

Idaho

**UNIFORM APPLICATION
2010**

**STATE IMPLEMENTATION REPORT
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT**

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

(generated on 2-13-2012 10:51:37 AM)

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

Unmet Service Needs

In May and June 2009, the Idaho State Planning Council on Mental Health developed and prioritized the following unmet service needs, which are taken from their June 2009 report, the *2009 Idaho State Planning Council on Mental Health Report to the Governor and Legislature*.

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.

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

Significant Events Impacting the Mental Health System in SFY 2010

1. Economic Downturn

Idaho's economy was negatively impacted by the recession in SFY 2009 and SFY 2010. Several companies laid off employees, with serious layoffs in construction, retail and manufacturing. One of Idaho's largest manufacturing employers, Micron, laid off over 3,000 employees between October 2008 and February 2009.

Idaho Department of Labor statistics indicate that the June 2009 unemployment rate of 8.3 percent was a 25-year high, and is reflective of a June 2009 figure of over 62,000 unemployed compared to a June 2008 number of less than 36,000. According to the State of Idaho Department of Labor (article 'Idaho jobless rate drops again as labor force declines' at <http://labor.idaho.gov/news/Press>), the June 2010 unemployment rate "...was forecast at 8.8 percent, matching the rate for October 2009 when unemployment across Idaho was climbing to a peak of 9.5% this February. While down substantially from that peak, the rate is still the highest prior to this recession since July 1983." The June 2010 number of unemployed was estimated at 66,700. Hiring levels for manufacturing, leisure and business were normal in June 2010, but the Department of Labor reports that "Government cut jobs by nearly triple the percentage typically shed in June, reflecting cuts made to accommodate tax revenues slashed by the recession." County unemployment rates ranged from a low of 4.9% in Teton County to a high of 12.6% in Power County.

According to the Department of Health and Welfare, more than 151,000 people qualified for food assistance in May 2009 compared to 100,000 in May 2008. The eligibility rules that prevented those with assets over \$2,000 from qualifying for food assistance were temporarily suspended on June 1, 2009. The Idaho Statesman reported (June 4, 2010; Idaho food stamp surge tops nation) that in the last half of SFY 2010, the Department of Health and Welfare "...processed an average of 8,500 applications for food stamp assistance per month." As of July 2010, Idaho had an estimated 200,000 citizens who were receiving food stamps (7/6/2010, Idaho Food Stamp Use Doubles National Increase; fox12idaho.com).

In response to concerns about increasing Medicaid cost, the 2009 Idaho Legislature passed House Bill 123 (2009), which reduced reimbursement rates to several categories of providers (including hospitals, nursing homes, intermediate care facilities, physicians and dentists) and removed non-emergency transportation from the program's basic plan. The 2010 Idaho Legislature set forth detailed directions in legislative intent language attached to the SFY 2011 appropriation (House Bill No. 701 (2010)) on the processes for Medicaid to follow in making any further reductions in payments or benefits. Those processes included reducing Medicaid rates to Medicare rates, negotiating rate reductions with providers, implementing additional managed care contracts, and exploring waivers for services, including mental health services. In an effort to invite public input to "...address a projected \$247 million budget deficit for SFY 2011.." the Idaho Division of Medicaid launched the (www.MedicaidNeedsYourIdeas.dhw.idaho.gov) website in May

2010. Medicaid also held a series of public meetings in May 2010 to gather information from providers before determining strategies, policy changes and temporary rules to recommend to the 2011 Legislature.

By October 2010, Medicaid was successful in cutting only \$36.2 million of the \$57 million it was tasked with cutting in SFY 2011 in order to offset financial losses in state general funds. Also in October 2010, the Idaho Department of Health and Welfare announced plans to cut \$8 million in Medicaid programs for low-income adults diagnosed with mental illness and children diagnosed with autism and developmental disabilities. The drafted temporary rules (effective January 2011 through June 2011) authorize cuts to services and programs in an effort to trim \$1.6 million of state funds from the SFY 2011 budget; this would result in the loss of an additional \$6.5 million in federal Medicaid matching funds.

Idaho also implemented a new Medicaid Management Information System (MMIS) which began operation on June 7, 2010. This system includes claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals. The implementation has added to difficulties being experienced in the Medicaid program that could impact clients. As of July 2010, some private providers reported that cuts in Medicaid payments and payment delays for services presented challenges to staying in business.

Idaho has had limited success in taking advantage of funds available through the American Recovery and Reinvestment Act of 2009. 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 match 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 initial approval for approximately 3,136 employees in SFY 2009, was affected by the economic downturn. An initial six percent across the board budget cut was addressed by layoffs, vacancy savings (20 positions) 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 layoffs of 23 people of whom 12.5 were from DBH; an additional required four days of furlough for all state employees; vacancy savings from keeping an additional 27 positions open of which 16 were in DBH; and a transfer of budget funds from operations to personnel.

The Department of Health and Welfare experienced additional cuts in SFY 2010. Furloughs for all staff were established from January 2010 through June 2010 on every other Friday. In response to SFY 2011 budget cuts, nine offices were closed in May 2010 in rural areas and 126 employees were laid off in an effort to save \$7 million.

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. 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).

In 2007, 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.

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff's Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision and Goals:

Vision

Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery.

Goals

1. Increase availability of and access to quality services
2. Establish an infrastructure with clear responsibilities and actions
3. Create a viable regional and/or local community delivery system
4. Efficiently use existing and future resources
5. Increase accountability for services and funding
6. Seek and include input from stakeholders and consumers

Using a number of subcommittees the BHTWG developed a proposed organizational structure and core services for the transformed state behavioral health system. During the late summer and early fall of 2010, the BHTWG will be soliciting feedback on its proposals in preparation for a report to the Governor and 2011 Legislature on its recommendations, including next steps.

3. Mental Health Data System Activities

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).

During SFY 2009, the two State Hospitals (North and South) completed basic activities related to 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 CLRP data element definitions of the NOMS. This was completed by June 2009, with implementation and training for AMH in October 2009. Efforts continued during SFY 2010 to train users and enhance the WITS system to eventually support report extraction

for all NOMS and URS. Implementation of the VistA system in the State Hospitals is also nearing completion. A data warehouse is anticipated to be completed in SFY 2011. The data warehouse will facilitate data storage and report extraction. Central Office is working on a WITS manual that will facilitate training and allow increased consistency and standardization of data entry into the WITS system for AMH. In addition, DBH is assessing the feasibility of converting children's mental health data to the WITS system.

4. Patient Assistance Program (PAP)

A Patient Assistance Program (PAP) software package was purchased for approximately \$50,000 in SFY 2009. 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. Estimated PAP cost savings for the first three quarters of SFY 2010 was \$9,694,973.

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, Idaho State School and Hospital 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.

Installed for over 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.

The federal government recently indicated that Idaho would be included in the list of states that will use videoconferencing to conduct mental health block grant review meetings in the fall of 2010. This process will save state employee time and federal money that has historically been directed to allow staff to travel to another state for block grant defense.

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. In May 2009, contracted psychiatrists were providing telemedicine from the Boise Central Office, with Region 2 estimating 360 clients receiving these services from 9/08 through 5/09. Region 7 used these services for an estimated 180 clients from 2/09 through 5/09. A total of 740 scheduled appointments (duplicative client count) were made for Region 2 clients from throughout the Region from July 7, 2009 through June 30, 2010. These services were provided through video equipped offices in Lewiston and Orofino.

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. In SFY 2010 (July 2009 to June 2010), the total estimated savings across all users was \$465,706.

6. Forensics

Idaho Code Section 19-2524, effective in SFY 2007, allows judges broadened sentencing options for felons with substance abuse and mental health disorders. The law allows a judge to order a substance abuse assessment and/or a mental health examination for felons and felony parole violators who appear before the court. Based on the results of an assessment or examination, a judge may order, as a condition of probation, that the defendant undergo treatment consistent with a treatment plan contained in the assessment or examination report. A treatment plan is subject to modification by the court.

DBH has formed strong collaborations with regional Mental Health Courts, and these courts refer individuals to DBH for treatment. The model used to support mental health court referrals are ACT teams that work with court representatives to develop an individualized treatment plans for court clients. The treatment plans are intended to help participants to stabilize and learn additional life management skills such as taking necessary medications, ending drug and alcohol abuse and avoiding criminal activities that brought them into the legal system. Regional AMH programs 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, and this was similar in SFY 2010.

Budget cuts in SFY 2009 and SFY 2010 resulted in reduced regional staff and closure of nine rural offices. The priority adult treatment populations to be served through the public mental health service system for SFY 2011 will be adults who are in crisis as determined by designated examinations and those individuals under statutory mandates related to court ordered services. This includes individuals who are court ordered under 19-2524, 18-211/212, and 66-329. While regional programs may continue to retain some clients who are voluntary without any insurance or other resources and some eligible individuals who have Medicaid and who are unable to be served in the private sector because of challenging needs or behaviors, efforts are being made to refer to private community resources.

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 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 demonstrated significant cost savings through hospital diversion and high reports of participant satisfaction, it was terminated in May 2010 because of lack of funds.

8. Wood Pilot Project

Beginning in State Fiscal Year 2007, the Idaho legislature allocated \$2,000,000 to support the development of **Service Plan Component grants** that proposed to meet an identified regional and unmet need pertaining to mental health and/or substance use disorders. In State Fiscal Year 2008, funds were allocated to support similar one-time projects. Additional funds in the amount of \$1,240,000 were allocated to support one Multi-year Development Grant project. The Multi-Year Development grant was awarded to the Bonneville County's Substance Abuse/Mental Health Treatment Program, aka the Wood Pilot Project. The Wood Pilot Project continues to operate with a focus on implementation of a Substance Abuse and Mental Health treatment program for male and female offenders who are likely to be sentenced to corrections facilities. Treatment services include assessments, drug testing, treatment curriculum and treatment staff. This project also included purchase of Client Reporting Software (i.e., WITS). The state funding for SFY 2011 was reduced by the Legislature to \$1,083,400 because of budget holdbacks.

9. Detoxification Center

The Allumbaugh House opened in Boise, Idaho on May 1 2010 as a resource to Idaho citizens in Region 4. Services provided by this facility include crisis mental health, medically monitored chemical detoxification and sobering stations. Operations are managed by Terry Reilly Health Services. An estimated 100 people per month were served in the first three months of operation, with an average length of stay of three to four days. Referrals to the sobering station must be from health care providers or local law enforcement. Mental health service referrals may be from public or private health care providers. The detoxification program accepts self referrals and referrals from public and private health care providers. Terry Reilly indicates that one of the biggest challenges and successes relates to the diversity of players (e.g., private groups, city, county, state government) that collaborated to create the Allumbaugh House. The state was originally scheduled to contribute \$900,000 annually to the project. However, this amount was reduced by the Legislature to \$787,400 for SFY 2011.

10. 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 in 2009. This project was funded with Mental Health Block Grant dollars. As of June 2010, there were 47 Peer Specialists who completed the training and passed the certification exam. The Office of Consumer Affairs supervises placement of seven certified Peer Specialists; 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.

11. Housing and Homelessness

An SFY 2009 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. While PATH funds were distributed to each of seven regional behavioral health centers in SFY 2010, plans for SFY 2011 are to offer a Request for Proposals for PATH service delivery across the State of Idaho.

The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness operated in Region 3 and Region 4 in SFY 2010. The process for accessing Shelter Plus Care beds was standardized in SFY 2009, leading to an increased level of regional involvement with these housing vouchers.

12. Behavioral Health Restructuring

Additional organizational changes are planned for DBH in SFY 2011. Effective July 1, 2010, the seven (7) Regions were organized into three service areas or "hubs." The Behavioral Health Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). Program Managers in Region 3, Region 4, and Region 5 report to the Mental Health Bureau Chief in DBH central office (southwestern hub).

The projected SFY 2011 organizational structure for DBH will consist of an Administrator with oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs. Central Office was re-organized to reflect these categories in November 2010. The proposed management team for the Division of Behavioral Health for SFY 2011 will be formed from the hub heads and the unit leads.

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 2010

MENTAL HEALTH BLOCK GRANT EXPENDITURE - Adults

Adult Mental Health	Federal Budget	Federal Expenditures to Date - (As of 10/27/10)
Adult Mental Health Services	\$1,197,346	\$0
Consumer/Family Empowerment	\$ 178,000	\$109,664.47
1)Consumer/Family Empowerment & Peer Specialists	Subcategory: \$153,000	
2)Quality Improvement System Development	Subcategory: \$25,000	
State Planning Council	\$ 20,000	\$6,475.04
Suicide Prevention	\$ 10,000	\$833.33
<i>Total Adult Services SFY 2010</i>	\$1,405,346	\$0
Administration at 5%	\$ 90,843	\$0
<i>Totals; Adult Services, Administration</i>	\$ 1,496,189	\$116,972.84

The above information shows how the State loaded and expended the 2010 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 and 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

Unmet Service Needs

In May and June 2009, the Idaho State Planning Council on Mental Health developed and prioritized the following unmet service needs, which are taken from their June 2009 report, the *2009 Idaho State Planning Council on Mental Health Report to the Governor and Legislature*.

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 area 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.

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

Significant Events Impacting the Mental Health System in SFY 2010

1. Economic Downturn

Idaho's economy was negatively impacted by the recession in SFY 2009 and SFY 2010. Several companies laid off employees, with serious layoffs in construction, retail and manufacturing. One of Idaho's largest manufacturing employers, Micron, laid off over 3,000 employees between October 2008 and February 2009.

Idaho Department of Labor statistics indicate that the June 2009 unemployment rate of 8.3 percent was a 25-year high, and is reflective of a June 2009 figure of over 62,000 unemployed compared to a June 2008 number of less than 36,000. According to the State of Idaho Department of Labor (article 'Idaho jobless rate drops again as labor force declines' at <http://labor.idaho.gov/news/Press>), the June 2010 unemployment rate "...was forecast at 8.8 percent, matching the rate for October 2009 when unemployment across Idaho was climbing to a peak of 9.5% this February. While down substantially from that peak, the rate is still the highest prior to this recession since July 1983." The June 2010 number of unemployed was estimated at 66,700. Hiring levels for manufacturing, leisure and business were normal in June 2010, but the Department of Labor reports that "Government cut jobs by nearly triple the percentage typically shed in June, reflecting cuts made to accommodate tax revenues slashed by the recession." County unemployment rates ranged from a low of 4.9% in Teton County to a high of 12.6% in Power County.

According to the Department of Health and Welfare, more than 151,000 people qualified for food assistance in May 2009 compared to 100,000 in May 2008. The eligibility rules that prevented those with assets over \$2,000 from qualifying for food assistance were temporarily suspended on June 1, 2009. The Idaho Statesman reported (June 4, 2010; Idaho food stamp surge tops nation) that in the last half of SFY 2010, the Department of Health and Welfare "...processed an average of 8,500 applications for food stamp assistance per month." As of July 2010, Idaho had an estimated 200,000 citizens who were receiving food stamps (7/6/2010, Idaho Food Stamp Use Doubles National Increase; fox12idaho.com).

In response to concerns about increasing Medicaid cost, the 2009 Idaho Legislature passed House Bill 123 (2009), which reduced reimbursement rates to several categories of providers (including hospitals, nursing homes, intermediate care facilities, physicians and dentists) and removed non-emergency transportation from the program's basic plan. The 2010 Idaho Legislature set forth detailed directions in legislative intent language attached to the SFY 2011 appropriation (House Bill No. 701 (2010)) on the processes for Medicaid to follow in making any further reductions in payments or benefits. Those processes included reducing Medicaid rates to Medicare rates, negotiating rate reductions with providers, implementing additional managed care contracts, and exploring waivers for services, including mental health services. In an effort to invite public input to "...address a projected \$247 million budget deficit for SFY 2011.." the Idaho Division of Medicaid launched the (www.MedicaidNeedsYourIdeas.dhw.idaho.gov) website in May

2010. Medicaid also held a series of public meetings in May 2010 to gather information from providers before determining strategies, policy changes and temporary rules to recommend to the 2011 Legislature.

By October 2010, Medicaid was successful in cutting only \$36.2 million of the \$57 million it was tasked with cutting in SFY 2011 in order to offset financial losses in state general funds. Also in October 2010, the Idaho Department of Health and Welfare announced plans to cut \$8 million in Medicaid programs for low-income adults diagnosed with mental illness and children diagnosed with autism and developmental disabilities. The drafted temporary rules (effective January 2011 through June 2011) authorize cuts to services and programs in an effort to trim \$1.6 million of state funds from the SFY 2011 budget; this would result in the loss of an additional \$6.5 million in federal Medicaid matching funds.

Idaho also implemented a new Medicaid Management Information System (MMIS) which began operation on June 7, 2010. This system includes claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals. The implementation has added to difficulties being experienced in the Medicaid program that could impact clients. As of July 2010, some private providers reported that cuts in Medicaid payments and payment delays for services presented challenges to staying in business.

Idaho has had limited success in taking advantage of funds available through the American Recovery and Reinvestment Act of 2009. 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 match 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 initial approval for approximately 3,136 employees in SFY 2009, was affected by the economic downturn. An initial six percent across the board budget cut was addressed by layoffs, vacancy savings (20 positions) 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 layoffs of 23 people of whom 12.5 were from DBH; an additional required four days of furlough for all state employees; vacancy savings from keeping an additional 27 positions open of which 16 were in DBH; and a transfer of budget funds from operations to personnel.

The Department of Health and Welfare experienced additional cuts in SFY 2010. Furloughs for all staff were established from January 2010 through June 2010 on every other Friday. In response to SFY 2011 budget cuts, nine offices were closed in May 2010 in rural areas and 126 employees were laid off in an effort to save \$7 million.

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. 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).

In 2007, 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.

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff's Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision and Goals:

Vision

Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery.

Goals

1. Increase availability of and access to quality services
2. Establish an infrastructure with clear responsibilities and actions
3. Create a viable regional and/or local community delivery system
4. Efficiently use existing and future resources
5. Increase accountability for services and funding
6. Seek and include input from stakeholders and consumers

Using a number of subcommittees the BHTWG developed a proposed organizational structure and core services for the transformed state behavioral health system. During the late summer and early fall of 2010, the BHTWG will be soliciting feedback on its proposals in preparation for a report to the Governor and 2011 Legislature on its recommendations, including next steps.

3. Mental Health Data System Activities

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).

During SFY 2009, the two State Hospitals (North and South) completed basic activities related to 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 CLRP data element definitions of the NOMS. This was completed by June 2009, with implementation and training for AMH in October 2009. Efforts continued during SFY 2010 to train users and enhance the WITS system to eventually support report extraction

for all NOMS and URS. Implementation of the VistA system in the State Hospitals is also nearing completion. A data warehouse is anticipated to be completed in SFY 2011. The data warehouse will facilitate data storage and report extraction. Central Office is working on a WITS manual that will facilitate training and allow increased consistency and standardization of data entry into the WITS system for AMH. In addition, DBH is assessing the feasibility of converting children's mental health data to the WITS system.

4. Patient Assistance Program (PAP)

A Patient Assistance Program (PAP) software package was purchased for approximately \$50,000 in SFY 2009. 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. Estimated PAP cost savings for the first three quarters of SFY 2010 was \$9,694,973.

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, Idaho State School and Hospital 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.

Installed for over 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.

The federal government recently indicated that Idaho would be included in the list of states that will use videoconferencing to conduct mental health block grant review meetings in the fall of 2010. This process will save state employee time and federal money that has historically been directed to allow staff to travel to another state for block grant defense.

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. In May 2009, contracted psychiatrists were providing telemedicine from the Boise Central Office, with Region 2 estimating 360 clients receiving these services from 9/08 through 5/09. Region 7 used these services for an estimated 180 clients from 2/09 through 5/09. A total of 740 scheduled appointments (duplicative client count) were made for Region 2 clients from throughout the Region from July 7, 2009 through June 30, 2010. These services were provided through video equipped offices in Lewiston and Orofino.

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. In SFY 2010 (July 2009 to June 2010), the total estimated savings across all users was \$465,706.

6. Forensics

Idaho Code Section 19-2524, effective in SFY 2007, allows judges broadened sentencing options for felons with substance abuse and mental health disorders. The law allows a judge to order a substance abuse assessment and/or a mental health examination for felons and felony parole violators who appear before the court. Based on the results of an assessment or examination, a judge may order, as a condition of probation, that the defendant undergo treatment consistent with a treatment plan contained in the assessment or examination report. A treatment plan is subject to modification by the court.

DBH has formed strong collaborations with regional Mental Health Courts, and these courts refer individuals to DBH for treatment. The model used to support mental health court referrals are ACT teams that work with court representatives to develop an individualized treatment plans for court clients. The treatment plans are intended to help participants to stabilize and learn additional life management skills such as taking necessary medications, ending drug and alcohol abuse and avoiding criminal activities that brought them into the legal system. Regional AMH programs 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, and this was similar in SFY 2010.

Budget cuts in SFY 2009 and SFY 2010 resulted in reduced regional staff and closure of nine rural offices. The priority adult treatment populations to be served through the public mental health service system for SFY 2011 will be adults who are in crisis as determined by designated examinations and those individuals under statutory mandates related to court ordered services. This includes individuals who are court ordered under 19-2524, 18-211/212, and 66-329. While regional programs may continue to retain some clients who are voluntary without any insurance or other resources and some eligible individuals who have Medicaid and who are unable to be served in the private sector because of challenging needs or behaviors, efforts are being made to refer to private community resources.

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 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 demonstrated significant cost savings through hospital diversion and high reports of participant satisfaction, it was terminated in May 2010 because of lack of funds.

8. Wood Pilot Project

Beginning in State Fiscal Year 2007, the Idaho legislature allocated \$2,000,000 to support the development of **Service Plan Component grants** that proposed to meet an identified regional and unmet need pertaining to mental health and/or substance use disorders. In State Fiscal Year 2008, funds were allocated to support similar one-time projects. Additional funds in the amount of \$1,240,000 were allocated to support one Multi-year Development Grant project. The Multi-Year Development grant was awarded to the Bonneville County's Substance Abuse/Mental Health Treatment Program, aka the Wood Pilot Project. The Wood Pilot Project continues to operate with a focus on implementation of a Substance Abuse and Mental Health treatment program for male and female offenders who are likely to be sentenced to corrections facilities. Treatment services include assessments, drug testing, treatment curriculum and treatment staff. This project also included purchase of Client Reporting Software (i.e., WITS). The state funding for SFY 2011 was reduced by the Legislature to \$1,083,400 because of budget holdbacks.

9. Detoxification Center

The Allumbaugh House opened in Boise, Idaho on May 1 2010 as a resource to Idaho citizens in Region 4. Services provided by this facility include crisis mental health, medically monitored chemical detoxification and sobering stations. Operations are managed by Terry Reilly Health Services. An estimated 100 people per month were served in the first three months of operation, with an average length of stay of three to four days. Referrals to the sobering station must be from health care providers or local law enforcement. Mental health service referrals may be from public or private health care providers. The detoxification program accepts self referrals and referrals from public and private health care providers. Terry Reilly indicates that one of the biggest challenges and successes relates to the diversity of players (e.g., private groups, city, county, state government) that collaborated to create the Allumbaugh House. The state was originally scheduled to contribute \$900,000 annually to the project. However, this amount was reduced by the Legislature to \$787,400 for SFY 2011.

10. 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 in 2009. This project was funded with Mental Health Block Grant dollars. As of June 2010, there were 47 Peer Specialists who completed the training and passed the certification exam. The Office of Consumer Affairs supervises placement of seven certified Peer Specialists; 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.

11. Housing and Homelessness

An SFY 2009 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. While PATH funds were distributed to each of seven regional behavioral health centers in SFY 2010, plans for SFY 2011 are to offer a Request for Proposals for PATH service delivery across the State of Idaho.

The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness operated in Region 3 and Region 4 in SFY 2010. The process for accessing Shelter Plus Care beds was standardized in SFY 2009, leading to an increased level of regional involvement with these housing vouchers.

12. Behavioral Health Restructuring

Additional organizational changes are planned for DBH in SFY 2011. Effective July 1, 2010, the seven (7) Regions were organized into three service areas or "hubs." The Behavioral Health Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). Program Managers in Region 3, Region 4, and Region 5 report to the Mental Health Bureau Chief in DBH central office (southwestern hub).

The projected SFY 2011 organizational structure for DBH will consist of an Administrator with oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs. Central Office was re-organized to reflect these categories in November 2010. The proposed management team for the Division of Behavioral Health for SFY 2011 will be formed from the hub heads and the unit leads.

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 State Mental Health Authority has allocated the FY 2010 SAMHSA Block Grant and amounts expended to date:

MENTAL HEALTH BLOCK GRANT

	Block Grant Funds	Expenditures to Date (10/31/10)
Children's Mental Health		
CMH Special Projects:		
-Contract with Family Run Organization	\$ 269,267	\$ 19,000
-Contract for Suicide Prevention Services	\$ 22,854	\$ 1,900
-Contract for Primary Care Physician Training	\$ 20,000	\$ 782
Total Children's Services	\$ 312,121	\$ 21,682
Administration (5%)	\$ 90,347	\$ 0
Adult Mental Health (See Adult Plan)	\$1,404,478	<i>See Adult MH Section</i>
TOTAL	\$1,806,946	

The above information documents how the state will load the 2010 SAMHSA Block Grant funds into its budget structure for the Children's Mental Health program and expenditures as of October 31, 2010. 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 or will be expended for community-based programming. Of the total \$312,121 for Children's Mental Health, \$269,267 is allocated to a contract with the Idaho Federation of Families for Children's Mental Health; \$20,000 is allocated to a contract with St. Luke's Hospital for training primary care physicians on the treatment of children with mental illness; \$22,854 is allocated to a contract with Benchmark Research to provide information on suicide prevention. As of October 31, 2010, **\$21,682** had been expended out of the 2010 Block Grant. Payments made prior to October 31, 2010 for the referenced contracts were made from the 2009 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	10,356	8,209	8,700	9,423	108.31
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** Persons with a serious mental illness will have access to SMHA services. While a small number will have Medicaid, the majority served do not have access to Medicaid or other forms of insurance.
- Target:** Provide state public mental health service access to at least 8,700 eligible persons who are without Medicaid or other forms of insurance.
- Population:** Adults with SMI who are served by the SMHA. While a small number will have Medicaid, the majority served do not have access to Medicaid or other forms of insurance.
- Criterion:** 2:Mental Health System Data Epidemiology
3:Children's Services
- Indicator:** Total number of persons who received services through the state operated mental health system.
- Measure:** Total number of persons receiving state operated mental health services.
- Sources of Information:** The WITS system for AMH was implemented for data entry on 10/1/09. Data entry specialists also entered data for the period from 7/1/09-8/31/09. Report extraction for NOMS and URS was under development in October 2010; numbers for access are from WITS.
- Special Issues:** The public mental health system provides adult mental health services through 7 regionally based community mental health centers. The WITS system for AMH was implemented 10/10 and this is the first year of data from WITS. For this performance indicator, the number of intakes was used. This number is based on numbers with intakes and includes enrolled, non-enrolled, assessed and not assessed clients. 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. Not enrolled may not meet the Serious and Persistent Mental Illness (SPMI) criteria but these individuals did receive at least one SMHA service.
- Significance:** National Outcome Measure. This is the first year that data has been gathered from the WITS electronic health record system that was implemented 10/1/09. In previous years, AMH data was gathered from an assortment of manual databases and EXCEL spreadsheets.

Activities and strategies/ changes/ innovative or exemplary model: The data reported on this measure reflects access data for eligible adult individuals who received intakes through 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. The number of assessments and ongoing cases is significantly lower than the number of intakes.

Target Achieved or Not Achieved/If Not, Explain Why: The number of intakes provided through the SMHA in SFY 2010 as measured through report extraction in the WITS system was 9,423. This target was achieved.

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	.22	2.71	5	5.69	87.87
Numerator	1	18	--	40	--
Denominator	457	663	--	703	--

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 5% 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 any state 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 (VistA).

Special Issues: This objective supports the Planning Council's priority on quality, continuum of care and community supports and is a required NOM. The 5% target reflects concerns about increased stressors on Idaho citizens related to the economy, as well as possible repercussions of budget cuts to staff in the mental health service delivery system.

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 2010, 40 individuals were readmitted to a state psychiatric hospital within 30 days out of a total number of 703 discharges. This reflects a 5.69% readmission rate within 30 days. This target was 87.87% 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	3.94	9.05	7	5.55	126.13
Numerator	18	60	--	39	--
Denominator	457	663	--	703	--

Table Descriptors:

Goal:	Adults with a serious 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 7% for re-admission to the two State Psychiatric Hospitals within 180 days of discharge.
Population:	Adults with a Serious Mental Illness
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 (VistA)
Special Issues:	VistA system implementation during SFY10 for the two state psychiatric hospitals improves Idaho's reporting of the NOMS. The 7% target reflects concerns about increased stressors on Idaho citizens related to the economy, as well as possible repercussions of budget cuts to staff in the MH service delivery system.
Significance:	National Outcome Measure. In SFY 2010, the economic downturn resulted in reductions in staff and closure of nine satellite offices in rural areas of the State of Idaho. The SFY 2011 priority population is adults with a serious mental illness who are are crisis and who are referred by the courts. These events may have impacted readmission to state hospitals within 180 days.
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	In SFY 2010, 39 individuals were readmitted to a state hospital within 180 days, out of a total number of 703 discharges. This results in a readmission within 180

Not Achieved/If days percentage of 5.55%. This target was achieved.
Not, Explain Why:

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	1	5	4	5	125
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal:	Persons with a serious 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 SFY 10.
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), and WITS.
Special Issues:	The only evidence based practice (EBP) reported in SFY 2008 was Assertive Community Treatment (ACT). In SFY 2009 and 2010, ACT continued to be offered, and additional data was captured on the EBP's of Supported Housing, Supported Employment, Integrated Treatment for Co-Occurring Disorders (MH/SA) and Medication Management. Supported Employment data was provided by the Idaho Division of Vocational Rehabilitation in 2009 and 2010. Numbers for ACT, Supported Housing, Co-Occurring Disorders & Medication Management were tracked on the BH Monthly Data report in 2009; 2010 is from WITS. Illness Self Management was not tracked in 2010 and not all regions provide this EBP.
Significance:	This is a required National Outcome Measure. This is the first year that data has been gathered from the WITS electronic health record system that was implemented 10/1/09. In previous years, AMH data was gathered from an assortment of manual databases and EXCEL spreadsheets. Extraction of reports from the WITS system was being worked out as of September/October/November of 2010 and these efforts will continue into SFY 2011.
Activities and strategies/ changes/ innovative or exemplary model:	ACT services are available in each of seven service regions of the Department of Health and Welfare's Adult Mental Health Program; clients include traditionally referred and Mental Health court referred individuals.
Target Achieved	The only evidence based practice (EBP) reported in SFY 2008 was Assertive

or Community Treatment (ACT). In SFY 2009 and SFY 2010, ACT continued to be
Not Achieved/If offered, and additional data was captured on Supported Housing, Supported
Not, Explain Why: Employment, Integrated Treatment for Co-Occurring Disorders (MH/SA) 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	85	69.76	82.07
Numerator	N/A	N/A	--	143	--
Denominator	N/A	N/A	--	205	--

Table Descriptors:

- Goal:** The goal is to increase independence and housing stability for adult Idaho citizens with SMI who are receiving supportive services from the SMHA and living in Shelter Plus Care housing.
- Target:** During SFY 2010, at least 85% of adults with SMI living in Shelter Plus Care housing and receiving supportive services from the SMHA will maintain their housing stability for at least 9 months.
- Population:** Adults with a serious mental illness (SMI) receiving SMHA supportive services who remain in the Shelter Plus Care program for nine (9) months or longer.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Numerator: number maintaining housing for 9 months.
Denominator: total number in Shelter Plus housing who are receiving SMHA supportive services.
- Measure:** At least 85% of adults with a SMI will remain in Shelter Plus Care programs for 9 months or longer.
- Sources of Information:** Shelter Plus Care data; manual counts from regional Shelter Plus Care Coordinators.
- Special Issues:** Six of seven regions collaborate with Idaho Housing and Finance Association (IHFA) to identify eligible Shelter Plus Care individuals. Those who receive Shelter Plus Care housing and who meet SMHA eligibility also receive mental health services (e.g., case management, counseling and other supportive services) from the SMHA. The number of eligible Shelter Plus Care slots is fixed. The SFY 2010 goal reflected an outcome measure related to the percentage of individuals that were able to benefit from SMHA services and maintain stability in their Shelter Plus Care housing for at least 9 months.
- Significance:** Adults with SMI who do not have stable and supported housing are at increased risk of relapse. Adults who remain in Shelter Plus Care programs for 9 months or longer are more likely to stabilize and to demonstrate increased resilience in other areas of their lives.
- Activities and strategies/ changes/ innovative or exemplary model:** Provision of Supported Housing through Shelter Plus Care programs and supportive services through the SMHA.

Target Achieved In SFY 2010, 143 of 205 individuals (70%) receiving SMHA supportive services
or remained in Shelter Plus Care programs for 9 months or longer. This goal was
Not Achieved/If 82% achieved.
Not, Explain Why:

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	54.07	156	30.29	19.42
Numerator	N/A	146	--	179	--
Denominator	N/A	270	--	591	--

Table Descriptors:

- Goal:** The Divisions of Behavioral Health (BH) & Vocational Rehabilitation (VR) collaborate to improve data capture of Supported Employment services provided to adults with SMI are served through the DHW SMHA service system.
- Target:** The SFY 2010 target was to provide CSE services to at least 156 adults with a serious mental illness served through the 7 CMHC service sites.
- Population:** Adults with a serious mental illness who are receiving BH and VR services through regional service programs.
- Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services
- Indicator:** At least 156 eligible adults served through BH and VR regional programs will receive CSE services and be employed in SFY 2010. Numerator: VR reports of the numbers served (closed Rehab + open employed). Denominator: VR reports total served.
- Measure:** VR reports of CSE services provided to BH clients whose cases were either closed (Rehab Closed, Employed) or open and employed from 7/1/2009 through 6/30/2010. Numerator: VR reports of the numbers served (closed Rehab + open employed). Denominator: VR reports total served.
- Sources of Information:** VR data on shared VR and BH clients who received CSE services and who are 1) employed and either closed in SFY 2010 (Rehab Closed) or 2) still open and employed as of 6/30/2010.
- Special Issues:** The Divisions of Behavioral Health and Vocational Rehabilitation (IDVR) collaborate to identify methods to improve CSE data capture and services to eligible adults served through both programs. During SFY 2010, IDVR provided monthly service reports to BH on vocational services provided to shared clients. VR regional staff attended at least one weekly ACT meeting in each region.
- Significance:** Ongoing collaboration and enhanced data capture will improve supported employment services and access to Idaho adult citizens with a serious mental illness receiving services from regional CMHCs.
- Activities and strategies/ changes/ innovative or exemplary model:** See special issues.

Target Achieved or Not Achieved/If Not, Explain Why: The SFY 2010 target was to serve a total number of 156 persons with Supported Employment. The Actual SFY 2010 number served was 179 (156 Closed Rehab + 20 open employed). 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	7.15	7.15	7.07	98.88
Numerator	525	587	--	666	--
Denominator	N/A	8,209	--	9,423	--

Table Descriptors:

Goal:	Persons with a serious and persistent mental illness have access to ACT or FACT services; at least 7.15% of total SMHA served will be those receiving ACT and Mental Health Court ACT services.
Target:	Provide ACT or FACT services to at least 7.15% of total served as measured by total number of ACT and Mental Health Court ACT served during SFY 2010 as a percentage of the total number served through the SMHA in SFY 2010.
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 from the SMHA.
Measure:	Total number of persons receiving ACT services. To determine a baseline percentage of ACT per total clients, the numerator is number of ACT clients (i.e.,666) and the denominator is total number served in SFY 2010 (i.e., 9,423).
Sources of Information:	WITS report extraction for SFY 2010 of ACT and MH Court ACT clients served.
Special Issues:	This is a required NOM. Assertive Community Treatment teams in Idaho serve traditionally referred and Mental Health Court (MHC) referred clients. In SFY 2010, there were a total of 995 ACT clients served. Idaho implemented a Peer Specialist Certification program in SFY 2009. Certified peer specialists have been placed with ACT teams across the State of Idaho in an effort to model best practice, recovery and resilience.
Significance:	Idaho continues to support the implementation of ACT/FACT 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/FACT teams collaborate with the courts to provide services to eligible individuals referred through regional Mental Health Courts. It is significant that counts of clients served was based on the manual Behavioral Health Monthly Data Report estimates in SFY 2009 and was based on WITS report extraction in SFY 2010.
Activities and strategies/ changes/ innovative or	ACT staff serve traditionally referred ACT clients and mental health court referred clients in each region.

exemplary model:

Target Achieved The total number of ACT/FACT clients served in SFY 2010 was 666 out of a total served of 9,423. The percentage of ACT clients served out of the total number served in SFY 2009 was 7.07, which was 98.88% of the maintenance target of 7.15%. This target was 98.88% achieved.

or

Not Achieved/If Not, Explain Why:

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 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: Implement the WITS data system in SFY 2010 and begin to track the number of adults with SMI served by the SMHA who received Family Psychoeducation to establish a baseline.

Target: Establish a baseline.

Population: Adults with SMI served through the regional SMHA receiving Family Psychoeducation services.

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

Indicator: Adults with SMI served through the regional SMHA receiving Family Psychoeducation services.

Measure: Adults with SMI served through the regional SMHA receiving Family Psychoeducation services.

Sources of Information: WITS data system.

Special Issues: Economic budget cuts resulted in closure of 9 of 22 field offices, staff furloughs and layoffs. Report extraction from the WITS system (implemented October 2009) did not include tracking of Family Psychoeducation services.

Significance: Family Psychoeducation services help to provide a strong resource for recovery and resilience for adults diagnosed with serious mental illness.

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 2010 and the WITS system did not include tracking of this EBP.

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	2.29	180	4.57	2.54
Numerator	256	188	--	431	--
Denominator	N/A	8,209	--	9,423	--

Table Descriptors:

Goal:	Provide co-occurring, integrated treatment to adults with co-occurring mental illness and substance use disorders to at least 180 adults receiving SMHA services in SFY 2010.
Target:	The target for SFY 2010 was to provide co-occurring, integrated treatment services to at least 180 eligible adults.
Population:	Eligible adults with co-occurring mental health and substance use disorders receiving SMHA treatment services.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Provision of co-occurring, integrated treatment services to at least 180 individuals with mental illness and substance use disorders receiving SMHA treatment services.
Measure:	See Indicator.
Sources of Information:	SFY 2009 data was from regional counts, court data, Behavioral Health Adult Mental Health Monthly Data Report. SFY 2010 data is from WITS report extraction; see NOMS/URS Table 17.
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 2010, the WITS system report extraction indicated that 431 adults received integrated treatment for co-occurring disorders through the SMHA.
Significance:	National Outcome Measure. Data for this performance indicator for SFY 2010 was obtained through report extraction from the WITS system that was implemented in October 2009. In previous years, data was obtained primarily from manual counts from the regions.
Activities and strategies/ changes/ innovative or exemplary model:	Dual diagnosis services were provided to mental health court referred clients served by regional ACT or forensic ACT teams.
Target Achieved or Not Achieved/If	The SFY 2010 target was provision of co-occurring, integrated treatment services provided to at least 180 mental health court referred ACT clients. The total number served according to report extraction from the WITS system for SFY 2010

Not, Explain Why: was 431. 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	12.69	N/A	N/A	N/A
Numerator	N/A	1,042	--	N/A	--
Denominator	N/A	8,209	--	N/A	--

Table Descriptors:

- Goal:** Implement the WITS data system in SFY 2010 and begin to track the number of adults with SMI served by the SMHA who received Illness Self Management to establish a baseline.
- Target:** Establish a baseline of adults with SMI served by the SMHA who received Illness Self Management.
- Population:** Adults diagnosed with a serious and persistent mental illness receiving Illness Self Management services through the SMHA.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Numbers of adults with SPMI receiving Illness Self Management through the SMHA.
- Measure:** Numbers of adults with SPMI receiving Illness Self Management through the SMHA.
- Sources of Information:** WITS data system.
- Special Issues:** Idaho has not regularly captured data related to the Illness Self Management EBP. During the course of developing an EXCEL spreadsheet with the Client Level Reporting Project data element definitions and tracking this data, Regions 1, 5 and 6 tracked and reported on the Illness Self Management EBP in SFY 2009. The WITS system was implemented for tracking AMH data in October 2009, but the Illness Self Management data was not tracked in WITS in SFY 2010. Not all regions provide this EBP, and no regions used this field in WITS in SFY 2010.
- Significance:** This is an evidence based practice.
- Activities and strategies/ changes/ innovative or exemplary model:** Idaho did not capture data related to the Illness Self Management EBP through the WITS system in SFY 2010.
- Target Achieved or Not Achieved/If Not, Explain Why:** Other than establishing a baseline, there was no specific target for this EBP projected for SFY 2010.

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	15.91	N/A	49.24	N/A
Numerator	N/A	1,306	--	4,640	--
Denominator	N/A	8,209	--	9,423	--

Table Descriptors:

- Goal:** Implement the WITS data system in SFY 2010 and begin to track the number of adults with SPMI who receive Medication Management to establish a baseline.
- Target:** Establish a baseline of adults with SPMI served by the SMHA who receive Medication Management.
- Population:** Adults diagnosed with SPMI receiving Medication Management services through the SMHA in SFY 2010.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The numerator is the number receiving Medication Management services. The denominator is the total number receiving SMHA services in SFY 2010.
- Measure:** The numerator is the number receiving Medication Management services. The denominator is the total number receiving SMHA services in SFY 2010.
- Sources of Information:** Report extraction from the WITS system (see Table 17 of the NOMS/URS report for SFY 2010).
- Special Issues:** The WITS system was implemented for tracking AMH data in October 2009, and the data elements were crafted to correspond with the Client Level Reporting Project data element definitions.
- Significance:** This is an evidence based practice.
- Activities and strategies/ changes/ innovative or exemplary model:** The WITS system was implemented for Adult Mental Health in October 2009. Report extraction for SFY 2010 data elements came from the WITS system.
- Target Achieved or Not Achieved/If Not, Explain Why:** According to WITS reports, there were 4,640 served with Medication Management out of a total served of 9,423 in SFY 2010. This target was achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:]

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	84.68	84.97	85	86.40	101.65
Numerator	763	656	--	667	--
Denominator	901	772	--	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 general satisfaction with services.

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

Sources of Information: 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: Idaho adopted and implemented the use of the MHSIP Adult Consumer Satisfaction Survey in October 2003. 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 were data entered into the DS2K+ website by support staff. The DS2K+ site is no longer hosted and efforts are being made to establish a new internal site for the collection of SFY 2011 MHSIP survey results.

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 667 out of a total of 772 respondents, for 86.4% reporting positively. This target was 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	54.07	50	N/A	N/A
Numerator	N/A	146	--	149	--
Denominator	N/A	270	--	N/A	--

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. Measure is VR report of Rehabilitated Closed clients (closed after 90 days of employment).
- 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. The agreement includes data capture and reporting, as well as IDVR presence during weekly ACT team meetings.
- Significance:** 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 2010.
- 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 2010 Performance Indicator was defined as the total number of persons receiving VR services who maintained employment for at least 90 days before their case was closed (Rehab Closed) by VR. The target was 112 individuals; the SFY 2010 Actual was 159 served. 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	85.90	92.97	86	93.70	108.95
Numerator	542	463	--	684	--
Denominator	631	498	--	730	--

Table Descriptors:

Goal:	Adults receiving SMHA services will report decreased arrests in the prior 12 month period on the MHSIP Consumer Survey.
Target:	To achieve 14% or less in arrests reported through the MHSIP system for clients served 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. This includes adults in service for at least 12 months and adults who began MH services during the 12 months of SFY 2010.
Measure:	Numbers of consumers responding to MHSIP survey question and indicating that they were not arrested during the previous 12 month period. This includes adults in service for at least 12 months and adults who began MH services during the 12 months of SFY 2010.
Sources of Information:	MHSIP consumer survey.
Special Issues:	Completion of the MHSIP Consumer Survey is voluntary and anonymous; the reported numbers capture only a subset of the total number of clients served through the mental health service system.
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 SFY 2010 target for this Performance Indicator was that 86% of consumers receiving mental health services that responded to the MHSIP consumer survey would report that they had not been arrested in the previous 12 month period. There were 730 responses to this question, with 684 reporting no arrests in the previous 12 month period. This goal was 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	81.11	70	82.61	84.74
Numerator	N/A	365	--	114	--
Denominator	N/A	450	--	138	--

Table Descriptors:

Goal:	The SFY 2010 goal was to increase stability in housing among adults receiving SMHA services who have been homeless or at risk of homelessness.
Target:	At least ten (10) persons per each of seven (7) regions who have received homeless services through the SMHA will retain stable housing for at least 3 months; total served in SFY 2010 will be 70.
Population:	Adults with a serious mental illness who have been homeless and who are at risk of becoming homeless.
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 three (3) months as measured by regional PATH reports from 7 regions.
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 three (3) months as measured by regional PATH reports from 7 regions.
Sources of Information:	Regional data sources.
Special Issues:	The AMH system has been challenged with an inadequate data capture system that requires regional hand counts. The National PATH Program indicated plans to initiate PATH outcome data tracking through Homeless Information Management system (HMIS) in SFY 2009. The HMIS system did not become available to ID PATH programs in SFY 09, so Idaho's SFY 09 goal to use HMIS to track 3 month housing stability was not feasible without PATH access to the HMIS system. For this reason, the SFY 2010 goal to track stability in housing relied on manual, regional counts of PATH clients that maintain stable housing for at least 3 months. Another factor that resulted in decreased numbers served than originally projected for SFY 2009 related to the economic downturn. As a result of the economy, there was a decreased amount of state dollars that were directed to the provision of homeless services and an increased number of people requiring emergency short-term services. While Idaho applied for ARRA and Neighborhood Stabilization Program funds, receipt of those funds went to IHFA and IHFA distributed those funds to private providers, not to the SMHA.
Significance:	This is a National Outcome Measure. Adults with SMI that are able to maintain supported housing for at least 9 months tend to have increased stability in other aspects of their lives as well. This contributes to recovery and resilience.

Activities and strategies/ changes/ innovative or exemplary model: Add a manually counted, regional outcome measure to track 3 month stability in housing for regional clients served by the PATH program. The SFY 2010 goal will be that at least ten (10) PATH clients served by the SMHA in each of the 7 regions will maintain housing for at least 3 months.

Target Achieved or Not Achieved/If Not, Explain Why: The SFY 2010 goal was to increase independence and housing stability for adult Idaho citizens with SMI receiving PATH services from the SMHA who maintain housing for at least 3 months. There were 114 out of 138 clients who maintained housing for at least 3 months; this translates to 82.61%. The target was 70% and this target was 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	63.50	64.25	67	62.78	93.70
Numerator	548	478	--	474	--
Denominator	863	744	--	755	--

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 MHSIP survey is sent to all open consumers once each year and upon case closure. The D2K system is no longer hosting the data system to support this data, and the data will be managed through an internal system for SFY 2011.

Significance: This is a National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model: Encourage completion and submission of MHSIP consumer surveys. Achieve a rating of at least 67% on MHSIP Consumer Survey positive reports of Social Connectedness in SFY 2010.

Target Achieved or Not Achieved/If Not, Explain Why: In SFY 2010, there were 755 surveys returned, with 474 of these respondents reporting positively on Social Connectedness. This is 62.78%; the SFY 2010 target was 67% positive responses on Social Connectedness and this goal was 93.7% 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	64.77	66.89	67	64.89	96.85
Numerator	559	497	--	486	--
Denominator	863	743	--	749	--

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 67% 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 MHSIP survey is sent to all open consumers once each year and upon case closure. The D2K system is no longer hosting the data system to support this data, and the data will be managed through an internal system for SFY 2011.

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 2010, there were 749 surveys returned with responses in the Improved Functioning category. There were 486 who reported Improved Functioning. This is 64.89%; this target was 96.85% 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	6	4	3	3	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 conducted during SFY 10.
- 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 program manager reviewer from another region. Assessments in FY 10 were done in Caldwell, and Pocatello.
- Target Achieved** The SFY 10 target was to review ACT fidelity on at least 3 regional ACT teams.

or The actual number of DACTS reviews in SFY 2010 was 3; this target was
Not Achieved/If achieved.
Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: AMH Data System

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 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. WITS was implemented for statewide data entry October 1, 2010. WITS report extraction began in November 2011.

Target Achieved The goal was to identify a viable data infrastructure system to support AMH.
or During SFY 2009, the VistA system continued to be implemented at both state
Not Achieved/If hospitals, and the WITS system was chosen to support the data needs for the
Not, Explain Why: AMH community mental health program needs. The WITS system was
implemented for AMH community programs in SFY 2010 (October 1, 2009). 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	67.60	N/A	70	87.28	N/A
Numerator	261	414	--	597	--
Denominator	386	549	--	684	--

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 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.
- 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 09 (4/1/09-6/30/09) and the first three quarters of SFY 10 (7/1/09-3/31/10).
- 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 follow-up 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** The SFY 2010 target for the Performance Indicator for attending the first

or medication appointment after state hospital discharge was 70%. In SFY 2010,
Not Achieved/If 597 of 684 returned surveys indicated they attended their medication
Not, Explain Why: appointment; this is 87.28%. 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	2	21	1	1	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 one (1) 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. In an effort to ensure cost-effective training during a context of budget cuts, DHW will develop a course based on Tip 42 that will be accessible by regional SMHA MH and SUD staff before 6/30/10.

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. The economic downturn decreased the amount of funds available for outside trainers. The Division of Behavioral Health implemented modules from SAMHSA's TIP 42 on the Department's Knowledge Learning Center website. State employees have access to this training website and continuing education credits are available for completion of each module.

Activities and strategies/ changes/ innovative or exemplary model: The economic downturn affected the ability to continue training with out of state contracts. The Department's Knowledge Learning Center educational website implemented the SAMHSA TIP 42 modules in SFY 2010, with continuing education credits for each completed module. This training opportunity is available at no cost to DHW employees in all seven regions of the State of Idaho.

Target Achieved or Not Achieved/If Not, Explain Why: The SAMHSA TIP 42 module of Substance Abuse Treatment for Persons with Co-Occurring Disorders was added to the Department of Health and Welfare's Knowledge Learning Center training website in SFY 2010. Material is available in modules, with an exam to assess competence. Successful completion of modules

and exams are documented with certificates and with continuing education credits. 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	89.10	88.90	85	91.08	N/A
Numerator	344	471	--	623	--
Denominator	386	549	--	684	--

Table Descriptors:

Goal:	Adults diagnosed 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 85% 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 09 (4/1/09-6/30/09) and the first three quarters of SFY 10 (7/1/09-3/31/10).
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 85% 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 2010 numbers were 623 out of 684 returned surveys indicating follow up appointments within 7 days of discharge for a percentage of 91.08%. 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	518	207	N/A	340	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** Data provided for baseline informational purposes in SFY 2009 suggested that there were 207 homeless persons served through the SMHA. The goal for SFY 2010 would be maintenance of that number.
- Target:** Data provided for baseline informational purposes in SFY 2009 suggested that there were 207 homeless persons served through the SMHA. The goal for SFY 2010 would be maintenance of that number.
- Population:** Adults diagnosed with a serious and persistent mental illness who are homeless.
- 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 WITS data system in SFY 2010.
- Measure:** The number of persons served by the SMHA who reported being homeless or living in a homeless shelter as measured by the WITS data system in SFY 2010.
- Sources of Information:** The WITS data system living situation data field for homeless or living in a homeless shelter.
- Special Issues:** The WITS data system was implemented for AMH data needs in October 2009. Report extraction was implemented in October 2010. This is the first year that data from the WITS data system has been used for 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 WITS data system indicates that mental health services were provided to 340 adults who reported living in a homeless shelter at one point in SFY 2010. 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	7	7	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 no SFY 2010 goal for homeless services providers. Data provided is for information only.

Target: There was no SFY 2010 goal for homeless services providers. Data provided is for information only.

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: There are seven regions and each region is responsible to provide outreach activities to those who are homeless and who have a serious mental illness in their regions.

Measure: There are seven regions and each region is responsible to provide outreach activities to those who are homeless and who have a serious mental illness in their regions.

Sources of Information: Regional self report of Point in Time count events and other outreach activities.

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 2010, Regional CMHCs provided a variety of outreach activities. Activities included regional Point in Time count (aka Homeless Stand Down) of those who were homeless. 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: Regions provided homeless outreach events in SFY 2010.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Increased Access to Independent Housing

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	76.10	78.76	N/A	66.41	N/A
Numerator	7,880	6,465	--	3,165	--
Denominator	10,356	8,209	--	9,423	--

Table Descriptors:

Goal:	The SFY 2010 Plan did not include a Performance Indicator goal for Increased Access to Independent Housing.
Target:	The SFY 2010 Plan did not include a Performance Indicator goal for Increased Access to Independent Housing. Numbers provided are for information only.
Population:	Adults diagnosed with a serious mental illness who report living in a private residence.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Adults with SMI 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 WITS data system for SFY 2010.
Measure:	Adults with a serious 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 WITS data system for SFY 2010.
Sources of Information:	WITS system implemented in October 2009; WITS report extraction began in October 2010 and these reports were used for the SFY 2010 NOMS/URS reports and the block grant performance indicator data.
Special Issues:	WITS system implemented in October 2009; WITS report extraction began in October 2010 and these reports were used for the SFY 2010 NOMS/URS reports and the block grant performance indicator data. Data from WITS may differ from data reported in previous years; past data reports were derived from a variety of unstable data sources that relied primarily on manual counts. Data from WITS is more credible than data reported in previous years that was gathered from an assortment of less reliable data sources.
Significance:	Access and maintenance of independent housing is an important recovery indicator for adults with a serious 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	The WITS data system indicates that 3,165 people out of 9,423 served in SFY 2010 reported living in a private residence. This calculates to 66.41% of those

Not Achieved/If served by the SMHA in SFY 2010.
Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	1	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:** There was not a specific SFY 2010 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 2010 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 mental illness (SMI).
- 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 2010.
- Measure:** The measure is the number of risk assessment and/or crisis intervention trainings that were available in the regions in SFY 2010.
- Sources of Information:** Regional reports of risk assessment and/or crisis intervention training opportunities in their respective regions in SFY 2010.
- 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 2010, regions reported multiple training opportunities. A workshop on Preventing Violence, Trauma & Use of Seclusion & Restraint in MH settings was offered (7/2009) to over 100 people. Crisis Intervention Training has been offered to law enforcement in Regions 2, 4 and 6. Region 2 offered ER training 5/2010 in Latah County and psychiatric oversight is augmented w/video conference equipment. Region 3 provided training to law enforcement in October 2009 and April/May/June 2010. Region 4 is a member of local groups, including the CIT curriculum committee. Region 5 provided training to law enforcement; Region 6 implemented CIT training and Region 7 offered de-escalation training (2/2010) to law enforcement.
- Target Achieved or Not Achieved/If** In SFY 2010, all regions provided designated examination training opportunities as needed. Additional Risk Assessment/Crisis Intervention trainings were offered across the state (see Activities and Strategies section above for details).

Not, Explain Why:

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	23,358	3,072	2,500	2,615	104.60
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To provide an array of mental health services to children representing the (SED) 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: Children/youth served by the Children's Mental Health program.

Sources of Information: FOCUS information system.

Special Issues: The decrease in children served between 2008 and 2009 reflects the separation of those served through the Children's Mental Health program and those served through community mental health providers funded by Medicaid in the count. The decrease in both the target and number served for FY 2010 reflects both reduction in funding for the program as well as transitioning to a redesign of the Children's Mental Health program.

Significance: National Outcomes Measure.

Activities and strategies/ changes/ innovative or exemplary model: The target for FY 2009 (2,500) was continued for FY 2010 with a goal of an increase of 1% in the number of children served through the Children's Mental Health program. The 1% increase was selected because it was difficult to predict the impact of reduced funding and beginning a redesign of the Children's Mental Health program.

Target Achieved or Not Achieved/If Not, Explain Why: This target has been ACHIEVED at 104%.

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	0	0	3.80	2.50	152
Numerator	0	0	--	2	--
Denominator	80	87	--	80	--

Table Descriptors:

Goal:	To decrease the need for psychiatric hospitalization through the provision of an array of community-based services to children with SED.
Target:	Readmission of youth to State Hospital South (SHS) Adolescent Unit will not exceed 3% at 30 days after discharge.
Population:	Children with SED that have been discharged from inpatient psychiatric treatment in State Hospital South (SHS).
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	The number of children/youth readmitted to SHS within 30 days of discharge from SHS.
Measure:	Numerator: Children/youth (0 through 17 years of age) readmitted into SHS within 30 days of discharge from SHS. Denominator: Total number of children/youth (0 through 17 years of age) discharged from SHS during the year/report period.
Sources of Information:	State Hospital South (SHS) VISTA information system.
Special Issues:	Idaho has only one public adolescent State psychiatric Hospital unit. 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 effective and meaningful discharge planning. For a child/youth to be placed at SHS, the regional CMH program must recommend the child's hospitalization 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 only 2 out of 80 children discharged from State Hospital South were readmitted within 30 days of discharge (2.5%).

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	5	5.75	8.50	3.75	226.67
Numerator	4	5	--	3	--
Denominator	80	87	--	80	--

Table Descriptors:

Goal: To 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 Unit will not exceed 9% at 180 days.

Population: Children with SED discharged from State Hospital South.

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 total number of children/youth discharged from SHS during the target year.

Sources of Information: State Hospital South (VISTA) 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 effective discharge planning. The regional CMH program must refer all children hospitalized in SHS and provide case management for the child during hospitalization and after discharge. By coordinating transition to community-based services, the child has a better chance of being successful in transitioning back to their home and receiving mental health services in their community.

Target Achieved or Not Achieved/If Not, Explain Why: This target was ACHIEVED at 226%.

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	3	2	2	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To provide community-based services that are evidence-based and demonstrate effective treatment.

Target: Maintain or increase the number of Evidence-Based Practices (EBP's) available to children with SED in Idaho.

Population: Children with SED

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

Indicator: The number of EBP's accessed through the Idaho CMH System of Care.

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

Sources of Information: CMH Information System (FOCUS), contract monitoring reports, and reports from Regional staff.

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 EBP, 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 TFC model, but quality assurances for the implementation and use of the Idaho model are in place. Idaho contracts with the Idaho Youth Ranch for FFT and that program adheres to the fidelity of the FFT 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 on best practices. Idaho makes Functional Family Therapy available through a contract between CMH the Idaho Youth Ranch.

Target Achieved This target was ACHIEVED at 100%.

or

Not Achieved/If

Not, Explain Why:

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	4.90	3.87	5	2.07	41.40
Numerator	156	119	--	54	--
Denominator	3,182	3,072	--	2,615	--

Table Descriptors:

- Goal:** To provide an array of community-based services that are evidence-based and demonstrate achievement of treatment outcomes.
- Target:** to maintain or increase the percentage of children/youth that receive Therapeutic Foster care.
- Population:** Children with SED placed in Therapeutic Foster Care.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The percentage of children/youth served through the CMH program that are placed in treatment foster care.
- Measure:** Numerator: The number of SED children/youth placed in treatment foster care.
Denominator: The total number of SED children/youth served through the Children's Mental Health services program.
- Sources of Information:** Children's Mental Health information system (FOCUS).
- Special Issues:** The model for Therapeutic Foster Care used by Idaho has been formalized but 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 does not 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 of 5% of children served through the CMH program would receive Therapeutic Foster Care services. The actual percentage of children placed in Therapeutic Foster Care was 2.07% which resulted in a percentage achieved of 41.4%. Accentuated efforts to treat children while they remained in their family home is the primary reason this indicator was not achieved. Idaho recognizes that treating children within their family environment and in their home community should be prioritized and used whenever the child can be safely and effectively treated in that setting.

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 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 Multi-Systemic Therapy is not available in Idaho.

or

Not Achieved/If Not, Explain Why:

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	5.53	5.73	2	2.68	134
Numerator	176	176	--	70	--
Denominator	3,182	3,072	--	2,615	--

Table Descriptors:

- Goal:** To provide an array of community-based services that are evidence-based and demonstrate achievement of treatment goals.
- Target:** Maintain or increase the number of children/youth that receive services using an evidence-based practice.
- 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 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. 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 at 134%.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	50.45	82.72	50	71.10	142.20
Numerator	112	158	--	123	--
Denominator	222	191	--	173	--

Table Descriptors:

- Goal:** To ensure that families of children with SED are full participants in identifying treatment needs and developing treatment plans.
- Target:** 50% or more families responding to the MHSIP YSS-F will provide a positive response.
- Population:** Children with SED served through the Children's Mental Health program.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The percentage of survey respondents expressing satisfaction with their involvement in treatment planning and implementation.
- Measure:** Numerator: The number of respondents to the MHSIP YSS-F survey rating their participation in treatment planning/implementation as positive. Denominator: The total number of respondents to questions on the MHSIP YSS-F related to participation in treatment planning/implementation.
- Sources of Information:** MHSIP satisfaction data base.
- Special Issues:** Families receive a MHSIP YSS-F 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 YSS-F. 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 at 142%. 71% 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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	85.53	72.19	75	84.91	113.21
Numerator	65	122	--	90	--
Denominator	76	169	--	106	--

Table Descriptors:

- Goal:** Children with Serious Emotional Disturbance are provided necessary mental health services that allow them to return/stay in school.
- Target:** A minimum of 75% of children/youth receiving CMH services will return to/stay in school.
- Population:** Children with SED served through the CMH program.
- 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 on the MHSIP YSS-F.
- Measure:** Numerator: The number of families reporting on the MHSIP YSS-F that their child returned to/stayed in school. Denominator: the total number of families reporting on their child's school status on the MHSIP YSS-F.
- Sources of Information:** MHSIP YSS-F reports from the Decision 2000+ Idaho Website
- Special Issues:**
- Significance:** National Outcome Measure
- Activities and strategies/ changes/ innovative or exemplary model:** On July 1, 2005, Idaho began using the MHSIP YSS-F. 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 at 113%. 84.9% of respondents indicated that their child returned to/stayed in school.

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	41.54	52.05	35	45.45	129.86
Numerator	27	38	--	35	--
Denominator	65	73	--	77	--

Table Descriptors:

Goal: Children served through the CMH program will have decreased criminal justice involvement.

Target: A minimum of 70% of parents/guardians will report on the MHSIP YSS-F that children, involved in the criminal justice system prior to the opening of a Children's Mental Health case, demonstrated 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 served through the CMH program 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 during and after receiving Children's Mental Health services.

Measure: Numerator: The number of families reporting decreased involvement with the criminal justice system on the MHSIP YSS-F.
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 YSS-F .

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 may impact meeting this 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 changes in the mental health system of care.

Target Achieved or This target was ACHIEVED at 129%.

**Not Achieved/If
Not, Explain Why:**

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	1	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 This data is not compiled in Idaho for children.
or

**Not Achieved/If
Not, Explain Why:**

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	73.60	73.40	65	70.86	109.02
Numerator	131	138	--	124	--
Denominator	178	188	--	175	--

Table Descriptors:

Goal: Children serviced through the Children's Mental Health program will have increased social supports/social connectedness.

Target: A minimum of 65% of those responding to social connectedness questions on the MHSIP YSS-F survey will responded that their child had increased social connectedness during or after receiving CMH services.

Population: Children with SED served through the CMH program.

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

Indicator: The percentage of children served through the CMH program that have a increased social supports/social connectedness as reported on the MHSIP YSS-F survey.

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

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

Special Issues:

Significance: National Outcomes Measure.

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why: 70.86% of those reporting on the social supports/connectedness reported positively. The target of 65% was ACHIEVED at 109.2%.

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 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	50.45	58.06	50	55.49	110.98
Numerator	112	108	--	96	--
Denominator	222	186	--	173	--

Table Descriptors:

Goal: Children served through the CMH program will demonstrate improved functioning during or after receiving Children's Mental Health services.

Target: A minimum of 50% of those responding to the improved level of functioning questions on the MHSIP YSS-F will respond that their child's level of functioning has improved during or after receiving CMH services.

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 percentage of children that have improved levels of functioning as reported on the MHSIP YSS-F.

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

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

Special Issues:

Significance: National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why: 55.49% of those reporting on the functioning questions on the MHSIP YSS-F reported positively. The target of 50% was ACHIEVED at 110.98%.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: CAFAS Outcomes

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	67	66	50	73	146
Numerator	215	404	--	563	--
Denominator	323	608	--	772	--

Table Descriptors:

- Goal:** To provide an array of effective community-based services to children with SED and their families.
- Target:** A minimum of 50% of children/youth receiving two (2) or more CAFAS evaluations will demonstrate a decrease in functional impairment.
- Population:** Children with SED served through the Children's Mental Health program.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** The percentage of children/youth with with a positive change (decrease in functional impairment) in their CAFAS scores over the course of receiving Children's Mental Health services.
- Measure:** Numerator: The number of children/youth receiving CMH 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 and at the closure of their case.
- Sources of Information:** 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 provides a measure for 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 and a measure of treatment outcomes.
- Target Achieved or Not Achieved/If Not, Explain Why:** This target has been ACHIEVED at 146%.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	89	92	75	92	122
Numerator	51,854,370	70,904,962	--	60,140,767	--
Denominator	58,247,862	77,187,319	--	65,505,595	--

Table Descriptors:

Goal: To prioritize funding for community-based services.

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

Population: Children with SED receiving mental health services funded by the State of Idaho.

Criterion: 5:Management Systems

Indicator: Percentage of total public funding for children's mental health services 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: FOCUS information system and Medicaid.

Special Issues: Medicaid data covers an 11 month period. During SFY 2010, Medicaid changed payment vendors and information for June 2010 is not available.

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.

Activities and strategies/ changes/ innovative or exemplary model: Children's Mental Health is dedicated to serving children in their own communities, whenever possible. It is recognized that children may require services that are more restrictive and not community-based. The priority, in Idaho, is to serve children in the least restrictive setting that can be expected to meet their safety and treatment needs.

Target Achieved or Not Achieved/If Not, Explain Why: This target was ACHIEVED at 122%.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Local Council Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	148	110	150	84	56
Numerator	148	110	--	84	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To provide an integrated service delivery system (Wraparound).

Target: The number of families with children with SED receiving Wraparound services will increase by 1%.

Population: Families with children with SED receiving Wraparound services.

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: The provision of Wraparound services has changed to a model whereby clinicians/case managers are trained to use Wraparound. Clinicians/case managers then use Wraparound in serving families on their caseload based on the severity of the family's service needs.

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 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 2010 was set for 150 children/families to receive Wraparound services. In 2010, 84 children/families received Wraparound services. Failure to meet the target is attributed to an overall decrease in children served through the CMH program and therefore a reduced pool of potential recipients of Wraparound. Additionally, in some cases, the provision of Wraparound-type services may not be counted as Wraparound because the services are provided within the context of providing case management services and not counted as a separate service. Consideration will be given to changing this indicator to a percentage of those served through the CMH program.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Services to rural populations

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	25	26.40	25	25.26	101
Numerator	785	834	--	436	--
Denominator	3,182	3,155	--	1,726	--

Table Descriptors:

- Goal:** To ensure that families residing in rural areas of the state have access to mental health services for their children with SED.
- Target:** A minimum of twenty five percent (25%) of children served by the CMH program will reside in rural areas of the state.
- Population:** Children with SED served through the CMH program.
- Criterion:** 4: Targeted Services to Rural and Homeless Populations
- Indicator:** The percentage of children receiving mental health services through the CMH program that reside in rural areas of the state. Rural areas are defined as counties other than the county in which the primary and largest Regional office is located. The number of children served in a rural service area is determined by those children receiving services through offices located in rural areas.
- Measure:** Numerator : The number of children/youth served through DHW offices located in rural areas of the state. Denominator: The total number of children/youth served through all counties/DHW field offices in the state.
- Sources of Information:** FOCUS information system.
- Special Issues:** With the closure of several rural offices during SFY 2010, calculating the number served based on field office location will not be an accurate means of calculating this measure in coming years. Efforts are underway to design a new report to provide this information.
- Significance:** Idaho is a very rural state and mental health services are limited in rural areas. It is critical that children and families have access to mental health services in all 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 availability of services in the urban areas. Because Idaho is a state-run system, information has been gathered based on the field office in which the child's case manager is located, not where the child lives. The Department is working on developing a new report to pull this information consistently and accurately using the child's residence.
- Target Achieved or Not Achieved/If** This target was ACHIEVED at 101%.

Not, Explain Why:

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Target Population Served

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	6,594	17,858	16,500	18,161	110
Numerator	6,594	17,858	--	18,161	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** To provide youth/children access to outpatient mental health services funded by Medicaid.
- Target:** To provide mental health services to no less than 16,500 children with emotional disturbance funded by Medicaid.
- Population:** Children with Emotional Disturbance receiving outpatient mental health services funded by Medicaid.
- 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 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 array of Medicaid out-patient mental health services includes services that do not require SED to access. Therefore, some of the unduplicated count of children/youth that are receiving these services may not be SED. However, all have a mental health diagnosis and have an emotional disorder.
- 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. A critical component to any system of care is the ability to provide early intervention and early identification. Intervention through the use of Medicaid funded services may prevent children/youth from moving deeper in the system.

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved This target was ACHIEVED at 110% of the target.
or
Not Achieved/If Not, Explain Why:

Upload Planning Council Letter for the Implementation Report

Idaho State Planning Council on Mental Health

Pete T. Cenarrusa Building, 3rd Floor

P.O. Box 83720

Boise, ID 83720-0036

MEMBERSHIP

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November 29, 2010

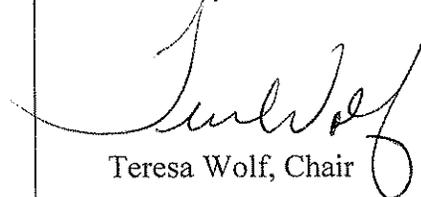
Barbara Orlando
Grants Management Specialist
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

The Idaho State Planning Council on Mental Health received the Implementation Report of the State of Idaho FFY 2010 Federal Community Mental Health Services Block Grant. The Idaho State Planning Council's Executive Committee reviewed the report by conference call and the Implementation Planners reported their findings in detail to the Executive Committee for discussion and comment. The Executive Committee accepted the Implementation Report as written with no modifications.

The Idaho State Planning Council on Mental Health appreciates the opportunity to review and provide comment on the FFY 2010 Implementation Report. The efforts of the State Planning Council to educate and advocate will be vital in the coming years as cuts to service and the impact of those cuts are realized across Idaho and our Nation. As always the Council will continue our efforts to advocate and promote improvement to Idaho's system of care for individuals with mental health needs.

Sincerely,



Teresa Wolf, Chair

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.