I: State Information

State Information

Plan Year: 2012-2013

I. State Agency to be the Grantee for the Block Grant

Idaho Department of Health and Welfare Division of Behavioral Health POB 83720 Boise, ID 83720

II. Contact Person for the Grantee of the Block Grant

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III. State Expenditure Period (Most recent State expenditure period that is closed out)

7/01/2010 to 6/30/2011

II: Planning Steps

ASSESSMENT OF THE STRENGTHS AND NEEDS OF THE SERVICE SYSTEM TO ADDRESS THE SPECIFIC POPULATIONS

Provide an overview of the State's behavioral health prevention, early identification, treatment and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Behavioral Health Prevention, Early Identification, Treatment and Recovery Support Systems

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff's Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision; "Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery. Goals included the following; 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

The BHTWG's efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho's Behavioral Health System (October 28, 2010). This report's recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council to the State Behavioral Health Council; establishing the Behavioral Health Interagency Cooperative to oversee transformation efforts; and adopting the BHTWG's proposed Array of Core Services "...as the 'floor' of services they seek to make available in each region." The report recommends, "...that this array be maintained as the goal for regional planning and capacity building; and that is also be used as a measure by which to indicate progress toward a truly transformed behavioral health system..." The following are the core regional services recommended by the BHTWG:

- 1. Psychiatric Emergency and Crisis Intervention Services
- 2. Assessments and Evaluations
- 3. Designated Examinations and Dispositions
- 4. Inpatient Psychiatric Hospitalization
- 5. Medication Management
- 6. Case Management Services

- 7. ACT, Intensive Case Management, Wraparound Services
- 8. Psychotherapy
- 9. Intensive Outpatient Services
- 10. Drug Screening
- 11. Alcohol and Drug Residential Treatment
- 12. 24Hour Out of Home Treatment Interventions for Children & Adolescents
- 13. Illness Self Management
- 14. Peer Support Services
- 15. Prevention Services
- 16. Early Intervention Services for Children & Adolescents
- 17. Supported Employment
- 18. Supported Housing
- 19. Transportation
- 20. Day Treatment, Partial Care, and Partial Hospitalization

The BHTWG recognized that the development of the entire array of core services in each region will take time. It is recommended that the core services be divided into two categories: 1) Initial Core Services that will be required from the start to be available to all consumers; and 2) Supplemental Core Services that will be evolved by the Regional Behavioral Health Community Development Boards. The following are lists of the Initial and Supplemental Core Services:

Initial Core Services

- 1. Psychiatric Emergency and Crisis Intervention Services
- 2. Assessments and Evaluations
- 3. Designated Examinations and Dispositions
- 4. Inpatient Psychiatric Hospitalization
- 5. Medication Management
- 6. Case Management Services
- 7. ACT, Intensive Case Management, Wraparound Services
- 8. Psychotherapy
- 9. Intensive Outpatient Services
- 10. Drug Screening
- 11. Alcohol and Drug Residential Treatment
- 12. 24Hour Out of Home Treatment Interventions for Children & Adolescents

Supplemental Core Services

- 1. Illness Self Management
- 2. Peer Support Services
- 3. Prevention Services
- 4. Early Intervention Services for Children & Adolescents
- 5. Supported Employment
- 6. Supported Housing
- 7. Transportation
- 8. Day Treatment, Partial Care, and Partial Hospitalization

Services will be provided in accordance with statewide standards which will include monitoring for quality, consistency, and effectiveness. The State Behavioral Health Authority will be responsible to develop and monitor the statewide standards of care for the initial and supplemental care services. Each Behavioral Health Regional Development Board will be expected to develop a Regional Transformation Implementation Plan that describes the availability, quality, consistency and effectiveness of Initial and Supplemental Core Services and plans for addressing gaps in any of the service areas. As the system evolves, criteria based on these factors will be used to assess the "readiness" of a region to assume greater responsibility for the management of core services offered in the region.

Governor Otter signed Executive Order 201101 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. One charge to the IBHIC is to "d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho's Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho's budget, current needs of the agencies, and recommendations of the Idaho Health Care Council."

As of 5/13/11, the IBHIC "to do" list was broken into four phases. All phases began with finalizing funding and ended with providing an annual status report to the Governor. **Phase 1** also included planning regional behavioral health development boards and state behavioral health planning council (e.g., identifying proposed membership, proposing an implementation timetable, soliciting and reviewing input and drafting legislation to implement regional behavioral health development boards to submit to the 2012 legislature); establishing core services for all regions and drafting 2012 legislation proposals; developing a transformation work plan, communications protocol and proposed transformation activity funding for SFY 2013; and reviewing SUDS treatment services and data report elements. Additional **Phase 2** activities included finalizing core services standards for the transformed behavioral health system; initiating regional transformation efforts and coordinating transformation activities with health

care reform activities. **Phase 3** activities included developing a 'Transformation Implementation Plan' that applies to all Cooperative entities; developing regional Transformation Implementation Plans; monitoring and evaluating phase in and recommending adjustments to State and Regional Transformation Plans; and coordinating transformation activities with health care reform activities. **Phase 4** included continuing phase in of transformation, drafting legislation to implement the next phase; and coordinating transformation activities with health care reform activities.

Public Behavioral Health System Organization at the State, Intermediate and Local Levels The Idaho Department of Health and Welfare (IDHW) operates within the Executive Branch of Idaho state government. IDHW is composed of the Divisions of Public Health, Behavioral Health, Family and Community Services, Welfare, Medicaid, Information Technology, and Operational Services.

The Department of Health and Welfare is designated by statute (Idaho Code Section 39 Chapter 3) as the State Mental Health Authority (SMHA) and as the Single State Authority (SSA) for Substance Use Disorders (SUD) prevention and treatment. Most of these responsibilities are carried out by the Department's Division of Behavioral Health. The Division of Behavioral Health's Central Office includes Adult Mental Health (AMH), Children's Mental Health (CMH), Substance Use Disorders (SUD) and a Data Unit. The Central Office component of the Division of Behavioral Health provides system coordination and leadership, policy and standards development, rule promulgation and interpretation, technical assistance, training, consultation, funding application and regulation, and quality assurance monitoring.

Adult and Children's Mental Health services and SUD services are provided in each of the seven (7) IDHW geographically defined Regions. The SMHA services are offered through state operated community mental health centers (CMHC's) in each region. Treatment services include crisis response, assessment and a range of mental health services available to eligible adults with serious mental illness, children with serious emotional disorders and their families. Idaho's two (2) state psychiatric hospitals, State Hospital North and State Hospital South, are also under the jurisdiction of the DBH Administrator. State Hospital North serves adults only while State Hospital South serves both adults and adolescents.

The SSA oversees treatment to adolescents, adults, pregnant women and women with dependent children who are below 200% of the federal poverty rate and who are diagnosed as substance dependent with at least an outpatient need according to the ASAM (PPC 2R, Level 1). Treatment referral sources include judges and Drug Courts. Treatment services include assessment using the Global Appraisal of Individual Needs (GAIN), individual and group counseling, education in social settings, residential and detoxification services and case management. The Division contracts with the Management Services Contractor, Business Psychology Associates (BPA), to manage the treatment service delivery through a network of Department approved treatment providers. BPA also provides care management utilization review. Care Management responsibilities include use of a statewide 1800 number for eligibility screenings, to make an initial ASAM PPC2R level of care determination and to prior authorize units of service. The Division's SUD program also oversees substance abuse prevention at three levels for those at no or low risk of substance abuse. At the State level, the Division supports an alcohol/drug clearinghouse and provides education funding to prevention professionals. At the community level, the Division provides technical assistance and support to the Community Coalitions of Idaho (i.e., a coalition of community anti alcohol/drug coalitions). At the individual level, the Division funds community based providers to deliver evidence based education and other prevention strategies designed to reduce the risk factors of universal, selective and indicated populations. The SUD prevention services also include prevention intervention for youth who are either at high risk for substance abuse or who may have experimented with tobacco or alcohol but do not meet the criteria for the .5 level of care.

The Division contracts with Benchmark Research and Safety (BRS), the Prevention Technical Assistance and Support Contractor (PTASC), to manage the community-based prevention provider network. Benchmark's responsibilities include conducting annual state and regional needs assessments used to identify at risk populations and underserved areas, supporting the preventionidaho.net website (i.e., the prevention data system that collects provider data),

collecting staff and program information, hosting online prevention course and generating data used for local and federal reporting requirements (e.g., block grant, prevention data for the National Outcome Measures (NOMS), etc.).

The Idaho Division of Behavioral Health focuses on mental health (adults and children) and substance use disorder (adults and children) policymaking, service planning and implementation for Idaho citizens diagnosed with a serious mental illness, a serious emotional disorder or a substance use disorder. Several organizational changes were implemented at the Division of Behavioral Health in SFY 2011. Effective July 1, 2010, the seven (7) Regions were organized into three service areas or "hubs." The management team for the Division of Behavioral Health (DBH) for is composed of the hub heads and the unit leads. The DBH Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). Program Managers in Region 3, Region 4, and Region 5 report to the southwestern hub Administrator. The DBH Administrator at Central Office has oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs.

The U.S. Census Bureau (2010) indicates that that Idaho's population is 1,567,582, with 9 rural counties (i.e., no population center of 20,000 or more and six or more persons per square mile), 17 frontier counties (i.e., less than six per square mile) and 18 urban counties. Idaho ranks 13th in area size of the fifty states, with 82,747 square miles and diverse areas that include mountains, deserts, farmland and canyons. Local SMHA service delivery is based on seven geographical Department of Health and Welfare service areas. Publicly funded adult mental health (AMH) and Children's Mental Health (CMH) services are provided through Regional DBH center sites, with one Regional Program Manager responsible to oversee service delivery and quality for both programs. Psychiatric services may be supplemented through tele-health video conferencing to rural and frontier locations. The high definition video conference system is also used for statewide meetings, including meetings of the State Planning Council on Mental Health. In SFY 2011, there was a cost savings for all video conference users (not just the Division of Behavioral Health) of \$312,366.00.

Priority local services for AMH and CMH are directed to crises and court-ordered clients, with voluntary clients served as there is room in the system. Efforts are made to refer Medicaid eligible clients to Medicaid eligible private provider resources. Idaho subscribes to an integrated service delivery system. Service components include mental health, social services, education, health, vocational services and corrections. Recognizing that services are provided by multiple public and private agencies, the Division continues to seek cooperative agreements with other departments and providers.

Highlights of the AMH service array include medication management, Assertive Community Treatment (ACT), cooccurring integrated disorders treatment, crisis response, collaboration with vocational rehabilitation and strong collaboration with mental health courts. Recovery and resilience are modeled through inclusion of Certified Peer Specialists on regional ACT teams and use of Certified Peer Specialists as outreach providers through the Projects for Assistance in

Transition from Homelessness (PATH) program. The AMH programs and the courts coordinate treatment plans and service delivery with mental health court referred clients, with most eligible clients provided individual and group services by regional ACT teams. During SFY 2009 and SFY 2010, Mental Health Court Utilization operated at approximately 90% of capacity.

The AMH program provides services to adults diagnosed with a serious mental illness who are homeless or at risk of becoming homeless. The SFY 2011 Projects for Assistance in Transition from Homelessness (PATH) grant funds were directed to a small contract with a Region 1 local provider; to a small amount for each regional CMHC to help with housing costs (i.e., one time rental assistance or security deposits); with the majority of funds allocated to a contract with the Office of Consumer and Family Affairs (OCAFA). The OCAFA contract allows for two PATH Certified Peer Specialists, each working 19 hours per week, to be assigned to each of seven regional DBH service sites. The PATH Certified Peer Specialists strive to conduct up to 75% of their time in face to face outreach to those in their region who have a mental health diagnosis and who are literally homeless. This program was implemented in April 2011. In addition to receiving training in evidence based practices related to Supported Housing, Supported Employment and SSI/SSDI Outreach and Recovery (SOAR), PATH Peer Specialists were also trained in Mental Health First Aid in June 2011 through a Center for Social Innovations technical assistance opportunity. Additional resources to the homeless include the Charitable Assistance to Community's Homeless (CATCH) program. This program mobilizes community resources for those who are homeless in Regions 3 and 4. The Idaho Housing and Finance Association (IHFA) manages Shelter Plus Care vouchers in all but Regions 3 and 4, where housing services are handled through the Boise City/Ada County Housing Association (BCACHA). The process for accessing Shelter Plus Care beds was standardized in SFY 2009, leading to an increased level of regional involvement with this program. Because the growth exceeded the supply, IHFA stopped accepting referrals to Shelter Plus Care in April, 2011 for an indefinite period of time.

Special projects serving adults diagnosed with serious mental illness and/or substance use disorder diagnoses include the Wood Project and the Allumbaugh House detoxification center. Both projects were initially supported through legislatively allocated funds to identify unmet local needs and develop a plan to address those needs. The Bonneville County's Substance Abuse/Mental Health Treatment Program (i.e., the Wood Project) provides mental health and substance abuse assessments, drug testing and treatment to male and female offenders who are likely to be sentenced to correctional facilities. This program SFY 2008 legislative allocation of \$1,240,000 was reduced to \$1,083,400 in SFY 2011. The Allumbaugh House opened May 2010 in Boise and is operated through a contract with Terry Reilly Health services. This facility offers treatment services that include crisis mental health, medically monitored chemical detoxification and sobering stations. Sobering station referrals are accepted from health care providers and local law enforcement. Legislative operating allocations for this facility were reduced from \$900,000 to \$787,400 in SFY 2011.

The CMH system's comprehensive system of care includes assessment, case management, family support (e.g., family preservation, counseling, transportation, parent skills training and education, flexible funding and peer support) and family respite. The Division contracts with a private provider to maintain a statewide family to family support network, to provide a statewide respite information and referral center, and to recruit and train respite care providers. The CMH

program also provides therapeutic foster care, crisis response, school mental health services, outpatient, residential and hospitalization. State Hospital

South's 16 bed Adolescent Unit provides inpatient stabilization and treatment, with average lengths of stay of 45 to 90 days. Longer term treatment may be provided by foster parents and residential facilities. Some unique aspects of the CMH program that are not available in the community or through existing benefit packages include provision of the evidence based Parenting with Love and Limits (PLL) intensive outpatient program, wraparound and clinical case management.

The CMH Division of Behavioral Health program works closely with the Department of Health and Welfare's Child Welfare Program and with the Department of Education. A memorandum between CMH and Child Welfare describes how services will be coordinated for shared clients. The Department's Service Integration program facilitates family efforts to navigate the range of Department programs and services. The Service Integration program works with Idaho's Health Information and Referral Center, or the 211Idaho CareLine. The CareLine provides referral information (including housing and other resources) through the statewide 211 number. The Bannock Youth Foundation (Pocatello) and Hays Shelter Home (Boise) provide federal grant funded crisis and emergency shelter to runaway and homeless youth; these programs coordinate mental health care needs with CMH. The Division's CMH program and the Department of Education collaborate with local school districts to implement intensive community and school based programs. All 114 independent Idaho local school districts respond to the Individuals with Disabilities Education Act (IDEA) for eligible children. IDEA services include child find/referral, evaluation/eligibility, individualized education plans (IEP), related services, least restrictive environments, review and reevaluation, transition requirements and consideration of behavior management needs.

The Division works collaboratively with juvenile corrections programs in several ways. Clinicians are placed in juvenile detention centers to assist with evaluations, service referrals and crisis counseling. The Juvenile Justice/Children's Mental Health (JJCMH) collaborative workgroup focuses on resolving obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored implementation of a Youth Mental Health Court in three counties (as of July 2011) with interest in expansion to other counties. The Youth Mental Health Court uses the wraparound service model to facilitate treatment planning and coordination. The SUD prevention staff also participates on the juvenile corrections sponsored Enforcing Underage Drinking Laws workgroup. This partnership enables Idaho to reduce duplication and increase effectiveness in service delivery to this population.

Local substance use disorders (SUD) services for adults and children are provided through an array of private treatment providers. The Management Services Contractor, BPA, manages this array of SUD treatment providers and prior authorizes services. Business Psychology Associates are also responsible to conduct SUD utilization reviews and provide data to the Division for state and federal reporting. Outpatient and inpatient services are available to residents in every region, but they are not necessarily located in every region. Three Pregnant Women and Women with Dependent Children (PWWC) specialized SAPT providers offer arrangements for prenatal care. Few services are available to parents with mental illness who have dependent children. Youth 15

years and under are required to have parental consent for services, while those 16 and older can access treatment services without parental consent.

Services for children and youth who are diagnosed with SED and a substance use disorder (SUD) are delivered by two different Division of Behavioral Health programs. The CMH comprehensive assessment includes assessment of substance use and service recommendations. The majority of CMH services (mental health and substance abuse) are delivered by private providers. For children and youth diagnosed with SED and a developmental disability, services are coordinated through the Department's Division of Behavioral Health and Division of Family and Community Services.

Benchmark Research and Safety (BSR) is responsible to conduct SUD prevention utilization reviews and provide data to the Division for state and federal reporting. Substance abuse prevention strategies include information dissemination, education, alternative activities, problem identification and referral, community based processes, environmental strategies. Prevention information dissemination is conducted through distribution of the Idaho RADAR Network Center's materials and video library to community members, coalitions, schools, prevention/treatment programs, social services/health care providers and other stakeholders and through the Idaho Preventing Underage Drinking campaign. Education is provided to groups and individuals identified in the DHW needs assessment as having one or more risk factors (i.e., Hawkins and Catalano Risk & Protective Factors). The Division's contract with BRS funds community based prevention providers' delivery of evidence based programs to universal, selective and indicated audiences (see www.preventionidaho.net for details). Alternative activities are funded based on needs assessment identified risks. Community based providers contracting with BRS offer drug free activities and support services to universal or selective youth and families (e.g., after-school programs, mentoring, modeling positive behaviors). Problem identification and referral services are also delivered by community-based providers with the goal of identifying at risk children early and referring them to services needed to reduce their risk of substance use. Community based processes are delivered by community coalitions through BRS prevention contracts. The Community Coalitions of Idaho (CCI) receive Division technical assistance and support to address risk factors identified in their respective communities. Environmental strategies are undertaken by community coalitions receiving block grant funds. The SSA also supports an annual media campaign targeting parents in an effort to reduce underage drinking.

Results of the 2011 legislative session included changes to the SFY 2012 state cost/general fund allocation for the Division's SUD funds to compensate for the loss of multi-agency coordination funds with the sunset of the Interagency Committee on Substance Abuse in June 2011. A total of \$625,200 was shifted to the Department of Correction for felony substance abuse treatment; a total of \$3,232,900 of dedicated substance abuse treatment funds was shifted from the Division's SUD program to the Judicial Branch for substance abuse treatment for drug and mental health courts; and a total of \$4,032,000 was shifted to the Department of Juvenile Corrections budget for juvenile offender substance abuse treatment. Legislators decreed that the Department of Health and Welfare would retain responsibility for adult misdemeanant treatment, Medicaid recipients, SAPT Block grant priority populations and community-based prevention.

The purpose of the Olmstead Act is to ensure that individuals who no longer need institutional level care are able to move into less restrictive community based settings. As of July 2011, the State of Idaho did not have a formal Olmstead Plan. Over the past three years, Idaho's allocation of federal Olmstead Grant funding has gone toward supporting the Peer Specialists programs through Mountain States Group. Idaho's new "Money Follows the Person" Program has similar goals to the Olmstead act with respect to assisting with community placements in lieu of institutions. The program that Idaho is adopting is called the Home Choice Program. This program is federally funded and allows for Transition Managers to help assist adults diagnosed with developmental disabilities or mental illness who no longer need institutional care to transition into the level of community based care that best meet their needs.

Medicaid benefits plans include the Medicaid Basic Plan Benefits, the Medicaid Enhanced Plan Benefits and the Medicare/Medicaid Coordinated Plan Benefits were effective as of July 1, 2006. The Medicaid Medicare Coordinated Plan was effective April 1, 2007. Blue Cross of Idaho started with their plan on April 1, 2007 and United Health Care started with their plan on May 1, 2007. Partial Care, Service Coordination and Psychosocial Rehabilitation mental health services are excluded from the Medicaid Basic Plan Benefits except for diagnostic and evaluation services to determine eligibility for these services. These services continue to be covered under the Medicaid Enhanced Plan Benefits. The services available in the Medicaid Enhanced Plan include the full range of services covered by the Idaho Medicaid program. One major policy change in SFY 2008 expanded Medicaid eligible locations for service delivery to allow physicians to perform tele-health in any setting in which they are licensed.

Several strategies were implemented in an effort to control rising Medicaid mental health service costs. In 2009, the number of Medicaid partial care hours was reduced from 36 to 12 per week, Psychosocial Rehabilitation (PSR) services were reduced from 20 to ten hours per week, and PSR crisis services were reduced from 20 to ten hours per week. The Medicaid Management Information System (MMIS) was implemented in May 2010 to address data needs related to claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals.

Legislation and relevant Idaho Code changes in SFY 2010 that pertained to rules governing Medicaid included House Bill (HB) 701 that provided legislative intent for Medicaid program flexibility for FY 2011. The 2010 Idaho State Legislature approved Rules Governing Medicaid Cost-Sharing (IDAPA Chapter 16.03.18) that described the sliding scale, premium payments and premium waivers. As noted on page 26, "The cost savings for this rulemaking for SFY 2010 is estimated at \$210,000 in state general funds." Medicaid Omnibus Bill (HB 708) continued pricing freezes from SFY 2010 through SFY 2011; this bill allowed additional budget reductions that included mandates for pharmacies to participate in periodic cost surveys. In SFY 2011, House Bill 260 reduced State Medicaid spending by \$34.6 million, which translated to a total reduction of \$100 million with the additional loss of matching federal funds. As of July 2011, Medicaid was pursuing a contract with a managed care organization (MCO) with a target implementation date of 7/1/12 for the administration of mental health benefits. A 1915b waiver will be in place as the funding authority to support the MCO contract. Qualis signed a three year contract renewal with Medicaid in June 2011 to provide case management and utilization management services.

The Division of Behavioral Health is able to extend services through an assortment of federal SAMHSA grants. The SUD program's Access to Recovery (ATR) grant serves military (includes veterans, military reserves and Idaho National Guard), adolescents reentering the community from state and county institutions (e.g., juvenile detention, state run correctional, hospitals) and adult supervised misdemeanants. Services include intensive SUD outpatient, safe and sober housing for adults and adolescents, case management, drug testing, transportation, child care, and life skills education. The Projects for Assistance in Transition from Homelessness (PATH) grant allows for outreach to adults with serious mental illness who are homeless. The CMHS Transformation grant, the Idaho Home Outreach Program for Empowerment (IDHOPE) supports provision of evidence based Critical Time Intervention (CTI) services in pilot Regions 3 and 4. Idaho's data infrastructure development efforts receive federal support through a transformation grant directed to implementing a data warehouse and through the Data Infrastructure Grant (DIG) that focuses on WITS development to collect and report on the National Outcome Measures (NOMS). Idaho's prevention data capacity has been significantly increased by the State Epidemiological Outcomes Workgroup (SEOW) grant, which funded the Division's development of the Idaho Prevention and Treatment Research website (www.patr.idaho.gov). This website provides county level risk factor data to enable community coalitions and other interested individuals and groups to easily access substance abuse related data.

Regional, County and Local Entities that Provide Behavioral Health Services or Contribute Resources

Idaho Code Section 192524 (effective SFY 2007), gives judges additional sentencing options for felons with substance abuse and mental illness diagnoses. The law allows a judge to order a substance abuse assessment and/or a mental health examination for felons and felony parole violators that appear before the court. Based on the results of an assessment or examination and as a condition of probation, a judge may order the defendant to undergo treatment consistent with the treatment plan (subject to modification by the court) contained in the assessment or examination report.

The priority adult populations to be served through the public mental health service system are 1) adults who are in crisis, 2) court ordered commitment to the Department (66329 and 18211/212), 3) Court ordered evaluation and treatment for offenders sentenced under criminal court (Idaho Code 192524), 4) mental health court referred individuals and 5) outpatient services for those who have no insurance or other resources. Regional Mental Health Courts refer individuals to treatment through Assertive Community Treatment (ACT) programs. While regional programs may continue to retain some eligible individuals who have Medicaid and who are unable to be served in the private sector because of challenging needs or behaviors, efforts are being made to refer all Medicaid eligible individuals to private community resources. The priority children's populations to be served through the public mental health system are 1) children and families in crisis, 2) court ordered evaluation and treatment for juveniles ordered by the court or through Juvenile Mental Health Court (see ID Code 20511(a), 66321,18211/212, and 3) outpatient services for those who have no other benefits.

The Division of Behavioral Health collaborates with the Social Security Administration to encourage collaborative efforts to educate Idaho providers about their system and to train them in SSI/SSD Outreach, Access and Recovery (SOAR). This training helps providers to facilitate more effective completion of eligible client SSI/SSDI benefit applications. The Division of Behavioral Health includes two staff trained in the SOAR benefits skills. These SOAR trainers began providing SOAR trainer to Idaho behavioral health providers in March 2011.

The Division has an Interagency Agreement with the Idaho Division of Vocational Rehabilitation. This Agreement supports the placement of a vocational rehabilitation (VR) counselor at each of the regional CMHC sites. The VR counselor is responsible to attend at least one weekly ACT team meeting. Often, the VR counselor attends more than one weekly ACT meeting and may also attend weekly mental health court meetings that relate to shared clients.

The Division is represented at monthly community networking meetings sponsored by the courts for the purpose of exploring the feasibility of creating a veteran's court. These meetings include representation from the courts, behavioral health treatment providers, the veteran's administration, law enforcement and other stakeholders. The veteran's group anticipates implementing a veteran's court in SFY 2012.

An ad hoc committee designed to identify treatment needs and resources for military populations meets at least quarterly. Representation includes the Idaho National Guard, the Division of Behavioral Health, behavioral health providers that contract with the Idaho National Guard and other stakeholders

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The Division meets regularly with the Department of Juvenile Corrections sponsored Enforcing Underage Drinking Laws workgroup. Representation on this workgroup includes Departments of Education and Transportation, the Liquor Division, the Idaho State Police, the Idaho College/Universities Coalition and Idaho Prosecuting Attorneys Association. This workgroup addresses issues identified by member agencies. In SFY 2011, workgroup efforts were instrumental in targeting parents to work with their children and adolescents to reduce underage drinking.

How Systems Address Needs of Diverse Racial, Ethnic and Sexual Gender Minorities
The 2010 Census Bureau estimates 89.1% of Idaho citizens self-identify as white; 84% as
White/not Hispanic; .6% Black, 1.4% American or Alaska Native; 1.2% Asian; o.1% native
Hawaiian/Pacific Islander and 11.2% Hispanic/Latino origin. Regions 3 and 4 contain the largest
concentrations of individuals with Hispanic heritage, with up to 15% of the population.

Cultural issues are addressed through learning applications available to all staff on the Department of Health and Welfare's Knowledge Learning Center (KLC) website, but this does not address specifics related to Native American tribes or Gay, Lesbian, Transgender, Bisexual or Questioning (GLTBQ) populations. The Idaho Minor in Prevention Curriculum includes attention to culture, age and gender.

Literacy is addressed during service delivery, and materials may be read to the individual if they are unable to read. Regional service information and treatment materials are available in English and Spanish in Behavioral Health offices, and other languages can be addressed through

translator resources. The 2011 Idaho Conference on Alcohol Drug Dependency (ICADD) offered a session on elements of culture.

With respect to GLTBQ populations, Annual Gay Pride week celebrations are held in the Treasure Valley (Region 4) and the Magic Valley (Region 5). The Boise Gay and Lesbian Community organizations in Idaho host educational and supportive websites at http://tccidaho.org (Boise) and http://sites.google.com/site/gayidahofalls/ (southeastern Idaho and Idaho Falls). Other websites are available to identify counseling resources that specialize in GLTBQ issues and services.

Idaho's six federally recognized tribes are the Shoshone Bannock, the Northwest Band of the Shoshone, the Nez Perce, the Coeur d'Alene, the Kootenai and the Duck Valley (Shoshone Paiute) Tribes. The Division of Behavioral Health's Substance Use Disorder provider network includes the tribally owned Benewah Medical and Wellness Center in northern Idaho (Plummer), but interaction with the Division on SUD treatment services is limited to the facility renewal process. Behavioral Health efforts to engage Tribal leaders would likely evolve into meetings between the Division of Behavioral Health and Tribal Mental Health and Substance Abuse programs. The Division provides funds to Benchmark Research Safety to contract with tribal organizations or school districts on tribal lands from three Idaho Tribes (i.e., Shoshone Bannock, Nez Perce and Kootenai) for SUD prevention programs.

IDENTIFICATION OF IDAHO'S UNMET SERVICE NEEDS AND CRITICAL GAPS

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority. The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving. In addition to instate data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Identification of Data Sources Used to Identify Needs and Gaps

Idaho's behavioral health unmet service needs and critical gaps are based on data from multiple sources. These numbers represent Idaho's best estimate to date of incidence, treated prevalence, and quantitative targets. Data represents our best estimates based on available data and reflects the limitations of our reporting and information systems. In some cases it is not possible to guarantee unduplicated counts. These numbers represent publicly provided and/or funded (including Medicaid) mental health services rendered by the public sector. Some individuals received services from both public mental health system and private sector providers during

FY2011. As of July 1, 2011, numbers served for adult mental health and children's mental health were captured in the Division's WITS system.

The State of Idaho uses the estimation methodology for adults and children required by the Substance Abuse Service Administration's Center for Mental Health Services (CMHS) and the National Prevalence figures prepared for MHSIP by the National Research Institute and distributed by CHHS to determine prevalence of Serious Mental Illness (SMI), Serious and Persistent Mental Illness (SPMI), homeless with SMI and children with Serious Emotional Disorders (SED). Background details on the definition for SMI were published previously in the Federal Register on May 20, 1993. Estimation methodologies were published in the Federal Register on June 24, 1999.

The Web Infrastructure for Treatment Services (WITS) system was implemented 10/1/09 for collection of Adult Mental Health (AMH) data for public services provided through regional mental health center (RMHC) sites. Implemented in SFY 2009, the VistA data infrastructure system is used by State Hospital South (SHS) and State Hospital North (SHN). The Division of Behavioral Health (DBH) has an Interagency Agreement with the Idaho Division of Vocational Rehabilitation (IDVR), and employment data is also collected from IDVR. The Office of Consumer Affairs (OCAFA) provides monthly reports of services for Consumer and Family Advocacy/Education, Peer Specialist Certification and PATH activities provided by PATH peer specialists. Children's mental health data has historically been collected and reported from the FOCUS system, but DBH is in the process of enhancing the WITS system to allow data collection and report extraction from WITS. Consumer survey information is based on annual and end of service MHSIP and YSSF survey requests. In an effort to support and crosswalk data from WITS, VistA and SUD data sources, DBH is also working on development of a data warehouse with a target implementation data of SFY 2012. Medicaid data must be requested. Medicaid's contract with the data management vendor, Molina, began in May 2010. This system handles Medicaid service and billing data.

The Substance Use Disorders (SUDS) program also gathers and reports data from several sources. The National Survey on Drug Use and Health (NSDUH) provides Idaho specific data to evaluate incidence and prevalence of substance use and abuse and to estimate populations in need of substance use disorders services. The Division of Health implements the Youth Behavioral Risk Survey (YRBS) and the Behavior Risk Factor Surveillance System (BRFSS), and this data is useful for substance use disorder needs assessments and planning. Substance use disorder service provider treatment data is collected by the Management Services Contractor, Business Psychology Associates, and uploaded to the Department. The SUD treatment data is used to create a number of standard reports that are utilized for State planning and assessment. Standard reports include State Utilization Management and Grant Data; Level of Care Capacity and Census Management; Budget Tracker; Treatment Completion Data; Length of Stay Report; County/Regional Utilization Report; Pregnant Women With Children (PWWC) Chart Audit Results and Client, Provider & Stakeholder Satisfaction reports. Each of the seven regions in Idaho has a Regional Advisory Committee (RAC) that provides an annual report and updated information to help determine regional and local needs, emerging trends, gaps in service and the need for programs and services in regions throughout the State. The SUD system is also working with the vendor, FEI, to develop the WITS system for SUD use. The Department plans to conduct monthly meetings with other state agencies during SFY 2012 2013 to assess and plan for SUD treatment needs and services. During SFY 20122013, the Department will continue to use the NSDUH, the Treatment Episode Data Set (TEDS), YRBS, BRFSS, substance use disorder treatment data and information from the RACs to assess SUD treatment needs in Idaho.

The Department's contract with Chestnut allows for the Global Appraisal of Individual Needs (GAIN) SS to be used for all client screenings and the GAINI for all clinical assessments. Chestnut Health Systems (Dennis, M. & Modisette, K.) created a PowerPoint presentation entitled "A Profile of Idaho's FY10 Data from the Global Appraisal of Individual Needs (GAIN)" for the Idaho Office of Drug Policy in January 2011 (see attachment). The PowerPoint states that "This presentation uses data collected by Idaho providers as part of the state mandate to use a common assessment across programs." Authors add, "In 2009 staff started using version 5.6 with a web-based software to assist with the interviewing …Data used here are 4,815 clients intaked by 51 providers collected in fiscal year 2010 (7/1/2009 – 6/30/2010)." This evaluation provides one source of information for assessment of unmet SUD needs and gaps at the State, local and provider levels, however it must be noted that the data provided does not identify clients by region or provider, nor does it account for differences in counties or service areas across the State.

The Idaho State Epidemiological Outcomes Workgroup (SEOW) is composed of state agency staff and other community stakeholders (Idaho Prevention Fellow, researchers) with an interest in the substance abuse treatment and prevention system. In regards to treatment and prevention, the SEOW operates as an ad hoc research resource for policy decision makers. Additionally the group maintains a web dissemination resource for more general data related questions. On the State level, the SEOW is identified as the Idaho Prevention and Treatment Research (PATR) work group. The PATR website at http://patr.idaho.gov/ states that "The Idaho Prevention and Treatment Research (PATR) Workgroup exists to develop a system of substance abuse related data collection, analysis and reporting that reflects substance abuse consumption and consequences throughout Idaho." This public site is accessible to all Idaho stakeholders and reflects 15 risk factors, 44 counties and 1,980 data points. Collected at the county level, the PATR website risk factor data (updated at least once every two years) is a resource for state agencies, communities and coalitions needing data to develop substance abuse (including underage drinking) or other plans for their specific needs. Data graphed by county on this site is based on Hawkins and Catalano's (1992) risk factors. Data reflects domains related to school (i.e., incidents of bullying, suspensions, truancies), individual (i.e., adolescent pregnancy, juvenile arrests for alcohol related charges and juvenile arrests for drug related charges), family (child abuse and neglect, heavy drinking, illicit drug use), and community (i.e., adult arrests for alcohol related charges, adult arrests for drug related charges, free or reduced school lunch eligibility (K12), impaired driving crashes, per capita sales of distilled spirits, unemployment rate). The PATR website uses data provided by the Idaho Liquor Division, the Idaho State Police and the Idaho Departments of Education, Transportation and Health and Welfare. The State of Idaho Epidemiological Profile of Substance Abuse 2010: State Epidemiological Outcomes Workgroup Report and the updated 2011 Report are attached.

The Division of Behavioral Health's SA/SUD program contracts with Benchmark Research and Safety, Inc., to serve as the Idaho SA prevention system manager. Benchmark manages the community based prevention system. This includes annual state and regional needs assessments

used to identify at-risk populations and underserved areas. Community based providers are able to utilize this data to secure funding for populations that need services in their respective communities.

Other behavioral health assessments were completed by the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) and the Governor's Transformation Workgroup. The ICSA workgroup's assessment resulted in a document entitled "Idaho Substance Use Disorder Prevention and Treatment System: A Collaborative Strategy for 20082012. It indicates that "The System addresses individual, community and tribal needs statewide for effective and accessible prevention, education, assessment, early intervention, treatment, recovery support services and post-treatment support," (p. 3). It adds that the "System strives to maintain an uninterrupted, well-coordinated continuum of services to clients and their families within and outside of the criminal justice system." Identified needs in the ICSA plan that were not complete by July 2011 (Appendices, p. 3, pp. 911) included collaboration with local and state correctional agencies and detention facilities to develop shared resource methods to ensure effective implementation and delivery of intervention and treatment services to adult and juvenile populations in correctional and detention facilities and collaboration with the Department of Education to implement core best practice and outcome measures for prevention services in K12. Other goals included collaboration with the Department of Health and Welfare to 1) assure a provider network to balance service availability and funding throughout the state; 2) identify core evidence based practices by population; and 3) work with the Idaho Department of Correction and Juvenile Corrections and county probation to identify protocols to integrate treatment with probation services.

The Idaho State Planning Council on Mental Health's 2011 Report to the Governor and State Legislature: Idaho Mental Health at the Crossroads (June 2011) document identifies critical gaps related to increased suicides, increased use of law enforcement and increased use of hospitals. Recommendations include identification of sustainable funding to support an Idaho Suicide Prevention Hotline; full funding for mental health services and priority on Crisis Intervention Training (CIT) for law enforcement; and adoption of the "...principles of the 10 X 10 SAMHSA Plan to support the need for a full continuum of care for people with mental illness services in their own communities, for both physical and mental health, thereby preventing costly hospitalizations, and supporting the system of recovery."

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff's Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision; "Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery. Goals included the following; 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5)

Increase accountability for services and funding, and 6) Seek and include input from stake-holders and consumers.

The BHTWG's efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho's Behavioral Health System (October 28, 2010). This report's recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council to the State Behavioral Health Council; establish the Behavioral Health Interagency Cooperative to oversee transformation efforts; and adopting the BHTWG's proposed Array of Core Services "...as the 'floor' of services they seek to make available in each region; that this array be maintained as the goal for regional planning and capacity building; and that is also be used as a measure by which to indicate progress toward a truly transformed behavioral health system..." The proposed array of core services is outlined in the chart below (p. 16): Governor Otter

₩o.	Core Service	Emergent	Medically Necessary	Structurally Necessary	Community-Based (nos-institutional)	Medicald covered	Substanceuse	Mental Health	Adult	Child
1.	Assertive Community Treatment (ACT), Intensive Case Management Services and Wraparound	x	х		Х	+f-	х	х	х	х
2	Assessments and Evaluations	X	X	X.	X	+#-	X	X	X	X
3.	Case Management Services		X		X	X	X	X	X	X
4	Designated Examinations and Dispositions	X	X	X.	X			X	X	X
5.	Intensive Outpatient Treatment				X	+	X	X	X	X
6.	liness Self-Management and Recovery Services				X.		X	X	X	
7	Ingetient Psychiatric Hospitalization	X	X			X	X	X	X	X
8.	Medication Management		X	X	X	X	X	X	X	X
9.	Drug Screening	X	X		X	X	X	Х	X	X
10.	Peer Support Services				X		X	X	X	X
11.	Prevention Services				X		X	X	X	X
12.	Early Intervention Services for Children and Adolescents				X		X	X		X
13.	Psychiatric Emergency and Crisis Intervention services (247 with open door access)	X	×	X	X	#-	Х	Х	х	X
14.	Psychotherapy (including trauma-informed care and cognitive behavioral therapy)		X		Х	X	х	Х	х	X
15.	Alcohol and Drug Residential Treatment	X	X				X		X	X
16.	Supported employment				X		X	X	X	X
17.	Supported housing				X		X	Х	Х	
18.	Transformation		X		X	X	X	Х	X	X
19.	24-Hour Out-Of-Home Treatment Interventions For Children And Adelescents	X		X			X	X		X
20.	Day Treatment, Partial Care and Partial Hospitalization			X	X	X	X	X	X	X

Governor Otter signed Executive Order 201101 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership is at the pleasure of the Governor and includes representation from the Department of Health and Welfare, the Office of Drug Policy, the Department of Correction, the Department of Juvenile Corrections, the State Mental Health Planning Council, Administrator of Idaho Courts, the Superintendent of Public Instruction and one representative of the counties. One purpose is to "d. Facilitate transformation

efforts as described in the BHTWG Plan for transformation of Idaho's Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho'[s budget, current needs of the agencies, and recommendations of the Idaho Health Care Council." As of 5/13/11, the IBHIC "to do" list was broken into four phases. Phase 1 included finalizing Phase 1 funding; planning regional behavioral health development boards and state behavioral health planning council (e.g., identifying proposed membership, proposing an implementation timetable, soliciting and reviewing input and drafting legislation to implement regional behavioral health development boards to submit to the 2012 legislature); establishing core services for all regions and drafting 2012 legislation proposals; developing a transformation work plan, communications protocol and proposed transformation activity funding for SFY 2013; review SUDS treatment services and data report elements and prepare a status report for the Governor. Phase 2 included determining available Phase 2 funding and resources; finalizing core services standards for the transformed behavioral health system; initiating regional transformation efforts, coordinating transformation activities with health care reform activities and preparing a status report for the Governor. Phase 3 included determining available Phase 3 funding and resources; developing a Transformation Implementation Plan that applies to all Cooperative entities; developing regional Transformation Implementation Plans; monitoring and evaluating phase-in and recommending adjustments to State and Regional Transformation Plans; coordinating transformation activities with health care reform activities and preparing a status report for the Governor. Phase 4 included determining available Phase 4 funding and resources; continuing phase-in of transformation, drafting legislation to implement the next phase; coordinating transformation activities with health care reform activities and preparing a status report for the Governor.

Unmet Service Needs and Critical Gaps

According to the U.S. Census Bureau data for 2010, Idaho total population estimate was **1,545,801**, with an estimate of **1,126,894** aged 18 or older and an estimate of **418,907** under age 18. Based on this data and the SAMHSA/CMHS estimation methodology establishing prevalence for adults at 5.4% for SMI, 2.6% for SPMI, 5% of the estimated SMI population as homeless and 5% for children/adolescents, it may be concluded that there are **60,852** adults in the state of Idaho with serious mental illness, **29,299** adults in the state of Idaho with serious and persistent mental illness, **3,043** adults with SMI who are also homeless and **20,945** children with serious emotional disorder diagnoses. Idaho's TEDS data for 2008 indicates a treatment admission rate of **5,683** aged 12 and older; an estimated **464** admitted per 100,000 population aged 12 and older; **2,110** primary alcohol admissions and **1,712** primary marijuana admissions. This data indicates that, for the total of **5,683** admissions 12 and older in 2008, **48.9%** were regular outpatient and **40.2%** were intensive outpatient; **11.1%** detoxification services were freestanding residential; **5.9%** residential services were short-term and **.03%** were long-term; **1.1%** of opioids treatment was outpatient, **.1%** was detoxification and **.2%** was residential.

Unmet service needs and critical gaps in Idaho's system of care relate to suicide, homelessness and residential/transitional options, employment, mental health (MH) and SA/SUD prevention, data infrastructure development and linkage, access to care (e.g., for those without criminal charges, primary health care resources for medical and dental needs, rural and frontier areas), cultural competency related to specialty populations, seamless service delivery for youth transitioning from children's services to adult services and recovery and resilience opportunities. These needs and gaps will be described in further detail below.

Suicide: There is no nationally certified suicide prevention hot line in Idaho. The National Suicide Prevention Lifeline reported 3,700 calls from Idahoans in 2010. The Suicide Prevention Action Network of Idaho (SPAN Idaho) provided a suicide fact sheet in July 2010 based on data from the Idaho Bureau of Vital Records and Health Statistics, the Idaho Department of Health and Welfare, the Centers for Disease Control and Prevention and YRBS Idaho (see attached). According to these statistics, suicide is the 2nd leading cause of death for Idahoans 1534 and for males 1014 years of age. The fact sheet reports that in 2009, 307 people completed suicide, with 77% by men, and 58% involving a firearm. Also in 2009, "14.2% of Idaho youth attending traditional high schools reported seriously considering suicide in 2009," with 6.9% reporting at least one attempt. The State Planning Council on Mental Health identified this as a top June 2011 concern. The Chestnut report of SUD client data from GAIN results for SFY 2010 (January 2011; see attached) indicated that 59% of the sample population reported cooccurring psychiatric problems, 28% reported major depressive disorder, 22% reported traumatic stress disorder, 61% reported a history of physical, sexual or emotional victimization, and 23% reported homicidal/suicidal thoughts in the past year. The SEOW report for 2010 (see attached, p. 1011) indicates that "Idaho's suicide rate (2005) was 45% greater than the national rate."

Housing and Homelessness: Homelessness remains an area of concern in Idaho. The website (http://www.endhomelessness.org/section/about_homelessness/cost_of_homelessness) for the National Alliance to End Homelessness Homelessness indicates that Idaho had a 32% increase in homelessness from 2008 to 2009, with an estimated total of 1,939 homeless individuals in 2009. The Idaho Housing and Finance Association's (IHFA) January 2011 Point in Time count estimates 2,199 homeless individuals statewide. Homeless students in Boise school districts was estimated at 1,717 in the 20092010 school year (ie., Nampa 757; Boise 656; and Meridian 304). In the Coeur d'Alene School District, 248 of the roughly 10,000 total students were identified as homeless in spring 2010. Project Safe Place provides services to teenagers in crisis at 78 locations spread around the greater Coeur d'Alene area. This program's services include a drop-in center, drug prevention education, crisis intervention and emergency shelter for youth under 18.

Prior to SFY 2011, the Projects for Assistance in Transition from Homelessness (PATH) grant divided PATH funds among seven Regional Mental Health Centers. The Idaho PATH Annual Report for 2009 indicated that, of the estimated (i.e., 5% of estimated SMI) 2,947 adults who were homeless with SMI, there were only 702 PATH clients served with federal, state and other funds (not including federal funds to Idaho Housing and Finance Association or Boise Ada Housing Authority that provide limited assistance to adults with SMI). In SFY 2011, the PATH grant contracted with other providers. The contract with St. Vincent de Paul in Coeur d'Alene was directed to provision of homeless services to adults diagnosed with a serious mental illness in that catchment area. The majority of PATH funds went to a contract with Mountain States Group's Office of Consumer and Family Affairs (OCAFA) to hire, train and supervise Certified Peer Specialists to provide up to 75% active face to face outreach to homeless adults with SMI. Two PATH Peer Specialists, each working 19 hours per week, were trained and began to provide PATH outreach in April 2011.

The Idaho Home Outreach Program for Empowerment (IDHOPE) project was funded through a CMHS transformation grant and the evidence based practice of Critical Time Intervention (CTI) began in pilot regions 3 and 4 in March 2011. The IDHOPE team is composed of a mix of Certified Peer Specialists and bachelors/masters level staff. This team includes specialists in housing and crisis services. In May and June, 2011, PATH and IDHOPE team members participated in the PATH to Housing phone and webinar technical assistance course offered by the Centers for Social Innovation. Idaho is also in the process of establishing Safe and Sober housing for adolescents in Regions 1, 3 and 4. While there is some concern about funding, initial costs will be covered through the Access to Recovery (ATR) project. Sustainability of these resources is a concern. The Chestnut study (January 2011) indicated that 39% of the SFY 2010 sample reported environmental stressors related to housing.

While Idaho has homelessness services, safe, decent and affordable Idaho housing resources are more difficult to access and retain for individuals diagnosed with mental health and/or substance use disorders. The Idaho Housing and Finance Association (IHFA) announced in April 2011 that it was no longer accepting applications for Shelter Plus Care, with an anticipated wait of 18 months or more before this resource would again be available. Landlords are often reluctant to rent to individuals with behavioral disorder diagnoses. Adolescent SUD residential facilities and/or transitional living resources have historically included funded from the Division of Behavioral Health and Idaho Division of Juvenile Corrections (DJC). Decreased funding for both programs has made it difficult to support the costs for the number of beds and bed days that are needed.

Employment: The Idaho Department of Labor reported an unemployment rate of 9.4% for May 2011, with an estimate of Idaho workers without jobs below 72,000 for the first time in nine months. The June 2011 report described variability in employment among Idaho counties. This report states that "Seventeen primarily rural counties posted double-digit unemployment rates, down from 18 in April. Two major urban counties remained in double-digits." While jobs are hard to find for the general Idaho populace, they are even harder to find and keep for those with mental health and/or substance use disorder diagnoses.

Prevention: Idaho has limited substance use prevention funds and no identified funding for mental health prevention (as of July 2011). Idaho uses the required 20% of the Substance Abuse Prevention and Treatment (SAPT) block grant to fund a range of Substance Abuse (SA) prevention services, but funds do not adequately meet the need. As of July 2011, there were no other state agencies funding primary substance abuse prevention activities. In Idaho, the Division of Behavioral Health's prevention database identifies the location of prevention services. Coalition information is determined from the Community Coalition of Idaho's membership list. According to these data sources, 49% of Idaho cities have no SA/SUD community-based prevention; 47% of school districts have no SA/SUD prevention and 61% of counties have no SA/SUD coalitions. According to the Idaho School Climate Survey (2006), 13.4% of 6th grade children report past month binge drinking. The YRBS results indicate that 24% of 11th grade males reported binge drinking in the past month, over 50% of high school seniors reported past alcohol use and one in three high school students reported that they had tried marijuana in the past. The Chestnut study (January 2011) indicated that results of their sample showed a pattern of weekly substance use (13+/90 days) of alcohol 16%; cannabis 15%; cocaine 1%;

opioid 8%; amphetamine 12%; other drugs 4%; needle use 16%; and tobacco 69. The 2010 SEOW report indicates that the percentage of drugs analyzed at the National Forensic Laboratory for Idaho includes approximately 48% methamphetamine, 39% marijuana and 4% cocaine.

Regarding mental health prevention, the Office of Consumer and Family Affairs (OCAFA) provides education on mental health issues, but there are no formal prevention efforts, programs or policies for Adult Mental Health (AMH). While the Children's Mental Health (CMH) program participates in anti-stigma awareness campaigns and the annual Children's Mental Health day, there are no ongoing, formal prevention efforts or policies in CMH. Prevention efforts are historically more beneficial and more cost effective than more intense treatment services. In addition to being less stigmatizing, community based services are significantly less expensive than hospitalization, jail or residential options.

Data Infrastructure: The Division of Behavioral Health continues to focus on development of a strong data infrastructure system capable of both collecting and extracting required data for local, state and federal reports and producing outcome data to guide resource decisions and best practice. The WITS system was implemented for Adult Mental Health (AMH) in October 2009, with current efforts on developing WITS for Children's Mental Health (CMH) and Substance Use Disorders (SUD) service needs. Requirements for a data warehouse capable of assisting with the interlinking of behavioral health data with the state hospitals' VistA and other systems were addressed in SFY 2011, with a planned data warehouse completion in SFY 2012. The WITS system does not link to data systems for Medicaid, courts, criminal justice, primary health, schools, community hospitals or Idaho Vocational Rehabilitation. Specific requests must be made to access data from these data resources, and their data is not necessarily based on the same data element definitions as that used by the Division of Behavioral Health's WITS system. As of July 2011, there was no resource that captured comorbidity data for behavioral health and physical health diagnoses, and this lack of data complicates efforts to accurately assess need. The SUD prevention program uses a web-based system with secure and nonsecure portions (see www.preventionidaho.net) to collect data on participant demographics, attendance, pre/post test scores, providers/staff and staff training. This site is also used for collection of required block grant and NOMS data, for providing information to contracted prevention providers, for accessing needs assessment reports and for locating funded prevention services.

Access to Care: Additional unmet needs relate to access to care. As of July 1, 2010, the priority population for mental health was adults in crisis and those referred through the court system. The priority population for SA/SUD included pregnant IV drug users and court ordered individuals. Access to behavioral health care for those without criminal charges is difficult in a context of limited funding. Access to primary medical and dental care resources and services can be difficult as well. The rural and frontier nature of Idaho's geography poses additional challenges with respect to transportation and to attracting and retaining health professionals.

The Chestnut study (January 2011) indicated that the SUD GAIN sample from SFY 2010 results suggested that biomedical common treatment planning needs included risky sex behavior 82%; tobacco cessation 68%; accommodation of medical conditions 39%; medications for physical health problems 26%; and current treatment for medical problem 26%. Some private providers (e.g., Terry Reilly Health Services) provide low or no cost services to those without insurance or

means to pay. There are more people who need Medicaid dental services than there are Medicaid dental providers.

Steven Snow, Executive Director of Idaho's Council for the Deaf and Hard of Hearing indicates that the deaf and hard of hearing in Idaho don't have access to services that adequately address deaf and hard of hearing needs. According to Steven, there is only one person in Idaho who signs and provides mental health counseling services. Steven suggests that the lack of access to adequate behavioral health services negatively affects the quality of life for deaf and hard of hearing Idaho citizens. The Council for the Deaf and Hard of Hearing has plans to implement a task force to identify needs for mental health, substance use, domestic violence and other issues in SFY 2012.

With respect to justice system involvement (JSI), Chestnut (2011) results indicated that the percentage reporting detention/jail for 30+ days was 26%; detention/jail for 1429 days was 8%; probation/parole for 14+ days with one or more drug screens was 25%; other probation/parole/detention was 16%; other JSI status was 13%; and past arrest/JSI status was 8%. According to Idaho State Police data in the 2011 SEOW report, there were 7.99% Idaho DUI and other alcohol related arrest rates per 1,000 population in 2009, and 8.62% per 1,000 population were arrested for possession.

Idaho is composed primarily of rural and frontier areas, and increased gas prices make it even more difficult for Idaho citizens to keep appointments with service providers that may be up to an hour away by car. In SFY 2008, there were two major changes in Medicaid. Policy changes expanded eligible locations for service delivery to allow physicians to perform telehealth in any setting in which they are licensed. A benefit was added to allow for family therapy without the client present.

Cultural Issues: Cultural issues are addressed through learning applications on the Department of Health and Welfare's Knowledge Learning Center (KLC) website, but this does not address specifics related to Native American Tribes or Gay, Lesbian, Transgender and Bisexual populations. The Idaho Minor in Prevention Curriculum includes attention to culture, age and gender. Service information and treatment materials are available in English and Spanish in regional Behavioral Health offices, and other languages can be addressed through translator resources. The SUD prevention program works to match providers and staff to the needs of individuals served. If a qualified member of the participant's preferred culture is not available, then Benchmark Research and Safety (Idaho's prevention system manager) works with the provider and the participant to identify a person that is mutually acceptable to deliver the service. The annual Idaho Conference on Alcohol and Drug Dependency offers courses in cultural elements or information on specific cultures.

Transitional Aged Youth: Transitional aged youth diagnosed with a serious emotional disorder who are served through the Children's Mental Health system (up to age 18) sometimes continue to require mental health services to ensure stability for recovery and resilience. Idaho's Children's Mental Health system requirements are different than the Adult Mental Health system requirements, and the transition from one system to another is sometimes challenging.

Evidence Based Practice for Criminal Justice Involved: The Division of Behavioral Health's priority service population is those who are court ordered for treatment. Behavioral health programs strive to provide best practice services, and this could be increased with additional training and implementation of evidence based practices that were specifically designed for criminal justice involved individuals with cooccurring behavioral health diagnoses.

Recovery and Resilience: One of the identified BHTWG core services is that of peer support. The BHTWG Plan for the Transformation of Idaho's Behavioral Health System (October 28, 2010) defines this (p. 35) as "Peer support services provide an opportunity for individuals to direct their own recovery and advocacy process and to teach and support each other in the acquisition and exercise of skills needed for management of symptoms and for utilization of natural resources within the community." As of July 2011, Certified Peer Specialists were working on teams providing mental health services related to Assertive Community Treatment, Projects for Assistance in Transition from Homelessness (PATH), and Critical Time Intervention (IDHOPE). The Substance Use Disorders program has explored the use of Recovery Mentors to model recovery, focus on wellness and encourage engagement in treatment services. The Division of Behavioral Health would like to continue to promote the use of peers as s ervice providers.

References

Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho's Behavioral Health System (October 28, 2010).

Dennis, M. & Modisette, K. (January 2011) of Chestnut Health Systems created a PowerPoint presentation entitled "A Profile ofIdaho's FY10 Data from the Global Appraisal of Individual Needs (GAIN)" for the Idaho Office of Drug Policy.

Hawkins, J. David; Catalano, Richard F. (1992). <u>Communities that Care: Action for Drug Abuse Prevention</u>. Hawkins, J. David; Catalano, Richard F.; Miller, Janet Y. (1992). <u>Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention</u>. Psychological Bulletin, Vol 112(1), Jul 1992, 64105.

Idaho Prevention and Treatment Research (PATR) website at http://patr.idaho.gov/.

<u>Idaho State Planning Council on Mental Health 2011 Report to the Governor and State</u> Legislature: Idaho Mental Health at the Crossroads. (June 2011).

Idaho Substance Use Disorder Prevention and Treatment System: A Collaborative Strategy for 2008-2012 (January 2008) prepared by Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) and the Governor's Transformation Workgroup.

<u>State of Idaho Epidemiological Profile of Substance Abuse 2010: State Epidemiological Outcomes Workgroup Report.</u> Prepared by Idaho Department of Health and Welfare, Division of Behavioral Health, Substance Abuse Program.

<u>State of Idaho Epidemiological Profile of Substance Abuse 2011: State Epidemiological Outcomes Workgroup Report</u>. Prepared by Idaho Department of Health and Welfare, Division of Behavioral Health, Substance Abuse Program.

 $Table\ 2\ Step\ 3\hbox{: Prioritize State Planning Activities 2012 - 2013 }$

Number	State Priority Title	State Priority Detailed Description
1	Mental Health - Adults:	Idaho's Division of Behavioral Health's (DBH) Adult Mental Health (AMH) program will provide a comprehensive, consumer-driven, client-centered, recovery-focused continuum of care for adults with a serious mental illness (SMI) or a SMI and a co-occurring substance use disorder (SUD).
2	Mental Health - Children	Idaho will provide a comprehensive, family-driven, recovery-focused, client-centered continuum of care for families and children and youth with a serious emotional disorder (SED) with or without a co-occurring substance use disorder diagnosis.
3	Substance Abuse Prevention	Idaho will provide evidenced-based substance abuse prevention services for at-risk youth and adults.
4	Substance Abuse Treatment	Idaho will provide evidence-based substance abuse treatment services for youth and adults.
5	Behavioral Health System Issues	In the next two years, the State Mental Health Planning Council will be replaced by the State Behavioral Health Council, and the Regional Mental Health Advisory Boards and Regional Advisory Councils (SUD) will merge to become Regional Behavioral Health Community Development Boards. The Behavioral Health Transformation Work Group's proposed Array of Core Services (see Unmet Needs section) will be adopted and implemented for each region. As transformation progresses, Regions will be responsible to develop and implement approved Regional Transformation Plans that address unique needs and resources in each region.
6	Data and Quality Assurance	The State of Idaho will manage the public behavioral health system with a focus on quality assurance, service outcomes and development of a robust data infrastructure system capable of capturing and extracting data to help guide service system development and implementation

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

Goal Name	Priority Area	Performance Indicator
Consumers and family members will have input into the behavioral health service system planning and service implementation.	Mental Health - Adults:	DBH will continue to support at least 18 state and/or contract-employed Certified Peer Specialists through state general and federal grant funds through PATH, ID-HOPE, and ACT by June 30, 2013.
Increase linkages for referral and collaboration between primary care providers and behavioral health care providers.	Mental Health - Adults:	DBH will meet with the Idaho Primary Care Association at least two (2) times to identify needs of shared behavioral and primary health care adult clients and collaborative opportunities between programs by June 30, 2012.
The state will implement the SSI/SSDI Outreach, Access, and Recovery (SOAR) program in three (3) of the seven (7) Department of Health and Welfare regions.	Mental Health - Adults:	At least one (1) Region will have appointed a Regional SOAR Lead, collaborated with their local Social Security Administration (SSA) office, and trained at least 25 Case managers by June 30, 2012
Increase awareness of mental health issues for children and families; decrease stigma and increase early access to information, education and other prevention activities.	Mental Health - Children	The DBH Family Supports Contract requirements will include holding a minimum of one (1) support group and (1) education group per region in the state, every other month, for youth ages 8 through 19 with emotional or behavioral disturbances.
Increase linkages between primary care providers and behavioral health care providers	Mental Health - Children	DBH will meet with the Idaho Primary Care Association at least two (2) times to identify needs of shared behavioral and primary healthcare child and family clients and collaborative opportunities between programs by June 30, 2012.
The Department of Behavioral Health (DBH) will implement parent support services for children with emotional and behavioral disturbances and their parents and families.	Mental Health - Children	The DBH Family Supports Contract will require implementation of at least 15 parent education/self-advocacy groups throughout the state by June 30, 2013.

DBH will contract with a provider manager to recruit, train, and maintain a provider pool in order to reduce the substance abuse rate in Idaho through prevention services.	Substance Abuse Prevention	The DBH contract with the provider manager will require at least (1) evidence-based program in each of at least 30 Idaho elementary, middle schools, and high schools by July 30, 2012.
Develop a comprehensive plan for Substance Use Disorder (SUD) services to clients whose services are funded through Substance Abuse Prevention and Treatment (SAPT) block grant funds.	Substance Abuse Treatment	SUD will use the developed assessment tools to gather baseline data on the existing SUD provider network and on the existing SUD service population by June 30, 2013
SUD will begin to move the provider network to a more client-driven system of treatment based on the Recovery Oriented Systems of Care model of service delivery.	Substance Abuse Treatment	SUD will develop a baseline for SUD client satisfaction using responses from the client satisfaction tool by June 30, 2013.
SUD will collaborate with Family and Children's Services (FACS) on the treatment of shared clients (i.e., clients with open child protection cases and SUD diagnoses).	Substance Abuse Treatment	FACS staff, including CPS liaisons and SUD program specialists will participate in at least three quarterly meetings to discuss issues related to collaborative service delivery and care coordination to clients with open child protection cases and SUD diagnosis.
By June 30, 2013, and as transformation progresses, regions will be responsible to develop and implement approved Regional Transformation Plans that address unique needs and resources in each region.	Behavioral Health System Issues	A written report describing the proposed board structure, roles and responsibilities will be presented to the Cooperative by June 30, 2012.
By June 30, 2013, the Regional Mental Health Advisory Boards and Regional Advisory Councils (SUD) will merge to become Regional Behavioral Health Community Development Boards.	Behavioral Health System Issues	The Regional Boards will identify regional needs, plans to develop regional capacity, and plans to provide input into regional behavioral health service provision by June 30, 2013.

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Evolve the role of the Division of Behavioral Health's (DBH) Quality Assurance unit.	Behavioral Health System Issues	The DBH Quality Assurance Unit will complete a written quality improvement plan for DBH services by June 30, 2012.
Include Tribal leader representation on the State Mental Health Planning Council and in the DBH collaborative meetings.	Behavioral Health System Issues	The State Mental Health Planning Council and the DBH collaborative meetings will include representation from Tribal leaders from at least two of Idaho's six federally recognized Tribes by June 30, 2013.
The DBH will provide a training curriculum for DBH service delivery staff on Gay, Lesbian, Transgender, Bisexual and Questioning cultural awareness.	Behavioral Health System Issues	Regional DBH service delivery staff will be required to complete this training module on GLTBQ cultural awareness, which will include the need for awareness of the high risk of suicide of this population, by June 30, 2013.
The Regional Behavioral Health Councils and the Division of Behavioral Health will make housing and employment resource development a priority for the homeless population	Behavioral Health System Issues	At least two (2) Safe and Sober Housing program beds for adolescents in each of three regions (Regions 1, 4 and 6) will be established and operational by June 30, 2012.
Complete the data warehouse for behavioral health data (SUD, CMH, AMH)	Data and Quality Assurance	The functional data warehouse will allow cross walking, increased tracking, and interlinking capability between WITS and VistaA for DBH by June 30, 2012.
DBH will complete the Web Infrastructure Information Technology System (WITS) implementation for Children's Mental Health (CMH) for credible, non-duplicative data collection and report extraction of local, state and federal (e.g., State Outcome Measures S	Data and Quality Assurance	DBH will test FEi produced enhancements and modules. FEi will migrate the final tested product into production by June 30, 2012.
DBH will complete the WITS implementation for SUDS for non-duplicative data collection and report extraction of local, state and federal (e.g., SOMS, TEDS) reporting requirements.	Data and Quality Assurance	DBH will establish timeline for implementation by June 30, 2012.

Establish kiosks at regional behavioral health main offices and at both state hospitals to allow adults with serious mental illnesses and children with emotional and behavioral disorders and their parents to directly input responses to the adult Mental He

Data and Quality Assurance Each of seven (7) DBH regions will have at least one consumer survey kiosk installed and ready to use by June 30, 2012.

III: Use Of Block Grant Dollars For Block Grant Activities

$\begin{tabular}{ll} Table 4 SAPT - Services Purchased Using Reimbursement Strategy \\ 2012 - 2013 \end{tabular}$

Reimbursement Strategy	Services Purchased Under this Strategy
Encounter based reimbursement	Encounter-based reimbursement—includes fee-for-service and other strategies that pay individuals or organizations a specific amount for a unit of service. Services provided through the Idaho Single State Authority (SSA for substance abuse services) or the Idaho State Mental Health Authority (SMHA) may include participant payment or co-payments according to a sliding scale that is based on income and family size
Grant/contract reimbursement	Grant/Contract reimbursement—includes annual or periodic payments to individuals or organizations that provide services or system improvements. Substance abuse prevention and treatment both provide contract reimbursements for all prevention activities and all treatment services identified in the block grant strategies. Children's mental health contracts for parent support services, respite, and public awareness activities. Adult mental health contracts for consumer support, peer specialist training, and peer specialists to work with consumers in the delivery of services. Adult mental health, children's mental health, and substance abuse combine block grant funds to contract for suicide prevention activities.
Risk based reimbursement	Risk based reimbursement includes annual or periodic payments to individuals or organizations that provide services or system improvements. The Division of Behavioral Health's Substance Use Disorders (SUD) program contracts with private provider Business Psychology Associates (BPA) to manage the array of private SUD treatment service providers. The administrative reimbursement to BPA is capitated, and the treatment services are reimbursed according to a fee per person per service.
Innovative Financing Strategy	Innovative financing strategies—This includes, but is not limited to pay-for-outcomes or payment for an episode of care. As of August 2011, Idaho's Behavioral Health program did not have existing innovative financing structures for substance use disorder treatment or for adult or children's mental health services.

Other reimbursement strategy (please describe)

Other reimbursement strategies—States using other reimbursement strategies for services and activities should describe the methodology and the services and activities that are purchased using this methodology. The adult mental health program uses a federally approved cost allocation method based upon a random moment time study to allocate block grant funds for personnel costs. The funds support the activities of staff throughout the state in providing direct services to clients such as crisis intervention, assertive community treatment, assessments, and other direct services. Behavioral health system development is funded through block grant support of costs associated with State

Reimbursement Strategy Services Purchased Using the Strategy

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Table 5 SAPT - Projected Expenditures for Treatment and Recovery Supports 2012 - 2013

Category	Service/Activity Example	Estimated Percentage of Funds Distributed
Healthcare Home/Physical Health	 General and specialized outpatient medical services Acute Primary Care General Health Screens, Tests and Immunization Comprehensive Care Management Care coordination and health promotion Comprehensive transitional care Individual and Family Support Referral to Community Services 	distribution range
Engagement Services	 Assessment Specialized Evaluation (Psychological and neurological) Services planning (includes crisis planning) Consumer/Family Education Outreach 	distribution range
Outpatient Services	 Individual evidence-based therapies Group therapy Family therapy Multi-family therapy Consultation to Caregivers 	distribution range
Medication Services	 Medication management Pharmacotherapy (including MAT) Laboratory services 	distribution range

Community Support (Rehabilitative)	 Parent/Caregiver Support Skill building (social, daily living, cognitive) Case management Behavior management Supported employment Permanent supported housing Recovery housing Therapeutic mentoring Traditional healing services 	distribution range
Recovery Supports	 Peer Support Recovery Support Coaching Recovery Support Center Services Supports for Self Directed Care 	distribution range
Other Supports (Habilitative)	 Personal care Homemaker Respite Supported Education Transportation Assisted living services Recreational services Interactive Communication Technology Devices Trained behavioral health interpreters 	distribution range
Intensive Support Services	 Substance abuse intensive outpatient services Partial hospitalization Assertive community treatment Intensive home based treatment Multi-systemic therapy Intensive case management 	distribution range

Out-of-Home Residential Services	 Crisis residential/stabilization Clinically Managed 24-Hour Care Clinically Managed Medium Intensity Care Adult Mental Health Residential Adult Substance Abuse Residential Children's Mental Health Residential Services Youth Substance Abuse Residential Services Therapeutic Foster Care 	distribution range
Acute Intensive Services	 Mobile crisis services Medically Monitored Intensive Inpatient Peer based crisis services Urgent care services 23 hour crisis stabilization services 24/7 crisis hotline services 	distribution range
Prevention (Including Promotion)	 Screening, Brief Intervention and Referral to Treatment Brief Motivational Interviews Screening and Brief Intervention for Tobacco Cessation Parent Training Facilitated Referrals Relapse Prevention /Wellness Recovery Support Warm line 	distribution range
System improvement activities		distribution range
Other		distribution range

Table 6 SAPT - Primary Prevention Planned Expenditures Checklist

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State
Information Dissemination	Universal	\$ 145,000	\$	\$
Information Dissemination	Selective	\$	\$	\$
Information Dissemination	Indicated	\$ 0	\$	\$
Information Dissemination	Unspecified	\$	\$	\$
Information Dissemination	Total	\$145,000	\$	\$
Education	Universal	\$ 915,000	\$	\$
Education	Selective	\$ 200,000	\$	\$
Education	Indicated	\$ 1,700	\$	\$
Education	Unspecified	\$ 0	\$	\$
Education	Total	\$1,116,700	\$	\$
Alternatives	Universal	\$ 0	\$	\$
Alternatives	Selective	\$ 5,000	\$	\$
Alternatives	Indicated	\$ 0	\$	\$
Alternatives	Unspecified	\$ 0	\$	\$
Alternatives	Total	\$5,000	\$	\$
Problem Identification and Referral	Universal	\$	\$	\$
Problem Identification and	Selective	\$ 0	\$	\$

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State
Referral				
Problem Identification and Referral	Indicated	\$ 9,000	\$	\$
Problem Identification and Referral	Unspecified	\$	\$	\$
Problem Identification and Referral	Total	\$9,000	\$	\$
Community- Based Process	Universal	\$ 50,000	\$	\$
Community- Based Process	Selective	\$ 0	\$	\$
Community- Based Process	Indicated	\$ 0	\$	\$
Community- Based Process	Unspecified	\$ 0	\$	\$
Community- Based Process	Total	\$50,000	\$	\$
Environmental	Universal	\$ 25,000	\$	\$
Environmental	Selective	\$ 0	\$	\$
Environmental	Indicated	\$ 0	\$	\$
Environmental	Unspecified	\$ 0	\$	\$
Environmental	Total	\$25,000	\$	\$
Section 1926 Tobacco	Universal	\$ 0	\$	\$
Section 1926 Tobacco	Selective	\$ 350,641	\$	\$
Section 1926 Tobacco	Indicated	\$ 0	\$	\$

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State
Section 1926 Tobacco	Unspecified	\$ 0	\$	\$
Section 1926 Tobacco	Total	\$350,641	\$	\$
Other	Universal	\$ 0	\$	\$
Other	Selective	\$ 0	\$	\$
Other	Indicated	\$ 0	\$	\$
Other	Unspecified	\$ 0	\$	\$
Other	Total	\$0	\$	\$

 Table 7 SAPT - Projected State Agency Expenditure Report

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	F. Other
1. Substance Abuse Prevention and Treatment	\$ 13,053,000	\$ 5,062,600	5,891,200	6,000,000	\$
2. Primary Prevention	\$	\$	\$	\$	\$
3. Tuberculosis Services	\$	\$	\$	\$	\$
4. HIV Early Intervention Services	\$	\$	\$	\$	\$
5. State Hospital		\$	\$	\$	\$
6. Other 24 Hour Care	\$	\$	\$	\$	\$
7. Ambulatory/Com munity Non-24 Hour Care	\$	\$	\$	\$	\$
8. Administration (Excluding Program and Provider Level)	\$ 687,000	\$	\$	\$ 633,200	\$ 18,200
9. Subtotal (Rows 1, 2, 3, 4, and 8)	\$13,740,000	\$5,062,600	\$5,891,200	\$6,633,200	\$18,200
10. Subtotal (Rows 5, 6, 7, and 8)	\$687,000	\$	\$	\$633,200	\$18,200
11. Total	\$13,740,000	\$5,062,600	\$5,891,200	\$6,633,200	\$18,200

Table 8 Resource Development Planned Expenditure Checklist

Activity	A. Prevention- MH	B. Prevention- SA	C. Treatment- MH	D. Treatment- SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	\$ 32,854	\$ 109,704	\$ 153,000	\$ 58,600		\$354,158
2. Quality Assurance	\$ 0	\$	\$ 25,000	\$ 236,900		\$261,900
3. Training (Post-Employment)	\$	\$ 20,000	\$	\$ 60,600		\$80,600
4. Education (Pre- Employme nt)	\$ 0	\$ 36,540	\$	\$ 100,000		\$136,540
5. Program Development	20,000	\$ 131,196	\$ 269,267	\$ 406,000		\$826,463
6. Research and Evaluation	\$	\$ 18,556	\$ 0	90,900		\$109,456
7. Information Systems	\$ 0	\$ 35,220	\$	\$ 384,000		\$419,220
8. Total	\$52,854	\$351,216	\$447,267	\$1,337,000	\$	\$2,188,337

IV: Narrative Plan

ACTIVITIES THAT SUPPORT INDIVIDUALS IN DIRECTING SERVICES

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following: 1)Either summarize your State's policies on participant directed services or attach a copy to the Block Grant application(s). 2) What services for individuals and their support systems are self directed? 3) What participant directed options do you have in your State? 4) What percentage of individuals funded through the SMHA or SSA self direct their care? 5) What supports does your State offer to assist individuals to self direct their care?

Idaho Policies on Participant Directed Services

There are several existing sources that focus on participant directed services and policies that are being developed for the Division of Behavioral Health that will provide further detail. The Children's Mental Health Practice Manual (http://infonetdhw/LinkClick.aspx?fileticket= xeHfEo3M9Q%3d&tabid=514&mid=2855), Chapter 1, describes family centered practice and its role in service delivery. Foundational aspects include recognition that families are experts capable of identifying their own goals and solutions, and these can be implemented with support from community partners. Tab 9 of this document (p. 131) describes core values that include "The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided."

The Quality Assurance Policy (see attached) includes a description of stakeholder review systems that provide input and feedback into the mental health system. Stakeholders include, and

are not limited to, the State Planning Council on Mental Health, regional mental health boards, the Office of Consumer and Family Affairs (OCAFA), consumers, family members, state and local correction agencies, courts, Vocational Rehabilitation, Education. Quality assurance reviews may include interviews with family members, treatment providers or other involved parties (see Continuous Quality Improvement Policy, attached).

Self Directed Services for Individuals and Their Support Systems

The Web Infrastructure for Treatment Services (WITS) system includes a treatment planning section. The treatment plan section was written to encourage use of the client's own words and goals (e.g., "My current situation is...," "My overall recovery goal is..."). The WITS discharge includes "My Continuing Care Plan," which is influenced by Mary Ellen Copeland's Wellness Recovery Action Plan (WRAP).

The Substance Use Disorders (SUDS) program contracts with Business Psychology Associates (BPA) to manage the array of community substance use providers, provide training, preauthorize services and collect and report SUD data to the Division. Training to providers includes training on the "Stages of Change" model, with an emphasis on Motivational Interviewing. Motivational interviewing is designed to meet the client where they are in their personal stage of recovery, and provide supports to meet the client's recovery goals. During the initial screening, BPA affirms the client's agreement with the screened level of care and offers the client options of providers that offer that level of care.

The Department of Health and Welfare provides web training through the Knowledge Learning Center (KLC). The SAMHSA Tip 42: Substance Abuse Treatment for Persons with Cooccurring Disorders course provides 20 CEUS, with an online quiz at the end of each module. Division staff have access to this training and are encouraged to complete it if they are working with individuals diagnosed with cooccurring mental health and substance use disorder diagnoses.

Participant Directed Options

The State of Idaho's mental health service delivery system values and supports participant directed options. Mental Health Block Grant funds help to support a contract with the Mountain States Group's Office of Consumer and Family Affairs (OCAFA). The OCAFA established a 40 hour Certified Peer Specialist training program in SFY 2009, based on the Appalachian Group's model. All Certified Peer Specialists are also required to complete an additional week of Wellness Recovery Action Plan (WRAP) training (based on Mary Ellen Copeland's work). The OCAFA supervises paid placements of Certified Peer Specialists at regional Division of Behavioral Health locations. Certified Peer Specialists model recovery and resilience through their work on Regional Mental Health Assertive Community Treatment (ACT) teams and Projects for Assistance in Transition from Homelessness (PATH) teams. Additional Certified Peer Specialists were hired by Pioneer Health to provide Critical Time Intervention (CTI) services through the CMHS Transformation grant funded Idaho Home Outreach Program for Empowerment (IDHOPE). The IDHOPE project began delivering services in pilot project regions 3 and 4 in March 2011.

Idaho also benefits from National Alliance for the Mentally Ill (NAMI) groups. These groups provide family education, support and advocacy. The Boise NAMI group sponsors an annual

NAMI walk as both an awareness event and as a fundraiser for their education and advocacy efforts. Additionally, some groups offer Family to Family education groups.

The Children's Mental Health program has a contract with the Federation of Families (July 2011) that uses some block grant funds to provide education, training and advocacy to families with children with serious emotional disorders. The Federation of Families collaborated with other agencies to develop and offer a Recovery conference in Boise, Idaho in June 2011. The OCAFA and the IDHOPE programs provided panel discussions of the services they provide and the ways that they are able to model recovery and resilience.

Percentage of SMHA and SSA Participants Directing Their Own Care

It is difficult to gauge the percentage of SMHA and SSA participants that direct their own care. Division staff are encouraged to focus on person centered planning for all service recipients. Treatment modalities are designed for consumer and family involvement.

For clients receiving SUD treatment services, BPA offers choice in providers. Some eligible SUD clients are referred through the corrections and/or court system. In SFY 2011, some corrections referred individuals indicated that their probation officer had asked them to see a specific provider. During the SFY 2011 legislative session, decisions were made to reallocate some treatment funds that were previously allocated to the Division were allocated instead to Adult Corrections, Juvenile Corrections and the courts. Fund reallocation was designed to give those partnering agencies control of how they could best determine treatment services for their specific populations.

One of the challenges in ensuring self directed care is that many of the service recipients have been court ordered to treatment. Under those conditions, participants may not have voluntarily chosen to receive Division of Behavioral Health Care services. Once they have been enrolled, efforts are made to encourage increased self direction and planning.

Idaho Supports to Assist Individuals to Self Direct Their Own Care

The Idaho Division of Behavioral Health designed the WITS system to encourage clinicians to focus on person centered treatment planning. Wellness recovery is available through the OCAFA WRAP trainings, and these are also offered in some of the regional programs to center clients. The discharge process for the Adult Mental Health program requires completion of "My Continuing Care Plan" for recovery. The Children's Mental Health program is designed with family involvement as a core principle. Motivational interviewing, stages of change and the SAMHSA Tip 42 training models provide treatment training to providers that encourage client involvement in treatment planning and decision making. The regional boards and the statewide board (both in the current and the planned compositions) focus on consumer and family involvement in system planning, implementation and evaluation.

DATA AND INFORMATION TECHNOLOGY

List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provides information on one or more of the following:

The Division of Behavioral Health's Adult Mental Health (AMH), Children's Mental Health (CMH), and Substance Use Disorders (SUD) programs provide information on publicly funded AMH, CMH and SUD services. The AMH program is using WITS for data collection needs. The CMH program is transitioning from use of FOCUS to use of WITS. The SUD program contracts with Behavior Psychology Associates (BPA) to collect data pertaining to substance use disorders services. Business Psychology Associates uses the eCura ProviderConnect system. This data is submitted to the Division of Behavioral Health. Once adaptations for substance use disorder services are completed and implemented for the Division of Behavioral Health's Web Infrastructure for Treatment Services (WITS) system, this information will be collected in WITS. The State Hospital systems (i.e., State Hospital North (SHN) and State Hospital South (SHS)) provide data on Idaho citizens psychiatrically hospitalized at SHN and SHS using the VistA system. Data on Division of Behavioral Health trainings and SUD prevention is tracked through EXCEL spreadsheets through the Division's Central Office location.

Provider characteristics

The Division of Behavioral Health contracts with vendor FEI to develop, train, implement and host the WITS system. The WITS system is capable of tracking service provider locations and other characteristics. This system has been implemented for Adult Mental Health (AMH) services; data element definitions for the National Outcome Measures were built in WITS using the Client Level Reporting Project data element definitions. The Division of Behavioral Health and FEI are in the process of building data elements to collect and report on required data for SUD and for Children's Mental Health (CMH) program services. The two state hospitals, State Hospital North (SHN) and State Hospital South (SHS) use the VistA data infrastructure system. The Division of Behavioral Health is working on a data warehouse that will allow client data from the VistA system to be crosswalked to the WITS system so that client services can be tracked. The SUD program relies on provider characteristic data provided through BPA, but once WITS is completed for SUD, this data will be collected through WITS.

Client enrollment, demographics, and characteristics

The AMH and CMH programs are able to capture client level data, including client demographics, characteristics, enrollments (admission/discharge), assessments, & nonMedicaid services (type, provider, duration, amount) through the WITS system. The SUD program relies on client characteristic data provided through BPA, but once WITS is completed for SUD, this data will be collected through WITS.

Admission, assessment, and discharge

The SUD program uses the Global Appraisal of Individual Need (GAIN) tool for assessments. The data collected from the GAIN is maintained by Chestnut Health Services and not accessible through BPA's eCura data collection system or through the Division of Behavioral Health's WITS system. Starting in October 2011, Chestnut will submit monthly and quarterly GAINS aggregate data to the Division of Behavioral Health and to individual providers in the SUD provider network.

Services provided, including type, amount, and individual service provider

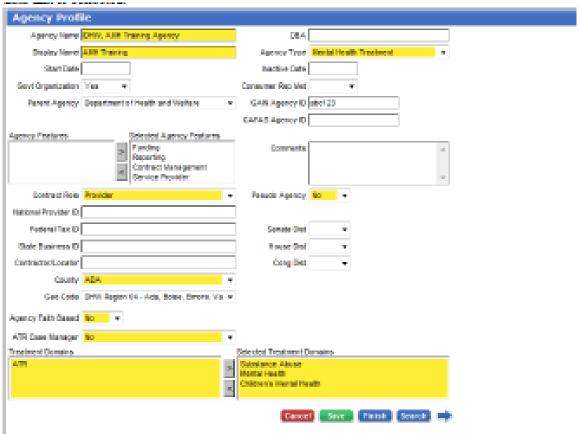
For AMH and CMH programs, service and service provider information is collected through WITS. With respect to SUD, services, types of services, service amounts and service provider information may be requested from BPA. Once WITS is completed for SUD, this information will be collected through WITS.

Prescription drug utilization

The Division of Behavioral Health uses WITS, VistA, Drug Assistant Software, LOCUS/CALOCUS and CAFAS/PECAFAS to track prescription drug utilization for AMH and CMH. Data pertaining to prescription drug utilization for SUD is not available.

As applicable, for each of these systems, please answer the following: For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?

Division of Behavioral Health SUD/AMH/CMH providers (excluding Medicaid) do not have to obtain national provider identifiers. The WITS system is capable of collecting and reporting national provider identifiers. In addition, the WITS screen shot below identifies other pertinent data that is collected:



Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?

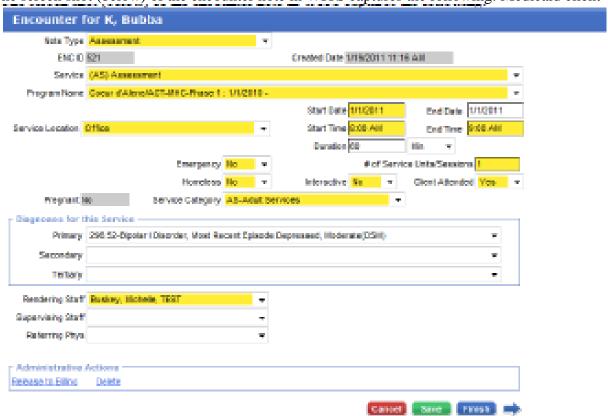
Please see the WITS screen shot above.

Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?

The WITS system uses a unique client identifier based on a numerical value assigned to the letters of the first and last name, the date of birth (DOB), and the Social Security Number (SSN). The identifiers cannot be duplicated in any given provider agency. In theory, extracting information for unduplicated clients can be pulled by identifier. Realistically, there could be the possibility of the same client being assigned multiple identifiers in WITS if the information used to assign the identifier is entered differently (e.g., a client DOB entered differently in Region 1 than in Region 2 will result in two different identifiers). For Division of Behavioral Health purposes, reports are built to look at the identifier and other unidentifiable information. The WITS system does have the ability to aggregate services rendered to the client.

Are client level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?

The screen shot (below) of the encounter note in WITS captures the following: Medicaid client



Medicaid client level encounter/claims service and provider data were not available for CMH in July 2011. Nonbilled service data will be available one year after CMH implements WITS in July 1, 2011.

Does the system comply with Federal data standards in the following areas (use of ICD10 or CPT/HCPCS codes)?

While the WITS system is now using the ICD9 with up to date CPT/HCPCS codes, there are plans to load ICD10

if funding can be identified for Behavioral Health programs. The

CPT/HCPCS codes are editable code tables. These may be updated as new codes and changes are released each year, as long as funding is available to support those costs.

AS APPLICABLE, PLEASE ANSWER THE FOLLOWING:

Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?

As of July 2011, provider and client identifiers in the WITS, VistA and BPA systems did not allow for linkage with Medicaid provider identifiers. Client identification numbers through WITS are generated based on name and birth date. While the WITS system does attempt to capture a consumer's Medicaid number, this is not required or always known when a client profile is created or updated. The Division of Behavioral Health is working on a data warehouse in an effort to allow linkage to other systems.

Are Medicaid data or linked Medicaid behavioral health data used to routinely produce reports?

As of July 2011, WITS was not linked with Medicaid behavioral health data The WITS system does capture the client's insurance type. If the client is identified in WITS as having Medicaid, some reports could be extracted (e.g., service utilization).

Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?

The Division of Behavioral Health works with the WITS vendor, FEI, to address issues related to system interoperability. FEI is working on a Meaningful Use certification. The Department of Health and Welfare's Idaho Health Data Exchange committee includes representation from Medicaid (see http://www.idahohde.org/news/idmedIMages040109.html).

Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?

Idaho received a section 3013 grant for development of a health information exchange under the HITECH Act; the Idaho Health Data Exchange (IHDE) is the state designated entity for recipient of the grant funding. IHDE is a statewide health information organization and has been operational as an HIE since 2009. IHDE includes a clinical data repository. Clinical staff at State Hospital North and State Hospital South can access the repository for clinical information, such as lab results, for patients they are treating. Mental health and substance abuse data are not currently included in the exchange. IHDE's Security and Privacy Committee is reviewing the SAMHSA FAQs related to substance abuse confidentiality and health information exchange to

determine IHDE's next steps in this regard. IHDE, at the invitation of the behavioral health bureau chief, sent a staff member to the SAMHSA Sponsored 2011 Health Information Technology Regional Forum to learn more about the issues and opportunities in this area.

Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

While Medicaid is engaged in efforts to improve their IT system, the Division of Behavioral Health is not routinely included in those plans or efforts.

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records. All public AMH and CMH providers will be using WITS in SFY 2012. The AMH system was implemented in October 2001 and the CMH system is scheduled for implementation in July 2011. Implementation for the State's SUD contracted network of substance use disorder providers is scheduled before the end of SFY 2012.

QUALITY IMPROVEMENT REPORTING

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

The State of Idaho's Division of Behavioral Health includes a Quality Assurance unit. The Quality Assurance unit is designed to ensure Continuous Quality Improvement (CQI) in administrative operations and service delivery. The Quality Assurance (QA) Policy (see attached) describes expectations for quality assurance that include 1) quality management team structure and responsibilities, 2) QA/CQI case reviews, 3) corrective action, 4) performance improvement and 5) stakeholder review systems.

Regional Quality Management Teams are expected to meet at least quarterly. During these meetings, the teams will track programmatic improvements, including customer satisfaction results; review complaints and adverse outcomes/incidents and develop resolution plans; and review data for opportunities to improve and to implement decision making strategies in response to identified trends.

The Continuous Quality Improvement (CQI) Policy (see attached) "...provides direction on the review of Adult Mental Health and Children's Mental Health cases to ensure compliance with Department of Health and Welfare and Division of Behavioral Health rules, policies and best practice standards."

The Division of Behavioral Health works with the Center for the Application of Substance Abuse Technologies (CASAT; go to http://casat.unr.edu/ for additional information) at the University of Nevada for treatment and recovery support service provider certification. CASAT conducts site visits at each provider location. If the provider does not meet Idaho code standards, CASA submits a Corrective Action Plan to the provider and to the Division. The provider submits a written response to each element of the Corrective Action Plan to the Division of Behavioral Health. If the provider submission meets standards, then the Division approves and signs off on the certification.

The Division of Behavioral Health contracts with Business Psychology Associates (BPA) to manage the array of private substance abuse providers. One aspect of this is ensuring the delivery of quality services. The BPA Clinical Quality Checklist and Clinical Chart Audit tools are attached.

CONSULTATION WITH TRIBES

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications. Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Idaho has six different federally recognized tribes. These are the Shoshone Bannock, the Northwest Band of the Shoshone, the Nez Perce, the Coeur d'Alene, the Kootenai and the Duck Valley (Shoshone Paiute) six tribes.

The Division of Medicaid has quarterly engagement with the Tribes which includes policy and process consultation. Quarterly, statewide meeting between Medicaid and the Idaho Tribes focuses on sharing planned Medicaid program changes and consulting with the Tribes about potential impacts of these changes on their programs and members medical care. A Medicaid SharePoint site provides advance notice of planned program changes, and this is available to the Tribes.

The Medicaid/Medicare meeting at Nimiipuu Clinic was initiated by Social Security Public Relations. The Social Security person initiating this meeting found that some Tribal questions relate to Medicaid, some to Medicare and some to Social Security. This office outreach to Tribes tends to be informal and usually includes invitations to local Division of Welfare staff as another resource to answer questions regarding Medicaid eligibility. These are not forums for compliance with Consultation requirements within the Department. These are rather select and small events specifically geared to clinic patient advocate type staff.

The Division of Welfare also has quarterly meetings surrounding Temporary Assistance for Needy Families (TANF) issues for basic welfare programs. The Division of Family and Children Services (FACS) has quarterly engagement with the Tribes through the Indian Child Welfare Advisory Council (ICWAC). The Division of Health has a Cultural Liaison who attends these functions along with the Legislative Council on Indian Affairs. It should be noted that each of the formal Divisional Tribal engagements described above involve different Tribal leadership and programs. For example, Medicaid involves Tribal Clinic managers, Welfare meets with TANF Tribal leaders, and FACS meets with Tribal Social Service leaders.

As of July 2011, the Division of Behavioral Health had no formal relationship with the Tribal leaders. The Division of Behavioral Health SUD provider network includes the tribally owned Benewah Medical and Wellness Center in northern Idaho (Plummer), but interaction with the Division is limited to the facility renewal process. Behavioral Health efforts to engage the Tribal leaders would likely evolve into meetings between the Division of Behavioral Health and Tribal Mental Health and Substance Abuse programs.

SERVICE MANAGEMENT STRATEGIES

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers. In the space below, please describe: 1) The processes that your State will employ over the next planning period to identify trends in over/underutilization of SAPTBG or MHSBG funded services, 2) The strategies that your State will deploy to address these utilization issues, 3) The intended results of your State's utilization management strategies, 4) The resources needed to implement utilization management strategies and 5) The proposed timeframes for implementing these strategies

SFY 20122013 Processes to Identify Over/Underutilization Trends of SAPT/MHBG Funded Services

The Division of Behavioral Health's Quality Assurance Unit was established in SFY 2011 to ensure appropriate regional Community Mental Health Center (CMHC) service utilization and quality of care. Central Office provides oversight of these activities. State Hospital North and State Hospital South are responsible to track and manage state hospital utilization and quality of care. As of July 2011, Medicaid was pursuing a contract with a managed care organization (MCO) with a target implementation date of 7/1/12 for the administration of mental health benefits. A 1915b waiver will be in place as the funding authority to support the MCO contract. Qualis signed a three year contract renewal with Medicaid in June 2011 to provide case management and utilization management services.

Utilization Strategies, Intended Results, Resources and Time Frames

The Quality Assurance Unit is responsible to implement the Division of Behavioral Health's CQI activities. As of July 2011, the central office unit was composed of a mental health clinician/program specialist and program manager. Another program specialist will be hired in SFY 2012 to focus on implementing quality assurance efforts related to the Substance Use Disorder program.

In January of 2011, the Division of Behavioral Health implemented two policies to address the quality and effectiveness of services provided to children and adults. The first policy entitled Quality Assurance, established a Quality Management Team in each of the seven regions in the state. The Quality Management (QM) Team is required to meet at least quarterly to review cases, complaints and customer satisfaction survey results. The QM team also reviews data to assess trends and practice implications. The second policy, Continuous Quality Improvement (CQI), established a process for the Quality Assurance Unit to conduct a random sample review of mental health case files in each region, using an established CQI instrument. The CQI instrument is designed to assess compliance with Idaho rules, policies, and best practice standards. A minimum of five (5) Adult Mental Health and five (5) Children's Mental Health cases are reviewed twice a year in each region. Regions are required to establish a corrective action plan to address each identified area of noncompliance.

The Division contracts with the Management Services Contractor, Business Psychology Associates (BPA), to manage the SUD treatment service delivery through a network of Department approved treatment providers. BPA also provides SUD care management utilization review. Care Management responsibilities include use of a statewide 1800 number for eligibility screenings, to make an initial ASAM PPC2R level of care determination and to prior authorize units of service. The Division's SUD program also oversees substance abuse prevention for those who do not require treatment for substance abuse. The Division contracts with Benchmark Research and Safety (BRS), the Prevention Technical Assistance and Support Contractor (PTASC), to manage an online system for generating program specific prevention data for the National Outcome Measures (NOMS).

The Division of Behavioral Health's Adult Mental Health (AMH) and Children's Mental Health programs are also responsible to assess level of care. The AMH program uses the LOCUS tool and the CMH program uses the CALOCUS tool to assess acuity and level of care service needs.

The two state psychiatric hospitals (i.e., State Hospital North and State Hospital South) operate utilization reviews of the hospital provided service system. The hospitals have their own set of policies and procedures for care utilization reviews. Data is tracked and shared during Division Leadership Team meetings.

The Division of Behavioral Health follows a Utilization Review Plan designed to ensure appropriate service utilization at the two state psychiatric hospitals, the regional Division of Behavioral Health centers (i.e., adult mental health and children's mental health) and the state funded Substance Use Disorder (SUD) provider sites. The Division's Utilization Review Plan is designed to ensure care is provided at a level appropriate to the client's treatment needs. The Plan includes use of a Utilization Review Subcommittee that meets quarterly to 1) review all stages of admissions (e.g., medical necessity for admission, over/underutilization of ancillary services, delays in services, quality of care indicators, adequacy of clinical/medical record documentation, length of stay, and discharge timeliness), 2) report review findings and recommendations to the Division of Behavioral Health's Leadership team, and 3) analyze issues, problems, or individual cases identified through utilization review activities, make recommendations for resolution, and/or recommend referral to other resources. The Division also

conducts a quarterly review of 1) system eligibility and admissions, 2) service utilization, and 3) effectiveness and appropriateness of ancillary and support services, quality of care and discharge planning.

Results of Quality Assurance assessment of trends and utilization review are used by the Division of Behavioral Health's Leadership Team to identify service delivery effectiveness. This information allows identification of services that work well and services that do not appear to be as effective. As efficient and cost effective services are identified that promote recovery and resilience, funds and services may be directed to those areas.

STATE DASHBOARDS (TABLE 10)

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard. In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Priority	Performance Indicator	Selected
Priority Area -Mental Health - Adults:	DBH will continue to support at least 18 state and/or contract- employed Certified Peer Specialists through state general and federal grant funds through PATH, ID-HOPE, and ACT by June 30, 2013.	V
Priority Area -Mental Health - Adults:	At least one (1) Region will have appointed a Regional SOAR Lead, collaborated with their local Social Security Administration (SSA) office, and trained at least 25 Case managers by June 30, 2012	
Priority Area -Mental Health - Adults:	DBH will meet with the Idaho Primary Care Association at least two (2) times to identify needs of shared behavioral and primary health care adult clients and collaborative opportunities between programs by June 30, 2012.	
Priority Area -Mental Health - Children	The DBH Family Supports Contract will require implementation of at least 15 parent education/self-advocacy groups throughout the state by June 30, 2013.	V
Priority Area -Mental Health - Children	DBH will meet with the Idaho Primary Care Association at least two (2) times to identify needs of shared behavioral and primary healthcare child and family clients and collaborative opportunities between programs by June 30, 2012.	
Priority Area -Mental Health - Children	The DBH Family Supports Contract requirements will include holding a minimum of 1 support group and 1 education group per region in the state, every other month, for youth ages 8 - 19 with emotional or behavioral disturbances.	

Priority Area- Substance Abuse Prevention	The DBH contract with the provider manager will require at least (1) evidence-based program in each of at least 30 Idaho elementary, middle schools, and high schools by July 30, 2012.	V
Priority Area -Substance Abuse Treatment	SUD will use the developed assessment tools to gather baseline data on the existing SUD provider network and on the existing SUD service population by June 30, 2013	
Priority Area -Substance Abuse Treatment	FACS staff, including CPS liaisons and SUD program specialists will participate in at least three quarterly meetings to discuss issues related to collaborative service delivery and care coordination to clients with open child protection cases and SUD diag	
Priority Area -Substance Abuse Treatment	SUD will develop a baseline for SUD client satisfaction using responses from the client satisfaction tool by June 30, 2013.	V
Priority Area -Behavioral Health System Issues	The Regional Boards will identify regional needs, plans to develop regional capacity, and plans to provide input into regional behavioral health service provision by June 30, 2013.	~
Priority Area -Behavioral Health System Issues	A written report describing the proposed board structure, roles and responsibilities will be presented to the Cooperative by June 30, 2012.	
Priority Area -Behavioral Health System Issues	The DBH Quality Assurance Unit will complete a written quality improvement plan for DBH services by June 30, 2012.	
Priority Area -Behavioral Health System Issues	At least two (2) Safe and Sober Housing program beds for adolescents in each of three regions (Regions 1, 4 and 6) will be established and operational by June 30, 2012.	
Priority Area -Behavioral Health System Issues	Regional DBH service delivery staff will be required to complete this training module on GLTBQ cultural awareness, which will include the need for awareness of the high risk of suicide of this population, by June 30, 2013.	
Priority Area -Behavioral Health System Issues	The State Mental Health Planning Council and the DBH collaborative meetings will include representation from Tribal leaders from at least two of Idaho's six federally recognized Tribes by June 30, 2013.	
Priority Area -Data and Quality Assurance	Each of seven (7) DBH regions will have at least one consumer survey kiosk installed and ready to use by June 30, 2012.	V
Priority Area -Data and Quality Assurance	DBH will test FEi produced enhancements and modules. FEi will migrate the final tested product into production by June 30, 2012.	
Priority Area -Data and Quality Assurance	DBH will establish timeline for implementation by June 30, 2012.	
Priority Area -Data and Quality Assurance	The functional data warehouse will allow cross walking, increased tracking, and interlinking capability between WITS and VistaA for DBH by June 30, 2012.	

SUICIDE PREVENTION

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target highrisk

populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women Active Duty, National Guard, Reserve, Veterans and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

There is no nationally certified suicide prevention hot line in Idaho. The National Suicide Prevention Lifeline reported 3,700 calls from Idahoans in 2010. The Suicide Prevention Action Network of Idaho (SPAN Idaho) provided a suicide fact sheet in July 2010 based on data from the Idaho Bureau of Vital Records and Health Statistics, the Idaho Department of Health and Welfare, the Centers for Disease Control and Prevention and YRBS Idaho (see attached). According to these statistics, suicide is the 2nd leading cause of death for Idahoans 1534 and for males 1014 years of age. The fact sheet reports that in 2009, 307 people completed suicide, with 77% by men, and 58% involving a firearm. Also in 2009, "14.2% of Idaho youth attending traditional high schools reported seriously considering suicide in 2009," with 6.9% reporting at least one attempt. The State Planning Council on Mental Health identified this as a top June 2011 concern.

The Department of Health and Welfare contracted with Idaho State University's Institute of Rural Health to assess the need and viability of establishing an Idaho Suicide Hotline. This report can be accessed at www.isu.edu/irh/publications/Hotline_Report_2010_web_pwp.pdf. While a suicide hotline is a recognized need, challenges remain in identifying funding sources to establish and maintain operations for this type of resource.

The Idaho Suicide Prevention Council (established in 2006) continues to actively collaborate with other agencies (e.g., Idaho National Guard, Idaho State University Institute of Rural Health, SPANIdaho, Mountain States Group and the Veteran's Administration) to identify funding and resources to establish and implement a suicide prevention hotline. Idaho's Suicide Prevention Council developed a suicide prevention plan in 2003 (go to website http://healthandwelfare.idaho.gov/Portals/0/Children/DocumentsSrtView.pdf. In an effort to update this plan, a Suicide Prevention Plan Development Group met in July and August 2010 to discuss new suicide prevention challenges and collaboration opportunities. Representation was Designed to be inclusive of a range of stakeholders, representation included former legislators, survivors, mental health consumers and their families, aging and adult care providers, youth and school services, public and private mental health providers and veteran's mental health services, Native Americans, Hispanics and advocates for lesbian, gay, bisexual, and transgender (LGBT) persons. The Idaho Council on Suicide Prevention is in the process of finalizing the new plan which should be completed by November 2011. The Idaho State University of Rural Health has been instrumental in supporting and funding the development of the updated Idaho Suicide Prevention Plan.

TECHNICAL ASSISTANCE NEEDS

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families.

The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

State, Providers, and Other Systems

Idaho's technical assistance needs relate to data, collaboration with primary medical and dental agencies and use of technology to enhance the existing service delivery system, especially in rural and frontier areas. As of July 2011, the Division of Behavioral Health's Web Infrastructure Treatment Services (WITS) system had been implemented for Adult Mental Health and Children's Mental Health data needs. The Substance Use Disorders (SUDS) system was in the process of being developed, with a tentative implementation target date by the end of SFY 2012. The VistA system was used for both state hospitals, and it did not link to the WITS data system. Requirements for a data warehouse capable of allowing a crosswalk of WITS and VistA data was being developed, with an implementation target date for SFY 2012. Technical assistance would be helpful with respect to linking WITS and VistA with other stakeholders (e.g., Medicaid, corrections, primary medical and dental care).

One of the focus areas identified by the Idaho Behavioral Health Interagency Cooperative (IBHIC) to transform Idaho's behavioral health care system is coordinating transformation activities with health care reform activities. Technical assistance in effective, cost efficient methods to do this could be useful.

The U.S. Census Bureau (2010) indicates that that Idaho's population is 1,567,582, with 9 rural counties (i.e., no population center of 20,000 or more and six or more persons per square mile), 17 frontier counties (i.e., less than six per square mile) and 18 urban counties. In an effort to expand psychiatric services to rural and frontier areas that are unable to attract or retain a psychiatrist, the Idaho system has used video conferencing to provide telehealth. The high definition video conference system is also used for statewide meetings, including meetings of the State Planning Council on Mental Health. In SFY 2011, there was a cost savings for all video conference users (not just the Division of Behavioral Health) of \$312,366.00. The SUDS system has been exploring the use of social media as an additional cost effective method of expanding treatment services. Technical assistance in this area may be helpful.

Persons Receiving Services, Persons in Recovery and Families

The economy has presented challenges for Idaho's behavioral health service system. Use of peers as service providers can empower the peer, model recovery and serve as a cost effective paraprofessional service modality. As of July 2011, Certified Peer Specialists were working on Assertive Community Treatment (ACT) teams, Projects for Assistance in Transition from Homelessness (PATH) teams and on the Idaho Home Outreach Program for Empowerment (IDHOPE) Critical Time Intervention (CTI) team.

Idaho peers received some technical assistance in SFY 2011. The Centers for Social Innovations provided technical assistance to PATH Certified Peer Specialists in Mental Health First Aid, Data, Outcomes and the PATH to Housing course. Some of the IDHOPE staff also participated in the PATH to Housing course. The IDHOPE project was chosen as a research site for teaching Critical Time Intervention skills, and this training occurred in June 2011. Technical assistance that may benefit persons receiving services, persons in recovery and families may include

training in 1) advocacy techniques, 2) education, 3) combating stigma, and 4) peer operated programs, supports and other services that model recovery and resilience.

INVOLVEMENT OF INDIVIDUALS AND FAMILIES

States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)? Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs? Does the State sponsor meetings that specifically identify individual and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns? How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system? How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Transformation

Idaho has been in the process of reviewing the behavioral health service system for several years with a focus on transforming the system such that "Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery." Goals included the following; 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

Governor Otter signed Executive Order 201101 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. One charge to the IBHIC is to "d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho's Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho's budget, current needs of the agencies, and recommendations of the Idaho Health Care Council." The IBHIC's supplemental list of core services includes Peer Support Services.

Utilization of Individuals in Recovery and Family Members in Development and Implementation of Recovery Oriented Services

The Division of Behavioral Health uses some block grant funds to contract with Mountain States Group's Office of Consumer and Family Affairs (OCAFA) to implement a Peer Certification program and to provide consumer and family member education and advocacy. The Certified Peer Specialist program began in SFY 2009. As of July 2011, there were 83 Peer Specialists who completed the training, with 68 of those passing the certification exam. Certified Peer Specialists are expected to complete their own Wellness Recovery Action Plans (WRAP) in addition to completing the 40 hour Peer Specialist Certification training. As of July 2011, there were 71 Peer

Specialists trained in WRAP, 16 WRAP trained facilitators, and 25 Certified Peer Specialists trained in Peer Support Whole Health. The OCAFA supervises placement of Certified Peer Specialists as Assertive Community Treatment (ACT) staff and as Projects for Assistance in Transition from Homelessness (PATH) staff at each of the seven regional DBH service sites. All PATH staff are also SOAR trained to assist with benefits applications. The OCAFA hired a family member in SFY 2011 to manage the consumer and family member education and advocacy activities; these activities include tracking and sharing information on legislative actions as well as coordinating with family groups (e.g., the National Alliance for the Mentally Ill for Idaho (NAMIID)).

Five Certified Peer Specialists are employed by private provider, Pioneer Health, as Critical Time Intervention (CTI) staff working on the state contracted Idaho Home Outreach Program for Empowerment (IDHOPE) pilot project in Regions 3 and 4. Through this program, Peer Specialists employed as outreach workers provide an assortment of services that include case management, crisis stabilization, assistance with SOAR applications, and helping participants find stable housing and/or employment. Besides helping others, Certified Peer Specialists also model recovery and resilience while working to achieve their own recovery goals.

The Substance Use Disorders program has explored the use of Recovery Mentors to model recovery, focus on wellness and encourage engagement in treatment services. The Division of Behavioral Health would like to continue to promote the use of peers as service providers.

The adult mental health system, delivered by the regions, uses person centered planning to engage eligible program participants and partners to be involved in the intake and assessment process when developing the initial treatment plan and goals. The child mental health system also uses a person centered planning process, which more often includes the family core (e.g., parents, siblings, guardian, etc.).

The Children's Mental Health's (CMH) comprehensive system of care is directed to family participation and involvement at all levels. Programmatic aspects include Parenting with Love and Limits (PLL), Wraparound and therapeutic foster care.

State Sponsored Ongoing Training and Technical Assistance for Child, Adult and Family Mentors

In SFY 2011, the OCAFA facilitated an assortment of training provided to the newly hired PATH Peer Specialists. A week long training in March 2011 addressed SAMHSA evidence based topic areas of Supportive Housing, Supported Employment, Family Psycho-education and Cooccurring Integrated Disorders. Additional March 2011 training covered PATH and cultural competency. The PATH and IDHOPE staff participated in the Centers for Social Innovations PATH to Housing Course in May and June 2011. The PATH Peer Specialists attended another Center for Social Innovations technical assistance training opportunity in June 2011. The June training covered Mental Health First Aid and PATH data and outcomes.

As of July 2011, the Division was contracting with the nonprofit Idaho Federation of

Families to provide several educational and specialized family support services. Federation activities were supported through a combination of block grant and other funds. Activities in SFY 2011 included public training events on topics related to stigma, treatment and transition; regional Family Support Specialists that served as family resources to help access CMH services; and use of the Youth Council that provided outreach and education on mental health issues to youth.

The Division of Behavioral Health's contract with St. Luke's Hospital for Primary Care Physician's training is funded through a mix of block grant and other funds. One eight hour annual conference and monthly training events are offered for primary care physicians, other medical professionals and providers of mental health services on topics related to treating children and adolescents with mental health treatment needs.

The Division of Behavioral Health requires that all state employees working with adults, children, and families complete the "Cultural Diversity" course and the "Cultural Issues in Mental Health Treatment" course on the Knowledge and Learning Center (KLC) Website and also expects adherence to the state policy on Cultural Competency and Linguistics. An intensive Treatment Plan training will be completed in SFY 2012 for all clinicians who develop treatment plans. This training package emphasizes person centered planning and matching client's needs with their goals. Clinicians who develop treatment plans will be expected to complete this Treatment Plan training on the KLC in SFY 2012.

State Sponsored Meetings Identifying Individual and Family Members Issues and Needs The State Mental Health Planning Council meets quarterly. The Council membership includes representation from adult consumers and child and adult family members. The Division of Behavioral Health uses some block grant funds for a Family Supports Contract. The SFY 2012 Request for Proposals (RFP) for this service requires that the contractor's board include at least 51% family driven membership, with at least one child/youth member who has been diagnosed with a serious emotional disorder (SED).

Collaborative efforts with the Department of Juvenile Corrections include the Juvenile Justice Children's Mental Health (JJCMH) meetings and Strengthening Families Round Table meetings. The JJCMH meets quarterly to resolve obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored implementation of a Youth Mental Health Court in three counties (as of July 2011) with interest in expansion to other counties. The Youth Mental Health Court uses the wrap around service model to facilitate treatment planning and coordination. The Strengthening Families Round Table meets every other month to brainstorm innovative ideas for family empowerment.

Opportunities for Individuals and Family Members to Participate in Treatment Planning, Shared Decision Making and the Behavioral Health Service Delivery System

All children, adults and families, along with the help of their clinician and/or case manager have input into the development of their treatment/recovery plan and in deciding what their treatment goals will be. This treatment planning usually occurs in a meeting between the clinician and the client and the client's family, if applicable, after the assessment is complete. In addition, individuals, along with their clinician or case manager develop their own WRAP (Wellness

Recovery Action Plan.) Family membersare often involved in the development of an individual adult's WRAP because many times family members are key persons involved when emergency situations arise. In an effort to make it easier for consumers to complete the MHSIP and YSSF Satisfaction surveys, the Division of Behavioral Health plans to install kiosks for this purpose at all main regional service sites and at both state hospitals by June 30, 2013. Data from these surveys will be used to guide the system of care.

The Idaho Behavioral Health Interagency Cooperative (IBHIC) includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. The IBHIC is charged with guiding transformation of the public behavioral health service system. Plans include establishing a statewide Behavioral Health Council to replace the Councils that were directed to mental health and substance use disorders and replacing similar regional groups with one Behavioral Health Regional Development Board per region. Each regional board will be expected to develop a Regional Transformation Implementation Plan that describes the availability, quality, consistency and effectiveness of Initial and Supplemental Core Services and plans for addressing gaps in any of the service areas. As the system evolves, criteria based on these factors will be used to assess the "readiness" of a region to assume greater responsibility for the management of core services offered in the region.

State Support to Strengthen and Expand Recovery Organizations, Family Peer Advocacy, Self Help Programs, Support Networks, and Recovery Oriented Services

Idaho's Division of Behavioral Health supports the use of Certified Peer Specialists in the Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) programs. Use of Certified Peer Specialists was expanded in SFY 2011 through a Projects for Assistance in Transition from Homelessness (PATH) grant to hire PATH Peer Specialists to provide up to 75% face to face outreach to adults with serious mental illness who were homeless at each regional Division of Behavioral Health site. In SFY 2011, the Division of Behavioral Health was awarded a Center for Mental Health Services Transformation grant to implement the Idaho Home Outreach Program for Empowerment (IDHOPE) pilot project in Regions 3 and 4. This project is based on the evidence based practice of Critical Time Intervention (CTI), but the CTI team for IDHOPE is made of a mix of bachelors/masters level staff and Certified Peer Specialists. The state also strongly supports the System of Care activities, and a new Request for Proposals will be available in SFY 2012 to identify a contractor to help support, empower, and teach families about the System of Care so they can learn to be better advocates for themselves.

USE OF TECHNOLOGY

The following definition is used to guide Idaho's responses to this section: "ICT is the back and forth dialog between the user and the computer. Games are always interactive, and most computer applications are interactive. The user selects a task, and the computer carries it out. Then the user selects another. Many Web pages are also interactive and increasingly function like locally installed applications. Not Interactive A static Web page that has only links to other pages would not be considered interactive. In addition, a small utility program that performs one specific task may run without user interaction. After launching, the utility executes a set of instructions and exits." Read more: http://www.answers.com/topic/interactivity#ixzz10ibJBPF3.

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?

The Division of Behavioral Health has deployed several strategies to support recovery in ways that leverage Interactive Communication Technology (ICT). One strategy includes use of high resolution video conferencing equipment for statewide meetings and for some tele-health medication monitoring services provided by psychiatrists to rural and frontier sites that have difficulty attracting and retaining adequate psychiatric staff. The Divisions of Behavioral Health, Family and Community Services and Self Reliance all have equipment. Equipment is set up in all seven regions of the State of Idaho, at Central Office and at both State Hospitals.

The Department of Health and Welfare maintains a website. This website includes the use of dynamic forms that can be updated when there are changes. In SFY 2012, this side will include the addition of MHSIP and YSSF Consumer Surveys that can be completed through survey monkey.

There are also other ICT uses. The Division of Behavioral Health helped design the Face Book page for CMH Awareness Day. The Division of Behavioral Health has used Go To Meeting and Secure Meeting sites for meetings and training sessions. Share Point use has allowed interactive user feedback and formation of a participant community of editors and donors. The SUD program researched the use of Social Media and presented at the June 2011 Idaho Conference on Alcohol and Drug Dependency (ICADD).

b. What specific applications of ICTs does the State plan to promote over the next two years?

During SFY 20122013, the Idaho Division of Behavioral Health plans to promote use of survey monkey to encourage online completion of MHSIP and YSSF consumer surveys. Additional plans are to establish kiosks at Regional Mental Health Center sites to allow clients to complete surveys at the office.

c. What incentives is the State planning to put in place to encourage their use?

Other than increased ease of use of kiosks and survey monkey to complete consumer surveys, the Division of Behavioral Health has no specific planned incentives to encourage use of ICTs. The use of the video conferencing system is an established way to connect with other parts of the state (especially rural and frontier areas) in a cost effective and efficient manner for trainings, meetings and tele-health.

d. What support systems does the State plan to provide to encourage their use?

The addition of kiosks at Regional Mental Health Center sites will allow clients to complete surveys confidentially at the office location. As surveys may be filled out in conjunction with other appointments, this increases ease of use and likelihood of a higher consumer survey response rate. Increased consumer survey response feedback will help to guide services toward improved outcomes.

e. Are there barriers to implementing these strategies? Are there barriers to wide scale adoption of these technologies and how does the State plan to address them?

There could be several barriers to implementing identified strategies. For example, there may be inadequate funds to support the costs of regionally located kiosks or other types of ICT equipment (palm pilots, laptops, etc). Challenges may arise with respect to implementing ICTs in light of state rules and/or regulations (e.g. setting up twitter, face book, etc). Not all clients may have access to the computer or to the Internet. Some clients may not trust or understand the computer software or how to use a computer. The Division of Behavioral Health will address barriers to ICT implementation through continued education, advocacy and training of both public service staff and clients.

f. How does the State plan to work with organizations such as FQHCs, hospitals, community based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

As of July 2011, the Division of Behavioral Health did not have a formal plan to work with organizations such as FQHCs, hospitals, community based organizations and other local service providers to identify ways that ICTs could support the integration of mental health and addiction treatment services with primary care and emergency medicine.

g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?

The MHSIP and YSSF data will be used to help evaluate program effectiveness. The survey monkey method could also be used to collect other program evaluation data at the client and provider levels.

h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

One measure that is used for judging effectiveness of the video conferencing equipment is the cost savings of holding meetings in this way as compared to paying for travel, lodging and per diem. Effectiveness of using survey monkey for MHSIP and YSSF consumer surveys will be judged by the number of responses that are submitted compared to previous years when surveys were mailed. While the Idaho Department of Health and Welfare's Division of Behavioral Health does not yet have a specific plan for measures and data collection to promote and judge use and effectiveness of all ICTs used, increased use of ICTs will result in development and implementation of data and outcome measures to judge use and effectiveness.

SUPPORT OF STATE PARTNERS

The success of a State's MHSBG and SAPTBG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

Idaho has been in the process of reviewing the public behavioral health service system (i.e., mental health and substance use prevention and treatment) for several years, with a focus on transforming the system such that "Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery." Governor Otter signed Executive Order 201101 on January 27, 2011, which established the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) Counties. One charge to the IBHIC is to "d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho's Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho's budget, current needs of the agencies, and recommendations of the Idaho Health Care Council."

State Education Agency

The Division of Behavioral Health recognizes the importance of collaborative relationships with the State Department of Education with respect to examining current regulations, policies, programs, and key data points in local school districts to ensure that children are safe; supported in their social emotional development; exposed to initiatives that target risk and protective factors for mental health and substance use disorders; and for those youth at risk of emotional, behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out of district placements.

The Division's Children's Mental Health (CMH) program and the Department of Education collaborate with local school districts to implement intensive community and school based programs for children and youth diagnosed with serious emotional disorders (SED). School programs range from traditional day treatment to classroom based models. Independent Idaho local school districts respond to the Individuals with Disabilities Education Act (IDEA) for eligible children. IDEA services include child find/referral, evaluation/eligibility, individualized education plans (IEP), related services, least restrictive environments, review and reevaluation, transition requirements and consideration of behavior management needs.

The Special Education Advisory panel is a federally funded group within each state that provides feedback to the department of education on issues that impact special education consumers. The Division of Behavioral Health participates as a voting member of the Idaho panel during their quarterly meetings. The Department of Health and Welfare provides technical assistance and professional subject matter expertise on youth diagnosed with serious emotional and/or social disorders.

The Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) workgroup's assessment is described in the "Idaho Substance Use Disorder Prevention and Treatment System: A Collaborative Strategy for 20082012." One of the focus areas described in this report is collaboration with the Department of Education to implement core best practice and outcome measures for substance abuse prevention services in grades K12.

State Medicaid Agency

The Division of Behavioral Health is the Medicaid provider for Substance Use Disorder treatment services in Idaho, and these services are managed through a contract with Business Psychology Associates. The Division of Medicaid contracts with private providers for delivery of mental health services to Idaho children and adults.

Medicaid benefits were designed to be reflective of participants' needs as a part of Medicaid Modernization. Three benefits plans, the Medicaid Basic Plan Benefits, the Medicaid Enhanced Plan Benefits and the Medicare/Medicaid Coordinated Plan Benefits were effective as of July 1, 2006. The Medicaid Medicare Coordinated Plan has been in effect since April 1, 2007. Blue Cross of Idaho started with their plan on April 1, 2007 and United Health Care started with their plan on May 1, 2007. Partial Care, Service Coordination and Psychosocial Rehabilitation mental health services are excluded from the Medicaid Basic Plan Benefits except for diagnostic and evaluation services to determine eligibility for these services. These services continue to be covered under the Medicaid Enhanced Plan Benefits. The services available in the Medicaid Enhanced Plan include the full range of services covered by the Idaho Medicaid program. Medicaid Basic Plan Benefit participants are limited to twenty six (26) separate outpatient mental health clinic services annually and ten (10) psychiatric inpatient hospital days annually.

In SFY 2008, there were two major changes in Medicaid. Tele-health services were expanded to allow physicians to perform tele-health in any setting in which they are licensed. A benefit was added to allow for family therapy without the client present.

The availability of mental health services in the private sector has been affected by the economy. The Division of Medicaid implemented several strategies to control rising expenditures in Medicaid Mental Health services. Legislatively approved changes to clinic option rules included decreasing the number of partial care hours from 56 to 36 hours per week in 2004, with this benefit subsequently reduced to 12 hours per week in 2009. Psychosocial Rehabilitation (PSR) services were reduced from 20 to ten hours per week, and PSR crisis services were reduced from 20 to ten hours per week in 2009. In SFY 2010, House Bill (HB) 701 provided legislative intent for Medicaid program flexibility for FY 2011. The 2010 Idaho State Legislature approved Rules Governing Medicaid CostSharing (IDAPA Chapter 16.03.18) that described the sliding scale, premium payments and premium waivers. Medicaid Omnibus Bill (HB 708) continued pricing freezes from SFY 2010 through SFY 2011; this bill allowed additional budget reductions. The 2010 Idaho legislature directed Medicaid to negotiate pricing and service changes with Medicaid providers to meet the projected \$247 million budget deficit for SFY 2011. Medicaid solicited input in May 2010 about service reductions through www.MedicaidNeedsYourIdeas.dhw. idaho.gov. The 2011 legislature capped psychosocial rehabilitation services for adults 21 and older diagnosed with serious and persistent mental illness to four hours per week.

As of July 2011, Medicaid was pursuing a contract with a managed care organization (MCO) with a target implementation date of 7/1/12 for the administration of mental health benefits. A 1915b waiver will be in place as the funding authority to support the Managed Care Organization (MCO) contract. The Divisions of Behavioral Health and Medicaid collaborate with consumers and other state agencies to implement the "Money Follows the Person" Home Choice Program. In SFY 20122013, the Division of Medicaid will consult with the Division of Behavioral

Health's SMHA and SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.

Health Insurance and Health Information Exchanges

In March 2010, the new health reform law (Patient Protection and Affordable Care Act; also called ACA) was enacted. It provides new options for coverage by expanding Medicaid eligibility to more low income people and creating state based health insurance "exchanges" through which insurance coverage can be purchased. The State of Idaho's Department of Insurance (DOI) obtained a grant for Health Insurance Exchange planning in October 2010.

Idaho received a section 3013 grant for development of a health information exchange under the Health Information Technology for Economic and Clinical Health (HITECH) Act; the Idaho Health Data Exchange (IHDE) is the state designated entity for recipient of the grant funding. Operational as a Health Information Exchange (HIE) since 2009, the IHDE statewide health information organization includes a clinical data repository. Clinical staff at State Hospital North and State Hospital South can access the repository for clinical information (e.g., lab results) for patients they are treating. IHDE's Security and Privacy Committee is reviewing the SAMHSA FAQs related to substance abuse confidentiality and health information exchange to determine IHDE's next steps in this regard. IHDE, at the invitation of the behavioral health bureau chief, sent a staff member to the SAMHSA sponsored 2011 Health Information Technology Regional Forum to learn more about the issues and opportunities in this area.

While mental health and substance abuse data are not currently included in the exchange, the Division of Behavioral Health has had preliminary discussions with IHDE staff regarding integration of Behavioral Health information into the exchange. The Division of Behavioral Health plans to participate on IHDE's privacy and confidentiality subcommittee in SFY 2012.

State Department of Justice

The Division of Behavioral Health works with the Department of Corrections and Department of Juvenile Corrections to 1) develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; 2) promote strategies for appropriate diversion and alternatives to incarceration; 3) provide screening and treatment; and 4) implement transition services for those individuals reentering the community.

As of July 2011, there were several established formats for collaboration between the Division of Behavioral Health and Juvenile Corrections. The Department of Health and Welfare has Memorandum of Agreements with the Department of Juvenile Corrections and all of the county administered juvenile detention facilities in the state for placement of clinicians in juvenile detention centers. Clinicians placed at juvenile detention centers assist with evaluations, service referrals and crisis counseling for both mental health and substance abuse. The State of Idaho uses some of the state general funds allocated to the Children's Mental Health program to support the costs of those placements. Other collaborative efforts with the Department of Juvenile Corrections include the Juvenile Justice Children's Mental Health (JJCMH) meetings

and Strengthening Families Round Table meetings. The JJCMH, which includes members from county probation, Department of Juvenile Corrections, Department of Education, parent advocates, the court system, Department of Health and Welfare, and outside providers meets quarterly to resolve obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored dissemination on the implementation of a Youth Mental Health Court in three counties (as of July 2011) with interest in expansion to other counties. The Youth Mental Health Court uses the wraparound service model to facilitate treatment planning and coordination. The workgroup has adopted a definition of family involvement and is working on specific strategies for family involvement across systems. The Strengthening Families Round Table meets every other month to brainstorm innovative ideas for family empowerment and support.

Collaborative efforts with the Department of Correction and courts include service to individuals referred through mental health courts. The Division of Behavioral Health's Adult Mental Health program serves eligible mental health court referred clients primarily through Assertive Community Treatment (ACT) teams in each region. ACT staff work closely with court representatives to develop individualized treatment plans for shared clients. Treatment plans are designed to help participants stabilize and learn additional life management skills (e.g., taking medications, ending drug/alcohol abuse, avoiding criminal activities). ACT staff attend weekly court sponsored meetings to discuss progress and needs of mental health court referred clients. During SFY 2009 and SFY 2010, Mental Health Court Utilization operated at approximately 90% of capacity. The Division of Behavioral Health's Substance Use Disorders (SUD) program has Memorandum of Understandings with Idaho Department of Correction, Idaho Department of Juvenile Corrections and the courts for coordination of the delivery of SUD services to their respective populations.

Two laws passed in 2011 were relevant for drug court and/or mental health court participants. The first, HO225, allows for some persons charged with or convicted of a crime of violence to be admitted to drug court after consultation with the drug court team and with the consent of the prosecuting attorney. Law HO226 allows courts the option to allow a defendant on probation to have a felony conviction reduced to a misdemeanor upon a finding that such action was compatible with the public interest. Providing a chance for such defendants to have their convictions set aside offers incentive to abide by the terms of probation and increases employment and educational opportunities.

The Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) workgroup's assessment is described in the "Idaho Substance Use Disorder Prevention and Treatment System: A

Collaborative Strategy for 20082012."

It indicates that "The System addresses individual, community and tribal needs statewide for effective and accessible prevention, education, assessment, early intervention, treatment, recovery support services and post treatment support," (p. 3). It adds that the "System strives to maintain an uninterrupted, well coordinated continuum of services to clients and their families within and outside of the criminal justice system." Identified needs in the ICSA plan that were not complete by July 2011 (Appendices, p. 3, pp. 911) included collaboration with local and state

correctional agencies and detention facilities to develop shared resource methods to ensure effective implementation and delivery of intervention and treatment services to adult and juvenile populations in correctional and detention facilities. Another goal identified in this report was to work with the Idaho Department of Correction and Juvenile Corrections and county probation to identify protocols to integrate treatment with probation services.

The 20122013

MHBG/SAPT Block Grant will focus on mental health and substance abuse prevention and treatment for children and adults. The Departments of Correction and Juvenile Corrections will continue to play a collaborative role in working toward achieving these goals through IBHIC efforts to implement the identified behavioral health transformation plan. The Division of Behavioral Health efforts will continue to collaborate with these Departments and with the courts to help individuals and families navigate the system of care continuum, prevent or divert from incarceration and facilitate smooth transitions for incarcerated individuals back into the community of choice.

State Public Health Authority (Including Maternal and Child Health Agency)

Medical services for children with SED may be funded by Medicaid, Children's Health Insurance Program (CHIP), private insurance, county welfare services or private pay modalities. House Bill 376 (2003) directs that medical coverage be provided for children and adults with income between 150185% of the Federal Poverty Guidelines. In response to this legislation, CHIPB provides low cost health coverage to children without insurance who do not not qualify for either Medicaid or regular CHIP services.

Eligible children and families may access medical and preventative health services through the Idaho Department of Health and Welfare seven regional offices, through Idaho's seven local public health districts, and other participating organizations and providers. Health districts collaborate with the Department of Health and Welfare and other state and local agencies. Each District has a Board of Health with members appointed by that district's county commissioners.

Districts respond to local service needs, with some resource and service variation among districts and through contracts with the Department of Health and Welfare. Services may include community and home health nursing (i.e.,family planning, immunizations, school based nursing); environmental health; Women with Infants and Children's (WIC) supplemental nutrition program for women, infants and children; and school based oral health services (i.e., education, fluoride mouth rinse, fluoride varnish and sealants). Other partners, such as Delta Dental and Terry Riley Health Services, provide oral health services. While few Idaho dentists accept Medicaid, there are Idaho dentists that donate time to provide free dental care for children and low income families. The Idaho Oral Health Alliance, a nonprofit organization, is also working toward increased access to oral health care.

The Division of Public Health's Bureau of Community and Environmental Health conducts a variety of health education and health promotion programs directed to encouraging healthy choices and healthy behaviors. Programs include adolescent pregnancy prevention, comprehensive cancer control, coordinated school health, diabetes prevention and control, environmental health (including a public listing of properties seized as clandestine drug

laboratories), Fit and Fall ProofTM (fall prevention exercise for seniors), heart disease and stroke prevention, tobacco prevention, sexual violence prevention, lchronic disease self management, physical activity and nutrition, oral health and injury prevention and surveillance (i.e., contract for poison control services). The Bureau of Community and Environmental Health is actively working on programs to promote healthy communities and to address chronic disease self management. Some of these areas are relevant to Idaho citizens from both primary and behavioral health perspectives. The Bureau of Community and Environmental Health's past collaborative efforts with the Division of Behavioral Health include the SFY 2010 H1N1 Response Workgroup and the Substance Prevention and Treatment Tobacco Project.

The Division of Public Health and the Division of Behavioral Health actively participate in the Idaho Suicide Prevention Council and the recent development of the Idaho Suicide Prevention Plan. This relationship fostered a collaborative effort with the State Department of Education to address suicide prevention, intervention and postvention in schools and local relationships between schools, law enforcement and regional Division of Behavioral Health staff. The Division of Public Health also provides emergency services, public health laboratory services, health preparedness and resource development (rural health), immunizations, food protection, epidemiology, Women's Health Check, WIC, family planning/STD/AIDS, children's special health and vital records and health statistics. Both Divisions welcome the opportunity to identify future collaborations and linkages that encourage primary and behavioral health care for Idaho citizens to address the whole person.

State Child Welfare/Human Services Department

The Division of Behavioral Health works with local child welfare agencies to address the trauma and mental and substance use disorders in families that often put their children at risk for maltreatment and subsequent out of home placement and involvement with the foster care system. The Department of Health and Welfare's Division of Behavioral Health (DBH) focus is on program and policies related to behavioral health (i.e., adults diagnosed with serious mental illness, children with serious emotional disorders and adults and children with substance use disorder diagnoses). The Department's Division of Family and Children's Services (FACS) is responsible to manage issues related to child welfare, protection, foster care and adoption.

The Division of Behavioral Health has a designated program specialist that serves as a liaison between the DBH and FACS for consultation on issues related to accessing mental health services for children served through the child protection and adoption programs. The two Divisions collaborated on the design of a Treatment Foster Care program and an associated program to train Treatment Foster parents. Staff from both Divisions were trained on the Treatment Foster Care model and the training program for foster parents.

The DBH Substance Use Disorders (SUD) program has a designated SUD program specialist who serves as a liaison with FACS to help coordinate care for clients with open child care cases who also need substance abuse services. The SUD program has also partnered with FACS and the courts to develop three Child Protection Drug Courts (Regions 2, 5 and 6). These courts and all related treatment services are funded through a five year Regional Partnership federal grant that was awarded to the Division of Behavioral Health, and that will end in September 2012.

Representatives from the Division of Behavioral Health participated in the development of the Child and Family Services Review's (CFSR) Program Improvement Plan (PIP) and also participated in onsite CFSR reviews. A Memorandum of Understanding between the DBH and FACS was signed 4/2011 regarding infant and early childhood mental health services (see DHW Infonet Children's Mental Health at http://infonetdhw/Divisions/BehavioralHealth/Childrens MentalHealth.aspx . Another Memorandum of Understanding outlines the process for coordinating services to children served in both programs. The Department's Service Integration program facilitates family efforts to navigate the range of Department programs and services. The Service Integration program works with Idaho's Health Information and Referral Center, or the 211Idaho CareLine. The CareLine provides referral information (including housing and other resources) through the statewide 211 number.

STATE BEHAVIORAL HEALTH ADVISORY COUNCIL

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHSBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State. Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

As of August 2011, the State Planning Council on Mental Health and the Regional Mental Health Advisory Boards provided consultation on issues and services for persons diagnosed with a serious mental illness and/or a cooccurring substance use disorder. The Idaho State Planning Council on Mental Health's responsibilities included participation in monitoring, reviewing and evaluating adequacy of services and providing review and input into the Mental Health Block Grant. During the next 21 months, the Idaho State Planning Council on Mental Health will change to reflect attention to behavioral health needs encompassing both mental health and substance use disorder issues and services.

For the past several years, Idaho has been reviewing the structure of the public behavioral health system. Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff's Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision; "Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery. Goals included the following; 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

The BHTWG's efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho's Behavioral Health System (October 28, 2010). This report's recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council to the State Behavioral Health Council; establishing the Behavioral Health Interagency Cooperative to oversee transformation efforts; and adopting the BHTWG's proposed Array of Core Services "...as the 'floor' of services they seek to make available in each region." The report recommends, "...that this array be maintained as the goal for regional planning and capacity building; and that is also be used as a measure by which to indicate progress toward a truly transformed behavioral health system..." Core regional services recommended by the BHTWG include psychiatric emergency and crisis intervention services; assessments and evaluations; designated examinations and dispositions; inpatient psychiatric hospitalization; medication management; case management; Assertive Community Treatment, intensive case management, Wraparound Services; psychotherapy; intensive outpatient; drug screening; alcohol and drug residential treatment; 24hour out of home treatment interventions for children & adolescents; illness self management; peer support; prevention; early intervention for children and adolescents; supported employment; supported housing; transportation; and day treatment, partial care and partial hospitalization.

Services will be provided in accordance with statewide standards which will include monitoring for quality, consistency, and effectiveness. The State Behavioral Health Authority will be responsible to develop and monitor the statewide standards of care for the initial and supplemental care services.

Each Behavioral Health Regional Development Board will be expected to develop a Regional Transformation Implementation Plan that describes the availability, quality, consistency and effectiveness of Initial and Supplemental Core Services and plans for addressing gaps in any of the service areas. As the system evolves, criteria based on these factors will be used to assess the "readiness" of a region to assume greater responsibility for the management of core services offered in the region.

Governor Otter signed Executive Order 201101 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. One charge to the IBHIC is to "d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho's Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho's budget, current needs of the agencies, and recommendations of the Idaho Health Care Council."

As of 5/13/11, the IBHIC "to do" list was broken into four phases. All phases began with finalizing funding and ended with providing an annual status report to the Governor. **Phase 1** also included planning regional behavioral health development boards and state behavioral health planning council (e.g., identifying proposed membership, proposing an implementation timetable, soliciting and reviewing input and drafting legislation to implement regional behavioral health development boards to submit to the 2012 legislature); establishing core

services for all regions and drafting 2012 legislation proposals; developing a transformation work plan, communications protocol and proposed transformation activity funding for SFY 2013; and reviewing SUDS treatment services and data report elements. Additional **Phase 2** activities included finalizing core services standards for the transformed behavioral health system; initiating regional transformation efforts and coordinating transformation activities with health care reform activities. **Phase 3** activities included developing a 'Transformation Implementation Plan' that applies to all Cooperative entities; developing regional Transformation Implementation Plans; monitoring and evaluating phase in and recommending adjustments to State and Regional Transformation Plans; and coordinating transformation activities with health care reform activities. **Phase 4** included continuing phase in of transformation, drafting legislation to implement the next phase; and coordinating transformation activities with health care reform activities.

TABLE 11 LIST OF ADVISORY COUNCIL MEMBERS

Name	Type of Agency	Agency or Organization Represented
Phyllis Vermilyea	State Employees	Mental Health
Gary Hamilton	State Employees	Vocational Rehabilitation
Julie Williams	Leading State Experts	Housing
Teresa Wolf	Providers	Region II MH Advisory Board
Pat Guidry	Leading State Experts	Medicaid
Rick Huber	Individuals in Recovery (from Mental Illness and Addictions)	Region V Consumers
Kathie Garrett	Leading State Experts	Idaho Council on Suicide Prevention
Pam Hirsch	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Native American Community
Michael Hinman	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Region VII MH Advisory Board
Sharon Block	Leading State Experts	Region V MH Board

Linda Hatzenbuehler	Leading State Experts	Region VI MH Advisory Board
Lisa Koltes	State Employees	Mental Health
Stan Calder	Individuals in Recovery (from Mental Illness and Addictions)	Region 1 Consumers
Martha Ekhoff	Individuals in Recovery (from Mental Illness and Addictions)	Office of Consumer Affairs
Linda Johann	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Region I Parents
Barbarba Kauffman	Individuals in Recovery (from Mental Illness and Addictions)	Region II Consumers
Courtney Santillan	Providers	Advocate- Idaho Federation of Families for CMH
Amber Seipert	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Region II Parents
Michael Stayner	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Region VI MH Advisory Board
Lynn Whiting	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Region VII Parent

TABLE 12 BEHAVIORAL HEALTH ADVISORY COUNCIL COMPOSITION BY TYPE OF MEMBER

Type of Membership	Number	Percentage
Total Membership	20	
Individuals in Recovery (from Mental Illness or Addiction)	4	
Family Members of Individuals in Recovery (from Mental Illness or Addiction)	6	
Vacancies (Individual or Family Members	0	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	10	50%
State Employees	3	
Providers	2	
Leading state Experts	5	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	10	50%

Comment on the State Plan

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

The Idaho Division of Behavioral Health values public comment on the State SAPT/MHBG block grant Plan for 20122013. Several opportunities for input were provided for public comment from an assortment of stakeholders during plan development.

Efforts were made to work with identified state partners that collaborate to serve Idaho citizens receiving SMHA or SSA behavioral health services. Discussion and letters of support were obtained from multiple other collaborating agencies (see attachments and Support of State Partners section).

The read only WebBGAS login was provided to multiple stakeholders as soon as it was available. Stakeholders included the State Planning Council on Mental Health, the Office of Consumer and Family Affairs, the Federation of Families and regional Division of Behavioral Health offices. Regional sites and Planning Council members were encouraged to share login information with Regional boards and other mental health and substance abuse providers and resources. Comments were sent to Heidi Lasser and Cynthia Clapper, the 20122013 Idaho State Planners for the combined block grant application.

The State Planning Council on Mental Health discussed the block grant application during their August 23, 2011 meeting. As appropriate, comments and plan revisions were included in the final product.