Regional Behavioral Health Board

Gaps and Needs Analysis

2015

Please provide a brief description for each of the columns listed. Include additional information as needed.

Identified Regional Service Needs and Gaps *Relating to Prevention, Treatment and Rehabilitation Services*	**Short Falls and Challenges**	**Project Proposals and Progress** *Including those related to Family Support Services and Recovery Support Services*	**Improvement and Strategy Measures**
MH/SUD Crisis Services Detox Regions – 1,2,3,4,5,7	• Lack of crisis services with health care status and 24 hour availability • Lack of general and intensive outpatient providers in rural areas • Lack of capacity for local ERs to identify/manage/address/ acute crisis needs • Lack of SUD prevention, early intervention services and residential options • Lack of case management services • Better crisis response plan • High demand on crisis center and additional centers are needed • Increased need for diversion	• Continue to survey steak-holds to prioritize needs • Research results submitted to legislature • All Substance Abuse Providers need to be certified to treat dual diagnosis • Adults: Community Recovery Centers to assist those in recovery • Improve communication about hospital actions that limit bed availability and result in diversion to other hospitals out of region • Engage the new BHC Director in community planning • Explore options for sub-acute detoxification services	• CDA selected as site of crisis center 23 hour voluntary holds • Collect data from primary and secondary consumers on perception of their needs for services • Latah County NAMI assisting with WSU data collections for Region 2 • Searching for funding that incorporates individuals with dual diagnosis legislature need to pass/approve Medicaid Expansion/Restructuring • Youth: Data/outcomes from Shelter Care, Prevention data/outcomes from schools,

	programs • Need to de-criminalize substance use disorders • Additional resources for community supervision • Lack of local detox facilities	• Increase number of beds available for adults and youth • Alternative resources for the waiting period until a bed becomes available • Create transportation options to transport to nearest available bed or crisis center • Have a crisis center open and running 24/7 in all Regions • Community support and awareness • Utilization of existing buildings to house the facility • Further support for community recovery centers • Provide for additional probation officer s based on per capita populations • Establish subsidized respite care program • Provide training for first responders on mentally ill children and their families	decrease in youth hospitalizations and referrals to juvenile probation • Adults: decrease in Probation and Parole, incarceration, hospitalization, client holds, and increase in case management. • Address psychiatric beds at the quarterly PCH (protective custody hold) Meetings. • Create a list of what is currently available with a payment source and seek funding opportunities • Create a list of what is being used now for detox • Enhance communications between provider and law enforcement to create a more efficient process • Increase awareness and promote the need for a Crisis Center
Access to Psychiatric Services for both Adults and Children Regions 1,2,4,5,7	• Funding for Tel-Health/ Insurance and the structure is inadequate • Best use of existing TH facilities • PCP not willing to prescribe psychotropic RX • Lack of Psychiatric Providers who can subscribe • Limited staff at BHC on weekends. • Lack of dependable access to	• Increased uses of Psych NP • Continue use of tele-health in outlying areas and provide state-subsidies for professionals willing to work in outlying areas. Load re-payment options and identify a facility/site to house the equipment • Psychiatric Mid-level providers • Use of existing facilities and	• ACA increased access • Advocate for local tele-health services and change IDAPA SUD regulations to allow clinical supervision via Tele-health • Partner with North-West Children's Home for psychiatric services • Acquire data on frequency of use of ERs for Behavioral

	psychiatric beds • Lack of understanding around medical necessity determination for CBRS • Mental health services for families in rural areas • Inability to access reimbursement for prevention or treatment • SOAR needs faster accessibility to Medicaid approval • Lack of available child psychiatrists • No short-term acute services for youth • Expand services for infant & toddlers • Psych-education for agencies, school personnel, & juvenile justice system on Trauma-Informed Care • Post adoption services for children with SED • Use of evidence-based practices for children & for parent education • Better pay for psychiatrists • School loan repayment for physicians • Increase Medicaid payments	building that are not currently being used to house Community Recovery Center, Centers for Community Health, and as satellite sites for providers • Provider Trainings – Demonstration of medical necessity for care to include CBRS • Support Medicaid expansion or Health Plan Idaho. • Increase SOAR trained professionals in the area. Decrease time frame for those in need to access services. • Children's Mental Health Planning Council • Psychiatric Mid-level Providers • Children's mental health first responder training	Health Services • Research and seek out funding sources and programs that support tele-health initiatives such as – The Healhtcare Connection Fund – Agency for Healthcare Research and Quality Small Research Grant program • Start a "mobile clinic" to take MH services to patients in remote areas • Engage and educate community leaders and private businesses about the positive effects that enhanced access to behavioral health has on communities • Reopen regional satellite office. • Collect data on psychiatrist's salaries • Publicize the loan repayment program
Financial help with Medications for both Children and Adults Regions 1,5	• Person to apply for aid from drug companies • Complicated paperwork requiring assistance to prepare • Demand exceeds availability	• Use a 340 B drug program for the community • Increase access to med-management to reduce avoidable readmissions • Enhance communication with	• Create awareness and provide accurate information about what med-management is • Engage and include community providers in the

		care-givers across the continuum of care • Improve the perception of "Med. Management" and why it is a necessary component of care	conversations addressing this need • Increase access to medications by addressing cost and affordability
Sustainable Housing for the Homeless and Transitional Populations **Regions 1,2,3,4,5,7**	• Community acceptance, stigma • Limited funding for housing • Lack of Safe and Sober Housing for males/females For both Adults and Juveniles • Lack of shelter, transitional, residential or supportive care facilities insufficient for the demand and need	• Apply for ID Housing monies • Housing for felons • PATH therapeutic foster care • Address housing policies that • Establish an Emancipation Home type of program • Develop temporary residential housing and treatment for youth with mental illness who are unable to remain in homes • Well-managed, clean transitional housing units • Housing opportunities that "screen in" individuals rather than "screen out" individuals • Engage more housing providers in case management of existing/potential residents, connect to Community Recovery Centers and peer/Recovery supports • Address policy of requiring 24 hours homelessness for those leaving institutions (jail, hospital) before eligible for shelter • Develop additional partnerships and linkages to increase housing options	• Develop sustainable housing for men, women, youth; group homes or secure homes • Explore grant opportunities for housing • Create Housing committee on Regional Boards • Partner with local colleges to research grants and work on data collection • Decrease risk of homelessness to this vulnerable population • Have a housing representative educate the RBHB regarding statistics and housing options for the behavioral health population. • Engage our community members while educating about the social and fiscal benefits of crisis/transitional housing • Capture sources of funding for first-month rent and deposits • Research functioning housing models in other regions/ states and address hurdles

			encountered during state-up • Research and collaborate regarding the opportunity to renovate and use existing vacant dwellings/structures.
Respite/Therapeutic Foster Care for both Children and Adults Regions 1,2,4 CMH Day	• Funding to provide training • Lack of available affordable respite care • Funding for services • Licensure for Day Treatment • Increase number of therapeutic foster homes	• Train volunteer families to accept referrals on temp basis • PATH therapeutic foster care • Youth: Shelter Care, a form of short-term intervention, residential respite care	
Suds/MH Parent Education, Training and Services for both Children and Adults to include Intervention & Prevention **Regions 1,3,4,5**	• Family education needed • Community education, survey of what is needed in specific communities • Parenting classes are available – need to help insure people know it is available • Community Acceptance; stigma • Individual SD Resistance • Funding from MH and SUD groups and connecting of current available resources • Idaho does not have DEC Alliance protocol in place; need system in place to identify kids at risk.	• Expansion of behavioral health youth mentoring program, connecting provides with needs in the community • Develop a resource for employers that addresses common questions in an effort to support success for both parties • Expand Mental Health First Aid training • Normalize the concept of attending parenting classes in effort to boost attendance and provide valuable tools for families • More afterschool programs with the assistance of applications for the State Dept. of Education 21st Century Grant, • Increase school participation in Prevention Block Grant	• Use resources of advocacy groups to start: NAMI, IFFCMH • Data/outcomes of referrals through judicial system, adult/juvenile probation and hospitalization. • Public education about behavioral health and community wellness issues • Seek funding sources for promotion and delivery of educational material • Collaborate with OPTUM to promote and expand the Mental health First Aid Trainings to a broader audience • Work towards evaluating why parenting classes have low attendance and consider re-evaluating • QPR Training

		funding, • Engage Mayor's Youth Advisory Councils to promote healthy youth involvement, • Engage BHB to assist in the writing of grant funding opportunities • Address needs of children in dangerous drug environments • Formation of community-based partnerships with agencies across multiple disciplines • Support state services and local communities to develop efficient/effective strategies/for avocation of victims • Implement more prevention programs within schools.	• Overall reduction of recidivism, incarceration, and hospitalization by changing environmental strategies • Identify drug endangered children the dangers they face. • Offer ongoing education, support and linking services
Transportation for MH/SUD Clients **Regions 1,2,3,4,5,**	• Currently no transportation in rural areas • Limited City Link bus routes • Taxi services are unaware of available funding to transport individuals with SUD • Limited access to transportation to access needed appointments and employment	• Establish a state supported bus pass program for MH/SUD individuals to attend treatment, medical, probation and other related appointments • Combine and coordinate individual vehicle fleets from multiple organizations/agencies/provides to offer efficient public transport from a single transit organization/central dispatch • Consider the use of existing transportation sources to provide services to	• Improve access to car/services/supports and decrease no show rates • Investigate rural transportation models that have proved successful in areas with similar geographic/populations make up • Seek expanding the use of Section 5311 funds to communities with populations less than 50,000 • Telehealth reduces need for transportation services • Need for continued reform of

		rural/frontier areas	shackling policy • Explore use of Virtual Behavioral Health Care to meet local mental health needs
Education for Law Enforcement and First Responders about MH and SUD issues **Regions 4,5**	• Increase funding for CIT Training • Time for officers to attend training • Resistance by LE Administration • Difficult for smaller areas to attend full trainings and keep staffed during that time	• CIT trainings are offered and well-received by local law enforcement, however many rural areas are unable to coordinate due to the length of the course	• More CIT training • Propose the idea of shorter mini-training sessions to reach locations that are unable to attend the week-long training in one block
Specialty Court Client Issues – including youth Mental Health Court **Regions 1,2,3**	• Case Management services are underutilized and in high need. • Housing is an issue • Funding, lack of grant writing experience (opportunities exist), engaging judicial involvement	• Offer housing and case management • Engage BHB to assist in the writing of grant funding opportunities, engage judicial system and juvenile probation. • Review models in other regions with date review.	• Data/outcomes of referrals through judicial system, juvenile probation, and hospitalization. • Need for approval by Idaho Drug and MH Coordinating Committee Funding
Access to Services without criminal involvement **Regions 3,4**	• Funding, a successful model(school disciplinary hearings), parental/caregiver involvement • Schools in more rural areas do not have the resources to provide services needed for children/families with mental illness • Lack of training and resource to hire within. These services are currently contracted out which limits response and resources	• Research funding sources such as the Juvenile Justice Commission, develop a model for schools/communities to refer at-risk youth, engage parents/caregivers in family supports (family therapy/groups) • Work with DHW for crisis services (law enforcement, schools, parents, caregivers). • Engage in community training such as trauma informed care,	• Decrease in referrals to juvenile probation, outcomes/data from successful model implementation and crisis calls deferred, and increase in parental/caregiver involvement in family supports • Adult Corrections accessing funds through Justice Reinvestment Act • Identify specific need for

	for the school • Minimal Trauma informed care and strengthening families training opportunities • Support for children of incarcerated parents • Limit incarceration terms, reassess risk levels • Increase services for this population • Difficulty in obtaining services under children's mental health unless involved in the system.	suicide prevention, at-risk youth behavioral education. • Establish and/or support these training opportunities • Establish a state-wide system, at the court level, to identify children of parents being incarcerated; provide professional to engage them in prevention interventions immediately. • Establish diversion programs in lieu of incarceration. • Develop Grant writing partnerships	recovery in each region • Legislature need to pass/approve Medicaid Expansion/Restructuring
Optum Idaho SUD Referrals Regions 1,2,3,4,5	• Lack of SUD diagnosis and internal referral processes • Policy barriers to qualify care and accessibility: H0001 code attached facility instead of license • No reimbursement from contractors for paperwork required from providers • Currently no path in place within contractors referral system to refer clients to a SUD Provider when a need is identified • Issues with Co-Occurring referrals • Establish a culture of collaboration with Medicaid provider and contractor. Increase oversight of Medicaid contractor, increase	• Engage Optum to provide data reports, monitoring/enforcing that providers are operating within their scope of practice, using evidenced based practices, appropriate referral of co-occurring clients. • Better communication between Medicaid/Behavioral Health division lines • Policy changes that allow for assessments to be conducted based on licenses not facility approval • Better oversight by Medicaid contractor to identify clients with SUD needs and conversely push toward drug Dependent Epidemiology (DDE) programs for all SUD providers	• Increase diagnosis and treatment of SUD and co-occurring • Request enhanced data reports and measures to ensure providers operate within scope of practice • Improved service provision and patient outcomes. Maintain capacity (provider networks). • Reimbursement rates are below average • Collaborate with Optum for Fall/Winter PCP/Provider Collaboration Education

	communication across lines.	• Incorporation of American Society of Addiction Medicine (ASAM) in Medicaid paperwork allowances in the billing matrix to bill for communication. • Develop system to track co-occurring client referrals • Increase SUD Provider network • Service Provider Contractors should reflect sub-categories being treated	
Interpreters/translators Regions 3,4,5	• Lack of training and availability of service	• Increase training • Increase access to care • Improve quality of care and outcomes	• Increase the number of available providers • Promote and educate regarding the need for this type of service in the regions • Seek funding sources that aim to address this need by promoting training, certification, and community education
Systems Issues Region 4	• Policy and legislation requirements are often redundant and in conflict with current licensing standards • Need for better communication and consistency across division lines • Need for better communication with contract managers • Need to create funding stream for gaps in care • Offender re-entry • Patients released for IDOC/SHS	• Establish and communicate measureable goals for state mental health/SUD system, in a fashion that incorporates input from all levels • Establish working relationship with licensing boards so that policy and legislation are written with current licensing standards in mind. • Division lines (Behavioral Health and Medicaid) collaborate, measure goals/	•

	• Medicaid expansion populations • Legislative support of program needs	outcomes of both populations concurrently, drill down with contract managers and into provider network. • Support of legislation related to proposed mental and behavioral health services and programs.	
Data Collection and Data Sharing Issues: **Region 7**	• There is a need for a database that would allow multiple agencies to share information on persons with mental illness in order to provide better response and ongoing care.	• Identify core performance indicators and collection points. • Determine a mechanism to be able to appropriately share critical information across those systems with a need to know (database)	• Continue to collaborate with OPTUM/Medicaid for data sharing • Compile a data request list to submit to Optum.
Primary Care **Regions 1,2,7**	• Ongoing funding for Federally Qualified Health Centers • Move towards holistic model • Often times clients are in need of medical, psychiatric, dental and vision services – but don't have access if they do not have insurance or benefits • Urgent care centers are not connected to the mental health system (but treat many individuals for mental health issues) • Lacking for clients not on Medicare, Medicaid or Private Insurance • Idaho needs to make use of Medicaid realignment funds • Clinics treating the uninsured	• Lack of medical insurance • Develop better linkages between mental health and primary medical care including physical health , dental care and vision care • Explore access barriers • Assist with necessary application for various medical assistance benefits • Expand community collaboration	• Collaborate with the 211 care line to ensure it accurately covers resources available in each of the regions • Create a cover letter to distribute to primary care providers throughout the region with information on how to access the newly updated 211 care line • ACA • SHIP Program • Legislature need to pass/approve Medicaid Expansion/Restructuring

	need increased funding and resources		
Peer Support and Recovery: Coaches **Region 7**	• Region would benefit from a broader availability of peer support and recovery coaches. All agencies need to have access to peer support and recovery coaches • Need to expand use of Peer support and Recovery coaches in the community to probation and parole	• Expand the availability and use of peer support and recovery coaches	• Develop a Community recovery Center • Provide more opportunities for peer Support/Recovery coach training in the region • Connect and collaborate with Optum's peer and family support • Create and maintain a current list of all recovery coaches and peer support specialists in the region
Accomplishments and Progress	**Accomplishments and Progress**	**Accomplishments and Progress**	**Accomplishments and Progress**
• Kootenai Co had two orgs present to BHB about group homes • Legislation passed ID House/Senate HB 264 • Legislation passed to offer loan repayment to Psych MDs to work at State Hospitals • Children's Mental Health Planning Council • Children's mental health first responder training • Developed Iris House/transitional housing with 1 crisis bed • Parenting with Love and Limits/Logic available • NAMI Family to Family	• Abbaddy House in Cottonwood • Transitional Housing Funds from IDOC • Shelter Plus Care is available • NAMI Family to Family • FFCMH Building Stronger Families; online courses, seminars • CMH ACE training in April 2015 • QPR Suicide Prevention Training • ACE (Adverse Childhood Experience) workshop April 30th, 2015 • April 10 Presentation Building a Trauma Informed Care Community at Kroc • 2014 Legislation approved loan repayment for physicians at state hospitals	• SHIP Program to focus on Patient Centered Medical Home • CIT Training for First Responders • Progress: Have requested data and measures to ensure SUD referrals • ACA increased access to needed care • CDA selected as site of crisis center 23 hours voluntary holds • Provided 5 scholarships to ICADD for providers • QPR Training in Silver Valley	• IFFCMH Building Stronger Families; online courses, seminars • CMH ACE training in April • QPR Suicide Prevention Training • CIT trainings, youth mentoring programs • Providing training (eating disorders, PLL Parent Support Groups • BH meeting with housing authorities to provide on-site BH referrals

• Region 3 was a pilot for Vallivue and Nampa School Districts that utilized funding to deter youth from the criminal justice system. Potential to follow that pilot model/outcomes. CIT Trainings within the schools, youth mentoring program • Progress/Youth: Working with Juvenile Probation to develop Shelter Care Model, increase transportation services to needed behavioral health services, increase individual/family group therapy, add full ACT options with Optum • Progress/Adult: Increase transportation services to needed behavioral health services, increase individual/family group therapy, youth mentoring programs • Shackling legislation passed in 2014 Session • Prescription drop-off boxes in the communities • Drug courts • FQHC's (Federally Qualified Health Centers) established in Idaho.	• State Healthcare Innovation Plan funded by Feds and awarded to DHW • Idaho Health Insurance Exchange • BH provided training to medical staff, schools and law enforcement • Region 2 Developed of Respite Care Training Curriculum • Adult Mental Health provide Designated Examiner Training for Psychologists • Improved relationships with Tribal representatives • Mental Health First Aid Training • Recovery Center in Latah County • Establishment of Children's Mental Health subcommittees • Children's Mental Health Council provided information, training for schools and public established support groups • ATR4 – allows for homeless SUD (substance use disorder) population to access needed services.		