUNTY CHRISTIAN HEALTH CENTER										
	2/04/20	02	VR	53- 40		604108	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB MENTAL HLTH CAR	1,083.00
										VENDOR TOTAL	1,083.00 *
15184	CHAMPAIGN COUNTY HEALTH CARE CONSUMERS						SUITE 208				
	2/04/20	02	VR	53- 41		604110	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CHW OUTRCH/BENF	4,941.00

CHAMPAIGN COUNTY

EXPENDITURE APPROVAL LIST

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VENDOR NO	VENDOR NAME / TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH											
	2/04/20	02	VR	53- 41		604110	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB JUSTICE INVOLVE	4,564.00
										VENDOR TOTAL	9,505.00 *
15400	CHAMPAIGN MULTIMEDIA GRP-MHB 99226307 DBA NEWS GAZETTE										
	1/22/20	90	VR	53- 491		603319	1/24/20	090-053-533.70-00	LEGAL NOTICES,ADVERTISING	303190539 12/8	37.49
	1/22/20	90	VR	53- 491		603319	1/24/20	090-053-533.70-00	LEGAL NOTICES,ADVERTISING	303190946 12/11	37.48
										VENDOR TOTAL	74.97 *
18230	COMMUNITY SERVICE CENTER OF NORTHERN CHAMPAIGN COUNTY										
	2/04/20	02	VR	53- 45		604126	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB RESOURCE CONNEC	5,633.00
										VENDOR TOTAL	5,633.00 *
18430	CONSOLIDATED COMMUNICATIONS										
	1/23/20	02	VR	28- 2		603337	1/24/20	090-053-533.33-00	TELEPHONE SERVICE	21738437760 1/1	30.34
										VENDOR TOTAL	30.34 *
19260	COURAGE CONNECTION										
	2/04/20	02	VR	53- 46		604137	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB COURAGE CONNECT	10,740.00
										VENDOR TOTAL	10,740.00 *
19346	CRISIS NURSERY										
	2/04/20	02	VR	53- 47		604139	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB BEYOND BLUE	6,250.00
										VENDOR TOTAL	6,250.00 *
20271	CUNNINGHAM CHILDREN'S HOME										
	2/06/20	05	VR	53- 48		604140	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB ECHO HOUSING/EM	7,981.00
	2/06/20	05	VR	53- 48		604140	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB PARENTING MODEL	23,412.00
										VENDOR TOTAL	31,393.00 *
22300	DEVELOPMENTAL SERVICES CENTER OF CHAMPAIGN COUNTY INC										
	2/06/20	05	VR	53- 49		604148	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB FAM DEV CENTER	48,262.00
										VENDOR TOTAL	48,262.00 *

CHAMPAIGN COUNTY

EXPENDITURE APPROVAL LIST

2/12/20

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
22730	DON MOYER BOYS & GIRLS CLUB											
		2/06/20	05	VR	53- 50		604152	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CU CHANGE	8,627.00
		2/06/20	05	VR	53- 50		604152	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CU NGHBRHD CHAM	5,393.00
		2/06/20	05	VR	53- 50		604152	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB YOUTH/FAMILY SV	13,333.00
											VENDOR TOTAL	27,353.00 *
22870	DREAAM HOUSE											
		2/07/20	04	VR	53- 13		604157	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	JAN DREAAM	6,666.00
		2/07/20	04	VR	53- 51		604157	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB DREAAM	6,666.00
											VENDOR TOTAL	13,332.00 *
24215	EAST CNTRL IL REFUGEE MUTUAL ASSIST CTR SUITE 4D											
		2/06/20	05	VR	53- 52		604162	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB FAM SUP/STRENGT	4,703.00
											VENDOR TOTAL	4,703.00 *
26000	FAMILY SERVICE OF CHAMPAIGN COUNTY GRANTS											
		2/06/20	05	VR	53- 53		604167	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB COUNSELING	2,500.00
		2/06/20	05	VR	53- 53		604167	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB SELF HELP CENTE	2,369.00
		2/06/20	05	VR	53- 53		604167	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB SENIOR SNSL/ADV	13,529.00
											VENDOR TOTAL	18,398.00 *
26760	FIRST FOLLOWERS											
		2/03/20	90	VR	53- 451		604172	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	DEC PEER MNTR REENT	7,916.00
		2/03/20	02	VR	53- 16		604172	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	JAN PEER MNTR REENT	7,916.00
		2/06/20	05	VR	53- 54		604172	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB PEER MNTR REENT	7,916.00
											VENDOR TOTAL	23,748.00 *
27970	FREDERICK & HAGLE											
		2/07/20	06	VR	53- 70		604174	2/12/20	090-053-533.07-00	PROFESSIONAL SERVICES	7.5HR 1/15-31	1,650.00
											VENDOR TOTAL	1,650.00 *
30550	GROW IN ILLINOIS											
		2/06/20	05	VR	53- 55		604179	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB PEER SUPPORT	6,436.00
											VENDOR TOTAL	6,436.00 *

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												
35050	I3 BROADBAND - CU											
		1/16/20	01	VR	53- 31		603172	1/17/20	090-053-533.29-00	COMPUTER/INF TCH SERVICES	INV 17701571 1/4	144.95
		2/07/20	06	VR	53- 72		604191	2/12/20	090-053-533.29-00	COMPUTER/INF TCH SERVICES	INV 17878551 2/4	144.95
											VENDOR TOTAL	289.90 *
38625	JACK DAVIS GRAPHICS											
		1/15/20	91	VR	53- 489		603181	1/17/20	090-053-533.07-00	PROFESSIONAL SERVICES	CCMHB LOGO AIR 12/3	400.00
											VENDOR TOTAL	400.00 *
44570	MAHOMET AREA YOUTH CLUB											
		2/06/20	05	VR	53- 56		604227	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB BLAST	1,250.00
		2/06/20	05	VR	53- 56		604227	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB MEMBERS MATTER	1,500.00
											VENDOR TOTAL	2,750.00 *
47690	MINUTEMAN PRESS SUITE B											
		2/07/20	06	VR	53- 69		604232	2/12/20	090-053-533.98-00	DISABILITY EXPO	INV 58519 2/3	99.69
											VENDOR TOTAL	99.69 *
49870	NATIONAL ALLIANCE ON MENTAL ILLNESS											
		2/06/20	05	VR	53- 57		604235	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB NAMI CHAMPAIGN	833.00
											VENDOR TOTAL	833.00 *
50106	NATL ASSC OF CNTY BEHAVRL HLTH & DEV DIS SUITE 400											
		1/27/20	05	VR	53- 37		603895	1/31/20	090-053-533.93-00	DUES AND LICENSES	2020 NACBHDD DUES	900.00
											VENDOR TOTAL	900.00 *
54650	PEPSI COLA CHAMPAIGN-URBANA BOTTLING											
		1/15/20	90	VR	53- 490		603201	1/17/20	090-053-522.02-00	OFFICE SUPPLIES	INV 81102953 12/17	25.68
		1/15/20	90	VR	53- 490		603201	1/17/20	090-053-522.02-00	OFFICE SUPPLIES	INV 81103133 12/30	13.12
		2/07/20	06	VR	53- 71		604251	2/12/20	090-053-522.02-00	OFFICE SUPPLIES	INV 81103299 1/13	13.12
		2/07/20	06	VR	53- 71		604251	2/12/20	090-053-522.02-00	OFFICE SUPPLIES	INV 81103451 1/27	32.24
											VENDOR TOTAL	84.16 *

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VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
58118	QUILL CORPORATION											
		1/15/20	01	VR	53- 32		603205	1/17/20	090-053-522.02-00	OFFICE SUPPLIES	INV 3664968 1/2	471.09
		1/15/20	01	VR	53- 32		603205	1/17/20	090-053-522.44-00	EQUIPMENT LESS THAN $5000	INV 3664968 1/2	56.76
		1/15/20	90	VR	53- 486		603205	1/17/20	090-053-522.02-00	OFFICE SUPPLIES	INV 3352461 12/13	96.97
		1/15/20	90	VR	53- 486		603205	1/17/20	090-053-522.02-00	OFFICE SUPPLIES	INV 3368428 12/16	14.98
		1/15/20	90	VR	53- 486		603205	1/17/20	090-053-522.02-00	OFFICE SUPPLIES	INV 3489041 12/19	189.98
		1/27/20	06	VR	53- 36		603907	1/31/20	090-053-522.02-00	OFFICE SUPPLIES	INV 4083755 1/16	49.28
		1/27/20	06	VR	53- 36		603907	1/31/20	090-053-522.02-00	OFFICE SUPPLIES	INV 4086117 1/16	37.58
											VENDOR TOTAL	916.64 *
59434	RAPE, ADVOCACY, COUNSELING & EDUC SRVCS SUITE 211											
		2/06/20	05	VR	53- 59		604263	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB SEX VIOL PREV/E	5,893.00
											VENDOR TOTAL	5,893.00 *
59472	RATTLE THE STARS											
		2/06/20	05	VR	53- 60		604264	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB YTH SUIC PREV/E	4,583.00
											VENDOR TOTAL	4,583.00 *
61780	ROSECRANCE, INC.											
		2/06/20	05	VR	53- 61		604271	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CRIMNL JUSTC PS	25,362.00
		2/06/20	05	VR	53- 61		604271	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CRIS/ACCSS/BENF	16,996.00
		2/06/20	05	VR	53- 61		604271	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB FRESH START	6,609.00
		2/06/20	05	VR	53- 61		604271	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB PREVENTION SVCS	5,000.00
		2/06/20	05	VR	53- 61		604271	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB RECOVERY HOME	16,666.00
		2/06/20	05	VR	53- 61		604271	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB SPECIALTY COURT	16,916.00
											VENDOR TOTAL	87,549.00 *
71050	SURFACE 51 SQUARE 1											
		1/15/20	91	VR	53- 487		603217	1/17/20	090-053-533.07-00	PROFESSIONAL SERVICES	MHDDB LOGO 70% 12/2	2,300.00
											VENDOR TOTAL	2,300.00 *
76867	UNIV OF IL SPONSORED PROG & RESEARCH ADM											
		2/06/20	05	VR	53- 64		604305	2/12/20	090-053-533.07-00	PROFESSIONAL SERVICES	FEB MHB20-039 CONSL	6,566.00
											VENDOR TOTAL	6,566.00 *

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VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
76916	UNIVERSITY OF IL FOUNDATION-EBERTFEST 119 GREGORY, MC462											
		1/23/20	02	VR	53- 33		4545	1/24/20	090-053-533.89-00	PUBLIC RELATIONS	EBERTFEST SPONS FY2	15,000.00
											VENDOR TOTAL	15,000.00 *
77280	UP CENTER OF CHAMPAIGN COUNTY											
		2/06/20	05	VR	53- 62		604308	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB CHLD/YTH/FAM PR	2,647.00
											VENDOR TOTAL	2,647.00 *
78120	URBANA NEIGHBORHOOD CONNECTION CENTER											
		2/06/20	05	VR	53- 63		604311	2/12/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	FEB COMM STUDY CNTR	2,125.00
											VENDOR TOTAL	2,125.00 *
78868	VINEYARD CHURCH											
		2/07/20	06	VR	53- 67		604328	2/12/20	090-053-533.98-00	DISABILITY EXPO	INV 2122 2/5	3,062.50
											VENDOR TOTAL	3,062.50 *
78888	VISA CARDMEMBER SERVICE - MENTAL HEALTH AC#4798510049573930											
		1/23/20	05	VR	53- 35		603443	1/24/20	090-053-533.29-00	COMPUTER/INF TCH SERVICES	3930 MICROSOFT 1/5	198.00
		1/23/20	05	VR	53- 35		603443	1/24/20	090-053-522.02-00	OFFICE SUPPLIES	3930 AMAZON 1/7	17.99
		1/23/20	92	VR	53- 493		603443	1/24/20	090-053-533.95-00	CONFERENCES & TRAINING	3930 NACO 12/11	490.00
		1/23/20	92	VR	53- 493		603443	1/24/20	090-053-522.44-00	EQUIPMENT LESS THAN $5000	3930 AMAZON 12/23	69.99
		1/28/20	01	VR	53- 38		603957	1/31/20	090-053-522.02-00	OFFICE SUPPLIES	3930 AMAZON 1/17	59.98
											VENDOR TOTAL	835.96 *
602572	BOWDRY, KIM MENTAL HEALTH BOARD											
		1/15/20	91	VR	53- 484		603242	1/17/20	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	110.9MILE 11/1-12/1	64.32
		1/15/20	91	VR	53- 484		603242	1/17/20	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	PARKING 11/1-12/17	10.70
											VENDOR TOTAL	75.02 *
604568	CANFIELD, LYNN MENTAL HEALTH BOARD											
		1/15/20	92	VR	53- 485		603246	1/17/20	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	123.5MILE 11/4-12/2	71.63
		1/15/20	92	VR	53- 485		603246	1/17/20	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	PARKING 11/4-12/27	10.25
											VENDOR TOTAL	81.88 *

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VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
615068	GALLAGHER WATKIN, LAURA											
		1/15/20	90	VR	53- 488		603251	1/17/20	090-053-533.18-00	NON-EMPLOYEE TRAINING,SEM	SOCIAL SEC TRG 11/7	500.00
											VENDOR TOTAL	500.00 *
										MENTAL HEALTH BOARD	DEPARTMENT TOTAL	415,869.60 *
										MENTAL HEALTH	FUND TOTAL	415,869.60 *

CHAMPAIGN COUNTY

EXPENDITURE APPROVAL LIST

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VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090	MENTAL HEALTH											
*** DEPT NO. 000	BALANCE SHEET											
108	CHAMPAIGN COUNTY TREASURER								DEV DIS BD FUND 108			
		2/21/20	80	VR	53- 498		605119	2/28/20	090-000-172.00-00	REVENUES	RFND DDB ADMIN FY19	244.16
											VENDOR TOTAL	244.16 *
											BALANCE SHEET TOTAL	244.16 *
*** DEPT NO. 053	MENTAL HEALTH BOARD											
16	CHAMPAIGN COUNTY TREASURER								GENERAL CORP FND 080			
		2/20/20	80	VR	53- 494		604566	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 AUDITOR SERV	5,207.81
		2/20/20	80	VR	53- 494		604566	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 HLTH/LIFE 020	542.40
		2/20/20	80	VR	53- 495		604566	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 AUDITOR SERV	341.85
		2/20/20	80	VR	53- 495		604566	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 HLTH/LIFE 020	35.61
		2/20/20	80	VR	53- 496		604566	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 AUDITOR SERV	1,241.13
		2/20/20	80	VR	53- 496		604566	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 HLTH/LIFE 020	129.27
		2/21/20	80	VR	53- 499		605112	2/28/20	090-053-533.29-00	COMPUTER/INF TCH SERVICES	FY19 COMPUTER SV 09	1,523.69
											VENDOR TOTAL	9,021.76 *
25	CHAMPAIGN COUNTY TREASURER								RENT-GENERAL CORP			
		3/03/20	04	VR	53- 107		605254	3/09/20	090-053-533.50-00	FACILITY/OFFICE RENTALS	MAR OFFICE RENT	1,841.37
											VENDOR TOTAL	1,841.37 *
41	CHAMPAIGN COUNTY TREASURER								HEALTH INSUR FND 620			
		2/21/20	02	VR	620- 26		605113	2/28/20	090-053-513.06-00	EMPLOYEE HEALTH/LIFE INS	FEB HI, LI, & ADMIN	3,951.15
		3/06/20	06	VR	620- 34		605255	3/09/20	090-053-513.06-00	EMPLOYEE HEALTH/LIFE INS	MAR-MAY LIFEWORKS	29.70
											VENDOR TOTAL	3,980.85 *
76	CHAMPAIGN COUNTY TREASURER								TORT IMMUNITY FND076			
		2/20/20	80	VR	53- 494		604570	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 WK COMP 020	31.24
		2/20/20	80	VR	53- 494		604570	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 UNEMP 020	28.81

CHAMPAIGN COUNTY

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VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090	MENTAL HEALTH											
		2/20/20	80	VR	53- 495		604570	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 WK COMP 020	2.05
		2/20/20	80	VR	53- 495		604570	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 UNEMP 020	1.89
		2/20/20	80	VR	53- 496		604570	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 WK COMP 020	7.45
		2/20/20	80	VR	53- 496		604570	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 UNEMP 020	6.87
											VENDOR TOTAL	78.31 *
88	CHAMPAIGN COUNTY TREASURER							I.M.R.F. FUND 088				
		2/20/20	01	VR	88- 5		604572	2/21/20	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 2/14 PR	1,148.05
		2/20/20	80	VR	53- 494		604572	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 IMRF 020	284.54
		2/20/20	80	VR	53- 495		604572	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 IMRF 020	18.68
		2/20/20	80	VR	53- 496		604572	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 IMRF 020	67.81
											VENDOR TOTAL	1,519.08 *
104	CHAMPAIGN COUNTY TREASURER							HEAD START FUND 104				
		3/03/20	04	VR	53- 83		605262	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR EARLY CHILDHD M	17,889.00
		3/03/20	04	VR	53- 83		605262	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR SOC/EMOT DEV SV	7,300.00
											VENDOR TOTAL	25,189.00 *
108	CHAMPAIGN COUNTY TREASURER							DEV DIS BD FUND 108				
		2/21/20	80	VR	53- 497		605119	2/28/20	090-053-571.08-00	TO DEV DISABILITY FUND108	TFR REV SHARE 090	6,504.85
											VENDOR TOTAL	6,504.85 *
161	CHAMPAIGN COUNTY TREASURER							REG PLAN COMM FND075				
		3/03/20	04	VR	53- 84		605265	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR HOMELESS COORD	4,464.00
		3/03/20	04	VR	53- 84		605265	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR JUSTICE SYS DIV	6,275.00
		3/03/20	04	VR	53- 84		605265	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR YOUTH ASSMT CTR	6,362.00
											VENDOR TOTAL	17,101.00 *
176	CHAMPAIGN COUNTY TREASURER							SELF-FUND INS FND476				
		2/18/20	80	VR	118- 178		604576	2/21/20	090-053-533.20-00	INSURANCE	090 PROPRTY INS FY1	429.87
		2/18/20	80	VR	118- 178		604576	2/21/20	090-053-533.20-00	INSURANCE	090 LIAB INS FY19	7,148.81
		2/18/20	01	VR	119- 8		604577	2/21/20	090-053-513.04-00	WORKERS' COMPENSATION INS	WK COMP 1/3,17,31 P	211.33

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												
		2/18/20	80	VR	119- 76		604577	2/21/20	090-053-513.04-00	WORKERS' COMPENSATION INS	WK COMP 1/3,17,31 P	100.71
											VENDOR TOTAL	7,890.72 *
179	CHAMPAIGN COUNTY TREASURER							CHLD ADVC CTR FND679				
		3/03/20	04	VR	53- 80		605268	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR CAC	4,396.00
											VENDOR TOTAL	4,396.00 *
188	CHAMPAIGN COUNTY TREASURER							SOCIAL SECUR FUND188				
		2/20/20	01	VR	188- 12		604580	2/21/20	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 2/14 PR	1,201.46
		2/20/20	80	VR	53- 494		604580	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 FICA 020	367.70
		2/20/20	80	VR	53- 495		604580	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 FICA 020	24.14
		2/20/20	80	VR	53- 496		604580	2/21/20	090-053-533.01-00	AUDIT & ACCOUNTING SERVCS	FY19 FICA 020	87.63
											VENDOR TOTAL	1,680.93 *
1191	ADAMS OUTDOOR ADVERTISING LP											
		3/06/20	08	VR	53- 109		605275	3/09/20	090-053-533.98-00	DISABILITY EXPO	INV 0320053 3/2	700.00
											VENDOR TOTAL	700.00 *
15127	CHAMPAIGN COUNTY CHRISTIAN HEALTH CENTER											
		3/02/20	02	VR	53- 81		605313	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR MENTAL HLTH CAR	1,083.00
											VENDOR TOTAL	1,083.00 *
15184	CHAMPAIGN COUNTY HEALTH CARE CONSUMERS							SUITE 208				
		3/02/20	02	VR	53- 82		605315	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR CHW OUTRCH/BENF	4,941.00
		3/02/20	02	VR	53- 82		605315	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR JUSTICE INVOLVE	4,564.00
											VENDOR TOTAL	9,505.00 *
18230	COMMUNITY SERVICE CENTER OF NORTHERN							CHAMPAIGN COUNTY				
		3/02/20	02	VR	53- 86		605328	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR RESOURCE CONNEC	5,633.00
											VENDOR TOTAL	5,633.00 *
19260	COURAGE CONNECTION											
		3/02/20	02	VR	53- 87		605336	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR COURAGE CONNECT	10,740.00
											VENDOR TOTAL	10,740.00 *

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VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
19346	CRISIS NURSERY											
		3/02/20	02	VR	53- 88		605338	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR BEYOND BLUE	6,250.00
											VENDOR TOTAL	6,250.00 *
20271	CUNNINGHAM CHILDREN'S HOME											
		3/02/20	02	VR	53- 89		605340	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR ECHO HOUSING/EM	7,981.00
		3/02/20	02	VR	53- 89		605340	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR PARENTING MODEL	23,412.00
											VENDOR TOTAL	31,393.00 *
22300	DEVELOPMENTAL SERVICES CENTER OF CHAMPAIGN COUNTY INC											
		3/02/20	02	VR	53- 90		605345	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR FAM DEV CENTER	48,262.00
											VENDOR TOTAL	48,262.00 *
22730	DON MOYER BOYS & GIRLS CLUB											
		3/02/20	02	VR	53- 91		605347	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR CU CHANGE	8,627.00
		3/02/20	02	VR	53- 91		605347	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR CU NGHBRHD CHAM	16,289.00
		3/02/20	02	VR	53- 91		605347	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR YOUTH/FAMILY SV	13,333.00
											VENDOR TOTAL	38,249.00 *
22870	DREAAM HOUSE											
		3/02/20	02	VR	53- 92		605351	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR DREAAM	6,666.00
											VENDOR TOTAL	6,666.00 *
24095	EMK CONSULTING LLC											
		3/02/20	03	VR	53- 78		605355	3/09/20	090-053-533.07-00	PROFESSIONAL SERVICES	INV 375 1/17	1,894.00
											VENDOR TOTAL	1,894.00 *
24215	EAST CNTRL IL REFUGEE MUTUAL ASSIST CTR SUITE 4D											
		3/02/20	02	VR	53- 93		605356	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR FAM SUP/STRENGT	4,703.00
											VENDOR TOTAL	4,703.00 *
26000	FAMILY SERVICE OF CHAMPAIGN COUNTY GRANTS											
		3/02/20	03	VR	53- 94		605364	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR COUNSELING	2,500.00

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VENDOR NO	VENDOR NAME / TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH											
	3/02/20	03	VR	53- 94		605364	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR SELF HELP CENTE	2,369.00
	3/02/20	03	VR	53- 94		605364	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR SENIOR CNSL/ADV	13,529.00
										VENDOR TOTAL	18,398.00 *
26760	FIRST FOLLOWERS										
	3/02/20	03	VR	53- 95		605366	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR PEER MNTR REENT	7,916.00
										VENDOR TOTAL	7,916.00 *
27970	FREDERICK & HAGLE										
	3/06/20	08	VR	53- 111		605368	3/09/20	090-053-533.07-00	PROFESSIONAL SERVICES	1.5HR FEB 3/2	330.00
										VENDOR TOTAL	330.00 *
30550	GROW IN ILLINOIS										
	3/02/20	03	VR	53- 96		605377	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR PEER SUPPORT	6,436.00
										VENDOR TOTAL	6,436.00 *
35050	I3 BROADBAND - CU										
	3/06/20	08	VR	53- 112		605382	3/09/20	090-053-533.29-00	COMPUTER/INF TCH SERVICES	INV 18057251 3/4	144.95
										VENDOR TOTAL	144.95 *
44570	MAHOMET AREA YOUTH CLUB										
	3/02/20	03	VR	53- 97		605409	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR BLAST	1,250.00
	3/02/20	03	VR	53- 97		605409	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR MEMBERS MATTER	1,500.00
										VENDOR TOTAL	2,750.00 *
45436	MARTIN ONE SOURCE										
	3/06/20	08	VR	53- 110		4667	3/09/20	090-053-533.98-00	DISABILITY EXPO	INV 404196 2/27	73.71
	3/06/20	08	VR	53- 110		4667	3/09/20	090-053-533.98-00	DISABILITY EXPO	INV 404220 2/28	372.50
	3/06/20	08	VR	53- 110		4667	3/09/20	090-053-533.98-00	DISABILITY EXPO	INV 404272 3/4	385.00
										VENDOR TOTAL	831.21 *
49870	NATIONAL ALLIANCE ON MENTAL ILLNESS										
	3/02/20	03	VR	53- 98		605414	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR NAMI CHAMPAIGN	833.00
										VENDOR TOTAL	833.00 *

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VENDOR NO	VENDOR NAME / TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH											
54650	PEPSI COLA CHAMPAIGN-URBANA BOTTLING										
	2/27/20	02	VR	53- 79		605177	2/28/20	090-053-522.02-00	OFFICE SUPPLIES	INV 81103632 2/10	13.12
	2/27/20	02	VR	53- 79		605177	2/28/20	090-053-522.02-00	OFFICE SUPPLIES	INV 81103801 2/24	13.12
										VENDOR TOTAL	26.24 *
58118	QUILL CORPORATION										
	3/02/20	03	VR	53- 75		605429	3/09/20	090-053-522.02-00	OFFICE SUPPLIES	INV 4600855 2/6	46.66
	3/02/20	03	VR	53- 75		605429	3/09/20	090-053-533.98-00	DISABILITY EXPO	INV 4600855 2/6	54.99
	3/02/20	03	VR	53- 75		605429	3/09/20	090-053-522.02-00	OFFICE SUPPLIES	INV 4618784 2/7	20.99
	3/02/20	03	VR	53- 75		605429	3/09/20	090-053-522.02-00	OFFICE SUPPLIES	INV 4646623 2/10	21.29
	3/02/20	03	VR	53- 75		605429	3/09/20	090-053-533.98-00	DISABILITY EXPO	INV 4646624 2/10	193.98
										VENDOR TOTAL	337.91 *
59434	RAPE, ADVOCACY, COUNSELING & EDUC SRVCS SUITE 211										
	3/02/20	03	VR	53- 100		605430	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR SEX VIOL PREV/E	5,893.00
										VENDOR TOTAL	5,893.00 *
59472	RATTLE THE STARS										
	3/02/20	03	VR	53- 101		605431	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR YTH SUIC PREV/E	4,583.00
										VENDOR TOTAL	4,583.00 *
61780	ROSECRANCE, INC.										
	3/02/20	03	VR	53- 102		605438	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR CRIMNL JUSTC PS	25,362.00
	3/02/20	03	VR	53- 102		605438	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR CRIS/ACCSS/BENF	16,996.00
	3/02/20	03	VR	53- 102		605438	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR FRESH START	6,609.00
	3/02/20	03	VR	53- 102		605438	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR PREVENTION SVCS	5,000.00
	3/02/20	03	VR	53- 102		605438	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR RECOVERY HOME	16,666.00
	3/02/20	03	VR	53- 102		605438	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR SPECIALTY COURT	16,916.00
										VENDOR TOTAL	87,549.00 *
76609	UNITED WAY OF CHAMPAIGN COUNTY										
	3/02/20	03	VR	53- 106		605466	3/09/20	090-053-533.07-00	PROFESSIONAL SERVICES	3RD QTR 211 PATH SV	4,516.00
										VENDOR TOTAL	4,516.00 *

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VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
76867	UNIV OF IL SPONSORED PROG & RESEARCH ADM											
		3/02/20	03	VR	53- 105		605467	3/09/20	090-053-533.07-00	PROFESSIONAL SERVICES	MAR MHB20-039 CONSL	6,566.00
											VENDOR TOTAL	6,566.00 *
77280	UP CENTER OF CHAMPAIGN COUNTY											
		3/02/20	03	VR	53- 103		605469	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR CHLD/YTH/FAM PR	2,647.00
											VENDOR TOTAL	2,647.00 *
78120	URBANA NEIGHBORHOOD CONNECTION CENTER											
		3/02/20	03	VR	53- 104		605472	3/09/20	090-053-533.92-00	CONTRIBUTIONS & GRANTS	MAR COMM STUDY CNTR	2,125.00
											VENDOR TOTAL	2,125.00 *
78888	VISA CARDMEMBER SERVICE - MENTAL HEALTH AC#4798510049573930											
		2/19/20	06	VR	53- 73		604749	2/21/20	090-053-533.95-00	CONFERENCES & TRAINING	3930 AMERICAN 2/6	735.40
											VENDOR TOTAL	735.40 *
81610	XEROX CORPORATION											
		2/25/20	90	VR	53- 500		605220	2/28/20	090-053-533.85-00	PHOTOCOPY SERVICES	INV 239909084 2/6	285.89
											VENDOR TOTAL	285.89 *
602572	BOWDRY, KIM								MENTAL HEALTH BOARD			
		3/02/20	03	VR	53- 76		605514	3/09/20	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	139 MILE 1/3-2/26	79.93
		3/02/20	03	VR	53- 76		605514	3/09/20	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	PARKING 1/6	2.00
											VENDOR TOTAL	81.93 *
611802	DRISCOLL, MARK								MENTAL HEALTH BOARD			
		3/02/20	01	VR	53- 77		605535	3/09/20	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	203 MILE 1/7-2/25	116.73
											VENDOR TOTAL	116.73 *
										MENTAL HEALTH BOARD	DEPARTMENT TOTAL	397,384.13 *
										MENTAL HEALTH	FUND TOTAL	397,628.29 *

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