CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

Location: Shields-Carter Room, Brookens Administrative Building, 1776 East Washington Street, Urbana, IL 61802
Zoom link: https://us02web.zoom.us/j/81559124557
Date/Time: **March 22, 2023/9:00 AM**

Pursuant to the Governor's Executive Order establishing a pandemic disaster in the State of Illinois that covers the County of Champaign, and the CCDDB President's determination that holding this meeting is not prudent at this time due to health concerns with COVID-19 cases and hospitalizations reported in the County, this meeting will be held remotely, via zoom, with a required representative at the physical meeting location listed above. The public may watch the meeting live through this link or later among archived recordings at https://www.co.champaign.il.us/mhddb/MeetingInfo.php

Champaign County Developmental Disabilities Board (CCDDB) Meeting Agenda

Zoom Link https://us02web.zoom.us/j/81559124557

Meeting ID: 815 5912 4557 1-312-626-6799

I. **Call to order**
II. **Roll call**
III. **Approval of Agenda***
IV. **Citizen Input/Public Participation** *All are welcome to attend the Board's meeting to observe and to offer thoughts during this time. The Chair may limit public participation to 5 minutes per person and/or 20 minutes total.*
V. **Chairperson's Comments – Dr. Anne Robin**
VI. **Executive Director's Comments – Lynn Canfield**
VII. **Approval of CCDDB Board Meeting Minutes** (pages 3 - 5)*
Minutes from the CCDDB's regular board meeting on 2/22/23 regular are included for review and approval. Action is requested.
VIII. **Vendor Invoice List** (page 6)*
Action is requested, to accept the "Vendor Invoice List" and place it on file.
IX. **New Business**
a) **Successes and Other Agency Information**
Providers and self-advocates are invited to report on individuals' successes. The Chair may limit Other Agency Information to 5 minutes per agency and/or total time to 20 minutes.
b) **CCDDB PY24 Funding Application Review** (page 7)
A chart of all PY24 funding requests related to I/DD is attached for information only, to support board discussion of the process. No action is requested.
X. **Old Business**
a) **Analysis of PY2022 I/DD Claims Data** (pages 8-23)

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A briefing memo details how the CCDDB and CCMHB-funded I/DD services were utilized by individual clients during PY2022. The I/DD Utilization Summaries Report is attached. No action is requested.

XI. **CCDDB and CCMHB Schedules and CCDDB Timelines** (pages 24-27)
No action is needed.

XII. **CCDDB Acronyms and Glossary** (pages 28-35)
No action is needed.

XIII. **Champaign County Mental Health Board Input**

XIV. **Staff Reports** (pages 36-66)
For information only is a memo from Lynn Canfield. Other staff reports are deferred due to focus on application review.

XV. **Board Announcements**

XVI. **Other Business - Review of Closed Session Minutes**
Board staff and attorneys request that the Board continue to maintain as closed the minutes of closed session held 2/19/2020, which have been distributed for review. If discussion is needed, the Board may move to "move the Board to an executive session, exception 5 ILCS 120/2(c)(11) of the Open Meetings Act, to review status of minutes of prior closed session meetings, and that the following individuals remain present: members of the Champaign County Developmental Disabilities Board, Executive Director Canfield, and Operations and Compliance Coordinator Howard-Gallo." When closed session discussion finishes, a motion to return to Open Session and roll call will be needed, followed by this recommended action: "motion to accept the closed session minutes as presented (or as revised) and to continue maintaining them as closed."

XVII. **Adjournment**

** Board action is requested.*

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

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

Minutes February 22, 2023

This meeting was held with representation at the Brookens Administrative Center and with remote access via Zoom.

9:00 a.m.

MEMBERS PRESENT:	Anne Robin, Kim Fisher, Deb Ruesch,Vicki Niswander
MEMBERS EXCUSED:	Georgiana Schuster
STAFF PRESENT:	Kim Bowdry, Leon Bryson, Lynn Canfield, Stephanie Howard-Gallo, Chris Wilson
OTHERS PRESENT:	Vickie Tolf, Sarah Perry, Jami Olsen, Annette Becherer, Laura Bennett, Patty Walters, Nicole Smith, Heather Levingston, Danielle Matthews, DSC; Mel Liong, PACE; Becca Obuchowski, Hannah Sheets, Community Choices; Brenda Eakins, GROW; Angela Yost, Jessica McCann, Jodi McGhee, CCRPC; Allison Jones, Citizen; Annie Bruno, The Autism Project; Leah Taylor, Champaign County Board

CALL TO ORDER:

Dr. Robin called the meeting to order at 9:00 a.m.

ROLL CALL:

Roll call was taken and a quorum was present.

APPROVAL OF AGENDA:

The agenda was in the packet for review and approved by a unanimous vote.

CITIZEN INPUT/PUBLIC PARTICIPATION:

None. (Citizen input was allowed again later in the meeting.)

PRESIDENT'S COMMENTS:

Leah Taylor was introduced as the new County Board representative to the CCDDB. Dr. Robin reviewed the meeting schedule in the coming months. In May 2023, in-person meetings may be required.

EXECUTIVE DIRECTOR'S COMMENTS:

No comments.

(Citizen Input) Allison Jones (a family member) spoke regarding the lack of services in our community for older developmentally disabled people.

APPROVAL OF MINUTES:

Minutes from the 1/18/2023 board meeting were included in the packet.

MOTION: Dr. Fisher moved to approve the minutes from the 1/18/23 CCDDB meeting. Ms. Ruesch seconded the motion. A roll call vote was taken. The motion passed.

VENDOR INVOICE LIST:

The Vendor Invoice List was included in the Board packet.

MOTION: Ms. Ruesch moved to accept the Vendor Invoice List as presented in the packet. Ms. Niswander seconded the motion. A roll call vote was taken and the motion passed unanimously.

NEW BUSINESS:

Successes and Other Agency Information:
Updates/successes were provided by Annette Becherer from DSC, Becca Obuchowski from Community Choices, Brenda Eakins form GROW, and Mel Liong from PACE.

CCDDB Application Review Process:
A briefing memorandum detailed the CCDDB Application Review process, including the timeline. A suggested review checklist for board members' use and a chart of all PY24 funding requests related to I/DD were attached for information only, to support board discussion of the process. Director Canfield reported all DD agencies submitted their funding applications by the deadline.

Risks of Loss Noted in Funding Requirements and Contracts:

A briefing memorandum offered background on those funding requirements which relate to potential loss of funds.

(Citizen Input) Nancy Uchtmann called the CCMHB/CCDDB office phone to participate in "citizen input" regarding the lack of services in Champaign County for developmentally disabled older adults.

OLD BUSINESS:

Agency PY2023 2nd Quarter Service Data Charts:
2nd quarter data charts were included in the board packet for information only.

PY2023 2nd Quarter Service Activity Reports:
2nd Quarter service hours and activities reports were included for information.

211 Quarterly Reports:
October through December 2022 reports for 211 calls for Champaign County were included in the board packet for information only.

CCDDB and CCMHB Schedules and CCDDB Timelines:
Updated copies of CCDDB and CCMHB meeting schedules and CCDDB allocation timelines were included in the packet.

Acronyms and Glossary:
A list of commonly used acronyms was included for information.

CCMHB Input:
The CCMHB will meet this evening. The CCMHB will have a presentation from Rosecrance on a newly funded CCMHB program.

Staff Reports:
Staff Reports from Kim Bowdry, Leon Bryson, and Shandra Summerville were included in the Board packet.

BOARD ANNOUNCEMENTS:

None.

ADJOURNMENT:

The meeting adjourned at 10:20 a.m.
Respectfully Submitted by: Stephanie Howard-Gallo
**Minutes are in draft form and are subject to CCDDB approval.*

Champaign County, IL

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
1 CHAMPAIGN COUNTY TREASURER									
2023 CILA Contrib		01/01/2023	020323A	15088	50,000.00	01/31/2023	INV	PD	2023 CILA Contrib
Feb'23 DD23-078		02/01/2023	020323A	15081	32,355.00	02/28/2023	INV	PD	DD23-078 Decision Support
Feb'23 DDB Admin Fee		02/01/2023	022423A	15957	33,926.00	02/28/2023	INV	PD	Feb'23 DDB Admin Fee
Jan'23 DDB Admin Fee		01/01/2023	022423A	15956	33,926.00	01/31/2023	INV	PD	Jan'23 DDB Admin Fee
					150,207.00				
10146 COMMUNITY CHOICES, INC									
Feb'23 DD23-075		02/01/2023	020323A	15142	14,250.00	02/28/2023	INV	PD	DD23-075 Self-Determinati
Feb'23 DD23-090		02/01/2023	020323A	15142	17,170.00	02/28/2023	INV	PD	DD23-090 Inclusive Commun
Feb;23 DD23-095		02/01/2023	020323A	15142	18,125.00	02/28/2023	INV	PD	DD23-095 Customized Emplo
Jan'23 DD23-075		01/01/2023	020323A	15142	14,250.00	01/31/2023	INV	PD	DD23-075 Self-Determinati
Jan'23 DD23-090		01/01/2023	020323A	15142	17,170.00	01/31/2023	INV	PD	DD23-090 Inclusive Commun
Jan'23 DD23-095		01/01/2023	020323A	15142	18,125.00	01/31/2023	INV	PD	DD23-095 Customized Emplo
					99,090.00				
10170 DEVELOPMENTAL SERVICES CENTER OF									
Feb'23 DD23-080		02/01/2023	020323A	15150	32,500.00	02/28/2023	INV	PD	DD23-080 Individual and F
Feb'23 DD23-081		02/01/2023	020323A	15150	44,666.00	02/28/2023	INV	PD	DD23-081 Community Living
Feb'23 DD23-082		02/01/2023	020323A	15150	70,638.00	02/28/2023	INV	PD	DD23-082 Community First
Feb'23 DD23-083		02/01/2023	020323A	15150	39,000.00	02/28/2023	INV	PD	DD23-083 Service Coordina
Feb'23 DD23-084		02/01/2023	020323A	15150	15,333.00	02/28/2023	INV	PD	DD23-084 Clinical Service
Feb'23 DD23-085		02/01/2023	020323A	15150	7,083.00	02/28/2023	INV	PD	DD23-085 Employment First
Feb'23 DD23-086		02/01/2023	020323A	15150	18,958.00	02/28/2023	INV	PD	DD23-086 Workforce Develo
Feb'23 DD23-091		02/01/2023	020323A	15150	36,250.00	02/28/2023	INV	PD	DD23-091 Community Employ
Feb'23 DD23-092		02/01/2023	020323A	15150	7,916.00	02/28/2023	INV	PD	DD23-092 Connections
Jan'23 DD23-082		02/01/2023	020323A	15150	70,638.00	02/28/2023	INV	PD	DD23-082 Community First
					342,982.00				
10424 PERSONS ASSUMING CONTROL OF THEIR ENVIRONMENT INC.									
Jan'23 DD23-079		01/01/2023	022423A	16030	2,280.00	01/31/2023	INV	PD	DD23-079 Consumer Control
					2,280.00				
21 INVOICES					594,559.00				

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

CCDDB and CCMHB I/DD Funding Requests for PY2024

July 1, 2023 thru June 30, 2024

Agency	Program Name	Current Awards PY23 DDB Award	PY23 DDB Amended	PY23 MHB	Requests PY24 DDB/MHB	% change	Reviewer
Priority: Self-Advocacy							
CU Autism Network	Community Outreach Program (funded PY22, not PY	-	n/a		**$79,132**	n/a	KF/GS
CU Autism Network	CUAN Planning Seed Grant NEW	-	n/a		**$65,217**	n/a	DR/GS
Priority: Linkage and Coordination							
CCRPC - Community Services	Decision Support PCP	**$388,271**	**$370,388**		**$433,777**	17%	DR/GS
DSC	Service Coordination	**$468,000**	n/a		**$496,080**	6%	GS/AR
Priority: Home Life							
Community Choices, Inc.	Inclusive Community Support (formerly Community L	**$203,000**	**$193,874**		**$198,000**	2%	DR/KF
DSC	Community Living (formerly Apartment Services)	**$536,000**	n/a		**$565,480**	6%	KF/VN
Priority: Personal Life							
Community Choices, Inc.	Transportation Support NEW	-	-		**$119,500**	n/a	VN/DR
DSC	Clinical Services	**$184,000**	n/a		**$241,000**	31%	VN/AR
DSC	Individual & Family Support	**$390,000**	n/a		**$250,000**	-36%	AR/VN
PACE	Consumer Control in Personal Support	**$27,367**	n/a		**$36,000**	32%	GS/KF
Priority: Work Life							
Community Choices, Inc.	Customized Employment	**$217,500**	n/a		**$226,500**	4%	DR/VN
DSC	Community Employment	**$435,000**	n/a		**$459,606**	6%	KF/AR
DSC/Community Choices	Employment First	**$85,000**	n/a		**$90,100**	6%	VN/GS
Priority: Community Life							
Community Choices, Inc.	Self-Determination Support	**$171,000**	n/a		**$176,500**	3%	AR/DR
DSC	Community First	**$847,658**	n/a		**$890,042**	5%	GS/KF
DSC	Connections	**$95,000**	n/a		**$106,400**	12%	KF/VN
Priority: Strengthening the I/DD Workforce							
Community Choices	Staff Recruitment and Retention NEW	-	-		**$34,000**	n/a	DR/AR
DSC	Workforce Development and Retention	**$227,500**	n/a		**$227,500**	n/a	multiyear
Priority: Young Children and their Families (CCMHB focus)							
DSC	Family Development		n/a	**$596,522**	**$656,174**	MHB Requ	KF/AR
CC Head Start/Early Head Start	Early Childhood Mental Health Svs (MH & DD)						
	(the amount here is dedicated to DD)		n/a	**$149,666**	**$149,666**		multiyear
	TOTAL	**$4,275,296**		**$746,188**	**$5,500,674**		
		total PY2023 = $5,021,484			*total PY24 requests, to both boards & inc multi year*		

Briefing Memorandum

DATE: March 22, 2023
TO: Members, Champaign County Developmental Disabilities Board (CCDDB) and Champaign County Mental Health Board (CCMHB)
FROM: Kim Bowdry, Associate Director for I/DD
SUBJECT: Program Year 2022 Service Activity Data

Background

In PY2018, CCDDB staff implemented a new data collection system for programs serving people with I/DD. Each year after this implementation, agencies have continued providing a higher level of detail about client specific service activities than prior to PY2018.

At the request of a CCDDB member, reporting categories were changed prior to PY2021. These new categories were meant to provide details on a client's presence with staff during the time entered as a claim and where the service activity took place. These new claims were entered as 'With Person Served' or 'On Behalf of Person Served.' Either of the new claims options could be used with one of the following new place options, 'Off Site (in the community or client home)' or 'On Site (at an agency facility)'. The units of service were changed from quarter hours to full hours during PY2021 and remain that way currently. While full hours of service may give an appearance of over service in some cases, it still allows to get closer to a more accurate description of service and takes some pressure off staff who are responsible for reporting and gives a much clearer description of the hours and types of services provided than before PY2018.

Some programs showing discrepancies in numbers reported in the 'Utilization Summaries for PY2022 CCDDB and CCMHB I/DD Programs' and totals listed below may not enter claims for all Treatment Plan Clients (TPCs) due to the nature of the service provided. Other programs serve a significant number of Non-Treatment Plan Clients (NTPCs), who benefit indirectly from CCDDB funded programs.

CCDDB Funded Program Information:

'Utilization Summaries for PY2022 CCDDB and CCMHB I/DD Programs' is attached for reference. This document was included in the October 19, 2022 CCDDB packet. Programs listed below reported service activity data for specific people served. PY2022 totals are listed by program.

CCRPC

- Decision Support Person Centered Planning served 308 people for a total of 3,600 hours, with total payments of $311,489.

Community Choices

- Community Living served 28 people for a total of 1,615 hours, with total payments of $164,069.
- Community Employment served 41 people for a total of 2,424 hours, with total payments of $201,000.

DSC

- Clinical Services served 65 people for a total of 1,399 hours, with total payments of $151,263.
- Community Employment served 70 people for a total of 4,282.75 hours, with total payments of $361,370.
- Community First served 44 people for a total of 19,596 hours, with total payments of $847,659.
- Community Living served 49 people for a total of 8,791.50 hours, with total payments of $444,219.
- Connections served 29 people for a total of 4,922 hours, with total payments of $85,000.
- Individual and Family Support served 39 people for a total of 8,535.25 hours, with total payments of $374,548.

- Service Coordination served 243 people for a total of 6,235.25 hours, with total payments of $435,858.

PACE

- Consumer Control in Personal Support registered 29 PSWs, with total audited payments of $22,730. The program also matched 8 Personal Support Workers (PSWs) to people with I/DD seeking PSWs.

Rosecrance

- Coordination of Services: DD/MI served 20 people for a total of 391 hours, with total payments of $8,787.50. This contract was terminated at the request of the agency on September 30, 2021.

As in past years, some programs did not report client level data as claims in the Online Reporting System. These programs, including support groups and another, are listed below. One program serves a significant number of Non-Treatment Plan Clients and does not report client level data on these services. For the programs below, this information can be found in the attached 'Utilization Summaries for PY2022 CCDDB and CCMHB I/DD Programs' document.

Champaign Urbana Autism Network

- Community Outreach Programs, $38,000

Community Choices

- Self-Determination Support, $160,251

DSC

- Employment First, $80,000

Programs and People with Service Level Data

- Of the programs reporting on specific individuals and service activities, we learn that there were **504 unduplicated adults or older children** and **897 young children.** Five children received some support from both DSC Family Development and CCRPC Head Start/Early Head Start Early Childhood Mental Health Services. Only 2 of the 5 children had a slight overlap in those supports.
- Of the unduplicated adults and older children served during PY2022, **26% had state waiver funding as well.**
- Of the unduplicated adults and older children served during PY2022, **74% had DDB/MHB funding only**.
- An individual may receive services from more than one agency and more than one program within a single agency. All adult TPCs in CCDDB funded programs should also be enrolled in CCRPC's Decision Support PCP program, receiving Conflict Free Case Management, or be enrolled in Medicaid waiver funded services. There was no overlap of adults or older children served between agencies with similar programs.
    - 352 people were served by **one agency only**;
    - 150 people were served by two agencies; and
    - 2 people were served by three agencies.

    - 307 people were served in **one program only**;
    - 94 people were served in two programs;
    - 50 people were served in three programs;
    - 26 people were served in four programs;
    - 17 people were served in five programs;
    - 9 people were served in six programs; and
    - 1 person was served in seven programs.

Profiles of People Receiving Services from Multiple Programs

Involvement with multiple agencies and multiple programs is often appropriate for each individual person's service needs and preferences. The need or preference for multiple agencies and/or program involvement should be documented in each person's person-centered plan. Below is a summary of agency and program involvement during PY2022.

- Of the **2 people served by three agencies**:
  - Both were served by CCRPC Decision Support PCP, Community Choices, and DSC. One person was closed from programs at Community Choices and DSC during PY22.

- One person served in **seven programs** was served by CCRPC Decision Support PCP, DSC Clinical, Community Employment, Community First, Community Living, Connections, and Service Coordination with CCDDB funding only.

- Of the **9 people served in six programs**:
  - 6 people were served by CCRPC Decision Support PCP and DSC Clinical Services, Community First, Community Living, Connections, and Service Coordination, with CCDDB funding only; 1 person transitioned to Home Based Support during the 4th Quarter of PY22; 1 person was closed from all DSC programs during the 4th Quarter of PY22;
  - 1 person was served by CCRPC Decision Support PCP and DSC Clinical, Community Employment, Community Living, Individual and Family Support, and Service Coordination, with CCDDB funding only; and
  - 2 people served by CCRPC Decision Support PCP, DSC Community Employment, Community First, Community Living, Connections, and Service Coordination.

- Of the **17 people served in five programs**:
  - 17 had CCDDB funding only;
  - 17 were served by CCRPC Decision Support PCP;
  - 5 were also served by DSC Community Employment, Community First, Connections, and Service Coordination;
  - 6 were also served by DSC Community First, Community Living, Connections, and Service Coordination;
  - 2 were also served by DSC Clinical, Community First, Connections, and Service Coordination;
  - 2 were also served by DSC Clinical, Community Employment, Community Living, and Service Coordination;
  - 1 was also served by DSC Community Employment, Community Living, Individual and Family Support, and Service Coordination; and
  - 1 was also served by DSC Community Employment, Community First, Community Living, and Service Coordination.

Samples of Total Hours of Services by Program

Client level data can be found below. This data exhibits how people with I/DD in Champaign County utilized the programs funded by the CCDDB for PY2022.

- Person A participated in **7 programs, 2 agencies**:
  - 41 hours of service from CCRPC Decision Support PCP, 1% of total program hours;
  - 15 hours of service from DSC Clinical Services, 1% of total program hours;
  - 40 hours of service from DSC Community Employment, 1% of total program hours;
  - 11 hours of service from DSC Community First, <1% of total program hours;
  - 275 hours of service from DSC Community Living, 3% of total program hours;
  - 6 hours of service from DSC Connections, <1% of total program hours; and

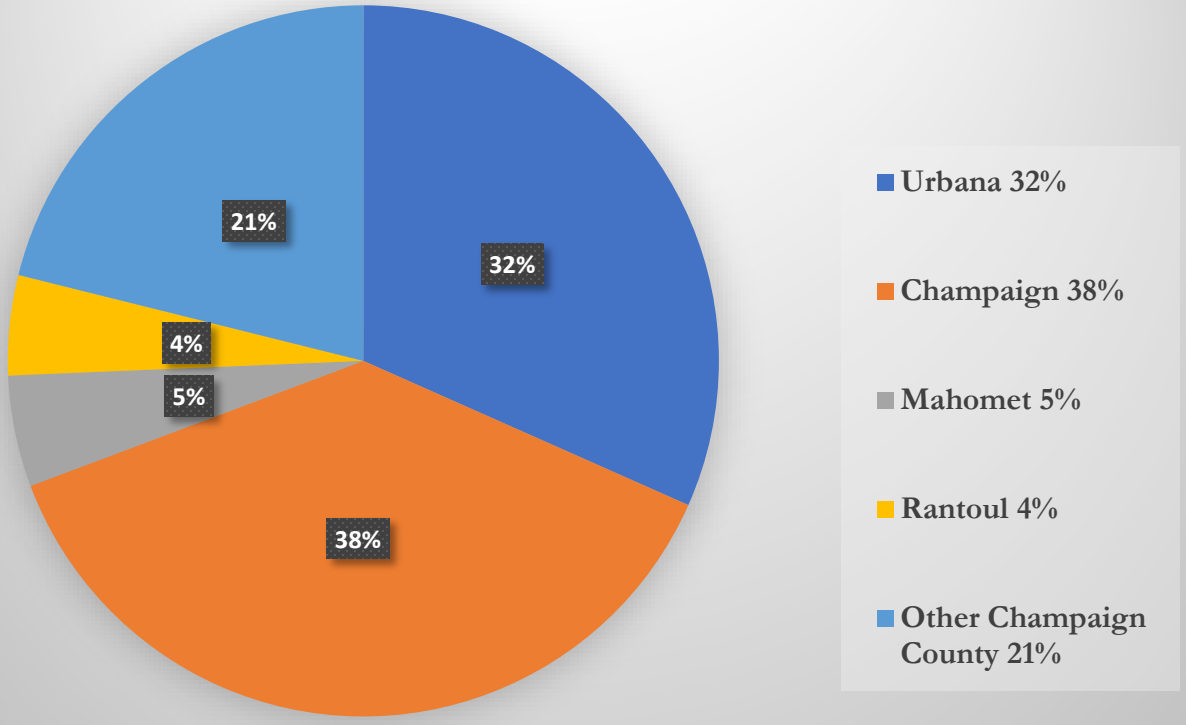
- 25 hours of service from DSC Service Coordination, <1% of total program hours.

- Person B participated in **6 programs, 2 agencies**:
  - 61 hours of service from CCRPC Decision Support PCP, 2% of total program hours;
  - 38 hours of service from DSC Clinical Services, 3% of total program hours;
  - 1,394 hours of service from DSC Community First, 7% of total program hours;
  - 284 hours of service from DSC Community Living, 3% of total program hours;
  - 163.25 hours of service from DSC Connections, 3% of total program hours; and
  - 45 hours of service from DSC Service Coordination, 1% of total program hours.
- Person C participated in **5 programs, 2 agencies**:
  - 24 hours of service from CCRPC Decision Support PCP, 1% of total program hours;
  - 99 hours of service from DSC Community First, 1% of total program hours;
  - 215 hours of service from DSC Community Living, 2% of total program hours;
  - 122.25 hours of service from DSC Connections, 2% of total program hours; and
  - 24 hours of service from DSC Service Coordination, <1% of total program hours.
  - This person also receives services through IDHS-DDD Home Based Services program.
- Person D participated in **3 programs, 2 agencies**:
  - 1 hour of service from CCRPC Decision Support PCP, <1% of total program hours;
  - 104 hours of service from Community Choices Community Living, 6% of total program hours; and
  - 138 hours of service from Community Choices Customized Employment, 6% of total program hours.
- Person E participated in **2 programs, 2 agencies**:
  - 31 hours of service from DSC Service Coordination, <1% of total program hours and
  - 3 hours of service from PACE Consumer Control in Personal Support. This person successfully matched with PSW's from the PACE registry three times during PY22.
  - This person also receives services through IDHS-DDD Home Based Services program.
- Person F participated in **4 programs, 2 agencies**:
  - 7 hours of service from CCRPC Decision Support PCP, <1% of total program hours;
  - 99 hours of service from DSC Community Employment, 1% of total program hours;
  - 72 hours of service from DSC Community Living, 7% of total program hours; and
  - 59 hours of service from DSC Service Coordination, 1% of total program hours.

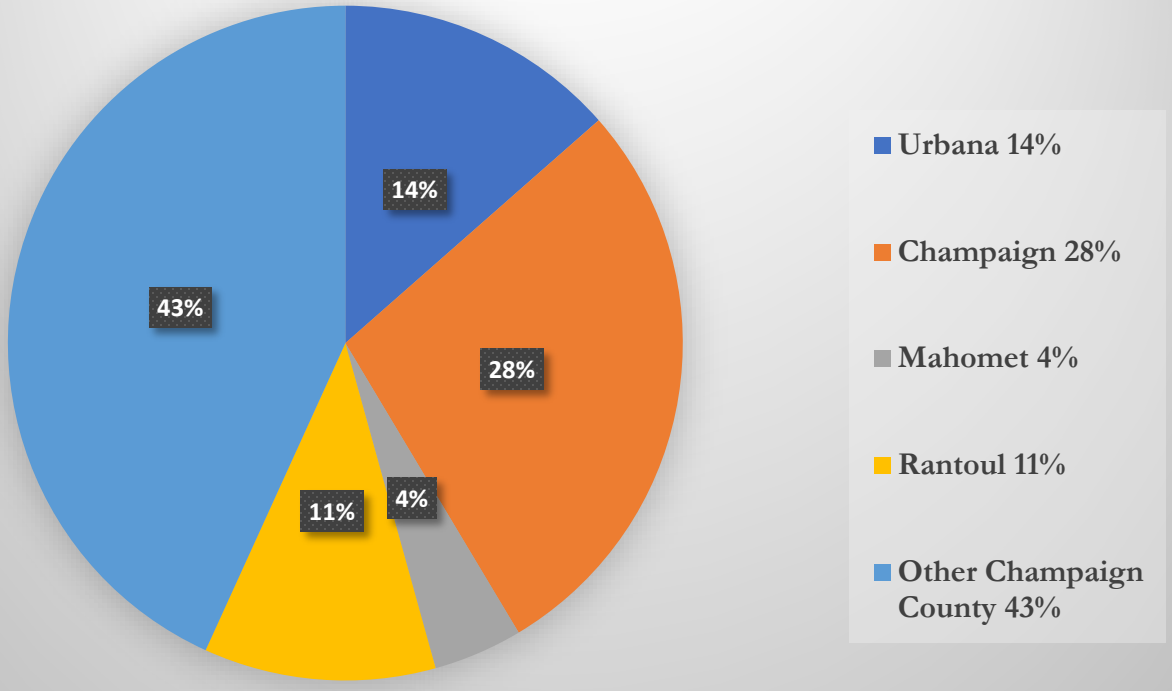
Characteristics of People Served through CCDDB and CCMHB I/DD Funding for PY2022

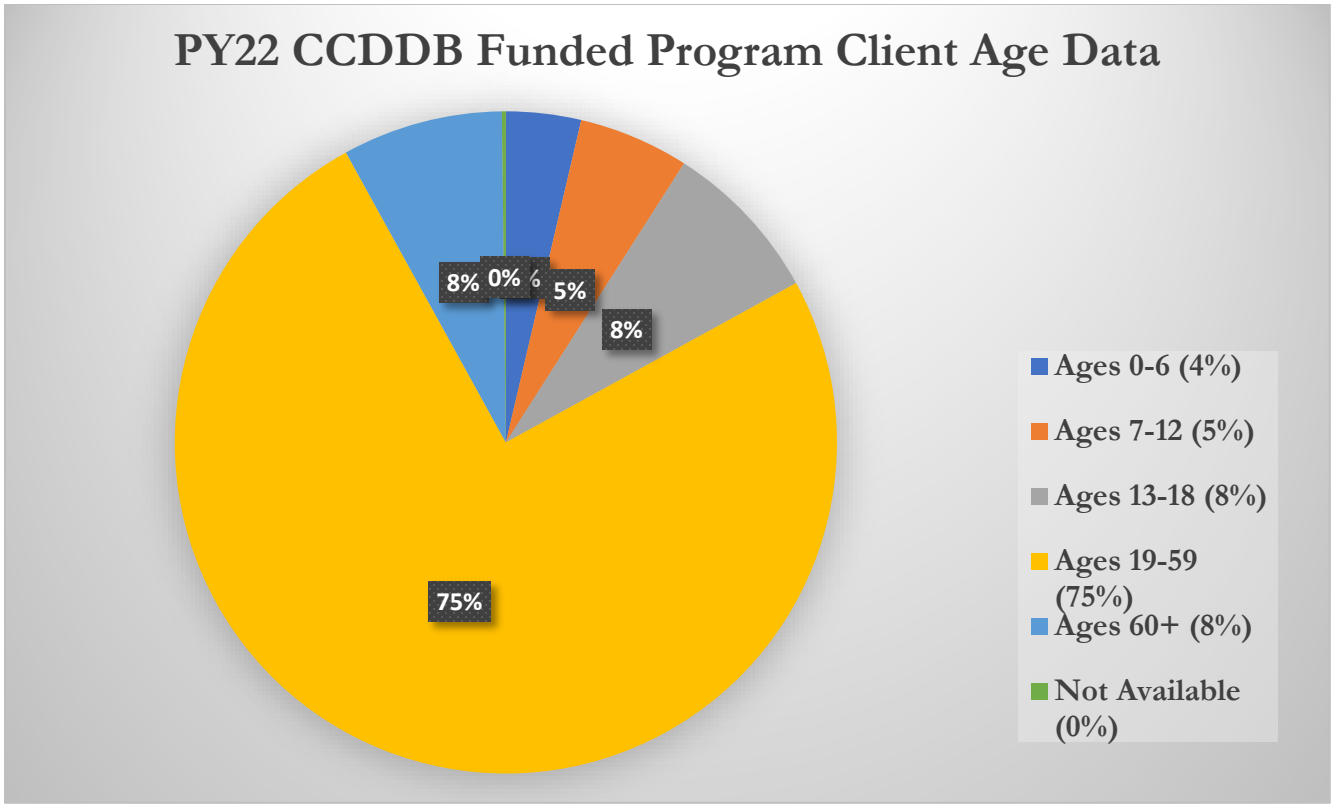
Included below are charts of aggregate agency service data per demographic category and residency, total hours of service by program, and total hours of service by type.

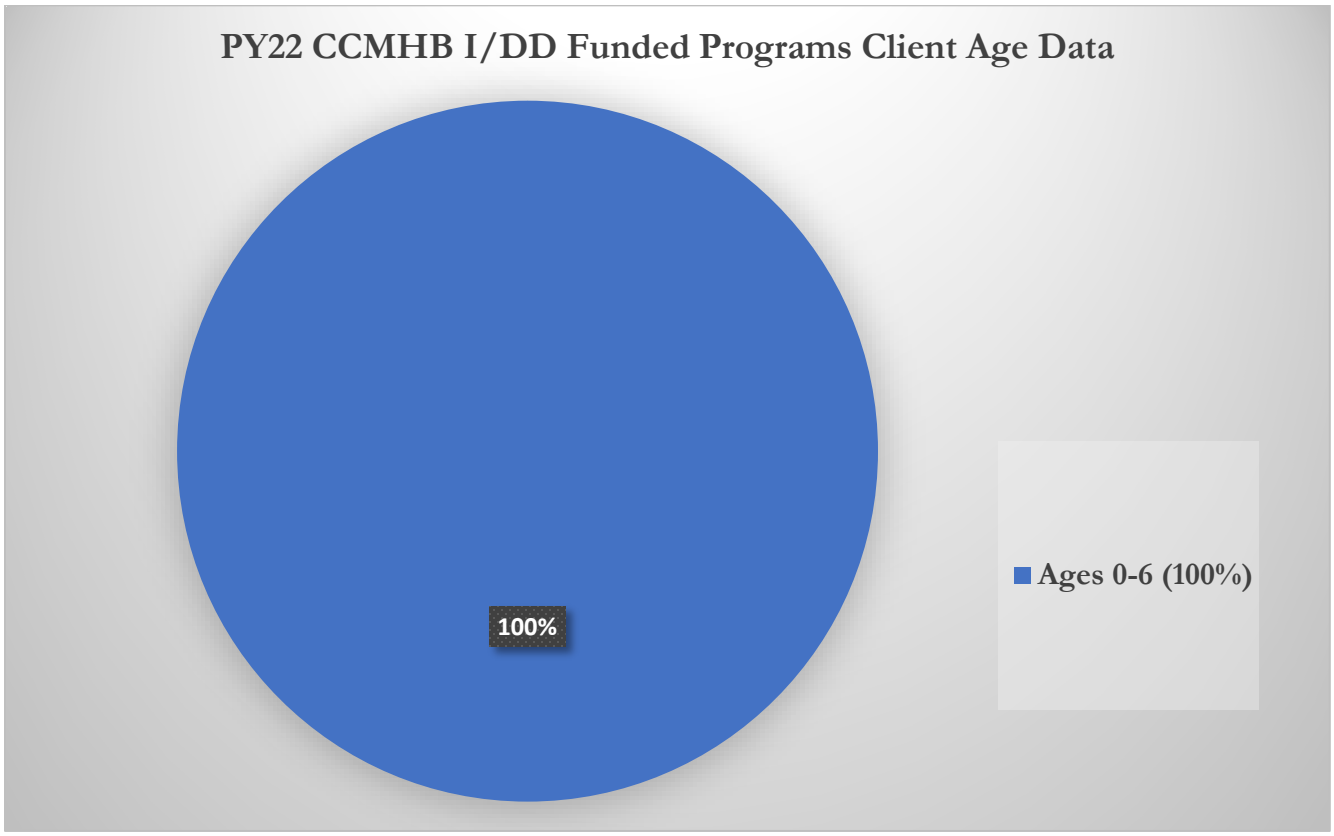
PY22 CCDDB Funded Programs Zip Code Data



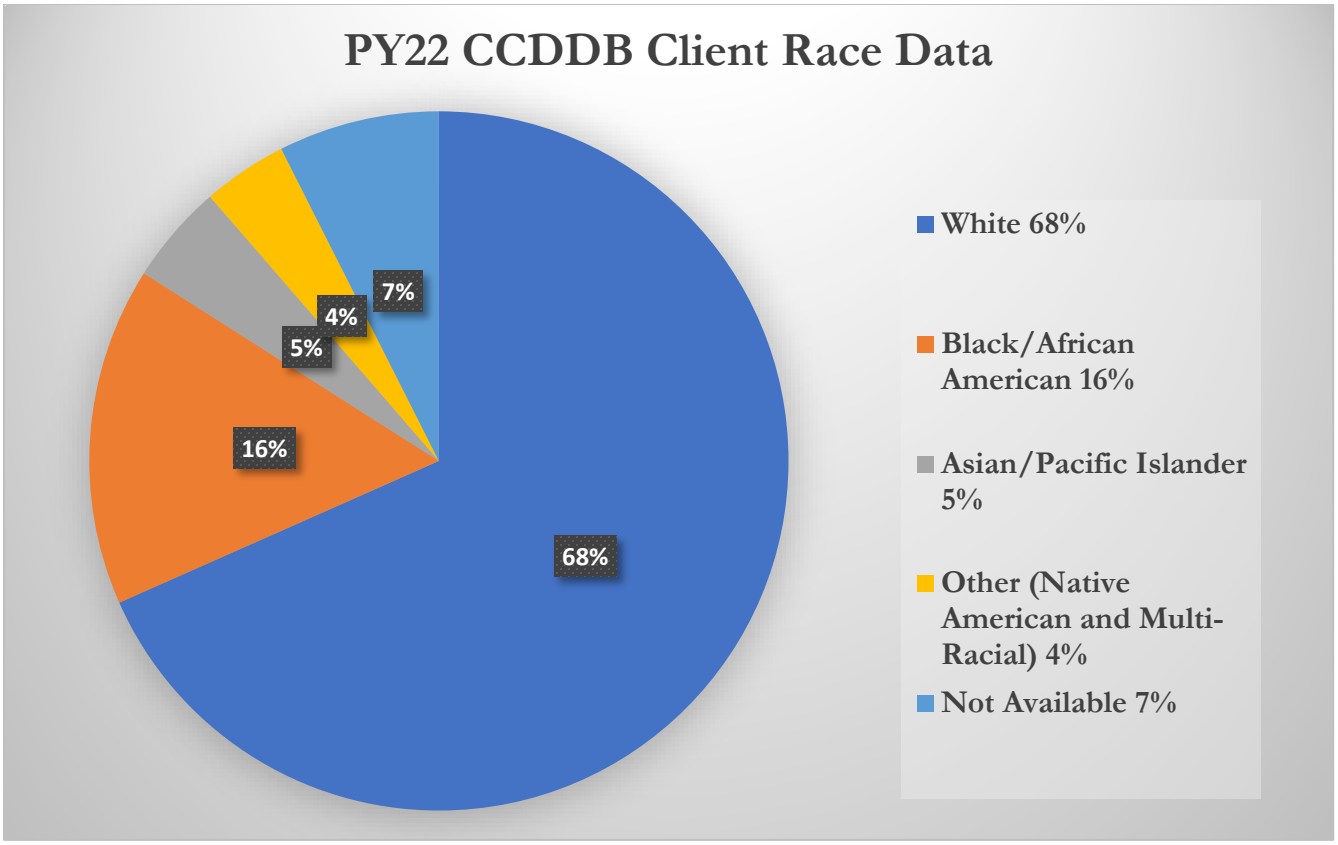
PY22 CCMHB I/DD Funded Programs Zip Code Data



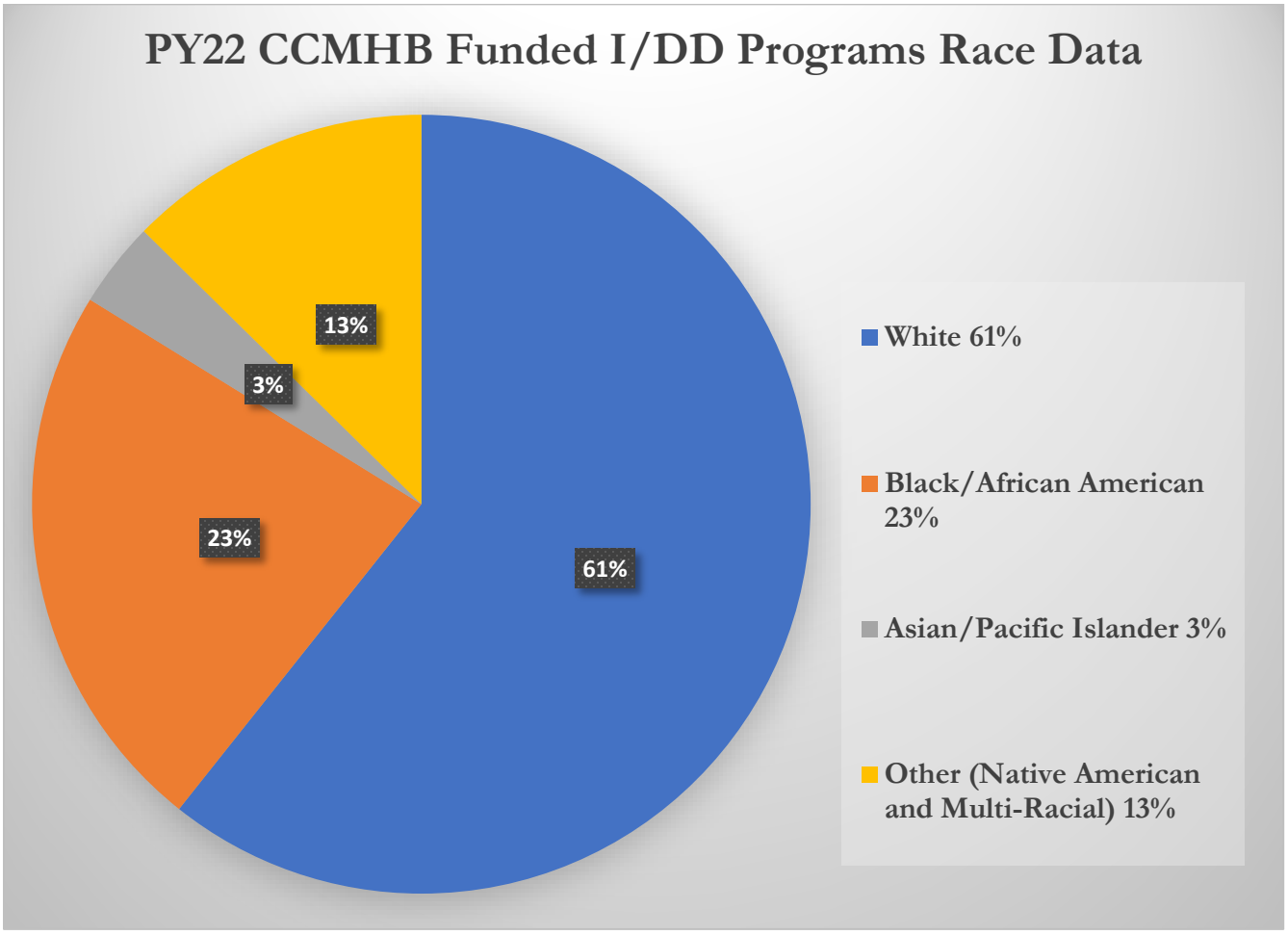

PY22 CCDDB Funded Program Client Age Data
8%
0%
5%
8%
75%
Ages 0-6 (4%)
Ages 7-12 (5%)
Ages 13-18 (8%)
Ages 19-59 (75%)
Ages 60+ (8%)
Not Available (0%)

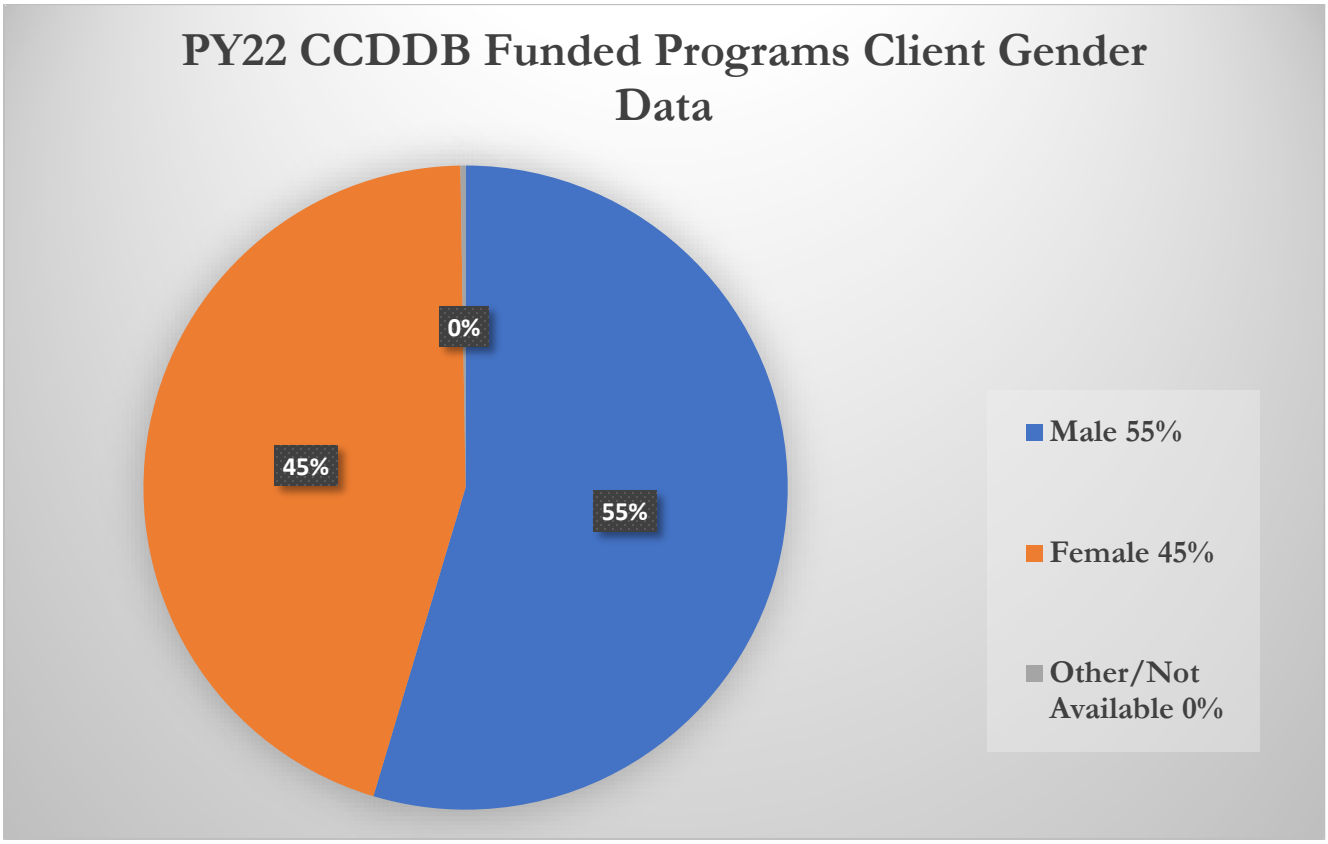

PY22 CCMHB I/DD Funded Programs Client Age Data
100%
Ages 0-6 (100%)

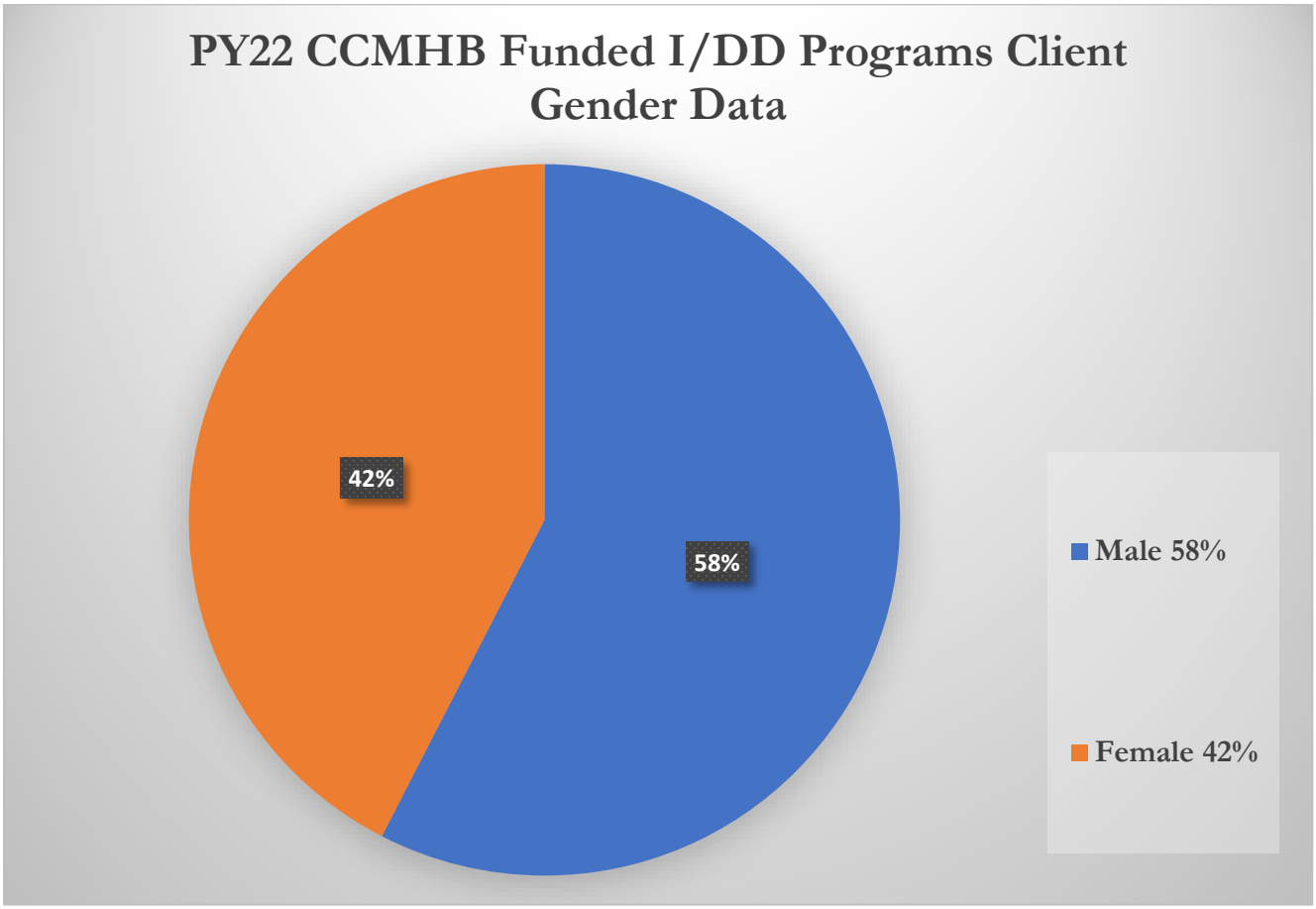
PY22 CCDDB Client Race Data



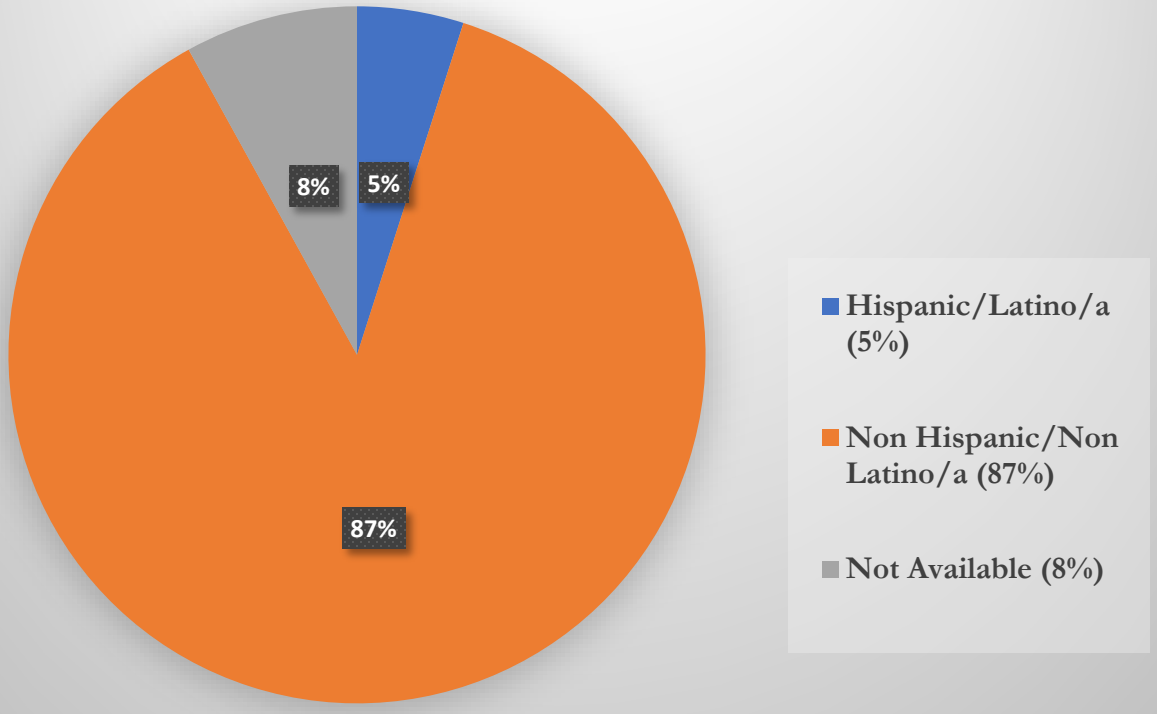
PY22 CCMHB Funded I/DD Programs Race Data



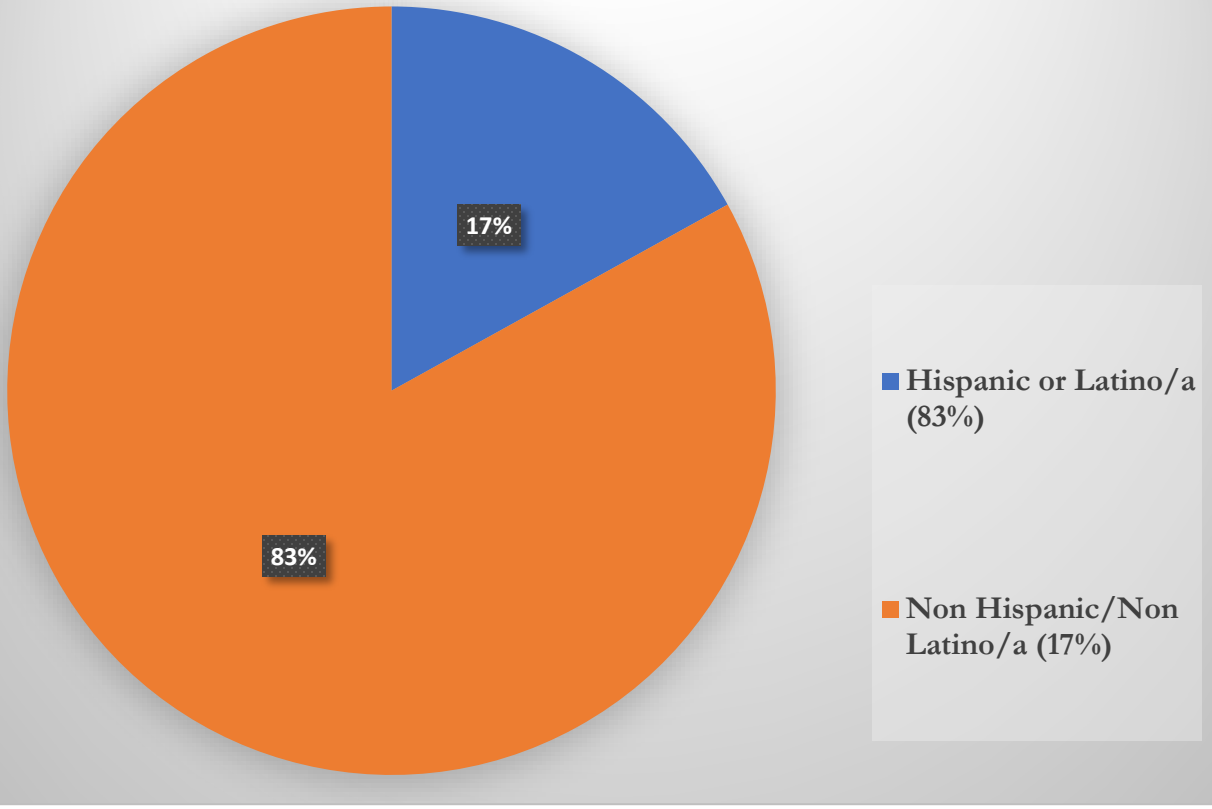

PY22 CCDDB Funded Programs Client Gender Data
0%
45%
55%
Male 55%
Female 45%
Other/Not Available 0%

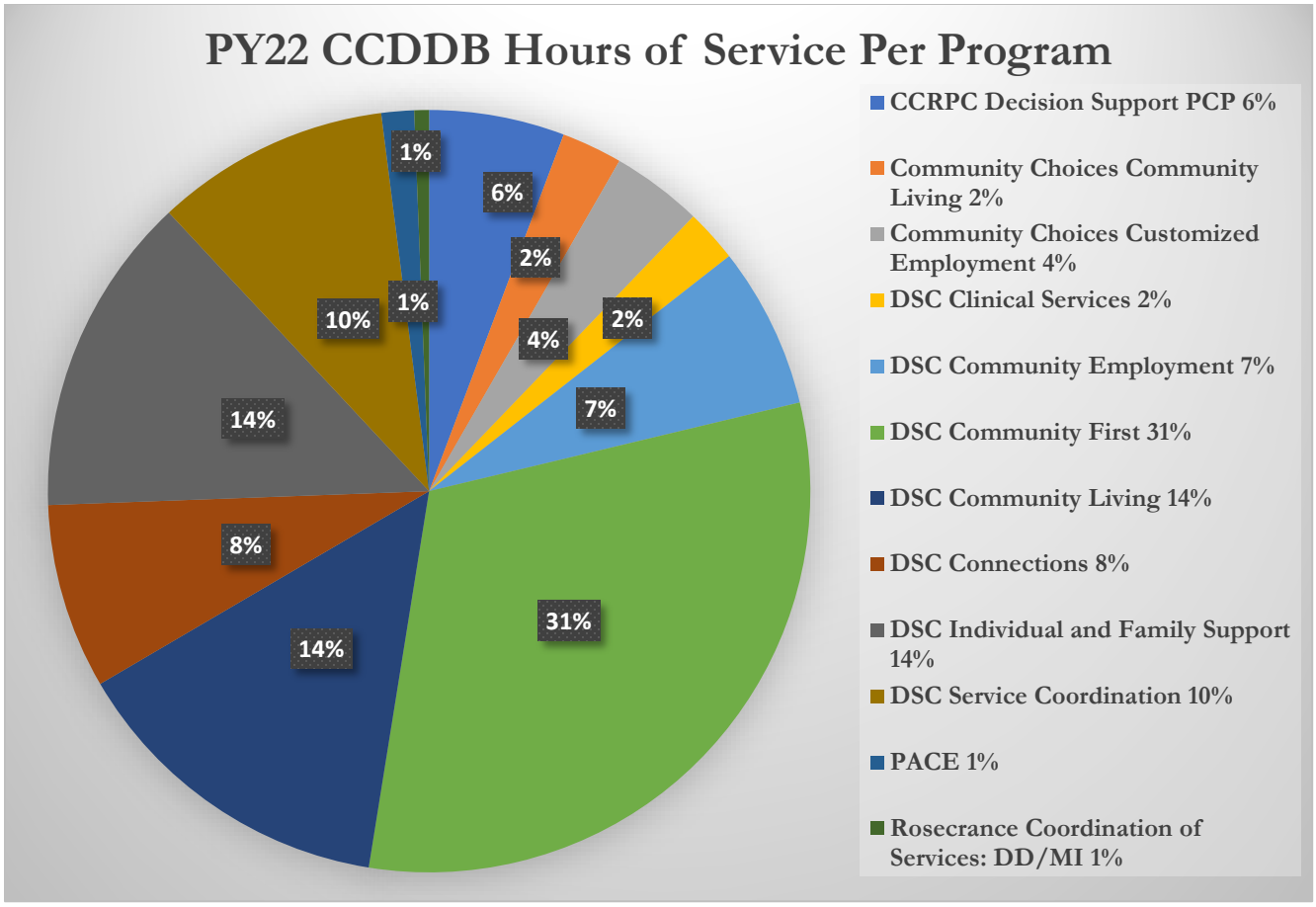

PY22 CCMHB Funded I/DD Programs Client Gender Data
42%
58%
Male 58%
Female 42%

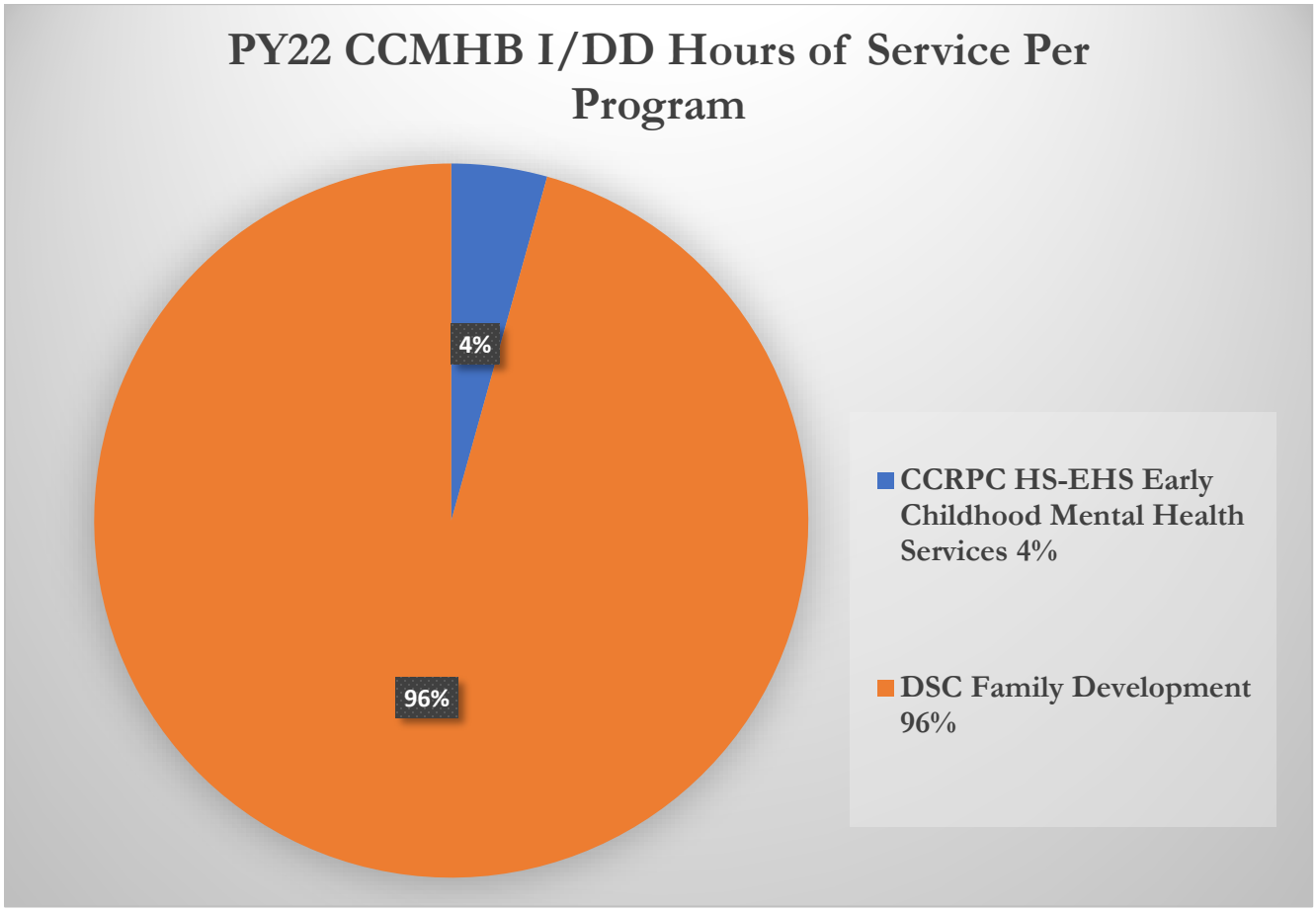
PY22 CCDDB Funded Program Client Origin Data



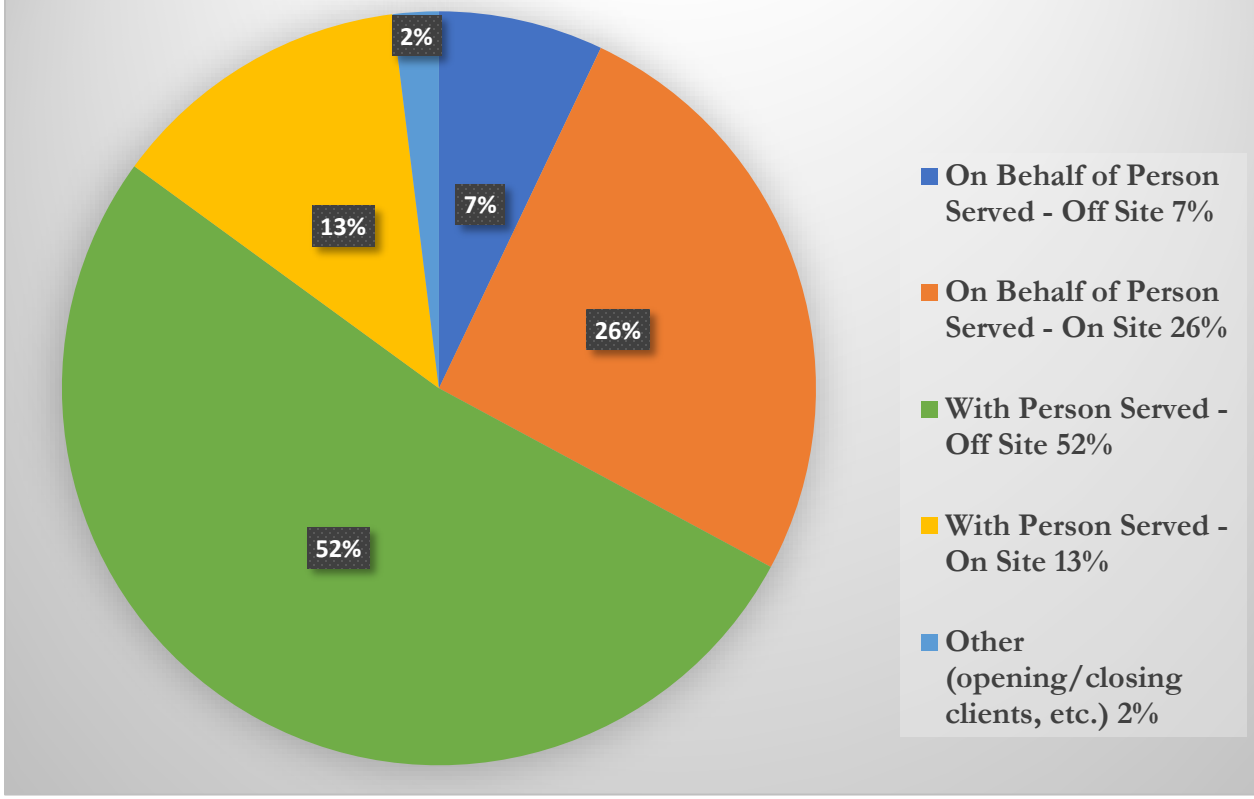
PY22 CCMHB I/DD Funded Programs Client Origin Data



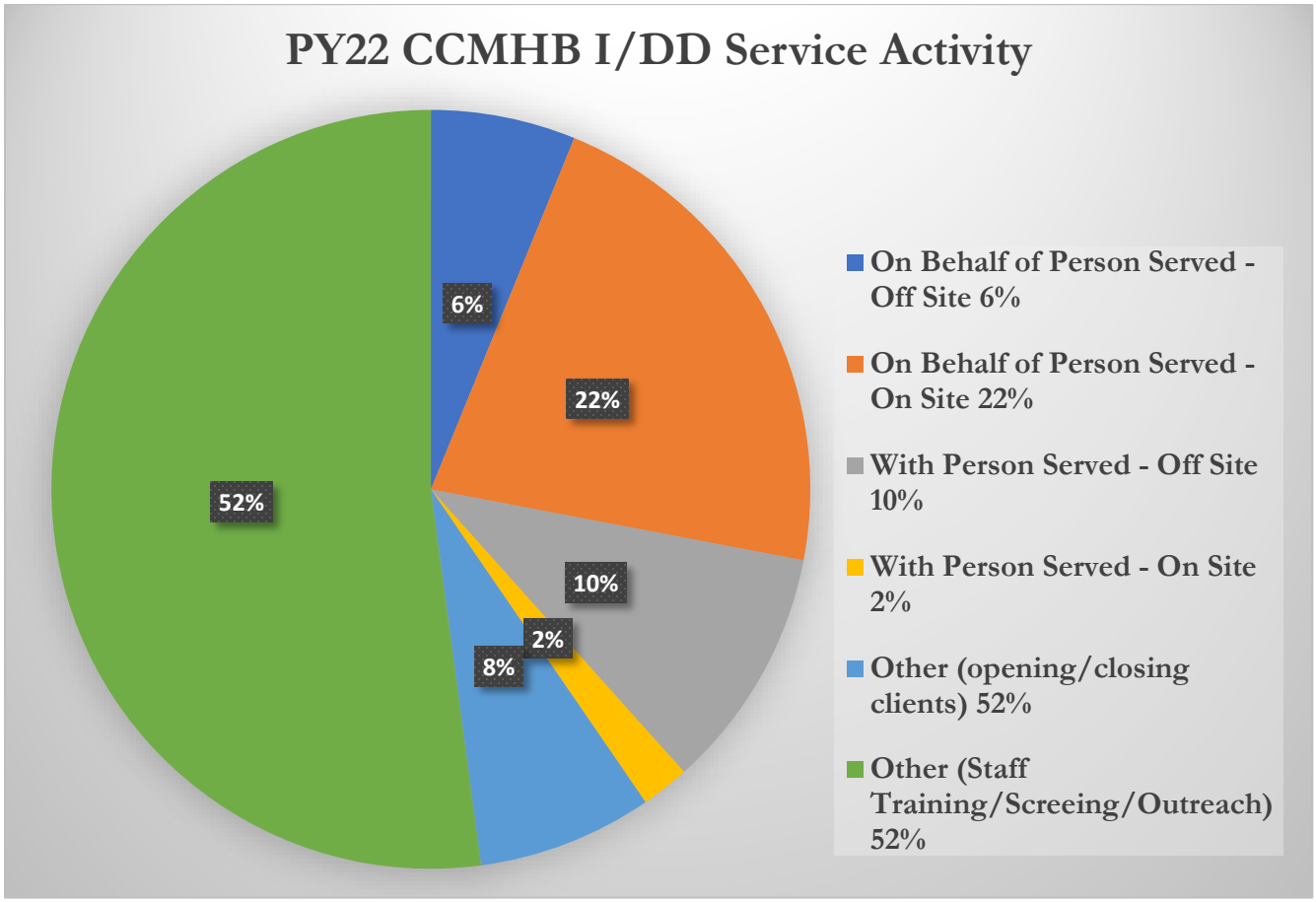

PY22 CCDDB Hours of Service Per Program
1%
6%
2%
4%
2%
7%
31%
14%
8%
14%
10%
1%
CCRPC Decision Support PCP 6%
Community Choices Community Living 2%
Community Choices Customized Employment 4%
DSC Clinical Services 2%
DSC Community Employment 7%
DSC Community First 31%
DSC Community Living 14%
DSC Connections 8%
DSC Individual and Family Support 14%
DSC Service Coordination 10%
PACE 1%
Rosecrance Coordination of Services: DD/MI 1%


PY22 CCMHB I/DD Hours of Service Per Program
4%
96%
CCRPC HS-EHS Early Childhood Mental Health Services 4%
DSC Family Development 96%

PY22 CCDDB Service Activity



PY22 CCMHB I/DD Service Activity



Utilization Summaries for PY2022 CCDDB and CCMHB I/DD Programs

Detail on each program's performance toward defined consumer outcomes during the funding year of July 1, 2021 to June 30, 2022 is available at http://ccmhddbrds.org, among downloadable public files toward the bottom of the page. The document is titled "CCDDB PY22 Performance Outcome Reports."

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

Priority: Self-Advocacy

CU Autism Network **Community Outreach Programs** $38,000

Services: Community resource information, education, and support through meetings emails, listserv, Facebook, and other networking outlets. Free, sensory friendly, family activities/pop-up play dates for people on the spectrum (skating, swimming, bowling etc.); Regular Lights Up Sounds Down Sensory Friendly Movies; Autism Aware Program; Community Outreach; Education Program; Beautification Community Program; Annual Walk and Resource Fair; Sensory Friendly Holiday events; Tailgate; and Parades. **Utilization targets:** 25 CSE. **Utilization actual:** 36 CSE.

Priority: Linkage and Coordination

Champaign County Regional Planning Commission Community Services
Decision Support Person Centered Planning $311,489

Services: ISC staff assess persons who are eligible for and may or may not be receiving IDHS-DDD waiver funding and who have not yet been assessed for service preferences. Transition Consultants assist people/families in conflict free transition planning. Extensive outreach, preference assessment, and person-centered planning services for Champaign County residents with I/DD who do not yet have Medicaid-waiver funding. Consultation and transition planning for people with I/DD nearing graduation from secondary education. Conflict free person-centered planning and case management services, using DHS' Discovery and Personal Plan tools currently utilized by ISC agencies throughout Illinois for those who do have Medicaid waiver funding. **Utilization targets:** 220 TPC, 220 NTPC, 300 SC, 40 CSE. **Utilization actual:** 292 TPC, 169 NTPC, 724 SC, 46 CSE.

DSC **Service Coordination** $435,858

Services: Serves children and adults with I/DD who request support to enhance or maintain their highest level of independence in the community, at work, and in their home. Focusing on the hopes, dreams, and aspirations serves as the basis of planning and outcomes for that person. With each person as the center of their team, Case Coordinators work closely with all members of each person's team assuring the most

person–centered and effective coordination. **Utilization targets:** 280 TPC, 36 NTPC, 75 SC, 2 CSE. **Utilization actual:** 242 TPC, 34 NTPC, 20 SC, 3 CSE.

Rosecrance Central Illinois **Coordination of Services – DD/MI** $35,150

Services: Emphasis on serving people who are presently in residential settings for persons with I/DD, are living in other settings (families, friends, or self) but are struggling in caring for self in these environments, or are at-risk of hospitalization or homelessness due to inadequate supports for their co-occurring conditions. Focus is to ensure that services are coordinated effectively, that consistent messages and language are used by service providers; and that service needs receive appropriate priority in both systems of care. **Utilization targets:** 28 TPC, 12 SC, 12 CSE. **Utilization actual:** 1 TPC, 1 SC, 0 CSE. ***Contract terminated effective September 30, 2021 due to agency request.***

Priority: Home Life

Community Choices **Community Living** $164,069

Services: Transitional Community Support – 4-phase model for supporting adults with I/DD to move into the community. Sustained Community Support - Team approach, supporting people with more complex support needs and/or fewer natural supports to move into the community. Personal Development Classes - building skills and confidence, topics include finances, community safety, technology, sexuality and relationships, communication, and cooking. Resources are generalized into real-world settings on an ongoing basis. **Utilization targets:** 30 TPC, 15 NTPCs, 4 CSE, 3529 SC, 1602 Other (direct support hours). **Utilization actual:** 26 TPC, 19 NTPC, 10 CSE, 1284 SC, 819.2 Other (direct support hours).

DSC **Community Living** $456,040

Services: Supports people with I/DD who reside in their own home in the community. The program has three primary goals: promote independence by learning/maintaining skills within a safe environment; provide long-term/on-going support in areas that cannot be mastered; provide increased support as needed due to aging, deteriorating health or other chronic conditions that jeopardize their ability to maintain their independence. Emergency Response is available for those needing assistance after hours and on the weekends. **Utilization targets:** 56 TPC, 8 SC. **Utilization actual:** 49 TPC, 7 SC.

Priority: Personal Life and Resilience

DSC **Clinical Services** $174,000

Services: Provides clinical supports and services to children and adults with I/DD. Consultants under contract include one Licensed Clinical Psychologist, two Licensed Clinical Social Workers, three Licensed Clinical Professional Counselors, one Licensed Professional Counselor and one Psychiatrist. Consultants meet with people at their private practice, at the person's home, or DSC locations. People schedule their appointments or receive support from family and/or DSC staff members for scheduling and transportation. **Utilization targets:** 61 TPC, 4 NTPC, 10 SC, 2 CSE. **Utilization actual:** 59 TPC, 4 NTPC, 11 SC, 1 CSE.

DSC **Individual & Family Support** $429,058

Services: Program serves children and adults with I/DD with priority consideration given to individuals with severe behavioral, medical, or support needs. Program is a flexible and effective type of choice-driven service to people and families. People may choose to purchase services from an agency or an independent contractor/vendor. Program continues to provide creative planning, intervention, and home/community support, collaborating with families, teachers, and other members of the person's support circle. **Utilization targets:** 17 TPC, 32 NTPC, 8 SC, 2 CSE. **Utilization actual:** 11 TPC, 30 NTPC, 6 SC, 4 CSE.

PACE, Inc. **Consumer Control in Personal Support** $24,267

Services: Personal Support Worker (PSW) recruitment and orientation, focused on Independent Living Philosophy, Consumer Control, and the tasks of being a PSW. Personal Assistant/Personal Support Worker Registry can be sorted by; location, time of day, services needed, and other information which allows consumers to get the PSW that best matches their needs. Service is designed to ensure maximum potential in matching person with I/DD and PSW to work long-term towards achieving their respective goals. **Utilization targets:** 65 NTPC, 200 SC, 15 CSE, and 3 Other (Successful PSW matches). **Utilization actual:** 76 NTPC, 359 SC, 23 CSE, and 7 Other (Successful PSW matches).

Priority: Work Life

Community Choices **Customized Employment** $201,000

Services: focus on individualizing relationships between employees and employers resulting in mutually beneficial relationships. Discovery identifies strengths, needs and desires of people seeking employment. Job Matching identifies employers and learns about needs and meeting those needs through customized employment. Short-term Support develops accommodations, support, and provides limited job coaching. Long-term Support provides support to maintain and expand employment. **Utilization targets:** 40 TPC, 1840 SC, 4 CSE, 2772 Other (direct support hours). **Utilization actual:** 41 TPC, 1795 SC, 5 CSE, 2346 Other (direct support hours).

DSC **Community Employment** $361,370

Services: Assists people to obtain and keep jobs. Including a person-centered job discovery; business exploration, online research, and speaking/listening to others' regarding job experiences; resume/portfolio development; interview prep and meetings with potential employers; identifying niches in local businesses that emphasize the job seeker's strengths; advocating for accommodations; self-advocacy support; provision of benefits information; discussion/experiential opportunities for soft skills; develop and maintain long-term business relationships. **Utilization targets:** 70 TPC, 2 CSE, 15 SC. **Utilization actual:** 69 TPC, 4 CSE, 11 SC.

DSC **Employment First** (with Community Choices) $80,000

Services: Emphasis and priorities include: individual and family education events; ongoing staff development to facilitate DSC's shift in culture to more community and employment focused outcomes; continued business/employer outreach to provide education and certification for disability awareness for employers; establishing and maintaining relationships with all newly certified businesses; engaging in communication and advocacy with various state agencies/representatives around Employment First implementation. **Utilization targets:** 25 CSE. **Utilization actual:** 29 CSE.

Priority: Community Life and Relationships

Community Choices **Self Determination Support** $160,251

Services: Leadership & Self-Advocacy: A Leadership Class, an Advocacy Board, and opportunities for members to mentor youth with disabilities within the CU 1:1 Mentoring program. Family Support & Education: educating families on the service system, helping them support each other, and advocating for improved services through public quarterly meetings and individual family consultation. Building Community: options for adults with I/DD to become engaged with others. Scaffolded Supports: Opportunities for adults with I/DD to participate in opportunities available in their community, with ongoing intermittent support from CC staff, including half-day small group social opportunities, support to attend a park district class, or community cooking class. **Utilization targets:** 170 NTPC, 2380 SC, 4 CSE, 1788 Other (direct support hours). **Utilization actual:** 202 NTPC, 3245 SC, 10 CSE, 1788 Other (direct support hours).

DSC **Community First** $847,659

Services: Serves those receiving community and site-based services, transitioning from a center-based model to community connection and involvement. Efforts to support people in strengthening connections with friends, family, and community through volunteering, civic duty, citizenship, and self-advocacy opportunities; enhancing quality of life through recreational activities, social events, educational, and other areas of interest; access to new acquaintances; and job exploration in interest area and detection of support for employment goals. **Utilization targets:** 55 TPC, 50 NTPC, 5 SC, 3 CSE. **Utilization actual:** 44 TPC, 63 NTPC, 8 SC, 4 CSE.

DSC **Connections** $85,000

Services: Focused on building connection, companionship, and contribution in the broader community and pursues creative employment possibilities. People have expressed a desire to expand on interest in art nurturing their creative self, fostering community engagement and pursuing a desire for employment opportunities. Individual and small group activities will occur during the day. Services are driven by each person. **Utilization targets:** 25 TPC, 12 NTPC, 0 SC, 3 CSE. **Utilization actual:** 26 TPC, 16 NTPC, 2 SC, 5 CSE.

Priority: Young Children and their Families

Champaign County Regional Planning Commission Head Start/Early Head Start
Early Childhood Mental Health Services $121,999 (CCMHB)

Services: Support from Social Skills & Prevention Coaches 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. Facilitation of 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 targets:** 90 TPC, 400 NTPC, 5 CSE, 3,000 SC, 12 Other (workshops, trainings, professional development efforts with staff and parents). **Utilization actual:** 163 TPC, 421 NTPC, 4 CSE, 2954 SC, 15 Other (workshops, trainings, professional development efforts with staff and parents).

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

Services: Serves children birth to five years of age, with or at risk of developmental disabilities, and their families. FDC responds to needs with culturally responsive, innovative, evidence-based services. Early detection and prompt, appropriate intervention can improve developmental outcomes for children with delays and disabilities and children living in at-risk environments. Family-centered intervention maximizes the gifts and capacities of families to provide responsive intervention within familiar routines and environments. **Utilization targets:** 655 TPC, 200 SC, 15 CSE. **Utilization actual:** 815 TPC, 173 SC, 13 CSE.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CCDDB 2023 Meeting Schedule

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

January 18, 2023 – Shields-Carter Room
February 22, 2023 – Shields-Carter Room *(Ash Wednesday)*
March 22, 2023 – Shields-Carter Room *(Ramadan begins)*
April 19, 2023 – Shields-Carter Room
May 17, 2023 – Shields-Carter Room
June 21, 2023 – Shields-Carter Room
July 19, 2023 – Shields-Carter Room
August 16, 2023 – Shields-Carter Room - *tentative*
September 20, 2023 – Shields-Carter Room
October 18, 2023 – Shields-Carter Room
October 25, 2023 5:45PM – Shields-Carter Room – *joint study session with the CCMHB*
November 15, 2023 – Shields-Carter Room *(off cycle)*
December 20, 2023 – Shields-Carter Room *(off cycle) - tentative*

This schedule is subject to change due to unforeseen circumstances.

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

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

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CCMHB 2023 Meeting Schedule

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

January 25, 2023 - *study session* - Shields-Carter Room
February 22, 2023 – Shields-Carter Room *(Ash Wednesday)*
March 22, 2023 – Shields-Carter Room *(Ramadan begins)*
March 29, 2023 – *study session* - Shields-Carter Room
April 19, 2023 – Shields-Carter Room
April 26, 2023 – *study session* - Shields-Carter Room
May 17, 2023 – *study session* - Shields-Carter Room
May 24, 2023 – Shields-Carter Room
June 21, 2023 – Shields-Carter Room
July 19, 2023 – Shields-Carter Room
August 16, 2023 – Shields-Carter Room - *tentative*
September 20, 2023 – Shields-Carter Room
September 27, 2023 – *study session* - Shields-Carter Room
October 18, 2023 – Shields-Carter Room
October 25, 2023 – *Joint Study Session with CCDDB* - Shields-Carter
November 15, 2023 – Shields-Carter Room
December 20, 2023 – Shields-Carter Room *(off cycle) - tentative*

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

IMPORTANT DATES - 2023 Meeting Schedule with Subjects, Agency and Staff Deadlines, and Allocation Timeline for PY24

This schedule offers dates and subject matter of meetings of the Champaign County Developmental Disabilities Board. Subjects are not exclusive to any given meeting, as other matters requiring Board review or action may be addressed. Study sessions may be added on topics raised at meetings or by staff, or with the CCMHB. Regular meetings are held at 9AM; joint study sessions at 5:45PM. Included are tentative dates for steps in the funding process for PY24 and deadlines related to PY22 and PY23 agency contracts.

1/2/23	*Online System opens for Applications for PY24 Funding*
1/18/23	**Regular Board Meeting**
1/27/23	*Agency PY23 2nd Quarter and CLC Progress Reports due*
2/10/23	*Deadline for submission of applications for PY2024 funding (Online system will not accept any forms after 4:30PM CST)*
2/22/23	**Regular Board Meeting –** List of PY24 Requests
3/1/23	*If approved, new Evaluation Capacity Project contract issued*
3/22/23	**Regular Board Meeting**
4/12/23	*Program summaries released to Board, posted online with the CCDDB April 19 meeting agenda and packet*
4/19/23	**Regular Board Meeting** Board Review, Staff Summaries of Funding Requests
4/28/23	*Agency PY2023 3rd Quarter Reports due*
5/10/23	*Allocation recommendations released to the Board and posted Online with CCDDB May 17 meeting agenda and packet*
5/17/23	**Regular Board Meeting** Allocation Decisions; Authorize PY2024 Contracts
6/1/23	*For contracts with a PY23-PY24 term, all updates to cloned PY24 forms should be completed and submitted by this date.*

6/17/23	*Deadline for agency application/contract revisions* *Deadline for agency letters of engagement with CPA firms* *PY2024 contracts completed*
6/21/23	**Regular Board Meeting:** Draft FY2024 Budget
6/30/23	*Agency Independent Audits, Reviews, or Compilations due (only for those with calendar fiscal year, per Special Provision)*
7/19/23	**Regular Board Meeting:** Election of Officers
8/16/23	**Regular Board Meeting** - *tentative*
8/25/23	*Agency PY2023 4th Quarter Reports, CLC Progress Reports, and Annual Performance Measure Reports due*
9/20/23	**Regular Board Meeting** Draft Three Year Plan 2022-24 with 2024 Objectives
10/18/23	**Regular Board Meeting** Release Draft Program Year 2025 Allocation Criteria
10/25/23	**Joint Study Session with CCMHB** at 5:45PM
10/27/23	*Agency PY2024 1st Quarter Reports due*
11/15/23	**Regular Board Meeting** (off cycle) Approve Three Year Plan, PY25 Allocation Criteria
12/10/23	*Public Notice of Funding Availability to be published by this date, giving at least 21-day notice of application period.*
12/20/23	**Regular Board Meeting** (off cycle) - *tentative*
12/31/23	*Agency Independent Audits, Reviews, or Compilations due*
1/2/24	*Online System opens for Applications for PY2025 Funding*

Agency and Program acronyms commonly used by the CCDDB

CC – Community Choices
CCDDB – Champaign County Developmental Disabilities Board
CCHS – Champaign County Head Start, a program of the Regional Planning Commission
CCMHB – Champaign County Mental Health Board
CCRPC – Champaign County Regional Planning Commission
CUAN – Champaign-Urbana Autism Network
DSC - Developmental Services Center
DSN – Down Syndrome Network
IAG – Individual Advocacy Group
ISC – Independent Service Coordination Unit
FDC – Family Development Center
PACE – Persons Assuming Control of their Environment, Inc.
PCMHC – Piatt County Mental Health Center
RCI – Rosecrance Central Illinois
RPC – Champaign County Regional Planning Commission

Glossary of Other Terms and Acronyms

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

AAC – Augmentative and Alternative Communication

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

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

ACA – Affordable Care Act

ACMHAI – Association of Community Mental Health Authorities of Illinois

ADA – Americans with Disabilities Act

ADD – Attention Deficit Disorder

ADHD – Attention Deficit/Hyperactivity Disorder

ADL – Activities of Daily Living

ASD – Autism Spectrum Disorder

ASL – American Sign Language

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

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

BD – Behavior Disorder

BSP – Behavior Support Plan

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

CARF- Council on Accreditation of Rehabilitation Facilities

CC – Champaign County

CDS – Community Day Services, formerly "Developmental Training"

CFC – Child and Family Connections Agency

CFCM – Conflict Free Case Management

C-GAF – Children's Global Assessment of Functioning

CILA – Community Integrated Living Arrangement

CLC – Cultural and Linguistic Competence

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

CNA – Certified Nursing Assistant

COTA – Certified Occupational Therapy Assistant

CP – Cerebral Palsy

CQL – Council on Quality and Leadership

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

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

CY – Contract Year, runs from July to following June. For example, CY18 is July 1, 2017 to June 30, 2018. May also be referred to as Program Year – PY. Most contracted agency Fiscal Years are also from July 1 to June 30 and may be interpreted as such when referenced in a Program Summary e.g. FY18.

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

DD – Developmental Disability

DDD – Division of Developmental Disabilities

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

DHS – (Illinois) Department of Human Services

DOJ – (US) Department of Justice

DRS – (Illinois) Division of Rehabilitation Services

DSM – Diagnostic Statistical Manual.

DSP – Direct Support Professional

DT – Developmental Training, now "Community Day Services"

DT – Developmental Therapy, Developmental Therapist

Dx – Diagnosis

ED – Emotional Disorder

EI – Early Intervention

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

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

ED – Emergency Department

ER – Emergency Room

FAPE – Free and Appropriate Public Education

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

FOIA – Freedom of Information Act.

FQHC – Federally Qualified Health Center

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

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

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

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

HCBS – Home and Community Based Services

HI – Hearing Impairment or Health Impairment

Hx – History

ICAP – Inventory for Client and Agency Planning

ICDD – Illinois Council for Developmental Disabilities

ICFDD – Intermediate Care Facility for the Developmentally Disabled

ID – Intellectual Disability

IDEA – Individuals with Disabilities Education Act

IDHS – Illinois Department of Human Services

IDOC – Illinois Department of Corrections

IDPH – Illinois Department of Public Health

IDT – Interdisciplinary Team

IEP – Individualized Education Plan

IFSP – Individualized Family Service Plan

IPLAN - Illinois Project for Local Assessment of Needs. The Illinois Project for Local Assessment of Needs (IPLAN) is a community health assessment and planning process that is conducted every five years by local health jurisdictions in Illinois. Based on the *Assessment Protocol for Excellence in Public Health* (APEX-PH) model, IPLAN is grounded in the core functions of public health and addresses public health practice standards. The completion of IPLAN fulfills most of the requirements for Local Health Department certification under Illinois Administrative Code Section 600.400: Certified Local Health Department Code Public Health Practice Standards. The essential elements of IPLAN are:

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

I&R – Information and Referral

ISBE – Illinois State Board of Education

ISC – Independent Service Coordination

ISP – Individual Service Plan, Individual Success Plan

ISSA – Independent Service & Support Advocacy

LCPC – Licensed Clinical Professional Counselor

LCSW – Licensed Clinical Social Worker

LD – Learning Disability

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

LPC – Licensed Professional Counselor

LPN – Licensed Practical Nurse

MCO – Managed Care Organization

MDC – Multidisciplinary Conference

MDT – Multidisciplinary Team

MH – Mental Health

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

MI – Mental Illness

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

MSW – Master of Social Work

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

NACO – National Association of Counties

NCI – National Core Indicators

NOS – Not Otherwise Specified

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

OMA – Open Meetings Act.

OT – Occupational Therapy, Occupational Therapist

OTR – Registered Occupational Therapist

PAS – Pre-Admission Screening

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

PCI – Parent Child Interaction groups.

PCP – Person Centered Planning, Primary Care Physician

PDD – Pervasive Developmental Disorders

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

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

PSH – Permanent Supportive Housing

PT – Physical Therapy, Physical Therapist

PTSD – Post-Traumatic Stress Disorder

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

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

QIDP – Qualified Intellectual Disabilities Professional

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

RCCSEC – Rural Champaign County Special Education Cooperative

RD – Registered Dietician

RN – Registered Nurse

RT – Recreational Therapy, Recreational Therapist

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

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

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

SEDS – Social Emotional Development Specialist

SEL – Social Emotional Learning

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

SH – Supportive Housing

SIB – Self-Injurious Behavior

SIB-R – Scales of Independent Behavior-Revised

SLI – Speech/Language Impairment

SLP – Speech Language Pathologist

SPD – Sensory Processing Disorder

SSA – Social Security Administration

SSDI – Social Security Disability Insurance

SSI – Supplemental Security Income

SST – Support Services Team

SUD – Substance Use Disorder

SW – Social Worker

TIC – Trauma Informed Care

TPC – Transition Planning Committee

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

VI – Visual Impairment

VR – Vocational Rehabilitation

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

WIOA – Workforce Innovation and Opportunity Act

BRIEFING MEMORANDUM

Date: March 22, 2023
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, CCDDB/CCMHB
Re: **Legislative & Policy Conferences,** National Association of Counties (NACO) and National Association of Behavioral Health and Developmental Disabilities Directors (NACHBDD)

Background

From February 11 through 16, 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, Vice Chair of its Behavioral Health Subcommittee, and member of the NACo Healthy Counties Advisory Board, I participated in related meetings. I attended all sessions of the NACBHDD board meeting and conference. Notes may be of interest to members of the CCDDB, CCMHB, CCB, and ACMHAI.

NACo Health Policy Steering Committee, Joint Subcommittee Meeting

"Call to Order and Welcome"

Hon. Helen Stone, Chatham County GA Commissioner and Committee Chair, welcomed us and introduced Vice Chairs, Subcommittee Chairs and Vice Chairs, and NACo Health Lobbyist Blaire Bryant. Review of process items and agenda.

"Leveraging Federal Resources to Prevent and Address SUD"

"Mental and behavioral health disorders, and specifically substance use disorders (SUD), remain prevalent in the US and have only been exacerbated as a result of the ongoing COVID-19 pandemic and current state of the US economy. In 2020, over 40 million Americans (15%) reported having an SUD, with only 10% receiving treatment, and only 6% of those needing both MH and SUD treatment received both services. Counties, as administrators of the local health care safety net, are critical agents in the prevention, recovery, and treatment of SUD."

Dr. Yngvild Olsen, Director of the Center for Substance Abuse and Treatment, SAMHSA, the lead agency for services related to MH and SUD. Of SAMHSA's five priorities, Overdose Prevention fits with Office of National Drug Control Policy (ONDCP) strategy. Of 80 ONDCP action items, SAMHSA touches 70; lots of overlap with Prevention, Harm Reduction, Treatment, and Recovery, and the integration of these 4 pillars. SUDs are chronic health conditions warrant a long-term approach, coordination and collaboration of local, state, and federal levels and across public health and other systems. Example: relationship between state/tribal opioid response program and companion MH and SUD block grants requires descriptions of how funding will be used across a continuum that *does* include county systems. In FY24, some grants will open up, a good time for counties and state partners to plan. Illicitly manufactured fentanyl is behind the

increase in overdose deaths. Naloxone and medications for OUD can reduce mortality by over 50%. Too few people are seeking and using treatment, especially these evidence-based treatments. "Cascade of Care" is a great public health framework (used in HIV prevention/reduction), focuses on screening for risk of SUD, engaging in treatment, how many get the evidence-based treatment, and then how many are retained in treatment. Hope to improve the numbers. Correctional settings and schools are good places to do screenings and engage people into services early, to reduce exposure. Current open funding opportunities across many of these areas, total $129m, can be found here. (https://www.samhsa.gov/grants/grants-dashboard)

Dr. Luis Padilla, Associate Administrator, Bureau of Health Workforce, Health Resources and Services Administration (HRSA). Oversees most workforce programs, close second to CMS with over 3,000 awards per year, for loan, scholarship, and grant programs. Across the US, 107,622 OUD and SUD deaths this year. Designate all health professions. Almost 8000 practitioners (psychiatrists and other MH providers) are needed. By 2035, project a shortage of over 15,000. The underlying data will be publicly available. Workforce development is a continuum, education early on, including elementary school. Also graduate practitioner programs. 475,000 trainees work in the areas of high need - where there are high OUD death rates and underserved, professional shortage areas. Coming soon, 7 distinct programs through National Health Service Corps, including loan repayment, discretionary funding to support SUD care, funding nearly every eligible applicant. Congress recognizes that our disciplines don't extend to nurses and other care team so this gap is addressed but not with enough $ to fund all, not even with additional funding this year. Focus on the highest mortality areas of the country. SUD Treatment & Recovery LRP program. Currently, 29% of loan/scholarship in SUD clinicians; 47% behavioral health. Need to avoid eroding the base, which is primary care. Integrated SUD Training Program now has authority to support clinical training, e.g., Social Workers, particularly into community-based settings. Expanding the Behavioral Health Workforce would increase # of graduates who go into the field; Congressional approval would support professional and paraprofessional growth with $175m. Addiction Medicine Fellowships in psychiatry residency and primary care; training in community-based settings with priority in the loan/scholarship programs. Collocation of services teaches coordination of care, continuity, and cross-pollination of knowledge. SUD is a subset of behavioral and MH care. Build the MH care team to have competency with SUD but not lose sight of MH and wellness. Data on shortage areas, area health resources files, field strength dashboards, clinical dashboards, workforce projections, and more can be found here (data.HRSA.gov) and here, a research center jointly supported by SAMHSA (www.bhw.hrsa.gov).

Melanie Fontes Rainer, JD, Director, HHS Office for Civil Rights (OCR). Leveraging Federal Resources to Prevent and Treat SUD. OCR has 8 regional offices, 11 offices, and is staffed to talk about civil rights. Nondiscrimination in Health Care is the focus. Privacy hub related to HIPAA. Protections for Individuals in Recovery from SUD - understanding the law with respect to this population: Section 504 of Rehab Act; Title II of ADA, specific to states and local governments; Section 1557 of ACA, which gets to insurance coverage and enforcement and guidance. How disability rights protect people with SUD: they can be protected for having SUD but must be in active recovery so that federal covered entities can't deny due to Medication Assisted Treatment (MAT) or having SUD. Recent enforcement examples: nursing facilities denying admission to people who are receiving SUD treatment, even though that's not what the facilities offer. OCR's Resources: OUD and Civil Rights video and webinar series, with colleagues at SAMHSA and ACF; helpful tools with follow-up as needed; guidance on HIPAA and SUD, including circumstances when treatment info can be disclosed. Some laws haven't caught up to the care needs; SAMHSA's Part 2 program (related to MAT) to make it easier to share records across providers to improve continuity of care (under 42 CFR part 2). Contact www.hhs.gov/ocr

Questions: Forsyth County, GA official on current grant expiring soon; is there any talk of expanding the grant supporting their Drug Council's work? SAMHSA says we all struggle with how to sustain successful service continua, but there are other SAMHSA grants that may fit this need. Washington state provider asked about how these agencies are incentivizing language access as a required element of Title 6. HHS

has recently relaunched its committee to put a plan in place for each of the required elements; much was lost in recent years and needs to be dusted off and updated; language access is an afterthought for most, or they don't have the money to support it. HHS is issuing rules about this, esp. related to insurance. The other speakers agreed. Workforce development needs to focus on cultural and linguistic competency. A Florida practitioner/commissioner who is pushing for diversion programs asked how to focus on ACEs and teach that medicine is poison, with opioids being a great example, and how to introduce these concepts to children early, to engage them to understand these problems and to attract them as part of the solution (workforce)? Also, do we need to distinguish SUD from OUD or isn't prevention the same? SAMHSA noted efforts across federal agencies to improve understanding of these issues; different treatments work for different types of SUD (MAT doesn't work as well for stimulant addiction, e.g.) but important to reduce mortality and improve quality of life and acknowledge individual and community level recovery across all behavioral health, to improve resilience and understand what people need for wellness. A New Hanover, NC official praised the panel, asked for the difference between treatment and recovery, since money is the issue for policy change, and how to define for laypeople? SAMHSA replied that treatment is clinical, recovery non-clinical, but they need to intersect.

"Upstream Policy Solutions for Building Community Resilience"

"Health security, preparedness, and community resilience depend on interconnected systems including public health, healthcare, and emergency management, systems for which counties are the primary stewards. The National Health Security Strategy establishes a framework for strengthening our national capability to prevent, detect, assess, prepare for, mitigate, respond to, and recover from disasters and emergencies… describes how as a nation we can improve readiness and adapt operational capabilities to address ever-changing health security threats. Overview of progress and lessons learned from the 2019-2022 National Health Security Strategy and feedback to inform NACo's comments on the 2023-2026 strategy on behalf of counties."

Travis Cryan, Emergency Management Professional, Principal Consultant, Bent Ear Solutions, moderated this panel. We need to bring stakeholders together before an emergency to identify what we each bring to the table. All communities should have an emergency manager and need county behavioral health system support. Starting in 2010 to look at regional needs differently; a challenge to get hospitals, licensed care, EMS, public health, and law enforcement all on the same page. Vital Importance of cross-collab between internal county agencies, between jurisdictions within counties, between neighboring counties. Learning opportunities from COVID, racial justice, political unrest, spikes in crime. Local govts more frequently turn to local Emergency Management programs for problem-solving that was historically the responsibility of other departments. Preparedness must be collaborative and a priority to our communities. Introduced the panel speakers.

Dr. Henry Walke, Director, Centers for Preparedness and Response, Centers for Disease Control and Prevention (CDC). Preparedness and Response Strategies and Programs; federal policy and strategy for public health emergencies; state and local engagement is the front line. Federal govt can work to address the challenges through the National Health Security Strategy (NHSS). Promising practices and need for improvement, esp. modernization for rural communities. To further advance health security in the US: address the disproportionate impact on marginalized communities with real health equity; bolster the health workforce; invest in public infrastructure to avoid supply chain disruptions. The new NHSS received over 500 public comments, many along these lines. The new strategy and implementation should be released soon, with 3 strategic areas: strengthen health systems; improve detection, surveillance, and cybersecurity; build a resilient public health base. To counter biological threats, CDC commits to improve early warning and detection tools. Shift from reactive to proactive posture to prevent escalation to pandemics. Data availability should be improved by modernization at federal, state, and local levels. Enhance analytics and modeling. Enhance workforce capabilities. Cooperative agreements to support state and local public health entities: PHEP (public health emergency preparedness); national response framework through FEMA, to preserve the foundations, revolutionize and integrate the knowledge gained through COVID. CDC awarded 652m in PHEP, including to local health depts. Direct funding to 4 metro

counties across the US, as 60% of US population are in those areas. Funding to engage with and improve rural and frontier health depts. Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) funding to strengthen the workforce. A guide to readiness can be found here (https://www.cdc.gov/orr/readiness/phep/index.htm). View the 2019-2022 NHSS here (https://aspr.hhs.gov/ResponseOperations/legal/NHSS/Documents/NHSS-Strategy-508.pdf).

Meredith Allen, VP for Health Security, Association for State and Territorial Health Officials (ASTHO). ASTHO is similar to NACo, representing health officials, with 59 members and working with their directors and staff. Advancing optimal health and health equity. Public health is organized differently per state, with centralized or decentralized health departments. Develop capacity building info, run CDC pilot programs, create policy drafts. For preparedness, health equity underlies everything. Workforce leadership development and more. Priorities for state public health: communicable disease control, linkage to help, and social determinants of health (SDOH). Top state health policy issues to look for relate to preparedness, erosion due to COVID fatigue, MH harmed by isolation, data privacy, health equity, public health workforce, access to rural healthcare, HIV, e-cigs. Main lessons learned from COVID-19: Leadership Matters - communication and outreach; modernized systems - lab results no longer faxed but data systems still not adequate, not communicating with each other; boom and bust funding cycles make it hard to create a foundational program, keep the surveillance going and the workforce ready; examine traveler health; federal-state-local partnerships should recognize the community as a partner and value their input. At the End of Emergency Declaration on May 11, 2023, two things will not expire: section 564 so that the Emergency Use Authorizations (EUAs) will not expire, the prep act (around liability) will not expire, and not clear what will happen with Medicaid. Need reauthorization of some programs this year, some to reduce administrative burden. Improving Communication and Transparency. Protecting Populations - including HVAC in schools, antibiotic stewardship, and building resilient communities. View this 2021 ASTHO blogpost on readiness (https://www.astho.org/communications/blog/public-health-preparedness-past-present-future/).

Lori Tremmel-Freeman, CEO, National Association of County and City Health Officials (NACCHO) - 3000 health departments across the country, directors and staff, to advocate on their behalf on the Hill and to create helpful information on policy. About 2/3 of local health depts are very small. Urban depts are small but serve over half of the country. In centralized states, local depts report to the state. A majority are decentralized, under home rule, and govern themselves. Rural residents need the same kind of access to resources as urban, to build resiliency. Strategies can have health depts at the center building risk reduction. How do we focus on resources needed in a non-political approach? Future policy decisions should consider these roles at all levels of govt. NACCHO does semi-annual assessment of members; many used NHSS objectives but were going the wrong direction pre-pandemic; local depts needed to see themselves as integral to success. Weather related activities, climate change adaptation, critical infrastructure, and cybersecurity are priorities. Strategies around workforce, health equity, climate change, supply chain, etc. Health Equity is an NHSS priority. Support local health as conveners bridging the gap to bring community partners together to respond. For supply chain, balance maintaining adequate inventory. Include local health depts in stockpile planning. Data Systems, Integration, and Security will require a full investment. Improve data sharing across jurisdictions. More information can be found here. (https://www.naccho.org/programs/public-health-preparedness)

Jeff Bokser, Senior Healthcare Executive, Hagerty Consulting. Responding to multi-year events is new to our systems. The response to 911 and Hurricane Katrina set in motion how hospitals prepare and respond, always expected to be able to create surge capacity, communicate as the voices of reason, and collaborate with local, state, and federal partners. This has not been enough. Hospitals did rise to the occasion to save as many lives as possible, e.g., vaccination programs and ICU surge capacity. Our healthcare system is now on the brink of collapse, even with great agendas ahead; this was brewing over the years but exacerbated by COVID-19. We have 40% fewer hospital beds than in the 1970s, in large part due to 'heads in beds' reimbursement payment systems. Consolidation of beds to keep the system affordable. People are sicker than ever, with lengths of stay up over 2.7 days, a massive increase, and

100,000 fewer caretakers. Now we hire contracted nurses at a much higher cost, with other increased costs, causing hospitals to operate at greater deficits. Medicines are coming from other nations. Funding has dried up, some ending May 11. Funding for emergency preparedness drills and recruitment decreased by 46%, over 6000 US hospitals. Many solutions could be brought back to our communities. First, restore trust in the healthcare system. 48% of Americans mistrust it. Without trust, patients are not compliant. In times of disaster, we need to have data and people to go to. Need triggers at the local level; pandemic fatigue set in during the global approach. We can't focus on rewarding hospitals for caring for the sickest patients and instead need to invest in health and preparedness. Look at our funding cycles. Prepare for a marathon rather than a sprint, bring joy back to health practice, and reenergize the healthcare workforce. Bring on force multipliers at any time. Finally, look at healthcare coalitions, as no one will remember who did better during an emergency - find better ways to work together as a continuum of care daily and not just in times of crisis. Not a matter of if but when. Watch H1N5 and more frequent viruses and events. Ask hospitals if we are prepared. More on Hagerty's work here. (https://hagertyconsulting.com/wp-content/uploads/2017/04/public-health-preparedness.pdf)

Questions: Why the distrust of the healthcare system? and How to add mental health to public health? Mistrust is multifaceted, some self-inflicted, some resulting from politics playing a role in healthcare decision making. We need to control messages in a time of crisis, connect with faith-based groups to broaden the reach of the messages, and respect that information will change and evolve. Also we tended to put out global messages, and people got tired. Related to gun violence, the CDC has some funding now to collect data on the impact of gun violence and which interventions are effective; a unified message from the federal govt. Movement against MH stigma is helping, through public health and K-12 education systems. Re trust and messaging, we are not used to change, and we like an absolute yes or no, but the science of evolving viruses is going to change as we go. MH looks very different at the local level, sometimes separate from public health. Question about increased funding needed and the framework, as most local funding is time-limited and inflexible, so what happens in five years when SAMHSA funding runs out? NHSS is working to reduce administrative burden, become more efficient. To avoid shouting down the good conversations that you have early on and not demonize some who were right after all, putting together a coalition and messaging is important. How to do it in a respectful way (e.g., long term care providers who didn't see updated guidance)? Looking at how to consolidate, esp. CDC which was stifled early on, need a unified voice around messages that are working; partnerships early on so that we're ready to respond; bring in local voice. What about racism and classism with regard to community preparedness, including with gun violence? Within hospitals and healthcare, equitable care and access to care are number one concerns, including how these play out across race and gender, looking at the healthcare workforce, to make sure they represent the communities they serve, and how to better manage more vulnerable communities and those with higher degree of mistrust. Find resources and trainings here. (https://www.cdc.gov/orr/readiness/resources/index.htm)

NACo Health Steering Committee, Committee Business Meeting

"Call to Order and Welcome"

Hon. Helen Stone, Chatham County GA Commissioner and Committee Chair reintroduced Blaire Bryant, HSC Vice Chairs, and subcommittee leadership and reviewed procedures for considering resolutions.

"Keynote Address: Policy Solutions for Advancing Long-Term Care"

"Joined by leadership from Centers for Medicaid and Medicare Services, to discuss how counties, as owners and operators of long-term care facilities, can enhance services for the 27% of older adults and Americans with disabilities requiring long term care through Medicaid innovation."

Hon. Mary Ann Borgeson, Commissioner, Douglas County, NE and Chair, Long Term Care Subcommittee. County governments play a central role in safety net and community-based systems to ensure care for the

over 20% of US pop who are elderly and the 6m+ with disabilities, though adult day care, caregiver training, in-home supports, counseling, guardianship, personal care, and more. Long term care facilities are in the frontlines of COVID response, which had a devastating impact on the landscape of long-term care. Innovation needed now.

Evan Shulman, Director, Division of Nursing Homes, Quality, Safety, and Oversight Group, Center for Medicaid and CHIP Services, CMS. Create guidance for inspectors of nursing homes, develop policy for non-compliance enforcement actions, but do not get involved in payments or technical assistance or non-nursing home settings (can collaborate with other depts of CMS on these). COVID cases are on the decline nationally, had been over 10k cases per week in US nursing homes but are now back to the national average of 9-10K per week. Layered approach to reducing infection rates, including up to date vaccinations. Resistance related to side effects, people aren't getting as sick, personal objection to vaccines, but the vaccines really have reduced severity and deaths, though not hospitalizations, and the bivalent does prevent transmission. Nursing home staff vaccination rates at around 22%; of people 65+, around 40%; and of NH residents over 50%. Public health emergency to end on May 11 although the declaration has been renewed up to that; a number of regulatory waivers will end when the emergency ends. The most controversial one is the Nurse Aide Training and Competency waiver, which waived the requirement that they be certified within four months of beginning work. We are concerned with training related issues we find upon inspection, so we ended this waiver in April 2022 but acknowledged barriers in some areas of the country and made exceptions, all of which will go away on May 11. New regulations and guidance around reporting of COVID and testing/vaccination of staff; expect more CMS guidance on winding down. August 2022 CMS bulletin on improving NH care, a call to the states to encourage being creative when formulating rates, to retain staff. Rebalance long term services and supports between community and institutional care. ARPA provided temporary funding. Watch this page for updates on Medicaid and CHIP (www.medicaid.gov). Last year, White House released 21 things to improve nursing home care; the top concern is staffing, as it was pre-pandemic; proposing a regulatory standard for minimum staffing. Barriers are too low rates, competition from other fields, budgetary decisions. Not a lot of transparency into NH financing. Issued measures of turnover in nursing and in administration. If you can't get staffing levels up, keep the people you've got, as this will help quality. CMS released information on change of ownership for each NH, with ownership not based on the NH company name but on the people associated with each NH. Antipsychotics are a long-standing issue, with a greater than ten-year campaign regarding adverse side effects in this population; these meds can help some, which has led to overdiagnosis; now some audits of NH for these incidents may result in downgraded ratings. A lot of 2022 guidance was implemented, regarding admissions to NH of people under 65 who have SUD or SMI. NHs have become the default place for these folks, absent appropriate care options. A challenging population for these settings. We hope states will create solutions, but we're not there yet. Compliance requirements must also consider that these settings are people's homes; some guidance on how to inspect. Partnership with SAMHSA to create a center of excellence with TA for anyone to upload from a public website, then on-demand contacts for support such as for de-escalation. Facilities should get extra training if they are going to take on these clients. This is very tough work on a strained industry, further strained by the pandemic.

"Health Resolutions and Platform Changes 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 2023 Annual Conference."

- Proposed Interim Policy Resolution **in Support of Protecting Kids from Fentanyl**. Sponsor: Commissioner Holly Williams, El Paso County, CO. Explained local context, asking NACo to advocate for this legislation. A motion to approve the amendment was seconded and unanimously approved. A motion to approve the resolution was seconded and approved, after discussion: ESSER funds do not extend to elementary and middle school; mention of fentanyl being cut into other drugs but may benefit from adding "other opioids" to the language.

- Proposed Interim Resolution **to Support Federal Action to Obtain Better Research on Kratom and to Promote Publication of Best Health Practices Related to Kratom**. Sponsor: Councilmember Atley Walker, Jr., West Baton Rouge Parish, LA; Commissioner Helen Stone, Chatham County, GA. A motion to approve the amendment was seconded, no discussion, and approved. The resolution passed after brief discussion, 25 to 1.
- Proposed Interim Resolution **in Support of Federal and Local Government Coordination to Advance Cardiopulmonary Resuscitation (CPR) and Automated External Defribrillator (AED) Training and Implementation.** Sponsor: Donna Miller, Cook County, IL Commissioner. Only 39% of women receive bystander CPR. Motion to approve the amendment was seconded and approved. Same with the resolution.
- Proposed Interim Resolution **Supporting County Behavioral Health Priorities.** Sponsor: County of Los Angeles, CA. Supervisor Katherine Barger of LA County, presented. Motion to approve the friendly amendment was seconded, with no discussion, and approved unanimously. Same with the resolution.
- Proposed Interim Resolution on **Tricare Reimbursement Adequacy.** Sponsor: Commissioner Janet St. Clair, Island County, WA; Supervisor Wendy Root-Askew, Monterey County, CA; Commissioner Robert Gelder, Kitsap County, WA; Councilmember Jani Hitchen, Pierce County, WA. A motion to approve the amendment was seconded, with no discussion, and approved unanimously.
- Proposed Interim Resolution **Supporting Repeal or Delay of Pending Statutory Cuts to Medicaid Disproportionate Share Hospital (DSH) Payments.** Sponsor: Board President Toni Preckwinkle, Cook County, IL. A motion to approve was seconded, with no discussion, and approved unanimously.

There were no emergency resolutions to consider. Our resolutions were approved unanimously by the NACo Board of Directors on Monday, February 13. All resolutions approved at the conference can be viewed at this link: https://naco.sharefile.com/share/view/s5412ebf8115f4dbbaac8cbf5b4203b65

"Legislative Update: 118th Congress Preview"

"Prognosis for the advancement of behavioral health policy priorities for the 118th Congress, overview of the committee's policy priorities, policy wins from the past year, and legislation to watch in the coming year."

Blaire Bryant, Health Legislative Director, NACo. Overview of 2023 priorities: advance legislation and administrative changes that will enhance counties' ability to provide comprehensive mental health services (also NACo's top priority); protect funding for core public health and prevention efforts and preparedness; protect the federal-state-local partnership (Medicaid) while maximizing flexibility to support local systems of care. Focus on repeal of IMD inmate inclusion, sustainable resources for comprehensive crisis response services, and enforcement of parity laws.
Key Accomplishments of 2022: approval of California's 1115 waiver for reinstatement of Medicaid benefits within 90 days of reentry; repeal of the Medicaid Inmate Exclusion Policy for juveniles, codified so they can access Medicaid, CHIP, and VA benefits while awaiting trial, similar for reentry, prerelease screening for services, within 30 days of release.
To do in 2023: cuts to Disproportionate Share Hospital (DSH) payment program will be a challenge; end of public health emergency and flexibilities which need to be retained; reauthorization an opportunity for more flexibilities (e.g., SUPPORT Act.)

Mr. Al Guida, Principle, Guide Consulting. Guide represents many organizations, lobbying for MH primarily, especially in Medicaid. The 117th Congress was unprecedented in behavioral health efforts - gun violence bill with MH, CCBHC extension from 10 states to all (10 states every two years), addition of licensed MH counselors to Medicaid, the first MH profession to be added since the 1970s. Challenges, with tragic reasons for behavioral health to remain bipartisan. Last year, record numbers of OUD deaths, mostly related to fentanyl, with anticipated increase in loss of life this year. MH crisis across the US, especially children's MH emergency hospitalizations. 48k Americans lost to suicide, another increase, connected to COVID pandemic. Homelessness is a pressing matter. All of these tragic factors cause MH to remain a bipartisan issue, giving us cause for hope. RI International, the Crisis TextLine, and the State MH

Agencies are all involved with 988-implementation. Could appeal to both houses for expansion of MH supports across the country. Less than one year into 988, a 45% increase in use of the National Suicide Prevention Lifeline and a 1400% increase in texts fielded by the Lifeline. SAMHSA estimates a 225% increase in its use during the first year of 988. New spending to expand crisis call centers, many run by counties. The federal message has been - we've provided money for the call system, the rest is up to you (states and counties), but there are three legs of the crisis response stool. After call center, the mobile crisis response, crisis receiving, and crisis stabilization (72 hours) all have to be supported through Medicaid. If we had a robust crisis receiving and stabilization network across the country, we would be able to divert from hospitals and ERs. These settings are not even beds, just barco-loungers and a 48 hour program if that de-escalation is not enough. IMDs include Nursing Homes, psychiatric hospitals, and other institutions. In 1965, such institutions had thousands of patients who stayed for years and years. While we do not want to return to that, proper financing of options has to be reexamined by Medicaid so that we can clearly support these often county-run centers. The response had been 1115 waivers and renegotiation with managed care companies. By 2029, imagine the numbers who will be inappropriately incarcerated or sent to hospitals: this makes no policy sense. If 988 is not going anywhere, we should not engage in partial solutions. Regarding inmate exclusion, a top priority for NACo for 15 years - Al Guida thanks us for that. The CA 1115 waiver could be a game-changer, and such waivers may be the path forward in the next 2 years. The recent Juvenile Justice reform is also a product of our advocacy. DSH is complicated. Congress has to reauthorize the community health center expansion fund; these provide primary health care for women, children, and single adults in expansion states. FQHC expansion is up for reauthorization along with DSH cut suspension. Hope for bipartisan support and action on both by September.

Questions: What issues can we get done through legislation for behavioral health, and what through regulatory action? Some focus will continue on MH and SUD, including workforce. BH workforce are not well targeted. The job of National Health Service Corps is to staff community health centers and FQHCs, paying for education of people who will work in those settings, while other community-based is not so well targeted. In the Finance Committee plan, a Medicaid Workforce Recruitment and Retention Program, financed by an FMAP bump, is to help providers hang on to their staff. The SUPPORT Act. Another (state) IMD exclusion for SUD will expire in September. On the regulatory front, section 5124 of the Consolidated Appropriations requires a CMS plan for financing the crisis continuum of care. Not sure how many states have applied for 1115 waivers to allow Medicaid for inmates. Regulatory rather than legislative action. The full Medicaid Reentry Act is too expensive for now. Regarding data on foster systems across the US: roughly 400-500k children; 50-80% prevalence of serious mental disorders or SUD; 80% of parents who commit abuse or neglect being under the influence of drugs or alcohol when they commit, with a strong trauma correlation; and very high incidents of residential care and psychotropic drug prescription for these children. Raise this with legislators to expand access to outpatient community-based care for these children and youth. The only option for many is residential care, with poor clinical outcomes. This is a Medicaid-wide issue.

See the recently approved 1115 waiver in CA which allows pre-release Medicaid at this link. (https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf)
To appreciate how groundbreaking the CA waiver approval is, read this Kaiser Family Foundation blogpost. (https://www.kff.org/policy-watch/section-1115-waiver-watch-how-california-will-expand-medicaid-pre-release-services-for-incarcerated-populations/)

NACo Healthy Counties Advisory Board Meeting

"The social determinants of health (SDOH) are the conditions in which we live, learn, work, and play that directly and indirectly impact the health and well-being of communities. Those who work within public health have a deep understanding of these issues and the importance of addressing them to drive improvements to community health. Other stakeholders, such as policymakers and the general public, may not share the same background as public health officials, but play a critical role in shaping how SDOH are addressed at the community level… strategies and

sharing ideas for increasing awareness and understanding of SDOHs among county leaders and community members to drive improvements to public health."

Hon. Brenda Howerton, Durham County NC, Chair, introduced the NACo staff and sponsors and Vice Chairs of the HCAB. SDOH and why they're important to public health. We work with stakeholders who may not have this knowledge. How can we use this knowledge to inform our work, including how to speak to the public about the critical need to improve these? Introduced the speaker.

"Keynote Address"

Dr. Brian Castrucci, President and CEO of de Beaumont Foundation. County elected officials will have more influence on health than all the healthcare providers in your region put together. We wait until Humpty Dumpty falls off the wall to realize we could put a pillow (SDOH) underneath them. Think of public health as a fishtank. People complain that policy takes too long, so we build a new clinic rather than addressing underlying policy causes and fixing them. Individual health is indelibly linked to public health. If you want to destroy a community, drop a liquor store in it that stays open until 4AM, with brown bags. We like to do fancy stuff, ideas and science included. Cancer is an example, since there is much we can do to prevent it. We end up having to get sick enough to be able to use the $20m clinic. Think of the circumstances many people faced during COVID when the best strategy was isolating from others (esp. those with no paid time off and no extra rooms in their home for quarantine). The politicization of public health has left us more vulnerable to pandemics than in 2020. We can break from the 'individual' lens with policies like Early Pre-K. The US leads the world in robot tourism; in our communities are children repeatedly hitting the ER with asthma, missing school, and their parents missing work, visiting different pediatricians, and using different insurance so that we cannot discover that they all live in a building with bad HVAC which could be repaired. If we don't solve these high-stake problems, our systems all fail. $3.2bn infrastructure from CDC, directed to states: what is that money doing in your community? Public health leaders need to communicate broadly and clearly rather than focus on their departments. Policy is the prescription for better health: the only way to fix SDOH is policy - kids going to school, clean indoor air, clean diesel fleet. We love pills and procedures but need to be talking about policy.

"Breakout Groups"

"Small groups to discuss ideas for improving communication about SDOH – for county officials, key staff, partners, and community members. Each group discussion was guided by a moderator and reported out key themes to the larger group; the moderator missed our group, but ours included a county commissioner with many years' experience in public health, so we were good."

Wrap up with highlights from each group:

- Building partnerships across systems and with the public, for support of those policies with long term potential; sometimes equity doesn't seem fair, so you have to communicate it properly/fully.
- Influence food and nutrition at the family level, toward healthier choices.
- Childcare needs assessment and programming; universal meal plans at school for better health outcomes; schools as a hub for a community, with culturally appropriate programming and resources; tax policy for sustainable revenue for these.
- All systems under one roof, one door; racism as a public health issue, including complex policy language which alienates people and pushback in those communities against declarations and policies to address racism; use GIS and vulnerability index; long-term public health staff to educate newly elected officials; rural health study proposing incentives for healthy behaviors.
- Clean water, clean food, and housing - the three fundamental SDOHs; lead abatement programs, including teaching people how to do it in their own homes; where rural wells are dry or septic tanks gone bad, we need suburban and urban residents need to care about it (it will create a very sick population); what food desserts really are and value of pop-up farmers markets that take SNAP; sister city programs through NACo.

- Education on healthy behaviors; partnerships between non-profits and community colleges; early childhood programming with wraparound supports.
- Mindful of political considerations of policy; learn from initiatives like Stepping Up; workforce development and apprenticeships, opportunities for retirees; how to settle people safely as many face evictions.
- For MH, broadband, food/neighborhood gardens, mentoring, career education, overcoming transportation barriers, allowing people to participate in and to own the solutions; operationalize strategies such as explicitly adding health goals into zoning rules and attaching policy to money.

"Disparities in Black Healthcare: Creating Healthcare for US"

"Sponsored by NABCO and NOBCO, discussion of medical mistrust in Black healthcare and creating healthcare that better serves communities, with related presentations and comments."

Kionne McGhee, President of National Association of Black County Officials, welcomed all and introduced the association and topic. Focus on healthcare and economic development, improving our constituency, supporting each other, and mentoring others. We talk about life after politics, need to empower all of our network to take care of each other.

Derek Albert, VP of Economic Development for National Organization of Black County Officials, reviewed the mission and purpose of the organization and introduced other officials, chairperson, board of directors. NACo President **Denise Winfrey** shared that this is a family and praised the members coming up. **Kevin Boyce**, Franklin County, OH, on the establishment of the bank. Income America presentation on retirement benefits for county employees. Presentations by the current 2nd Vice President of NACo and candidates for next 2nd VP. Representatives of Aetna. Announcement of NABCO/NOBCO conference June 21-25 in Miami, FL.

Jerica Richardson, Cobb County, GA, Commissioner. GA general assembly tried to eliminate her seat halfway through her term through redistricting, and her community stood up for her. There will be a NABCO conference panel discussion of Cobb County Commission's efforts to prevent this happening again. Shelby County Commission was praised for the pole cams which resulted in justice for Tyre Nichols.

Dr. Cheryl Rucker-Whitaker, MD, MPH, FACP and Managing Director, Health2407, Inc., spoke on The Business of Health Equity. From years of research on racial disparities in health outcomes she describes Structural Determinants of Life/Health/Death, which include slavery, reconstruction, Jim Crow, education redlining (GI Bill), health care segregation, 13th amendment, prison industrial complex, and redlining. Constitution permits slavery for prisoners - who is in jail disproportionately? The history of redlining - widely accepted from the 1930s to Fair Housing Act of 1968; appraisals of homes reflect institutional racism. Result is ongoing, chronic stress. How does the sustained stress of institutionalized racism impact health? Form follows function, housing inequity leads to health equity. Your body reacts to worry, e.g., about her young adult son. Physiology of the body's stress axis explained, with consequences like obesity and diabetes. If you overlay the map of neighborhood life expectancy in Chicago, you see the impact of housing as a structural determinant of death (legacy of redlining and underinvestment in neighborhoods); COVID impacts match this map. The wealth gap between US whites and Blacks is projected to cost the US economy $1- $1.5 trillion in lost consumption and investment 2018-2028, a projected GDP penalty of 4-6%, and intergenerational wealth disparity. We spend $25bn a year on Medicaid, and there is no minority business plan. Economic inclusion is vital to equity: educate yourself, review RFPs, partner with private sector to create vehicles for capital access, include black vendors for discretionary or emergent work. This is also vital to health equity by lowering stress/cortisol, also improving psychological mental health. Business Equity = Structural Equity = Health Equity. Call Dr. Whitaker for support regarding every healthcare contract your county considers.

Shahida Mausi, Wayne County, MI, and Senior Strategic Partner of Black Promoters Collective. Operates a 6000-seat amphitheater on the Detroit River, with the philosophy that you can do good while doing well, offering events with ticket prices below market rate each Wednesdays for 25 years. Internships, graduations, neighborhood services non-profit org to address homelessness, weekend of fundraising concerts/services, scholarships, and great shows. Then COVID happened, and we couldn't do anything, so colleagues across the US pulled together the Black Promoters Collective to support tours and create marketing strength. We know how to deliver messages to Black consumers and can communicate about your RFPs, other opportunities, mental health, healthcare, financial literacy, etc.

Dr. Marvin Arrington, Jr, has completed "Bo Legs…" a documentary about his father, who was elected in 1968 and served on the city council for 18 years, then the Fulton County Bench, and his key role in developing Atlanta. Broad distribution of this rags-to-riches story.

Anil Chitkara, Founder of Evolv, regarding the technology used at the doors of this session to detect weapons without traumatizing attendees - applicable in our schools. Started the company after the Boston marathon bombing which cost his friend his health. Video demonstration of this technology which allows people to walk through while being scanned, not stopped unless a concealed weapon is detected. In 2022, detected over 100,000 concealed weapons. Students and educators feel safer, can focus on school. Anxiety keeps kids from learning and leads to poor health outcomes.

"Paving a Path through the Overdose Epidemic: Enhancing Health and Safety through Harm Reduction"

"The overdose epidemic has become increasingly exacerbated in recent years, claiming the lives of over 100,000 Americans in 2021 - more than any year in American history. Harm reduction, like prevention, treatment, and recovery, is one of the pillars of the National Drug Control Policy. However, the availability of proven harm reduction services, like naloxone distribution and fentanyl test strips, is far below the levels needed to save lives and reduce the consequences of untreated SUD… explore the role of harm reduction in effective county opioid abatement through the lens of first responders, health providers, and people with lived experience of SUD."

Nick Szubiak, MSW, LCSW Integrated Health Consultant, NSI Strategies, moderated the discussion. Harm Reduction Services in 3 counties and their role in effective system of care; county leaders can advance evidence-based policies in harm reduction. The path that got us here is crisis-oriented, professionally directed, focused on acute care, discrete treatment episodes with limited options. New path is evidence-based care like MOUD/MAT, Recovery-Oriented Systems of Care, Trauma Informed Care, Measurement Based Care (abstinence is overrated as an indicator, doesn't tell the story), SBIRT. Social Drivers of Health, addressing environmental as well as individual risk factors. SUD Treatment Continuum of Care, which includes enhancing health, primary prevention, early intervention, treatment, recovery support. BUT how do we get these 'buckets' to the people in our communities who need them? Harm reduction is also a movement for social justice at a macro level. Not about the substance or abstaining from it but toward health equity and health engagement. Peer support services, community outreach, syringe exchange, drug checking strips, etc. are aimed at meeting people where they are and not leaving them there, not minimizing or ignoring the role. Mezzo level policy considerations: same day buprenorphine starts, starting medication prior to completion of assessment. Micro level is dynamic and not just one thing, both a philosophy and a skillset, involves the belief that any interaction can be the starting point of someone's recovery, seeks to engage a person into treatment at a level they are comfortable pursuing. "Compassionate Pragmatism" - support not punish (despite harmful consequences). Harm Reduction Impact - naloxone access saves lives; syringe service programs prevent OD, reduce crime and litter, and link people to SUD treatment. Integrates MH and SUD treatment orgs to increase their adoption of harm reduction services and partnerships with community-based harm reduction orgs. Challenges include funding, staff capacity, policies, laws.

Dr. Gregory Wm Branch, Director and Health Officer, Baltimore County (MD) Dept of HHS. Heroin remains the drug of choice in Baltimore.
Lauren Carr, Executive Director, Graves County (KY) Agency for Substance Abuse Prevention. Personal experience with childhood trauma and addiction (family members), recent arrest involving enough fentanyl to kill 57k people, lost 2251 people to OUD death, most involving fentanyl. Coordinates a syringe exchange program. People who use these programs are 5 times as likely to engage with SUD treatment. When actively using, people feel dehumanized.
Marlene Collick, Deputy Director, Genesee County, MI Community Corrections. Humanizing those who enter judicial system, identifying whether the cause is SUD or other. Introduces herself as 'in recovery' not 'an addict' because words are powerful. MI Public Act 511, community-based program alternatives to incarceration.

Discussion: examples from each community. People reusing one syringe for so long that they have abscesses or MRSA. Vivitrol is not different from antabuse, in addition to abstinence-only focus, which doesn't help all people. Legislators can work on zoning policies regarding treatment facilities (even if you don't want a facility in your neighborhood, people actively using are already there). This disease affects all communities. Relationships are treatment. When you say I have had enough and I'm ready, we should be able to provide the services you need in your community. Audience comments and questions: Gary Moore - the national settlement, phase one, money has been sent, and communities are making decisions about how to direct these funds, some through county stakeholder collaborations, but how do we allocate to create the wraparound services? These funds are coming over an 18-year period, so it comes without the ills of grant funding. Harm reduction - community NARCAN and fentanyl test strip distribution, Quick Response Team (non-fatal overdose response by peers and law enforcement to leave resource info with family/individual), syringe exchange. Holistic approach (SUD and MH issues) including 23-hour stabilization centers as alternative to detention centers or ERs. NARCAN is wonderful but will put people into withdrawal, so add immediate buprenorphine. The one opioid a doctor can't provide is methadone, a very effective treatment but only available through a methadone clinic (where you have to stand in line and take it there, making it hard to get to work on time, etc); as long as we treat this disease this way, we'll never get ahead of it, so we need fundamental policy changes. MAT - it's 5 years before you can go home with your own medication. Collective approach, due to the relatively small annual amounts of funding. Creating places for communities to talk about what they have and what they experience. Questions about treatment for those incarcerated. Safe-use injection sites and recovery homes work; navigate carefully and do it when your jurisdiction is ready. Dead people don't recover. Promote 'never use alone' cards. This session is captured here. (https://www.naco.org/articles/counties-weigh-strategies-allocating-opioid-settlements)

NACBHDD 2023 Day 1: Spring Board Meeting

"Welcome Board and Platinum Partners Breakfast"

Dave Kishler, federal legislative advocacy and industry relations at NetSmart. Overview of mission, serving 251 communities and 21 states, in human services (MH, autism, I/DD, and child & family services) and post-acute (private duty nursing, senior living settings, etc.) The electronic health record (EHR) has become a repository for other things in these sectors, into care coordination, referral management, scheduling, and crisis response management. Value-based care since 2010, certifying health records, and now more post-acute which don't require certifications but they're doing so ahead of requirement. Advocacy, partnership with other associations, securing funding for behavioral health providers, especially because many don't have the data systems they need and because this involves legislation. The SUPPORT Act helped. Authorization for an EHR financing renovation did not happen, so we continue to push for that (7 years now). 'Meaningful use' effort, not yet announced, is being triggered by legislation in the original appropriations bill, requiring more data from inpatient psychiatric, with specific deadlines coming soon, which will affect future payment rates. Eligibility would likely include a broader section than inpatient

psych, into related services, and may involve hospital associations and others, creating attention beyond the behavioral health community. NetSmart serves about 220 CCBHCs and advocated for expansion to all states (funding is in place, to add 10 states every 2 years). Finally, 42 CFR Part 2 reform, which has troubled counties and providers for many years; the original concern was police seizing records from methadone clinics and arresting people based on the content; advocated to amend the rule for the sake of coordination of care, to avoid inappropriate Rx combinations, e.g.; now records can be redisclosed to appropriate providers without additional consent. For HIEs to work properly, following a chain of command, amendment is needed. Mobile crisis response platform is key, what happens after the call.

"Introduction"

David Weden, TX, Vice Chair, NACBHDD, led introductions and welcomed our presenter.

"Presentation: GW Regulatory Studies Center"

Bridget C.E. Dooling, George Washington University's Regulatory Studies Center and author of this report on Methadone regulation and avenues for easing access: (https://regulatorystudies.columbian.gwu.edu/federal-regulation-of-methadone) The basics of administrative law, the rulemaking process, and how it affects behavioral health and I/DD. She was with the Office of Management and Budget working on draft regulations prior to public release; 'rules' is a policy process right before release, asked about costs and benefits and what problem is being addressed, legal authority, purpose, all to get the material ready for the public. With the new composition of the Supreme Court, House, and pressures of election/reelection campaigns, there is a scramble among federal agencies toward the shared goals of releasing regulations.

Questions: Chance of full repeal of Medicaid inmate exclusion, while states and counties chip away at the edges? Reimbursement for licensed professionals serving seniors was approved in the Omnibus, along with juvenile justice reform (pre-adjudicated youth, through CHIP). Some standards set for 1115 requests. Regarding states' various interpretations of CMS rules, which often seem wrong, is there someone within CMS who can confirm interpretations? Not clear, but ideally they issue regulatory advice. David Coe went the route of the two US Senators from VA asking CMS, and within 12 hours there was an email and letter answering his question about Home and Community Based Services.

Question about the unwinding of regulations related to the public health emergency ending May 11. Some flexibilities (e.g., allowing the first visit for OUD med treatment to be telehealth) are connected to the emergency, which the advocacy community immediately asked be made permanent. Another example regards the amount of medication which can be taken home from a methadone clinic; sometimes with an older statute being the barrier, you go to Congress, which might then kick it back to the agencies' authority, getting the issue stuck in a loop. Now trying to drive a wedge into that loop to define authorities and limits, since Congress gives the agencies their powers. In both cases, they found that the agencies did have authority. SAMHSA has agreed to extend both the take-home and initial buprenorphine telehealth flexibilities, but SAMHSA's reach is limited to those working in the methadone clinics. From DEA with the larger set, no response, though they have a proposal pending regarding telehealth. As of May 11, some hope that SAMHSA will continue various flexibilities, while the DEA seemed to tie to the public health emergency and congressional authority. Compounding risk aversions can lead to things like pharmacists unwilling to keep enough on hand. Finishing up a review with NYU on these 2 flexibilities, of which there are dozens of studies. Last year, the President called for agencies to look at rescheduling of marijuana, and there was talk of adding methadone to that process. To view rules which have gone to the process and may be released to the public within 90 days, use this link (www.reginfo.gov). Contact bdooling@email.gwu.edu

"Spring Updates"

Jonah Cunningham, DC gave an overview of the agenda, internal updates, and introduced NACBHDD Program Manager Makana Meyer.

Joint Projects: Sozosei Project with NACo, paper on crisis funding, to be followed by papers on various aspects of this work. Hopefully for each state, a paper on the intersection of crisis call centers, behavioral health authorities, and other systems, starting with TX and MI and funded by Takeda Pharmaceutical, with the hope of future funding opportunities based on the first one. Later this week, releasing a funding chart with county examples and fact sheets for BH and DD directors. View the paper, also mentioned during NACo sessions, here.
(https://www.naco.org/resources/county-funding-opportunities-support-community-members-experiencing-behavioral-health)
Congressional Outlook: will be a difficult time now. 1917 statute where the congress takes on x number of bonds, that number arbitrarily set, and must be lifted by summer. There are ways around it, to fund the federal government, so there will be lots of 'jockeying around' for the next few months, and while SS and Medicare were named, Medicaid was not, which is a cause of concern. Presidential budget to be reviewed March 7 (these are always set aside) followed most likely by several appropriations bills. SUPPORT Act is up for reauthorization by October 1, as are Community Health Clinics and Disproportionate Share of Hospital Cuts. Conversations about the Medicare Trust Fund will be separate from the debt ceiling, but no such protection for Medicaid, which is always harder to talk about but is also the main funder of behavioral health and DD (and other long-term care) services.

"NACBHDD Committee Reports"

President's Report, David Weden, TX: in honor of Kyle Kessler (unable to attend today), a movie quote from The Replacements: "You know what separates the winners from the losers? Getting kicked in the teeth and getting back up on the horse that kicked you." And the final scene where they recognize greatness in spite of no ticker tape… that's us, at this point in history. Review of federal events focusing on the issues we care about - suicide loss, comprehensive BH services, Medicaid inmate exclusion repealed for pre-adjudicated youth, multiple 1115 waivers addressing food and housing insecurity, CA 1115, etc. We will join this afternoon's conference with NACo on their new MH commission, with us in advisory role and 14 people appointed.

Behavioral Health and Justice, Lynn Canfield, IL: monthly meetings with brief presentations, lately by each of the members. This is a good time for partnerships with justice, which is a focus of all committee members. Would like to discuss children's mental health, members' preferences for meeting date/time, and building neighborhood-level resilience to meet future unprecedented disaster-related mental health challenges. Also update on NACo Health Committee, BH subcommittee work.

I/DD, Maria Walker, IA: NACo and NACBHDD resolution a victory. Presentations by experts at regular committee meetings. Priorities for this year are to expand on the federal advocacy work.

Communications & Advocacy, Rene Hurtado, TX: discussions on how to better use social media, additional advocacy opportunities; moving away from Facebook.

NARMH, David Weden: In Kevin Martone's absence, David announced the conference in September and increased/improved use of social media messaging.

"NACBHDD Reports"

Directors of State Associations Committee, Bob Sheehan, MI: state association members can join at a low rate, get a taste of our work, go back to their members to discuss. New state associations are: PA,

MO's IDD authority, and MD. Hopeful for NY (has a new director) and MN. A nice approach is for the DSAC to bring one of their board officers, representing membership. DSAC meeting tomorrow.

Treasurer's Report, Rene Hurtado, TX: Budget Report distributed, some catch up to do on the corporate partners' side. Jonah explained each expenditure line and updates where relevant. Doesn't include the anticipated 25k from Takeda and other revenue from sponsorships. The deficit will be closed by membership dues. Also review of assets and liabilities sheet.

"President and CEO Evaluation"

Bob Sheehan, MI. Thanks to all who completed the review of Jonah's performance in five areas. The comparison of us with the National Council is not helpful - just say who we are and what we do. Loss of laptop and membership information still not resolved (from when the previous staff left suddenly.)

"Establishment of Membership Chair"

Jonah Cunningham. After messaging/marketing materials are developed and approved, we may be recruiting membership co-chairs, to represent each of behavioral health and I/DD, for a committee to meet monthly for discussion of outreach to potential new members. Maria Walker will bring this up at I/DD committee. Tim DeWeese offered to serve on behalf of BH.

"Discussion of Year Ahead"

Jonah Cunningham - the brief papers on issues and state systems, directed to I/DD directors and MH directors. Regarding NACo collaboration on crisis response, focus on rural counties. Focus on 988 funding chart, state system papers, etc. Staff retreat. Calendar of committee meetings and other activities. Positioned us with the NACO mental health commission. Pursuing some projects through philanthropic organizations.

NACo Mental Health Policy Summit

"Congressional, federal agency leaders, and national thought leaders will gather with county officials to discuss priorities for curbing the ongoing MH crisis, including strengthening the local crisis response infrastructure, policy solutions for addressing SUD, and enhancing behavioral and mental health services for justice-involved individuals."

NACo HSC Chair Helen Stone welcomed us to the first ever NACo MH Policy Summit. Counties provide these services and should direct policy. $83bn in community health services through 750 county BH and community providers, to improve personal outcomes and avoid incarceration/institutionalization. These systems are not sufficient to meet the scale and urgency of the national crisis.

Dr. Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use, SAMHSA. National Snaphot of BH Data/National Survey on Drug Use and Health Data show that: 1 in 4 adults had an MI within the past year (1 in 3 among people aged 18-25); 107k died of overdose last year; every 11 minutes a young person dies by suicide (now the 2nd leading cause of death for them); 7 in 10 adults with an SUD consider themselves to be in recovery; and 2 in 3 who have MI do. SAMHSA funding nearly doubled from FY22 to FY23. SAMSHA'S Five priorities (enhancing suicide prevention, crisis care, promoting resilience, integrating BH and PH, improving workforce) have cross cutting principles that services be culturally competent, data- informed, and trauma-informed. Update on 988 since the July 16, 2022 launch: calls increased by 48%, chats by 263%, and texts by 1445%; chat and text are largely with young people; subnetworks established for Spanish/bilingual, LGBTQ, and tribal communities. Long range vision is to have someone to talk to, someone to respond, and a safe place for help (if needed). 200 call centers across the country; working on messaging for communities that may be struggling and not accessing services. CCBHCs (over 500 of them) - essential services, regardless of ability to pay - data show greatly improved outcomes; new funding to scale this up across the country. SOR and TOR (opioid response

programs) to address SUD/OUD needs. Collaborating with Bureau of Prisons and DEA, on MOUD during incarceration, connection to services at reentry, decrease overdose, and increase connection to care. Workforce training and development, through technical assistance centers; increased training to work with diverse populations; mentoring program. View SAMHSA's website here. (www.samhsa.gov)

Questions: How to build crisis care continua in our very different communities? So far, 98% of callers have gotten a lot of what they were seeking just through the call, though connection to care is also critical. How to recruit and retain diverse providers? Workplace wellness is a focus (burnout, e.g.), so connection to other providers helps. Incentives, e.g., Minority Fellowship program, partnerships with HCBUs. Example of Chatham County, GA "Breaking the Cycle" program video. After this session, I spoke with Dr. Delphin-Rittmon about CLC and certifications/mentoring through Georgetown Leadership Academy not currently funded by SAMHA. She recalled participating in that program herself and acknowledged my request that SAMHSA fund it once again.

"Federal Policy Solutions for Addressing Youth Mental Health Priorities"

Hon. Dow Constantine, County Executive, King County WA. Decade long decline in youth MH, often resulting in juvenile justice detention.

US Surgeon General Vivek Murthy. Having good public services in these roles is more important than ever. Quickest way to get our attention is to create anxiety, e.g., the 24/7 news and social media. Impact on children is a prevalent and justified concern. Social media makes them feel worse about themselves and their friendships, but they can't get off it. They're also looking at climate change and racism and asking if the future really can be brighter than the past. We should not say they're weaker or less resilient because they're presented with new challenges. Unprecedented unhappiness among young girls. MH is foundational to development. Stress can be good in the gym but bad if you hold a weight for five hours; intermittent small dose stress can build strength, but chronic, protracted stress leads to inflammation and its related diseases (including MI). Stress can harm our relationships. Work on authorities such as parity laws, but also on resources to address MH (bns of dollars recently into school MH, workforce, expansion of coverage - need to be sustained). Health workforce burnout - beyond that industry and everywhere. Loneliness and isolation impact MH, physical health, civic engagement, school and work performance. Investing in rebuilding community and strengthening social connection is the best way to do this, e.g., Becoming a Man program in Chicago. Community-based programs, layout of community spaces, peer programs are also investments in social structure, creating more tightly bound communities which will have positive impact on MH and other health. We should not be going it alone, since we were not designed that way. Partnership across federal, state, and local governments.

"Addressing the MH Needs of Justice Involved Individuals"

Hon Janet Thompson, Boone County, MO Commissioner, introduced the topic and speaker. High cost/low outcomes of incarceration, local innovations through Familiar Faces Initiative.

US DOJ Associate Attorney General Vanita Gupta. Prioritized in several of their offices now, to understand why the paradigm should change and where to focus policy change and resources. Social supports specific to conditions and focused on community-based treatment as an alternative to contact with law enforcement. Cost impact. On the enforcement side, lots of Olmstead litigation in civil offices: need to break down some silos, currently working on a more integrated approach, across offices and federal agencies, to address specific problems we're all facing. Directing resources to county sheriff departments to strengthen connection to care. 2m people with SMI in county jails each year. Pretrial justice reform, also technical assistance and training (including for law enforcement to better understand MI and SUD), grants (support for co-responders, lifting up successful pilot programs, and to promote innovation nationwide.) Aware of the Stepping Up Initiative, an important collaboration to provide counties with resources to innovate for folks in crisis - 565 counties so far. Commissioner Thompson explained the initiative, identifying resources and barriers in your community, then getting stakeholders

into one room to share. Low availability of services, esp in rural and tribal communities. National Guidelines for BH Crisis Care, a no-wrong door approach. Crisis response centers that don't turn anyone away. Resources and TA for rural communities? Now prioritizing rural communities for grant consideration, offering a webinar to potential applicants. Acknowledgement of the trauma and stress experienced by first responders. Help jurisdictions adopt these programs to improve all of their work. Video of Lane County, Oregon's FITT program.

"Closing Keynote Remarks & Fireside Chat"

Hon. Kathryn Barger, Supervisor, LA County, CA introduced Secretary Becerra and shared his background, including championing BH improvement, esp SUD, Youth MH, and Suicide.

US Health and Human Services Secretary Xavier Becerra. If we get resources or new authorities, we need to work for the counties. 1/3 of girls have contemplated suicide, 15% say they were forced to have sex, 90% of Americans say we're in an MH crisis. Thank you to those who worked to implement 988, which is not a national system but a state-run call/text/chat system, which we poured more money into than ever. Need a focus on rural and small counties, as roughly 1/3 have no psychiatrist. Average of 11 years from onset of MH symptoms to treatment. The second largest killer of kids aged 10-14 is suicide.

Questions: Becerra went on a national tour to learn from counties about their particular challenges and innovations in MH/SUD; what were the findings? People don't believe the federal govt is listening, so they don't share at first. $2.5bn into MH in the last two years, but do you even feel it? That's how fast it was absorbed. A challenge to building this integrated adequate system is the workforce shortage; how can local behavioral health attract and retain a qualified workforce, as they continue to burn out? Again, big investments in the last couple of years, but also taking some of the public health scholarship funding and adding to it (e.g., if you commit to 5 years of service, 4 years of medical school can be paid off.) If people start their residency in a particular community, they tend to stay. With the success of CCBHCs and CAHOOTS, how does HHS respond? 24/7 crisis centers work and save a lot of money down the road; currently not many states have CCBHCs, a pilot from several years ago, so new funding will add more states. Some discussion of MH parity laws and enforcement. Groundbreaking approval of CA 1115 waiver to connect people to services upon release from jail/prison - permanent and federal? Prequalifying people for Medicaid before they leave institutions so there will be less wait for connection upon release saves a lot of money and pain. Housing and food security through Medicaid waivers: food is medicine, unhoused individuals are much less healthy and therefore rely on more expensive healthcare (acute, chronic). Wellness should be part of healthcare. Given all of this, collaborative inter- and intra-governmental partnerships will need updated data systems, but how? Counties have to deliver because these are our people no matter what. With the end of the public health emergency, 1.3m people may be coming off of Medicaid. We will work with counties to be transparent regarding how far we can reach, including into data use agreements. We don't have the ability to get this kind of local data without counties, different from the data exchange authorities during COVID. 51 have already signed data use agreements similar to those, hoping another 13 will sign off; many states have additional privacy law barriers.

NACo announced its new Commission on Mental Health and Wellbeing, to which NACBHDD will be an advising organization. Read more here. (https://www.naco.org/resources/signature-projects/naco-commission-mental-health-and-wellbeing)

NACBHDD Legislative and Policy Conference

Day 2: Workforce, Partners, and Skill Building

"Welcome"

David Weden, Vice Chair of NACBHDD. Sympathy to our colleagues from MI and their constituents.

"Workforce Presentation Panel 1: Landscape, challenges, and Policies"

"Through local, state, and federal perspectives, panelists will outline the current landscape of the behavioral health and intellectual/developmental disabilities (I/DD) workforce. Shortage areas, policy opportunities, and resources available through the Health Resources and Services Administration (HRSA) will be analyzed within the context of BH and I/DD."

Robert Sheehan, CEO, Community Mental Health Association of Michigan, moderated the discussion. Workforce gap in every field grew worse during COVID.

Patsy Cunningham, MA, NCC, LCPC, Behavioral Health Advisor, Health Resources and Services Administration (HRSA). Focus on equitable health care to highest-need communities (Community Health Centers = FQHCs), for health and MH and SUD services. HRSA's Behavioral Health Initiatives address: recruitment and retention, getting providers to stay where they're most needed; reducing burnout; culturally competent care and humility. Goal 1 - Expand the health workforce to meet evolving community needs. Goal 2 - improve the distribution of the health workforce to reduce shortages. (Goal 3 and 4 less a focus.) Started in 2014, Behavioral Health Programs; in 2021-2022 academic year, 12,974 trainees, 50% trained in medically underserved communities, 65% have SUD/OUD training, 8,555 graduated, 35% plan to continue in medically underserved communities. Requiring academic institutions to develop curricula related to trauma-informed care, SUD treatment, and other areas appropriate to the populations served. Workforce Resiliency Program started in 2022, with $103m of ARPA funds; $68.2m to 34 grantees for Health and Public Safety Workforce Resiliency training, e.g. several National Health Service Corps programs, including the SUD Treatment and Recovery (STAR) Loan Repayment Program to focus on medically underserved areas. Facilitating Equitable Access to Care through school-based services, community partnerships and events, community sites, and related. 1 in 9 children access care through HRSA funded centers, which are trusted sites for other resources and BH services. Behavioral Health and Telehealth (95% of centers offered MH, 64% SUD). Leadership Education in Neurodevelopmental and Other Related Disabilities: address SDOH in underserved communities and educate the future workforce; didactic and practicum experiences (impact of SDOH on health status of children); required to have self-advocates who are people with disabilities as well as family members of people with disabilities as trainees and faculty members. Developmental Behavioral Pediatrics: address Social and Structural Determinants of Health in curriculum and practicum experiences, increasing the diversity of the workforce too. Family to Family Health Information Centers: support, information, resources, and training to families of children with special health care needs; staffed by parents of children with special health care needs, there are 59 family-staffed centers in the US. Pediatric MH Care Access: promotes BH integration in pediatric primary care; supports pediatric MH care telehealth-access programs in 45 states, tribes, and territories; immediate resources for families in great need. US Dept of HHS and Dept of Education joint letter on Resources for School-Based Health Centers. Rural Communities Opioid Response Program: a multiyear, $500m initiative launched by HRSA in FY18, new investments this year focus more on children. Contact Patsy Cunningham (Pcunningham@hrsa.gov) and see HRSA's website here (www.hrsa.gov).

Elise Aguilar, Director, Federal Relations, ANCOR. I/DD Workforce: Landscape and Challenges. Members include 2000 private providers of I/DD services, 57 state associations, and 10 100% state associations. DSP Workforce Emergency is a longstanding crisis from years of underinvestment and stagnant reimbursement rates/low wages. In 2020, median hourly wage was $13.36, and average turnover rate was 43.6% across states. Impact of COVID - 55% of DSPs reported burnout, 56% anxiety, 43% sleep difficulties, 40% depression, and of those with a negative health/MH impact, 77% indicated their daily work life was affected. Termination of the flexibilities and funding from the Public Health Emergency will add challenge. Other results from the 2022 workforce survey: an issue of access, with people losing services and access to their communities. Phases toward the end of the PHE: lowering the FMAP increases by stages this year, Jan-Mar 6.2%, Apr-June 5%, July - Sept 2.5%, and then Oct-Dec 1.5% and then back to base next year, though states can begin the determination process on April 1. Loss of 1915c appendix K

flexibilities, esp where significant workforce shortfalls exist. Policies to Bolster Access to Community Services: support legislation such as the "Better Care Better Jobs Act" (10% increase in FMAP for states, frequency of HCBS payment rates, permanently extend Medicaid protections against spousal impoverishment, permanently extend Money Follows the Person program); support grant programs to strengthen the workforce (DSP initiatives); "Recognizing the Role of DSP Act" (Hasset and Collins/Fitzpatrick and Rolly) is bipartisan legislation to circumvent the lengthy OMB SOC revision process, to establish a separate code (31-1123) as standard occupational classification for DSPs as a healthcare support occupation, subset of 31-1120. ANCOR SOC Advocacy: reach out to OMB and BLS, provide input to SOC policy committee, etc. New Dynamics in 118th Congress, so some of the vehicles we had last year are not available, and we need to focus on what has bipartisan support. Proposed rulemaking assuring access to Medicaid services, updating the Fair Labor Standards Act, and transition to community employment. See ANCOR's website here (www.ancor.org) and contact Elise Aguilar (eaguilar@ancor.org).

Alexandra "Alix" Ginsberg, MPH, Senior Director, Congressional & Federal Relations, and Special Projects, American Psychological Association. Psychologists provide many services, some as part of a treatment team, to people with I/DD, including direct and indirect supports and in some states prescription orders; they are also researchers and scientists informing development of new testing tools and interventions. Challenges Facing the Psychology Workforce: burnout, student debt, no billing for services provided by trainees; coverage and reimbursement issues, unnecessary administrative burdens to coverage, costs of adopting new forms of treatment (e.g., telehealth, EHR systems); retention in rural and underserved areas; students of color looking to provide culturally competent services often need support during their training and practice, support which is ALSO culturally competent. Legislators agree that MH is an issue; where they disagree is how much money to put into it. Protecting Funding for Key Workforce Programs, IMHO Act, ADAPT Act, preserving access to new and effective forms of treatment, integrating MH/BH clinicians in primary care settings, ensuring access to new forms of treatment/digital therapeutics. Contact Alix Ginsberg (aginsberg@apa.org).

Questions: What gives you hope? Patsy Cunningham - seeing the passion of the grantees training the workforce; Elise Aguilar - that so many people are becoming aware, including the President's acknowledgement of care for seniors and those with disabilities; Alix Ginsberg - the new acknowledgement of the importance of MH/BH broadly, changing the dialog.

"Workforce Panel 2: Responses and Necessary Innovations"

"Panelists will discuss the opportunities created by the workforce challenges and policy responses including the recently passed Omnibus Bill. The use of technology and innovation necessary to support the expansion of access and local responses will be examined."

Maria Walker, Program Planner, Polk County Behavioral Health and Disability Services, and NACBHDD I/DD Committee Chair, moderated the discussion.

Roger D. Smith, JD, Director of Government and Corporate Affairs & General Counsel, American Association for Marriage and Family Therapy (AAMFT). Marriage and Family Therapists have masters or doctoral degrees, supervised clinical experience (most direct client contact), clinical exam, systemic orientation. LMFTs work in a wide variety of settings, recognized by insurance companies, Medicaid, VA, Medicare (in 2024), and other payers. Medicare update: additional BH providers as of Jan 1, 2024, after a 30-year battle, congress will recognize LMFTs and LMHCs as Medicare-eligible providers, per the Omnibus bill. Mental Health Access Improvement Act of 2021 (HR432 and S828), advocated for by Medicare MH Workforce Coalition, comprised of numerous associations, federations, or centers. Adding these providers in traditional settings, Medicare Advantage, RHCs, FQHCs; they are 40% of the masters trained MH workforce. Adding these folks, who don't have experience billing Medicare, to work in 2023 on engagement with CMS, provider enrollment, educating stakeholders about the change, impact on agencies and clinics. Issues: workforce shortage, low reimbursement rates, telehealth reimbursement,

licensure portability, loan repayment, minority fellowship program, state-level programming for diversity. The Mental Health Access Improvement Act can be found here (https://www.congress.gov/bill/117th-congress/house-bill/432). AAMFT's blog is linked here (https://blog.aamft.org/2022/12/breaking-news-on-mfts-in-medicare-.html).

Neal Tilghman, MPA, General Manager, Integrated Care, Netsmart. Market dynamics include the same things that drive our policy initiatives: workforce challenges, more choice driving competition, whole-person care, national focus on BH, shift to value-based care, and economic uncertainty. We were talking about integrated care back in the 1980s but didn't have technology to support it. We finally understand the importance of BH care but now don't have an adequate workforce to meet the needs, and we are competing for the same staff. The right technology optimizes workforce recruitment and retention: platforms appropriate to the service, automation (AI, machine learning), and Intuitive UX (extreme usability) for two types of user, one who's tech savvy and expects the same technology as they have in their personal life, with a simple user experience. Regarding overload, no one says they went into human services because they enjoy documentation; for natural language processing to help users write their notes, developed an app called 'scribbles' which can be entered on the phone and then automatically synchs into work files when in the office. People were having trouble coding SDOH, so when 'housing', 'food', or 'nutrition' are mentioned, the appropriate SDOH code will attach. Workforce Management - more services than ever, so developed support for niches, starting with EVV, Mobile Caregivers, CareRouter, Route Optimization, Capacity Management, and Shift Bidding (which becomes a retention strategy). The impact is optimized revenue, improved care, and operational efficiencies. Contact Neal Tilghman (wtilghman@ntst.com) or 913-272-2177.

Brian Hart, COO, Living Arrangements for the Developmentally Disabled (LADD). Smart Living is a new way of delivering services with a technology-first mindset. We have had staff for the "what if" and can change the way we look at services, using a technology mindset to address any needs which can be handled safely and appropriately, and then bringing in staff for the rest. Smart Living Pilot: 3 years, Smart home technology, wearable technology, staffing efficiencies, and remote supports in place. Outcomes: publishable research on which technology investments have the greatest return on investment (ROI) and/or impact on independence; a means for remote supports once a person leaves their home. DSPs shared detail on what they did during shifts, were providing 308 different tasks that were important to people, with 148 of those related to health and safety; 89% of 'total requirements' have an identified solution, and over 99% of 'must have requirements' have an identified solution. Working on an I/DD specific design for med dispenser. Solution Development Summary: 6 communication requirements related to simple, voice, video, and staff assistance; 16 for daily routines; etc. No longer do we plan around staff just waiting; a new staffing model addresses what's left that technology does not exist to handle: DSPs can be intervention specialists in areas they're passionate about; remote support staff provide anticipatory supports, monitor for needs and drop in virtually for scheduled supports; all time spent by staff is value-added; model allows for reduced staffing. No one has been replaced with a robot! Heidt Smart Living Home in Cincinnati, after 18 months, reduced over 100 hours of direct support, increased levels of independence for residents and satisfaction for them and staff. Xavier University Occupational Therapy 3-year study on technology and independence showed incredible results (watch out for power outage, when you have to send in staff, but the people living there might not like it). Partnership with health companies on tech. Smart Living Pilot Successes: wearable technology to assist with transportation; smart refrigerator for meal assistance; smart shoe insoles to increase inclusive community independence; new model significantly reduces staffing needs for expansion. Gaps are Transportation, Integration, Customization of Needs, and Buy-In. Contact Brian Hart (bhart@laddinc.org) and visit the Ladd smart homes website here (https://laddinc.org/program/smart-living/).

Questions: How does increased demand for services affect the workforce challenges? People are coming into services and living longer, but the workforce is getting smaller, and they're covering more. It's not a new problem but just much worse, getting legislators' attention, and a greater pull into private practice and out of community-based settings. Technology does not replace staff but should help us do more with

less, since there won't be a huge influx of any type of worker, though many people fear we're trying to replace clinicians and caregivers. How can we leverage technology to supplement our current workforce? What are the tradeoffs? An app can specialize and simplify any workflow. How can local authorities respond to the opportunities in workforce development? Support for supervision, loan repayment and student aid, since we are putting a lot of attention into direct care. Don't get excited about shiny, new technology without thinking about how to operationalize it past the pilot phase; some off-the-shelf technology is effective for remote support. As you're thinking about changing the way you do things using technology, consider whether a 10k innovation grant is really going to do anything; find out what others are already doing, esp because they don't have an option; think bigger, try out pilots from larger funding sources. How did you meet requirements for face-to-face time, within state regs? Ohio is a tech-first state, the rule was vague - go to state officials regarding whether a rule should be waived for a pilot and consider what face to face means (virtual or physical presence). For a rule-oriented state like Iowa, pilot wherever possible, then show results (guardians may be reluctant initially) and look at the rule for 24 hour supports to understand if being available, as opposed to physically present, is actually the service.

"Workforce Panel 3: Aspirations and Where We Need to Go-Local & State Solutions"

"Considering the expansion of opportunities within BH and I/DD service provision, local and state leaders will reflect on the future of workforce development within their communities and the nation at large."

Cherryl Ramirez, Executive Director, Association of Oregon Community Mental Health Programs (AOCMHP). Sustainable funding for the systems will stabilize the workforce.

Mary P. Sowers, Executive Director, National Association of State Directors of Developmental Disability Services (NASDDS). Landscape of Services/Challenges: struggle to provide community MH services for people with IDD; those with ID/MI dual diagnosis stretch the systems of care; lawsuits related to care in multiple states; lack of expertise, resources, and capacity to best support people with dual dx; siloed systems responsible for different elements of care; lack of trained medical, law enforcement, and crisis care providers. Disproportionate impact of new challenges. Promising practices and trauma-informed, person-centered, multidisciplinary approach: commitment to trauma-informed, holistic, and person-centered practices to provide support to individuals in a manner that meets their specific needs; national partnerships, initiatives, and research projects to address the growing need; identification of multi-level system interventions to enhance capacity; collaboration and coordination within state systems and cross-sector initiatives. State of the workforce survey showed: 30% closed locations during pandemic, many not reopened; 40% ended some types of services and stopped serving people with complex needs; more engagement with families but need to protect autonomy and choice for individuals. Isolation of both staff and individuals. Early turnover is not uncommon as people often don't realize what the job really is, requiring better communication up front. Every state has made investments in the workforce with ARPA funds, some permanent increases, but not moving the needle on the vacancy rates. Leveraging technology, with many caveats, esp respecting privacy and not increasing social isolation. Increased interest in self-direction, with people hiring their own staff and deciding how their resources are allocated, and growing recognition of the essential nature of this workforce. Preliminary data on the survey results, with full publication soon, National Core Indicators survey with a workforce component: vacancy rates still too high; turnover not budging from 2020 to 2021; race/ethnicity data, gender, etc. Need for federal, state, and partner efforts to devise long range solutions: BLS classification legislation; sustainable investments; wage control; professionalizing the workforce; ensuring benefit analysis to recognize the nature and needs of workforce. Working with other associations to make these happen, e.g. NASMHPD and NADD. National Resource Center for People with Intellectual and Developmental Disabilities and Co-occurring Mental Health and Related Conditions - goals of the TA center are Systems Change, DSW and Clinical Capacity, and Service Access. Clinical training on such things as the words you use and their meanings, relationships will provide the opportunities for co-learning across the systems.

Tim DeWeese, Director, Johnson County Mental Health, KS. Workforce Development - this is an employee shortage. Johnson County had an alarming rate of youth suicide in 2018 and created a student-led

campaign called 'Zero Reasons Why', with subsequent decrease even through the pandemic. Hopeful about the future due to working with these young people; they had no idea of BH or I/DD systems and thought of social workers as people who remove children from families, also thought you had to have a doctorate to work in community MH. Shifted energy to educating people at these early ages, to communicate a career path to middle and high school students. Most school districts are responsible for some career tracks but usually nothing related to our work. Two students spent the summer with Tim devising a plan through focus groups, to communicate better and replicate the success of Zero Reasons Why. If any school asked for a presentation, they were there; career fairs not just at universities; offered high school internships, a week or a semester, by signing up through a website; then developed a relationship with the local junior college. Three essential qualities of a 21st century public servant in MH: openness to learn; desire to help others; ability to engage others. Four reasons to consider it: saving lives; improving communities; influencing social change; personal fulfillment. The young people he works with want to support each other, have shifted from wanting to be 'content creators' and toward wanting their parents to put down their phones. They benefit from learning about the 'why' of our work, can learn the rest later. From the federal or state level, the focus on money is good, but there need to be people, so develop relationships to let decision makers know what is important in secondary education.

Questions: The one-pager showing a pathway is helpful, pay range on second page - pushing for associate's degree, and what are you doing about a peer workforce? In some rural areas, requirements might shift from bachelor's to associate's, so design an associate's program for this work. People with a background in direct care and retail have an edge, having learned to deal with people. Johnson County has an economist on staff as an analyst; although 'pay is not why people stay' their data show that for every 8% they raise salary, there's a 10% reduction in turnover. As for peers, provide opportunities for career tracks for those willing to share their story and what they've learned; create an environment that allows people to speak on their lived experience.

"Partner Discussion Panel"

Collaboration is imperative for improving access to BH and I/DD services. NACBHDD partners will share the vision and mission of their respective organizations, building an image of the landscape or work being done in behavioral health and I/DD within various interest groups.

Jonah Cunningham, President & CEO, National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) moderated the panel discussion.
Michael Linskey, Director, Congressional Affairs, National Alliance for Mental Illness (NAMI). 49 state and over 600 local chapters, educating and advocating on MI.
Stephanie Katz, JD, MPH, Assistant Vice President, Public Policy and Advocacy, National Council for Mental Wellbeing. Representing 3200 organizations, primarily serving low-income patients. Prioritizing MH as a core component of health.

Discussion: Last year was a high watermark, with Safer Communities Act expanding CCBHCs, which was a pilot for about ten years, as an alternative payment model for people with BH conditions, going very well. People receive all health, basic primary care, MH, SUD services, and care coordination in one place. Now the opportunity is expanded to all states. Currently 12 states, now 10 every two years from among applicant states, using the demonstration format. Then waivers to continue the model. The ROI is incredibly high, with better access and lower wait times (average 48 days across US, but 1/3 are seen day off and the rest within 10 days). NAMI supports the model too, seeing that people get timely care; recall that average 11-year gap between symptom onset and seeking care. How has the launch of 988 gone from your perspectives? The transition to 988 and results so far are phenomenal - 1200% increase in text and chat; second component is a qualified person to talk to - people need an MH response to an MH crisis, rather than law enforcement contact or ER; the third component is places for people to go for 48-72 hours to stabilize. Continue advocating with legislators about the need for MH funding to be sustained. Mental Health First Aid modules. Alternative payment model structure - you can build more in that

prospective payment system (PPS) to help stabilize the safety net, but it's not enough for recruitment. To engage the workforce, make HRSA programs easier to access (open the interpretation, esp to reach people where they are.) Increasing the numbers of peer support specialists in the workforce. Regarding enforcement of parity, we will not be able to fill this gap until commercial insurance makes some contribution to these effective programs. Request for advocacy in two areas: more demos with the PPS, as opposed to the SAMHSA grants; the telecom industry doesn't want to pay for all of 988, but our communities don't have enough funding to stand up crisis stabilization centers. FQHCs get other funding through 330 grants, so convert SAMHSA grants into those. Some states are appropriating bridge funds. What are you planning for 2023? Prepared for it not to be as lucrative, but youth MH is a shared priority, as are maternal MH and the criminal justice space where MH is incredibly costly, also licensure for the workforce sitting and waiting (some unable related to SUD - these would be a huge asset) and engaging a culturally competent workforce. Some reform in the IMD exclusion area and the reauthorization of acts. Successfully lobbying involved educating people about the SUD/OUD crisis and the $ cost to Medicare and Medicaid. $30m of Harm Reduction funding (fentanyl test strips) just went out the door! The IMD exclusion is outdated - 60% of people in jails have not been adjudicated and yet go without Medicaid - any hope for advocating, with Sheriffs as well? Yes, they are a crucial partner. The physical cost can be overdose death upon release. Due Process Continuity of Care Act (led by a Republican) got a piece of this done, but it was expensive so they cut it to juveniles. That was the first step, so we should keep moving this, as adjudication can take a very long time. For resources on 988, use this link (www.reimaginecrisis.org). View the Council's Impact Report on CCBHCs here (https://www.thenationalcouncil.org/resources/2022-ccbhc-impact-report/).

"Executive Coaching: Increasing Retention through Leadership Actions"

"As part of NACBHDD's mission to provide professional development to its members, executive coach Anne Collier will bring participants through a training in using executive leadership skills to increase workforce retention."

Anne E. Collier, MPP, JD, PCC, CEO, Arudia. Resilience and Leadership Styles (style, shadow, cultural implications, steps to improve culture). Select Resilience Measures (autonomy, feeling supported, your opinion matters to leadership, not feeling overwhelmed - all help people want to stay). Perceptions of Leadership (trust, models good behavior, cares about us, effective). Group Culture: underlying personality that is expressed in its ability to regulate collective emotionality; factors include the leader's ability to regular emotionality (and team and environment). An actualized leader. Dynamic: passion and authenticity, open. Protect the team from too many external distractions or influences, celebrate team successes, provide resources and realistic performance feedback, no micromanaging. Optimistic, thoughtful, curious, patient, communicates, listens, etc. What happens under stress is what we don't want - reactivity (impatient, blaming, venting, worrying, fretting, obsessive, anxious). Impact of leadership on culture: Dr Sparks' actualized leader framework, which is based on the work of Maslow, McClelland, Jung, and Frankl; at the apex you operate out of self-actualization; to manage stress and the shadow side, focus on the test presented by this shadow.

Affirmers. At the most disempowered and irrational moments, Affirmers are sensitive, insecure, indecisive, complacent, accommodating, dependent, possessive, anxious, and jealous. When stressed, the amygdala is hijacked, but you can choose objectivity or shadow. Cultural implications: when your leadership is in a good place, collegial environment (friendly, inclusive, supportive, community, dedicated, courageous), but the shadow side is dramatic with frustration and despair (norm of overly polite, warm, friendly atmosphere, looks to the future for salvation, differences smoothed over rather than resolved, lacks candor and encourages gossip). 47% of people feel hopeful but frustrated in this culture. To transform the Dramatic to Dynamic: provide honest and critical feedback; address poor performance, unrealistic expectations, or obvious problems; set challenging performance goals and standards; appoint a devil's advocate to critique the team's performance, plans, and decisions; and encourage expression of concerns, doubts, or criticism.

Asserters can be risk-takers, skeptical, slow to trust, and challenge the status quo; they are rational, objective, analytical, critical, focused, hard-working, results-driven, strategic, negotiators, solving complex problems. Their shadow when disempowered and irrational: arrogant, impatient, condescending, blunt, domineering, autocratic, manipulative, rude, intolerant, belligerent, and domineering. Cultural implications of an actualized asserter, when aligned: interdependent, risk/reward, take charge, progress, strategic, fearless. With the shadow fear of betrayal: dependent, fear, anxiety. The characterization of that culture is not recommended as a workplace, not easily forgiven. How do you transform dependent to dynamic? Provide clear direction and purpose; involve team in developing specific performance goals; provide info to move to interdependence.

Achievers are dependable, organized, responsible, committed to results, serious about work, cut to the chase, and independent. Protocols clear and administered precisely. High individual achievers, driven, focused, competent, and controlled, perfectionist, excellent planners, back-up plan, requires concrete feedback, risk averse, focused on expertise and competence. They prefer consistency and predictability, are detail-oriented, disciplined, focused, efficient. When empowered: detailed, organized, structured, thorough, serious, and getting it done. The shadow is fear of failure with triggers of scarcity, prospect of losing, imperfection, ambiguity, so at their most disempowered and irrational, they can be rigid, cautious, tedious, stubborn, critical, narrow-minded, inflexible, obsessive, argumentative, pessimistic. The first sign of Achiever shadow is being critical, obsessive, cautious, rigid, pessimistic, inflexible. Historically, inadequate resources are allocated to this industry, so there is often a hangover culture related to problems like that after they've been solved. The impact on workplace culture of actualized achiever vs shadow fear of failure: when independent, a sense of ownership, dig in, initiative, serious, deliver accountability; when detached, there are delays making commitments or difficult decisions, some members don't participate, physical and psychological withdrawal, lacks overall sense of us or we, focus on individual agendas, "easier to do it myself.: Transforming Detached to Dynamic: realize that surface problems are often symptomatic of the real underlying issues; allow members to acknowledge their anger or apathy.

Actualized leaders are confident, perform well, and have a sense of renewal. Do you think in a way that allows you to be immersed in an issue? Do you trust your team (trust is reparable)? If you are in flow, you perform incredibly well. Optimal time orientation is about being in the present most of the time. Acceptance (self). Solitude. Having a solution-focused mindset and not spending time blaming people, bring the team along. Candor is kindness; affirmers blow things off and let frustration mount to the point of blowing up. To avoid dominating the conversation (because you're nervous, e.g.) - ask open-ended questions, allow people to develop confidence in their own ideas. Be curious, encourage the expression of doubts, which can be valuable. Step 1 - establish focus. Step 2 - brainstorm options. Step 3 - create action plan. Step 4 - remove obstacles. Step 5 - review and commit, follow up. Use Trust as a Management Tool - if you don't trust someone, find out why and solve it (openness, reliability, integrity, benevolence/caring, competence); sometimes just a need for apologies. Address Problems: not pretending that working harder will work, when the truth is that our systems are too stressed. Be realistic about workload and make choices about what is not getting done. Ruthlessly prioritize. Engage with staff. Arudia Leadership and Management Academy has certificates in leadership and excellence. Contact Anne Collier (anne@arudia.com)or 202-449-9751. Organizations can take the survey at Arudia's website (https://arudia.com).

Day 3: Crisis Response, Criminal Justice, Federal Partners, Keynote

"Keynote Address"

Dr. Rahul Gupta, MD, MPH, MBA, FACP, Director of National Drug Control Policy. Referring to the State of the Union address. 107k Americans die each year from overdoses and drug poisoning; that's 1 every 5 minutes. Started with prescription drugs and heroin, but now people are buying drugs through apps, e.g. what they think is percoset, and die from one pill. For the first time, we have passed the milestone of 100k death per year. ONDCP in operation since 1989, the principal drug policy adviser to the President,

manages the NDC budget of over $40bn. Map of High Intensity Drug Trafficking Areas and overview of HIDTA program; law enforcement officials bring all the other systems together, effective to address trafficking. Across the country are 745 Drug-Free Community Coalitions, to delay or prevent drug use in kids (2.6m middle school and 3.8m high school youth in these communities); this funding opportunity is open. Drivers of the epidemic are untreated addiction, lack of treatment infrastructure, and drug trafficking profits. Synthetic drugs (meth, fentanyl) are replacing those grown. In the SotU, he addressed: cracking down on fentanyl trafficking through a new surge to disrupt trafficking, distribution, and sale; a concerted diplomatic push with China and Mexico; National ad campaign to educate young people on saving lives from fentanyl; and making sure everyone can access treatment. Working with Congress to make permanent scheduling. Carrying Naloxone/NARCAN with you, to help others. 80% of overdoses are related to fentanyl, so this is a realistic harm reduction tool, along with fentanyl test strips. Challenges facing the medical and public health community are lack of additional treatment infrastructure, lack of enforcement of parity laws, workforce strain (including by COVID), and critical shortages of psychiatrists, counselors, and other key roles. People in recovery are some of the most passionate and hard-working. Equity Lens: last fall, the administration committed to pardoning people who had marijuana convictions and asked state governors to do the same; working to reschedule it. The sentencing disparity between crack and powder cocaine is largely racial. Got a letter from an inmate who had created a program specifically for drug dealers. 60% of those incarcerated have an SUD; an expensive way to address the problem. In all of the 122 federal facilities, treatment will be made available to all. Will ask states to offer 1115 waivers so that people can restart Medicaid 90 days prior to release. Upon release, people are much more likely to die if they are not connected to treatment. Less than 10% of people get treatment. Advancing Racial Equity. Going After the Entire Supply Chain is another priority: seizing historic amounts of fentanyl at the border and domestically; leading the world to tackle the fentanyl supply chain; nearly $9bn denied to traffickers and producers. Provide the technology needed. Commercial disruption of transnational criminal organizations. Illicit fentanyl supply chain - from source to end user to profits, which involves mapping tunnels and routes, identifying the illicit finance structures, commercial transportation, and manufacturing to go after the lawyers and real estate agents and accountants who are also involved, to create disincentives. “The X Waiver is Officially Dead” - to ensure universal access to medication for SUD care, to increase prescribers and pharmacies comfortable with it. 30% of counties don’t have an x waiver prescriber. ONDCP’s Model State Acts: naloxone; syringe services programs; deflection to treatment by law enforcement and first responders; opioid settlement funds; overdose fatality review teams; model overdose mapping and response; SUD treatment in correctional settings. Policymakers and first responders have access to near real-time, actionable data from 911 - along with DOT, a first of its kind non-fatal overdose dashboard. On two week lag, we can track nonfatal opioid overdoses nationwide. Positive response from Congress, press, and researchers. Through ARPA, Inflation Reduction Act, and Omnibus, more resources than ever to address these. Inflation Reduction Act - lowering Rx and health insurance costs for millions; Dr. Lorna Breen Health Care Provider Protection Act; SUD block grant, state opioid response grants, and more. Contact Dr. Gupta (ONDCPDirector@ondcp.eop.gov) or Twitter @DrGupta46. Visit the Office’s website (www.ondcp.gov).

Questions: Local direction? Congress providing authority through ONDCP was to ensure the funding would go all the way to the local level. State SUD and public health leaders are in collaboration with them. Glad to hear the early warning (just as with TIA, intervene at the point of a non-fatal overdose), wondering how to coordinate hospitals and SUD care. Understand addiction as well as we do other diseases. Reimbursement pieces needed but also that people see it as part of health care and share responsibility, the right thing to do. Some resistance from ER doctors; another was people were not allowed to hand out naloxone. High threshold, high dose, how to connect back to care.

“Crisis Response Presentation Panel”

“Crisis response efforts such as the National Suicide Prevention Lifeline have filled a gap between behavioral health care and emergency services. The importance of these services has been underscored by the recent launch of 988. Panelists will discuss the impact, infrastructure, and future of local crisis services.”

Michelle Cabrera, Executive Director, County Behavioral Health Directors Association of CA, moderated this discussion. Only 30% of CA population is covered by Medicaid, no solution for those with private insurance. Infrastructure not complete - workforce, funding for the other 70% - to build out this vision of a parallel BH crisis system. We hear about burden those with MH or SUD crisis place on hospital and law enforcement.

Chelsea Thomson, MPP, Program Manager, Justice, NACo. Best Practices side. Counties Developing Local Behavioral Health Continuums of Care: investing at the front end to address SDOH. SAMHSA's crisis response framework calls for: someone to contact, someone to respond, and somewhere safe to go. Adapting this to local needs, assessing each community's resources and needs. Some of the smaller counties are innovating due to lack of resources. Examples of successes in each of the three components of the framework from: Taylor County, TX (p 143k), Montgomery County, OH (p 537k), Santa Barbara County, CA (p 1.9m), Johnson County, KS (p 609k), Summit County, CO (p 31k), East Baton Rouge Parish, LA (p 457k), Sebastian County, ARK (p 128k), and Kitsap County, WA (p 275k). Providing data that officials can use to justify continued support for these programs. Many of the communities took ten years to get there. County funding opportunities to support community members experiencing a BH crisis - paper (linked and referenced in earlier session) from NACBHDD/NACO, with funding chart and 30 examples. County elected officials are ready to do this work and encouraged to see their neighbors doing so. Contact Chelsea Thomson (cthomson@naco.org).

Kenneth Minkoff, VP and COO, Zia Partners Inc. Zia Partners' website is here (www.ziapartners.com). Planning and Implementing an Ideal Crisis System: the essential role of county/regional leaders and collaborations. For more on the Crisis Roadmap, visit this site (www.crisisroadmap.com). Too much of the planning has involved SAMHSA, the states, and providers with the idea that whatever we throw out there, the local systems will just handle. Our starting place was beyond the SAMHSA framework and emphasizing not a list of services but a system responsive to your population. Who is responsible for the quality of the airport? In this metaphor, the programs are planes, first responders are airlines, the clients are passengers, but who is responsible for the operation of the whole airport? Roadmap to the Idea Crisis System, a report of the Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. Reviewed every detail they could find and put them into a package with objective measures of performance. Focusing on section 1 of the Roadmap report, regarding an accountable entity: county/community collaborations; state and regional/local partnerships; adopting the vision of an ideal system; accountability and performance management; engaging multiple funding partners; developing a strategic implementation plan. The county isn't responsible for funding the full emergency medical system but is responsible for coordinating it, a similar dilemma. Started the Roadmap with a vision: every individual and family in the US will have access to best practice BH crisis services that are welcoming, person-centered, recovery-oriented, and continuous; an excellent BH crisis system is not a luxury but an essential community component; every community should expect a highly effective BH crisis response system to meet the needs of its population, more than a single crisis program. Three Interacting Design components are clinical practices, service continuum, and accountability and finance, including governance. Must have a mechanism to finance and implement a continuum of services and a mechanism to ensure oversight, accountability, and quality of the performance of that continuum. This accountable entity is a regional/local collaborative structure, the necessary missing link to bring in multiple funding sources and create seamless services. Each state has intermediary structures - regions, counties, managing entities, designated agency catchment areas, regional and local BH authorities, community service boards, etc. Conveners and partners from many systems. "Nothing about us without us" has not been adequately recognized yet. Contact Dr. Minkov (kminkov@aol.com).

Crista M. Taylor, President and CEO, Behavioral Health System Baltimore. Baltimore City is under a consent decree but was doing this work before that. Transforming Behavioral Health Crisis Care: hard to hold yourself accountable if you're the service provider; core functions are advocacy and planning, managing public funds, local partnerships, public education, and system management - blending it behind

the scenes to make sure it's working for the community. As a non-profit, they can say more about how the system is really working. 17 hospitals and numerous BH providers in the 4 jurisdiction region, making this non-profit a good choice for regional administrative manager.

Adrienne Breidenstine, VP, Policy and Communications, Behavioral Health System Baltimore. GBRICS project, years in the making, even before the funding of hospital dollars, reinvested into local crisis response - $45m over 5 years to invest in BH crisis services and infrastructure. Goal is to reduce unnecessary ED and law enforcement interaction. Regionalized 988 call center (had been separate centers) by investing in software technology and same phone system regardless of provider. Doing open access, a bit outside of the 'crisisnow' model. Community engagement is a big piece, to change the culture of calling 911 and going to the ED for help - a broad 'call 988' campaign. Implementation Milestones specific to their role as the local BH authority: convene hospitals and other partners; grant award; planning and community management; and service implementation start. Prior to funding, developed influence by attending and hosting many meetings. Contracts with 17 hospitals. MOU with other local BH authority partners. What to do with other money to align services, deliverables, etc. Working with the state Medicaid office for coverage and reimbursement, critical for sustaining the services. Advocacy at the state level for 988. Politics with regionalizing, leading change management, 988 rollout and what that means at the local level, least police response possible, unique needs and expertise needed to develop child services. Communities must be meaningfully involved.

Tess Parker, LMSW, Clinical Consultant, tdb Solutions. Why/How/What - working through policy research, assessment, training and TA, and identifying funding sources. What US BH crisis care looked like pre 1970: 911 (which started in 1968), EMS, law enforcement, ER, inpatient psych hospital regardless of level of support needed. We know community-based care is better, reduces the chance of iatrogenic harm (which happens in EDs and inpatient - wearing gowns, being secluded, etc). We measure what we care about, e.g., how much gas is in the car or money in the wallet. Great to have personal stories paired with data to tell how services are operating and how to improve them. The development of crisis services is unique to each community and sustainable, keeping people closer to home and families where care coordination can be effective. SAMHSA framework is great but not enough; to avoid unnecessary ER visits, collect data, including voluntary and who left; mobile crisis won't get all of those, so create BH urgent care centers, then point out to payers how they'll save $ and replicate systems in small, medium, and large counties. Support rural regions through telehealth.

"Criminal Justice, State Hospitals, and Community Care Presentation Panel: The Need to Coordinate Services"

"As the demand for BH and I/DD services grows, it is important that we consider how to maximize our resources through coordination. Whether an individual interacts with the criminal justice system, hospitals, or community care providers, they should be connected to the services they need to ensure a continuum of care. Led by the panelists today, we will discuss the impact of recent initiatives and their effect on the need to coordinate services."

Lynn Canfield, Executive Director, Champaign County Mental Health and Developmental Disabilities Boards, and Chair of NACBHDD Behavioral Health and Justice Committee, moderated the discussion.

A. J. Walker, MPA, Policy Director, National Association of State Mental Health Program Directors (NASMHPD). Key themes of focus for 988: sustainability, technology, workforce (increased need, reduce barriers), equity, and communications. See NASMHPD website (https://nasmhpd.org) for papers such as "Lending Hands…" Law enforcement, EMS, BH crisis responders are key stakeholders; need accessible crisis responses, equitably distributed across all neighborhoods and areas. Police partners need tools and training and least restrictive approaches; ADA guidance helps dictate proper crisis practice to divert from justice system as much as possible. Workforce able to function in traumatic sessions. MH-based MH response such as mobile crisis, direct response at the scene, where law enforcement may or may not be involved. Street outreach workers, peer responders, some tailored to veterans, multi-disciplinary team responses, or a blend. Recommendations: sufficient federal funding; policies; mechanisms for

transportation while upholding safety; research on models; and data collection which is examined with an equity lens. Contact AJ Walker (aaron.walker@nasmhpd.org).

Monica Porter, Policy & Legal Advocacy Attorney, Judge David L. Bazelon Center for Mental Health Law. Again, as a non-profit, she can say things public officials cannot, including with data. The Need for Community-Based Responses: Black people and other BIPOC with MH disabilities in MH crisis are at great risk of arrest, incarceration, and fatal harm by law enforcement, 3x more likely to be killed by LE, with 1 in 5 who were shot and killed by LE being in an MH crisis. Black people and other BIPOC are also at great risk of racially biased harm by MH providers. Is 988 the Answer? An excellent intention, many calls can be resolved by skilled call staff, but there are concerns with real world application. 988 can lead to some of the same harmful results; LE may still be the responders; we need community-based MH support. Examples of communities with MH crisis teams or alternative model, with positive results are: Albuquerque NM, Denver CO, Minneapolis MN, Stockton CA, and GA's statewide crisis line. "Strategies for Delivery of BH Crisis Services in Rural and Frontier Communities of the US" highlights Alaska and others. Advocate for alternative response models. Regarding San Francisco and NYC: CA has a new civil court system, Care Court, which lowers the standard to enter treatment involuntarily and will lead to disproportionate outcomes, perpetuating institutional racism and worsening health disparities, as it denies autonomy and is less effective, where housing and person centered, culturally competent community based care are the solution; NYC mayor ordered that people be involuntarily admitted for such behaviors as mumbling and standing in the street, which will cause disproportionate harm to Black people and those with MH disabilities, where safe, supportive housing and voluntary services would lead to stability. Learn more on the Bazelon Center website here (www.Bazelon.org).

Michelle Cabrera, Executive Director, County Behavioral Health Directors Association of CA. Can also say things that those bound by local politics cannot. They are fierce advocates and say inspiring things privately. Before Care Court, our equity agenda included racist roots in psychiatry, such as the overdiagnosis of schizophrenia among Black people. It is a court order civil process inspired by the ACLU suit against CA regarding too-long wait list for hospitalization. As a result, the state turned to the counties and gave them responsibility for the felony IST population, and the counties responded that only through contracting with the state. This mobilized CA's policy work significantly. During pandemic lockdowns, with no one going in or out, the work got more complicated. Corrections budget is a threat. We've launched many policy initiatives, and the state is focused on solving it for felony IST, with bundled payments. The limitations of the current expression take us back to the core: we don't have workforce to staff to fidelity or resources to connect people to, such as housing. Exponential rise of felony IST with MH has been blamed on lack of treatment (blaming low treatment for ballooning homelessness), but the counties tell a different narrative - homelessness is driven by housing markets and availability, such that even residential treatment settings are nudged out of the market, and this increases negative visibility of people who use MH services. If we don't get to these core issues, our crisis systems, no matter how cool, won't work. Rather than hyperfocus on continuum of crisis, hold health insurers accountable for access to outpatient MH and build a better SUD care system. Take a structural perspective.

Patti Tobias, Principal Court Management Consultant, Court Consulting Services. The National Judicial Task Force to Examine State Courts' Response to Mental Illness: Report and Recommendations. Conference of Chief Justices and Conference of State Court Administrators started this work. All state courts should lead and support state-level MH task forces and support local judges and courts in the creation of champions, to engage with BH administrators to assess, develop shared solutions, and examine resources and tools in the report. Recommend judges exercise their power to convene because people will show up. Recommend the GAINS Sequential Intercept Mapping for all communities. Educate and train judges, court personnel, and communities. Advocate for public health model rather than CJ approach, to direct funding to divert people from courts and into treatment. So many people with SMI are being arrested or taken to ER, which is not the public health response. They do not belong in the court system. Reform the 'competency to stand trial' system. Deflect and divert to treatment. Address the needs of children and their parents before they are moved into foster care. SMI impacts all court dockets.

Contact your judges, share this report, meet and learn to work together. Visit the NCSC website for the report and more (https://www.ncsc.org/behavioralhealth).

Questions: How can we better the outcomes for those diverted away from the criminal justice system? National conversation around OUD, but in CA, meth, which triggers what looks like psychosis, causes new problems; we need to be adaptable (FEP is wonderful, but this is different); we need the 70% of commercial insurance to step up to keep things like this from becoming permanent disability. Medicaid pilots to do contingency funding. Stigma that 'the MH system is broken' when we haven't fully supported it due to MH stigma; acknowledge our collective responsibility. Second answer: connect to treatment as soon as there is contact with LE; Oklahoma police use ipads to connect people ASAP. Third answer: we have to collaborate across these systems, and at federal, state, and community levels. Fourth answer: Olmstead array of services should include ACT, supported employment, supported housing, intensive case management, and peer services. Voluntary engagement has better outcomes than AOT and better in integrated settings. Funding is limited, and where it goes the services will happen; we may be trending back toward reinstitutionalization and IMDs. Focus on home and community integrated settings. In policy, as we build the mobile crisis benefit, Medicaid won't reimburse if LE respond when not needed; this is a parity problem, so this restriction should be removed, and the solution to LE is not to tie BH up in knots; Care Court flips the concept of other specialty courts and puts the judge in a different position, no longer a partner. Housing is either non-existent or not open to our clients (due to felony, credit check, etc.) County BH in CA - 15k individuals into services in 2021, housed 7k and unable to house 8k even though they wanted it; outreach and engagement are not reimbursed, and it takes about 40 contacts to get this to happen. Need the support to do this on scale. CA courts did not create or propose this court - it came from the 13 big cities and governor. Locally members don't sound as strident because they have to work with the judges and LE, but in some cases, they come around and say these things too; when residential care is inappropriate we do need hospitals. Research on how AOT can impact outcomes is limited to cases where AOT was the only option. A report on MEPD, pilot study by 10 or 11 states and DC on the use of IMDs for MH treatment, summarily found it doesn't work. Acknowledge our shared goals and pair with them that research does not support these approaches; invest in programs that break the cycles. Homelessness is a motivator of politics - CA will see proposals to expand involuntary as a way to reduce homelessness, but what changes on the ground if we don't have services and places for people to live? MI has some judges and programs, a Detroit Probate Judge, e.g. Need more research on AOT, the role of the judge, and other practices that are not evidence informed. In MD, a pilot uses peers and builds evidence for it; are peers in other AOT models or other areas of the CJ system? First answer: peers working in the diversion program are very effective (not sure specifically on AOT); also listen to families. Second answer: NASMHD is pushing for peer support due to connection to community, teaching ADLs. Third answer: CA draft of 1115 waiver for counties to self-finance the ACT, supported employment, and forensic peers. 49th state to bring on peer support into Medicaid.

"Legislative Discussion Panel"

"As the highest lawmaking body in the country, Democrat and Republican legislative leaders will contextualize the role of congress within BH and I/DD policy."

Rene Hurtado, Chief of Staff, Emergency Health Network and Chair of NACBHDD Communications Committee, moderated the discussion. Shifting focus to legislative advocacy, a tenet of NACBHDD.

Joseph Ciccone, Legislative Director, Rep. Grace F. Napolitano (CA-31). Represents a portion of LA County and large group of members. Napolitano is the founder and cochair of the Mental Health Caucus. With 91 members, hard to get them all together. We disseminate info on legislation they're working on. Children's MH was included in a big package last year that wasn't signed into law and will be introduced this year. We've seen the benefits of school-based MH. The earlier we can help students, the better. Need proper funding and policy to back up good ideas. The Suicide Prevention Lifeline Improvement Act added some quality assurances and funding. Also on the Congressional Hispanic Caucus and working on a bill to ask

SAMHSA to put together a culturally competent program for Hispanic communities, similar consideration for Black Americans, and one for immigrants (esp with traumatic experiences along the way). Looking at the IMD payment provision, to repeal in circumstances and use data on community interventions and cost. Some people go from the park to the hospital and back. Campus-based and school-based services also face staffing shortfalls: working on a bill originally co-led by Katko who retired last year, The Mental Health Professionals Workforce Shortage Student Loan Repayment Act, with up to 250k in loans paid off in exchange for up to 5 years' service in an area, and looking for other ways to support the workforce. Telehealth MH being led by other offices, though we support it. What is the vision for 988 with your bill? The omnibus added $520m for 988 call centers to add text and chat and culturally and linguistically appropriate services. Making sure to connect 911 calls with 988 when appropriate and to work with SAMHSA to make things work as hoped. Other Congresspersons besides Napolitano have become interested in MH, which is very helpful - we want to know what the local impact is. Scholarship programs in addition to loan repayment? Will look into that. On the House side, waiting to see what the committee will focus on but still in organizational stage, still going to push Energy and Commerce to take up MH and addiction. For the Senate, wish we knew more. How to support the CLAS standards, which are unfunded, to build real cultural competence? Working on that. With workforce of so few qualified professionals to do the work, any expansion proposal that comes without staffing resources means that private insurers and schools are much bigger competitors, and we're not well-positioned to compete for workers. Nothing Congress wants to achieve is possible without significant investment. Again, get upstream (not loan repayment) to pay for education of a diverse set of professionals. A stipend program, paying $30k a year to get people out of the workforce and into a year of grad school, with the condition of three years in the field later. Enrollment in SSW is way down across the country. We need to get it together regarding marijuana. Scholarships are better for national and for diversification, plus assistance with costs of licensure and certification as well as grad school. Workforce includes administration and financial management. Cultural competence gets translated into services rather than having communities generating systems of care. As CCBHCs are expanded, the payment incentives will have to keep up with requirements such as SDOH. TX passed a law that for any hour a school provides education on healthcare profession, they should provide similar for BH care. Some HUD rules on the housing side, that if a person has been incarcerated or in a treatment facility for over 90 days, they are not considered chronically homeless and are therefore not prioritized for housing: fixing this might be a place where federal, state, and local interests are aligned. Advocacy communications committee. The Senate Finance Committee was focused on workforce, which may benefit from our local input. Joseph does put together a list of legislation related to MH and list of Caucus priorities and appropriations letters. The Omnibus had $26bn for MH.

"Federal Partners Update Presentation Panel"

"Impactful policy hinges on cross sectional relationships, especially those spanning between local and federal authorities. By understanding federal efforts in relation to behavioral health and I/DD policy, local providers better utilize available support systems."

Jonah C. Cunningham, President & CEO of NACBHDD, moderated his favorite panel.

Anita Everett, MD, DFAPA, Director of the Center for Mental Health Services (CMHS), SAMHSA. At CMHS, work through grants administration, TA in the field, products in our website store, and convenings to develop policies or discuss problems. Grants: half are block grants to states, which they have some flexibility with (e.g., workforce for crisis); homeless grants through the states to their communities; 40 types of discretionary grants which counties can apply for, including MH awareness training, AWARE grant for schools K-12 through BH authorities to increase awareness of MH and create pathways to treatment, Zero Suicide grants; and funding for 500 CCBHCs nationally at this time. Technical assistance centers of 23 different types, oriented to providing info to providers working in the field (SMI Advisor, Zero Suicide, e.g.); free CEUs; email a question (about SMI, e.g.) through the site and get an answer back from an expert; national guidelines for preventing suicide in children; trauma-informed care. Convenings: policy

and best practices academies, e.g. on crisis services; rising rates of suicide among Black youth. Visit SAMHSA's website here for more information (https://samhsa.gov).

Judy Qualters, PhD, MPH, Director, Division of Injury Prevention, National Center for Injury Prevention and Control, CDC. Top priorities: ACEs, overdose, and suicide are related public health challenges, with consequences for all of our communities. Data on prevalence and impact of each. 75% of 2021 overdoses were related to opioids. After 2 years of suicide declines, rates rose again. Public health approach, Framework for Prevention: define the problem using data; identify risk and protective factors; develop and test prevention strategies; and assure widespread adoption. Expand use of evidence-based practices. Collect and use data to support. CDC's comprehensive suicide prevention program: focus attention on populations with greatest risk- tribal, veteran, rural, LGBTQ; strong leadership that convenes multi-sectoral partners; data to ID vulnerable populations and characterize risk and protective factors; leverage existing suicide prevention programs; effective communication; promote connectedness. WISQARS injury data - interactive database can create customized reports. Take the SPACECAT, view the results, explore the toolkit; this tool is on ASTHO's website linked here (https://my.astho.org/spacecat/home), along with an interactive data dashboard. Need to build strengths at the community level. More information is linked here (https://www.cdc.gov/injury).

Kellie Kubena, Rural Health Liaison, US Department of Agriculture (USDA). 8 mission areas which have agencies within them. Rural Development is her area. Innovation Center with 3 agencies - Rural Business and Cooperative Service, Rural Utilities Service, and Rural Housing Service. Typically supporting capital cost, as the third largest bank in the country. Primarily implemented through the 47 state offices. Staff live and work in rural communities. Open Funding Announcements are linked at the bottom of the map under USDA Rural Development. This liaison role was created in the 2018 Farm Bill to collaborate and connect with community leaders, state and local health agencies, philanthropic partners, and federal and state governments. An inventory of MH rural mental health resources, but only available through people with usda.gov email addresses. Agricultural outlook forum will have a session on farm stress. Rural Data Gateway is now externally available, showing FQHCs and where USDA invested in them. Mental Health Awareness activities in May. Visit this link for information (Rural.health@usda.gov) and contact Kellie Kubena (kelliekubena@usda.gov) or by phone 202-579-5715. Subscribe to rural health govdelivery list. Two tracks of grants relate to pandemic, one to help hospitals be made whole, and the other to support innovation at the regional level. Rural Partners Network to identify needs and priorities and to access resources.

Kirsten Beronio, JD, Senior Policy Advisor, Center for Medicaid and CHIP Services, CMS. Medicaid & CHIP Developments to Improve Access to Behavioral Health Care. New role created by the administration. CCBHC demonstration to integrate MH and SUD with primary care, covering crisis response issues. ARPA increased Medicaid funding for mobile crisis, 85% FMAP for qualified services for 12 fiscal year quarters and $15m in planning grants awarded to 20 states. Workforce challenges continue, additional guidance on crisis response and on Medicaid and CHIP financing is needed. Support for school-based services, billing guidance issued and more in progress, a TA center with Dept of Ed, and improving transitions from jails and prisons.

Questions: What federal resources are available for local communities in this space? Panelists agreed they learn so much from counties, esp. about crisis services. To stuff as many mobile crisis services into the code to get 85% FMAP, is there a ballpark % that Medicaid will cover? ARPA established that match enhancement only to 2027. What % of the whole community? Commercial insurance should pay for some but does not.

NACBHDD presentations are here (https://www.dropbox.com/s/jfs28endknqa1vb/2023%20Legislative%20%26%20Policy%20Conference%20Slides.pdf?dl=0).