Regional 4 Behavioral Health Board

Gaps and Needs Analysis

2014

(Prepared and submitted April 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**	**Recommendations** *Including those related to Family Support Services and Recovery Support Services*	**Improvement and Strategy Measures**
HOUSING Some housing options exist in Ada County, but there are no options in Valley, Elmore or Boise counties.	-Affordable and accessible housing	Address housing policies that support eviction due to lack of compliance; support alternative policies that do not threaten housing but support accountability.	Decrease risk for homelessness in our vulnerable populations.
	-Supported housing for chronic mentally ill	Establish a supported housing entity that supports independent living through medication management and life skills checks, internal access to MH service and community planned support groups.	
	-Supported housing for youth unable to return home after state care (or other residential)	Establish an Emancipation Home type program.	
	-Additionally: lack of housing and	Develop temporary residential	

	treatment options for youth unable to remain at home	housing and treatment for youth with mental illness who are unable to remain in homes.	
TRANSPORTATION	-Bus system does not support all areas	Bus system expansion.	Improve access to care/services/supports and decrease no show rates.
	- Bus pass availability for MH/SUD treatment needs	Establish a state supported bus pass program for MH/SUD individuals to attend treatment, medical, probation and other related appointments in areas with transportation.	
	-Lack of transportation options in rural areas	Develop transportation options in rural areas and/or increase tele-medicine.	
SERVICES FOR NON-CRIMINAL JUSTICE AT-RISK YOUTH	-Schools in more rural areas do not have the resources to provide services needed for children/families with mental illness.	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 trainings such as trauma informed care, suicide prevention, at-risk youth behavior education.	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.
	-Lack of training and resources to hire within. These services are currently contracted out which limits response and resources for the school.	Provide for funding streams to allow for training school staff on mental illness and behavioral health. Funding stream to hire these positions in-house.	
	-Minimal trauma informed care and strengthening families training	Establish and/or support these training opportunities.	

	opportunities		
	-Support for children of incarcerated parents	Establish a state-wide system, at the court level, to identify children of parents being incarcerated; provide professionals to engage them in prevention interventions immediately.	
RESILIENCY, RECOVERY AND WELLNESS SUPPORT	-Support for community mental health crisis centers in all regions	Further support to develop Recovery Idaho. Further support for community recovery centers.	
	-Additional resources for community supervision	Provide for additional probation officers based on per capita population.	
	-Lack of available respite care that is affordable for families with kids diagnosed as mentally ill	Establish subsidized respite care programs.	
	-Lack of support/education/training for Crisis Intervention Teams (CIT) to respond to families	Provide training for first responders on mentally ill children and their families.	
SYSTEM ISSUES -Lack of clarity around desired outcomes from authorities	- Policy and legislation requirements are often redundant and in conflict with current licensing standards	Establish and communicate measureable goals for state mental health/SUD system, in a fashion that incorporates input from all levels.	
	-Need for better communication and consistency across division lines	Establish working relationship with licensing boards so that policy and legislation is written with current licensing standards in mind.	

	-Need for better communication with contract managers		
	-Need to create funding stream for gaps in care -Offender re-entry -Patients released from IDOC/SHS -Medicaid expansion population	Division lines (Behavioral Health and Medicaid) collaborate, measure goals/outcomes of both populations concurrently, drill down with contract managers and into provider network.	
	-Establish a culture of collaboration with Medicaid provider and contractor. Increase oversight of Medicaid contractor, increase communication across lines.	Need increase in town hall meetings with Optum-Medicaid.	
	-Legislative support of program needs	Support of legislation related to proposed mental and behavioral health services and programs.	
TREATMENT SERVICES AND INTERVENTION			
-Reduction in Community Based Rehabilitation Services (CBRS)	-Lack of understanding around medical necessity determination for CBRS	Provider Trainings-- Demonstration of medical necessity for care to include CBRS.	
-Optum Idaho SUD Referrals	-Lack of SUD diagnosis and internal referral process	Engage Optum to provide data reports, monitoring/enforcing that providers are operating within their scope of practice, using evidence based practices, appropriate referral of co-occurring clients. Progress: Have requested data and measures to ensure SUD referrals.	Increase diagnosis and treatment of SUD and co-occurring.
-Lack of integration between Substance Use Disorder and Mental Health treatment	-Policy barriers to quality care and accessibility: H0001 code attached facility instead of license	Multiple solutions needed: Better communication between Medicaid/Behavioral Health	Improved service provision and patient outcomes. Maintain capacity (provider networks).

		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, incorporation of American Society of Addiction Medicine (ASAM) in Medicaid paperwork, allowances in the billing matrix to bill for communication.	
-Insufficient access to SUD services	-Lack of SUD residential treatment options longer than 30 days. Lack of services for non-intravenous drug users (non-IVDU), Pregnant Women and Women with Children (PWWC), non-felony individuals with addictions	Provide support for treatment of adults with addictions (non-criminal justice).	
ACCESS TO SERVICES	-Mental health services for families in rural areas	Increase Tele-health utilization; provide state-subsidies for professionals willing to work in outlying areas. Load re-payment options.	
	-Inability to access reimbursement for prevention or treatment	Support Medicaid expansion or Healthy Plan Idaho.	
	-SOAR needs faster accessibility to Medicaid approval.	Increase SOAR trained professionals in the area. Decrease time frame for those in need to access services.	
ACCESS TO SERVICES WITHOUT CRIMINAL JUSTICE INVOLVEMENT	-Increased need for diversion programs	Establish diversion programs in lieu of incarceration.	
	-Legislation to de-criminalize substance use disorders	Work toward addressing recommendation outlined in	

		Justice Reinvestment Initiative (JRI).	
	-Limit incarceration terms, reassess risk levels	Establish diversion programs that include treatment and community supervision in lieu of incarceration for low risk offenders.	