CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

Champaign County Developmental Disabilities Board (CCDDB) Meeting Agenda

Wednesday, March 23, 2022, 9:00AM
Shields-Carter Room, Brookens Administrative Building
1776 East Washington Street, Urbana, IL
https://us02web.zoom.us/j/81559124557 312-626-6799, Meeting ID: 815 5912 4557

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 in person 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. Public comment also will be taken remotely. The public may watch the meeting live through this link or view it later in archived recordings at https://www.co.champaign.il.us/mhbddb/MeetingInfo.php

Public Input: *All are welcome to attend the Board's meetings, using the Zoom options or in person, to observe and to offer thoughts during the "Public Participation" period of the meeting. For support to participate during a meeting, let us know how we might help by emailing stephanie@ccmhb.org. If the time or format of the meeting are not convenient, you may still communicate with the Board by emailing stephanie@ccmhb.org any written comments 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 5 minutes.*

1. Call to Order
2. Roll Call
3. Zoom Instructions - https://us02web.zoom.us/j/81559124557 **(page 3)**
4. Approval of Agenda*
5. Citizen Input/Public Participation
   The chairperson may limit public participation to five minutes per person.
6. Chairperson's Comments – Dr. Anne Robin
7. Executive Director's Comments – Lynn Canfield
8. Approval of CCDDB Board Meeting Minutes **(pages 4-7)***
   Minutes from the 2/23/2022 board meeting are included. Action is requested.
9. Expenditure List **(pages 8 and 9)***
   An "Expenditure Approval List" is included. Action is requested, to accept the list and place it on file.
10. New Business
    A. Analysis of PY2021 Claims Data **(pages 10-20)**
       A briefing memo details how the CCDDB and CCMHB funded I/DD services were utilized by individual clients during PY2021. Utilization summaries are attached. No action is needed.
    B. Review of PY23 I/DD Funding Requests **(pages 20 and 21)**
       The packet includes a suggested board checklist and spreadsheet of PY23 requests for I/DD funding, with primary and secondary board reviewers. No action is requested.

11. Successes and Other Agency Information

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

12. Old Business

A. Premium Pay for Essential DSPs **(pages 22-35)**

A cover memo, two-page fact sheet from They Deserve More Coalition, and personal statements are included for information only, to be shared with the Champaign County Board for discussion of use of ARPA Fiscal Recovery Funds.

B. CILA Update **(pages 36-46)***

A decision memorandum and attachments are included. Board action is requested.

C. CCDDB and CCMHB Schedules and CCDDB Timeline **(pages 47-50)**

D. Acronyms and Glossary **(pages 51-58)**

A list of commonly used acronyms is included for information.

13. CCMHB Input

14. Staff Reports **(pages 59-77)**

Included for information only are reports from Lynn Canfield and Chris Wilson. Due to focus on review of applications, other staff reports are deferred until the May meeting.

15. Board Announcements

16. Adjournment

**Board action requested*

#3

Instructions for participating in Zoom Conference Bridge for CCDDB Meeting March 23, 2022 at 9:00 a.m.

You will need a computer with a microphone and speakers to join the Zoom Conference Bridge; if you want your face broadcast you will need a webcam.

Go to Join Zoom Meeting
https://us02web.zoom.us/j/81559124557
Meeting ID: 815 5912 4557

One tap mobile
+13126266799,,81559124557# US (Chicago)
+16465588656,,81559124557# US (New York)

Dial by your location
+1 312 626 6799 US (Chicago)
+1 646 558 8656 US (New York)
+1 301 715 8592 US (Germantown)
+1 669 900 9128 US (San Jose)
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
Meeting ID: 815 5912 4557
Find your local number: https://us02web.zoom.us/u/kCrkmcope

When the meeting opens, choose to join with or without video. (Joining without video doesn't impact your participation in the meeting, it just turns off YOUR video camera so your face is not seen. Joining without video will also use less bandwidth and will make the meeting experience smoother).
Join with computer audio.

Once you are in the meeting, click on "participants" at the bottom of the screen.
Once you've clicked on participants you should see a list of participants with an option to "Raise Hand" at the bottom of the participants screen. **If you wish to speak, click "raise hand" and the Chair will call on you to speak.**

If you are not a member of the CCDDB or a staff person, **please sign in by writing your name and any agency affiliation in the Chat area.** This, like the recording of the meeting itself, is a public document. There are agenda items for Public Participation and for Agency Input, and we will monitor the 'raised hands' during those times.

If you have called in, please speak up during these portions of the meeting if you would like to make a contribution. If you have called in and therefore do not have access to the chat, there will be an opportunity for you to share your 'sign-in' information. If your name is not displayed in the participant list, we might ask that you change it, especially if many people join the call.

Members of the public should not write questions or comments in the Chat area, unless otherwise prompted by the Board, who may choose to record questions and answers there.

#8

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

Minutes February 23, 2022

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, Deb Ruesch, Georgiana Schuster, Kim Wolowiec-Fisher
STAFF PRESENT:	Kim Bowdry, Leon Bryson, Lynn Canfield, Stephanie Howard-Gallo, Shandra Summerville, Chris Wilson
OTHERS PRESENT:	Annette Becherer, Josh Cornwell, Patty Walters, Greg Schroeder, Danielle Matthews, Laura Bennett, DSC; Becca Obuchowski, Hannah Sheets, Community Choices; Sherry Longcor, Mel Liong, PACE; Angela Yost, Regional Planning Commission; Christine Leeb, Real Life Families; Joel Fletcher, Champaign County State's Attorney's Office

CALL TO ORDER:

Dr. Robin called the meeting to order at 9:01 a.m. Executive Director Canfield was present at the Brookens Administrative Center as per the Open Meetings Act.

ROLL CALL:

Roll call was taken and a quorum was present.

ZOOM INSTRUCTIONS:

Instructions were included in the packet.

APPROVAL OF AGENDA:

The agenda was in the packet for review. The agenda was approved unanimously by a roll call vote.

CITIZEN INPUT/PUBLIC PARTICIPATION:

None.

PRESIDENT'S COMMENTS:

None.

EXECUTIVE DIRECTOR'S COMMENTS:

Ms. Canfield discussed the application review process and timeline. She also discussed important upcoming Illinois General Assembly bills.

APPROVAL OF MINUTES:

Minutes from the 1/19/2022 board meeting and study session were included in the packet.

MOTION: Dr. Fisher moved to approve the minutes from the January 19, 2022 meeting. Ms. Ruesch seconded the motion. A roll call vote was taken and the motion passed unanimously.

EXPENDITURE LIST:

The Expenditure List was included in the Board packet.

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

NEW BUSINESS:

CCDDB Application Review Process:
A briefing memo detailed the CCDDB Application Review process, including the timeline. A chart of all PY23 I/DD funding requests, list of all PY23 funding requests, and a suggested review checklist were included in the packet as well. There was a lengthy Board discussion regarding the review process.

Champaign County ARPA Fiscal Recovery Funds:
A briefing memo provided an update on ARPA Fiscal Recovery Funds with a focus on premium pay. Included in the board packet were the 2021 project request form and current year report forms and an excerpt from Ed McManus' newsletter. Board discussion included a plan for formal communication with the Champaign County Board.

Successes and Other Agency Information:
Information was shared from Becca Obuchowski from Community Choices and Annette Becherer from DSC.

OLD BUSINESS:

Agency PY2022 2nd Quarter Service Data Charts:
These charts were included in the packet.

PY2022 2nd Quarter Service Activity Reports:
2nd Quarter service hours and activities reports were included for information.

211 Quarterly Reports:
October through December 2021 reports for 211 calls for Champaign County were attached for information only.

CILA Update:
A briefing memorandum providing a CILA update was included in the Board packet for information only.

CCDDB and CCMHB Schedules and CCDDB Timeline:
Meeting schedules were included in the Board packet.

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

CCMHB Input:
The CCMHB will meet this evening.

Staff Reports:
Included in the board packet were reports from Kim Bowdry, Leon Bryson, Stephanie Howard-Gallo, and Shandra Summerville.

BOARD ANNOUNCEMENTS:

None. (Dr. Robin excused herself from the meeting.)

Other Business – Closed Session*:

MOTION: At 10:11 a.m. Dr. Fisher moved to move the Board to an executive session, exception 5 ILCS 120/2(c)(11) of the Open Meetings Act, to discuss litigation and that the following individuals remain present: members of the Champaign County Developmental Disabilities Board; Champaign County Assistant State's Attorneys Joel Fletcher and Matthew J. Sullard; CCDDB Executive Director Canfield, and Operations and Compliance Coordinator Howard-Gallo.

The CCDDB returned to open session at 10:39 a.m. by roll call.

MOTION: Ms. Ruesch moved to accept the closed session minutes from February 19, 2020 as presented and to continue maintaining them as closed. Ms. Schuster seconded the motion. The vote passed unanimously.

ADJOURNMENT:

The meeting adjourned at 10:45 a.m.
Respectfully Submitted by: Stephanie Howard-Gallo

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

Champaign County, IL

VENDOR INVOICE LIST

INVOICE	P.O.	INV DATE	CHECK RUN	CHECK #	INVOICE NET	DUE DATE	TYPE	STS	INVOICE DESCRIPTION
1 CHAMPAIGN COUNTY TREASURER									
2022 CILA Contrib		01/01/2022	011422A	103	50,000.00	01/31/2022	INV	PD	2022 CILA Contribution
Jan Admin Fee		01/01/2022	011422A	100	32,952.00	01/31/2022	INV	PD	DDB JAN ADMIN FEE TO MHB
Jan DD22-078		01/01/2022	011422A	101	25,957.00	01/31/2022	INV	PD	DD22-078 Decision Support
					108,909.00				
10094 C-U AUTISM NETWORK									
Jan DD22-087		01/01/2022	011422A	96	3,166.00	01/31/2022	INV	PD	DD22-087 Community Outrea
10146 COMMUNITY CHOICES, INC									
Jan DD22-075		01/01/2022	013122A	417	13,889.00	01/31/2022	INV	PD	DD22-075 Self Determinati
Jan DD22-090		01/01/2022	013122A	417	14,161.00	01/31/2022	INV	PD	DD22-090 Community Living
Jan DD22-095		01/01/2022	013122A	417	16,750.00	01/31/2022	INV	PD	DD22-095 Customized Emplo
					44,800.00				
10170 DEVELOPMENTAL SERVICES CENTER OF									
Jan DD22-080		01/01/2022	011422A	114	35,754.00	01/31/2022	INV	PD	DD22-080 Individual and F
Jan DD22-081		01/01/2022	011422A	114	38,003.00	01/31/2022	INV	PD	DD22-081 Community Living
Jan DD22-083		01/01/2022	011422A	114	36,321.00	01/31/2022	INV	PD	DD22-083 Service Coordina
Jan DD22-084		01/01/2022	011422A	114	14,500.00	01/31/2022	INV	PD	DD22-084 Clinical Service
Jan DD22-085		01/01/2022	011422A	114	6,667.00	01/31/2022	INV	PD	DD22-085 Employment First
Jan DD22-091		01/01/2022	011422A	114	30,114.00	01/31/2022	INV	PD	DD22-091 Community Employ
Jan DD22-092		01/01/2022	011422A	114	7,083.00	01/31/2022	INV	PD	DD22-092 Connections
					168,442.00				
10424 PERSONS ASSUMING CONTROL OF THEIR ENVIRONMENT INC.									
Jan DD22-079		01/01/2022	011422A	149	2,022.00	01/31/2022	INV	PD	DD22-079 Consumer Control
					2,022.00				
15 INVOICES					327,339.00				

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

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									
Feb Admin Fee		02/01/2022	020722A	633	32,952.00	02/07/2022	INV	PD	DDB Admin Fee to MHB
Feb DD22-078		02/01/2022	020722A	631	25,957.00	02/07/2022	INV	PD	DD22-078 Decision Support
					58,909.00				
10094 C-U AUTISM NETWORK									
Feb DD22-087		02/01/2022	020722A	623	3,166.00	02/07/2022	INV	PD	DD22-087 Community Outrea
10146 COMMUNITY CHOICES, INC									
Feb DD22-075		02/01/2022	020722A	649	13,889.00	02/07/2022	INV	PD	DD22-075 Self Determinati
Feb DD22-090		02/01/2022	020722A	649	14,161.00	02/07/2022	INV	PD	DD22-090 Community Living
Feb DD22-095		02/01/2022	020722A	649	16,750.00	02/07/2022	INV	PD	DD22-095 Customized Emplo
					44,800.00				
10170 DEVELOPMENTAL SERVICES CENTER OF									
Feb DD22-080		02/01/2022	020722A	662	35,754.00	02/07/2022	INV	PD	DD22-080 Individual and F
Feb DD22-081		02/01/2022	020722A	662	38,003.00	02/07/2022	INV	PD	DD22-081 Community Living
Feb DD22-082		02/01/2022	020722A	662	64,535.00	02/07/2022	INV	PD	DD22-082 Community First
Feb DD22-083		02/01/2022	020722A	662	36,321.00	02/07/2022	INV	PD	DD22-083 Service Coordina
Feb DD22-084		02/01/2022	020722A	662	14,500.00	02/07/2022	INV	PD	DD22-084 Clinical Service
Feb DD22-085		02/01/2022	020722A	662	6,667.00	02/07/2022	INV	PD	DD22-085 Employment First
Feb DD22-091		02/01/2022	020722A	662	30,114.00	02/07/2022	INV	PD	DD22-091 Community Employ
Feb DD22-092		02/01/2022	020722A	662	7,083.00	02/07/2022	INV	PD	DD22-092 Connections
Jan DD22-082		02/01/2022	020722A	662	64,535.00	02/07/2022	INV	PD	DD22-082 Community First
					297,512.00				
10424 PERSONS ASSUMING CONTROL OF THEIR ENVIRONMENT INC.									
Feb DD22-079		02/01/2022	020722A	741	2,022.00	02/07/2022	INV	PD	DD22-079 Consumer Control
					2,022.00				
16 INVOICES					406,409.00				

b

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

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

BRIEFING MEMORANDUM

DATE: March 23, 2022
TO: Members, Champaign County Developmental Disabilities Board (CCDDB)
FROM: Kim Bowdry, Associate Director for I/DD
SUBJECT: Program Year 2021 Service Activity Data

Background:

In PY2018, CCDDB staff implemented a new data collection system for programs serving people with I/DD. Each year since, agencies have provided a much higher level of detail about client specific service activities.

Beginning in PY2021, at the request of a CCDDB member, the reporting categories changed. The new categories were meant to detail whether the client was present with the staff during the time being reported as claims and where the activity took place, at the agency or in the community. These new claims were entered as 'With Person Served' or 'On Behalf of Person Served' and 'Off Site (in the community or client home)' or 'On Site (at the agency facility)'. It is imperative to remember that these services were being provided during the early days of the Covid-19 pandemic and likely had an effect the hours of services delivered. It was also during this program year that units of service were changed from quarter hours to full hours. This change may give the appearance of over service to some individuals, especially in cases where multiple staff are serving the same person each day and is especially true in DSC's Community First program. Because most of these programs were not Fee for Service, there is no perfect way to capture a completely accurate description of the hours and types of services provided, but this has allowed us to get significantly closer than before PY2018.

Some programs showing discrepancies in numbers reported in the 'Utilization Summaries for PY2021 CCDDB and CCMHB I/DD Programs' and totals listed below may not enter claims for all Transition 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 PY2021 CCDDB and CCMHB I/DD Programs' is attached for reference. The original document was included in the October 20, 2021, CCDDB packet. Programs listed below reported service activity data for specific people served, PY2021 totals are listed by program.

CCRPC

- Decision Support Person Centered Planning served 348 people for a total of 4,476.25 hours, with total audited payments of $309,080.

Community Choices

- Community Living served 14 people for a total of 1,226 hours, with total payments of $89,000.
- Community Employment served 36 people for a total of 1,021 hours, with total payments of $182,000.

DSC

- Clinical Services served 61 people for a total of 1,263 hours, with total audited payments of $148,555.
- Community Employment served 70 people for a total of 3,968 hours, with total payments of $361,370.
- Community First served 52 people for a total of 18,288.75 hours, with total payments of $847,659.
- Community Living served 56 people for a total of 10,298.50 hours, with total audited payments of $397,032.
- Individual and Family Support served 45 people for a total of 9,020.50 hours, with total audited payments of $372,882.
- Service Coordination served 257 people for a total of 7,682.25 hours, with total audited payments of $369,561.

PACE

- Consumer Control in Personal Support registered 31 PSWs, with total audited payments of $23,493. The program also matched 8 Personal Support Workers (PSWs) to people with I/DD seeking PSWs.

Rosecrance

- Coordination of Services: DD/MI served 25 people for a total of 2,063 hours, with total audited payments of $29,357.

As with previous years, some programs did not report client level data as claims in the Online Reporting System. These programs, including support groups and other, are listed below. Other programs serve a significant number of Non-Treatment Plan Clients and do not report client level data on these services. This information can be found in the attached 'Utilization Summaries for PY2021 CCDDB and CCMHB I/DD Programs' document.

CU Able

- Community Outreach, $17,200

Champaign County Down Syndrome Network

- Champaign County Down Syndrome Network, $15,000

Champaign Urbana Autism Network

- Community Outreach Programs, $15,000

Community Choices

- Self-Determination Support, $146,000

DSC

- Connections, $85,000
- 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 **538 unduplicated adults or older children** and **573 unduplicated young children.**

- Of the unduplicated adults and older children served during PY2021, **36% had state waiver funding as well.**
- Of the unduplicated adults and older children served during PY2021, **64% were enrolled or re-enrolled in PUNS.**
- Of the unduplicated adults and older children served during PY2021, **64% 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.
    - 361 people were served by **one agency only;**
    - 170 people were served by two agencies;
    - 6 people were served by three agencies; and
    - 1 person was served by four agencies.

    - 323 people were served in **one program only;**
    - 98 people were served in two programs;
    - 50 people were served in three programs;
    - 41 people were served in four programs;
    - 19 people were served in five programs; and
    - 7 people were served in six 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 PY2021.

- Of the **6 people served by three agencies**:
    - 5 were served by CCRPC Decision Support PCP;
    - 2 were served by DSC & Rosecrance;
    - 1 was served by only DSC, PACE, & Rosecrance, this person also has waiver funding (HBS);
    - 2 were served by Community Choices and DSC;
- **1 person was served by four agencies** was served by CCRPC Decision Support PCP, Community Choices, DSC, and Rosecrance.

- Of the **7 people served in six programs**:
    - 5 were served by CCRPC Decision Support PCP and DSC Clinical Services, Community First, Community Living, Connections, and Service Coordination, with CCDDB funding only;
    - 1 was served by CCRPC Decision Support PCP and DSC Community Employment, Community First, Community Living, Connections, and Service Coordination, with CCDDB funding only;
    - 1 was served by CCRPC Decision Support PCP, Community Choices' Customized Employment, DSC Community Employment (opened 10.15.20), Community First (closed 10.15.20), Individual and Family Support (closed 10.15.20), and Service Coordination (closed 10.15.20). This person was selected from PUNS during PY2021.
- Of the **19 people served in five programs**:
    - 18 were served by CCRPC Decision Support PCP;
    - 1 was served by DSC Community Employment, Community First, Individual and Family Support and Service Coordination, DDB funding only;

- 2 were served by Community Choices Customized Employment, DSC Community First, Connections, and Service Coordination, CCDDB funding only;
- 3 were served by DSC Community First, Community Living, Connections, and Service Coordination, CCDDB funding only;
- 1 was served by DSC Community Employment, Community First, Community Living, and Service Coordination, CCDDB funding only;
- 1 was served by DSC Community Employment, Community Living, Individual and Family Support (closed 06.11.21), and Service Coordination, CCDDB funding only;
- 3 were served by DSC Clinical Services, Community First, Community Living, and Service Coordination, with CCDDB funding only;
- 1 was served by DSC Community Employment, Community First, Community Living, and Service Coordination, CCDDB funding only. Closed from all DSC programs on 06.30.21.
- 2 were served by DSC Clinical, Community Employment, Community Living, and Service Coordination, CCDDB funding only;
- 1 person was served by DSC Community First (closed 04.15.21), Community Living (closed 04.15.21), and Service Coordination (closed 06.22.21) and Rosecrance Coordination of Services: DD/MI, CCDDB funding only;
- 1 person was served by Community Choices Community Living and Customized Employment, DSC Individual and Family Support (closed 05.28.21), and Rosecrance Coordination of Services: DD/MI, CCDDB funding only;
- 1 was served by DSC Community First (closed 06.01.21), Community Employment, Community Living, and Service Coordination, CCDDB funding only;
- 1 was served by DSC Community First (closed 06.15.21), Community Employment, Community Living (opened 06.29.21), and Service Coordination, CCDDB funding only;
- 1 person was served by DSC Clinical Services, Individual and Family Support (closed 06.11.21), and Service Coordination, PACE Consumer Control in Personal Support, and Rosecrance Coordination of Services: DD/MI. This person also receives funding through IDHS-DDD Home Based Support program. Based on their enrollment in the IDHS-DDD Home Based Support program, this person is not eligible for enrollment in the CCRPC ISC Decision Support Person Centered Planning program, as similar services are funded through the HBS program.

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 PY2021.

- Person A participated in **6 programs, 2 agencies**:
  - 16 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 29 hours of service from DSC Clinical Services, 2% of total program hours
  - 150 hours of service from DSC Community First, <1% of total program hours
  - 157 hours of service from DSC Community Living, 2% of total program hours
  - 48 hours of service from DSC Service Coordination, <1% of total program hours
  - Person A was also enrolled in DSC Connections, although PY21 hours were not tracked.
- Person B participated in **5 programs, 4 agencies**:
  - 25 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 107 hours of service from Community Choices Community Living, 9% of total program hours
  - 21 hours of service from Community Choices Customized Employment, 2% of total program hours
  - 211 hours of service from DSC Individual and Family Support, 2% of total program hours

- 11 hours of service from Rosecrance Coordination of Services: DD/MI, 1% of total program hours

- Person C participated in **2 programs, 2 agencies**:
  - 10 hours of service from DSC Service Coordination, <1% of total program hours.
  - 2 hours of service from PACE Consumer Control in Person Support, <1% of total program hours, this person was successfully matched with a Personal Support Worker.
  - This person also receives services through IDHS-DDD Home Based Services program.
- Person D participated in **5 programs, 2 agencies**:
  - 28 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 3 hours of service from DSC Clinical Services, <1% of total program hours
  - 163 hours of service from DSC Community Employment, 4% of total program hours
  - 208 hours of service from DSC Community Living, 2% of total program hours
  - 62 hours of service from DSC Service Coordination, <1% of total program hours
- Person E participated in **5 programs, 2 agencies**:
  - 17 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 12 hours of service from DSC Community Employment, <1% of total program hours
  - 1,103 hours of service from DSC Community First, 6% of total program hours
  - 18 hours of service DSC Service Coordination, <1% of total program hours
- Person F participated in **3 programs, 2 agencies**:
  - 29 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 136 hours of service from Community Choices Community Living, 11% of total program hours
  - 72 hours of service from Community Choices Customized Employment, 7% of total program hours
- Person G participated in **2 programs, 2 agencies**:
  - 29 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 27 hours of service from Rosecrance Coordination of Services: DD/MI, 1% of total program hours
- Person H participated in **1 program, 1 agency**:
  - 7 hours of service from CCRPC Decision Support PCP, <1% of total program hours
- Person I participated in **6 programs, 2 agencies**:
  - 13 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 2 hours of service from DSC Clinical Services, <1% of total program hours
  - 730 hours of service from DSC Community First, 4% of total program hours
  - 42 hours of service from DSC Community Living, <1% of total program hours
  - 32 hours of service from DSC Service Coordination, <1% of total program hours
  - Person I was also enrolled in DSC Connections, although PY21 hours were not tracked.
- Person J participated in **2 programs, 2 agencies**:
  - 23 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 52 hours of service from Community Choices Customized Employment, 5% of total program hours
- Person K participated in **3 programs, 2 agencies**:
  - 8 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 41 hours of service from DSC Clinical Services, 3% of total program hours
  - 25 hours of service from DSC Service Coordination, <1% of total program hours
- Person L participated in **4 programs, 2 agencies**:
  - 8 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 135 hours of service from DSC Community First, <1% of total program hours
  - 58 hours of service from DSC Community Living, 1% of total program hours
  - 26 hours of service from DSC Service Coordination, <1% of total program hours

- Person M participated in **3 programs, 2 agencies**:
  - 16 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 682 hours of service from DSC Community First, 4% of total program hours
  - 86 hours of service from DSC Service Coordination, 1% of total program hours
- Person N participated in **5 programs, 2 agencies**:
  - 12 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 28 hours of service from DSC Clinical Services, 2% of total program hours
  - 249 hours from DSC Community First, 1% of total program hours
  - 251 hours of service from DSC Community Living, 2% of total program hours
  - 99 hours of service from DSC Service Coordination, 1% of total program hours
- Person O participated in **4 programs, 2 agencies**:
  - 23 hours of service from CCRPC Decision Support PCP, 1% of total program hours
  - 311 hours of service from DSC Community Employment, 8% of total program hours
  - 1,044 hours of service from DSC Community First, 6% of total program hours
  - 41 hours of service from DSC Service Coordination, <1% of total program hours
- Person P participated in **3 programs, 2 agencies**:
  - 40 hours of service from CCRPC Decision Support PCP, 1% of total program hours
  - 161 hours of service from Community Choices Community Living, 13% of total program hours
  - 43 hours of service from Community Choices Customized Employment, 4% of total program hours
- Person Q participated in **4 programs, 2 agencies**:
  - 11 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 1,177 hours of service from DSC Community First, 6% of total program hours
  - 18 hours of service from DSC Service Coordination, <1% of total program hours
  - Person Q was also enrolled in DSC Connections, although PY21 hours were not tracked.
- Person R participated in **4 programs, 2 agencies**:
  - 24 hours of service from CCRPC Decision Support PCP, <1% of total program hours
  - 12 hours of service from DSC Community Employment, <1% of total program hours
  - 167 hours of service from DSC Community Living, 2% of total program hours
  - 44 hours of service from DSC Service Coordination, <1% of total program hours

Utilization Summaries for PY2021 CCDDB and CCMHB I/DD Programs

Detail on each program's performance toward defined consumer outcomes during the funding year of July 1, 2020 to June 30, 2021 is available at http://ccmhddbrds.org, among downloadable public files toward the bottom of the page. The relevant document is titled "CCDDB PY21 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: Young Children and their Families

Champaign County Regional Planning Commission Head Start/Early Head Start
Social Emotional Development Services $121,081 (CCDDB & CCMHB)

Services: Program seeks to identify and address social-emotional concerns in the early childhood period, as well as to promote mental health among all Head Start children. The social-emotional portion of the program focuses on aiding the development of self-regulation, problem solving skills, emotional literacy, empathy, and appropriate social skills. Accomplishments in these areas will affect a child's ability to play, love, learn and work within the home, school and other environments. All fit together to form the foundation of a mentally healthy person. **Utilization targets:** 50 TPC, 50 NTPC, 20 CSE, 600 SC, 10 Other (newsletter articles, staff training). **Utilization actual:** 45 TPC, 90 NTPC, 14 CSE, 729 SC, 39 Other (newsletter articles, staff training).

Developmental Services Center **Family Development Center** $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, 4 CSE. **Utilization actual:** 828 TPC, 189 SC, 21 CSE.

Priority: Self-Advocacy

CU Able **CU Able Community Outreach** $17,200

Services: Networking, education and social opportunities for families of people with disabilities, regardless of disability type. Monthly meetings for caregivers of people with disabilities, professionals and students from the University of Illinois and Parkland. Online community is an extremely important part of community allowing for quick feedback and providing support at all hours of the day. Annual Moms Retreat provides opportunity for respite for female caregivers to come together for networking, relaxation and educational opportunities. **Utilization targets:** 90 TPC, 125 NTPC, 200 SC, 16 CSE. **Utilization actual*:** 77 TPC, 85 NTPC, 209 SC, 10 CSE.

Champaign County Down Syndrome Network **CC Down Syndrome Network** $15,000

Services: Support to people with Down Syndrome and their families, providing current DS related information for members, parents, professionals and the general public. DSN reaches out to new parents, providing many networking & social opportunities as well as education, support & connections to local resources. DSN hosts many community awareness events each year, helping to promote inclusion for individuals with Down syndrome in our community. **Utilization targets:** 145 TPC, 50 NTPC, 15 CSE. **Utilization actual:** 20 TPC, 13 NTPC, 15 CSE.

Community Choices **Self Determination Support** $146,000

Services: Leadership & Self-Advocacy: a two-tiered Leadership Class, co-developed by self-advocates, focusing on fostering leadership skills and putting leadership into action. Family Support & Education: a public monthly meeting, to learn best practices and options, community family, and a family specific support group. Building Community: options for adults with disabilities to become engaged with others. **Utilization targets:** 145 NTPC, 2129 SC, 4 CSE, 1713 Other (direct support hours). **Utilization actual:** 160 NTPC, 4845 SC, 4 CSE, 2144 Other (direct support hours).

Priority: Linkage

Champaign County Regional Planning Commission Community Services

Decision Support Person Centered Planning $311,488

Services: ISC staff continue to assess persons transitioning from other counties who are eligible for and may or may not be receiving DHS waiver funding, who have not yet been assessed for service preferences. Transition Consultants assist people/families in conflict free transition planning. Provides extensive outreach, preference assessment, and person-centered planning services for Champaign County residents with I/DD without waiver funding. Consultation and transition planning provided to people with I/DD (and families) nearing graduation from secondary education. New in 2018: Provides 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 with Medicaid waiver funding. **Utilization targets:** 200 TPC, 250 NTPC, 300 SC, 40 CSE. **Utilization actual:** 423 TPC, 228 NTPC, 340 SC, 48 CSE.

Developmental Services Center **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, 20 SC, 2 CSE. **Utilization actual:** 257 TPC, 39 NTPC, 75 SC, 1 CSE.

Rosecrance Champaign/Urbana **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:** 25 TPC, 12 SC, 7 CSE.

Priority: Work

Community Choices **Customized Employment** $182,000

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:** 42 TPC, 1824 SC, 4 CSE, 2772 Other (direct support hours). **Utilization actual:** 36 TPC, 928 SC, 4 CSE, 1071 Other (direct support hours).

Developmental Services Center **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:** 72 TPC, 2 CSE, 14 SC.

Developmental Services Center **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:** 30 CSE. **Utilization actual:** 11 CSE.

Priority: Non-Work

Developmental Services Center **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:** 65 TPC, 3 NTPC, 12 SC, 0 CSE.

Developmental Services Center **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:** 50 TPC, 55 NTPC, 5 SC, 3 CSE. **Utilization actual:** 52 TPC, 75 NTPC, 14 SC, 3 CSE.

Developmental Services Center **Community Living** (formerly Apartment Services) $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:** 56 TPC, 7 SC.

Developmental Services Center **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, 4 CSE. **Utilization actual:** 21 TPC, 2 NTPC, 4 CSE.

Developmental Services Center **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, 5 SC, 2 CSE. **Utilization actual:** 16 TPC, 36 NTPC, 11 SC, 1 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:** 30 NTPC, 200 SC, 12 CSE, and 3 Other (Successful PSW matches). **Utilization actual:** 32 NTPC, 409 SC, 14 CSE, and 9 Other (Successful PSW matches).

Priority: Housing

Community Choices **Community Living** $89,000

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

Utilization targets: 15 TPC, 15 NTPCs, 2 CSE, 250 SC, 1602 Other (direct support hours). **Utilization actual:** 14 TPC, 23 NTPC, 3 CSE, 317 SC, 1404 Other (direct support hours).

Individual Advocacy Group, **CILA Expansion** $50,000 (CCMHB and CCDDB)

This annual investment pays for property management costs of two of the three local small group homes run by Individual Advocacy Group, which was selected in 2014 through an RFP process to provide services to people with I/DD living in MHB/DDB owned-homes. During 2019, the CCMHB contributed a larger share in order to pay off the mortgage loan in full; the CCDDB continues to transfer $50,000 to this fund each year until their total payments are equal to the CCMHB contribution. **Utilization:** 7 TPCs with staffing ratios from 1:4 to 2:3 and a choice between IAG 'Flexible Day Experience' and day programs run by other local providers. One house closed in December 2020, the other July 2021, with all 4 individuals moving to CILAs in other counties.

#10.B.

CCDDB Application Review Checklist

Minimal responsiveness:	Y/N	concerns/comments
Are services or supports directly related to I/DD?		
Does the application address how this program will improve the quality of life of those with I/DD?		
Does the application include evidence that other possible funding has been identified and explored and found not available or to have been maximized?		
Does the application demonstrate coordination with providers of similar or related services?		
Does the application include planning for continuation of services during pandemic or epidemic?		
Does the application build on successes with technology and virtual platforms, increasing training and access for direct staff and people served?		
Does the application provide too much information? Does the application provide enough information? Is the purpose of the funding request clearly stated?		

Priority Categories: check appropriate

Self-Advocacy _____
Linkage and Coordination _____
Home Life _____
Personal Life and Resilience _____
Work Life _____
Community Life and Relationships _____
Strengthening the I/DD Workforce *(possible collaboration with the CCMHB)* _____
Young Children and their Families (collaboration with CCDDB) _____

Overarching Considerations:	Y/N	concerns/comments
Does the program plan narrative reflect CLC work, to engage underserved populations?		
Does the agency address whether and how rural residents may use the program?		
Are inclusion, integration, and anti-stigma addressed?		
Does the proposal cite an evidence-based, evidence-informed, recommended, or promising practice/approach?		
Are staff qualifications, credentials, or specialized training identified?		
Are other resources leveraged by this proposal?		
Are measurable and meaningful outcomes included?		
Does the program use Person Centered Planning which allows people to control their day, build connections, create and use networks of support, and advocate for themselves?		
Is there a clear connection between budget and proposed program?		

I/DD Program Funding Requests for PY2023

July 1, 2022 thru June 30, 2023

Agency	Program Name	Current Awards PY22 DDB Award	PY22 DDB Amende	PY22 MHB	Requests PY23 DDB/MHB	% change	Reviewer
Priority: Self-Advocacy							
CU Autism Network	Community Outreach Programs	**$38,000**	**n/a**		**n/a**	n/a	n/a
Priority: Linkage and Coordination							
CCRPC - Community Services	Decision Support PCP	**$311,489**	**n/a**		**$388,271**	25%	AR/GS
DSC	Service Coordination	**$435,858**	**n/a**		**$468,000**	7%	KF/AR
Rosecrance Central Illinois	Coordination of Services: DD/MI	**$35,150**	**$8,787.50**		**n/a**	n/a	n/a
Priority: Home Life							
Community Choices, Inc.	Inclusive Community Support (formerly Community Li	**$201,000**	**$155,381**		**$203,000**	1%	KF/DR
DSC	Community Living (formerly Apartment Services)	**$456,040**	**n/a**		**$536,000**	18%	AR/DR
Priority: Personal Life and Resilience							
DSC	Clinical Services	**$174,000**	**n/a**		**$184,000**	6%	DR/AR
DSC	Individual & Family Support	**$429,058**	**n/a**		**$390,000**	-9%	KF/GS
PACE	Consumer Control in Personal Support	**$24,267**	**n/a**		**$27,367**	13%	DR/KF
Priority: Work Life							
Community Choices, Inc.	Customized Employment	**$201,000**	**n/a**		**$217,500**	8%	GS/KF
DSC	Community Employment	**$361,370**	**n/a**		**$435,000**	20%	GS/KF
DSC/Community Choices	Employment First	**$80,000**	**n/a**		**$85,000**	6%	AR/DR
Priority: Community Life and Relationships							
Community Choices, Inc.	Self-Determination Support	**$162,000**	**$160,251**		**$171,000**	6%	DR/GS
DSC	Community First	**$847,659**	**n/a**		**$847,658**	22 amount	AR/GS
DSC	Connections	**$85,000**	**n/a**		**$95,000**	12%	DR/AR
Priority: Strengthening the I/DD Workforce							
DSC	Workforce Development and Retention	**$0**	**n/a**		**$227,500**		GS/AR
Priority: Young Children and their Families (CCMHB focus)							
DSC	Family Development		**n/a**	**$596,522**	**$596,522**	2 year cont	n/a
CC Head Start/Early Head Start	Early Childhood Mental Health Svs (MH & DD)						
	PY22 total = $326,369, PY23 request = $347,235		**n/a**	**$121,999**	**?**	MHB Req	GS/KF
	TOTAL	**$3,841,891**		**$718,521**	**$4,871,818**		
		total PY2022 = $4,560,412			*total PY2023 requests = $4,871,818 plus ?*		
					MHB will cover more than $718,521		

12

#12.A.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

DATE: April 12, 2022
TO: Members, Champaign County Board
FROM: Members, Champaign County Developmental Disabilities Board (CCDDB) and Lynn Canfield, Executive Director, CCDDB
SUBJECT: Premium Pay for Direct Support Professionals in I/DD Service Settings

It is no longer a secret that the country's community-based behavioral healthcare and intellectual and developmental disabilities (I/DD) service systems are in crisis. To the former, broad bipartisan acknowledgement brings hope for legislation that would rightsize some challenges which got us here. For the latter, a catastrophic workforce shortage results from decades of underinvestment, but as a lesser-known catastrophe impacting fewer Americans, there is no similar hope for effective, immediate action.

For over a decade, advocates have repeated their message to the State of Illinois regarding the salaries of the core of the I/DD workforce. As individuals and on behalf of the CCDDB and Champaign County Mental Health Board (CCMHB), we support legislation to establish wages commensurate with the responsibilities and potential of the Direct Support Professional (DSP) workforce. *Attached is a two-page fact sheet from a coalition of advocacy organizations.*

At the federal level, we advocate for various repairs to the I/DD service delivery system. Through two national associations, we have advanced a policy resolution supporting bills that create a distinct classification for DSPs within the Bureau of Labor Statistics; this will facilitate clearer data on the roles, core competencies, and actual cost of turnover and credentialling for these workers. There is abundant public praise for DSPs who stepped up during the most dangerous phases of the global pandemic and made a great contribution for little financial gain and often at great personal cost; being called 'angels' and 'heroes' was not enough to keep them.

Locally, the DSP shortage cost the CCDDB and CCMHB their CILA facilities project. Unable to fully staff the small groups homes, the provider of services began to downsize, vacating one home by January 2021 and the other in July. Residents are served outside the County and in settings with more housemates than standard for community-based care, per Ligas and the Olmstead rule within the Americans with Disabilities Act. *Attached are local personal stories.*

ARP Fiscal Recovery Funds may be used "to offer premium pay to essential workers, in recognition of their sacrifices over the last year." DSPs are exactly such essential workers. The pandemic took an already endangered I/DD service system and added great risk for the people served, their families, and those providing services. Annual 'premium pay' could be awarded to Champaign County's DSPs who have showed up during the pandemic. Premium pay caps can be up to $13/hr in addition to wages, with total annual cap $25,000 per worker. The I/DD workforce crisis calls for such an action on behalf of DSPs, while the State considers permanent solutions.

DSP premium pay is consistent with our community needs assessment:
https://www.co.champaign.il.us/mhbddb/PDFS/Full_2021_Community_Needs_Report_ENGLISH.pdf
https://www.co.champaign.il.us/mhbddb/PDFS/Full_2021_Community_Needs_Report_ESPANOL.pdf

We hope this solution aligns well with your own allocation priorities and that you will consider dedicating fiscal recovery funds to this group of essential workers.

People with Disabilities **Deserve More**

THE CRISIS NOW

People with intellectual and developmental disabilities (IDD) deserve the opportunity to lead full, meaningful lives. But most need support for everything from eating, bathing and administering medication to job and life-skills training. That support comes from a statewide network of community provider agencies and their dedicated, trained workforce of **direct support professionals (DSPs)** — a workforce that is in tragically short supply.

Long before COVID-19, community providers were already struggling to keep and recruit DSPs because of significant underfunding from the state. The current "Great Resignation" only worsens the existing problem as qualified caregivers seek higher paying, less demanding jobs. Unlike retail or restaurants facing staff shortages all over the country, providers can't trim back hours or close on certain days. **People with IDD need consistent, uninterrupted care — most need it 24/7, 365 days a year.**

DSPs have been risking their own health and family time daily to keep people with disabilities safe and healthy. Sadly, these frontline heroes continue to be among the low-income workers hit hardest by the pandemic's economic and societal fallout. And, more and more providers have been forced to shut down programs or homes and turn families away who need and deserve support.

THE SOLUTION

After decades of inadequate support, the state has increased funding to providers in steady increments over the past five years, including $170M in FY'22, a major portion dedicated toward implementation of the state's Guidehouse Rate Study recommendations, which provide a roadmap to stabilizing services.

This is a step forward, but not nearly enough to address the funding crisis facing agencies who care for people with disabilities. Additionally, historically high inflation has blunted the impact of DSP wage increases, and the percentage difference between the minimum wage and the state DSP wage rate has actually decreased over time.

The state must provide an increase of $246.8M to fully fund the Guidehouse Rate Study recommendations for FY'23.

Support HB4832 and SB4063.

Without this critically needed funding, the safety and well-being of thousands of people with disabilities is gravely at risk.

THE STAFFING CRISIS BY THE NUMBERS

The following data is from a January 2022 survey conducted by They Deserve More. Sixty-seven community providers and agencies from across the state participated, representing a majority of people served.

2,514

Number of unfilled DSP positions at 67 Illinois provider agencies, averaging 38 unfilled positions per agency

27%

DSP vacancy rate — providers reported an **additional 17%** of staff were unable to work for COVID-related reasons

14,000+*

Number of people unable to access services because of limited State funding and capacity for providers to care for them

54%

Percentage of agencies actively planning to consolidate residential sites due to inadequate staffing

59%

Percentage of agencies actively planning to suspend admissions due to inadequate staffing

Source: Illinois Department of Human Services, 1/18/22

PROVIDERS FOCUS ON STAFF WITH STATE DOLLARS

DSPs are the backbone of the community provider system. Agencies have always prioritized increases to DSP wages in order to reward and retain this essential workforce. Here are a just few examples of how providers utilize increases from the state as part of a total compensation package to retain and recruit:

- Hourly wage increases
- Sign-on bonuses
- Retention bonuses
- Seniority bonuses
- Length of service bonuses
- Year-end recognition bonuses
- Extra paid time off
- No cap on sick time accrual
- Holiday/overtime pay
- Monthly bonuses for those who have taken on extra responsibilities
- Increases to retirement plan matching
- Improvements to health, life and disability insurance
- Raffles, gift cards and cash prizes

As a result of the DSP staffing crisis, providers are competing fiercely to fill widespread vacancies while an increasing number of jobs in the marketplace pay more than they are reimbursed by the state. If a provider does not retain the flexibility to reward staff in a variety of ways, it would soon lose its direct support staff to other providers and other jobs.

ABOUT THEY DESERVE MORE

They Deserve More is a statewide coalition of nearly 90 community provider agencies, trade and advocacy organizations, and friends and family of people with disabilities. The coalition was founded in 2017 to ensure that Illinois meets its obligation to support people with intellectual and developmental disabilities.

Lynn Canfield, Executive Director
lynn@ccmhb.org
Champaign County (IL) Developmental Disabilities Board
Brookens Administrative Building, Suite 201
1776 East Washington Street
Urbana, IL 61802

March 8, 2022

Dear Executive Director Canfield,

I am writing to support the allocation of American Rescue Funds, by the Champaign County Board, to directly support DSPs (Direct Support Professionals) in the care of people with intellectual and developmental disabilities in community settings in Champaign County. Direct Support Professionals are critically needed in our safety and support network, whether they work for a provider in a CILA (Community Integrated Living Arrangement) Setting, or directly for an individual under the Home Based Support waiver. Staffing has been in crisis for some time as Medicaid reimbursement rates to providers have not kept pace with rising costs and inflation. Individuals with the Home Based Support waiver often have difficulties with stretching their award dollars and finding qualified individuals willing to help them in their homes.

The recruitment and retention of these essential caregivers is especially challenging in Champaign County due to competition for qualified persons by few agencies, the availability of other higher paying employment, as well as the higher cost of living in the county. My family has directly felt the impact of the difficulty of hiring part time people to help my brother Norman stay in his home in Gifford since our father's death in 2014. We have also suffered from the extremely difficulty in accessing providers of CILA and CILA funded residential services and lack of CILA providers willing to provide services to my brother in his own home.

Due to the lack of choice and openings in residential services in Champaign County, my brother had been living in our parent's retirement house since our father's death at age 83 in 2014. This required that I manage and coordinate all of his services, medical appointments, financial affairs, and personal support workers for most of this time while working full time as a tenured Librarian at Governors State University, 100 miles away from his home in Gifford. We also received assistance and support from Community Choices, and benefitted from 2 years of the "Building Inclusive Communities" project of the Illinois Association of Microboards and Cooperatives, funded by the CCDDB in 2015-2017. We were not able to create a Microboard and sustain the self-directed

supports following the ending of the project. However, thanks to Community Choices and the IAMC, Norman was able to live safely in his own home with Medicaid waiver funding and my help until June of 2021, when he suffered a devastating accident, which required a rehabilitation stay at Country Health Care and Rehab in Gifford.

Even though we are 6th generation residents of Compromise Township, (our family has been here since 1872), we were forced to look outside the county for help and a place for Norman to live in order to receive the supports he needed. Due to the extremely limited availability of direct support personnel to help him stay in his own home without my full-time involvement, and the lack of support from his case manager, I decided I needed to retire by Summer 2021 in order to help him. Norman had his accident 2 days before my retirement date of June 30, at the time I was selling my suburban house and moving to Mahomet as well. As Norman's rehabilitation was completed (100 days of Medicare pay), I made it clear that I could not let him go home to continue on his own, but no openings anywhere were available, and quite frankly, his case manager would do little to help find options anywhere in the state because I did not have guardianship. I petitioned for Guardianship in October 2021 in order to make residential placement decisions. Our efforts to find placement in Champaign County were unsuccessful over the past 8 years, but a family told me of an opening in Clinton Illinois, in a new house operated by Marion County Horizon Center in early 2021. Even though the house had been purchased, Marion County Horizon Center could not hire the qualified staff needed to expand their services in Clinton, until January of this year. Thankfully, I was able to move Norman to Clinton in January, but he misses Gifford and his familiar surroundings and friends.

Improving the recruitment and retention of personnel to work in this field is critically needed in our county. I have suffered personally from single handedly carrying the burden of all of my brother's care and affairs on my shoulders, worrying about the devastating impact to him if I were to become ill or pass away.

The Champaign County Developmental Disabilities Board has experience with funding innovative projects to improve the lives of people with ID/DD in Champaign County, and continues to fund worthy projects that truly impact the quality of life for everyone in our county. I urge the Board to generously fund the CCDB for projects and programs that directly help our critical direct support personnel.

Paul Blobaum

Paul Blobaum
1513 Forest Ridge Drive,
Mahomet, IL 61853

pblobaum@gmail.com

From: Joyce Dill
To: Lynn Canfield
Subject: Re: FW: a very special request
Date: Thursday, March 10, 2022 12:50:35 PM

I am writing in support of funding Direct Service Providers who are working hard to provide necessary care for adults with developmental disabilities who live in group homes where they can live with dignity. I hope my story will be informative and helpful.

When my brother was born in 1952 there were no services for him in Champaign County. My mother and father were very active in finding a way for him. They were able to start a school and recreation program for developmentally delayed children, and as time passed.. group homes as well. Children who have developmental delays grow up to be adults with developmental disabilities and their parents grow older too. The question they and we have is what kind of life will my child have when we are gone?

I am 76 years old now. My brother is 70 years old. He lives in a group home in Urbana. Our son is also living in a group home in Champaign. We didn't know we had a genetic disorder called Fragile X and we had never heard of it. My daughter decided
not to have children because of this disorder. My brother and son are living their best lives now in a home that is staffed by hard working, compassionate, and well-trained people. We have been blessed to have DSP's working very hard to provide a safe home where the consumers become a "family" and live together. They had to change their schedules from the consumers going to work during the day, to being in the home and providing activities which included everyone in the group home. DSP's have done double shifts at times during this pandemic. They work for the people they serve...and they deserve better pay. I know the world is a crazy place right now, but if there is indeed some money to help, it should go to these workers who give their time to the people who give direct service to these consumers.

To: Champaign County Board Members
From: Barbara Jewett, Mahomet
RE: I/DD Adult Service Shortages in Champaign County

What happens when the school bus stops coming?

That's the question, and the fear, of any parent or guardian of a person with a disability, especially those of us caring for individuals with intellectual or developmental disabilities. Families are often forced to make difficult choices such as moving to other states away from family and friends or a parent or guardian leaving employment to stay home and care for their loved one once the individual ages out of the school system.

The state of Illinois devotes very few resources to providing for adults with I/DD. Waits for services are years long, and the options and quality of services available vary by region. We are so fortunate in Champaign County that taxpayers voted to fund a Developmental Disabilities (377) Board. But alas, that sadly hasn't been enough to erase the question "What happens when the school bus stops coming?"

The adult service journey for our 29-year-old son, Jason, has been fraught with frustration, disappointment, joy, and sorrow. And we're one of the lucky families! Our son has services!

Allow me to share our story....

About Jason
Jason was diagnosed with Down syndrome at birth. Down syndrome is a genetic disorder caused by the presence of all or part of a third copy of chromosome 21. It is usually associated with physical growth delays, developmental delays, and mild to moderate intellectual disability. When Jason was six, his teachers suspected he may also have autism although an official diagnosis was not forthcoming until his teen years as is not uncommon for children with Down syndrome to also exhibit many of the same tendencies as those on the autism spectrum. Jason then became one of the estimated 10 - 15 percent of people with Down syndrome to also have a dual-diagnosis of autism.

Jason's disability hinders his ability to perform many of the acts of daily living that afford independence. And while his comprehension of spoken words is quite high, his disability negatively affects his ability to speak to others. This inability to communicate often led to frustration, which leads to unacceptable behavior.

The Educational Pivot
In 2008, our local school district informed us that they were no longer able to meet Jason's educational needs in-district and recommended out-of-district placement. Other districts in the area also were incapable of meeting Jason's needs, which made Jason eligible for out-of-state residential school placement with the bulk of the expense covered by the Illinois State Board of Education and the local district chipping in a small percentage.

Jason became a student at Heartspring in Wichita, Kansas, in July 2008. He was 16, an age when many families are looking at colleges and next steps, so for our family it wasn't crushing to have him away from home as we knew he was getting the care and services he needed to develop to his full potential. Jason attended Heartspring until he turned 22, which is the age Illinois ceases serving students with I/DD through the public school system.

The Golden Ticket

We were optimistic about Jason's future. Jason had blossomed in his six years at Heartspring, learning a job skill (filling newspaper kiosks with assistance from a job coach) and becoming more proficient at activities of daily living.

We knew adult services in Illinois were extremely difficult to obtain but we had the golden ticket; at that time (2014) students in residential services automatically slid over to adult services funding without having to wait for their name to be pulled from the service selection lottery. And since 2010, we'd been working with former 377 board executive director Peter Tracy on a board/parent/private partnership initiative to expand adult services in Champaign County. The 377 board had approved buying some homes to be used as CILA homes, an agency selected to provide the CILA staffing as well as community-based day programming services bid and selected, in just a few months when the agency had everything up and running Jason would begin his new life as an adult. Jason had obtained paid employment as a delivery agent for The PrimeLife Times, a monthly newspaper geared for senior citizens, filling kiosks in Mahomet and Monticello. Life was good!

The Reality Roller Coaster

And then the roller coaster that is adult services in Illinois and Champaign County began.

The 377 board and the agency ran into delays getting the homes licensed, staffed and ready to open. What we anticipated being a three-month timeframe until Jason moved into the CILA turned into 16 months. My employer had graciously allowed me to work from home for the three anticipated months, extending it for another three months, but finally had to insist I return to the office or resign as remote work was not then the norm as it is now. With the assistance of friends and the staff at Community Choices I was able to hire a daytime caregiver for Jason. Paying this caregiver consumed all but $17 of my monthly take home pay each month. But hey, it was only going to be for a month or two until the CILA opened. The CILA finally opened – 10 months later.

Life was good again! Jason was living in a beautiful, spacious home in a safe neighborhood and had fantastic staff. He blossomed even more. He was happy, we were ecstatic.

We lived in utopia for three months. And then began our ride on the reality roller coaster of adult services in Illinois and Champaign County.

CILA and day program staff began leaving the agency. Sometimes their replacements were equally skilled; mostly it was a warm body who then also moved on in a matter of weeks or months. After nearly three years of the revolving staff door, we finally had a handful of good staffers who liked the work and the clients and stayed with it, despite the long hours and low pay. These staffers regularly worked 60 - 80 hours a week owing to staff shortages; someone needed to provide the 24-hour care my son and his housemates required and they were it. We consider ourselves fortunate they were willing to answer the call. However, the staff shortages meant not all the services that were in Jason's plan were able to be provided as there was no staff to do so. So Jason did not receive all the services to which he was legally entitled and for which he was funded.

Staff = services; no staff = no services.

The staff wages in Illinois are set by the legislature and are low compared to wages for comparable positions in other states and other aspects of healthcare. This makes it difficult to hire and retain staff for what can be rewarding yet physically and mentally demanding positions. In addition, anecdotal evidence from my friends who manage retail, grocery, and fast-food establishments in Champaign County tell a story of frequent job hopping among workers in this pay range – workers are quick to move on to a job that is perceived to be better.

The Next Chapter

We re-entered the cadre of panicked parents and guardians when notified that the agency contracted by the 377 board to provide CILA and day programming services was ceasing operations in Champaign County and Jason's CILA was closing December 1, 2020. We immediately reached out to our I/DD parent network asking for names of agencies that provided good service. We reached out to Jason's case manager at Champaign County Regional Planning for the list of agencies currently accepting clients; a list that was smaller than normal because of the effects of the pandemic wrought on agencies. The case manager sent Jason's packet to 10 agencies, none responded.

Upon Jason's Champaign CILA closing he moved home with us and began day program services at Piatt County Developmental Center in Monticello. After years of living "on my own," Jason was not happy back under mom and dad's roof. A chance conversation with a friend in another county yielded the name of an agency that had just opened a CILA on their block. An inquiry to that agency revealed they were expanding their service area and led to Jason being accepted for some new CILA homes they were opening. In February 2021 he moved into a CILA in Clinton. He participated in the Piatt County day services until he developed an aversion to riding in his agency van; he's now on hiatus from their program and participating in an at-home program.

The Future

Our family is extremely fortunate and privileged to have adult I/DD services for our son, even though they are not local. Too many in our state, our county, have nothing.

While we wish Jason lived locally, at least he has a CILA placement and day services with a quality provider. We miss being able to pop in to say hello on the way home from work or while out running errands, or easily pick up Jason for dinner or an outing. We now must plan our visits into our schedule and travel the 40 miles one-way to Clinton over crumbling highways. And he just celebrated his seventh anniversary as a delivery agent for The PrimeLife Times. He loves his job and is so proud to have it that we schlepp the 200 miles each month necessary for him to maintain it (pick him up in Clinton, pick up his paper bundles in Champaign, deliver papers in Mahomet and Monticello, return him to Clinton, travel home to Mahomet). Many of our local I/DD community would not have that privilege so are limited in their work options.

When we joined our current agency, we'd mentioned the opportunity to operate the Champaign County CILAs in hopes they would be willing to negotiate a service contract and Jason could move back into the home in southwest Champaign he'd known for five years. Their management responded they'd heard about the possibility but were not interested as they knew from past experiences working for local agencies it was difficult to hire and retain staff in Champaign County.

It was heartbreaking to see the 377 board CILA program die, especially to circumstances beyond the board's control. So many parents, advocates, experts, and community members came together to launch the program, investing years in the effort. It exemplified the can-do creativity that exists in Champaign County.

That can-do creativity is still there, waiting to be tapped yet again. The state is working, albeit slowly, to increase wages for the direct support professionals, those staffers on the front lines in the CILA homes and day programs. That's a small start toward easing the staffing crisis that hamstrings adult I/DD day services.

With some imagination and the support of the 377 board and the Champaign County Board, we can do more.

These are real people, real citizens of this county, real people in your districts that you represent along with all your other constituents. They have hopes and dreams and a desire to live full, productive lives in their local community.

They're counting on you. Please vote to support needed services for our I/DD community.

Thank you.

"What They Don't Tell You About Working with People with Developmental Disabilities

By Jesse Pridemore

I don't remember the exact moment that my life was changed by someone with a developmental disability but I do remember the days when it wasn't. The memories seem far away, blurry, like they don't belong to me. And in a way they don't, because I am nowhere near the same person – I have been changed.

I have been working with people with developmental disabilities for eight years and that happens. You change. They don't tell you that when you're filling out your application, when you're a newbie to the field. They tell you about the health benefits, the hours, the 401K, the programs, the strategies – but they don't tell you about the fact that if you do it right, you will never be the same.

They don't tell you that it will be on some days the most amazing job you've ever had, and on others the worst. They can't put onto paper the emotional toll it will take on you. They can't tell you that there may come a time where you find that you are more comfortable surrounded by people you work with than many you've known your whole life. They don't tell you that you will come to love them. That there will be days when you feel more at home when you're at "work" than when you're actually at home, sitting on your couch. But that's what happens.

They don't tell you that there will come a time, when you're in the community with someone and have to deal with the ignorance of someone who doesn't know any better. That people stare. Adults will stare. They will alternate between

getting out of your way so quick that they almost fall over themselves and those who refusing to acknowledge you enough to even get out of your way. That there are people on this earth who still think it's okay to say the r-word. You will want to say something, anything, to these people to make them see. But at the end of the day your hands will be tied because some things, as you learn quickly, cannot be said with something as simple as words. They can only be felt. And most of the time until someone has had their own experience with someone who has a developmentally disability – they just don't know.

They train you in CPR and first aid, but they can't tell you what it feels like to have to use it. They don't tell you what it is like to learn that someone is sick and there is nothing that can be done. They can't explain the way it feels when you work with someone for years and then one day, they die.

They can't explain the bond that Direct Support Professionals (DSPs) develop with the people they are supporting. I know what it is like to have a conversation with someone who has been labeled "non-verbal" or "low functioning". I know that after a while of working with someone, you develop a bond so strong that they can just give you a look and you know exactly what it means, what they want, what they are feeling. And most of the time all that boils down to is that they want to be heard, listened to, included. Loved.

They don't tell you that you will become a part of a million little routines - that you will belong and are important and that it is mutual. Every day the same man comes by my desk and requests a heart shaped candy from my top desk drawer. Another man brings me old pictures of himself, one by one; the wall beside my desk is plastered in pictures of this man throughout his many different ages.

One time, I was having the crappiest day, up to my elbows in work, and one of the men I work with brought me a cup full of handpicked flowers – it made my day. One of the ladies I work with can't quite pronounce my name, so she gave me a new one and before long it spread to the point that I am no longer Jesse, I am Jebby – and damn proud of it.

I am free to walk around singing songs or to break out into a dance whenever I feel like it and not only will they not judge me – but they will join in. The longer I've worked in this field, the more obvious it has become the world should not

aspire so much to make people with IDD blend in more, but instead maybe everyone should aspire to be a little more like them. But they don't tell you that.

They don't tell you that no matter how much you try, no matter what you do – you will never be able to give back to the people you work with, what they have given to you.

People with IDD have taught me more than I will ever teach them. I have learned that it is okay to forgive myself when I have a bad day – there is always tomorrow and a mess up here and there doesn't equal up to the end of the world. I have learned to accept myself, just as I am, right now – because that is enough. I have learned to slow down, to ponder, to take the time to just look around and take in this beautiful world and all of the simple joys we are blessed to encounter on this earth every day.

Something that they do tell you when you apply for this job is that you will be working to teach life skills and independence. But they don't tell you that while you work to teach someone, they will be teaching you, and you won't even know it until you have already been changed.

I look back and try to pinpoint the exact moment it happened, what was said, who said it, if anyone said anything at all.

But instead of finding that one pivotal moment, I've realized that it is not one moment that has changed me. It is instead a million little moments, each important in their own way, that when added together created a changed life. And I am grateful for each one.

Epilogue – This was written by a woman who worked in Community Day Services many years ago. She fell in love with the people she worked with – individuals and her coworkers/peers. Then, because the funding was and continues to be woefully inadequate, she left the field all together like many others before her and since then. It was either that or work a second job, which is still the case for many employees. She had to leave a job she was genuinely passionate about in order to support her family. Fast forward after a five-year forced financial hiatus, a position as a residential manager became available and Jesse has returned "home".

The DSP crisis is real. This story is beautifully written and personal, but others tell a similar story all over the State of Illinois. A lot. High turnover takes away from the continuity of support people with IDD deserve and it forces frequent changes in staff. It's very hard on those receiving services to watch DSPs who care about them come and go. How sad that the DSP wages drive people away from jobs they are truly passionate about. That is worthy of attention and investment. We are so very grateful that Jesse returned home to DSC in 2021!

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

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

DECISION MEMORANDUM

DATE: March 23, 2022
TO: Champaign County Developmental Disabilities Board (CCDDB)
FROM: Lynn Canfield, Executive Director
SUBJECT: Update on CILA Facilities Project

Background:

The CILA Facilities Project is a collaboration of the CCDDB and the Champaign County Mental Health Board (CCMHB), initiated in 2014 on behalf of residents who had I/DD and complex support needs and had been unable to secure residential services in or near their home community. For several years, challenges were met by the service provider, families of those served, Independent Service Coordination staff, and CCDDB/CCMHB members and staff. By 2020, difficulties securing a workforce were insurmountable. With our CILAs empty, the Boards made the difficult decision to sell them and reinvest in meaningful supports for this population.

Updates:

The first home was sold in September, adding **$226,017.05** to the CILA Facilities Fund, with insurance refund of **$681**. Repairs to the second home were identified prior to listing, and two inspections indicated the need for roof replacement. This was not covered by our insurance.

- Removal of dead tree and landscaping stones - **$475+$195** *done*
- Replace garage door -**$1876** *done*
- Refinish hardwood flooring - **$2275** *done*
- Replace broken face plates – **$20** *done (completed with other work)*
- Remove panel under kitchen sink, install cabinet doors - **$603.46** *done*
- Repair/repaint kitchen ceiling, remove stickers, paint interior - **$2650** *done*
- Repair front railing, repair and restain rear deck, remove picket fence, fill in holes, plant grass seed - **$1635** *done*
- Remove signs from interior – *waiting, due to potential buyer*
- Roof replacement – **$14,432** *done*

When the home was listed in September, there were 11 realtor showings and an offer, contingent on the buyer's inspection report repairs, which could not be completed by closing. The home was taken off the market to resolve issues:

- Repair/replace downspouts as needed – *work order placed*
- Prep and paint trim around exterior doors – *work order placed*

- Repair auto-retract feature of garage door – **$84** *done*
- Qualified electrician to correct double tapping in electrical panel. Properly secure wiring in crawlspace. – *work order placed - can be done for below* **$300**
- Professional HVAC company to inspect the heating system and the scorching issue. All repairs and/or replacement to be completed as recommended. – *servicing and inspection* **$216.50** *done - functioning normally, do not replace/repair.*
- Qualified plumber to replace improper piping material with appropriate materials, make necessary repairs to low water flow at left side back bathroom sink, and identify the source of the moisture and perform necessary repairs. - **$729** *(repair shower pan, faucet, showerhead in master bath and showerhead and faucet in hall bath, install downspout extensions to correct water in crawlspace). Shower pan replaced.*
- Issue with standing water in the crawlspace to be corrected by the installation of a sump pit and sump pump with appropriate plumbing to move the water away from the home - *downspout extensions will correct it, given the amount of seepage and lack of proper downspout extensions; sump pump unnecessary.*
- Properly secure wiring in crawlspace. Install ductwork to vent the dryer to the exterior of the building. Replace improper filter. – *work order placed.*
- Replace cover plates and outlet in back bathroom; repair ceiling fan in SE bedroom; replace 2 outlets on east side of kitchen island; replace doorbell button; replace garage attic access ladder; vent dryer outside. - **$950**
- Effected subfloor and floor joists to be replaced by a qualified contractor. Any mold/mildew remaining after repairs will be cleaned and treated by a professional contractor (below back bedroom shower). Bathroom flooring to be repaired or reinstalled after repairs (below back bedroom shower). – *Joists appear to be fine - **$11,722.02**. More damage discovered, **$840**. Because the 2015 remodel caused this damage, an insurance claim has been filed to cover the repair cost.*

With the bathroom subfloor repaired, resolving water incursion problems and the most important issues, the realtor has completed a new Market Analysis *(see attached)* and suggests list price of $285,000. The previous buyer has remained in contact with the realtor and made an offer of $275,000 *(attached)* and subsequently agreed to waive the inspection contingency. If the Boards authorize the Director to accept this offer but sale does *not* go through, the house will be relisted.

Possible Next Steps:

As a shared project of the Boards, further discussion will determine appropriate uses of the fund. Suggestions are ranked by alignment with the original purpose:

- Specific assistance to people who have I/DD and complex service needs, especially those who are unable to secure services here, covering the types of purchase made through the CCDDB mini-grant process.

- Fund treatment for people who have I/DD and co-occurring behavioral or physical health issues which result in complex support needs.
- Pay DSPs working in Champaign County to complete accredited trainings and offer retention payments after a period of employment within the County.
- Lease or purchase a space to provide staff offices, to exhibit works by artists with I/DD, and to host board and group meetings. CILA funds could support a subset of expenses.

Recommended Action:

During 2021, the Boards selected a realtor and authorized the Executive Director to approve listing and sale of the properties. The approved resolution remains valid, so that those decisions do not need to be made again. For transparency, each Board is asked to consider the new offer of $275,000 (with inspection contingency waived) as well as the relisting of the property at $285,000, per the updated market analysis.

Decision Section:

Motion to authorize the Executive Director to accept the offer on the Englewood property at $275,000, pending CCMHB approval.

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

Motion to authorize relisting of the Englewood property at $285,000, pending similar approval by the CCMHB.

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

JOEL WARD HOMES REALTORS®

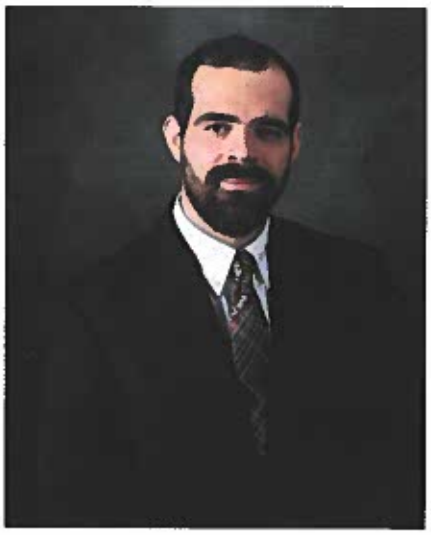
Real Estate Market Update

February 2022

By Nick Ward

Solid information about our **local market** is helpful for everyone, and especially for our clients who are thinking about entering into a real estate transaction this year.

This update is based upon information supplied by the Champaign County Association of REALTORS Multiple Listing Service for all attached and detached single-family properties in Champaign, Savoy or Urbana. **It is important to keep in mind that specific segments of the market may have performed better or worse than the overall market analyzed below.**

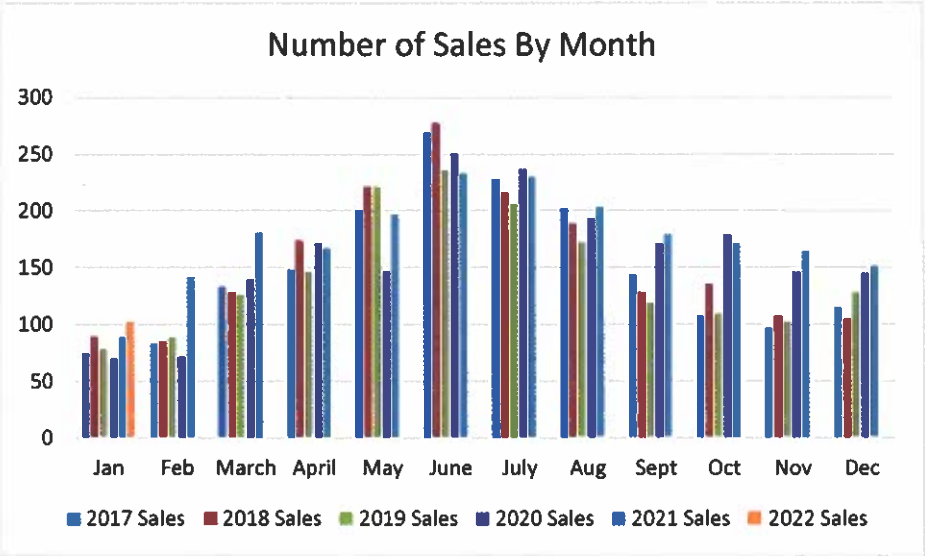


Comparing the Last 12 Months with the Previous 12 Months

For the most recent twelve months (02/01/2021-1/31/2022) the MLS reported 2,121 sales with a median sale price of $180,000 and a reported average marketing time of 44 days. For the prior twelve months (02/01/2020-1/31/2021) the MLS reported 1,945 sales with a median sale price of $172,500 and a reported average marketing time of 83 days.

This shows an increase in the number of sales of 176 homes or 9.0%. The median sale prices saw a 4.3% increase. There are currently 138 homes on the market with an average marketing time of 127 days. This results in a 0.7-month supply of homes in inventory, which is a significant shortage relative to historical supply demand relationships in this market.

Please note that while the number of sales still significantly higher than the historical average for the month of November, the market has slowed considerably since its peak in July of this year.



Interest Rates

The Interest Rate Story: For most of 2017, 30-year fixed rate mortgages were available from 3.75% to 4.125%. Interest rates increased rapidly in January and February of 2018 and had remained relatively stable within the range of 4.5% to 4.75%. In September 2018, rates moved as high as 5% before starting to decline as the year ended. Beginning in 2019 rates started a decline.

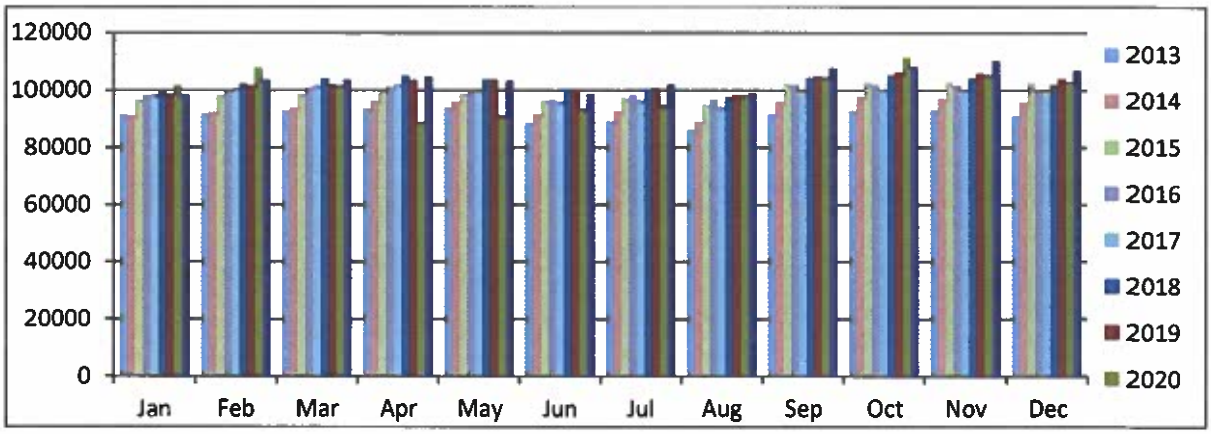
In 2020, rates varied from 3.5% to 3.6% through March. Since then, and with the advent of the novel coronavirus pandemic and the Federal Reserve cutting the interest rate, rates have been more volatile and fluctuating within the 2.5% to 3.5% range. This trend continued in 2021 and into early 2022, but interest rates are beginning to rise. Currently, 30-year fixed rate mortgage financing is available at 4.00%. Many experts are projecting interest rates to increase over the coming 12 months. Please note that the interest rate can vary significantly between lending institutions and borrower qualifications. Contact your Joel Ward Homes agent for recommendations!

Local Employment Analysis

The close connection between employment levels and the strength of housing markets has been well established, both locally and on a national basis. **In December 2021 (the last month for which data has been published) there were 106,818 employed people in Champaign County and an unemployment rate of 3.2% In December 2020 there were 102,913 people employed with an unemployment rate of 5.1%. This results in a 3.8% increase in the number of people employed.** The current rate of unemployment is consistent with the rates since prior to the Covid-19 pandemic.

What follows is a graph showing the number of jobs in Champaign County, by month, based upon non-seasonally adjusted U.S Bureau of Labor Statistics data.

NUMBER OF JOBS IN CHAMPAIGN COUNTY NON-SEASONALLY ADJUSTED DATE PER BLS

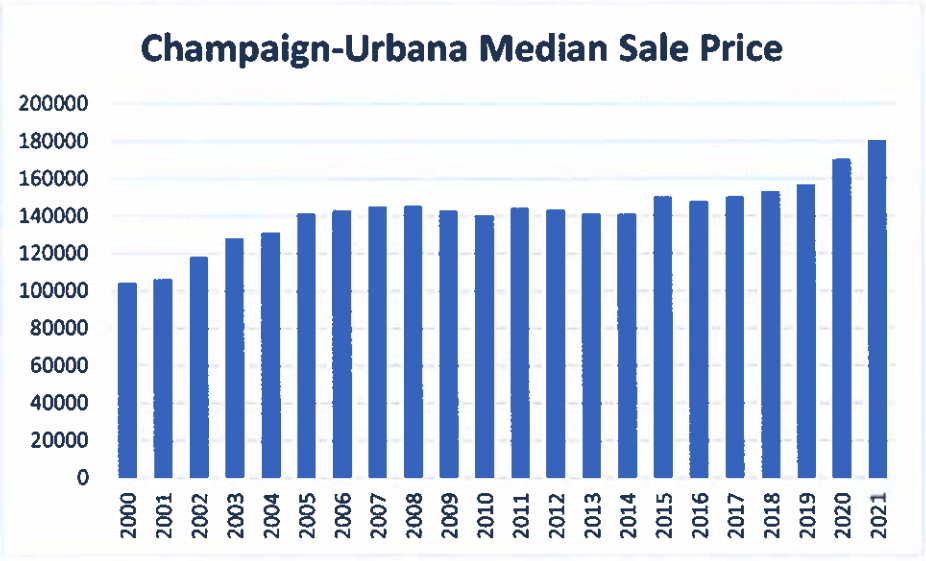


Conclusions

It is most notable that there is a significant shortage of homes in inventory, which is putting upward pressure on sales prices. This is most likely due to the combination of pent-up demand being released, along with the historically low interest rates.

What does this mean to the home seller? While we are currently in the slowest time of year, we are still seeing atypically short marketing times and high sales prices. The shortage of homes available, combined with the likelihood of higher interest rates are continuing to push sale prices upward. It is likely this will stabilize as interest rates right, but it is currently an excellent time to sell for top dollar. Contact your Joel Ward Homes REALTOR for the best options!

For buyers, the primary concern is the rising interest rates. Some project that rate increases will be significant, and it is very likely that interest rates will continue to increase during the year. This makes it important for buyers to move quickly and lock in long-term financing to offset risks posed by inflation and increasing interest rates. The current supply of homes in inventory is exceedingly low, which is likely going to make it more difficult to find suitable housing. This makes it even more important for your REALTOR to stay current on all homes which are listed for sale and meet your criteria.



Overall, Champaign-Urbana real estate has proven to be a good investment over time with an average annual appreciation rate of 2.6% since 2000, and this includes the 2009-2013 financial crisis and recession.

Remember that each particular segment of the market is different. If you are thinking about selling your home, or buying one, the best decision is to contact your Joel Ward Homes REALTOR to obtain current information about the specific segment of the market relevant to your property.

Real Estate Market Report

3707 Englewood, Champaign
Updated as of 2/28/2022

OVERALL MARKET CONDITIONS: See attached "February 2022 Market Update."

SPECIFIC MARKET CONDITIONS: At the current time, for one-story detached homes in Champaign and Savoy with 1,500 to 2,500 square feet of living space, listed or sold from $180,000 to $280,000, the MLS reports 105 sales in the prior year with a median sale price of $2018,300, and an average marketing time of 18 days. Comparing the year over year data for this market segment, there was a 10.5% increase in the number of sales (105 and 95 the year prior), a 0.1% decrease in the median sales price (within the range of stable), and a 33.3% decrease in average marketing time. Currently there is 1 listing in this market segment with marking time of 4 days. This results in a 0.1-month supply of homes in inventory which is in balance relative to the overall market at 0.7-months of supply. Please note that the current supply and demand relationship is in a historic state of shortage compared to the 5-year average of 3.2 months of supply.

SUBJECT HISTORY: The subject was purchased in 2015 for $215,500 and has been used as an assisted living home since.

MARKETING STRENGTHS: The primary strength of the subject is that it has been updated with a new roof, refinished hardwood flooring, and new tile in one bathroom. It has also been updated with handicap accessible amenities and doors, a feature that is unique in our market. It also has a superior view with the lake in the rear and is located in a popular neighborhood of Champaign.

MARKETING CHALLENGES: The primary marketing challenge is that the kitchen now appears dated due to the recent improvements to walls and flooring.

COMPETITIVE LISTINGS: MLS data sheets on all competitive listings are attached. There is currently only 1 other listing in the subject's market segment. It is 1412 Mayfair, a 3-bedroom/ 1.5 bath house with 1609 square feet and a partial basement. This house is currently listed for $219,900 with 4 days of marketing time.

RECENT SALES OF SIMILAR HOMES: MLS data sheets and a "Price Adjusted Comparables" sheets are attached. Please note that of the 4 comparable sales provided, Sale #4 is located in a different neighborhood and has been afforded the least weight in a determination of likely sales price. It has been included primarily to bracket the upper end of the range, as the more similar sales all have upward adjustments.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS: "Price Adjusted Comparable Sales" indicate a likely sale price in the range of $263,000 (rounded) to $280,000 (rounded). With an average sale to list price ratio of 97%, this would indicate a list price in the range of $271,000 to $288,600 (rounded). The significant shortage of homes indicates that an initial list price at the upper end of the range is most appropriate. Additionally, we are entering the prime marketing time of the season. Based on these factors, a recommended list price at the upper end of the indicated range is most appropriate.

STATE OF ILLINOIS MANDATED DISCLOSURES:

INTENDED PURPOSE: The intended purpose of this Comparative Market Analysis (CMA) is to provide information, analysis and recommendations to assist the homeowner in pricing their property.

PROPERTY INTEREST: The property interest being considered in this CMA is a fee-simple interest.

SCOPE OF WORK: The subject property was inspected and its strengths and weaknesses with respect to its marketability were analyzed and reported. The subject's market segment defined. The market segment was analyzed to determine the supply and demand relationships, to identify those competitive properties most similar to the subject and to identify those sold properties most similar to the subject. A selection of sold properties was made, and a "Price Adjusted Comparable" analysis was made, making quantitative adjustments to comparable sales intended to produce a indicated likely sale price of the subject. In the context of existing and expected overall market conditions, the above information and analyses were reconciled to produce a recommended list price range for the subject.

CMA NOT AN APPRAISAL: This is a comparative market analysis, not an appraisal of the market value of the real estate and was prepared by a licensed real estate broker or managing broker, not by a state certified real estate appraiser acting in his or her role as a state certified real estate appraiser. (Note that Nicholas Ward is a licensed residential real estate appraiser acting only in the role of managing broker in relationship to this client.)

Respectfully Submitted,

Nicholas Ward, Managing Broker

Price Adjusted Comparable Sales

	Subject	Sale #1		Sale #2		Sale #3	
Street Address	3707 Englewood	1105 Waters Edge Rd		1401 Casselbury Ln		1503 Casselbury	
City	Champaign	Champaign		Champaign		Champaign	
Sale Price			$245,000		$249,900		$298,000
Price/SF		$151.99		$151.27		$125.00	
Sale Date		2/9/2022		11/17/2021		9/21/2021	
Days on Mkt		160		17		8	
Concessions		None		750	-$750	1000	-$1,000
Location & View	Good/Lake	Average	$10,000			Good/Lake	
Lot Size	8,190 sf	8,190 sf					
Curb Appeal	Average	Average		Average		Average	
Age	24	19	0	24		25	
Quality	Average	Average	-5,000	Average	-5,000	Average	
Exterior	Average	Average		Average		Average	
Condition	Average	Average		Average	10,000	Average	10,000
Square Footage	1988	1,612	16,920	1652	15,120	2,384	-17,820
Total/BDBS/BTHS	7/4/2.0	7/4/2.0		6/3/2.0	0	9/4/2.1	-2,500
Basement Size	None	None		None		None	
Basement Finish	None	None		None		None	
Fireplace	Fireplace	Fireplace		Fireplace		Fireplace	
Garage	2 Car Attached	2 Car Attached		3 Car Garage	-5,000	3 Car Garage	-5,000
Porch/Patio/Deck	Deck	Deck		Porch/Patio	-2,000	LgDeck	-2,000
Net Adjustments			21,920		12,370		-18,320
Indicated Sale Price			$266,920		$262,270		$279,680
Features:	Remodel 2015	Roof 2021		Updated kitchen			
	Roof 2021	Updtaed Kitchen		Updated bath			
	Refin HW	Updated bath		Granite Counters			
	New Flooring 1 BA	Updated Carpet					
	Repainted	Granite Counters					
	New Garage Door						

45

From: Nick Ward
To: Lynn Canfield
Subject: Offer on Englewood
Date: Monday, March 7, 2022 10:12:15 AM
Attachments: 3707 Englewood - Purchase Contract (2).pdf

Good morning Lynn,

We received an offer for 3707 Englewood from DCF/DSC and I have attached it below. They have offered $275,000 and would be having another home inspection, closing on 4/15. They also requested that I include the below message. I've let them know we likely can't make any decisions until the board meets, but they still wanted to get their offer in. Please let me know if you have any questions, and what your thoughts are! Also, I'm out of town for a conference so I may be slow to respond at times, but I am still working.

DCF and it's Board are very excited to work out the purchase of this property. It will help with the overall structure of services that DSC is able to provide to their residential clients. We had hoped to complete the transaction last fall when we had the property under contract but understand the time needed for the County Board to evaluate the extent of the damages found in the home inspection and the cost of repairs.

We are offering $275,000. This is $26k over the original agreed upon sale price from the last contract. We feel this accounts for the change in value in the overall market for this property. We understand that there were additional costs incurred to resolve the inspection issues and feel that those were generally maintenance items that for better or worse come with any property.

3707 Englewood is a great fit for DSC/DCF with the various components of a group home already included (fire alarms and fire systems, accessibility and other operational components of a group home) but we also feel those benefits adversely affect the market value of the home for the typical home buyer.

A more traditional buyer would likely spend a significant amount of money to convert the property back into a typical home (removing fire alarms, installing residential flooring in all bedrooms and the living room, replacing all interior doors with standard doors, etc.

The home has also been 'well-loved' with quite a bit of wear and tear in the bathrooms, and kitchen and we anticipate spending a fair amount of money updating counters, cabinets, etc.

We hope the Board finds our offer exciting and the potential to sell the home to DCF/DSC as an added bonus. We look forward to working out the details.

Sincerely,

Mark Waldhoff
Past-President - DSC Board of Directors
217-714-3603

Nicholas Ward / Designated Managing Broker IL Lic#471.020454
Joel Ward Homes, Inc / www.joelwardhomes.com

#12.C.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CCDDB 2022 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 312-626-6799, Meeting ID: 815 5912 4557

January 19, 2022 – Shields-Carter Room
February 23, 2022 – Shields-Carter Room
March 23, 2022 – Shields-Carter Room
April 20, 2022 – Shields-Carter Room
May 18, 2022 – Shields-Carter Room
June 22, 2022 – Shields-Carter Room
July 20, 2022 – Shields-Carter Room
August 17, 2022 – Shields-Carter Room - *tentative*
September 21, 2022 – Shields-Carter Room
October 19, 2022 – Shields-Carter Room
October 26, 2022 5:45PM – Shields-Carter Room – study session with CCMHB
November 16, 2022 - Shields-Carter Room
December 21, 2022 – Shields-Carter Room

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, using the Zoom options or in person, in order 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 2022 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 312-626-6799 Meeting ID: 813 9367 5682

January 19, 2022 – Shields-Carter Room
January 26, 2022 – *study session* - Shields-Carter Room
February 16, 2022 – *study session* - Shields-Carter Room
February 23, 2022 – Shields-Carter Room
March 23, 2022 – Shields-Carter Room
April 20, 2022 – Shields-Carter Room
April 27, 2022 – *study session* - Shields-Carter Room
May 18, 2022 – *study session* - Shields-Carter Room
May 25, 2022 – Shields-Carter Room
June 22, 2022 – Shields-Carter Room
July 20, 2022 – Shields-Carter Room
September 21, 2022 – Shields-Carter Room
September 28, 2022 – *study session* - Shields-Carter Room
October 19, 2022 – Shields-Carter Room
October 26, 5:45PM –*study session with CCMHB* - Shields-Carter
November 16, 2022 – Shields-Carter Room *(off cycle)*
December 21, 2022 – 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.
Meetings are archived at http://www.co.champaign.il.us/mhbddb/MHBMeetingDocs.php

Public Input: All meetings and study sessions include time for members of the public to address the Board. All are welcome to attend meetings, using the Zoom options or in person, in order 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 - 2022 Meeting Schedule with Subjects, Agency and Staff Deadlines, and Allocation Timeline for PY23

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 PY23 and deadlines related to PY21 and PY22 agency contracts.

1/3/22	*Online System opens for Applications for PY23 Funding*
1/19/22	**Regular Board Meeting**
1/28/22	*Agency PY22 2nd Quarter and CLC Progress Reports due*
1/31/22	*Deadline for submission of updated eligibility questionnaires*
2/11/22	*Deadline for submission of applications for PY2023 funding (Online system will not accept any forms after 4:30PM)*
2/23/22	**Regular Board Meeting** List of Requests for PY2023 Funding
3/23/22	**Regular Board Meeting**
4/13/22	*Program summaries released to Board, posted online with the CCDDB April 20 meeting agenda and packet*
4/20/22	**Regular Board Meeting** Board Review, Staff Summaries of Funding Requests
4/29/22	*Agency PY2022 Third Quarter Reports due*
5/11/22	*Allocation recommendations released to the Board and posted Online with CCDDB May 18 meeting agenda and packet*
5/18/22	**Regular Board Meeting** Allocation Decisions; Authorize PY2023 Contracts

6/22/22	**Regular Board Meeting:** Draft FY2023 Budget
6/24/22	*Deadline for agency application/ contract revisions* *Deadline for agency letters of engagement with CPA firms* *PY2023 contracts completed*
6/30/22	*Agency Independent Audits, Reviews, or Compilations due (only for those with calendar fiscal year, per Special Provision)*
7/20/22	**Regular Board Meeting:** Election of Officers
8/17/22	**Regular Board Meeting** - *tentative*
8/26/22	*Agency PY2022 4th Q Reports, CLC Progress Reports, and Annual Performance Measure Reports due*
9/21/22	**Regular Board Meeting** Draft Three Year Plan 2022-24 with 2023 Objectives
10/19/22	**Regular Board Meeting** Release Draft Program Year 2024 Allocation Criteria
10/26/22	**Joint Study Session with CCMHB** at 5:45PM
10/28/22	*Agency PY2023 First Quarter Reports due*
11/16/22	**Regular Board Meeting** (off cycle) Approve Three Year Plan, PY24 Allocation Criteria
12/11/22	*Public Notice of Funding Availability to be published by this date, giving at least 21-day notice of application period.*
12/21/22	**Regular Board Meeting** (off cycle)
12/31/22	*Agency Independent Audits, Reviews, or Compilations due*
1/2/23	*Online System opens for Applications for PY2024 Funding*

~~4~~ 12.D.

Agency and Program acronyms

CC – Community Choices
CCDDB – Champaign County Developmental Disabilities Board
CCHS – Champaign County Head Start, a program of the Regional Planning Commission
CCMHB – Champaign County Mental Health Board
CCRPC – Champaign County Regional Planning Commission
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

(#14)

Executive Director's Report – *Lynn Canfield, March 2022*

Background - Strategic Plan Goals:

Champaign County Mental Health Board Current Three-Year Plan Goals

1. Support a **continuum of services** to improve the quality of life experienced by individuals with mental or emotional disorders, substance use disorders, or intellectual and/or developmental disabilities (I/DD) and their families residing in Champaign County.
2. Sustain commitment to addressing health disparities experienced by **historically underinvested populations.**
3. Improve **access** to supports, services, and resources currently available and beneficial.
4. Continue the collaborative working relationship with the CCDDB.
5. Building on progress achieved through the six-year Cooperative Agreement between the Federal Substance Abuse and Mental Health Services Administration (SAMHSA), the Illinois Department of Human Services (IDHS), and the CCMHB, **sustain the SAMHSA/IDHS system of care** model.
6. **Divert persons with behavioral health needs or I/DD from the criminal justice system**, as appropriate.
7. In conjunction with the Champaign County Sheriff's Office, other law enforcement, and community stakeholders, pursue a continuum of services as an **alternative to incarceration and/or overutilization of local Emergency Departments** for persons with behavioral health needs or I/DD.
8. Support **interventions for youth** who have juvenile justice system involvement.
9. Address the need for **acceptance, inclusion, and respect** associated with a person's or family member's mental illness, substance use disorder, intellectual and/or developmental disability through broad based community education efforts to increase community acceptance and positive self-image.
10. Engage with other local, state, and national stakeholders on **emerging issues.**

Champaign County Developmental Disabilities Board Current Three-Year Plan Goals

1. Support a **continuum of services** to meet the needs of people with I/DD, along with their families, residing in Champaign County.
2. Sustain the commitment to improving outcomes for members of **underrepresented and underserved populations.**
3. Improve **access to and engagement in services** through increased coordination among providers, community stakeholders, people with I/DD, their families, and other key supporters.
4. Encourage high-quality **person-centered planning** and follow-through for people served by funding from the CCDDB and, through the Intergovernmental Agreement, from the CCMHB.
5. Continue the collaborative working relationship with the Champaign County Mental Health Board.
6. Identify children at-risk of developmental delay or disability and support **early intervention services and family supports**.
7. Support **access to services and programs** for youth and adults with I/DD, with a preference for evidence-based practices to increase positive outcomes.
8. Promote **inclusion and respect** of people with I/DD, through broad based community education efforts.
9. Stay abreast of **emerging issues** affecting service and support systems and be proactive through concerted **advocacy efforts**.

Activities of Staff and Board Members:

To support CCMHB Three Year Plan goals 1-8 and CCDDB Three Year Plan goals 1-7, we are focused on review of 14 applications for DDB funding and 25 MHB, submitted between January 3 and February 11. In the last three days of the open application period, there was an explosion of agency activity, with many questions requiring technical assistance. We relied heavily on the online system developer for solutions. As applications were submitted, we sent emails acknowledging them and I set up drafts of the long-form staff program summary/analysis of each one. This year, we will add a 'summary of the summary' to support the Boards' review and decision processes. The Board packet includes a list of applications to be considered. When the system closed at 4:30PM on Friday,

February 11, I replaced the NOFA with a statement on the public page of the online system and took an early look at possible budgets toward understanding the affordability of allocations. The estimate I started with then has already been increased and will increase again later in the spring, but we do not yet have some of the information required for full budget planning for 2023. While I am eager to put those together, we can focus on application review and discussion for now, and affordability later.

Contracts with service providers appear as Contributions & Grants, the largest expenditure line in each Board's budget. A small share of costs are non-agency activities in support of individuals, families, agencies, and community, which impact Personnel, Professional Services, Expo, Public Relations, and Non-Employee Training costs and are accomplished with independent contractors, associations, or partnerships. Many activities and collaborations are referenced in other staff reports. We have a new IT service provider and are using the County's new accounting system (on the ERP). Costs related to the ERP appear in the budget as an interfund transfer to the County but will be charged to a service line. Many activities and collaborations are referenced in staff reports.

Anti-Stigma and Community Awareness:

(MHB goals 1, 3, 4, and 9 and DDB goals 1, 3, 5, and 8)

Resource information: 211 is a call-based service provided by PATH and cofunded by United Way, the CCMHB, and the CCDDB. A research project of the UIUC Community Data Clinic offers an online directory using these data, working to improve provider information and feedback to 211 and the CDC site. PATH currently serves as call center for 988 (National Suicide Prevention Lifeline) for counties other than Champaign, which relies on the crisis line operated by Rosecrance, expanded through a state grant for 988 implementation. PATH has been selected to provide 988 services for the region, so I look forward to learning how these will coordinate. In recognition of the UIUC CDC's lead student researcher, I submitted a letter of support for his nomination for a Campus Award for Excellence in Public Engagement.

Alliance for Inclusion and Respect (AIR) social media continue anti-stigma messaging and promotion of members and local artists. AIR will sponsor an 'anti-stigma' film (not yet selected) and post-screening Q&A during the Roger Ebert's Film Festival, April 20-23, and the annual art show and sale on Saturday, April 23 in front of the Virginia Theatre.

disABILITY Resource Expo Steering Committee is working toward an October 15 in-person event at Vineyard Church. All are welcome to join the Steering Committee and subcommittees which bring the event together. I have volunteered for the Marketing/Sponsorship Committee. Dylan and Allison Boot of BootBooks, LLC, are coordinating all Expo planning with support from outgoing coordinator Barbara Bressner and graphic designer Pat Mayer. ChrispMedia maintains AIR and Expo websites, now with short videos, and provides additional technical support for Expo events. The exhibitor videos were produced by UIUC students.

CCMHB/CCDDB CILA:

(MHB goals 1 and 4 and DDB goals 1 and 5)

This packet includes a memo with updates. Because the core issue ending the original iteration of this project was the direct support professional (DSP) workforce shortage, and because we want to preserve existing local CILA capacity, we monitor the state and federal funding situation and raise this advocacy issue at state and national association meetings (more below).

Support for Agency Programs:

(MHB goals 1, 3, 5, 6, 7, and 8 and DDB goals 1, 2, 3, 4, 6, and 7)

Support Activities of CCDDB/CCMHB Staff: Cultural and Linguistic Competence training and technical assistance; numerous collaborations, such as Champaign County Transition Planning Committee, Continuum of Service Providers to the Homeless, Champaign County Community

Coalition, Champaign County Reentry Council, Drug Court Steering Committee, Coalition Race Relations Subcommittee, Human Services Council, CUPHD I-Plan Behavioral Health Committee, Youth Assessment Center Advisory Committee, Child and Adolescent Local Area Network Meeting; Monthly Provider Learning Opportunities free of charge and offering CEUs to a primary audience of case managers, joined by family advocates and social workers; and exploration of professional development curricula such as those offered by College of Direct Support, National Association of DSPs, and Georgetown Institute Leadership Training.
Independent Contractors: Alex Campbell of EMK offers technical support for users of our online application and reporting system. Board members interested in learning to view forms may reach him at afcampbell9@msn.com. We are archiving data and adding new capacities, such as a compliance dashboard to track required submissions (other than quarterly and semi-annual reports); this will include audit reports, board meeting minutes, certificates of liability, letters of engagement with CPAs, subcontracts, etc. John Brusveen, CPA, reviews all agency audits, compilations, and financial reviews, summarizing findings and recommendations. The CCMHB has a new bookkeeping support pilot project, through which consultants from MTF and Allaso-Stevenson are working with two small agencies each (Terrapin Station, UP Center, Well Experience, and WIN Recovery) to improve bookkeeping, financial reporting, and audit-readiness. In June, they will make recommendations for any subsequent phase of support.
UIUC Evaluation Capacity Project: intensive support offered to new and continuing programs (RPC Independent Service Coordination, Community Choices, Well Experience, RACES, WIN Recovery, and UP Center) and workshops and consultation bank to a broader network.

Executive Director Activities:

In addition to collaborations described above, I continue to review audits/reviews and request explanations or return of excess revenue when relevant. We are still waiting for three audits/reviews and for additional information about two others. Payments are suspended for three agencies with late audits; payments are released for two others due to proof of timely engagement and that the delay resulted from the CPA firm staffing issues. For most audits and reviews submitted after the deadline, payments have been restarted and concerns addressed, with some excess revenue returned. As mentioned above, I prepared initial drafts of long-form program summaries/analyses for each request for funding. While not always easy on the eyes, it was encouraging to read all the agency plans, including some well-thought-out new proposals. As the season progresses and we begin to clarify affordability, these detailed analyses may be helpful for making decisions.

Intergovernmental/Interagency Collaborations:

(MHB goals 1, 2, 4, 9, and 10 and DDB goals 1,2, 3, 5, 8, and 9)

Champaign County Department Heads: with the County Executive, Admin staff, and other Departments' representatives, this bimonthly meeting covers budgets, ERP implementation, facilities issues, ARPA fiscal recovery fund requests, budget process, and employee recognition.
Community Advisory Network for the 2022 Community Tech Fellowship: an effort led by the UIUC Community Data Clinic, this group evaluated applications for $5,000 technology related grants and awarded four. Feedback from the organizations resulted in monthly workshops on: Trauma, Resilience, & Healing; Local Art Production Resources; Working with At-Risk Youth; Affordable Digital Media Production; and Budgeting/Financing Social Justice for Sustainability. I will attend as possible, but they conflict with other meetings.
Mental Health and Developmental Disabilities Agency Council: monthly meeting of agency representatives, not all of which are funded by the Boards, for discussion of agency activities, federal and state updates, special topics, and announcements.
Regional Champaign-Vermilion Executive Committee: bimonthly meeting of public and private entities responsible for community health plans. The most recent I-Plan identified

behavioral health and community violence as priorities. A new community health needs assessment survey is in use. The search for a coordinator has begun, with financial commitments from members to support increased salary to attract and keep qualified candidates.

UIUC School of Social Work, Community Learning Lab, and We CU: While we hesitate in Spring to take projects through the CLL due to review of agency applications and development of recommendations and subsequent contracts, we have support from We CU for translation of board documents and Expo materials. I submitted a letter of support for the nomination of WE CU co-directors for a Campus Award for Excellence in Public Engagement. I met with the "Social Work 542: Program Evaluation" class for discussion of community needs assessment and strategic planning; students will send feedback on our assessment report, strategic plan, and annual priorities later in the semester.

Partnerships related to Underrepresented Populations and/or Justice System:

(MHB goals 1, 2, 5, 6, 7, 8, and 10 and DDB goals 1, 2, 3, and 7)

Champaign Community Coalition: monthly Goal Team meetings include updates from law enforcement, reports on positive youth programming, trauma-informed system work, and efforts to reduce community violence. The Executive Committee meets less frequently, but we have discussed programming which may result from the City of Champaign's ARPA investments in these priority areas, through grants with some of our own currently funded organizations.

Crisis Intervention Team (CIT) Steering Committee: bimonthly meetings of representatives of law enforcement, EMS, hospital, behavioral health, providers of service to people with housing insecurity, support network leaders, and other interested parties, to promote CIT training, review data analyzed by City of Urbana, and share updates. I have asked the committee for a special meeting to consider whether Champaign County could be a pilot community for a NACBHDD project featuring **Cloud9** technology and consultants, to improve our cross-sector data collection and reporting, for better human and system outcomes: https://www.cloud9telehealth.com/.

"Empowering youth impacted by violence in Champaign County to promote health equity: a photo-voice project." - a collaboration between Judge Ford, Charles Burton on behalf of the Don Moyer Boys and Girls Club, and Dr. Windsor of UIUC School of Social Work. Application has been submitted to UIUC, aligned with the Chancellor's Call to Action. I met with Judge Ford prior to their submission and have agreed to serve as an external reviewer.

Illinois Mental Health Task Force Regional Council – the Behavioral Health Administrator for Illinois Courts hosts monthly Resource Mapping Workshops to complete a Sequential Intercept Map for each region of the state; our region is well-represented.

State and National Associations and Advocacy:

(MHB goal 10 and DDB goal 9)

Association of Community Mental Health Authorities of Illinois (ACMHAI): Executive, Legislative, Medicaid, Strategic Planning, and I/DD committees address contracting and monitoring processes, state funding and policies, levies, goal setting, community awareness, etc. Government Strategy Associates updates the membership on state legislative activity and uses our input for advocacy. I accepted the role of Vice President when the serving VP resigned and have been replaced as I/DD committee chair. ACMHAI Legislative Committee Highlights:

- SB3215 and HB4228 – Mental Health Validation bills would ensure that current 377 and 708 boards are 'validated'. This bill allows for continuation of any 377 and 708 boards which were established after passage of PTell but prior to the relevant change in 377 and 708 referendum language and sees that future 377 and 708 boards are properly established. Our Committee Chair testified to the Senate, where the bill passed and was assigned to Revenue & Finance. The House version passed and was referred to Assignments. The SB is amended, the 'clean bill' and the one we'd like to see move forward; witness slips will be needed.

- Other bills to support: HB4452 also cleans up referendum language in the Community Mental Health Act; HB4729 and HB5086 establish and appropriate for a Safe Gun Storage campaign – response to increased gun suicides and accidents in many of our counties; HB4616 and SB3607 would increase DSP wages by $3.50; HB4832 and SB4063 would increase the underlying rates methodology to support DD wage increases; HB4606 and SB3156 fix an incorrect term in the MHDD Act and establish a pilot DSP credentialing program – referred to Rules; SB3438 and HB5333 MH Assessment Reform simplify the IMCANS process; SB2948 for 988 Trust Fund – referred to Rules; SB3681 would fund MH crisis through probation – referred to Senate Appropriations; and SB2910 would have created an MH oversight officer - though not currently moving, it is now included in the Governor's budget.
- A change in state and local government lobbying may make it more difficult for non-profit organization representatives to offer comment to any government entities, but we will wait for rules from JCAR and Secretary of State to clarify actual impacts. The worst interpretation would inhibit our own needs assessment and policy-setting processes and may also create a barrier for elected officials who serve on non-profit boards.

National Association of Counties (NACO): monthly Health Steering Committee meetings with legislative updates, local innovations, and policy issues; quarterly Healthy Counties Advisory Board and Stepping Up Innovator County calls. At the pre-conference HSC meeting, our NACBHDD-sponsored policy resolution (advocating for a Bureau of Labor Statistics classification for DSPs) was approved. *Notes from the February 12 NACO Legislative and Policy Conference HSC Meetings are below, with NACBHDD notes.*

National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD): as the current board secretary, I attend Executive Committee meetings, reviewing policies and financials, and planning meetings and events. I also attend Monthly I/DD committee meetings and chair monthly meetings of the reconstituted Behavioral Health and Justice Committee. I moderated the first "Candid Conversation" on the topic of Youth Mental Health.

The remainder of this report is a collection of my notes from the NACBHDD Annual Legislative and Policy Conference and the NACO HSC meetings, held virtually between February 12 and 16.

"Preparing for Change: 988 Rollout and the Crisis Response Continuum" *– I moderated this session on behalf of the NACBHDD Behavioral Health and Justice Committee. 988, the three-digit number for behavioral health crises, will go live on July 16, 2022. Experts predict call volumes to increase beyond current call levels, building off the National Suicide Prevention Lifeline and network of over 180 local crisis centers, many dependent on volunteers, and expanding the focus on behavioral health crises. The FCC approved new text capabilities for 988 although many 911 systems lack similar capabilities.*

Nichole Cunha, LCSW, Crisis Program Administrator, Utah Division of Substance Abuse and Mental Health – system is being designed for anyone, anytime, anywhere, with goals of better care, hospital diversion, law enforcement/jail diversion. Mobile Crisis Outreach teams. All receiving centers connected to subacute hospitalization or residential services. Utah has a Behavioral Health Crisis Response Commission (to operationalize 988) which includes legislators, system stakeholders, people with lived experience, and Medicaid. Utah's Crisis System Specific Statutes, starting around 2015. Review of the last decade of developments toward the system. Two-year legislative study to explore policies and funding of crisis systems. Continuum goes beyond the traditional components in that there are specialized ACT teams and bridge services ('hospital without walls' for those with SMI), robust CIT through state contracts, and youth receiving centers in addition to adult centers.

Rachel Lucynski, MBA, Director, Community Crisis Intervention and Support Services, the Huntsman Mental Health Institute – described how this system looks on the ground. Team staffs and operates the 24/7 crisis call lines. Training and certification, statewide coordination of services with 'least restrictive' level of care as guiding philosophy. They also staff and operate the Utah Warm Line with certified peer support specialists. Mobile Crisis Outreach Teams act as dispatch; information sharing agreements across the state

for continuity of care and documentation; SafeUT Crisis Chat & School Safety App; Receiving Center. 92k crisis calls last year, expect an increase, so there's a recruitment effort and certification process with local universities statewide. At least 50% of the workforce is remote, which will increase; focus on CLC; strategic education, collaboration, and formalized partnerships.

Mary Abrams, MA, Senior Health Policy Analyst, New Jersey Association of Mental Health and Addiction Agencies, Inc. – NJ is a little behind; we have pieces of a crisis system, not yet linked. 988 legislation just heard in committee in early February, rewritten many times, not yet moved. Would give 6 months from passage for their Dept of Human Services to solicit a contract for crisis call services, with award likely early 2023. NJ has a large network of hotlines in operation, lots of work on connectedness so that 988 calls will be taken; teams and training to come, as there was no appropriation for mobile teams; fees from telecom would fund the entire system (no opposition from telecom during the hearing). Have to move through two committees, budget and appropriations, prior to reaching the governor. A coalition in NJ (of statewide associations representing many systems and consumers) has been around a few years and meets informally to make recommendations on the bill, all of which have been accepted. NJ also has many established services to be connected. NJAMA has long advocated for screening centers. 11 of 21 NJ counties have early intervention, walk-in urgent care style programs, 7 of which are operated by the organization which runs the screening center. Expanding to the other 10 through an RFP just released. Block grant funds are putting up 9 mobile crisis centers.

Matthew Taylor, Director of Network Development, National Suicide Prevention Lifeline – Preparing for 988 Implementation. Review of the Lifeline Mission, currently a network with 196 independent call centers (in good news for us, IL just awarded one organization a contract to provide back up for all call centers). 3.6m answered contacts in FY2021. 9 national backups. 3 Spanish Centers. 42 Crisis Chat and Text Centers. 1 Veterans call line backup. 36% received public funds to answer lifeline calls, but this is dramatically increasing due to SAMHSA grants to communities. Routing of calls is increasingly negotiated with the state level. Review of the 988 legislation/definitions. Robust series of backups and redundancies. 988 builds on the Lifeline by: scale of access and visibility (3 digits should be easier); scope of services beyond suicide; access to omni-channel services; access to specialized services (rural, LGBTQ+, AI/AN people, communities of color); and stakeholder investment (greater public funding, though more is needed)). Private funds used for 50 988 state planning grants around 8 core planning assumptions: follow up services, 24/7 primary access, diversified funding, volume growth projections, operational and clinical and performance standards, implementation coalitions, consistency in public messaging, referral listings and linkages to local crisis services. Majority of current centers need more staff to meet the anticipated call volume; 80% offer follow up, some with services in crisis continuum; mobile crisis teams in the area for 96%, and 39% were operated by the same organization as the call center. Where to direct the public for information? Get to know the local Lifeline center. https://suicidepreventionlifeline.org/our-network/

Richard McKeon, Ph.D., Chief, Suicide Prevention Branch, Center for Mental Health Services, SAMHSA - Suicide has increased over the last decade, encouraging to see a small decrease in 2019 and 2020, but these are uneven, with concern for particular populations (Black Americans and youth in particular). SAMHSA guidelines on behavioral crisis care – https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf - start with the crisis line but connect to mobile teams, facilities, connection to post-crisis wraparound services, next day appointments with Mental Health Clinic if needed; lower reliance on police. Lifeline doesn't currently have geolocation. SAMHSA designated $282m to strengthen and expand the existing Lifeline. NOFOs released in December 2021, all states eligible, non-competitive; SAMHSA will make up to 56 awards, by April 15, to start April 30. https://samhsa.gov/988. SAMHSA also convened a co-sponsorship group, open to associations.

Q&A:

Question about the UT team about where centers are located and for more info about the specialized youth centers. Answer: local centers plus the Salt Lake County system (managed by Optum); some varying interpretations in UT but encouraging lots of follow up communication; team of dispatchers coordinate between the crisis line and MCOT teams (for ETA, standard questions about safety) but still working on these processes, with technology improvements to support that; Youth Receiving Centers are operated by the juvenile justice system, community based service arm, not zero refusal, don't necessarily take aggressive or violent youth, and this service is not managed directly by DHS, but they provide technical assistance; not staffed by clinicians in the same way, but referrals are made to other systems.

Question about plans to expand the number of local or regional crisis lines with which 988 will partner. Matthew Taylor answered: still accepting applications from new local and regional crisis contact centers

who wish to join the Lifeline; when applications are received, meeting with the State Mental Health authority to hear preferences on further expanding the Lifeline network in their state; some states are wishing to keep the number of centers as is at the moment to ensure that they can best support the centers who have been longstanding and historically underfunded services; a few states are welcoming more centers to join the network; Lifeline and SAMHSA's focus is to shore up the existing network and staff up the current centers to meet anticipated 988 volume growth, particularly as it launches this summer.
Question as to which actions, policy or otherwise, to coordinate with public safety to ensure behavioral health emergencies are responded to properly. McKeon answered: co-sponsorship agreement includes variety of stakeholders (Dept of Transportation, National Emergency Number Association, etc); all state grants require 988 and 911 coordination within the state; convening a Community of Practice, because this is vitally important on national, state, and local levels; collocation of call centers with stakeholders and multiple streams of effort.
Question about geolocation. https://www.fcc.gov/document/988-geolocation-report-national-suicide-hotline-designation-act; complex (safety, privacy, and technology) and many discussions with FCC; very focused on moving this forward. There is movement across the country to create a uniform credentialling/training program, as crisis call workers have been trained in many different ways; variation outside the standards for suicide risk assessment, so SAMHSA and the Lifeline are both looking at revising some curricula and developing others. Lifeline looks at the centers' standards, lots of latitude in trainings but must map clearly to the risk protocols; "standards in training and practice" dept will be expanding these; make sure we have a voice so there's no disconnect between state and national policies. In Utah, a lot of work in this area, requirements in addition to the NSPL standards, core competencies, and robust training, extended beyond the crisis line and to the whole continuum staff. John Buckner added 'As a reminder, geolocation is especially important to Active Duty Military. A good majority of military retain their home state area code or first duty station during their service. I have a 760 area code, dialed 988 to test and got San Diego and understand the delay of implementation. I live in Norfolk with almost 100k military in the region alone." Note that some area codes are several hours wide.
Question: Being from rural/frontier Michigan and having been on a "Mobile Crisis Team" back in the 1990's and the death of a worker back then. We have very limited cell coverage and no law enforcement coverage for large periods of time. I am extremely concerned about the safety of staff being sent out particularly with potential SUD issues. How is this addressed frontier and rural communities?
Response: this is a challenge and active discussion in Utah, also safety concerns which present themselves due to delays. Team can opt not to place themselves at risk or co-respond. Rural and frontier cel phone coverage is an issue, so teams can access the radio network used by law enforcement.

***"Partner Spotlight" - Blaire Bryant**, Associate Legislative Director, NACo:*

Summary of ARPA's direct funding to counties, with final rule released on January 6, 2022 outlining all eligible uses. Behavioral health was in the interim rule and expanded dramatically in the final rule, with an array of services in prevention, recovery, harm reduction, BH facilities and equipment, diversion programs, equitable access, peer support groups, 988, evidence-based OUD treatment and recovery, and more. Final rule also addressed violence prevention in this category due to the increased rates of violence resulting from the pandemic: focused deterrence, street outreach, violence interrupters, hospital-based, capacity building, reduction of gun violence, trauma informed care, wraparound, prevention.
Policy highlights: Congress looking to remove barriers to MH and SUD care, sought feedback from stakeholders; NACO response highlighted the county role, lifting some of the IMD exclusion (jails, esp), financing BH enhancements of crisis response infrastructure. Webinars on 988 to watch on demand.

***"Behavioral Health in Rural Communities: Unique Challenges and Opportunities"** - moderated by Kevin Martone, NARMH President, Executive Director, TAC: access is a major issue, dependent on workforce, financing, telehealth, etc. - how do we work with children and youth and serve diverse populations, including tribal?*

Shauna Reitmeier, CEO, Alluma, and NARMH President-Elect - Alluma is a CCBHC in NW Minnesota, 90 miles from Canada so that when their cel pones roam, they often access Canadian towers, with large fees. This is very large geographically but only 68K people. 'Structural urbanism' informs policies and models, not translating well to rural áreas. Challenges: fee for service; in large ag áreas, give us the flexibility and we'll figure it out; timely response hard when the team is 45 minutes from hospital; used

telemedicine early on but Broadband not sufficient; to meet people where they are, relationships with primary care clinics and schools have been critical. ACT not required of their CCBHC, very hard to get this up and running due to the limited workforce; they have to offer so much choice within one organization serving many counties. Discussion of other states trying to implement ACT, maybe needing special consideration for rural ACT teams.

Chip Johnston, Executive Director, Centra Wellness Network (MI) – always shortstaffed! Collaborations across crisis, schools, inpatient, senior centers with strategy to avoid driving many hours to hospital setting. The fidelity issues of CCBHC were too much, given the staff and time needed, so they backed out. Of several major EBPs, only three were studied in rural areas. Our area is about 20 people per square mile, with many of the same problems noted in MN. Instead of ACT, intensive case management team serving around 10 clients. With Medicaid, the state is often limited to basic models; Medicaid waivers or state plans could include population-based guidelines or exceptions to the models. Urbanized models don't work here.

Q&A:

Bob Sheehan raised the question: what's the rural equivalent of these models? We apologize but don't pilot them; let's add to the agenda as a national advocacy point, e.g., instead of ACT, 24/7 response.

Cherryl Ramirez added that Oregon also has lots of rural and frontier areas; one member had an audit of their COE ACT, which may be paused now due to difficulties, when it seems people would still benefit from the intensive services. ACT fidelity is hard right now. Many rural and frontier community mental health programs are struggling. The first version of OR's 988 legislation did not include any input from our CMHPs - had to insert ourselves to make the revised version reflective of the actual existing crisis system.

Chris Printer - Neither evidenced based practices nor emerging telehealth/virtual platforms have been normed to sparse, rural population areas... which is in reality most of the nation.

Sarah Paige Fuller – if we are having trouble with keeping enough psychiatry and /registered nurses for ACT/ICT in Norfolk VA, I can't imagine how hard for rural communities.

Kevin Martone – BH crisis services should be BH led; trickiest in rural/frontier areas, so states should give them consideration in their plans. Panelists added that social media and websites help get the word out; also use word of mouth, senior centers, and church bulletin boards. For large immigrant populations in some rural areas, now hiring cultural liaisons to work specifically in community outreach areas.

Joanie Blamer - We have done a lot of marketing in the last year and it has helped with citizens understanding who we are and what we do. It also helped with getting more applicants.

"Partner Spotlight" - Stephanie Katz, JD, MPH, *Assistant Vice President, Public Policy and Advocacy, National Council for Mental Wellbeing (formerly National Council for Behavioral Health):*

NCMW is a large organization, doing lots of behavioral health policy and advocacy work. History of the org, with 3500 members. 2022 Priorities: increase access to MH and SUD care; protect and grow resources for these; support the MH/SUD workforce; bolster crisis care services; reduce stigma and discrimination. COVID impacts on BH organizations: wait lists have increased dramatically (48-day wait is the national average); difficulty recruiting staff (a BH crisis in itself). The new model, CCBHC, with focus on service continuum and timely access, includes care coordination, tons of guidance on collaboration, payment rates that allow for higher staff salaries. Implementation of 988; expected increased of billions of calls, and we need services for people after they make that call. Telehealth continuation, esp seeing huge decrease in no-shows. Expanding who can bill to Medicare (esp SUD workforce). Loan repayment programs. Great cost savings to other systems are associated with the CCBHCs, as well as dramatic reductions in wait time.

Q&A:

Bob Sheehan suggested we combine our Hill Day events post-virtual meeting life. Shauna Reitmeier reminded us that the Medicare population is about to increase as well, into a system with barriers we still need to work through. Medicare doesn't cover a broad array of services as Medicaid does.

"Panel Discussion State of the Behavioral Health and I/DD Workforce," - hosted by NACBHDD's I/DD Committee, with moderator Maria Walker, Program Planner, Polk County Health Services - increased needs during COVID, 302% increase in use of teleservices, projected shortages of behavioral health providers, psychiatrists, and more, adding to the already high burnout rates in each; increase in vacancies and turnover in DD workforce causing community-based agencies to turn away new clients. Maria introduced three national experts to address these shortages.

Robert Espinoza, Vice President of Policy, PHI – overview of workforce crisis; long term services will need to fill about 7.4m jobs in direct care between 2019 and 2029, amplified by COVID. Calls for reform of long-term care financing to improve the quality of jobs. Washington State has adopted the first and only long-term care policy for all. Increase compensation for direct care workers, as the median wage is near $12/hr, so that 45% of these workers live in poverty. A wage parity law to establish a wage floor, adjusted for regional cost of living and hopefully addressing recruitment and retention. Training system for personal care aides requiring 75 hours of training and passing a competency exam plus 12 hours of continuing education. Examples of direct care workforce interventions: advancement opportunities; recruitment efforts; MercyCare's Innovation Fund in Arizona, Minnesota's Direct Support Connect Registry to link people to workers based on preferences; Workforce Reporting Requirements in Texas (data collection). Shift the public narrative on direct support: Wisconsin's WisCaregivers Career Program (Public Education) to recruit nursing assistants, adopted in other states. See more at http://PHInational.org

Mary P. Sowers, Executive Director, National Association of State Directors of Developmental Disabilities Services – unprecedented Challenge for State I/DD systems: HCBS Workforce, where the pandemic exacerbated an already fragile situation. Almost half of providers have stopped offering some services, and many have closed. DSPs are among a diverse array of professionals, with varying skills and job descriptions: community integration and employment supports require unique sills, credentialling strategies different for each role; ARPA enhanced match allows HCBS to provide a one-time investment opportunity, with bonuses, wage/benefit enhancements, training and career paths, provider capacity building around recruitment and retention, data collection and quality improvement. Almost all states have included an explicit investment in workforce issues. Need for federal, state, and partner efforts to devise long-range solutions: sustainable investments in the whole workforce, professionalizing the workforce, ensuring benefit analysis to avoid disincentives to long range career commitments.
https://www.nationalcoreindicators.org/staff-stability-survey/

Joseph M. Macbeth, President and Chief Executive Officer, National Alliance for Direct Support Professionals – "Rebuilding the Direct Support Workforce:" make and keep some promises that lead to systemic change. DSPs should be recognized and celebrated because once again they met a crisis head on and rose to the occasion with skill, dedication, and grace. Share their stories, struggles, and achievements with decision makers. They have earned our deepest respect, and our system would fold without them. We expect much more from them than others. If DS workforce issues are the highest priority for I/DD providers, then a standard occupational code with the USBLS is the highest priority for the DS workforce. Nothing we do is as important as this: for professional identity (nomenclature, behaviors, perception, qualifications, status, and structure) and for data collection. All direct care jobs are critically important, but they're all different. DSP definition, with 15 nationally validated competency areas, crosswalked with other caregiving jobs using data pulled from ONET/US BLS - found that they do share a lot of skills with others, but the reality is that DSPs have a unique and complex skills profile. BLS doesn't open these during the 8-10 year period, but 2026 or 2028 are too long to wait. There are 840 classifications; registered nurse is one category working in multiple systems sharing core competencies; DSP is the same kind of umbrella category, sharing skill standards but requiring additional training for specialty areas. SB1437 (Hassan, Collins) recognizes the DSP role, and HR 4779 would circumvent the BLS process and require the OMB to work with BLS on details of the category. Amplify DSP voices and let them lead: share their stories via video, unfiltered by employers, trade associations, and unions; help them engage in policy considerations – this could very well be a social justice issue. 2022 NADSP Advocacy Symposium hopes to bring thousands of DSPs together to advocate. NADSP is urging congress to stay on this, with Bobby Scott (VA) leading the workforce committee. Build Back Better included considerations for HCBS; cautiously optimistic that some provisions might continue now that BBB will not, with bipartisan support. Healthcare benefits for DSPs are a major recruitment factor (10% of workers have no coverage, many work in states with limited Medicaid); employers avoid health coverage by keeping people part time. Median age of DSP is 43, so the perception of youthful workforce is a myth. Older DSPs leave due to poor retirement benefits. 335 providers could not accept eligible individuals due to staff shortages; this has not improved during the pandemic. Concern about competition for workers into the field, when so many fields have a shortage: reflected in some state's ARPA plans, with population-specific wage increases to counter this possibility.
https://phinational.org/resource/competitive-disadvantage-direct-care-wages-are-lagging-behind/

"Federal Stakeholders and Funded Partners Update" *– moderated by Robert Sheehan, NACBHDD Chair and Chief Executive Officer, Community Mental Health Association of Michigan – one question*

was about what NOT to fund: some prevention strategies not feasible, but the shift to teleservices helped against the disrupted infrastructure, now adapt strategies to new circumstances. Money should go to orgs not typically included, especially on behalf of disproportionately impacted groups. Work on how to protect people's safety and privacy as we make telehealth permanent. Without policies, not sustainable. Regarding collaboration, currently in MI, school-based mental health is VERSUS community-based mental health, while coordination involves sectors in their respective roles.

Anita Everett, M.D., DFAPA, Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration – a good example of what makes sense for Medicaid to pick up is mobile crisis teams. Admin has doubled SAMHSA's mental health block grants to states and counties. The SIM is very helpful to map out what falls into each sector's lane and gives a procedure for partnership, hopefully justifying the staff time involved in partnering. Priorities: CCBHC, tremendous amount of additional funding; crisis services development and 988; and school-based MH services.

Carole Warshaw, MD, Director, National Center on Domestic Violence, Trauma, and Mental Health - developed guidelines with SAMHSA for suicide and other hotlines many years ago which will continue to influence policy now. Cross-sector collaboration requires funding for that activity/time; fee for service took that away (e.g., when IL switched to Medicaid); working out confidentiality agreements depends on these. Can't determine (IL again the example) whether domestic violence is contributing to overdose, due to the siloed data and administration systems. Website is www.nationalcenterdvtraumamh.org

Judith R. Qualters, PhD, MPH, Director, Division of Injury Prevention, Centers for Disease Control and Prevention – re Domestic Violence, we have a lot of money for four years, looking to build sustainable partnerships and cross-sector collaboration, but people are so exhausted just trying to sustain a workforce, they're not feeling especially creative to do this. Building evidence for it and then working at the federal policy level. Most programs need to work with others for implementation, e.g., comprehensive suicide prevention funding to ten states and the U of Pittsburgh requires development of MDTs; thoughtful about engaging with NGOs to understand their constituents' needs; work very closely with state and local health departments, e.g., assessment of strategies in place. We target things which are preventable, using the same scientific methods we'd use to prevent other diseases, targeting risk factors and using proven strategies; in overdose, we administer "Drug Free Communities" grants, suicide prevention program, ACEs, etc. and focus on special populations and rural communities. Engage esp when there are funding opportunities (mailing lists). Focus upstream to prevent crisis; equity and disproportionate impacts; suicide, overdose, and ACE assessment tool (SPACECAT) https://www.cdc.gov/injury SPACECAT: Suicide, Overdose, and Adverse Childhood Experiences Prevention Capacity Assessment Tool. https://my.astho.org/spacecat/home https://www.cdc.gov/suicide/prevention/index.html https://www.cdc.gov/injury/wisqars/index.html

Nancy Kirchner, Technical Director, Division of Benefits and Coverage, Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services – to sustain and scale up these recent efforts, states have a lot of flexibility. Recent attention to crisis services has highlighted opportunities many states could already take advantage of; ARPA includes a nod to crisis and may prod states to do more and then sustain it through Medicaid. Best practice example: mobile crisis work in partnership with SAMHSA. Primary partners are the state Medicaid agencies; states tend to want to run programs, whereas the Medicaid state plan is a collection of benefits, each with different rules. An idea can be captured in a state plan amendment. There may be pieces you can't do, or the benefit isn't the best fit for the project. Crisis services, MH services, mobile crisis services, and SUD services are not categories you can find in Medicaid; what we do have are benefits areas which can be used for these. In Dec 2021, issued guidance for use of ARPA funds for mobile crisis services for the increased federal match. mobile crisis CMS guidance link https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf

Congressman Katko's (NY) recorded video message to us.

"Social Media Workshop" *- hosted by NACBHDD's Communications & Public Affairs Committee Chair Rene Hurtado, Chief of Staff, Emergence Health Network - most of us are not trained marketing professionals, but we need to use social media as a strategy. Traditional print media has been hit hard as more people consume news digitally, but website audience traffic is growing (digital newspaper subscriptions too). Combine print and social media. Traditional broadcast media on the decline as*

streaming and unplugging increase. Local news station viewership increasing, along with the hours they dedicate to news each day.

André B. Treiber, Legislative and Communications Director, Texas State Representative Sheryl Cole. – Benefits of social media in BH: provide resources; raise awareness (not bound by the gatekeeping of traditional journalism); combat misinformation; meet people where they're at; remote advocacy (no longer only letters and in-person visits to communicate with lawmakers, harder to ignore than email campaigns). Example: "Strengthening Mental Health Crisis Response in Maryland" used data and listed relevant bills and info. Advance the issues you care about. Emerging trends: over 80% get news from digital devices, and over 50% prefer them; generational divides, with the youngest (18-29) preferring it from social media sites. Survey of our own group showed that: most get news from newspapers, then cable news and local news, then facebook, and "other" was greater than news shows; our organizations use facebook, then twitter, then instragram/youtube/other.

Blending old and new media: big differences within social media platforms (audiences, content, algorithms); remain relevant while still feeding the old media markets. Example: NAMI partnered with Sheryl Cole's office on an end-stigma campaign; she tells her story of bipolar; NAMI Walk. Posting content across platforms.

Tips for effective social media advocacy and outreach: variety of voices; specific goals and targets in mind; build around a committee hearing or bill or day of action; and look for opportunities to work with allies. The art of the 'like' and the 'share': audience engagement and other useful metrics, being aware of best practices for each channel; organization-wide involvement (don't reinvent the wheel on resources, experts can work with the communications team to develop the content of posts); and inoculation (constantly changing strategy for the language used as clickbait strategies, don't be outdated).

There are 2.9 billion facebook, 1.1b Instagram (less rural), 211m Twitter, 800m LinkedIn (skewed to professional audience), 444 Pinterest (mostly female), 1b TikTok, and 306m Snapchat users. To reach LGBTQ youth, the best method is TikTok. Helpful tips to improve your posts: personal, visual, and conversational; shared hashtags with other advocacy orgs; boost content of orgs you support by liking, sharing, and retweeting their posts; follow the accounts of lawmakers, post on their FB pages, and tweet at them. For success on FB, keep it short and sweet, make it visual, post regularly, ask your networks to share and like, brand, create events, and push traffic to your website. For success on Twitter, use hashtags, keep tweeting, make it visual, follow and follow back, and ask community collaborators to retweet.

"How the Behavioral Health and I/DD Systems Are Using COVID Funds to Close Long-Standing Gaps & Support Stability" *- moderated by Cherryl Ramirez, Executive Director, AOCMHP, introduced panelists, posed a series of questions, and offered comments on each topic. Some Oregon members have emptied out their reserves in order to keep staff.*

Shelly Chandler, CEO, Iowa Association of Community Providers – prioritizing the flexible funding, telehealth and audio-only were important especially since broadband is inconsistent; low wages contribute to the loss of workforce (gap has continued). ARPA are one-time dollars, waiting for initial distribution; twice weekly meetings with state Medicaid director, DHS; ministerial orgs weekly, raising visibility of the importance of BH and DD services, but we are in a catastrophe not a crisis. Peer support to expand in the I/DD system. Medicaid director is aware of the admin burden in IA, which is very rule-heavy and doesn't let go of anything. We actually can pivot on a dime, as we did March 17, 2020; we need to give up long established rules that are now barriers, e.g, Institutions for Mental Disease (IMD) and the vast majority of MI and DD rules written in the 1980s, when it was new to be come out of institutional care. An I/DD provider in IA gives tours to 2nd graders so they remember when they return on High School Career Day.

Aaron "AJ" Walker, MPA, Policy Manager, National Association of State Mental Health Program Directors – some states using funds for workforce training; may not even have enough staff in the office to get these funds out. Regarding use of telecom fees, telecom providers did not like that funds could be used outside of the call centers, for mobile crisis, e.g. Start with call centers and then move out to the continuum of services; also clarify it's not a tax but exactly like 911. Consider building on program successes when seeking reauthorizations through Congress – include people with DD, MI, and co-occurring disorders, to break down some siloes with the one-time funding (we've never had that co-occurring disorder focus but can't ignore it now). We can't go back to the way it was, with the social service umbrella we had. States will start paying attention to these services and invest their discretionary funds.

Tim DeWeese, LMSW, Director, Johnson County Mental Health Center – getting these funds into services at the county level. Locally, we looked at: most immediate needs, new or exacerbated barriers to access, and community engagement. Post card campaign! We are able to offer competitive pay, but still fewer and fewer people take an interest in direct care. Burnout and the administrative burden of public systems has also driven providers away from the community-based systems. $1.2m in municipal funds are coming to the MH Center now – know how to demonstrate your value, including with data on savings. We always struggle with sustainability, but this is a great example of a time for trying some new things; collect data to compare before and after. Go way upstream with workforce, including to high schools, to engage real world learning opportunities for HS seniors so they know that public health careers are viable.

Q&A and Comments:

Oregon I/DD programs, lots of ARPA funded programs, developing PSWs, technology to continue virtual services, workforce development, state DD worked well with communities. Maria Walker warned to be cognizant of the limited number of workers, even for the great new ideas. Mike Hammond, Optum, added that states are asking the MCOs to address workforce issues.

***Keynote Address** – introduced by Robert Sheehan, CEO, Community Mental Health Association of Michigan, Chair of NACBHDD Board of Directors.*

Miriam E. Delphin-Rittmon, Ph.D., Assistant Secretary for Mental Health and Substance Use, U.S. Department of Health and Human Services – committed to well-being of the country, focusing on key areas across priorities: equity, workforce, financing, recovery. Priorities for preventing overdose (huge increases in fentanyl), enhancing access to suicide prevention and crisis care, promoting children and youth BH, using performance measures, data (qualitative and quantitative) and evaluation, integrating primary and behavioral healthcare. Overall negative MH impacts of the pandemic are reported; across the board, services were also negatively impacted (for all age groups), including that many unable to access due to long wait lists, limited broadband or equipment. Great impact on health disparities, disproportionate impacts, amplifying social and economic factors as well (social determinants of health). Data from the beginning of the pandemic showed some of these disparities in hospitalization rates. SAMSHA Crisis Response includes the rollout of 988 and crisis system. Budget increase for SAMHSA in response to the pandemic. Continue to reduce health disparities and ensure the safe delivery of BH services.

Q&A:

How will SAMSHA turn the incredible infusion of dollars during the pandemic into a sustained solution to the workforce needed to deliver behavioral health and intellectual and developmental disability services with access to all? Critical areas of the moment; expand the workforce and its diversity with a fellowship program. Adding funding for the non-CCBHC folks, very hard to do in states without Medicaid expansion or demonstration funds. Lots of discussion of this model and how to expand it, CMS and SAMHSA have met twice with states about expansion of these and crisis services across the country.

Request for comment on the challenges with delivering care in rural areas, transferring evidence-based policies to areas which lack the resources. Not a new issue; EBPs may be the gold standard, but we have to consider context (rural areas or participant demographics, e.g.), so introduce adaptations to the model; policy lab will be releasing a guide adapting EBPs to be contextually and culturally responsive. EBPs emerged because someone strayed from the standard model, in every single case, a science-driven model. Let's blow out the evidence spectrum to include practice-based and community-based evidence, expanding the pool, technology transfer, basics of data collection to develop evidence for innovative models. Promising practices around the edges are important, even if not fully validated. A huge advantage of CCBHC in the context of this philosophy is the federal standardization of an effective continuum but implemented in a way that is defined by and meets the needs of the communities where they live. It offers our communities the best of evidence and customization. How do you incorporate this philosophy within your grants to bolster the CCBHCs? Examining the language of the NOFAs to create some wiggle room for community-based practices and culturally responsive traditions.

National Association of Counties (NACO Legislative and Policy Conference HSC Meetings:

"Innovators & Implementers: How Counties are Supporting the Strategic Vision for Medicaid and CHIP" - counties have an important role and distinct perspective when it comes to delivering health care services, having the closest proximity to residents of all forms of government and direct oversight of the

provision of healthcare services as purveyors of the local healthcare system... counties are the driving force behind the Centers for Medicare and Medicaid Service's (CMS) strategic vision for Medicaid and CHIP, which centers around: coverage and access; equity; and innovations & whole-person care.

Daniel Tsai, Deputy Administrator & Director, Center for Medicaid & CHIP Services, CMS - the main goals of this administration's work with Medicaid: expansion for all states; preparing for eligibility renewals when the public health emergency ends; access to behavioral health and physician networks, whether managed care or Medicaid, and removing barriers to coverage; and value-based care, including equity. Medicaid financing remains important, but the admin wants to partner to work on all the county-level aspects. Lots of opportunity to improve coordination at federal and local levels – Medicaid, Medicare, SAMHSA are working on consistent frameworks, definitions, and messaging. Interest in working with NACo to understand county experiences.

Helen Stone, HSC Vice Chair and Commissioner, Chatham County, GA – because GA is a non-expansion state, Chatham County has had to be creative, especially around care in the detention center, courts, and jail, where they've seen high prevalence of MH and SUD, and folks have no access to care if living under or just above poverty level. Because this is the large portion of the county's operating budget, they started a behavioral crisis/diversion center focusing on Intercept 0. Expanded CIT. People access the center on their own or referred by law enforcement. Last summer, began planning a 24/7 walk-in center for juveniles and their families, asking $16m from the state. Specialty Court also sees the need. Legislation introduced to address those incarcerated for voluntary and involuntary treatment. FQHC has mobile units and can go out to the jail to treat people, and this House Bill might address the gap.

Nick Macchione, Chair, HSC Medicaid & Indigent Care Subcommittee Director and Deputy Chief Administrative Officer of San Diego County Health and Human Services Agency - accidental overdose deaths continue to increase in San Diego (fentanyl deaths a 990% increase), 1 in 13 ppl have an SUD, and COVID created interrelated issues. SUD Harm Reduction Strategy with four components: cross sectoral convening, healthcare integration and access, housing, and workforce. The Drug MediCal Organized Delivery System was part of their 1115 waiver, required county match (not state), had to increase number of people served and volume of care, and had to create financial sustainability to drive real savings. Significant increase in people served. In the first year, it was a challenge to get providers Medicaid certified, with no federal money, requiring a huge local investment. In year 2, drew down from Medicaid. Over 90% had access to care, over 90% initiated treatment, and individualized care increased (from 46% to 76% in case management, 14% to 40% in intensive outpatient services). This has been re-approved to build out the SUD delivery system with the health care system through 'Whole Person Wellness' coordinated care. Had to move the fidelity from psychosocial model to evidence-based; providers did not have IT infrastructure or medical oversight, so connected to FQHCs and attracted new providers. As to how savings through early intervention are tracked, the County had to build those data collection systems; the first savings were from a great reduction of those who cycle through jail; getting better with metrics for evaluation as we go.

Hon. Derek Young thanked panelists and called for an emphasis on housing in the coming year.

***"Public Health Forward: County Strategies for Modernizing the U.S. Public Health System"** - in July 2021 the Bipartisan Policy Center convened a task force of current and former federal, state, and local government officials and a key health stakeholder to develop a 5-year roadmap for public health leaders and elected officials to build a more robust and sustainable public health system. The work is in response to what is being described as a "critical crossroads" for the nation's public health system, which in light of the ongoing pandemic, has seen historic federal investments following years of underfunding.*

Anand Parekh, MD, MPH, Chief Medical Advisor, Bipartisan Policy Center - recommendations from the task force report: public health is too big to fail; we don't place the resources where we know they will make a difference; focus on local and state officials, with significant funding coming to counties through ARPA and COVID relief. 12 Actions identified: provide flexible funding and maximize existing assets; evaluate the social and economic impact of public health programs; strengthen collection of timely and actionable data to guide programs, respond to emergencies, and address inequities; invest in data sharing; invest in recruitment and retention of diverse and inclusive workforce (gap of 80k public health workers nationally); improve hiring and promotion policies; review, modernize governance structures and statutory responsibilities; support and communicate roles of public health departments to the public; incentivize partnerships across sectors; establish a dedicated body charged with monitoring, assessing, and influencing

the implications of all policy on health; invest in relationship and partnership development; invest in the capacity of community based organizations.

Hon. Phyllis Randall, Chair, HSC Behavioral Health Subcommittee and Chair At-Large, Loudon County, VA - summarized the work of the breakout groups: Is it the responsibility of counties to do as much Prevention work as possible? E.g., mobile dental units visiting schools. Other groups identified benefits enrollment, especially for seniors, workforce development, paying for childcare and school for those in training, public relations endeavor for health care, and more.

Congressional Update: Health Policy "Hot Topics" *- Health Steering Committee Chair Hon. Derek Young introduced all committee officers and speakers for this session - impending policy on two leading health issues: behavioral health & maternal and child health; challenges and opportunity for policy advancement in the current congressional landscape.*

Miranda Lynch-Smith, Deputy Assistant Secretary for Human Services Policy, Office of the Assistant Secretary for Planning and Evaluation – HHS has tackled the greatly increased new Medicaid enrollees, vaccination programs and related investments, and greater focus on health equity and maternal health with several initiatives and new investments. Behavioral health is another key priority, with multiple crisis points, including increased overdose deaths and disproportionate racial and ethnic impacts; a full continuum of services is needed for recovery from SUD, with coordinated harm reduction efforts and budget requests in the billions focused on prevention; a new oversight position is created, working on data and evaluation, overdose prevention, development of a diverse workforce, and increasing the IT workforce as well. Addressing community-level social determinants/drivers of health is critical, as they impact as much as 50% of people's individual health outcomes, while individual treatment impacts 20%. Enthusiastic focus on health equity across all departments within HHS, seeking to engage those with lived experience at all levels, as they are the experts on barriers and potential solutions.

Rodney Whitlock, Vice President of Health Policy, McDermott+ Consulting - politics and impact on policy; funding the government will come together but also talk of supplemental appropriations - will cogent arguments for these be made? Demolition is easier than construction, but 2022 is not without possibility. User fee acts (Rx drugs) will pass because they are necessary to fund the FDA; could be a lot of talk but not much action about MH and SUD needs, CURES 2.0, and telehealth. The wild card is that the public health emergency designation needs to end for political reasons unless there is an obvious reason; if so, there will be tremendous pressure on congress to keep some of the enhancements in place, which could compel action - likely not done by September 30, so that after elections there may be a productive lame duck session driven by political activity. From July 29 to election day, of 70 days total, there are only 11 voting days for Congress; they do need to be home to listen to constituents, so these 11 days are the opportunities to act on legislation. The public health emergency stands in the middle of that. There won't be a data-driven conversation about the election. The biggest trend to understand is that the last president who went into midterms with both houses of congress controlled by his party was Jimmy Carter in 1978. Discussion of whether portions of Build Back Better will be broken out, movement to talk about the Mental Health sections. Driver for a package which can pass the Senate (60 votes) will be about money, which solutions to MH crisis rely on, so they might not happen. Maybe not the same for SUD, as we saw a bill pass a few years back under these circumstances. The focus on Opioids has made room for talk about meth.

"Proposed Interim Resolutions" *– see below for details of each. No discussion or amendment, and unanimous approval for resolutions on maternal health and 988. Regarding DSP classification, there was a question about educational requirements (answer - certification based on completion of trainings) and unanimous approval. Regarding lifting the Medicaid inmate exclusion prior to re-entry, discussion about changes which have made this narrower than the resolution we previously supported (30 days prior to release now, in order to get more support); supportive comments regarding getting SUD treatment started earlier; unanimous approval. The resolution proposing national standards for medical examiners and coroners had a friendly amendment, unanimous approval of the amended proposal.*

- **Proposed Interim Resolution on Improving Maternal Health Outcomes**

Issue: Lack of health care access for postpartum women and children, and workforce shortages including lack of diversity are key contributors to poor maternal health outcomes. Policy changes are needed to

improve maternal health outcomes through improved access to postpartum healthcare coverage under Medicaid and growing and diversifying the perinatal workforce.
Proposed Policy: The National Association of Counties (NACo) urges the federal government to enact policies that will assist counties in improving maternal health outcomes by (1) making investments in the perinatal workforce and (2) removing the 5-year sunset on the American Rescue Plan Act of 2021 provision that would give states the option to extend Medicaid postpartum coverage from 60 days to 12 months.
Background: The United States has a high maternal mortality rate, with approximately 700 deaths of new or expectant birthing people each year, and an additional 60,000 individuals experiencing life-threatening postpartum complications. Maternal mortality has been increasing in the United States for decades. About three in five of the pregnancy related deaths are thought to be preventable. There are large racial disparities, with African American individuals two and a half times as likely to die. Medicaid covers over half of all births in this country. Under current law, Medicaid must provide postpartum coverage for 60 days. Complications and even death due to pregnancy and birth, is not limited to the first 60 days. There are many conditions, including cardiovascular disease, hypertension and behavioral health , that account for significant share of pregnancy related mortality and morbidity due to a lack of proper length of disease management. Extending Medicaid coverage does help prevent maternal deaths.
There is a need to grow and diversify the clinical and non-clinical maternal health care workforce. By investing in the workforce, the United States can provide equitable care for women who are disproportionately impacted by death and disease. Women often have better health outcomes with people from similar backgrounds to themselves.
Fiscal/Urban/Rural Impact: Would provide extended Medicaid postpartum coverage to individuals in counties, including county-owned health care delivery system.
Sponsor(s): Erica C. Crawley, Commissioner, Franklin County, Ohio; Kenneth Wilson, Administrator, Franklin County, Ohio

- **Proposed Interim Resolution Supporting 988 Implementation and Comprehensive Behavioral Health Crisis Care**

Issue: Federal support is needed for implementing nationwide local crisis support systems for people experiencing a behavioral health crisis and calling the new 988 call centers.
Proposed Policy: The National Association of Counties (NACo) supports federal legislation to ensure that all people have access to comprehensive crisis care services to stabilize patients in crisis and direct them to the most appropriate treatment options. Such legislation should direct the U.S. Department of Health and Human Services (HHS) to ensure a standard set of behavioral health crisis services are universally available, including: 24/7 crisis hotlines and call center; mobile crisis services; behavioral health urgent care facilities; 23-hour crisis stabilization and observation beds; and short-term crisis residential options. Legislation should also provide coverage of behavioral health crisis services for all patients no matter the source of their health insurance. The U.S. Congress should authorize and appropriate adequate funding for the development of these services in counties, including technical assistance from HHS and a platform for communities to share successful ideas and services. The legislation should establish a panel of experts to improve coordination among 911 dispatchers and 988 crisis hotline call centers, so that those in need are quickly connected to the appropriate service. NACo further supports legislative and regulatory action that provides flexibility and direct funding to counties for the launch, infrastructure, and modernization of the new hotline through establishing a Behavioral Health Crisis Coordinating Office; supporting the 250+ existing regional and local National Suicide Prevention Lifeline call centers; permanently authorizing $2.23 billion in Mental Health Block Grant (MHBG) funding with a 10 percent crisis services set-aside; forming a new pilot program for mobile crisis response, peer teams, and in- home crisis stabilization; and providing resources for specialized services, including language services, for underserved populations. NACo supports amending Medicaid by authorizing Medicaid financing for regional and local NSPL call center operations, and crisis programs; excluding psychiatric acute care crisis beds from the institutions for mental disease (IMD) payment prohibition; and expanding the existing 10 state Medicaid Certified Community Behavioral Health Centers (CCBHC) demonstration to permit any state to participate. NACo supports legislation to support behavioral health crisis response on the ground with Health Resources Services Administration (HRSA) Capital Development Grants that include crisis receiving and stabilization programs, and call centers; behavioral health workforce training program expansions; and access to and oversight of mental health and substance use disorder crisis response services

Background: The United States is facing a national mental health pandemic and the COVID-19 public health emergency has only worsened these devastating numbers. Our country's lack of an effective and widely available mental health crisis system is leading to tragic results for people in crisis. Too often law enforcement is dispatched to respond to individuals experiencing crises, including behavioral health crises. For marginalized communities, limited access to crisis care and mental health specialists can cause even more devastation. In response, in 2020 the U.S. Congress enacted bipartisan legislation directing the Federal Communications Commission (FCC) to implement the three-digit dialing code 988, which will replace the National Suicide Prevention Lifeline on July 16, 2022. Like 911 but for mental health emergencies, the 988 response system is intended to provide callers with local crisis support, instead of law enforcement response. The Substance Abuse and Mental Health Services Administration (SAMHSA) has worked with state leaders to provide guidance on the continuum of crisis services that should be accessible by 988. Key components include 24/7 call centers who can dispatch mobile crisis teams, and crisis facilities, where people can get the help they need in a supportive environment. While the 988 number is expected to support millions of people each year who face a mental health or substance use crisis, robust investment in the hotline and crisis response care is necessary to ensure that people who call 988 can access crisis services. Without congressional action, many areas of the country will continue to lack the ability to provide crisis services to those who call for help in an emergency.
Fiscal/Urban/Rural Impact: These measures would provide county behavioral health authorities, county public health departments and county health care and hospital systems with critical resources to expand services available to meet the needs of individuals experiencing crisis. They would establish standards regarding crisis care and a continuum of care for individuals experiencing mental or behavioral health crisis with the objective of stabilizing individuals and engaging them in appropriate treatment settings. They would also improve the quality of behavioral health crisis services and expand the availability of such services so that more individuals in need receive care.
Sponsor(s): Los Angeles County, Calif.; California State Association of Counties; Dr. Theresa M. Daniel, Commissioner, Dallas County, Texas

- **Proposed Interim Resolution Supporting the Role of Direct Support Professionals**

Issue: Direct support professionals (DSPs) play a critical role in the care provided to people with intellectual and developmental disabilities. There is an inaccurate representation of the number and turnover rates of DSPs due to miscategorization in the Standard Occupational Classification System.
Proposed Policy: The National Association of Counties (NACo) supports federal efforts to develop a discrete occupational category for direct support professionals (DSPs) to help states and the federal government better interpret the shortage of these professionals in the labor market and collect data on the high turnover rate of DSPs.
Background: The Standard Occupation Classification system is designed and maintained solely for statistical purposes and is used by Federal statistical agencies to classify workers and jobs for the purpose of collecting, calculating, analyzing, or disseminating data. Establishing a discrete occupational category for DSPs will result in an accurate representation and better align data collection with the experiences in communities.
Fiscal/Urban/Rural Impact: Would positively impact both rural and urban communities due to collection of accurate data to better understand the scope of workforce shortages.
Sponsor(s): National Association of County Behavioral Health & Developmental Disability Directors

- **Proposed Interim Resolution Supporting Legislation and Administrative Waivers to Lift the Medicaid Inmate Exclusion Prior to Reentry**

Issue: Support for federal legislation and Medicaid Section 1115 waivers to lift the statutory Medicaid inmate exclusion for services provided to persons in custody for a certain period prior to their reentry into their communities.
Proposed Policy: The National Association of Counties (NACo) supports legislation which would allow Medicaid payment for medical services furnished to an incarcerated or detained individual in local or state custody during a specified period preceding the individual's release. NACo also supports advancing such provisions via the earliest available legislative vehicle. NACo also urges the U.S. Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS) to approve, with maximum flexibility, states' requests for Section 1115 waivers to test delivering and paying for Medicaid services to

an incarcerated or detained individual in local or state custody during a specified period preceding the individual's release.
Background: NACo has long supported, and actively advocated for, legislation to ease the Medicaid inmate exclusion for individuals in custody in county jails, including expansive legislation to fully repeal the payment exclusion in Medicaid, Medicare, the Children's Health Insurance Program (CHIP) and other federal health insurance programs. In 2018, during the 115th Congress, Rep. Paul Tonko (D-N.Y.) introduced legislation to permit Medicaid coverage for services provided to inmates 30 days prior to reentry. Rep. Tonko's bill, the Medicaid Reentry Act, was reintroduced in the 116th and the current 117th Congress (H.R. 955). Also, in the 117th Congress, a Senate companion bill (S. 285) was introduced by Sen. Tammy Baldwin (D-Minn.). With the support of a broad coalition of stakeholders, including NACo and the National Sheriffs' Association, the provisions of the Medicaid Reentry Act garnered sufficient support to be included in the House-passed version of the Build Back Better Act (H.R. 5376) and the legislative text of the sections of the Build Back Better Act under the jurisdiction of the Senate Finance Committee released on Dec. 11, 2021. In recent years states, including Vermont, Arizona, California, Kentucky, Montana and Utah, have asked CMS for Section 1115 waiver authority to test various models for their Medicaid program to deliver and pay for medical services for inmates during specified periods of time prior to their release from custody. Both the provisions of the Medicaid Reentry Act and the various state waiver proposals are aimed at improving health outcomes for individuals as they transition from custody back to life in their communities.
Fiscal/Urban/Rural Impact: Nearly all counties own and operate jails and are responsible for the health of individuals held in custody. It is worth noting that the vast majority of those individuals incarcerated in county jails are detainees awaiting adjudication and have not been convicted of a crime. Many counties also provide public health and health care services, including behavioral health services, to their residents. Lifting the Medicaid inmate exclusion by legislation or by a Section 1115 waiver would support better and more equitable health outcomes for the justice-involved population.
Sponsor(s): Toni Preckwinkle, Board President, Cook County, Ill.

- **Proposed Interim Resolution on Advancing the Implementation of National Standards and Accreditation Requirements for Coroners/Medical Examiners Workers**

Issue: For countless decades, Coroner and Medical Examiner Offices have struggled with common challenges; funding, staffing, training opportunities, and lack of resources. Currently, medicolegal death investigations are highly varied and inconsistent. This mixed system hinders public safety with a lack of qualifications and any professional development requirements. The poor understanding of disease and underlying mechanisms of death ultimately results in inaccurate conclusions and skewed death statistics. These miscalculations affect the development and implementation of needed policies and practices, thereby directly affecting members of the community. Also, of great concern, is that without best practice guidelines, both criminal and civil litigation may suffer egregiously negative consequences.
Proposed Policy: The National Association of Counties (NACo) supports federal legislative and regulatory changes that do the following: 1) Advances research and provides technical assistance for data collection and analysis that chart a pathway for enhancing statewide training and standards for coroners and medical examiners; 2) Assists in the obtainment of coroner and medical examiner accreditation(s) through the International Association of Coroners and Medical Examiners (IACME) and/or the National Association of Medical Examiners (NAME) through direct federal resources to counties; and/or 3) Assists in the obtainment of certification of non-forensic pathologists, coroners, and medicolegal death investigators through the American Board of Medicolegal Death Investigators (ABMDI) through direct federal resources to counties to enhance the proficiency of medicolegal death investigations.
Background: The county Coroner/Medical Examiner is an integral partner in public health, criminal justice, environmental health, education, and many other aspects of the community. In addition to investigating and certifying the cause and manner of deaths, they are essential in tracking important community trends such as suicides, opioid overdoses, motor vehicle accidents, and homicides. Coroners/Medical Examiners also often serve as monitors to potential public health threats, and are subsequently responsible for overseeing and confirming all pandemic deaths outside of established medical facilities. Current mortality statistics report approximately 2.6 million deaths every year in the United States. Of these deaths, about 1 million are investigated by a Coroner or Medical Examiner systems. Today, there are approximately 2,500 Coroner/Medical Examiner systems in the United States. Of these, approximately 1,900 of these are Coroner jurisdictions. These entities' primary responsibility is that of

investigating unexpected and suspicious deaths falling under their governmental jurisdiction and determining the cause and manner of death. Additionally, identification of the decedent, notification of the next of kin, and public health reporting may also be required actions. The American Coroner/Medical Examiner Offices have continuously struggled with all too familiar challenges. These include a lack of funding, inadequate staffing, inadequate training, and a lack of uniformed forensic standards, along with the acknowledgment and recognition of the importance of this essential role within the community.
Fiscal/Urban/Rural Impact: The impact of the lack of funding allocation and appropriate resources currently experienced not only negatively impacts community members of all counties but puts the county in question at risk for unnecessary litigation and financial responsibilities. These negative outcomes directly stem from the insufficiency of proper resources, training, funding, and availability of qualified and certified Death Investigators, Coroners, and Medical Examiners. As a cautious estimate, we request an allocation of $2.5 million in a two-year commitment to complete an assessment and development of the national research and technical assistance project as proposed.
Sponsor(s): Dotti Owens, M.A., D-ABMDI, Coroner, Ada County, Idaho

"Health Policy Wins & Priorities Update" *- Blaire Bryant, NACo, presented her top three picks for 2021 wins in health policy: historic investments in public health as congressional appropriations to the CDC for grants to local health departments; bipartisan legislation, the Medicaid Reentry Act, due process continuity of care act (addresses the former by letting people keep Medicaid when booked); HHS is now coordinating all agencies to advance health equity, Medicaid to incentivize it, and legislation supports equity waivers (e.g., 12 months post-partum). Review of 2021-2022 priorities: legislation to help counties offer more behavioral health care; protection of the federal-state partnership for healthcare financing (Medicaid); funding for prevention and infrastructure in public health.* ***Finally, all of our interim resolutions were passed at the NACo Board meeting.***

Champaign County Mental Health Board

FY21 Revenues and Expenditures as of 12/31/21

Revenue	Q4	YTD	Budget	% of Budget
Property Tax Distributions	$ 941,846.37	$ 5,282,003.99	$ 5,312,965.00	99.42%
From Developmental Disabilities Board	$ 71,764.94	$ 366,343.94	$ 404,296.00	90.61%
Gifts & Donations	$ -	$ 200.00	$ 18,000.00	1.11%
Other Misc Revenue	$ 553.53	$ 773,984.08	$ 113,000.00	684.94%
TOTAL	**$ 1,014,164.84**	**$ 6,422,532.01**	**$ 5,848,261.00**	**109.82%**

Expenditure	Q4	YTD	Budget	% of Budget
Personnel	$ 153,554.57	$ 564,541.97	$ 580,633.00	97.23%
Commodities	$ 2,495.39	$ 8,632.43	$ 16,295.00	52.98%
Contributions & Grants	$ 1,409,384.00	$ 5,063,438.00	$ 5,267,226.00	96.13%
Professional Fees	$ 49,423.50	$ 129,830.11	$ 140,000.00	92.74%
Other Services	$ 61,535.28	$ 167,111.06	$ 229,055.00	72.96%
TOTAL	**$ 1,676,392.74**	**$ 5,933,553.57**	**$ 6,233,209.00**	**95.19%**

77

Champaign County Developmental Disability Board

FY21 Revenues and Expenditures as of 12/31/21

Revenue	Q4	YTD	Budget	% of Budget
Property Tax Distributions	$ 773,377.54	$ 4,337,207.70	$ 4,360,483.00	99.47%
From Mental Health Board	$ 971.56	$ 971.56	$ 6,800.00	14.29%
Other Misc Revenue	$ 322.85	$ 790.59	$ 19,000.00	4.16%
TOTAL	**$ 774,671.95**	**$ 4,338,969.85**	**$ 4,386,283.00**	**98.92%**

Expenditure	Q4	YTD	Budget	% of Budget
Contributions & Grants	$ 726,958.72	$ 3,514,153.04	$ 3,931,987.00	89.37%
Professional Fees	$ 71,764.94	$ 366,343.94	$ 404,296.00	90.61%
Transfer to CILA Fund	$ -	$ 50,000.00	$ 50,000.00	100.00%
TOTAL	**$ 798,723.66**	**$ 3,930,496.98**	**$ 4,386,283.00**	**89.61%**

Wilson

474