

Idaho

UNIFORM APPLICATION
2009

STATE IMPLEMENTATION REPORT
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

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Center for Mental Health Services

Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

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Idaho State Planning Council on Mental Health

Pete T. Cenarrusa Building, 3rd Floor
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Boise, ID 83720-0036

June 30, 2009

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The Honorable C. L. "Butch" Otter
Office of the Governor
Statehouse Box 83720
Boise, Idaho 83720-0034

Subject: 2009 Report from the Idaho State Planning Council on
Mental Health

Dear Governor Otter:

On behalf of the Idaho State Planning Council on Mental Health it
is my pleasure to submit to you the Council's Annual Report to the
Governor for 2009 on the status of mental health services in Idaho.

The State Planning Council membership worked collectively in
providing information and expertise in forming this report for your
review. We hope you find our report informative and look forward
to any comments that you may have.

Sincerely,

The Idaho State Planning Council on Mental Health


Teresa Wolf, Chair
P.O. Box 896
Lewiston, Idaho 83501

Mental Health Report



2009

**Idaho State Planning Council on Mental Health
Report to the Governor & Legislature**

Our Goal:

Our goal is for everyone in Idaho to be offered treatment that is not only consumer and family driven, but effective and recovery oriented so that persons and families affected by mental illness can participate fully in their communities.

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Idaho State Planning Council on Mental Health

Pete T. Cenarrusa Building, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0036

Annual Report to the Governor and State Legislature

June 30, 2009, Boise, Idaho

Executive Summary

The Idaho State Planning Council on Mental Health (SPCMH) provides a voice and advocacy for children, youth, adults, and families on a broad range of mental health issues. Our annual report is designed to provide a clear overview of the vast array of accomplishments of the SPCMH, Regional Mental Health Boards, and the Division of Behavioral Health. It is essential to the success of Idaho's Mental Health System of Care to improve access to treatment, expand system collaboration, and continue to strengthen community partnerships.

Our report includes accomplishments, opportunities captured, and challenges left to address. A sampling of the issues contained in the annual report is listed below:

- Improved communication and centralized reporting with the Governor, Legislature, and the Regional Mental Health Boards.
- Transformation of Idaho's Mental Health System in conjunction with WICHE and the Governor's Transformation Workgroup, Medicaid Reform, inclusion of the Wellness Recovery Action Plan to assist Peer Specialists, Parenting with Love and Limits, and increased focus on housing issues.
- Supporting adult and juvenile court collaboration and provide needed resources to many citizens seeking treatment.
- A number of issues surrounding Idaho's Mental Health system continue to challenge us and include:
 - ❖ Development of a Consumer/Family Driven System of Care
 - ❖ Recovery as a focus
 - ❖ Access to Community Based Services
 - ❖ Support for a Statewide Suicide Prevention Hotline

What to Expect in 2009/2010 from the Idaho State Planning Council on Mental Health:

- **Continued Improvement of Communication Methods**
 - Information sharing with affiliates and other agencies on current issues and events is one key to a successful system
 - Encouraging the Regional Mental Health Boards to report centrally promotes distribution of information, ideas, and successes

- **Committee Involvement and Project Development**
 - Children's, Transformation/Housing, Membership, Legislative, and Education/Communication subcommittees are accountable for forming guidelines and responsibilities, goal setting, and project development.

- **Further Strengthen Collaborative Efforts with all Related Agencies and Affiliates**
 - Be more accessible
 - Clarify and advance our mission and direction
 - Become more visible
 - Develop sustainable partnerships

Information sharing is a key component to a successful system.

Using the SPCMH as a hub for distributing information by and between Regional Mental Health Boards will improve the system as a whole. This distribution will allow successful ideas and projects to be replicated throughout Idaho.

By requiring the State Planning Council subcommittees to focus on our mission and direction, the Council will become more visible to our partners, and the mission clarified.

The SPCMH will become more visible to the public and associate agencies by participating in active ways in local issues, communicating goals, visions and values, and being a robust voice for Idahoans living with mental health issues.

Being a viable part of the mental health system promotes cooperation and collaboration.

The SPCMH plays a key role in the mental health system of care. We are charged with serving as an advocate, advising, and providing guidance, monitoring and evaluating the system, and ensuring access. Our mission is to serve as a vehicle for policy and program development and to report on those achievements and system impacts. The SPCMH is dedicated to achieving those responsibilities with which we have been entrusted.

INTRODUCTION

Background:

The State Planning Council on Mental Health (SPCMH) was organized in Idaho pursuant to Public Law 99-660, which established a Federal mental health block grant program to states and territories in the 1980's. The public law requires that the majority of membership of the SPCMH be made up of individuals affected by mental illness and their families, as well as representatives from key state agencies which provide services to this population.

In addition to meeting the Federal membership requirements, Idaho's SPCMH also has excellent representation from across the state. Each of the seven Regional Mental Health Boards is represented within our membership.

The federal law requires the SPCMH to oversee the annual plan for Federal block grant dollars that have been awarded to states to assist them in the development of mental health services, to monitor those mental health services funded through both state and federal dollars and to serve as advocates for the improvement of mental health services within the state.

In 2006, the Idaho Legislature placed the SPCMH into Idaho Code 39-3125. The SPCMH is directed to:

"... serve as an advocate for adults with a severe mental illness and for seriously emotionally disturbed children and youth; to advise the state mental health authority on issues of concern, policies and programs and provide guidance to the mental health authority in the development and implementation of the state mental health systems plan; to monitor and evaluate the allocation and adequacy of mental health services within the state on an ongoing basis; to ensure that individuals with severe mental illness and serious emotional disturbances have access to treatment, prevention and rehabilitation services including those services that go beyond the traditional mental health system; to serve as a vehicle for intra-agency and interagency policy and program development; and to present to the Governor and the Legislature by June 30 of each year a report on the council's achievements and the impact on the quality of life that mental health services has on citizens of the state..."

The SPCMH provides a consumer voice for publicly funded mental health services available to our residents (this was a key recommendation of The President's New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America published in July, 2003). We are here to assure that Idaho's public mental health system continues to move forward in quality and efficiency.

The membership of the SPCMH is committed to developing a public mental health system in Idaho in which recovery from mental illness is expected, programs to prevent mental illness are consumer and family driven and are available in all parts of the state. We stand ready to assist in whatever may be necessary to accomplish this end.

ENDORSED GOALS

The President's New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America' goals endorsed by the SPCMH.

In a transformed Mental Health System:

1. Americans Understand that Mental Health Is Essential to Overall Health.
2. Mental Health Care Is Consumer and Family Driven.
3. Disparities in Mental Health Services Are Eliminated.
4. Early Mental Health Screening, Assessment and Referrals to Services Are Common Practice.
5. Excellent Mental Health Care is Delivered and Research Is Accelerated.
6. Technology Is Used to Access Mental Health Care and Information.

IDAHO STATE PLANNING COUNCIL ACCOMPLISHMENTS

1. Influencing change to Mental Health Board membership

- a. The SPCMH was kept well informed by the membership on legislative issues and was able to provide the needed support for addition of children's representation and clarification of membership on the Regional Mental Health Boards. With the loss of the Children's Mental Health Councils it was imperative that each regional board continued to address children's issues.
- b. Our representative gave a report to the House Health and Welfare Committee during this legislative session on the concerns, gaps and needs identified by the SPCMH.
- c. The SPCMH formed a subcommittee to keep us apprised on all legislative activity and issues of concern that affect our legally mandated responsibilities. The information was communicated to the membership to insure inclusion of the regional mental health boards.

2. Informing Legislators regarding housing and the need to recognize recovery as issues of high importance to the citizens of Idaho at the Annual Legislative Breakfast and other times throughout the year

- a. The SPCMH membership met with each Legislator in attendance at our legislative breakfast to discuss the importance of the need to continue to make suitable, stable and affordable housing a priority for persons with mental illness and their families, as this is key to their recovery. The housing shortage in Idaho is at a critical level and needs to remain a top priority for the regions and the Legislature. We have formed a subcommittee to continue to keep the SPCMH apprised of the housing issues in Idaho so that we may assist others in their quest to solve regional problems.
- b. The membership regularly provides legislators up-to-date information regarding mental health issues to assist them in making informed decisions.

3. Functioning with minimal cost and no financial increases

- a. The SPCMH understands and has risen to the challenge to keep expenses at a minimum and within our allotted budget. We have utilized videoconferencing, teleconferencing, and e-mail whenever possible. We have reduced the number of members and are currently reviewing the membership for further efficiencies. While still fulfilling our legally mandated responsibilities, we are trying to maintain and insure statewide representation. While costs have risen

dramatically over the last decade, our budget has not had a single increase in that time.

4. Adopted Suicide Prevention council as subcommittee

- a. The SPCMH recognizes the importance of the Suicide Prevention Council's efforts and voted to include them as a subcommittee of the SPCMH to keep us informed of their activities and educational efforts across the state.

5. Development of a State Planning Council Brochure

- a. A brochure was developed to provide more visibility for the SPCMH. This brochure gives a brief overview of our purpose and contact information. The brochure forged new partnerships with Idaho State Independent Living Council, who volunteered to print the brochure and the Office of Consumer Affairs offered use of their website for a resource link to assist in information distribution.

6. Idaho state law (Title 39-3124) expanded our membership to include representatives from the Legislature and Judiciary

- a. This change has enhanced our communication efforts to keep the Legislature informed of changes, gaps and needs in the mental health system. It has also given the Judiciary the opportunity to bring forth issues and identify additional resources available.

7. Centralized reporting to the Council of regional council activities

- a. Each council member is encouraged to report on the activities of their Regional Mental Health Board to share their successes and challenges so that all may benefit.
- b. The SPCMH has established an email list of the membership of the Regional Mental Health Boards (RMHB) to encourage continued communication, sharing information and mutual appraisal of current issues and concerns.

8. Serving as a vehicle for intra-agency and interagency policy and program development.

- a. The chair for this body has served on the Behavioral Health Transformation Workgroup this year.

OPPORTUNITIES

1. **The Idaho Mental Health and Substance Abuse System Redesign Project, otherwise known as the WICHE Report, offers Idaho a great opportunity to transform the current mental health system.**

The WICHE Report was commissioned and funded by the Legislature in 2007 through SCR 105. The findings and recommendations of the WICHE Report were presented to the Legislature via the Health Care Task Force. The report was strongly endorsed by that group's Mental Health Subcommittee. The report identified the need to create a statewide "transformation workgroup" to identify and address barriers to transformation. In January 2009 a Governor issued Executive Order created the Behavioral Health Transformation Workgroup. In his Executive Order No. 2009-04 the Governor stated "Idaho citizens and their families should have appropriate access to quality services through the public mental health and substance abuse system that are coordinated, efficient and accountable." The Legislature has appropriated \$250,000 to support the mission of this Workgroup. The Workgroup is to develop a plan for a coordinated, efficient state behavioral health infrastructure and present a plan to the Governor by December 2009 and the Legislature in 2010.

2. **The WICHE report has identified increasing accountability through information and data as a priority.**

According to the report, "Idaho's mental health data system did not appear to be robust, with a solid, valid set of statewide data available on program specifics, including outcomes. There appeared to be more data available for the substance abuse program, however, there remain gaps in the ability to track service delivery and outcomes in that system also (page 37)." A more robust data system will help the Department of Health and Welfare to provide oversight of providers, track services and outcomes and lead to more evidence based practices. Experience of the substance abuse treatment programs, Office of Drug Policy and Interagency Committee on Substance Abuse (ICSA) has demonstrated that outcome data is the key to policy maker's support of programs. Policy makers and Legislators want to see that the programs they support with funding are having positive outcomes.

3. **Continued work and refinement of Medicaid Reform.**

Medicaid reform has seen significant cuts in hours of PSR (not heavily utilized) and Partial Care services (the current model has not proven to be recovery oriented) along with significant changes in requirements for Community Providers. Medicaid should continue to work with Community Providers to make sure that the transition to a system that is based on the new requirements is both manageable and productive. Medicaid should continue their efforts on a reform package that offers services with an emphasis on recovery.

4. Enhancing the Efficiency of the State's Hospital Capacity

Recommendation 5.1: Conduct a review of State Hospital utilization data (both sites) to identify:

1. Valid mean (average) and median lengths of stay by region over a year;
2. The number of individuals who would benefit from community-based services and the type(s) of service(s) required;
3. The cost accrued per day by these individuals in the state hospitals; and,
4. The potential State Hospital cost avoidance that could be realized by decreasing inpatient stay and increasing community tenure.

Recommendation 5.2: Allocate specific, acute bed capacity to the regional behavioral health authorities.

Recommendation 5.3: Achieve and maintain accreditation for **both** state hospitals.

Recommendation 5.4: Utilize deliberate planning and program development in secure facilities. This will ensure that civilly committed persons treated in these facilities are served in the least restrictive environment based upon their clinical and legal circumstances.

PUBLIC MENTAL HEALTH ACCOMPLISHMENTS (STATE)

1. Training Program.

The first statewide Wellness Recovery Action Plan (WRAP) training occurred this fiscal year. WRAP plans help clients to understand recovery from mental illness is possible. They also serve to help clients understand warning signs, symptoms, and serve as a plan to follow when signs and symptoms of mental illness begin to exacerbate. This training was in preparation of the roll out of the peer specialist certification program.

2. Peer Specialist Certification Program has benefited virtually every region in the state.

Peer Specialists started being placed on regional ACT teams in March of this year. Their purpose is to model recovery and resiliency for individuals receiving services through the ACT team model. Although Peer Specialists may have additional responsibilities that vary from region to region, they bring their own unique talents and special interests that serve to enhance the success of the ACT teams.

3. Youth Suicide Prevention.

SPAN is active in some regions providing community and civic presentations. There was a town hall meeting in Idaho Falls on suicide prevention.

4. Medicaid Developments.

Statewide assessment tools, to assist individuals with substance abuse problems, have been adopted. Benefits are now in place for substance use disorder treatment in Substance Abuse agencies and in primary care providers' offices. New requirements also increase participants' rights, promote parental involvement in children's treatment, restrict the use of seclusion and restraint, ensures diagnostic assessments are available to all who need them, require certification of unlicensed PSR workers, and ensure services that are developmentally appropriate for children. Additionally, 69% of Medicaid-reimbursed mental health agencies in Idaho have now been credentialed or are in the process.

5. Community Collaboration Grant funding for Crisis Intervention Training.

For three years in a row, the Legislature has allocated funds for collaborative community projects, at the local level, to improve mental health services. Through the Development Grant process, the Division provided funding to allow Crisis Intervention Team (CIT) training for law enforcement officials in two regions. With the chronic under-funding of our state system it is critical that first responders have knowledge of mental health issues and community resources. Communities throughout the state are supporting Crisis Intervention Team (CIT) Training for law enforcement.

6. Youth Programs: Parenting With Love and Limits (PLL)

PLL, an evidence-based intervention for children and families has been implemented in each region. For the non-criminal justice population, utilization of costly residential treatment has been decreased in favor of more effective family-based therapy (PLL, for example).

7. The first responder video was completed and distributed statewide, to groups such as: law enforcement, paramedics, mental health professionals, and others.

This DVD has also generated interest from several law enforcement agencies and advocacy organizations across the country. This video uses scenarios to teach first responders how to appropriately respond to juveniles who are experiencing mental health crisis situations.

8. Increased focus on housing.

The community collaboration grant which has been exhausted helped the Idaho Falls community see the need for crisis housing. Transitional/supportive housing is being developed, at the local level, in many communities in Idaho. The process for accessing Shelter Plus Care beds has been standardized, leading to an increased level of regional involvement with these housing vouchers. The CATCH program, a program in Region 4 that mobilizes community resources to help address homelessness, is expanding to Region 3.

9. Assertive Community Treatment (ACT)

Ten ACT team sites were assessed for fidelity to the ACT model according to the Dartmouth Assertive Community Treatment Scale (DACTS). The results were favorable and were used to identify strengths and opportunities for improvement.

10. Mental health court is now available in all regions.

This program provides access to treatment for persons with mental illness who have been charged with a crime, it also fosters evidence-based treatment (Assertive Community Treatment is available in all regions). Mental Health Court utilization has increased to 90% since its inception.

11. Clinicians in county juvenile detention centers.

This model has been adopted in all detention centers. By screening all incoming adolescents, mental health issues are being identified and treated. All juveniles in detention facilities are now screened for mental health issues.

12. Video conferencing equipment installed in each Region, State Hospital North, State Hospital South, and Idaho State Hospital and School.

This equipment was procured to help compensate for a statewide shortage of psychiatrists. The technology has been used to allow psychiatrists based in Boise to see patients in Idaho Falls (Region 7) and Lewiston (Region 2). This equipment is also used for meetings while avoiding costly travel arrangements. For fiscal year 2009 to date, the Department has avoided approximately \$198,000 in travel costs as a result of installing this equipment. Doctors, patients and the court system feel this is an excellent alternative to transporting a handcuffed patient to the courthouse for commitment hearings.

13. "Home Recovery Team" (HRT)

This program provides in-home support, treatment, and resource development for individuals at risk of out of home placement in higher levels of care. Although this program is new, early results have been promising.

14. Psychiatric residency program in Idaho is continuing to progress.

A Forensic Psychiatrist was recruited and hired to work in Region 4. Because of the increasing caseload of clients from the criminal justice system, this has been a tremendous asset to the Division.

15. The Continuous Quality Improvement (CQI) process in Children's Mental Health (CMH) has been standardized.

This process has resulted in the development and implementation of corrective action plans to help ensure standards are adhered to.

16. Patient Assistance Program (PAP) software package was purchased for approximately \$50,000.00.

This software automates the application process for indigent benefits offered by many pharmaceutical companies. The automation frees up staff time and offers benefits to more clients. Costs of the medications received at not cost calculated at average wholesale price (AWP) indicate benefit received by the clients for February 2009 alone exceeds \$800,000.

17. The Client Level Reporting Project (CLRP).

Idaho was one of nine states awarded the CLRP to explore definitions and protocols for use in reporting the National Outcome Measures (NOMS) used in Federal Mental Health Block Grant processes. This will allow Idaho to capture client level data in participating Regions 1, 5 and 6. Idaho was asked to present its experiences in collecting and reporting that data at the Data Infrastructure Grant (DIG) Conference in Washington, DC in April 2009.

CHALLENGES

Challenge 1: Idaho's mental health system is not Recovery focused or fully consumer/family driven.

All publicly-funded mental health systems need to be more recovery/strength based. The mental health system should focus on recovery and discovery of the individual's strengths. "The National Consensus Conference on Mental Health Recovery and Mental Health Systems, Transformation, convened by SAMSHA, identified 10 fundamental elements of recovery: self-direction, individualized and person-centered care, empowerment, holistic care, non-linear growth (continual growth and occasional setbacks), strength-based models, peer support, respect, responsibility and hope."

Issue 1a: The WICHE group noted that there was "significant bifurcation of systems between adults and children". Idaho needs one system of care and treatment not multiple agencies with an array of different rules and regulations resulting in individuals giving up or forgoing necessary treatment.

Challenge 2: Inadequate access to community-based services.

There is a great deal of concern for both adults and children. One of the concerning trends in the state is the increased involvement of individuals affected by mental illness and their families in the court system. The ability to access mental health services is very limited for Idahoans without mental health insurance that do not qualify for Medicaid. Hence, court involvement is often their entry point into Idaho's publicly funded mental health system.

Issue 2a: Access to mental health service needs to include non-serious mental illness diagnoses. People that have insufficient access to community services and/or Medicaid simply do not receive needed treatment until they decline to the point of needing costly inpatient care and services.

Issue 2b: Due to budget and service cuts there are less community based service providers available. Several agencies have closed or pulled out of rural areas leaving communities and families with no alternatives for community treatment. The WICHE report shows Idaho as 49th in the Nation on spending for community based services (page 25).

Issue 2c: PSR and Partial Care services have been significantly cut. The results and impact of these cuts are uncertain at this time. Medicaid is a claim driven system and is therefore unable to monitor the clients who either dropped their services or had their service provider

discontinue services. They will only resurface (within the system) as a claim is made. The provider can take up to one year to generate a claim, for these reasons this will be a difficult situation to monitor.

Challenge 3: Adult and juvenile transition services are underdeveloped.

Reentry issues for adults and juveniles coming out of incarceration or institutions continue to be a major problem both with housing issues and with needed follow-up services.

Challenge 4: Idaho lacks a statewide suicide prevention hotline.

The Joint Finance and Appropriation Committee (JFAC) cut the Community Collaboration Grant program by half from one million to \$500,000. In February we were notified that the Idaho Suicide Prevention Hotline Grant would be terminated effective March 3, 2009. *Suicide is the second leading cause of death for Idaho's youth.* Idaho is one of only three states without a suicide hotline. Having a suicide crisis hotline in Idaho is especially important to citizens in rural areas where access to mental health services are limited. There is currently a call center in another state that is taking these calls. This is a Band-Aid solution. The regional call center does not have access to resources that are local to the calling parties.

Challenge 5: Re-establish community resource workers in Idaho's 114 school districts.

The resource workers helped to identify the unmet needs of children and families by providing information and support in seeking available community resources for families and should be re-established. Evidence shows that linking families to support systems reduces unnecessary stressors.

Challenge 6: Minimal access to substance use/abuse and mental health treatment is currently available outside the criminal justice system in Idaho.

Director Armstrong's report entitled "A Profile: Substance Use Disorders in Idaho SFY 2009" states that "currently, almost all adolescents entering treatment are involved with the juvenile justice system".

Challenge 7: Publicly-funded hospitals in Idaho should be accessible voluntarily.

Currently, the majority of individuals hospitalized are court committed. Voluntary admissions should be the norm not the exception. Idaho needs to identify and provide a payment source for indigent patients to including short term Medicaid and help insure the least restrictive and most appropriate treatment settings are available.

Challenge 8: Early intervention and detection programs need to be developed.

Recommendation 4.1 in the WICHE Report states “amend eligibility criteria for public mental health and substance abuse services to support access to screening, assessment, early intervention, and recovery” – all of which the State Planning Council supports. The National Mental Health Information Center reports that about two-thirds of the young people needing mental health services in the United States are not getting them. Providing early intervention can result in less children moving into the juvenile justice system requiring mental health treatment.

Challenge 9: Lack of trainings available to school resources who serve children with mental health needs.

This need is at a critical point and must be addressed.

Challenge 10: State Hospital beds need to be accredited.

State Hospital North continue to seek accreditation in order to attract competent and quality staff to serve the needs of Idaho citizens.

Challenge 11: Strengthen voice of the Regional Mental Health Boards.

Idaho needs to explore better ways to connect the Regional Mental Health Boards with the State Planning Council by using the State Planning Council as the “hub” for information sharing across the state. This would allow each Regional Mental Health Board insight into what is working well in other regions.

Challenge 12: Oversight for the quality of public mental health services in Idaho is lacking.

The WICHE Report identified this as a priority. Recommendation 1.1 of the WICHE report suggests transforming the Division of Behavioral Health into a Division that directly and promptly improves the quality of care at the ‘point of care’. This transformation will include:

1. Becoming a guarantor of care rather than a deliverer of care by administering, monitoring and ensuring the quality of care;
2. Leading collaborative efforts that include key community stakeholders and other departments divisions and agencies to improve systems; and,
3. An integration of operations within DBH; across divisions within the Department; and amongst executive branch agencies, including the Office of Drug Policy. Transforming the role of DBH is not a small or simple recommendation. There currently is almost no quality assurance or monitoring of mental health and substance abuse services. No one agency appears to be responsible for ensuring that treatment services are provided appropriately or that they ‘work’. Moreover, there is no agency overseeing the DBH-provided direct services to ensure that their services are necessary, appropriate and beneficial. This situation results

in a relatively high risk for the state. These risks are not present in most states, as their mental health (and substance abuse) authorities do not provide direct care services in the community. In most states, the mental health authority provides oversight and technical assistance, and monitors service contracts with community providers.

Challenge 13: Veterans returning to Idaho from military service currently lack adequate services and information regarding resources through Idaho's Veterans Administration.

Returning Veterans are not always aware of, or have access to the services in their areas. The Veterans Administration needs to provide more information to returning Veterans regarding mental health and general health care services available in both Idaho and Washington.

Challenge 14: Loss of Community Incentive Grant.

The loss of the community grants has severely impacted the development of identified regional resources that are specific to the needs of each of the individual regions. The grant projects helped develop collaboration and a sense of community involvement in solving the gaps in services. Idaho needs to consider restoring this program in better economic times.

Idaho State Planning Council on Mental Health - 2009

Name	Type of Membership	Agency or Organization Represented	Address
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Adult - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

Most Significant Events that Impacted the State Mental Health System in SFY 2009

1. Economic Downturn

Idaho's economy was negatively impacted in SFY 2009. One of Idaho's largest employers, Micron, laid off approximately 1,500 employees in October 2008 and announced plans to lay off another 2,000 in February 2009. Idaho Department of Labor statistics indicate that Idaho's unemployment rate increased from 2.8% in January 2007 to 3.3% in January 2008 and 6.5% in January 2009. By October 2009, the unemployment rate was 9%, or over 67,800 unemployed. Unemployment rates in rural counties are higher, with an average of 10-12% unemployed in June 2009 (Idaho Department of Labor). In addition to unemployment, Idaho is experiencing a significant decrease in state tax revenue. The Idaho Division of Financial Management reports that total state General Fund tax revenue dropped 15.26% from FY 2008 to FY 2009.

Regarding Medicaid, the legislature passed House Bill 123, which amended "...existing law relating to public assistance and welfare to provide for Medicaid reduction." This bill states that "With the exception of the nursing facilities at Idaho state veterans homes, each skilled care facility's quarterly rate will be decreased two and seven-tenths percent (2.7%) from July 1, 2009 through June 30, 2010. Legislators approved \$20.1 million for completion of the Medicaid Management Information System (MMIS) which is targeted to start in 2010. This system will include claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals.

Although there were Federal Center for Medicare and Medicaid (CMS) funding opportunities, Idaho Medicaid did not receive any of these dollars. Idaho was not aware that the Cash and Counseling funding option applied to mental health services. Idaho did not apply for the Home and Community-Based Waiver (HCBS) or Home and Community Based Services Option because the State budget did not have the required State match funds. There were increased federal funds allocated through January 1, 2011, which decreased the State's Medicaid contributions by \$52 million for SFY 2009 and by \$73 million for SFY 2010.

The Department of Health and Welfare, with approval for approximately 3,136 employees, was affected by the economic downturn. An initial six percent across the board budget cut was addressed by service reductions, vacancy savings and having all state employees take a mandatory, unpaid three days of furlough, as well as cuts in operating, capital, and trustee and benefits from January to April 2009. The plan to address the additional mandated five percent personnel cut of \$9.5 million for SFY 2010 included restructuring the Regional Directors such that three positions serve all seven regions instead of one per region. Cutting positions of four Regional Directors and their assistants resulted in an estimated \$500,000 cost savings. Additional activities include layoffs (23 people); an additional required four days of furlough for all state employees; vacancy savings (an additional 27 positions); and a transfer of budget funds from operations to personnel. Estimates indicate that the four furlough days alone will save 37 full time jobs.

With respect to cost cuts, increased efficiencies and best practice service delivery for the Adult Mental Health (AMH) system, several factors have been considered. Every effort has been made to save jobs of front line staff. Several community hospitalization contracts have been re-negotiated, many at reduced rates. Policy and procedure development and implementation efforts are ongoing in order to ensure core business practice consistencies across regions. An Adult Mental Health Appeal Process has been established. A client-perspective outcome measure, the Outcome Questionnaire (OQ) and the youth version of this instrument, the Youth Outcome Questionnaire (YOQ) continues to be piloted in Region 6 in an effort to inform interventions based on client outcome perceptions. Videoconferencing allowed for less expensive meetings and telehealth (see #5 for more detail on this), and Patient Assistance Program (PAP) software also resulted in cost savings (see #4). Additionally, Region 3 developed an incentive program to decrease no-shows for psychiatric appointments.

2. Idaho Mental Health Transformation

Mental Health Transformation is an ongoing focus for the State of Idaho. Efforts to address transformation have included initial developmental efforts of a transformation workgroup, a review of the mental health and substance use service delivery system by the Western Interstate Commission for Higher Education (WICHE) Mental Health Program, and the establishment of a new transformation workgroup.

Under the direction of Governor Dirk Kempthorne, Idaho initiated the Idaho Mental Health Transformation Work Group (TWG) in early 2006 in response to the recommendations of the President's New Freedom Commission report (2003). Guided by a steering committee composed of local and state government leadership, professional associations, consumer groups and other stakeholders, the TWG met from 2006 until 2007 and delivered a *Comprehensive Statewide Mental Health Transformation Action Plan 2007: The First Steps* (December 2006). According to this plan, the goals of a transformed system in Idaho were to 1) "Effect a paradigm shift by transforming the way we as a community think about and embrace mental health, understanding that mental health is essential to overall health...[2] Achieve a consumer-driven system of care by transforming the mental health delivery system to one that is based on individual strengths and needs, emphasizes resiliency and recovery, and features accessibility...[3] Organize the structure to sustain the vision by transforming the manner in which resources are provided, coordinated and delivered." (p. 3).

According to Senate CR Number 108 (2007) and through the Legislative Health Care Task Force, the Idaho State Legislature directed implementation of a study to review Idaho's mental health and substance abuse treatment delivery system and to recommend system improvements. The Legislature contracted with the Western Interstate Commission for Higher Education (WICHE) Mental Health Program to conduct this study. Areas assessed included treatment capacity, cost, eligibility standards and areas of responsibility. The study process included five site visits, 150 stakeholder interviews and use of a web-based survey with responses from 550 Idaho stakeholders. The final written report with recommendations, *2008 Idaho Behavioral Health System Redesign*, was submitted in August 2008.

The Governor convened the Behavioral Health Transformation Workgroup in April 2009 to review the recommendations in the WICHE report regarding the advancement of the provision of core services for indigent clients from state employees to private provider community settings as outlined in the WICHE *2008 Idaho Behavioral Health System Redesign* report. This group includes 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, business, the Association of Counties, and the Department of Correction. Recommended WICHE goals that were being considered in SFY 2009 included 1) Establish a coordinated, efficient state infrastructure with clear responsibilities and leadership authority and action, 2) Create a comprehensive, viable regional or local community delivery system, 3) Make efficient use of existing and future resources, 4) Increase accountability for services and funding, 5) Provide authentic stakeholder participation in the development, implementation and evaluation of the system, and 6) Increase the availability of, and access to, quality services. The WICHE contract has been discontinued, but the Governor's Behavioral Health Transformation Workgroup continues to meet.

3. Adult Mental Health Data System Activities

The Behavioral Health (BH) Monthly Data Report was piloted in December 2006, using regional hand counts of each element that were submitted to Central Office, where they were manually tallied into a statewide monthly report. This report has continued to evolve since that time, as the Leadership Team refines data definitions and identifies either more effective means of data capture or additional elements that need to be tracked.

During SFY 2009, the two State Hospitals (North and South) completed Vista installation and implementation. The AMH program pursued the joint purchase and use of the WITS system by both the AMH and the Substance Use Disorders (SUD) programs. On the AMH side, the WITS system was programmed with the Client Level Reporting Project (CLRP; see paragraph below) data definitions of the NOMS. Development of WITS was completed by June 2009. Implementation and training activities were scheduled through SFY 2010, and the system began being used in October 2009.

The Division of Behavioral Health continues to pursue strategies to allow improved data infrastructure development for both the long and short-term data needs in the AMH program. The AMH program is currently working with data entry specialists from each region to identify data needs and training opportunities. The Data Infrastructure Grant (DIG) helps to support these efforts.

The Division of Behavioral Health was awarded a Client Level Reporting Project (CLRP) grant in the winter/spring of 2008. This award allowed three regions (i.e., Regions 1, 5 and 6) to pilot the Data Dictionary and Protocol that were developed by the nine participating states in an effort to create increased consistency and standardization in data capture and reporting of the National Outcome Measures (NOMS). This project completed a test case deliverable, a deliverable of FY 2008 service data with CLRP data

definitions and a final deliverable of SFY 2009 NOMS data by the project end date in September of 2009.

4. Patient Assistance Program (PAP)

A Patient Assistance Program (PAP) software package was purchased for approximately \$50,000. This software automates the application process for the indigent benefits offered by many pharmaceutical companies, allowing clients to receive needed medications at no cost. The automation frees up staff time and essentially offers these benefits to more clients. If the costs of the medications received for free are calculated at average wholesale price (AWP), the benefit received by clients for February 2009 alone exceeds \$800,000.

5. Telehealth Service Implementation (TSI) Project

The Department of Health and Welfare established a Telehealth System Implementation (TSI) videoconferencing work group that produced a Strategy for Video Conferencing Plan in April 2008. The purpose of the TSI project was to use information technology to assist government efforts to increase efficiency, reduce costs, and improve health and behavioral health access, services and education to Idaho citizens. Videoconferencing equipment priority use is the need for telemedicine to expand psychiatric service access to prevent crises and maintain client stabilization, especially in rural and frontier areas.

During SFY 2009, equipment (i.e., the Polycom HDX 7000 Series with high definition video, voice and content sharing capabilities, Sony Bravia HDTVs and flat panel audiovisual carts with locking cabinets) was installed and tested at Central Office, State Hospital South, State Hospital North and each of seven regions. As of September 2008, eleven high definition videoconferencing sites were available for site to site use. Sites included regional main offices, central office and three state hospitals (State Hospital South, State Hospital North and Idaho State School and Hospital). Since that time, the system was expanded to allow multi-site videoconferencing. As of May 2009, up to eight sites could participate simultaneously. Alternatively, four sites could simultaneously videoconference in high definition.

Although installed for less than a year, the videoconferencing equipment has been used for a multitude of purposes by a variety of agencies. Purposes include availability to coordinate statewide communications in the event of a disaster, provision and enhancement of psychiatric services, site reviews, hospital discharge planning, statewide meetings, supervision, training and education. The Behavioral Health program has expanded access to psychiatric care and services to adults with a serious mental illness in rural and frontier areas through high definition videoconferencing. The Self Reliance program used this system to facilitate implementation of the Idaho Benefits Information System. Medicaid found it useful for provider trainings on new mental health rules. Idaho State School and Hospital used the system to evaluate drug wholesalers. The State Planning Council on Mental Health has found videoconferencing to be an effective way to extend their budget while continuing to have meetings to address mental health issues. The Second District Drug Court has used it for training and education. The Idaho

Supreme Court has offered team training sessions on topics such as child protection and drug court.

As of May 2009, three contracted psychiatrists were providing telemedicine from the Boise Central Office. From September 2008 through May 2009, Region 2 estimated that 360 clients received psychiatric services through this system. Region 7 began using these services in February 2009, with an estimated 180 clients benefitting through May 2009.

Idaho is primarily a rural and frontier state with all Idaho counties designated as mental health professional shortage areas. Psychiatric coverage is difficult to ensure across the State. Travel costs can be expensive. In a lean economic climate, all methods of cost reduction without compromising services are critical. Use of videoconferencing technology reduces costs with a high return on investment. High definition equipment allows for the provision of telemedicine, education, site reviews and meetings without the requirement of travelling to a central location for a face to face meeting.

Use of the videoconferencing equipment began slowly from September through December 2008, but increased rapidly from January 2009. From September through December 2008, the recognized cost savings was \$15,485. From January through May 2009, the cost savings for all users totaled \$182,388. The cost savings related to the TSI project as measured by reduction in travel costs (i.e., mileage, airfare, staff time to travel, per diem, hotel and other miscellaneous costs accrued in the course of travel to attend face to face meetings) has exceeded installation costs in less than a year. The total equipment costs of \$189,000 included cameras, monitors, carts, routers and a Multi-Channel Unit (MCU) device that enables simultaneous linkages to more than two connections. From September 2008 through May 2009, the total savings across all users was \$197,873.

6.Forensics

Regional AMH Program Managers continue collaboration efforts in response to increased requests for best practice services to mental health court referrals. During SFY 2009, Mental Health Court Utilization increased to approximately 90% of capacity. A Forensic Psychiatrist was hired in Region 4 to provide services to increased numbers of clients referred from the criminal justice system.

The model used to support mental health referrals as an alternative to jail is a provision of intensive ACT services and collaboration with court representatives to develop an individualized treatment plan that allows participants to stabilize and learn additional life management skills such as taking necessary medications, avoiding drug and alcohol use and avoiding criminal activities that brought them into the legal system.

During the 2009 legislative session, HB 321 authorized \$846,600 "...of ongoing funding within the Mental Health Grants Program for the Region 4 Dual Diagnosis Crisis Intervention beds...[and]... \$1,165,000 base ongoing funding to be continued in fiscal year 2010 for the Region 7 grant project that was selected in fiscal year 2008." The

Region 7 project referred to provides mental health and substance use treatment at the jail in Bonneville County.

In addition to collaborating with the courts and corrections to establish referral, assessment, monitoring and treatment procedures, regional AMH programs also review and revise treatment services as needed in an effort to provide best practice, efficient and effective services. Besides use of the Comprehensive, Continuous, Integrated System of Care (CCISC) model of treatment for co-occurring disorders, all regional programs also have access to the Eli-Lilly Wellness curriculum and the Eli-Lilly Differential Diagnosis materials.

7. Crisis Services; Crisis Intervention Teams and Home Recovery Teams

The 2006 Legislature allocated two million dollars in State Fiscal Year 2007 to fund collaborative regional projects designed to meet unmet service needs for adults and/or children diagnosed with a serious mental illness and/or substance abuse. Eight projects were offered grant awards. One of these Service Plan Component projects provided for joint crisis training for law enforcement and mental health staff. In State Fiscal Year 2008, additional funds were allocated to support similar One-Time Development (i.e., \$2,000,000) projects. One award funded early intervention and crisis treatment (mental health, substance use, criminal involvement), including a transitional housing component. These training opportunities have allowed the development of Crisis Intervention Teams (CIT) in Regions 4 and 6.

During SFY 2009, an innovative public-private partnership was formed in Region 4. The Home Recovery Team (HRT) provides in home support, treatment and resource development for individuals who are at risk of out of home placement in more restrictive levels of care. Although this program is new, results have been promising.

8. Peer Specialist Certification and Placement with ACT Teams

Through a contract with the Division of Behavioral Health, the Office of Consumer Affairs took responsibility to develop and implement a Peer Specialist Certification program in Idaho. Fifteen consumers were trained in February 2009, with twelve passing the certification exam. Seven certified Peer Specialists have been placed; one in each of seven regional Assertive Community Treatment (ACT) teams. Certified Peer Specialists are expected to complete their own Wellness Recovery Action Plans (WRAP) in addition to completing the Peer Specialist Certification training.

In SFY 2009, seven certified Peer Specialists were placed; one on each of seven regional Assertive Community Treatment (ACT) teams. In addition to receiving consultation and support from regional ACT supervisors and the Office of Consumer Affairs, those Peer Specialists who are enrolled with the Division of Vocational Rehabilitation (VR) are able to avail themselves of additional support from their VR staff as needed. The Division of Vocational Rehabilitation has also been open to discussing other placement possibilities for certified Peer Specialists. The Division of Labor has expressed interest in the possible pilot of a Peer Specialist placed in one of the Labor offices to assist with those

unemployment applicants who are experiencing symptoms of depression or other mental illness, as this has increased in the course of the economic downturn.

9. Housing and Homelessness

During SFY 2009, there were several activities directed to housing and homelessness. A federal audit of the Pathways in Transition from Homelessness (PATH) grant provided an opportunity for each region to use feedback to develop an action plan to reflect opportunities for improvement in efforts to provide outreach and prevent homelessness among adults diagnosed with a serious mental illness. The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness was expanded to include Region 3 in addition to Region 4. The process for accessing Shelter Plus Care beds has been standardized, leading to an increased level of regional involvement with these housing vouchers.

Adult - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

Manner in which Idaho expended the grant in FY 2009

MENTAL HEALTH BLOCK GRANT EXPENDITURE - Adults

Adult Mental Health	Federal Budget	Federal Expenditures to Date - (As of 11/10/09)
Adult Mental Health Services	\$1,197,346	\$1,197,346
Consumer/Family Empowerment	\$ 178,000	\$1,553
1)Consumer/Family Empowerment & Peer Specialists	Subcategory: \$153,000	
2)Quality Improvement System Development	Subcategory: \$25,000	
State Planning Council	\$ 20,000	\$0
Suicide Prevention	\$ 10,000	\$0
<i>Total Adult Services SFY 2009</i>	\$1,405,346	\$1,198,899
<i>Total Children Services (see detail in Children's Plan)</i>	\$ 312,121	\$69,267
Administration at 5%	\$ 90,843	\$90,843
<i>Totals; Adult Services, Children's Services, Administration</i>	\$ 1,808,310	\$1,359,009

The above information shows how the State loaded and expended the 2009 SAMHSA block grant funds into its budget structure for the Adult Mental Health Program. All block grant funds pertaining to adult and children's mental health obtained through SAMHSA and in accordance with PL 102-321 were expended for community based programming.

The Adult Mental Health portion of the Block Grant funds are dedicated to support the State Planning Council on Mental Health (\$20,000), to support suicide prevention through a contract with Suicide Prevention of Idaho (SPAN-Idaho; \$10,000), to fund a contract with Mountain States Group (\$178,000) to support the Office of Consumer Affairs' efforts to provide advocacy and education to consumers and family members; to develop and oversee a Peer Specialist Training, Certification, Placement and Supervision program; and to support Quality Improvement efforts through Peer Specialist evaluation interviews. The remaining \$1,197,346 in Federal CMHBG funds are placed in the Department of Health and Welfare's Mental Health Cost Pool and allocated to the seven regional CMHC budgets to fund various community mental health program categories by the use of a Random Moment Time Study.

Child - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

Idaho State Planning Council on Mental Health

Pete T. Cenarrusa Building, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0036

June 30, 2009

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Judge Brent Moss
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Teresa Wolf
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The Honorable C. L. "Butch" Otter
Office of the Governor
Statehouse Box 83720
Boise, Idaho 83720-0034

Subject: 2009 Report from the Idaho State Planning Council on
Mental Health

Dear Governor Otter:

On behalf of the Idaho State Planning Council on Mental Health it
is my pleasure to submit to you the Council's Annual Report to the
Governor for 2009 on the status of mental health services in Idaho.

The State Planning Council membership worked collectively in
providing information and expertise in forming this report for your
review. We hope you find our report informative and look forward
to any comments that you may have.

Sincerely,

The Idaho State Planning Council on Mental Health


Teresa Wolf, Chair
P.O. Box 896
Lewiston, Idaho 83501

Mental Health Report



2009

**Idaho State Planning Council on Mental Health
Report to the Governor & Legislature**

Our Goal:

Our goal is for everyone in Idaho to be offered treatment that is not only consumer and family driven, but effective and recovery oriented so that persons and families affected by mental illness can participate fully in their communities.

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Idaho State Planning Council on Mental Health

Pete T. Cenarrusa Building, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0036

Annual Report to the Governor and State Legislature

June 30, 2009, Boise, Idaho

Executive Summary

The Idaho State Planning Council on Mental Health (SPCMH) provides a voice and advocacy for children, youth, adults, and families on a broad range of mental health issues. Our annual report is designed to provide a clear overview of the vast array of accomplishments of the SPCMH, Regional Mental Health Boards, and the Division of Behavioral Health. It is essential to the success of Idaho's Mental Health System of Care to improve access to treatment, expand system collaboration, and continue to strengthen community partnerships.

Our report includes accomplishments, opportunities captured, and challenges left to address. A sampling of the issues contained in the annual report is listed below:

- Improved communication and centralized reporting with the Governor, Legislature, and the Regional Mental Health Boards.
- Transformation of Idaho's Mental Health System in conjunction with WICHE and the Governor's Transformation Workgroup, Medicaid Reform, inclusion of the Wellness Recovery Action Plan to assist Peer Specialists, Parenting with Love and Limits, and increased focus on housing issues.
- Supporting adult and juvenile court collaboration and provide needed resources to many citizens seeking treatment.
- A number of issues surrounding Idaho's Mental Health system continue to challenge us and include:
 - ❖ Development of a Consumer/Family Driven System of Care
 - ❖ Recovery as a focus
 - ❖ Access to Community Based Services
 - ❖ Support for a Statewide Suicide Prevention Hotline

What to Expect in 2009/2010 from the Idaho State Planning Council on Mental Health:

- **Continued Improvement of Communication Methods**
 - Information sharing with affiliates and other agencies on current issues and events is one key to a successful system
 - Encouraging the Regional Mental Health Boards to report centrally promotes distribution of information, ideas, and successes

- **Committee Involvement and Project Development**
 - Children's, Transformation/Housing, Membership, Legislative, and Education/Communication subcommittees are accountable for forming guidelines and responsibilities, goal setting, and project development.

- **Further Strengthen Collaborative Efforts with all Related Agencies and Affiliates**
 - Be more accessible
 - Clarify and advance our mission and direction
 - Become more visible
 - Develop sustainable partnerships

Information sharing is a key component to a successful system.

Using the SPCMH as a hub for distributing information by and between Regional Mental Health Boards will improve the system as a whole. This distribution will allow successful ideas and projects to be replicated throughout Idaho.

By requiring the State Planning Council subcommittees to focus on our mission and direction, the Council will become more visible to our partners, and the mission clarified.

The SPCMH will become more visible to the public and associate agencies by participating in active ways in local issues, communicating goals, visions and values, and being a robust voice for Idahoans living with mental health issues.

Being a viable part of the mental health system promotes cooperation and collaboration.

The SPCMH plays a key role in the mental health system of care. We are charged with serving as an advocate, advising, and providing guidance, monitoring and evaluating the system, and ensuring access. Our mission is to serve as a vehicle for policy and program development and to report on those achievements and system impacts. The SPCMH is dedicated to achieving those responsibilities with which we have been entrusted.

INTRODUCTION

Background:

The State Planning Council on Mental Health (SPCMH) was organized in Idaho pursuant to Public Law 99-660, which established a Federal mental health block grant program to states and territories in the 1980's. The public law requires that the majority of membership of the SPCMH be made up of individuals affected by mental illness and their families, as well as representatives from key state agencies which provide services to this population.

In addition to meeting the Federal membership requirements, Idaho's SPCMH also has excellent representation from across the state. Each of the seven Regional Mental Health Boards is represented within our membership.

The federal law requires the SPCMH to oversee the annual plan for Federal block grant dollars that have been awarded to states to assist them in the development of mental health services, to monitor those mental health services funded through both state and federal dollars and to serve as advocates for the improvement of mental health services within the state.

In 2006, the Idaho Legislature placed the SPCMH into Idaho Code 39-3125. The SPCMH is directed to:

"... serve as an advocate for adults with a severe mental illness and for seriously emotionally disturbed children and youth; to advise the state mental health authority on issues of concern, policies and programs and provide guidance to the mental health authority in the development and implementation of the state mental health systems plan; to monitor and evaluate the allocation and adequacy of mental health services within the state on an ongoing basis; to ensure that individuals with severe mental illness and serious emotional disturbances have access to treatment, prevention and rehabilitation services including those services that go beyond the traditional mental health system; to serve as a vehicle for intra-agency and interagency policy and program development; and to present to the Governor and the Legislature by June 30 of each year a report on the council's achievements and the impact on the quality of life that mental health services has on citizens of the state..."

The SPCMH provides a consumer voice for publicly funded mental health services available to our residents (this was a key recommendation of The President's New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America published in July, 2003). We are here to assure that Idaho's public mental health system continues to move forward in quality and efficiency.

The membership of the SPCMH is committed to developing a public mental health system in Idaho in which recovery from mental illness is expected, programs to prevent mental illness are consumer and family driven and are available in all parts of the state. We stand ready to assist in whatever may be necessary to accomplish this end.

ENDORSED GOALS

The President's New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America' goals endorsed by the SPCMH.

In a transformed Mental Health System:

1. Americans Understand that Mental Health Is Essential to Overall Health.
2. Mental Health Care Is Consumer and Family Driven.
3. Disparities in Mental Health Services Are Eliminated.
4. Early Mental Health Screening, Assessment and Referrals to Services Are Common Practice.
5. Excellent Mental Health Care is Delivered and Research Is Accelerated.
6. Technology Is Used to Access Mental Health Care and Information.

IDAHO STATE PLANNING COUNCIL ACCOMPLISHMENTS

1. Influencing change to Mental Health Board membership

- a. The SPCMH was kept well informed by the membership on legislative issues and was able to provide the needed support for addition of children's representation and clarification of membership on the Regional Mental Health Boards. With the loss of the Children's Mental Health Councils it was imperative that each regional board continued to address children's issues.
- b. Our representative gave a report to the House Health and Welfare Committee during this legislative session on the concerns, gaps and needs identified by the SPCMH.
- c. The SPCMH formed a subcommittee to keep us apprised on all legislative activity and issues of concern that affect our legally mandated responsibilities. The information was communicated to the membership to insure inclusion of the regional mental health boards.

2. Informing Legislators regarding housing and the need to recognize recovery as issues of high importance to the citizens of Idaho at the Annual Legislative Breakfast and other times throughout the year

- a. The SPCMH membership met with each Legislator in attendance at our legislative breakfast to discuss the importance of the need to continue to make suitable, stable and affordable housing a priority for persons with mental illness and their families, as this is key to their recovery. The housing shortage in Idaho is at a critical level and needs to remain a top priority for the regions and the Legislature. We have formed a subcommittee to continue to keep the SPCMH apprised of the housing issues in Idaho so that we may assist others in their quest to solve regional problems.
- b. The membership regularly provides legislators up-to-date information regarding mental health issues to assist them in making informed decisions.

3. Functioning with minimal cost and no financial increases

- a. The SPCMH understands and has risen to the challenge to keep expenses at a minimum and within our allotted budget. We have utilized videoconferencing, teleconferencing, and e-mail whenever possible. We have reduced the number of members and are currently reviewing the membership for further efficiencies. While still fulfilling our legally mandated responsibilities, we are trying to maintain and insure statewide representation. While costs have risen

dramatically over the last decade, our budget has not had a single increase in that time.

4. Adopted Suicide Prevention council as subcommittee

- a. The SPCMH recognizes the importance of the Suicide Prevention Council's efforts and voted to include them as a subcommittee of the SPCMH to keep us informed of their activities and educational efforts across the state.

5. Development of a State Planning Council Brochure

- a. A brochure was developed to provide more visibility for the SPCMH. This brochure gives a brief overview of our purpose and contact information. The brochure forged new partnerships with Idaho State Independent Living Council, who volunteered to print the brochure and the Office of Consumer Affairs offered use of their website for a resource link to assist in information distribution.

6. Idaho state law (Title 39-3124) expanded our membership to include representatives from the Legislature and Judiciary

- a. This change has enhanced our communication efforts to keep the Legislature informed of changes, gaps and needs in the mental health system. It has also given the Judiciary the opportunity to bring forth issues and identify additional resources available.

7. Centralized reporting to the Council of regional council activities

- a. Each council member is encouraged to report on the activities of their Regional Mental Health Board to share their successes and challenges so that all may benefit.
- b. The SPCMH has established an email list of the membership of the Regional Mental Health Boards (RMHB) to encourage continued communication, sharing information and mutual appraisal of current issues and concerns.

8. Serving as a vehicle for intra-agency and interagency policy and program development.

- a. The chair for this body has served on the Behavioral Health Transformation Workgroup this year.

OPPORTUNITIES

1. **The Idaho Mental Health and Substance Abuse System Redesign Project, otherwise known as the WICHE Report, offers Idaho a great opportunity to transform the current mental health system.**

The WICHE Report was commissioned and funded by the Legislature in 2007 through SCR 105. The findings and recommendations of the WICHE Report were presented to the Legislature via the Health Care Task Force. The report was strongly endorsed by that group's Mental Health Subcommittee. The report identified the need to create a statewide "transformation workgroup" to identify and address barriers to transformation. In January 2009 a Governor issued Executive Order created the Behavioral Health Transformation Workgroup. In his Executive Order No. 2009-04 the Governor stated "Idaho citizens and their families should have appropriate access to quality services through the public mental health and substance abuse system that are coordinated, efficient and accountable." The Legislature has appropriated \$250,000 to support the mission of this Workgroup. The Workgroup is to develop a plan for a coordinated, efficient state behavioral health infrastructure and present a plan to the Governor by December 2009 and the Legislature in 2010.

2. **The WICHE report has identified increasing accountability through information and data as a priority.**

According to the report, "Idaho's mental health data system did not appear to be robust, with a solid, valid set of statewide data available on program specifics, including outcomes. There appeared to be more data available for the substance abuse program, however, there remain gaps in the ability to track service delivery and outcomes in that system also (page 37)." A more robust data system will help the Department of Health and Welfare to provide oversight of providers, track services and outcomes and lead to more evidence based practices. Experience of the substance abuse treatment programs, Office of Drug Policy and Interagency Committee on Substance Abuse (ICSA) has demonstrated that outcome data is the key to policy maker's support of programs. Policy makers and Legislators want to see that the programs they support with funding are having positive outcomes.

3. **Continued work and refinement of Medicaid Reform.**

Medicaid reform has seen significant cuts in hours of PSR (not heavily utilized) and Partial Care services (the current model has not proven to be recovery oriented) along with significant changes in requirements for Community Providers. Medicaid should continue to work with Community Providers to make sure that the transition to a system that is based on the new requirements is both manageable and productive. Medicaid should continue their efforts on a reform package that offers services with an emphasis on recovery.

4. Enhancing the Efficiency of the State's Hospital Capacity

Recommendation 5.1: Conduct a review of State Hospital utilization data (both sites) to identify:

1. Valid mean (average) and median lengths of stay by region over a year;
2. The number of individuals who would benefit from community-based services and the type(s) of service(s) required;
3. The cost accrued per day by these individuals in the state hospitals; and,
4. The potential State Hospital cost avoidance that could be realized by decreasing inpatient stay and increasing community tenure.

Recommendation 5.2: Allocate specific, acute bed capacity to the regional behavioral health authorities.

Recommendation 5.3: Achieve and maintain accreditation for **both** state hospitals.

Recommendation 5.4: Utilize deliberate planning and program development in secure facilities. This will ensure that civilly committed persons treated in these facilities are served in the least restrictive environment based upon their clinical and legal circumstances.

PUBLIC MENTAL HEALTH ACCOMPLISHMENTS (STATE)

1. Training Program.

The first statewide Wellness Recovery Action Plan (WRAP) training occurred this fiscal year. WRAP plans help clients to understand recovery from mental illness is possible. They also serve to help clients understand warning signs, symptoms, and serve as a plan to follow when signs and symptoms of mental illness begin to exacerbate. This training was in preparation of the roll out of the peer specialist certification program.

2. Peer Specialist Certification Program has benefited virtually every region in the state.

Peer Specialists started being placed on regional ACT teams in March of this year. Their purpose is to model recovery and resiliency for individuals receiving services through the ACT team model. Although Peer Specialists may have additional responsibilities that vary from region to region, they bring their own unique talents and special interests that serve to enhance the success of the ACT teams.

3. Youth Suicide Prevention.

SPAN is active in some regions providing community and civic presentations. There was a town hall meeting in Idaho Falls on suicide prevention.

4. Medicaid Developments.

Statewide assessment tools, to assist individuals with substance abuse problems, have been adopted. Benefits are now in place for substance use disorder treatment in Substance Abuse agencies and in primary care providers' offices. New requirements also increase participants' rights, promote parental involvement in children's treatment, restrict the use of seclusion and restraint, ensures diagnostic assessments are available to all who need them, require certification of unlicensed PSR workers, and ensure services that are developmentally appropriate for children. Additionally, 69% of Medicaid-reimbursed mental health agencies in Idaho have now been credentialed or are in the process.

5. Community Collaboration Grant funding for Crisis Intervention Training.

For three years in a row, the Legislature has allocated funds for collaborative community projects, at the local level, to improve mental health services. Through the Development Grant process, the Division provided funding to allow Crisis Intervention Team (CIT) training for law enforcement officials in two regions. With the chronic under-funding of our state system it is critical that first responders have knowledge of mental health issues and community resources. Communities throughout the state are supporting Crisis Intervention Team (CIT) Training for law enforcement.

6. Youth Programs: Parenting With Love and Limits (PLL)

PLL, an evidence-based intervention for children and families has been implemented in each region. For the non-criminal justice population, utilization of costly residential treatment has been decreased in favor of more effective family-based therapy (PLL, for example).

7. The first responder video was completed and distributed statewide, to groups such as: law enforcement, paramedics, mental health professionals, and others.

This DVD has also generated interest from several law enforcement agencies and advocacy organizations across the country. This video uses scenarios to teach first responders how to appropriately respond to juveniles who are experiencing mental health crisis situations.

8. Increased focus on housing.

The community collaboration grant which has been exhausted helped the Idaho Falls community see the need for crisis housing. Transitional/supportive housing is being developed, at the local level, in many communities in Idaho. The process for accessing Shelter Plus Care beds has been standardized, leading to an increased level of regional involvement with these housing vouchers. The CATCH program, a program in Region 4 that mobilizes community resources to help address homelessness, is expanding to Region 3.

9. Assertive Community Treatment (ACT)

Ten ACT team sites were assessed for fidelity to the ACT model according to the Dartmouth Assertive Community Treatment Scale (DACTS). The results were favorable and were used to identify strengths and opportunities for improvement.

10. Mental health court is now available in all regions.

This program provides access to treatment for persons with mental illness who have been charged with a crime, it also fosters evidence-based treatment (Assertive Community Treatment is available in all regions). Mental Health Court utilization has increased to 90% since its inception.

11. Clinicians in county juvenile detention centers.

This model has been adopted in all detention centers. By screening all incoming adolescents, mental health issues are being identified and treated. All juveniles in detention facilities are now screened for mental health issues.

12. Video conferencing equipment installed in each Region, State Hospital North, State Hospital South, and Idaho State Hospital and School.

This equipment was procured to help compensate for a statewide shortage of psychiatrists. The technology has been used to allow psychiatrists based in Boise to see patients in Idaho Falls (Region 7) and Lewiston (Region 2). This equipment is also used for meetings while avoiding costly travel arrangements. For fiscal year 2009 to date, the Department has avoided approximately \$198,000 in travel costs as a result of installing this equipment. Doctors, patients and the court system feel this is an excellent alternative to transporting a handcuffed patient to the courthouse for commitment hearings.

13. "Home Recovery Team" (HRT)

This program provides in-home support, treatment, and resource development for individuals at risk of out of home placement in higher levels of care. Although this program is new, early results have been promising.

14. Psychiatric residency program in Idaho is continuing to progress.

A Forensic Psychiatrist was recruited and hired to work in Region 4. Because of the increasing caseload of clients from the criminal justice system, this has been a tremendous asset to the Division.

15. The Continuous Quality Improvement (CQI) process in Children's Mental Health (CMH) has been standardized.

This process has resulted in the development and implementation of corrective action plans to help ensure standards are adhered to.

16. Patient Assistance Program (PAP) software package was purchased for approximately \$50,000.00.

This software automates the application process for indigent benefits offered by many pharmaceutical companies. The automation frees up staff time and offers benefits to more clients. Costs of the medications received at not cost calculated at average wholesale price (AWP) indicate benefit received by the clients for February 2009 alone exceeds \$800,000.

17. The Client Level Reporting Project (CLRP).

Idaho was one of nine states awarded the CLRP to explore definitions and protocols for use in reporting the National Outcome Measures (NOMS) used in Federal Mental Health Block Grant processes. This will allow Idaho to capture client level data in participating Regions 1, 5 and 6. Idaho was asked to present its experiences in collecting and reporting that data at the Data Infrastructure Grant (DIG) Conference in Washington, DC in April 2009.

CHALLENGES

Challenge 1: Idaho's mental health system is not Recovery focused or fully consumer/family driven.

All publicly-funded mental health systems need to be more recovery/strength based. The mental health system should focus on recovery and discovery of the individual's strengths. "The National Consensus Conference on Mental Health Recovery and Mental Health Systems, Transformation, convened by SAMSHA, identified 10 fundamental elements of recovery: self-direction, individualized and person-centered care, empowerment, holistic care, non-linear growth (continual growth and occasional setbacks), strength-based models, peer support, respect, responsibility and hope."

Issue 1a: The WICHE group noted that there was "significant bifurcation of systems between adults and children". Idaho needs one system of care and treatment not multiple agencies with an array of different rules and regulations resulting in individuals giving up or forgoing necessary treatment.

Challenge 2: Inadequate access to community-based services.

There is a great deal of concern for both adults and children. One of the concerning trends in the state is the increased involvement of individuals affected by mental illness and their families in the court system. The ability to access mental health services is very limited for Idahoans without mental health insurance that do not qualify for Medicaid. Hence, court involvement is often their entry point into Idaho's publicly funded mental health system.

Issue 2a: Access to mental health service needs to include non-serious mental illness diagnoses. People that have insufficient access to community services and/or Medicaid simply do not receive needed treatment until they decline to the point of needing costly inpatient care and services.

Issue 2b: Due to budget and service cuts there are less community based service providers available. Several agencies have closed or pulled out of rural areas leaving communities and families with no alternatives for community treatment. The WICHE report shows Idaho as 49th in the Nation on spending for community based services (page 25).

Issue 2c: PSR and Partial Care services have been significantly cut. The results and impact of these cuts are uncertain at this time. Medicaid is a claim driven system and is therefore unable to monitor the clients who either dropped their services or had their service provider

discontinue services. They will only resurface (within the system) as a claim is made. The provider can take up to one year to generate a claim, for these reasons this will be a difficult situation to monitor.

Challenge 3: Adult and juvenile transition services are underdeveloped.

Reentry issues for adults and juveniles coming out of incarceration or institutions continue to be a major problem both with housing issues and with needed follow-up services.

Challenge 4: Idaho lacks a statewide suicide prevention hotline.

The Joint Finance and Appropriation Committee (JFAC) cut the Community Collaboration Grant program by half from one million to \$500,000. In February we were notified that the Idaho Suicide Prevention Hotline Grant would be terminated effective March 3, 2009. *Suicide is the second leading cause of death for Idaho's youth.* Idaho is one of only three states without a suicide hotline. Having a suicide crisis hotline in Idaho is especially important to citizens in rural areas where access to mental health services are limited. There is currently a call center in another state that is taking these calls. This is a Band-Aid solution. The regional call center does not have access to resources that are local to the calling parties.

Challenge 5: Re-establish community resource workers in Idaho's 114 school districts.

The resource workers helped to identify the unmet needs of children and families by providing information and support in seeking available community resources for families and should be re-established. Evidence shows that linking families to support systems reduces unnecessary stressors.

Challenge 6: Minimal access to substance use/abuse and mental health treatment is currently available outside the criminal justice system in Idaho.

Director Armstrong's report entitled "A Profile: Substance Use Disorders in Idaho SFY 2009" states that "currently, almost all adolescents entering treatment are involved with the juvenile justice system".

Challenge 7: Publicly-funded hospitals in Idaho should be accessible voluntarily.

Currently, the majority of individuals hospitalized are court committed. Voluntary admissions should be the norm, not the exception. Idaho needs to identify and provide a payment source for indigent patients to include short-term Medicaid and help insure the least restrictive and most appropriate treatment settings are available.

Challenge 8: Early intervention and detection programs need to be developed.

Recommendation 4.1 in the WICHE Report states “amend eligibility criteria for public mental health and substance abuse services to support access to screening, assessment, early intervention, and recovery” – all of which the State Planning Council supports. The National Mental Health Information Center reports that about two-thirds of the young people needing mental health services in the United States are not getting them. Providing early intervention can result in less children moving into the juvenile justice system requiring mental health treatment.

Challenge 9: Lack of trainings available to school resources who serve children with mental health needs.

This need is at a critical point and must be addressed.

Challenge 10: State Hospital beds need to be accredited.

State Hospital North continue to seek accreditation in order to attract competent and quality staff to serve the needs of Idaho citizens.

Challenge 11: Strengthen voice of the Regional Mental Health Boards.

Idaho needs to explore better ways to connect the Regional Mental Health Boards with the State Planning Council by using the State Planning Council as the “hub” for information sharing across the state. This would allow each Regional Mental Health Board insight into what is working well in other regions.

Challenge 12: Oversight for the quality of public mental health services in Idaho is lacking.

The WICHE Report identified this as a priority. Recommendation 1.1 of the WICHE report suggests transforming the Division of Behavioral Health into a Division that directly and promptly improves the quality of care at the ‘point of care’. This transformation will include:

1. Becoming a guarantor of care rather than a deliverer of care by administering, monitoring and ensuring the quality of care;
2. Leading collaborative efforts that include key community stakeholders and other departments divisions and agencies to improve systems; and,
3. An integration of operations within DBH; across divisions within the Department; and amongst executive branch agencies, including the Office of Drug Policy. Transforming the role of DBH is not a small or simple recommendation. There currently is almost no quality assurance or monitoring of mental health and substance abuse services. No one agency appears to be responsible for ensuring that treatment services are provided appropriately or that they ‘work’. Moreover, there is no agency overseeing the DBH-provided direct services to ensure that their services are necessary, appropriate and beneficial. This situation results

in a relatively high risk for the state. These risks are not present in most states, as their mental health (and substance abuse) authorities do not provide direct care services in the community. In most states, the mental health authority provides oversight and technical assistance, and monitors service contracts with community providers.

Challenge 13: Veterans returning to Idaho from military service currently lack adequate services and information regarding resources through Idaho's Veterans Administration.

Returning Veterans are not always aware of, or have access to the services in their areas. The Veterans Administration needs to provide more information to returning Veterans regarding mental health and general health care services available in both Idaho and Washington.

Challenge 14: Loss of Community Incentive Grant.

The loss of the community grants has severely impacted the development of identified regional resources that are specific to the needs of each of the individual regions. The grant projects helped develop collaboration and a sense of community involvement in solving the gaps in services. Idaho needs to consider restoring this program in better economic times.

Idaho State Planning Council on Mental Health - 2009

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Child - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

NEW DEVELOPMENTS AND ISSUES

Children's Mental Health

1. Economic Downturn

Idaho's economy was seriously negatively impacted in SFY 2009. One of Idaho's largest employers, Micron, laid off approximately 1,500 employees in October 2008 and another round of lay offs occurred in February 2009. Idaho Department of Labor statistics indicate that Idaho's unemployment rate increased from 2.8% in January 2007 to 3.3% in January 2008 to 6.5% in January 2009 and to 9% in October 2009. The October 2009 percentage converts to a record of over 67,800 unemployed. Unemployment rates in rural counties are higher, with an average 10 to 12 percent unemployed in June 2009 (Idaho Department of Labor statistics). In addition to unemployment, Idaho is experiencing a significant decrease in state tax revenue. The Idaho Division of Financial Management reports that in FY2009, total state General Fund tax revenue dropped 15.26% from FY2008.

Idaho did not receive Federal Center for Medicare and Medicaid (CMS) funding as Idaho was not aware that the "Cash and Counseling" funding option applied to mental health services. The Idaho Department of Health and Welfare did not apply for the "Home and Community-Based Waiver (HCBS)" or "Home and Community Based Services Option" because the State budget did not have the required State match funds. There were increased federal funds allocated through January 1, 2011, which decreased the State's Medicaid contributions by \$52 million for SFY 2009 and by \$73 million for SFY 2010.

The Idaho Department of Health and Welfare, with approval for approximately 3,136 employees, was affected by the economic downturn. An initial six percent across the board budget reduction was addressed by reduction in services, not filling vacant staff positions, requiring all state employees to take three days of furlough, and reductions in operating, capital, and trustee and benefits budgets from January to April 2009. The plan to address the additional mandated five percent personnel cut of \$9.5 million for SFY 2010 included restructuring the assignment of Regional Directors such that three Regional Directors serve all seven regions instead of one Regional Director per region. Eliminating four Regional Directors and their assistants resulted in an estimated savings of \$500,000. In SFY 2010 the Idaho Department of Health and Welfare experienced an additional layoff of 23 staff, an additional four days of furlough for all state employees, an additional 27 positions held vacant, and a transfer of budget funds from operating to personnel. Estimates indicate that the four furlough days will save 37 full time jobs.

In an effort to maintain service delivery, in spite of budget reductions, every effort has been made to retain direct service staff positions. In addition, increased efficiencies are sought through the development of new or revised policies and procedures in an effort to ensure consistency in business practices across the state. Included in new practices was the adoption of a "case acuity" model whereby cases are assigned an acuity level, based on the level of service need, with associated practice requirements. Included in this model are frequency of contact requirements and treatment monitoring requirements.

The requirement to administer the Child and Adolescent Level of Care Utilization System (CALOCUS) provides a framework for defining the appropriate type and intensity of both services and resources to meet the needs of children and families. Additionally, a client-perspective outcome measure, the Youth Outcome Questionnaire (YOQ) has been piloted and will be implemented statewide in SFY 2010.

2. Idaho Mental Health Transformation

Mental Health Transformation has been an ongoing focus for the State of Idaho. Transformation efforts have included the initial establishment of a transformation workgroup, a review of the mental health and substance use service delivery system by the Western Interstate Commission for Higher Education (WICHE) Mental Health Program, and the establishment of a second transformation workgroup.

Under the direction of Governor Dirk Kempthorne, Idaho initiated the Idaho Mental Health Transformation Work Group (TWG) in early 2006 in response to the recommendations of the President's New Freedom Commission report (2003). Guided by a steering committee composed of representatives from local and state government leadership, professional associations, consumer groups and other stakeholders, the TWG met from 2006 until 2007 and delivered a *Comprehensive Statewide Mental Health Transformation Action Plan 2007: The First Steps* (December 2006). According to this plan, the goals of a transformed system in Idaho were to 1) "Effect a paradigm shift by transforming the way we as a community think about and embrace mental health, understanding that mental health is essential to overall health...[2] Achieve a consumer-driven system of care by transforming the mental health delivery system to one that is based on individual strengths and needs, emphasizes resiliency and recovery, and features accessibility... and [3] Organize the structure to sustain the vision by transforming the manner in which resources are provided, coordinated and delivered." (p. 3).

According to Senate CR Number 108 (2007) and through the Legislative Health Care Task Force, the Idaho State Legislature directed implementation of a study to review Idaho's mental health and substance abuse treatment delivery system and to recommend system improvements. The Legislature contracted with the Western Interstate Commission for Higher Education (WICHE) Mental Health Program to conduct this study. Areas assessed included treatment capacity, cost, eligibility standards, and areas of responsibility. The study process included five site visits, 150 stakeholder interviews, and use of a web-based survey with responses from 550 Idaho stakeholders. The final written report with recommendations, *2008 Idaho Behavioral Health System Redesign*, was submitted to the legislature in August 2008.

In April 2009, Governor "Butch" Otter convened the "Behavioral Health Transformation Workgroup" to review the recommendations in the WICHE report regarding the advancement of the provision of core services for indigent clients from state employees to private provider community settings as outlined in the WICHE *2008 Idaho Behavioral Health System Redesign* report. The "Behavioral Health Transformation Workgroup" includes representation from the Department of Health and Welfare, 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 mental health provider, private business, the Association of Counties, and the Department of Correction. Goals under consideration by the workgroup include the following: 1) Establishing a coordinated, efficient state infrastructure with clear responsibilities and leadership authority and action, 2) Create a comprehensive, viable regional or local community delivery system, 3) Make efficient use of existing and future resources, 4) Increase accountability for services and funding, 5) Provide authentic stakeholder participation in the development, implementation and evaluation of the system, and 6) Increase the availability of, and access to, quality services. Recommendations by the workgroup are due to the Governor by the end of 2009.

3. Court Ordered Evaluation and Services

Two statutes have been implemented in Idaho that significantly affect both capacity and population served by Children's Mental Health. The first statute is Rule 19 of Idaho Juvenile Rules. This rule requires that before commitment of a juvenile to the custody of the Department of Juvenile Corrections, a magistrate must make findings on the record that the court has convened a screening team to evaluate alternatives to commitment. Rule 19 also includes additional requirements to be met before youth under the age of 12 years can be committed to the Department of Juvenile Corrections. The screening team may consist of the prosecuting attorney; the defense attorney; representatives of Juvenile Probation, the Department of Juvenile Corrections, and the Department of Health and Welfare; local school officials; and any other persons that the court may deem appropriate. Children's Mental Health clinicians are consistently required to attend screening teams and devote considerable time to those meetings. The expressed intent of Rule 19 was to decrease commitments to the Department of Juvenile Correction and that objective has been effective in achieved. However, referrals to Children's Mental Health have increased in proportion to decreases in commitments to the Department of Juvenile Corrections. The second statute, I.C. 20-511a, gives the court authority to order the Department of Health and Welfare to submit mental health assessments and a plan of treatment for a child or youth under jurisdiction of the juvenile court. The court may accept recommendations by the Department of Health and Welfare, other members of a screening team, or make other orders. The Children's Mental Health program has been impacted by court orders to serve youth when the youth does not meet eligibility criteria for the Children's Mental Health program and when the court orders treatment, including alternate-care placement, that is in opposition to recommendations by Children's Mental Health. No additional funding or other resources were dedicated to the Department of Health and Welfare as a result of these changes in code.

4. Infant and Early Childhood Mental Health

For over five years, a workgroup composed of representative from the Idaho Infant Toddler Program, Boise State University, Children's Mental Health, the Developmental Disabilities Program, the Early Childhood Coordinating Council, the Idaho Federation of Families for Children's Mental Health, and private providers have met to discuss issues related to infant and early childhood mental health. During the past year, the workgroup

has been involved in supporting the establishment of the Idaho Association for Infant and Early Childhood Mental Health and has sponsored consultation related to the accreditation of mental health providers serving infants and children up to the age of 5 years. An accreditation process and criteria has been purchased from Michigan and a strategic plan is being developed to implement the process. The objective is to increase the provider base of those with experience and training specific to providing mental health services to infants, young children, and parents.

5. Telehealth Service Implementation (TSI) Project

The Department of Health and Welfare established a Telehealth System Implementation (TSI) videoconferencing work group that produced a “Strategy for Video Conferencing Plan” in April 2008. The purpose of the TSI project was to use information technology to assist efforts to increase efficiency, reduce costs, and improve health and behavioral health access, services and education to Idaho citizens. The priority for using videoconferencing equipment is to expand psychiatric service access to prevent crises and maintain client stabilization, especially in rural and frontier areas.

During SFY 2009, equipment (i.e., the Polycom HDX 7000 Series with high definition video, voice and content sharing capabilities, Sony Bravia HDTVs and flat panel audiovisual carts with locking cabinets) was installed and tested in central office, State Hospital South, State Hospital North, and each of seven regions. As of September 2008, eleven high definition videoconferencing sites were available for site-to-site use. Sites included regional main offices, central office and three state hospitals (State Hospital South, State Hospital North, and Idaho State School and Hospital). The system has since been expanded to allow multi-site videoconferencing. As of May 2009, up to eight sites could participate simultaneously. Alternatively, four sites could simultaneously videoconference in high definition.

Although installed for less than a year, the videoconferencing equipment has been used for a multitude of purposes by a variety of agencies. Purposes include the provision and enhancement of psychiatric services, site reviews, hospital discharge planning, statewide meetings, supervision, training and education. The Behavioral Health program has expanded access to psychiatric care and services to children with serious emotional disturbance in rural and frontier areas. Medicaid found videoconferencing useful in providing trainings on new mental health rules and the Idaho State School and Hospital used the system to evaluate drug wholesalers. In addition, the State Planning Council on Mental Health has found videoconferencing effective in extending their budget while continuing to have meetings to address mental health issues.

As of May 2009, three contracted psychiatrists were providing telemedicine from the Boise Division of Behavioral Health central office. From September 2008 through May 2009, Region 2 estimated that 240 children received psychiatric services remotely through this system.

Idaho is primarily a rural and frontier state with all Idaho counties designated as mental health professional shortage areas. Psychiatric coverage is difficult to ensure across the State and travel costs are expensive. In a lean economic climate, all methods of cost reduction without compromising services are critical. Use of videoconferencing technology reduces costs with a high return on investment. High definition equipment allows for the provision of telemedicine, education, site reviews, and meetings without the requirement of travel.

The use of the videoconferencing equipment by the Department of Health and Welfare began in September 2008 and has increased rapidly since January 2009. From September through December 2008, the cost savings was \$15,485. From January through May 2009, the cost savings for all users totaled \$182,388. The cost savings related to the TSI project as measured by reduction in travel costs (i.e., mileage, airfare, staff time to travel, per diem, hotel and other miscellaneous costs accrued in the course of travel) has exceeded installation costs in less than a year. The total equipment costs of \$189,000 included cameras, monitors, carts, routers and a Multi-Channel Unit (MCU) device that enables simultaneous linkages to more than two connections. From September 2008 through May 2009, a combined savings for all users was \$197,873.

6. Wraparound

Services using the Wraparound model are available, in all regions of the state, to families when a child and family are assessed as requiring that level of intervention. Children's Mental Health clinicians receive training on the Mary Grealish wraparound model and use wraparound in working with families on their caseload. In addition, representatives from other agencies such as county probation, private providers of psychosocial rehabilitation, and the Department of Juvenile Corrections, have been trained by Children's Mental Health central office staff on the wraparound model. Representatives from Children's Mental Health and other agencies commonly co-facilitate wraparound meetings.

7. Parenting with Love and Limits (PLL)

Children's Mental Health began providing Parenting with Love and Limits (PLL) in June of 2008 and continues to provide PLL in all regions of the state. Children's Mental Health (CMH) has expanded the provision of PLL to youth and families involved in the juvenile justice system even when those youth do not meet CMH eligibility criteria. A summary of the results of the first year of implementation reveals the following: the cases of 51% of all families opened for PLL services were closed within 3 months (verses 12 months or longer for non-PLL cases), youth receiving PLL services showed significant reduction in extreme emotional and behavioral problems as measured by the Child Behavior Checklist (CBCL), 74% of parents and youth entering PLL services graduated, and diverting 143 families into PLL services has led to a potential cost savings of \$228,371 or a 51.6% cost reduction. It should also be noted that PLL has been added by SAMHSA as an evidence-based practice.

8. Transfer of Medicaid Mental Health Service Prior-Authorization to Medicaid

On July 1, 2009, Medicaid assumed responsibility for the prior-authorization of Medicaid services for children with SED. Prior to this change, the Regional Mental Health Authority was responsible for prior-authorization of Medicaid services. Under the Regional Mental Health Authority model, prior-authorization numbers were counted as served by the State Mental Health Authority. Since the change, those receiving prior-authorization services are counted as served by Medicaid and no longer counted as served by the State Mental Health Authority.

Child - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

Below is a description of how the Children's Mental Health Authority has allocated the FY2009 SAMHSA Block Grant and amounts expended to date:

MENTAL HEALTH BLOCK GRANT

	Federal Budget	Expenditures To Date (11/10/09)
Children's Mental Health		
CMH Special Projects:		
- Contract with Family Run Organization	\$200,000	0
- Contract for Suicide Prevention Services	\$22,854	0
- Contract for Primary Care Physician Training	\$20,000	0
-Transformation and System of Care Activities	\$69,267	\$69,267
Total Children Services	\$312,121	\$69,267
Administration	\$90,415	\$0
<i>Adult Mental Health</i> (see Adult Plan)	\$1,405,774	See Adult Section
TOTAL	\$1,808,310	\$69,267

The above information documents how the state will load the 2009 SAMHSA Block Grant funds into its budget structure for the Children's Mental Health program and expenditures as of November 10, 2009. This assures that all block grant funds pertaining to Children's Mental Health obtained through SAMHSA and in accordance with P.L. 102-321 were expended for community-based programming. The Children's Mental Health portion of the Block Grant will be allocated for special projects. Of the total **\$312,121** for Children's Mental Health, **\$200,000** is allocated to a contract with the Idaho Federation of Families for Children's Mental Health; **\$20,000** is allocated to a contract for the training of primary care physicians on the treatment of children with mental illness; **\$22,854** is allocated to a contract with Benchmark Research to provide information and efforts toward suicide prevention; and **\$69,267** is devoted to transformation and system of care activities to fund part of a parent management program, Parenting with Love and Logic. As of November 10, 2009, the only payment made from the 2009 Block Grant was a payment of **\$69,267** for the parent management program. Payments made prior to November 10, 2009 for the other Children's Mental Health allocations were made out of the 2008 Block Grant.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	8,707	10,356	8,500	8,209	96.58
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** Persons with a serious and persistent mental illness who do not have access to Medicaid or other forms of insurance will have access to SMHA services.
- Target:** Provide state public mental health service access to at least 8,500 eligible persons who are without Medicaid or other forms of insurance.
- Population:** Adults with SMI who are served by the SMHA and who do not have Medicaid or other forms of insurance.
- Criterion:** 2:Mental Health System Data Epidemiology
3:Children's Services
- Indicator:** Total number of persons without Medicaid or other forms of insurance who received services through the state operated mental health system.
- Measure:** Total number of persons without Medicaid or other forms of insurance receiving state operated mental health services.
- Sources of Information:** DAR, Manual Count (Behavioral Health Monthly Data Report), IMHP data system
- Special Issues:** Due to limitations with our current data systems we are unable to guarantee unduplicated client counts. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 22 field offices across the state. In the past the SMHA had primary responsibility for the prior authorization of all Psychosocial Rehabilitation services in Idaho through the Regional Mental Health Authority (RMHA) unit. This unit was transferred to Medicaid on July 1, 2008. Clients previously reported as served by the RMHA are now captured under the Medicaid system and th SMHA no longer includes these figures in this report of eligible clients served. Idaho's target population is defined as serious and persistent mental illness. The Department counts both enrolled and non-enrolled clients when determining the total persons served. Enrolled clients are those opened for services in the public mental health system and included in the Department's ongoing caseload count. Non-enrolled clients served are those that received at least one Department provided adult mental health service but are not formally opened or included in the ongoing services caseload count. These services include Consumer Activities, Advocacy & Development, Designated Exams, Disposition & Court services, and Information & Referral services.
- Significance:** National Outcome Measure.
- Activities and strategies/ changes/ innovative or exemplary model:** The data reported on this measure will rely on access data for eligible adult individuals in the SMHA. The Adult Mental Health program is not able to capture the data of those persons with a serious and persistent mental illness who receive services from private providers and who receive Medicaid.
- Target Achieved or Not Achieved/If Not, Explain Why:** Projections for total adults served for State FY 2009 was at least 8,500. The economic downturn in SFY 2009 resulted in layoffs and furloughs of DHW staff. Keeping in mind that system used for data capture in SFY 2009 was not entirely reliable, the actual number served was determined to be 8,209. This number was less than the target of 8,500, and this may be related to data reliability and to events stemming from the economic challenges in Idaho.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	2.30	.22	10	2.71	369
Numerator	13	1	--	18	--
Denominator	566	457	--	663	--

Table Descriptors:

- Goal:** Adults with a serious and persistent mental illness will be re-hospitalized less often as they will be able to access community based mental health services.
- Target:** Achieve a rate not to exceed 10% for re-admission to the two State Psychiatric Hospitals within 30 days of discharge.
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Percentage of persons who are re-admitted to a psychiatric hospital within thirty days of a state hospital discharge.
- Measure:** Numerator-Number of persons readmitted within thirty days of state hospital discharge
Denominator- Number of persons discharged from a state hospital
- Sources of Information:** State hospital data system.
- Special Issues:** This objective supports the Planning Council's priority on quality, continuum of care and community supports and is a required NOM.
- Significance:** National Outcome Measure.
- Activities and strategies/ changes/ innovative or exemplary model:** An adult mental health program policy requiring that persons discharged from a state psychiatric hospital can be opened (if there are no other providers) for follow up services by the regional CMHC for not less than 30 days, in most cases allows for consistent and coordinated discharge planning between the hospitals and the CMHC's. A post discharge survey is conducted by the regional CMHC staff on all persons discharged from a state psychiatric hospital. The surveys are then sent to State Hospital South for data tabulation. Implementation of the VistA data infrastructure system at both state hospitals and upgrades to the pharmacy management data system improves our ability to provide state hospital related data.
- Target Achieved or Not Achieved/If Not, Explain Why:** In SFY 2009, 18 individuals were readmitted to a state psychiatric hospital within 30 days out of a total number of 663 discharges. This reflects a 2.7% readmission rate within 30 days. This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	7.42	3.94	10	9.05	110.50
Numerator	42	18	--	60	--
Denominator	566	457	--	663	--

Table Descriptors:

- Goal:** Adults with a severe and persistent mental illness will be re-hospitalized less often as they will be able to access community based mental health services.
- Target:** Achieve a rate not to exceed 10% for re-admission to the two State Psychiatric Hospitals within 180 days of discharge.
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Percentage of persons re-admitted to a state psychiatric hospital within 180 days of discharge from a state psychiatric hospital.
- Measure:** Numerator- Number of person readmitted within 180 days of discharge.
Denominator- Total number of discharges.
- Sources of Information:** State hospital data system
- Special Issues:** VistA system implementation during SFY09 for the two state psychiatric hospitals improves Idaho's reporting of the NOMS. We are unable to report FY 2008 data without duplication, because the previous state hospital data system was only able to report the total number of readmission occurrences and could not unduplicate between the two hospitals or a single person with several re-admission episodes.
- Significance:** National Outcome Measure.
- Activities and strategies/ changes/ innovative or exemplary model:** A policy implemented in the adult mental health program requires that persons discharged from a state psychiatric hospital can be opened (if there are no other providers) for follow up services by the regional CMHC for not less than 30 days. In most cases, this allows for consistent and coordinated discharge planning between the hospitals and the CMHC's. A post discharge survey is conducted by the regional CMHC staff on all persons discharged from a state psychiatric hospital. The surveys are then sent to State Hospital South for data tabulation. Implementing the VistA data infrastructure system in both of the state hospitals improves our ability to provide state hospital related data.
- Target Achieved or Not Achieved/If Not, Explain Why:** In SFY 2009, 60 individuals were readmitted to a state hospital within 180 days, out of a total number of 663 discharges. This results in a readmission within 180 days percentage of 9%. This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	1	1	1	5	500
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Persons with a severe and persistent mental illness will have increased access to evidence based mental health services.

Target: Maintain the number of Evidence-Based Practices in Idaho in SFY 2009 and increase the number of persons served by those programs during SFY08.

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Total number of evidence based practices provided by the SMHA.

Measure: Total number of evidence based practices that are implemented by the adult mental health program.

Sources of Information: Regional reports, Vocational Rehabilitation (Supported Employment, the Behavioral Health (BH) monthly data report (Co-Occurring), the Client Level Reporting Project (CLRP) data for Regions 1, 5 and 6 (Illness Self Management and Medication Management).

Special Issues: The only evidence based practice (EBP) reported in SFY 2008 was Assertive Community Treatment (ACT). In SFY 2009, ACT continued to be offered, and additional data was captured on the EBP's of Supported Employment, Integrated Treatment for Co-Occurring Disorders (MH/SA), Illness Self Management and Medication Management. Supported Employment data is provided by the Idaho Division of Vocational Rehabilitation, and they provide this data for the SFY 2009 report. Numbers of individuals receiving Co-Occurring Disorders treatment began being tracked on the BH Monthly Data report in 1/09. This was limited to numbers of ACT clients (both MH court referred and non-MH court referred) with MH/SA diagnoses and treatment, and data was based on only six of 12 months of SFY 2009. Illness Self Management and Medication Management data was derived from data gathered by the three regions in the CLRP, and does not reflect the other four service regions in Idaho.

Significance: This is a required National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model: Assertive Community Treatment services are available in each of seven service regions of the Department of Health and Welfare's Adult Mental Health Program. These services are available through main sites and satellite offices. Clients include traditionally referred and Mental Health court referred individuals. ACT staff work collaboratively with mental health courts in each region. The numbers served with co-occurring, integrated disorders treatment services primarily reflect services available to ACT clients.

Target Achieved or Not Achieved/If Not, Explain Why: The only evidence based practice (EBP) reported in SFY 2008 was Assertive Community Treatment (ACT). In SFY 2009, ACT continued to be offered, and additional data was captured on Supported Employment, Integrated Treatment for Co-Occurring Disorders (MH/SA), Illness Self Management and Medication Management. This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why: The EBP of Supported Housing is not provided through the SMHA at this time in Idaho.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	112	54.07	48.28
Numerator	N/A	N/A	--	146	--
Denominator	N/A	N/A	--	270	--

Table Descriptors:

Goal: Idaho's Division of Behavioral Health is collaborating with Idaho Division of Vocational Rehabilitation to improve data capture of Supported Employment services provided to adults with SMI are served through the DHW SMHA service system.

Target: The target for SFY 2009 was to ensure that at least sixteen adults with a serious mental illness per each of 7 CMHC service sites receives supported employment services, for a total of 112.

Population: Adults with a serious mental illness who are receiving services through regional behavioral health mental health service programs.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Collaboration between regional adult mental health and vocational rehabilitation programs to provide best practice supported employment services to at least 112 persons served also by the SMHA (i.e., 16 eligible consumers per region) by June 30, 2009.

Measure: Numerator is the number of Rehabilitated Closed cases (146) in SFY 2009; this is the number employed for 90 days, after which the case is closed. Denominator is the Rehab Closed (146) + Open (Employed or in Training) (124) = total 270 served.

Sources of Information: Idaho Division of Vocational Rehabilitation data on regional adult mental health service center clients that are also provided supportive employment services during SFY 2009.

Special Issues: The Division of Behavioral Health and the Idaho Division of Vocational Rehabilitation (IDVR) are in the process of identifying methods to better capture supported employment service data. During SFY 2009, IDVR provided monthly service reports to the Division of Behavioral Health. IDVR regional staff attended at least one weekly ACT meeting in each region.

Significance: Increased collaboration and data capture improves supported employment service and access to Idaho adult citizens with a serious mental illness receiving services from regional CMHC's.

Activities and strategies/ changes/ innovative or exemplary model: See special issues.

Target Achieved or Not Achieved/If Not, Explain Why: The SFY 2009 target was to serve a total number of 112 persons with Supported Employment. The actual SFY 2009 number served was 146 (as measured by served and closed after 90 days of employment) out of 270 served (this number includes rehabilitated plus open and either employed or in training). This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	547	N/A	525	7.15	1.36
Numerator	N/A	525	--	587	--
Denominator	N/A	N/A	--	8,209	--

Table Descriptors:

Goal: Persons with a severe and persistent mental illness have access to assertive community treatment and forensic assertive community treatment services.

Target: Provide ACT services to at least 525 persons as measured by total number of ACT served plus total number of Mental Health Court ACT served during SFY 09.

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Total number of persons receiving Assertive Community Treatment Services (i.e., total ACT plus total MH Court ACT) from the SMHA.

Measure: Total number of persons receiving ACT services (total traditionally referred ACT plus mental health court referred ACT). To determine a baseline percentage of ACT per total clients, the numerator is number of ACT clients and the denominator is total number served in SFY 2009.

Sources of Information: Regional data bases, Behavioral Health monthly data report of ACT and MH Court ACT clients served, IMHP

Special Issues: This is a required NOM.

Significance: Idaho continues to support the implementation of ACT teams in the public mental health system as a strategy to decrease psychiatric hospitalizations and to maintain persons in their communities with the necessary supports. Additionally, Idaho ACT teams collaborate to provide services to eligible individuals referred through regional Mental Health Courts.

Activities and strategies/ changes/ innovative or exemplary model: ACT staff serve traditionally referred ACT clients and mental health court referred clients in each region.

Target Achieved or Not Achieved/If Not, Explain Why: The SFY 2009 target of 525 was defined as the total numbers of ACT clients. The actual total number of ACT clients in SFY 2009 was 587. The total number of clients served in SFY 2009 was 8,209. The percentage of ACT clients served out of the total number served in SFY 2009 was 7.15%. This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why: The Idaho SMHA did not provide the EBP of Family Psychoeducation in SFY 2009.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	150	2.29	1.53
Numerator	N/A	256	--	188	--
Denominator	N/A	N/A	--	8,209	--

Table Descriptors:

Goal: Provide co-occurring, integrated treatment to adults with co-occurring mental illness and substance use disorders to at least 150 adults referred through regional Mental Health courts by June 30, 2009.

Target: The target for SFY 2009 is to provide co-occurring, integrated treatment services to at least 150 eligible adults referred through regional mental health courts

Population: Adults with co-occurring mental health and substance use disorders referred through regional mental health courts.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Provision of co-occurring, integrated treatment services to at least 150 individuals with mental illness and substance use disorders referred through regional mental health courts.

Measure: The goal was defined as a total number served. In order to identify a baseline percentage, the numerator is the number of MH court referred ACT clients receiving co-occurring, integrated MH/SA treatment. The denominator is total number served.

Sources of Information: Regional counts, court data, Behavioral Health Adult Mental Health Monthly Data Report.

Special Issues: Idaho has worked to standardize the process to capture system data from mental health and substance use programs. Regional ACT teams provide dual diagnosis groups and other dual diagnosis services to adults referred through mental health courts. In SFY 2008, 201 mental health court referred clients were served by regional ACT teams; approximately 140 of these individuals received dual diagnosis services. In SFY 2009, 188 mental health court referred clients received co-occurring, integrated services. Additionally, there were also 197 traditionally referred ACT clients who were diagnosed with co-occurring disorders in SFY 2009. Out of a total of 587 ACT clients, 385 of these were identified with co-occurring MH/SA diagnoses. At least 188 of these (i.e., the MH court referred) received integrated disorders treatment services.

Significance: National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model: Provide dual diagnosis services to at least 150 mental health court referred clients served by regional ACT or forensic ACT teams.

Target Achieved or Not Achieved/If Not, Explain Why: The SFY 2009 target was provision of co-occurring, integrated treatment services provided to at least 150 mental health court referred ACT clients. The total number served was actually 188. This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	12.69	N/A
Numerator	N/A	N/A	--	1,042	--
Denominator	N/A	N/A	--	8,209	--

Table Descriptors:

- Goal:** The State of Idaho did not have a targeted SFY 09 goal for the EBP of Illness Self Management.
- Target:** The State of Idaho did not have a targeted SFY 09 goal for the EBP of Illness Self Management.
- Population:** Adults diagnosed with a serious and persistent mental illness receiving illness self management services in the 3 Client Level Reporting Project pilot regions (i.e., Regions 1, 5 and 6).
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The number of clients receiving illness self management services in Regions 1, 5 and 6 as reported in the FY 2009 Client Level Reporting Project data deliverable.
- Measure:** The number of clients receiving illness self management services in Regions 1, 5 and 6 as reported in the FY 2009 Client Level Reporting Project data deliverable.
- Sources of Information:** The Client Level Reporting Project SFY 2009 data deliverable for pilot regions 1, 5 and 6.
- Special Issues:** Idaho has not previously captured data related to the Illness Self Management EBP. The data system that was used was not robust, and did not track this EBP. The WITS system was implemented for tracking AMH data in October 2009, and the data elements were crafted to correspond with the CLRP data element definitions. This EBP should be available for the entire state next year.
- Significance:** This is an evidence based practice.
- Activities and strategies/ changes/ innovative or exemplary model:** Idaho has not captured data related to the Illness Self Management EBP. During the course of developing an EXCEL spreadsheet with the CLRP data element definitions and tracking this data, Regions 1, 5 and 6 also tracked and reported on the Illness Self Management EBP. Descriptions according to the SAMHSA site were provided to each region on this EBP, and the numbers reported on the CLRP related to the CLRP definitions and the SAMHSA criteria.
- Target Achieved or Not Achieved/If Not, Explain Why:** There was no specific target for this EBP projected for SFY 2009. The CLRP allowed this EBP to be tracked for the participating pilot regions (Regions 1, 5 and 6). The total served in those three regions in SFY 2009 with Illness Self Management services was 1,042.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	15.91	N/A
Numerator	N/A	N/A	--	1,306	--
Denominator	N/A	N/A	--	8,209	--

Table Descriptors:

- Goal:** Idaho did not have a targeted SFY 2009 goal for the Medication Management EBP.
- Target:** Idaho did not have a targeted SFY 2009 goal for the Medication Management EBP.
- Population:** Adults diagnosed with a serious and persistent mental illness receiving Medication Management services in the three Client Level Reporting Project (CLRP) regions (i.e., Regions 1, 5 and 6) in SFY 2009.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The numerator is the number receiving Medication Management services in the CLRP pilot regions (1,5 and 6).
The denominator is the total number receiving SMHA services in the entire State (7 regions) in SFY 2009.
- Measure:** The numerator is the number receiving Medication Management services in the CLRP pilot regions (1,5 and 6).
The denominator is the total number receiving SMHA services in the entire State (7 regions) in SFY 2009.
- Sources of Information:** The Client Level Reporting Project SFY data element deliverable for SFY 2009 for Regions 1, 5 and 6.
- Special Issues:** Idaho has not previously captured data related to the Medication Management EBP. The data system that was used was not robust, and did not track this EBP. The WITS system was implemented for tracking AMH data in October 2009, and the data elements were crafted to correspond with the CLRP data element definitions. This EBP should be available for the entire state next year.
- Significance:** This is an evidence based practice.
- Activities and strategies/ changes/ innovative or exemplary model:** During the course of developing an EXCEL spreadsheet with the CLRP data element definitions and tracking this data, Regions 1, 5 and 6 also tracked and reported on the Medication Management EBP. Descriptions according to the SAMHSA site were provided to each region on this EBP, and the numbers reported on the CLRP related to the CLRP definitions and the SAMHSA criteria.
- Target Achieved or Not Achieved/If Not, Explain Why:** There was no SFY 2009 target for Medication Management. The number served as reported by Regions 1, 5 and 6 in the SFY 2009 CLRP deliverable was 1,306 individuals receiving Medication Management.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	88	84.68	85	84.97	99.96
Numerator	704	763	--	656	--
Denominator	800	901	--	772	--

Table Descriptors:

Goal: Persons receiving SMHA services will report a positive perception of care received from the SMHA.

Target: To achieve an 85% or higher approval rating in consumer's positive satisfaction with services.

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of consumers receiving DHW provided mental health services who rate positive satisfaction with services.

Measure: Numerator- Number of consumers who rate positive satisfaction with services
Denominator- Number of completed consumer satisfaction surveys

Sources of Information: DS2k+ Website, MHSIP Adult Consumer Survey

Special Issues: This is a required NOM.

Significance: Measurement of consumer satisfaction is an important component in assessing the overall quality and appropriateness of services. This supports the Planning Council's priorities related to Quality.

Activities and strategies/ changes/ innovative or exemplary model: Beginning in October 2003, Idaho adopted and implemented the use of the MHSIP Adult Consumer Satisfaction Survey. The survey is offered annually and at discharge to all persons receiving ongoing publicly provided adult mental health services for 30 days or more. Consumers are asked to voluntarily complete the survey. Completed paper surveys are sent to central office where they are data entered into the DS2K+ website by support staff.

Target Achieved or Not Achieved/If Not, Explain Why: The target for this Performance Indicator was 85% of consumers responding to the MHSIP consumer survey would report positively about general satisfaction with services. Actual numbers were 656 out of a total of 772 respondents, for an 84.97% reporting positively. This target was 99.96% achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	112	54.07	48.28
Numerator	N/A	N/A	--	146	--
Denominator	N/A	N/A	--	270	--

Table Descriptors:

- Goal:** Provide increased and/or retained employment for adults receiving SMHA services.
- Target:** Provide employment services to at least 16 persons per region for a total of at least 112 persons.
- Population:** Eligible adults with a serious mental illness who are able to work.
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Number of adults able to work who are receiving SMHA services and who are employed.
- Measure:** Number of adults able to work who are receiving SMHA services and who are employed.
- Sources of Information:** Division of Vocational Rehabilitation, Regional information
- Special Issues:** The Division of Behavioral Health has an Interagency Agreement with Idaho Division of Vocational Rehabilitation (IDVR) to provide vocational services to SMHA adults with a serious and persistent mental illness. This year, the agreement includes additional data capture and reporting. It also includes increased IDVR presence during weekly ACT team meetings.
- Significance:** This is a National Outcome Measure. The Idaho Division of Vocational Rehabilitation defines Community Supported Employment according to the number of days of ongoing employment. Clients that are able to retain employment for a period of 90 days are determined to be successful, and their case is closed under the Rehabilitations, Closed category. The numbers reported on this Performance Indicator are SMHA clients receiving IDVR services and determined to be Rehabilitated, Closed during SFY 2009.
- Activities and strategies/ changes/ innovative or exemplary model:** The SMHA and IDVR collaborate to increase and retain the number of adults with SMI able to work and that are working and retaining jobs.
- Target Achieved or Not Achieved/ If Not, Explain Why:** The SFY 2009 Performance Indicator was defined as the total number of persons receiving Supported Employment, with a projected number of 112 clients. The actual number receiving these services was 146 clients who retained employment at least 90 days before their case was closed. The percentage above reflects the 146 clients retaining employment out of the total number of VR clients who retained employment plus those currently open and employed and those open and engaged in training to be employed. This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	83.52	85.90	4	92.97	2,324.25
Numerator	527	542	--	463	--
Denominator	631	631	--	498	--

Table Descriptors:

- Goal:** Adults receiving SMHA services will report decreased arrests.
- Target:** To achieve 4% or less in arrests reported through MHSIP system, or 96% of reports of not being arrested in the previous 12 month period.
- Population:** Adults served by regional community mental health programs with SMI and also with criminal justice involvement.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Numbers of consumers responding to MHSIP survey question and indicating that they were not arrested during the previous 12 month period.
- Measure:** Establish a baseline on numbers of adults with SMI with criminal justice involvement. Numbers of consumers responding to MHSIP survey question and indicating that they were not arrested during the previous 12 month period.
- Sources of Information:** Regional data sources, courts, corrections, MHSIP consumer survey
- Special Issues:** The Adult Mental Health system has been challenged with an inadequate system to capture relevant data. For SFY 2009, this measure was reliant on data reported by consumers who returned their MHSIP surveys. While the total number of individuals responding to this question on the MHSIP survey was 521 individuals, 23 did not respond to the question of whether they had been arrested in the previous 12 month period, and those 23 were subtracted from the total of 521 to yield a total of 498 individuals who actively responded to this question. Of those 498 individuals, 35 reported that they had been arrested in the previous 12 month period, and 463 reported that they had not been arrested.
- Significance:** This is a National Outcome Measure.
- Activities and strategies/ changes/ innovative or exemplary model:** Continue to track reported arrests through MHSIP. Work to develop an internal data infrastructure system to capture arrest data related to clients receiving services through the SMHA.
- Target Achieved or Not Achieved/If Not, Explain Why:** The target for this Performance Indicator was 96% responding to the MHSIP consumer survey question that they had not been arrested in the previous 12 month period. There was 92.97% that reported that they were not arrested in the previous 12 month period. This goal was 89% achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	450	81.11	554.80
Numerator	N/A	N/A	--	365	--
Denominator	N/A	N/A	--	450	--

Table Descriptors:

- Goal:** Increase stability in housing among adults receiving SMHA services who have been homeless or at risk of homelessness.
- Target:** At least 450 persons who have received homeless services through the SMHA will retain stable housing for at least 6 months.
- Population:** Adults with a serious mental illness (SMI).
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Adults receiving SMHA services who have been homeless or at risk of becoming homeless will retain stable housing (i.e., permanent housing) for at least 6 months.
- Measure:** Adults receiving SMHA services who have been homeless or at risk of becoming homeless will retain stable housing (i.e., permanent housing) for at least 6 months.
- Sources of Information:** Regional data sources, PATH, Idaho Housing (Shelter Plus Care data).
- Special Issues:** The Adult Mental Health system has been challenged with an inadequate data capture system that requires regional hand counts. Data will be captured through the WITS system in SFY 2010.
- In SFY 2009, the economy resulted in layoffs and required furloughs. This decreased staff capacity may have affected the intensity of services that were available to assist clients in maintaining stability in housing.
- Significance:** This is a National Outcome Measure.
- Activities and strategies/ changes/ innovative or exemplary model:** A tracking measure in the PATH data reports allows measurement of stability in permanent housing for those adult clients who received PATH services. Shelter Plus Care data is tracked by the Idaho Housing Agency.
- Target Achieved or Not Achieved/If Not, Explain Why:** The SFY 2009 goal was to ensure that at least 450 adults who were homeless or at risk of becoming homeless would retain stable housing for at least six (6) months. The Actual number for SFY 2009 was 288 served by PATH and 77 with Shelter Plus Care for a total of 365. This goal was 81% achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	63.50	67	64.25	95.90
Numerator	N/A	548	--	478	--
Denominator	N/A	863	--	744	--

Table Descriptors:

Goal: Adults receiving SMHA services will report a stronger sense of social connectedness.

Target: To achieve a 67% or higher rating on social connectedness.

Population: Adults with a serious mental illness (SMI).

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Responses on consumer survey (MHSIP).

Measure: Responses on consumer survey (MHSIP).

Sources of Information: Consumer survey (MHSIP).

Special Issues: The Adult Mental Health program began implementing the VistA system for state hospital reporting in SFY 2008. The WITS system began implementation for tracking community mental health services in October, 2009. It is hoped that these systems will improve data and data reporting for the NOMS, URS and Block Grant reports, in addition to providing better data to inform the mental health service system in Idaho.

Significance: This is a National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model: Encourage completion and submission of MHSIP consumer surveys.

Target Achieved or Not Achieved/If Not, Explain Why: In SFY 2009, there were 744 surveys returned, with 478 of these respondents reporting positively on Social Connectedness. This is a 64.24 percentage; the SFY 2009 target was 67% positive responses on Social Connectedness and this goal was 96% achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	64.77	63	66.89	106.17
Numerator	N/A	559	--	497	--
Denominator	N/A	863	--	743	--

Table Descriptors:

- Goal:** Adults receiving SMHA services will report an improved level of functioning as a result of treatment services provided.
- Target:** To achieve at least 63% or higher report of improved functioning.
- Population:** Adults with a serious mental illness (SMI).
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations
- Indicator:** Subjective report of improved functioning; objective regional reports of increased functioning in areas of psychiatric stability, work, housing, family, etc.
- Measure:** Subjective report of improved functioning on the MHSIP consumer survey; objective regional reports of increased functioning in areas of psychiatric stability, work, housing, family, etc.
- Sources of Information:** Consumer survey (MHSIP) and regional data submissions.
- Special Issues:** The Adult Mental Health program began implementing the VistA system for state hospital reporting in SFY 2008. The WITS system began implementation for tracking community mental health services in October, 2009. It is hoped that these systems will improve data and data reporting for the NOMS, URS and Block Grant reports, in addition to providing better data to inform the mental health service system in Idaho.
- Significance:** This is a National Outcome Measure.
- Activities and strategies/ changes/ innovative or exemplary model:** Track and report improved functioning via MHSIP consumer survey responses.
- Target Achieved or Not Achieved/If Not, Explain Why:** In SFY 2009, there were 743 surveys returned with responses in the Improved Functioning category. There were 497 who reported Improved Functioning. This is 67%, which is greater than the SFY 2009 target of 63% positive responses on Improved Functioning. This goal was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: ACT Outcomes and Fidelity Measurement

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	7	6	3	4	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** The State will continue to develop and fund innovative projects, enhance service delivery, provide training as well as provide adequate funding to provide accessible, high quality and evidence based mental health services.
- Target:** The Adult Mental Health Program will conduct ACT fidelity assessment on no less than three existing ACT or forensic ACT teams.
- Population:** Adults with SMI who are receiving ACT or forensic ACT (FACT) services from regional SMHAs.
- Criterion:** 5:Management Systems
- Indicator:** The number of completed ACT or FACT fidelity assessments.
- Measure:** Total number of completed ACT or FACT fidelity assessments conduct during SFY 09.
- Sources of Information:** Adult Mental Health Program DACTS scores/review, regional information, Behavioral Health Monthly Data Report.
- Special Issues:** This objective supports the State Planning Council's priorities on quality and continuum of care. While the Dartmouth Assertive Community Treatment Scale (DACTS) is used for determining fidelity, the DACTS does not completely and accurately reflect ACT services in rural and frontier areas, or effectiveness of services provided to mental health court referred clients. For example, one item on the DACTS encourages a low graduation rate. Mental health court referred clients are successful when they graduate from the program.
- Significance:** ACT teams provide community based services to adults with a serious and persistent mental illness who require intensive services to maintain in a least restrictive, community setting and forensic ACT services to eligible adults referred through regional Mental Health Courts. Fidelity assessments help to determine fidelity to the model and provide an opportunity for both feedback and sharing of information on best practice service delivery.
- Activities and strategies/ changes/ innovative or exemplary model:** Data relating to ACT services and to MH Court ACT services is manually counted through the Behavioral Health Monthly Data Report form. The Adult Mental Health Program has selected the DACTS Fidelity Scale as the assessment tool to be used to measure the fidelity of the ACT program in Idaho. Assessments were conducted on four regional ACT teams by a team led by the Division office with a peer reviewer from another region. Assessments were done in Caldwell (7/2/08), Lewiston (7/8/08), Orofino (7/9/08) and Twin Falls (9/10/08).
- Target Achieved or Not Achieved/If Not, Explain Why:** The SFY 09 target was to review ACT fidelity on at least 3 regional ACT teams. The actual number of DACTS reviews in SFY 2009 was 4; this target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: AMH Data System

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	1	1	1	1	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Provide standardized, accurate and timely outcome based data reports for the Adult Mental Health Program.

Target: Identify a viable data infrastructure system to invest in that will allow reliable AMH data tracking of data related to NOMS, URS and other mental health outcomes and services.

Population: Adults with SMI

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Division Administration will choose and commit to pursuit of a specific data system for AMH data capture.

Measure: Division Administration will choose and commit to pursuit of a specific data system for AMH.

Sources of Information: ITSD, Division of Behavioral Health

Special Issues: The Division of Behavioral Health's FY07 business needs analysis identified multiple problems with the existing IMHP system. Regions developed an interim method of manually capturing critical data through the Behavioral Health Monthly Data Report; this was piloted in December 2006 and has undergone revisions since that time. The Adult Mental Health program explored requirements in SFY 2008, and chose the WITS system in SFY 2009 to support the community mental health center data tracking needs. Efforts to install and implement the VistA system at SHS and SHN were delayed when the contract with the first vendor was terminated. A second vendor was secured, and implementation of VistA continued throughout SFY 2009.

Significance: It is critical that the SMHA accurately report and identify the populations being served and the outcomes of services provided. Reliable and valid data is necessary for informed decision making by Health and Welfare, the State Planning Council on Mental Health and the Idaho Legislature.

Activities and strategies/ changes/ innovative or exemplary model: The VistA data system was installed at both state hospitals in July 2007. The Division of Behavioral Health's efforts to identify and implement a more robust data infrastructure were aided by the DIG grant and the CLRP grant. The WITS system was informed by the data element definitions for the NOMS and URS from the CLRP grant. The legislature allocated SFY 2009 funds to support a joint data system to serve the needs of the Adult Mental Health and Substance Use Disorders programs.

Target Achieved or Not Achieved/If Not, Explain Why: The goal was to identify a viable data infrastructure system to support AMH. During SFY 2009, the VistA system continued to be implemented at both state hospitals, and the WITS system was chosen to support the data needs for the AMH community mental health program needs. This goal was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Attend Medication Appointment After State Hospital Discharge

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	70.70	67.60	70	N/A	N/A
Numerator	323	261	--	414	--
Denominator	457	386	--	549	--

Table Descriptors:

- Goal:** Persons with serious mental illness discharged from a state hospital will have ready access to community-based mental health services.
- Target:** Achieve a rate of 70% or higher for persons discharged from a state psychiatric hospital who attend their scheduled first medication follow-up appointment with their physician or physician extender.
- Population:** Adults diagnosed with a serious and persistent mental illness.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of persons discharged from a state hospital who keep their first medication follow-up appointment with a physician or physician extender at their community mental health provider.
- Measure:** Numerator- Number of persons who keep their first medication follow-up appointment with a physician after discharge Denominator- Number of persons discharged from a state hospital as measured by total number of discharge survey results.
- Sources of Information:** State Hospital data bases, discharge survey, Behavioral Health Monthly Data Report.
- Special Issues:** Results of the discharge survey are sent to Central Office and entered into the Behavioral Health monthly data report. Because of the delay in receiving and processing the results of discharge surveys, the data for this measure is one quarter behind. In other words, this data reflects the 4th quarter of SFY 08 (4/1/08-6/30/08) and the first three quarters of SFY 09 (7/1/08-3/31/09).
- Significance:** Attending the first medication follow-up appointment in the community is a key indicator of successful community reintegration and treatment compliance. This objective supports the Planning Council's objective on quality, continuum of care and community supports.
- Activities and strategies/ changes/ innovative or exemplary model:** All persons discharged from a state hospital have a medication followup appointment with their community mental health provider scheduled prior to their being discharged from the state hospital. A post discharge survey is conducted by the regional CMHC staff on all persons discharged from a state psychiatric hospital. The surveys are sent to SHS for data tabulation. The state hospital sends the results (one quarter behind) to Central Office for inclusion in the Behavioral Health Monthly Data Report.
- Target Achieved or Not Achieved/If Not, Explain Why:** The SFY 2009 target for the Performance Indicator for attending the first medication appointment after state hospital discharge was 70%. The actual figure was 78%. This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Co- Occurring Disorders Training

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	3	2	2	21	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Idaho is developing and implementing a best practice model of integrated treatment to serve those with co-occurring substance use and mental health diagnoses.

Target: The Adult Mental Health Program will provide at least two (2) training opportunities for CMHC staff on treatment strategies for co-occurring disorders.

Population: Adults with SMI

Criterion: 5:Management Systems

Indicator: Co-occurring treatment training provided

Measure: The number of trainings completed.

Sources of Information: Adult Mental Health Program, number of training opportunities on integrated treatment for co-occurring disorders.

Special Issues: A primary emphasis of the ACT teams in Idaho is provision of collaborative services to participants in the Idaho Mental Health Court programs. One of the the essential core components is the ability to provided integrated treatment for persons with co-occurring disorders.

Significance: This objective supports the Planning Council's priorities on continuum of care as well as the President's New Freedom Recommendations related to Goal 5. This has also been identified as a system training priority by the Adult Mental Health Program Managers. Continue training staff; implement the Idaho DDCAT in at least 3 regional DHW mental health provider sites by June 30, 2009. Provide at least two training opportunities by June 30, 2009. Potential trainers include Ken Minkoff, Christie Cline, Davie Mee-Lee and trainers from the Co-Occurring Center for Excellence (COCE).

Activities and strategies/ changes/ innovative or exemplary model: The Adult Mental Health Program allocated funds and coordinated training on implementing co-occurring treatment for regional CMHC staff during the first half of SFY 2009. The economic downturn affected the ability to continue training, especially with respect to out of state contracts. Co-occurring training opportunities did continue in the regions. Region 1 offered 10 trainings; Region 2 had one training; Region 3 had 1 event; Region 4 had 3 training events; Region 5 had 2 training events, Region 6 had one event and Region 7 had 3 training events.

Target Achieved or Not Achieved/If Not, Explain Why: Regions reported a total of 21 Co-Occurring Disorders Training opportunities in SFY 2009. This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Follow Up Appointment Within 7 Days of Discharge

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	90.20	89.10	80	88.90	100
Numerator	412	344	--	471	--
Denominator	457	386	--	549	--

Table Descriptors:

- Goal:** Adults with a serious mental illness discharged from a state hospital will have ready access to community based mental health services.
- Target:** Achieve a rate of 80% or higher for the number of persons seen for a first face to face appointment at their community mental health provider within 7 days of discharge from an Idaho state hospital.
- Population:** Adults diagnosed with a serious and persistent mental illness (SPMI).
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of persons seen at their community mental health provider within 7 days of discharge from an Idaho state hospital.
- Measure:** Numerator: Number of persons seen by their community mental health provider within 7 days of discharge from a state hospital.
Denominator: Number of persons discharged from a state psychiatric hospital as measured by discharge survey results.
- Sources of Information:** State hospital database, discharge survey.
- Special Issues:** Results of the discharge survey are sent to Central Office and entered into the Behavioral Health monthly data report. Because of the delay in receiving and processing the results of discharge surveys, the data for this measure is one quarter behind. In other words, this data reflects the 4th quarter of SFY 08 (4/1/08-6/30/08) and the first three quarters of SFY 09 (7/1/08-3/31/09).
- Significance:** Timely follow-up in the community is a significant indicator for successful community integration and reduction of re-hospitalization. This objective supports the Planning Council priorities on quality, continuum of care and community supports.
- Activities and strategies/ changes/ innovative or exemplary model:** A post discharge survey is conducted by regional CMHC staff on all persons discharged from a state psychiatric hospital, with surveys sent to SHS for data tabulation.
- Target Achieved or Not Achieved/If Not, Explain Why:** The target for this Performance Indicator was that at least 80% of persons would be seen for a first face to face appointment at their community mental health provider within 7 days of discharge from an Idaho state hospital. The actual SFY 2009 percentage was 88.9%. This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Homeless Persons Served

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	1,104	518	N/A	207	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** This was not a targeted Performance Indicator goal in SFY 2009. Data is provided for informational purposes.
- Target:** This was not a targeted Performance Indicator goal in SFY 2009. Data is provided for informational purposes.
- Population:** Adults diagnosed with a serious and persistent mental illness.
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** The number of persons served by the SMHA who reported living in a homeless shelter as measured by the IMHP data system in SFY 2009.
- Measure:** The number of persons served by the SMHA who reported being homeless or living in a homeless shelter as measured by the IMHP data system in SFY 2009.
- Sources of Information:** The IMHP data system living situation data field for homeless or living in a homeless shelter.
- Special Issues:** The IMHP data system has not provided consistently reliable data but it is the best source available for reporting SFY 2009 data. The WITS data system was implemented in Idaho in October 2010 and will be used for future NOMS/URS and block grant reporting.
- Significance:** Provision of mental health services to eligible individuals who are homeless or who are at risk of homelessness helps to develop recovery, resilience and stabilization.
- Activities and strategies/ changes/ innovative or exemplary model:** Activities and strategies to serve those who are homeless or at risk of becoming homeless and who have a diagnosis of a serious and persistent mental illness include assessment; linkage to, and collaboration with, other resources and providers; and provision of an array of mental health services that are individualized to the needs of the person.
- Target Achieved or Not Achieved/If Not, Explain Why:** The IMHP data system indicates that mental health services were provided to 207 adults who reported living in a homeless shelter at one point in SFY 2009. This information related only to those indicating that they were homeless or that they lived in a homeless shelter during the reporting period; it did not include those who were doubled up or at risk of becoming homeless.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Homeless Services Providers

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	7	7	7	7	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** The goal is to improve access and quality of services provided to individuals who are homeless and diagnosed with a serious and persistent mental illness.
- Target:** Each regional Community Mental Health Center will provide at least one outreach activity to local area providers of homelessness services in order to facilitate access to necessary mental health services for individuals who are homeless or at risk of homelessness, and who have a diagnosis of a serious and persistent mental illness.
- Population:** Adults who are either homeless or at risk of becoming homeless and who have a diagnosis of a serious and persistent mental illness.
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** Number of outreach activities; the target is at least one per region. There are seven regions and the target is seven outreach activities.
- Measure:** Number of outreach activities; the target is at least one per region. There are seven regions and the target is seven outreach activities.
- Sources of Information:** Regional Point in Time count events with outreach activities included. Regional self-report.
- Special Issues:** Each regional CMHC works collaboratively with local area homeless service providers.
- Significance:** Providing outreach to homeless services providers improves the availability of quality services for all Idaho citizens who need mental health services.
- Activities and strategies/ changes/ innovative or exemplary model:** During SFY 2009, each Regional CMHC provided outreach in the course of a regional Point in Time count (aka Homeless Stand Down) of those who were homeless in their regions. These events provided assistance to those who were homeless and requested assistance with applying for benefits or services and/or with referrals to other resources. Outreach brochures and mental health service applications were passed out at these events, and participating organizations networked and collaborated to meet the needs of those who attended and needed help.
- Target Achieved or Not Achieved/If Not, Explain Why:** There were a total of 7 outreach events in SFY 2009.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Increased Access to Independent Housing

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	95.24	76.10	N/A	78.76	N/A
Numerator	14,827	7,880	--	6,465	--
Denominator	15,567	10,356	--	8,209	--

Table Descriptors:

- Goal:** The SFY 2009 Plan did not include a Performance Indicator goal for Increased Access to Independent Housing. Data is provided on this indicator for information purposes.
- Target:** The SFY 2009 Plan did not include a Performance Indicator goal for Increased Access to Independent Housing. Data is provided on this indicator for information purposes.
- Population:** Adults diagnosed with a serious and persistent mental illness.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Adults with SPMI served by the SMHA will demonstrate increased access to Independent Housing as measured by the numbers of clients reporting that they reside in a Private Residence in the IMHP data system for SFY 2009.
- Measure:** Adults with a serious and persistent mental illness served by the SMHA will demonstrate increased access to Independent Housing as measured by the numbers of clients reporting that they reside in a Private Residence in the IMHP data system for SFY 2009.
- Sources of Information:** IMHP system
- Special Issues:** There are challenges with data in the existing IMHP data system. This system will be replaced by the WITS data infrastructure system for CMHC service tracking in SFY 2010. The State Hospitals are implementing the VistA system to capture hospital related data.
- Significance:** Access and maintenance of independent housing is an important recovery indicator for adults with a serious and persistent mental illness. This objective supports the Planning Council's priorities to provide a continuum of care.
- Activities and strategies/ changes/ innovative or exemplary model:** The CMHC provides an array of services (e.g., psychosocial rehabilitation, medications, ACT, etc.) directed to encouraging independence in the community of choice.
- Target Achieved or Not Achieved/If Not, Explain Why:** The IMHP data system indicates that 6,465 people out of 8,209 served in SFY 2009 reported living in a private residence. This calculates to 78.76% of those served during that time period.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Risk Assessment/Crisis Intervention Training

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	1	1	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** There was not a specific SFY 2009 goal for the Performance Indicator related to Risk Assessment/Crisis Intervention training. The data here is for informational purposes.
- Target:** There was not a specific SFY 2009 goal for the Performance Indicator related to Risk Assessment/Crisis Intervention training. The data here is for informational purposes.
- Population:** Adults with a diagnosis of a serious and persistent mental illness (SPMI).
- Criterion:** 5:Management Systems
- Indicator:** The indicator is the number of risk assessment and/or crisis intervention trainings that were available in the regions in SFY 2009.
- Measure:** The measure is the number of risk assessment and/or crisis intervention trainings that were available in the regions in SFY 2009.
- Sources of Information:** Regional reports of risk assessment and/or crisis intervention training opportunities in their respective regions in SFY 2009.
- Special Issues:** All regions have access to videotaped Designated Examination training. Regions also provide face to face training for designated examination and dispositioner responsibilities.
- Significance:** Staff that are trained are better able to assess risk and resolve crisis situations in least restrictive and effective ways.
- Activities and strategies/ changes/ innovative or exemplary model:** All regions provide designated examination training as needed. Some regions use the Crisis Intervention Training (CIT) in collaboration with law enforcement. In SFY 2009, regions reported multiple training opportunities. Region 5 offered a 7.5 hour training in 5/09 on Forensic Mental Health Assessments. Region 1 offered a series of CIT trainings and 4 designated examination trainings in SFY 2009.
- Target Achieved or Not Achieved/If Not, Explain Why:** In SFY 2009, all regions provided designated examination training opportunities as needed. Region 5 offered a 7.5 hour training in Forensic Mental Health Assessment. Region 1 offered a series of CIT trainings and 4 Designated Examination trainings.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	22,403	23,358	2,500	3,072	122.88
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Provide an array of mental health services to children representing the target population.

Target: Increase by 1% the number of children with an open case and provided services through the Children's Mental Health program.

Population: Individuals under the age of 18 years (Children) with SED.

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: The number of children/youth served by the Department of Health and Welfare's Children's Mental Health program.

Measure: Persons under the age of 18 years served by the Children's Mental Health system.

Sources of Information: FOCUS information system.

Special Issues: The decrease in children served reflects the separation of those served through the Children's Mental Health program and those served through community mental health providers funded by Medicaid.

Significance: National Outcomes Measure.

Activities and strategies/ changes/ innovative or exemplary model: The target was set at an increase of 1% in the number of children served through the Children's Mental Health program. The 1% increase was selected acknowledging that it was difficult to predict the impact of efforts to reduce Medicaid expenditures and the secondary impact on services provided through the Children's Mental Health program.

Target Achieved or Not Achieved/If Not, Explain Why: This target has been ACHIEVED.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	0	0	3	0	100
Numerator	0	0	--	0	--
Denominator	79	80	--	87	--

Table Descriptors:

Goal: Ensure that an array of community-based services are available to children with SED to decrease the need for psychiatric hospitalization.

Target: Readmission of youth to State Hospital South (SHS) Adolescent Unit will not exceed 3% at 30 days.

Population: Children with SED.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The number of children/youth readmitted to SHS at within days of discharge.

Measure: Numerator: Children/youth (0 to 17 years of age) who are readmitted to SHS within 30 days of discharge.
Denominator: Children/youth (0 to 17 years of age) who were discharged from SHS during the year.

Sources of Information: State Hospital South (SHS) information system.

Special Issues: Idaho has only one public adolescent State Hospital unit and that unit has a capacity of 16 beds.

Significance: National Outcomes Measure.

Activities and strategies/ changes/ innovative or exemplary model: State Hospital South (SHS) continues to work toward the reduction of readmissions through thorough discharge planning. In order for a child/youth to be placed at SHS, the regional CMH program must assess the child, disposition the child to SHS, and follow the child during hospitalization and after discharge. CMH clinicians are engaged in case management throughout the hospitalization and assist the child and family with transition home and to community services. By coordinating transition to community-based services, the child has a better chance of being successfully treated in their home and community.

Target Achieved or Not Achieved/If Not, Explain Why: This target was ACHIEVED as no children discharged from State Hospital South were readmitted within 30 days.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	5.06	5	9	5.75	156.52
Numerator	4	4	--	5	--
Denominator	79	80	--	87	--

Table Descriptors:

- Goal:** Ensure that an array of community-based services are available to children with SED to decrease the need for psychiatric hospitalization.
- Target:** Readmission of children/youth to State Hospital South (SHS) Adolescent Unity will not exceed 9% at 180 days.
- Population:** Children with SED.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The number of children/youth readmitted into SHS within 180 days of discharge from SHS.
- Measure:** Numerator: Children/youth readmitted into SHS within 180 days of discharge from SHS.
Denominator: The number of children/youth admitted into SHS during the target year.
- Sources of Information:** State Hospital South information system.
- Special Issues:** Idaho has only one (1) State Hospital adolescent unit and that unit has a capacity of 16 beds.
- Significance:** National Outcomes Measure.
- Activities and strategies/ changes/ innovative or exemplary model:** State Hospital South (SHS) continues to work toward the reduction of readmissions through thorough discharge planning. In order for a child/youth to be placed at SHS, the regional CMH program must assess the child, disposition the child to SHS, and follow the child during hospitalization and after discharge. CMH clinicians are engaged in case management throughout the hospitalization and assist the child and family with transition home and to community services. By coordinating transition to community-based services, the child has a better chance of being successfully treated in their home and community.
- Target Achieved or Not Achieved/If Not, Explain Why:** This target was Achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	2	3	150
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Provide an array of community-based services that are evidence-based and that demonstrate achievement of treatment outcomes.

Target: Maintain the number of Evidence-Based Practices utilized in Idaho and increase the number of youth served in those programs.

Population: Children with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The number of EBP's used by the Idaho CMH System of Care.

Measure: The number of EBP's that are used by the Idaho Children's Mental Health system to serve children and youth with SED.

Sources of Information: CMH Information System: FOCUS and Regional self-report

Special Issues: Three (3) Evidence Based Practices are currently in use by Idaho's Children's Mental Health program. Two of the EBP's, Functional Family Therapy (FFT) and Therapeutic Foster Care (TFC), are listed in the Block Grant Guidelines for Reporting Evidence-Based Practices. The third EBT, Parenting with Love and Limits (PLL), is listed on SAMHSA's National Registry of Evidence-Based Practices but is not listed in the Block Grant Guidelines. Idaho does not follow fidelity to the EBP model in TFC, but has quality assurances for the implementation and utilization of the Idaho model. Idaho contracts with the Idaho Youth Ranch for FFT and that program adheres to the fidelity of that model.

Significance: National Outcome Measure

Activities and strategies/ changes/ innovative or exemplary model: Idaho's Treatment/Therapeutic Foster Care program is an Idaho developed system and does not necessarily adhere to the fidelity of the EBP model. The fidelity of Idaho's TFC system is connected to a set of practice standards that were developed based off of best practices. The adherence to these standards are measured through the use of a case review instrument and quality assurance practices. Please refer to Criterion 5 for an overview of the CQI system in Idaho. Idaho also utilizes Functional Family Therapy. This is delivered through a contract with the Idaho Youth Ranch. Currently, the service is only available through DHW in two of the seven regions, however it is available through juvenile justice in every region of the state. DHW will be working to expand FFT to other regions.

Target Achieved or Not Achieved/If Not, Explain Why: This target was Achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	129	4.90	132	3.87	2.93
Numerator	N/A	156	--	119	--
Denominator	N/A	3,182	--	3,072	--

Table Descriptors:

- Goal:** Provide an array of community-based services that are evidence-based and demonstrate achievement of outcomes.
- Target:** Increase the number of children/youth that receive Evidence Based Practices including Therapeutic Foster care.
- Population:** Children with SED.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The number of children/youth with SED that are placed in treatment foster care.
- Measure:** Numerator: The number of SED children/youth placed in treatment foster care by Children's Mental Health.
Denominator: The total number of SED children/youth receiving Children's Mental Health services.
- Sources of Information:** Children's Mental Health information system (FOCUS).
- Special Issues:** The model for Therapeutic Foster Care used by Idaho has only recently been formalized and does not follow a proven EBP model.
- Significance:** National Outcome Measures.
- Activities and strategies/ changes/ innovative or exemplary model:** The Therapeutic Foster Care program in Idaho was developed by the state and doesn't adhere to fidelity of an established evidence-based practice model.
- Target Achieved or Not Achieved/If Not, Explain Why:** This target was Not Achieved. The target number to receive therapeutic foster care services was 132 and that target was NOT ACHIEVED. There were, however, 119 children/youth placed in treatment foster care. Budget constraints and a limited number of therapeutic foster homes contributed to not achieving this target. The variable of the number of children/youth that required this level of alternate care/treatment must be considered and not achieving this measure could indicate that children/youth were treated at the least restrictive level of care. Idaho recognizes that children/youth need supervised treatment and treatment foster care can be the most natural treatment setting available.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: **Indicator Data Not Applicable:**

Name of Implementation Report Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance: National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why: Multi-Systemic Therapy is not available in Idaho.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	82	5.53	82	5.73	6.99
Numerator	N/A	176	--	176	--
Denominator	N/A	3,182	--	3,072	--

Table Descriptors:

Goal: To provide an array of community-based services that are evidence-based and demonstrate achievement of treatment goals.

Target: Maintain the number of children/youth that receive evidence-based practices in Idaho.

Population: Children with SED.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The number of children/youth receiving Functional Family Therapy.

Measure: Numerator: The total number of children/youth receiving FFT during the target year.
Denominator: The total number of children/youth receiving services through the Children's Mental Health program during the target year.

Sources of Information: Provider/contractor reports.

Special Issues: FFT services are provided through a contract with the Idaho Youth Ranch. The contract requires the contractor to practice in accordance with fidelity to the FFT model and compliance is monitored through contract monitoring.

Significance: National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model: FFT is available to all seven regions of the state through a contract administered by one region. Four Department of Health and Regions provided FFT services to children/youth served through the Children's Mental Health program. Children/youth and their families also received FFT services through the Department of Juvenile Justice and county programs during the report year.

Target Achieved or Not Achieved/If Not, Explain Why: This target was ACHIEVED.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	51.19	50.45	51	82.72	162.20
Numerator	172	112	--	158	--
Denominator	336	222	--	191	--

Table Descriptors:

Goal: To ensure that families of children with SED are full participants in identifying treatment needs and developing treatment plans.

Target: To remain above an average family satisfaction score of 50% as measured using the MHSIP.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

Indicator: The percentage of respondents expressing satisfaction with their involvement in treatment planning and implementation.

Measure: Numerator: The number of respondents to the MHSIP rating their participation in treatment planning/implementation as positive. Denominator: The total number of respondents to questions on the MHSIP related to participation in treatment planning/implementation.

Sources of Information: MHSIP satisfaction data base.

Special Issues: Families receive a MHSIP satisfaction survey on July 1st of each year and at closure of the Children's Mental Health case.

Significance: National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model: On July 1, 2005, Idaho began using the MHSIP Youth Services Survey for Families (MHSIP-YSSF). Surveys are mailed by regional offices to the parents/guardians of children/youth receiving services through the Children's Mental Health program. Surveys are mailed on July 1st of each year and at closure of the Children's Mental Health case.

Target Achieved or Not Achieved/If Not, Explain Why: This target was ACHIEVED. 82% of survey respondents reported satisfaction with their involvement in treatment planning and implementation of treatment.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	85.53	75	72.19	96.25
Numerator	N/A	65	--	122	--
Denominator	N/A	76	--	169	--

Table Descriptors:

Goal: Children with Serious Emotional Disturbance are provided necessary mental health services that allow them to return/stay in school.

Target: 75% of children/youth will return to/stay in school.

Population: Children with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The number of children with SED that returned/stayed in school as reported in the MHSIP Youth Satisfaction Survey for Families (YSSF).

Measure: Numerator: The number of families reporting that their child returned/stayed in school on the MHSIP YSSF. Denominator: the total number of families reporting on their child's school status.

Denominator: The total number of families reporting on whether their child returned/stayed in school on the MHSIP YSSF.

Sources of Information: MHSIP Youth Satisfaction Surveys for Families Reports from the Decision 2000+ Idaho Website

Special Issues: This will be the second year that Idaho has collected this data. Therefore, this year will be the first year that Idaho has a target. Based off of one year's data, it is difficult to hold a state to 100% compliance when there are not multiple years data to establish the target.

Significance: National Outcome Measure

Activities and strategies/ changes/ innovative or exemplary model: Idaho has recently created new practice standards for surveying families with the latest MHSIP YSSF. It is anticipated that this will increase the return rate and therefore yield more reliable data. The surveys will be sent out to all families that are currently receiving services from the CMH program on July 1st each year. Additionally, every family that is discharged from services will also receive a survey. Each survey will include a self-addressed, pre-posted envelope. The surveys will be sent to the Central Office and entered into the MHSIP site. This relieves the burden from the regional offices. This information will be used throughout the year as a management instrument, but also reported annually as a NOM in the MH Block Grant.

Target Achieved or Not Achieved/If Not, Explain Why: This target was Not Achieved at 100%. However, the target was 96.25% Achieved. It should be noted that this is only the second year Idaho has collected this data and this is the first year Idaho had a target. Based on one year of data, it is difficult to hold a state to 100% compliance when there is only one year of data to establish the target. It should also be noted that the survey does not capture the number of children/youth that returned to school after the survey was completed.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	41.54	70	52.05	74.36
Numerator	N/A	27	--	38	--
Denominator	N/A	65	--	73	--

Table Descriptors:

- Goal:** Children provided with mental health services will have decreased criminal justice involvement.
- Target:** Parents/guardians will report that 70% of children/youth involved in the criminal justice system prior to the opening of a Children's Mental Health case, demonstrate a decrease in criminal justice involvement, after the opening of a Children's Mental Health case and receiving Children's Mental Health services.
- Population:** Children with SED that have been involved in the criminal justice system.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The number of children with SED that have decreased involvement with the criminal justice system after receiving Children's Mental Health services.
- Measure:** Numerator: The number of families reporting decreased involvement with the criminal justice system on the MHSIP-YSSF.
Denominator: The total number of families reporting same, increased, and decreased involvement with the criminal justice system after and/or during receiving Children's Mental Health services.
- Sources of Information:** MHSIP Youth Satisfaction Surveys for Families.
- Special Issues:** Children's Mental Health is experiencing an increased number of youth being ordered by the juvenile court to receive mental health services. The increase in the number of juvenile justice involved youth being served by the Children's Mental Health program combined with frequent disagreement between the program and the court as to services needed by the youth are expected to impact meeting the target.
- Significance:** National Outcome Measure.
- Activities and strategies/ changes/ innovative or exemplary model:** Idaho will continue to evaluate the target for this measure based on additional annual information as the target of 70% is higher than can be expected to achieve immediately.
- Target Achieved or Not Achieved/If Not, Explain Why:** This target was NOT ACHIEVED at the 70% target established for this year. The number of children/youth demonstrating a decrease in criminal justice involvement did increase from 41.54% in 2008 to 52.05% in 2009. The increase in referrals and orders from the juvenile corrections court/agencies has significantly increased the number of children/youth referred for mental health services that are involved in the juvenile corrections system.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Denominator: The total number of families reporting increased stability in housing on the MHSIP YSSF.

Sources of Information:

Special Issues:

Significance: National Outcome Measure

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why: This data is not compiled in Idaho for children.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	73.60	N/A	73.40	N/A
Numerator	N/A	131	--	138	--
Denominator	N/A	178	--	188	--

Table Descriptors:

Goal: Through the provision of Children's Mental Health services, children with SED will have increased social supports/social connectedness.

Target: Data is being used to establish a baseline target of 65% reporting increase in social supports/social connectedness.

Population: Children with SED.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The number of children with SED that increase social supports/social connectedness as reported on the MHSIP YSSF survey.

Measure: Numerator: The number of children/youth reported to have increased social supports/social connectedness after receiving Children's Mental Health services.
Denominator: The total number of MHSIP surveys responding to the questions related to social supports/social connectedness.

Sources of Information: MHSIP-YSSF surveys administered annually and at case closure.

Special Issues: This is the first year Idaho has data to establish a baseline for this item.

Significance: National Outcomes Measure.

Activities and strategies/ changes/ innovative or exemplary model: A target was not established in 2008 due to absence of baseline data. Using 2008 and 2009 data a target has been established.

Target Achieved or Not Achieved/If Not, Explain Why: A target was not previously established due to not having adequate data. However, the percentage achieved for 2009 is only .20% lower than the data from 2008 and this target should be considered ACHIEVED.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	50.45	N/A	58.06	N/A
Numerator	N/A	112	--	108	--
Denominator	N/A	222	--	186	--

Table Descriptors:

Goal: Children with Serious Emotional Disturbance demonstrate improved functioning after the opening of a Children's Mental Health case and receiving mental health services.

Target: 2009 was the second year Idaho collected this data. A target will be established for children receiving children's mental health services will report an improved level of functioning in 2010.

Population: Children with SED.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: The number of children with SED that have improved levels of functioning as reported on the MHSIP-YSSF.

Measure: Numerator: The number of children reported to have improved levels of functioning as reported on the MHSIP-YSSF.
Denominator: The total number responses to the MHSIP-YSSF survey addressing the area of functioning.

Sources of Information: MHSIP- Youth Satisfaction Surveys for Families.

Special Issues: 2008 was the first year Idaho collected this data. 2008 and 2009 data will be used to establish a target for 2010.

Significance: National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model: Idaho will use data from 2008 and 2009 to establish a baseline and target.

Target Achieved or Not Achieved/If Not, Explain Why: 2008 and 2009 data will be used to establish a target. In the absence of a target for this year and considering that the percentage reported for 2009 increased from the 2008 percentage, this target is ACHIEVED.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: CAFAS Outcomes

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	50	67	50	66	66
Numerator	81	215	--	404	--
Denominator	105	323	--	608	--

Table Descriptors:

Goal: Provide an array of community-based services to children with SED and their families.

Target: 50% of children/youth receiving two (2) or more CAFAS evaluations will demonstrate a decrease in functional impairment as measured by the CAFAS total score.

Population: Children with SED served through the DHW Children's Mental Health program.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of children/youth with with a positive change (decrease in functional impairment) in their CAFAS score over the course of receiving Children's Mental Health services.

Measure: Numerator: The number of children/youth receiving services with an improved CAFAS score (decrease in functional impairment). Denominator: The total number of children/youth on whom a CAFAS was administered at least two (2) times while receiving Children's Mental Health services or while receiving services and at the closure of their case.

Sources of Information: Service evaluation data base/FOCUS information system.

Special Issues: Families/children may terminate services prior to the administration of the second CAFAS making comparison and a determination of improvement not possible.

Significance: Improved functioning/decrease in functional impairment demonstrates the effectiveness of services provided through the Children's Mental Health program.

Activities and strategies/ changes/ innovative or exemplary model: Children's Mental Health will continue to implement a continuous quality improvement (CQI) program to address the effectiveness of services and other measures. The CAFAS will continue to be used to measure functional impairment. The Children's Mental Health program and the Department of Health and Welfare, in general, are moving toward outcome driven programs and services.

Target Achieved or Not Achieved/If Not, Explain Why: This target has been ACHIEVED.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Expenditures on Community-Based Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	92	89	75	92	92
Numerator	69,789,340	51,854,370	--	70,904,962	--
Denominator	75,748,250	58,247,862	--	77,187,319	--

Table Descriptors:

Goal: Prioritize funding for community-based services to ensure appropriate resource allocation of the community-based system, and to ensure continuous quality improvement of the service system.

Target: 75% of all funding for CMH services by DHW will be spent on community-based services.

Population: Children with SED

Criterion: 5:Management Systems

Indicator: Percentage of total funding for children's mental health services, including block grant funds, expended on community-based services.

Measure: Numerator: Total funds (CMH and Medicaid) spent on children's mental health community based programs (out-patient).
Denominator: Total funds (CMH and Medicaid) spent on all children's mental health services including in-patient and out-patient services.

Sources of Information: Divisional information systems, Division of Management Services information systems, and Medicaid system information.

Special Issues: In Idaho, many of the in-patient psychiatric hospitals are long distances from the child's home and some of the stays are longer than short-term crisis stabilization. The data system cannot differentiate which admissions may be local and short term versus distant and longer term. Subsequently, for purposes of this performance indicator, community-based services are defined as outpatient services that clearly are community-based and are less restrictive than in-patient treatment.

Significance: A community-based service system is a core value and standard of practice in Idaho. Community-based services have been shown to be the most normalized, effective, and cost effective services. Data systems are needed to address not only client encounter and funding data parameters, but also quality and service effectiveness measures. This objective relates to the State Planning Council's CMH priority: Enhancing community-based efforts at all levels within the child's community.

Activities and strategies/ changes/ innovative or exemplary model: The Department is dedicated to serving children in their own communities, whenever possible. It is recognized that often children may require services that are not community-based. However, the focus in Idaho has been on developing the array of core services in each region of the state. The Department is monitoring the use of residential and in-patient care, including the development of reports that provide information on multiple hospitalizations, in an effort to address the need for community-based services to avoid out-of-community care. The Department will continue to expand the use of Local Councils as resources to families.

Target Achieved or Not Achieved/If Not, Explain Why: This target was ACHIEVED.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Local Council Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	153	148	152	110	N/A
Numerator	153	148	--	110	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Provide a system of integrated social services, educational services, juvenile justice services, and substance abuse services together with mental health services.

Target: The number of families with children with a serious emotional disorder receiving Wraparound services will increase by 1%.

Population: Families with children with SED

Criterion: 3:Children's Services

Indicator: Number of families with children with SED participating in the Wraparound process.

Measure: Unduplicated count of children/families served through the Wraparound process.

Sources of Information: FOCUS information system and reports by staff providing Wraparound services.

Special Issues: This indicator has changed due to a change in the model of using regional and local councils and the avenue of accessing Wraparound services. The new model includes the training of all clinician/case managers on the Wraparound model. Clinician/case managers use Wraparound in serving families on their caseload as selected based on service need.

Significance: This indicator was selected as the TRANSFORMATION INDICATOR for the children's plan because the Wraparound process is family and consumer driven. This relates to the President's New Freedom Commission Report Goal #2, "Mental Health Care is Consumer and Family Driven."

Activities and strategies/ changes/ innovative or exemplary model: Idaho will continue to use the Wraparound model for case planning and service provision on select cases. Training for all case managers/clinicians on using the Wraparound model will continue.

Target Achieved or Not Achieved/If Not, Explain Why: This target was NOT ACHIEVED. The target for 2009 was set at 152 and 110 children received Wraparound services during SFY2009. The model of providing Wraparound services has changed from one of having a designated staff providing Wraparound to all clinicians being trained to use the model. Failure to meet the target is attributed to a change in the model and the provision of Wraparound type services not being counted as Wraparound because the services are provided within the context of providing case management services.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Services to rural populations

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	26.30	25	25	26.40	26.40
Numerator	957	785	--	834	--
Denominator	3,642	3,182	--	3,155	--

Table Descriptors:

- Goal:** Ensure that families residing in rural areas have access to services for their children with a serious emotional disturbance.
- Target:** Twenty five percent of children served by Department programs are from rural areas.
- Population:** Children with SED
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** The percentage of children receiving CMH services from the MHA that reside in rural areas. The number of children served in a rural service area is defined as those children served from counties and field offices other than the county in which the primary regional service center is located.
- Measure:** Numerator : The number of children/youth served from rural areas. Denominator: The total number of children/youth served across all counties/field offices.
- Sources of Information:** Divisional information system database.
- Special Issues:** The figures reflecting numbers of children served represent youth receiving community-based services through DHW's regional Programs.
- Significance:** Idaho is a very rural state. A large percentage of Idaho citizens reside in rural areas. It is important for citizens that they have access to services in rural areas. Rural service delivery is a requirement of federal law if states are to receive federal block grant monies. This objective relates to the State Planning Council's CMH priority: Increasing services, increase continuous access to these services and removal of barriers in rural areas of the state.
- Activities and strategies/ changes/ innovative or exemplary model:** The Department is maintaining the previously established target for this performance indicator. This target involves the maintenance or expansion of services in rural areas of the state to be consistent with the delivery of services in the urban areas. It is more difficult to build and sustain a provider based in a rural geographical area. Because Idaho is a state-run system information is gathered based on where the clinical case manager serving the child is located, not where the child lives. The Department will be working on developing a report to pull this information consistently and accurately.
- Target Achieved or Not Achieved/If Not, Explain Why:** This target was ACHIEVED.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Target Population Served

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	6,343	6,594	16,500	17,858	108
Numerator	6,343	6,594	--	17,858	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To provide youth/children with a serious emotional disturbance access to outpatient mental health services through Medicaid.

Target: To provide mental health services to no less than 16,500 children with emotional disturbance through the Medicaid's outpatient mental health programs.

Population: Children with Emotional Disturbance

Criterion: 2:Mental Health System Data Epidemiology

Indicator: The number of children/youth with emotional disturbance that receive a Medicaid funded outpatient mental health service.

Measure: The total unduplicated number of children/youth with emotional disturbance that receive a Medicaid funded outpatient mental health service.

Sources of Information: Medicaid's Business Objects report (HWMF-0342).

Special Issues: The Medicaid out-patient mental health services array includes services that do not require an SED to obtain. Therefore, some of the unduplicated count of children/youth that are receiving these services may not be SED, though all have a mental health diagnosis and are emotionally impaired.

Significance: This is an important measure because Medicaid is a large funder of mental health services in Idaho. It is necessary to track services and continue to provide effective mental health services to children in Idaho that are SED and those that have not been determined SED. An critical component to any system of care is the ability to provide early intervention and early identification. The Medicaid programs often prevent children/youth from having to move deeper in the system.

Activities and strategies/ changes/ innovative or exemplary model: Medicaid is currently working with a stakeholder group, including the Division of Behavioral Health, on the improving the behavioral health services Medicaid funds. Historically, Medicaid has heavily funded psychosocial rehabilitation and has done so with little oversight over the quality of services. This Medicaid project is intended to move the system further toward best practices. One important component that has been missing in Medicaid has been the option to provide services to children and families because of the rigidity of the medical model used by Medicaid.

Target Achieved or Not Achieved/If Not, Explain Why: This target was ACHIEVED.

Upload Planning Council Letter for the Implementation Report

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.