I: State Information

State Information

Plan Year

Start Year:
2014

End Year:
2015

State SAPT DUNS Number

Number
825201486

Expiration Date

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

Agency Name
Idaho Department of Health and Welfare

Organizational Unit
Division of Behavioral Health

Mailing Address
450 West State Street

City
Boise

Zip Code
83720-0036

II. Contact Person for the SAPT Grantee of the Block Grant

First Name
Richard

Last Name
Armstrong

Agency Name
Idaho Department of Health and Welfare, Division of Behavioral Health

Mailing Address
450 West State Street

City
Boise

Zip Code
83720-0036

Telephone
208-334-5500

Fax
208-334-6558

Email Address
OsbornJ@dhw.idaho.gov

State CMHS DUNS Number

Number
825201486

Expiration Date

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

Agency Name

Idaho Department of Health and Welfare

Organizational Unit

Division of Behavioral Health

Mailing Address

450 West State Street

City

Boise

Zip Code

83720-0036

II. Contact Person for the CMHS Grantee of the Block Grant

First Name

Richard

Last Name

Armstrong

Agency Name

Idaho Department of Health and Welfare, Division of Behavioral Health

Mailing Address

450 West State Street

City

Boise

Zip Code

83720-0036

Telephone

208-334-5500

Fax

208-334-6558

Email Address

OsbornJ@dhw.idaho.gov

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

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

8/29/2013 3:06:11 PM

Revision Date

1/6/2014 5:00:21 PM

V. Contact Person Responsible for Application Submission

First Name

Terry

Last Name

Pappin

Telephone

208-334-6542

Fax

208-332-7305

Email Address

pappint@dhw.idaho.gov

Footnotes:

Please see the attachments section of this application for signed assurance and certification forms.

C.L. "BUTCH" OTTER
GOVERNOR

August 31, 2007

Ms. LouEllen M. Rice
Grants Management Officer
Substance Abuse and Mental Health Services Administration
Office of Program Services
Division of Grant Management
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms. Rice:

I hereby delegate to the Director of the Idaho Department of Health and Welfare, Richard M. Armstrong, to make application to the United States Department of Health and Human Services for the Substance Abuse Prevention and Treatment (SAPT) Block Grant for the State of Idaho.

This delegation of authority is effective immediately. It extends to any changes or additions to the SAPT Block Grant required by Congress or the Executive Branch, including assurances, certifications, the grant or application requirements.

As Always – Idaho, "Esto Perpetua"

C.L. "Butch" Otter
Governor of Idaho

CLO:/ss

cc: Richard Armstrong
Richard Humiston

STATE CAPITOL • BOISE, IDAHO 83720 • (208) 334-2100

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including 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 the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Richard M. Armstrong
Title	Director
Organization	Idaho Department of Health and Welfare

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Richard M. Armstrong
Title	Director
Organization	Idaho Department of Health and Welfare

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements and Delegation Letter (Form 3) - Fiscal Year 2014 [SA]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee: Richard M. Armstrong

Title: Director

Signature of CEO or Designee[1]: _____ Date: _____

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

Please see attachments section of this application for signed certifications and assurances.

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart I of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee	Richard M. Armstrong
Title	Director

Signature of CEO or Designee[1]: _____ Date: _____

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	Richard M. Armstrong
Title	Director
Organization	Idaho Department of Health and Welfare

Signature: _____ Date: _____

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

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

Footnotes:

Response to question about the Idaho Office of Drug Policy is managing the substance abuse prevention system

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.
Page 46 of the Application Guidance
Narrative Question: Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

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

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

The BHTWG's efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho's Behavioral Health System (October 28, 2010). This report's recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council with the State Behavioral Health Planning Council; establishing the Behavioral Health Interagency Cooperative to oversee transformation efforts; and adopting the BHTWG's proposed Array of Core Services "…as the 'floor' of services they seek to make available in each region." The report recommends, "…that this array be maintained as the goal for regional planning and capacity building; and that it also be used as a measure by which to indicate progress toward a truly transformed behavioral health system…" Core regional service recommendations include 1) psychiatric emergency and crisis intervention, 2) assessments and evaluations, 3) designated examinations/dispositions, 4) inpatient psychiatric hospitalization, 5) medication management, 6) case management, 7) Assertive Community Treatment, intensive case management and wraparound, 8) psychotherapy, 9) intensive outpatient, 10) drug screening, 11) alcohol and drug residential treatment, 12) 24-hour out-of-home treatment interventions (children & adolescents), 13) illness self-management, 14) peer support, 15) prevention, 16) early intervention (children & adolescents), 17) supported employment, 18) supported housing, 19) transportation, 20) day treatment, partial care, and partial hospitalization. Services will be provided in accordance with statewide standards which will include monitoring for quality, consistency, and effectiveness. The State Behavioral Health Authority is responsible to develop and monitor the statewide standards of care.

Governor Otter signed Executive Order 2011-01 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. One charge to the IBHIC is to "d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho's Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho's budget, current needs of the agencies, and recommendations of the Idaho Health Care Council." The IBHIC expectations and description of a transformed behavioral health service system are identified on the http://www.bhic.idaho.gov/ website.

The Division of Behavioral Health submitted draft legislation to the 2013 legislature to transform Idaho's mental health and substance use services into an Integrated Behavioral Health System of Care. This proposed legislation includes plans to integrate mental health and substance use treatment through the creation of a governor appointed Behavioral Health Planning Council (Council) and Regional Behavioral Health Boards (Regional Boards). The Council will directly communicate with Regional Boards and with the Department of Health and Welfare (Department). The Council will monitor and evaluate the statewide behavioral health system of care and the laws that govern that system.

Proposed legislation also describes Regional Board responsibilities. Regional Boards will work with local communities to recommend behavioral health services, identify service gaps and promote plans for improvement through communication with the Council and the Department. Regional Boards may facilitate community-based recovery support services as behavioral health treatment transitions to managed care plan coverage. Recovery support services (e.g., community education, housing assistance, employment, transportation, prevention) will help those with behavioral health diagnoses to live in the community of choice and avoid hospitalization.

Regional Behavioral Health Centers operated through the Department's Division of Behavioral Health will retain responsibility for recovery support services until Regional Boards are ready to oversee these services. Readiness includes identification of adequate state and federal pass-through and grant funding to support Regional Board service administration. Once Regional Boards are funded and independent, the Regional Behavioral Health Centers will provide services that are complementary to those provided by the Council and Regional Boards in an effort to implement a statewide, comprehensive behavioral health system of care.

Public Behavioral Health System Organization at the State, Intermediate and Local Levels

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

The Department of Health and Welfare is designated by statute (Idaho Code Section 39 Chapter 3) as the State Mental Health Authority (SMHA) and as the Single State Authority (SSA) for Substance Use Disorders (SUD) prevention and treatment. Most of these responsibilities are carried out by the Department's Division of Behavioral Health. The Division of Behavioral Health's Central Office includes a Policy Unit, a Quality Improvement Unit, an Operations Unit and a Data Unit. The Central

Office component of the Division of Behavioral Health provides system coordination and leadership, policy and standards development, rule promulgation and interpretation, technical assistance, training, consultation, funding application and regulation, needs assessment and evaluation resources, minors' access to tobacco prevention, contract management, quality improvement and quality assurance monitoring.

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

The SSA oversees treatment and recovery services for adolescents, adults, pregnant women and women with dependent children who are below 200% of the federal poverty rate and who are diagnosed as substance dependent with at least an outpatient need according to the ASAM (PPC 2R, Level 1). Treatment referral sources include child protection, education agencies, probation and parole, youth-serving organizations, faith-based groups, judges and Drug Courts. Treatment services available to a client are based on the individual's need. Services available are assessment using the Global Appraisal of Individual Needs (GAIN), individual and group counseling, recovery support activities, case management, transportation, detoxification and education in the outpatient, residential and half-way house settings. The Division is in the process of identifying a contractor through a Request for Proposal (RFP) process to manage the treatment and recovery service delivery through a network of Department approved treatment providers. This contractor will also be responsible to provide care management utilization review. Care Management responsibilities include 1) use of a statewide 1-800 number for eligibility screenings, 2) making an initial ASAM PPC-2R level of care determination and 3) prior authorizing units of service.

The Division's SUD program is responsible to oversee substance abuse prevention for those at no or low risk of substance abuse through SFY 2013. In SFY 2014, the substance abuse prevention services will be assigned to the Office of Drug Policy (ODP) within the Governor's office. In SFY 2014-2015, the ODP will be responsible to manage the community-based prevention provider and coalition network. Responsibilities will include conducting annual state and county needs assessments used to identify at-risk populations and underserved areas, funding evidence-based services to meet the identified needs, supporting the preventionidaho.net website (i.e., the prevention data system that collects provider data), collecting participant demographic data and staff and program information, hosting online prevention courses and generating data used for local and federal reporting requirements (e.g., block grant, prevention data for the National Outcome Measures (NOMS), etc.). The goal for prevention is to continue the data driven focus where services are funded based on the needs assessment. Program delivery is evaluated based on the proposed plan and staff and participant feedback, and outcome data is collected on all recurring services. Idaho's Prevention and Treatment Research Website (PATR) will continue to be a data source for community coalitions to use for planning as well as evaluating changes over time. Strategies to be supported for individuals will be education, alternative activities and problem identification and referral. Population level strategies to be funded for community coalitions will be

information dissemination, community-based processes and environmental activities. All recurring service providers who propose to use evidence-based programs will receive priority for funding.

The Idaho Division of Behavioral Health focuses on mental health (adults and children) and substance use disorder (adults and children) policymaking, service planning and implementation for Idaho citizens diagnosed with a serious mental illness, a serious emotional disorder or a substance use disorder. Several organizational changes were implemented at the Division of Behavioral Health in SFY 2011. Effective July 1, 2010, the seven (7) regions were organized into three service areas or "hubs." The management team for the Division of Behavioral Health (DBH) is composed of the hub heads and the unit leads. The DBH Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). Program Managers in Region 3, Region 4, and Region 5 report to the southwestern hub Administrator. The DBH Administrator at Central Office has oversight over units directed to policy, operations, quality assurance and data.

The U.S. Census Bureau (2012) indicates that that Idaho's population is 1,595,728, with a 2011 estimate of 93.9% white persons; .8% black; 1.7% American Indian/Alaska Native; .2% Native Hawaiian or Pacific Islander; 2.1% reporting two or more races; 11.5% Hispanic and 83.6% white, not Hispanic. The United States Census Bureau estimated the Idaho has 19 residents per square mile, compared to a national average of 87.4 per square mile. Idaho has eighteen rural counties (less than 100 persons per square mile), twenty-two frontier counties (i.e., less than seven per square mile) and three urban counties. (More than 100 persons per square mile) Idaho ranks 13th in area size of the fifty states, with 82,643 square miles and diverse areas that include wilderness, mountains, deserts, farmland and canyons. The Idaho Department of Labor's jobless report (1/18/2013) indicated a 6.6 unemployment rate in December 2012, with an estimated 2012 average unemployment rate of 7.4 percent.

Local SMHA service delivery is based on seven geographical Department of Health and Welfare service regions. Publicly funded adult mental health (AMH) and Children's Mental Health (CMH) services are provided through Regional DBH center sites, with one Regional Program Manager responsible to oversee service delivery and quality for both programs. Psychiatric services may be supplemented through tele-health video conferencing to rural and frontier locations. The high definition video conference system is also used for statewide meetings, including meetings of the State Planning Council on Mental Health. In SFY 2011, there was a cost savings for all video conference users (not just the Division of Behavioral Health) of $312,366.00. The SFY 2012 cost savings was $438,710.05.

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

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

Specialists as outreach providers through the Projects for Assistance in Transition from Homelessness (PATH) program. The AMH programs and the courts coordinate treatment plans and service delivery with mental health court referred clients, with most eligible clients provided individual and group services by regional ACT teams. During SFY 2012, Mental Health Court Utilization operated at an average of approximately 86% of capacity.

The AMH program provides services to adults diagnosed with a serious mental illness who are homeless or at risk of becoming homeless. The SFY 2013 Projects for Assistance in Transition from Homelessness (PATH) grant funds included the allocation of a small amount for each regional CMHC to help with housing costs (i.e., one time rental assistance or security deposits); with the majority of funds allocated to a contract with the Office of Consumer and Family Affairs (OCAFA). The OCAFA contract allows for two PATH Certified Peer Specialists, each working 19 hours per week, to be assigned to each of seven regional DBH service sites. The PATH Certified Peer Specialists strive to conduct up to 75% of their time in face to face outreach to those in their region who have a mental health diagnosis and who are literally homeless. This program was implemented in April 2011. In addition to receiving training in evidence based practices related to Supported Housing, Supported Employment and SSI/SSDI Outreach and Recovery (SOAR), PATH Peer Specialists were trained in Mental Health First Aid in June 2011 through a Center for Social Innovations technical assistance opportunity. PATH peer specialists assisted in SFY 2012 Point in Time (PIT) homelessness activities in all regions.

Additional resources to the homeless include the Charitable Assistance to Community's Homeless (CATCH) program. This program mobilizes community resources for those who are homeless in Regions 3 and 4. The Idaho Housing and Finance Association (IHFA) manages Shelter Plus Care vouchers in all but Regions 3 and 4, where housing services are handled through the Boise City/Ada County Housing Association (BCACHA). The process for accessing Shelter Plus Care beds was standardized in SFY 2009, leading to an increased level of regional involvement with this program. Because the growth exceeded the supply, IHFA stopped accepting referrals to Shelter Plus Care in April, 2011, with limited referrals available in SFY 2013.

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

The Division of Behavioral Health oversees two SAMHSA grant projects with a recovery focus. The Idaho Home Outreach Program for Empowerment (ID-HOPE) grant was a five year award, beginning in 2010. ID-HOPE is designed to implement transformative changes in mental health services delivery

through the use of an adapted Critical Time Intervention (CTI) team, with a goal of preventing or reducing state and community psychiatric hospital admissions. The CTI team provides 9 months of linkage/coordination/advocacy case management and practical and emotional support in an effort to build a strong foundation for community recovery. The ID-HOPE team is composed of staff members with a bachelor's degree and Certified Peer Specialists. Specialty team members have responsibilities in supported housing, supported employment and short-term crisis stabilization. In January 2012, Idaho was notified of a 55% cut in federal funding for the transformation grant projects. This translated to a year 3 federal budget of $329,790 compared to the original projection of $734,500 per year. As of March 2013, the ID-HOPE Advisory Board was consulting with SAMHSA project officer William Hudock to identify short term and long term sustainability options to continue this project in Region 4 and to consider expansion to other areas of the state.

The Recovery Infrastructure Training for Empowerment Transformation Transfer Initiative (RITE-TTI) grant was awarded through the National Association of Mental Health Program Directors (NASMHPD) in December 2012. The RITE-TTI project period ends September 30, 2013. The RITE-TTI grant proposes to provide training to build an integrated infrastructure for behavioral health recovery (mental health and substance use) in three ways. First, a group of up to 50 people will be trained in Recovery Coaching (substance use focus), with up to fifteen trained as trainers. Participants will include substance use peers, regional board members and Community Resource Development Specialists. Second, regional behavioral health boards anticipate increased responsibility to identify regional issues (e.g., housing, transportation, etc.) and to implement plans to address those issues. Regional representatives will be trained in skills for Action Plan (AP) issue identification, planning and implementation. Third, there is no clear recovery training in Idaho. Regional representatives will be recruited to develop and disseminate materials from a behavioral health Recovery Toolkit (RT) that includes a focus on trauma. These three training areas will coalesce to build an integrated mental health and substance use recovery infrastructure for boards and service systems across the state of Idaho.

The CMH system's comprehensive system of care includes assessment, case management, family support (e.g., family preservation, counseling, transportation, parent skills training and education, flexible funding and peer support) and family respite. The Division contracts with a private provider to maintain a statewide family to family support network, to provide a statewide respite information and referral center, and to recruit and train respite care providers. The CMH program also provides therapeutic foster care, crisis response, school mental health services, outpatient, residential and hospitalization. State Hospital South's 16-bed Adolescent Unit provides inpatient stabilization and treatment, with average lengths of stay of 45 to 90 days. Longer term treatment may be provided by foster parents and residential facilities. Some unique aspects of the CMH program that are not available in the community or through existing benefit packages include provision of the evidence based Parenting with Love and Limits (PLL) intensive outpatient program, wraparound and clinical case management.

The CMH Division of Behavioral Health program works closely with the Department of Health and Welfare's Child Welfare Program and with the Department of Education. A memorandum between CMH and Child Welfare describes how services will be coordinated for shared clients. The Department's Service Integration program facilitates family efforts to navigate the range of Department programs and services. The Service Integration program works with Idaho's Health Information and Referral Center, or the 211-Idaho CareLine. The CareLine provides referral information (including housing and other

resources) through the statewide 211 number. The Bannock Youth Foundation (Pocatello) and Hays Shelter Home (Boise) provide federal grant funded crisis and emergency shelter to runaway and homeless youth; these programs coordinate mental health care needs with CMH. The Division's CMH program and the Department of Education collaborate with local school districts to to implement intensive community and school based programs. All 114 independent Idaho local school districts respond to the Individuals with Disabilities Education Act (IDEA) for eligible children. IDEA services include child find/referral, evaluation/eligibility, individualized education plans (IEP), related services, least restrictive environments, review and re-evaluation, transition requirements and consideration of behavior management needs.

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

Local substance use disorders (SUD) treatment services for adults and children are provided through an array of private and public organizations. A Management Services Contractor is responsible to manage this array of SUD treatment providers, prior authorize services, conduct SUD utilization reviews and provide data to the Division for state and federal reporting. The Division is in the process of identifying a contractor through a Request for Proposal (RFP) process to manage the treatment service delivery through a network of Department approved treatment providers for SFY 2014. This contractor will also be responsible to provide care management utilization review. Care Management responsibilities include 1) use of a statewide 1-800 number for eligibility screenings, 2) making an initial ASAM PPC-2R level of care determination and 3) prior authorizing units of service, collecting client demographic and service data and client outcome data.

Outpatient services are available to residents in every region. Inpatient services are also available to all Idaho residents, but they are not necessarily located in every region. Two Pregnant Women and Women with Dependent Children (PWWC) specialized SAPT providers deliver or refer clients to all required services. In addition, all treatment providers who treat pregnant women and women involved in the child protection system are required to directly offer or partner with the child protection agency to ensure all PWWC required services are available. Few services are available to parents with mental illness who have dependent children. Youth 15 years and under are required to have parental consent for services, while those 16 and older can access treatment services without parental consent. Services for children and youth who are diagnosed with SED and a substance use disorder (SUD) are delivered by two different Division of Behavioral Health programs. The CMH comprehensive assessment includes assessment of substance use and service recommendations. The majority of CMH services (mental health and substance abuse) are delivered by private providers. For children and youth diagnosed with SED and a developmental disability, services are coordinated through the Department's Division of Behavioral Health and Division of Family and Community Services.

In SFY 2011, the Division of Behavioral Health contracted with Benchmark Research and Safety (BRS) to manage the substance abuse prevention system. They were responsible for the conduct of annual statewide needs assessments, review of community-based provider and coalition funding applications, development of regional services plans, collection of participant and provider data and provision of data to the Division for state and federal reporting. Substance abuse prevention strategies included information dissemination, education, alternative activities, problem identification and referral, community based processes, environmental strategies. Prevention information dissemination was conducted through distribution of the Idaho RADAR Network Center's materials and video library to community members, coalitions, schools, prevention/treatment programs, social services/health care providers and other stakeholders and through the Idaho Preventing Underage Drinking campaign. Community coalitions also engaged in information dissemination as a part of their awareness campaigns. Education was provided to groups and individuals identified in the DHW needs assessment as having one or more risk factors (i.e., Hawkins and Catalano Risk & Protective Factors). The Division's contract with BRS funded community based prevention providers' delivery of evidence based programs to universal, selective and indicated audiences (see www.preventionidaho.net for details). Alternative activities were funded based on needs assessment identified risks. Community based providers contracting with BRS offered drug free activities and support services to universal or selective youth and families (e.g., after-school programs, mentoring, modeling positive behaviors). Problem identification and referral services were also delivered by community-based providers with the goal of identifying at-risk children early and referring them to services needed to reduce their risk of substance use. In SFY 2013, prevention responsibilities and funds were reallocated to the Office of Drug Policy (ODP) in the Governor's office. Community coalitions were funded to undertake community-based processes and environmental strategies. All recurring services were evaluated using pre and posttests. Community-based and environmental strategies were evaluated using data collected under the SEOW grant. In SFY 2014-2015, the ODP will be responsible to contract for SUD prevention programs.

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

The Medicaid benefits plans, including the Medicaid Basic Plan Benefits, the Medicaid Enhanced Plan Benefits and the Medicare/Medicaid Coordinated Plan Benefits were effective as of July 1, 2006. The Medicaid Medicare Coordinated Plan was effective April 1, 2007. Blue Cross of Idaho started with their plan on April 1, 2007 and United Health Care started with their plan on May 1, 2007. Partial Care, Service Coordination and Psychosocial Rehabilitation mental health services are excluded from the Medicaid Basic Plan Benefits except for diagnostic and evaluation services to determine eligibility for these services. These services continue to be covered under the Medicaid Enhanced Plan Benefits. The services available in the Medicaid Enhanced Plan include the full range of services covered by the Idaho

Medicaid program. Medicaid eligible locations for service delivery were expanded in SFY 2008 to allow physicians to perform telehealth in any setting in which they are licensed.

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

Legislation and relevant Idaho Code changes in SFY 2010 that pertained to rules governing Medicaid included House Bill (HB) 701 that provided legislative intent for Medicaid program flexibility for FY 2011. The 2010 Idaho State Legislature approved Rules Governing Medicaid Cost-Sharing (IDAPA Chapter 16.03.18) that described the sliding scale, premium payments and premium waivers. As noted on page 26, "The cost savings for this rulemaking for SFY 2010 is estimated at $210,000 in state general funds." Medicaid Omnibus Bill (HB 708) continued pricing freezes from SFY 2010 through SFY 2011; this bill allowed additional budget reductions that included mandates for pharmacies to participate in periodic cost surveys. In SFY 2011, House Bill 260 reduced State Medicaid spending by $34.6 million, which translated to a total reduction of $100 million with the additional loss of matching federal funds. As of July 2011, Medicaid was pursuing a contract with a managed care organization (MCO) with a target implementation date of 7/1/12 for the administration of mental health benefits. This was delayed and the Request for Proposal was only available in fall of 2012. A 1915b waiver will be in place as the funding authority to support the MCO contract. Qualis signed a three year contract renewal with Medicaid in June 2011 to provide case management and utilization management services.

The agency that is awarded the contract to implement Medicaid Managed Care will provide an integrated oversight of all behavioral health Medicaid services (mental health and substance use disorder) to adults and children in the state of Idaho. Eligible services are expected to start with currently available Medicaid behavioral health services. Depending on who ends up with the contract award, there may be enhancements in the areas of crisis, prevention and service access.

The Division of Behavioral Health is able to extend services through an assortment of federal SAMHSA grants. The SUD program's Access to Recovery (ATR) grant serves military (includes veterans, military reserves and Idaho National Guard), adolescents re-entering the community from state and county institutions (e.g., juvenile detention, state run correctional, hospitals) and adult supervised misdemeanants. Services include intensive SUD outpatient, safe and sober housing for adults and adolescents, case management, drug testing, transportation, child care, and life skills education. The Projects for Assistance in Transition from Homelessness (PATH) grant allows for outreach to adults with serious mental illness who are homeless. The federally funded (Center for Mental Health Services) Idaho Home Outreach Program for Empowerment (ID-HOPE) transformation grant supports provision of evidence based Critical Time Intervention (CTI) services in pilot Region 4. Idaho's prevention data capacity has been significantly increased by the State Epidemiological Outcomes Workgroup (SEOW) grant, which funded the Division's development of the Idaho Prevention and Treatment Research website (www.patr.idaho.gov). This website provides county level risk-factor data to enable community coalitions and other interested individuals and groups to easily access substance abuse-related data.

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

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

Several adult populations are served through the public mental health service system. These include adults who are in crisis and adults with court ordered commitment to the Department (66-329 and 18-211/212). Judges may impose court ordered evaluation and treatment for offenders sentenced under criminal court (Idaho Code 19-2524). Regional Mental Health Courts refer individuals to treatment through Assertive Community Treatment (ACT) programs. Regional programs may serve eligible adults without other resources. While regional programs may continue to retain some eligible individuals who have Medicaid and who are unable to be served in the private sector because of challenging needs or behaviors, efforts are being made to refer all Medicaid eligible individuals to private community resources. The priority children's populations to be served through the public mental health system are children and families in crisis, juveniles ordered by the court or through Juvenile Mental Health Court (see ID Code 20-511(a), 66-321, 18-211/212) to undergo court ordered evaluation and treatment, and eligible children requiring outpatient services who have no other benefits.

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

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

The Division participated in community networking meetings sponsored by the courts for the purpose of creating a veteran's court in SFY 2011. These meetings included representation from the courts, behavioral health treatment providers, the veteran's administration, law enforcement and other stakeholders. In SFY 2012, there were veteran's courts operating in Ada, Canyon and Bannock counties. There are plans to implement another veteran's court in Nez Perce County in SFY 2013.

The Veteran's networking committee meets at least quarterly to identify treatment needs and resources for military populations. Representation includes the Idaho National Guard, the Division of Behavioral Health, the Veteran's Administration, the courts, behavioral health providers that contract with the Idaho National Guard and other stakeholders.

The Division meets regularly with the Department of Juvenile Corrections sponsored Enforcing Underage Drinking Laws workgroup to facilitate coordination of substance abuse prevention activities. Representation on this workgroup includes Departments of Education and Transportation, the Liquor Division, the Idaho State Police, the Idaho College/Universities Coalition and Idaho Prosecuting

Attorneys Association. This workgroup addresses issues identified by member agencies and seeks to use research based strategies to address youth access, desire and opportunities to drink alcohol. Workgroup efforts have been instrumental in targeting parents to work with their children and adolescents to reduce underage drinking. A primary prevention services funded by the SSA are delivered by community-based organizations or community coalitions. These groups receive small amounts of funding from the SSA which enables them to deliver substance abuse prevention services as a part of other activities provided. This integration of services makes prevention resources available to a broad range of populations within Idaho.

How Systems Address Needs of Diverse Racial, Ethnic and Sexual Gender Minorities and Often Underserved Youth

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

Cultural issues are addressed through learning applications available to all staff on the Department of Health and Welfare's Knowledge Learning Center (KLC) website, but this does not address specifics related to Native American Tribes. A curriculum specific to Gay, Lesbian, Transgender, Bisexual or Questioning (GLTBQ) populations was developed and included in the KLC in SFY 2012. The Idaho Minor in Prevention Curriculum includes attention to culture, age and gender. Literacy is addressed during service delivery, and materials may be read to the individual if they are unable to read. Regional service information and treatment materials are available in English and Spanish in Behavioral Health offices, and other languages can be addressed through translator resources. The 2011 Idaho Conference on Alcohol Drug Dependency (ICADD) offered a session on elements of culture.

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

Idaho's six federally recognized tribes are the Shoshone Bannock, the Northwest Band of the Shoshone, the Nez Perce, the Coeur d'Alene, the Kootenai and the Duck Valley (Shoshone Paiute) Tribes. The Division of Behavioral Health's Substance Use Disorder provider network includes the tribally owned Benewah Medical and Wellness Center in northern Idaho (Plummer). Interaction with the Division on SUD treatment services is limited to the facility renewal process. The Division continues to contract with Benchmark Research Safety to provide funds to tribal organizations, school districts on tribal lands or other entities serving tribal populations. Historically three Idaho Tribes (i.e., Shoshone Bannock, Nez Perce and Kootenai) have applied for substance abuse prevention programs. In SFY 2014, prevention responsibilities and funds will be reallocated to the Office of Drug Policy (ODP) in the Governor's office. In SFY 2014-2015, the ODP will be responsible to contract for substance abuse prevention programs.

The Idaho Tobacco Project which is dedicated to preventing minors' access to tobacco has met with the Shoshone Bannock and the Nez Perce Tribes to provide retailer education resources.

Behavioral Health efforts to engage Tribal leaders are anticipated to involve meetings between the Division of Behavioral Health and Tribal Mental Health and Substance Use Disorder programs. The Division of Behavioral Health values the development of opportunities to collaborate with Tribal leaders The Division formally identified a representative to serve as an active liaison to leaders of Idaho tribes. This liaison will work with the Department of Health and Welfare's Tribal Relations Manager to build relationships with Tribal leaders from each Tribe, and to invite ongoing input into behavioral health planning and service implementation.

Step 1: ODP Response:
You gave detailed examples of how the Division of Behavioral Health in SFY2011 managed the substance abuse prevention system. Please elaborate on how the Office of Drug Policy (ODP) will manage the the substance abuse prevention system and SABG block grant.

The Idaho Office of Drug Policy is using its needs assessments and available data to identify the types of primary prevention services that are needed by:

1. Establishing Regional Grant Review Boards to identify priority target populations, risk and protective factors and service types for substance abuse prevention funding. In SFY 2014, the Office of Drug Policy utilized data collected by the current contractor, Benchmark Research & Safety, Inc., to guide all funding decisions. Regional needs assessments provided the foundation for individualized Regional Substance Abuse Prevention Strategic Plans in each of Idaho's seven service areas. Target Populations (the types of people whose attitudes, knowledge, skills, risk/protective factors, and behaviors who could benefit from substance abuse prevention program or initiatives); Risk Factors (attributes or conditions individual, families, schools or communities that increase the likelihood of substance use/abuse problems); Protective Factors (attributes or conditions that buffer an individual from the influence of risk factors or reduce the likelihood of use); Prevention Strategies (method or mechanisms of substance abuse prevention delivery); and, Prevention Services were charted. Program awards were based on the presenting data. For example: in Region I, students in Upper Elementary School, Junior High School, and High School were identified as target populations. Because of that prioritization, the decision not to fund prevention programs in grade K-3, in that region, was made based on the available data.

2. Making data, its analysis, and pertinent reports easily accessible and understandable to the general public. Regional Substance Abuse Prevention Needs Assessments for each of the seven Idaho Department of Health & Welfare regions are posted to the state's prevention services website: www.preventionidaho.net. Additionally, Idaho's Prevention and Treatment Research Website (PATR) is a data source available to prevention providers and the public for use in program planning and outcome evaluation. Updated reports, as well as findings from the biannual Youth Behavior Risk Survey (YRBS), are distributed to prevention providers. This provides them with the appropriate data to allow them to target their prevention efforts in their local communities.

3. Providing training and technical assistance to individual communities and prevention providers related to reviewing, analyzing and accessing available data for use in substance abuse prevention efforts to insure that services and programs are provided to appropriate groups who need prevention services the most. *Community Assessment* and Data *and Evaluation* sessions will be added to the agenda at the annual Idaho Conference on Alcohol and Drug Dependency in May 2014 to further assist prevention providers in these areas.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

State of Idaho Epidemiological Profile Of Substance Abuse 2012

State Epidemiological Outcomes Workgroup Report

Prepared by:
Idaho Department of Health and Welfare
Division of Behavioral Health
Bureau of Quality Assurance and Policy
Data Unit

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Glossary of Acronyms

DHW – Idaho Department of Health and Welfare

SEOW – State Epidemiological Outcome Workgroup

PIRE – Pacific Institute for Research and Evaluation

BRFSS – Behavioral Risk Factor Surveillance Survey

VS – Vital Statistics Unit

ISP – Idaho State Police

FACS – Division of Family & Community Services

Executive Summary

Over the past several years Idaho has seen several positive trends in regards to substance abuse epidemiology. Nearly all consumption related indicators are steady, or falling. Surveys indicate that methamphetamine use rates have been cut in half in the past decade. Fewer and fewer students are having their first drink of alcohol before the age of 13 (27.6% in 2001, 17.6% in 2011). Drug possession arrests have fallen.

These are welcome improvements, but two population measures continue to cause concern.

> Idaho's drug mortality rate was once well below the national average. It is now treading to pass the national rate in 2012.
>
> The last two years saw a 20% increase in students using marijuana.

Our hope is that by reviewing past that this document will provide information, insight, and inspiration to better address the substance abuse related challenges our state faces today and in the future.

Introduction

This profile is an attempt to gain better understanding of substance use and abuse patterns within a specific geographic area. The profile relies mainly on three potential sources of data for information on substance users; surveys containing self-reported data on substance abuse, drug-related arrest data, and mortality data. While these information sources are good, they do have limitations. As such, this profile should be combined with other data sources (e.g., local experts, other archival data) to provide a more thorough basis for understanding substance use practices within the specific areas of the state.

In an effort to provide a more useable product to our stakeholders, the Idaho State Epidemiological Outcomes Workgroup selected to update and change the format previously implemented in past years for the State of Idaho Epidemiological Profile. For methodological and purpose driven reasons, some previously reported data that is still available was not reported in this year's profile. For any questions beyond the contents of this report, feel free to contact the appropriate individual or program listed as a partner in Appendix A.

Demographics

To better understand the state of Idaho this portion of the profile examines the various parts of the state by Division of Behavioral Health Region and county. The following six maps on the next few pages highlight demographic characteristics of Idaho. See Appendix B for map with labels referencing Idaho counties.

Idaho Population per Square Mile, 2010

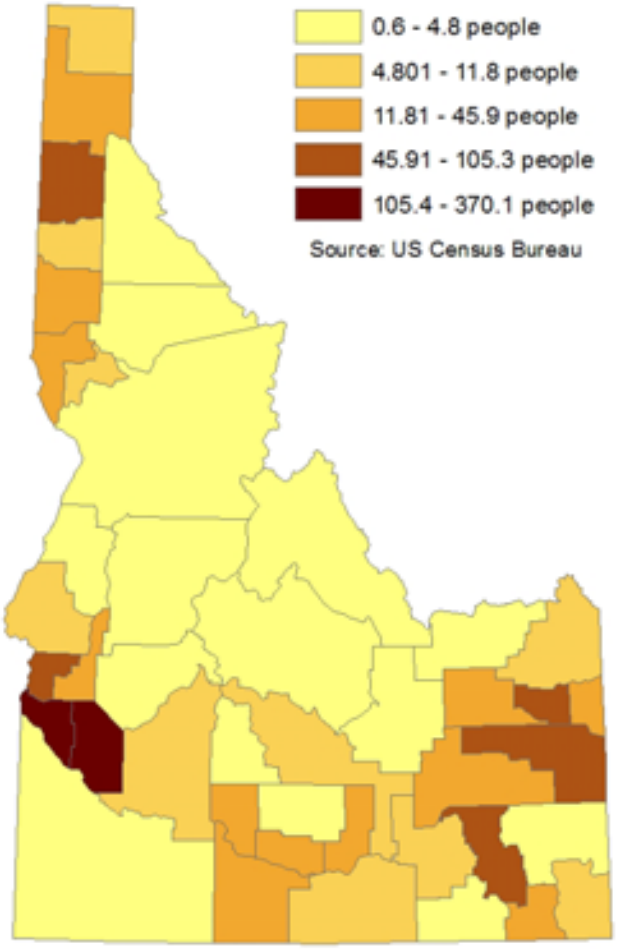


Figure 1

Idaho's most populated counties are Ada, Canyon, and Kootenai counties. Idaho's population in 2010 was 1,567,582. This figure is up 21.1% from the 2000 Census. During the 1990's the population in Idaho increased by 28.5 percent and this rate of growth still occurs in some areas. It should be noted that the population growth in metropolitan areas has continuously outpaced growth in nonmetropolitan areas.

Idaho Population Change, 2000 to 2010

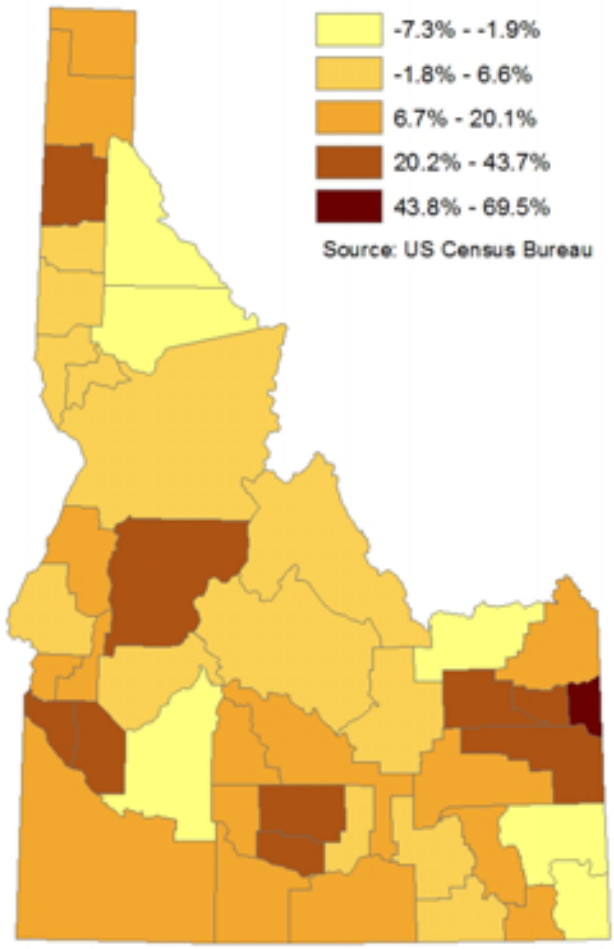


Figure 2

Counties which experienced the highest levels of growth were urban or resort based economies. Counties with natural resource based economies often shrunk.

Percent Population age 25+ with Bachelor's Degree or Higher

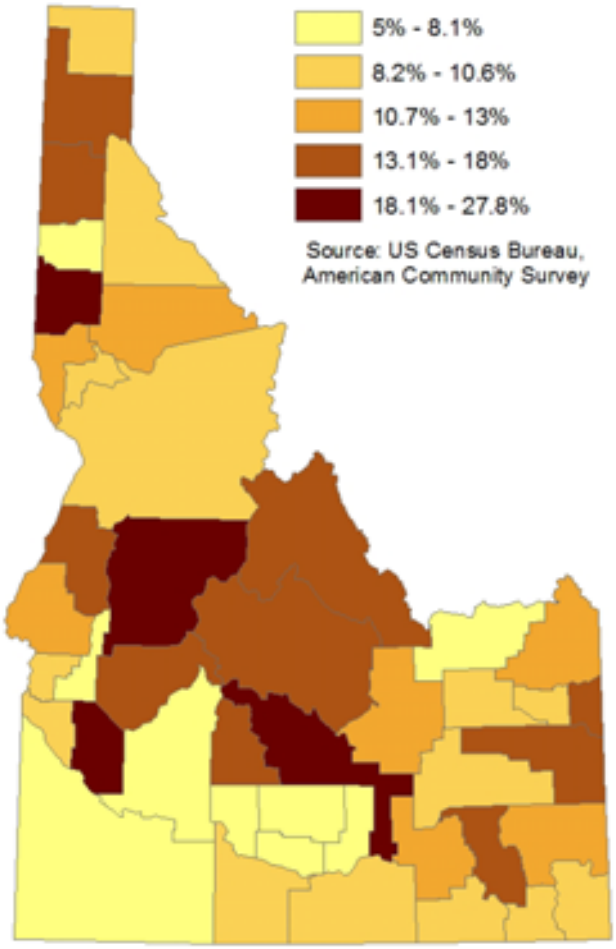


Figure 3

The percent of the population age 25 and over that has earned either a Bachelor's Degree or higher is 27.9% nationally. In Idaho that rate is 24.3%.

Percent of Households with Income below Poverty Level

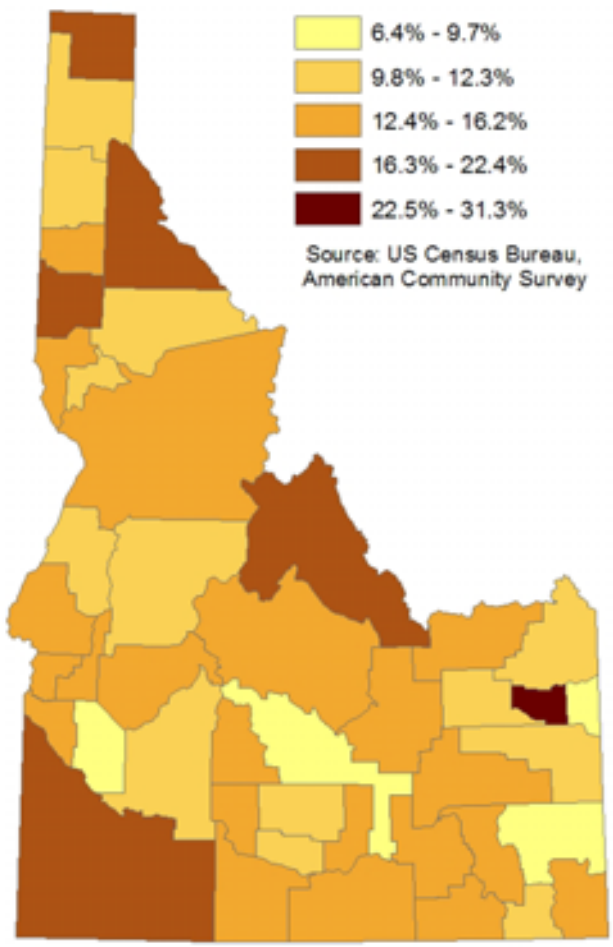


Figure 4

In 2004, nationally, the percent of the population in poverty was 12.7%, and in Idaho the rate was 11.5%. The counties with the lowest percent of the population in poverty were Blaine (5.9%) and Camas (7.3%). Counties with the highest percent of the population in poverty included Shoshone (16.3%), Madison (15.6%), and Owyhee (15.4%).

Median Household Income, 2010

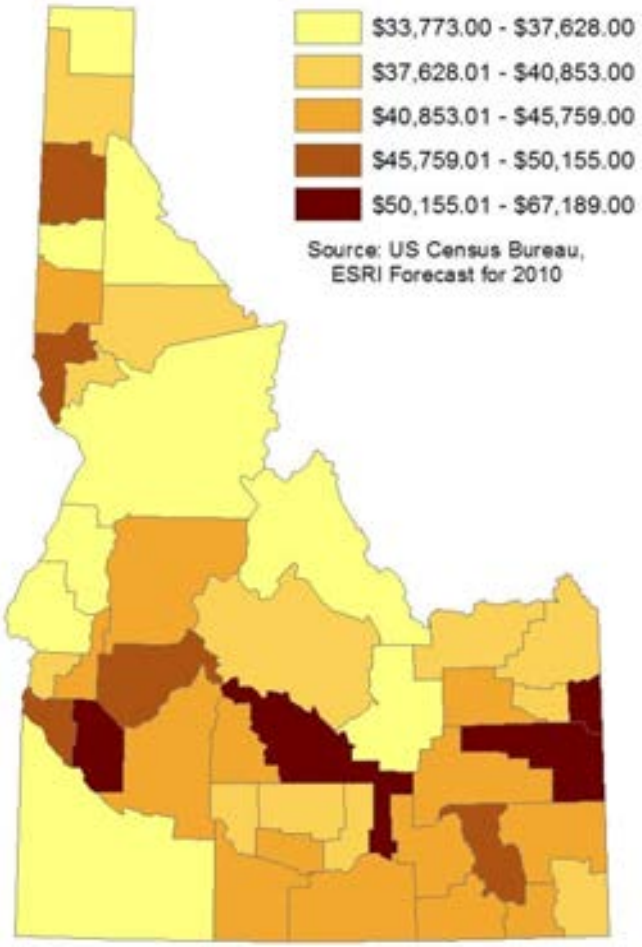


Figure 5

Within Idaho the median household income from 2006-2010 was $46,423, while nationally this figure was $51,914. Median household income in the counties ranged from $38,399 in Clark County to $94,241 in Blaine County.

Unemployment Rate, March 2011

Figure 6

The March 2011 unemployment rate in Idaho was 8.7%, compared to 8.8% for the nation. In the counties, the unemployment rate ranged from 4.5% in Owyhee County, to 14.9% in Adams County.

Methodology

The State of Idaho Epidemiological Profile of Substance Abuse has been developed under the State Epidemiological Outcomes Workgroup (SEOW) Contract and in turn the methodology used to develop this report is a standard format provided to all SEOWs. The following is a review of that methodology developed by the Pacific Institute for Research and Evaluation.

Substance abuse prevention planning begins with a clear understanding of alcohol, tobacco, and other drug use and their chief consequences (Figure 7).

***Figure 7: Outcomes-Based Prevention* Model**

In such an outcome-based approach, understanding the nature and extent of substance use and related problems (consumption and consequences) is critical for determining prevention priorities and aligning relevant and effective strategies to address them. CSAP recommended that State epidemiological profiles predominantly focus on substance use and related consequences as the first step in developing an outcomes based approach to prevention.[1]

CONSUMPTION:

Consumption is defined as the use and high-risk use of alcohol, tobacco, and illicit drugs. Consumption includes patterns of use of alcohol, tobacco, and illicit drugs, including initiation of use, regular or typical use, and high-risk use.

CONSEQUENCES:

Substance-related consequences are defined as adverse social, health, and safety consequences associated with alcohol, tobacco, or illicit drug use. Consequences include mortality and morbidity and other undesired events for which alcohol, tobacco, and/or illicit drugs are clearly and consistently involved. Although a specific substance may not be the single cause of the consequence, scientific evidence must support a link to alcohol, tobacco, or illicit drugs as a contributing factor to the consequence.

Each of the two major groupings (consumption and consequences), can be broken down into discrete categories or prevention-related "constructs" for each of the three major substance types—alcohol, tobacco, and illicit drugs. The constructs provide a way to conceptualize and organize key types of consumption patterns and consequences. For example, with respect to alcohol, constructs related to consequences include mortality and crime and constructs related to consumption patterns include

[1] Focusing on consumption and consequences does not by any means undermine the importance of measuring and understanding causal factors that lead to substance abuse and substance abuse-related consequences. Understanding the factors that contribute to substance use and related problems (also referred to as "intervening variables or "risk and protective factors") is the logical next step after the State has developed a full understanding of the substance use patterns and consequences it seeks to address.

current binge drinking and age of initial use. For each construct Idaho attempted to fine one or more specific data measure (or "indicators") to assess and quantify the prevention-related constructs. Idaho's indicator data is collected and maintained by the various community and government organizations that are listed in Appendix A.

Numerous constructs and indicators for substance use and related consequences exist at the national, State, and sub-State level. Assembling and interpreting *all* of the available prevention-relevant data, however, would be an overwhelming challenge. Starting with a set of key constructs assisted Idaho in organizing and narrowing our search for data relevant to the particular decisions Idaho needed to make. As suggested by PIRE, Idaho was guided in this process by what we wanted to know rather than starting with an inventory of all the data we have. That is, Idaho didn't let the *existence* of data drive decisions about which problems to focus on. We first specified the constructs of real interest and then identified what indicators were available to measure those constructs. If no data was available we choose not to represent that construct.

Given the limited time and resources for data analysis and interpretation, the Idaho SEOW focused on those constructs and indicators that proved most useful for prevention decision-making. All indicators included in this profile have been found to be valid and reliable measures of the constructs they were intended to reflect. Additionally, with respect to consequences, this meant focusing on constructs for which there is strong research evidence regarding the causal influence of alcohol, tobacco, and/or illicit drug use.

Data sources & Indicators

An effort was made to ensure that as many constructs as possible were represented by the fact sheets in the profile. For the data associated with each indicator refer to the fact sheet for the corresponding source.

Alcohol Related Indicators

Alcohol Consumption		
Construct	**Indicator**	**Source**
Current Use	Percent of persons aged 18 and over reporting any use of alcohol in the past 30 days	DHW-BRFSS
	Percent of students in grades 9 through 12 reporting any use of alcohol in the past 30 days	Education
Heavy drinking	Percent of adults aged 18 and older reporting average daily alcohol consumption greater than 2 (male) drinks or greater than 1 drink (female) per day	DHW-BRFSS
Age of initial use	Percent of students in grades 9 through 12 who report first use of alcohol before age 13	Education
Alcohol Consequences		
Alcohol-related mortality	Number of deaths attributable to alcohol per 100,000 population	DHW-VS
Crime	Number of DUI arrests per 1000 population	ISP
	Number of alcohol related arrests per 1000 population	ISP
	Number of DUI court filings per 1000 population	Courts

Tobacco Related indicators

Tobacco Consumption		
Construct	**Indicator**	**Source**
Current Use	Percent of persons aged 18 and older who report smoking 100 or more cigarettes in their lifetime and now smoke cigarettes either every day or on some days	DHW-BRFSS
	Percent of students in grades 9 through 12 reporting any use of cigarettes in the past 30 days	Education
	Percent of students in grades 9 through 12 reporting any use of smokeless tobacco in the past 30 days	Education
Daily use	Percent of adults aged 18 and older who report smoking 100 cigarettes in their lifetime and now smoke every day	DHW-BRFSS
Age of initial use	Percent of students in grades 9 through 12 initiating tobacco use before age 13	Education
Tobacco Consequences		
Tobacco-related mortality	Number of deaths from lung cancer per 100,000 population	DHW-VS
	Number of deaths from cardiovascular disease per 100,000 population	DHW-VS

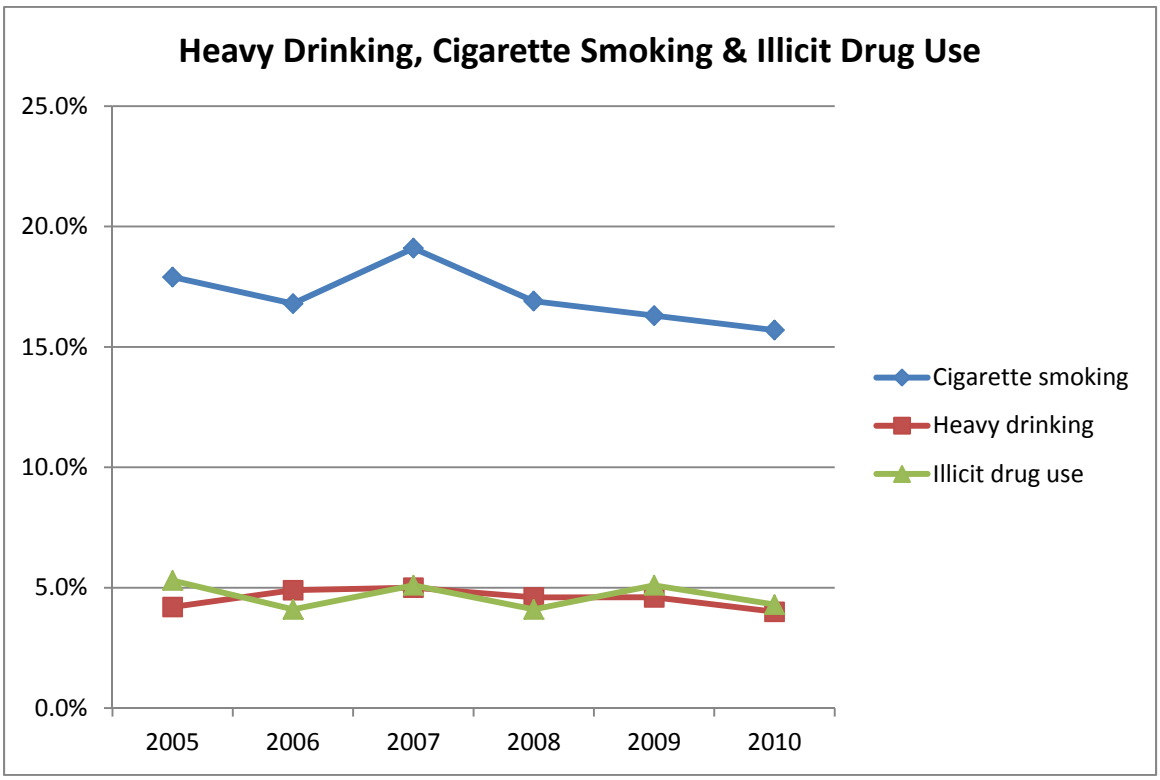
Drug Related Indicators

Illicit Drug Consumption		
Construct	**Indicator**	**Source**
Current Use	Percent of students in grades 9 through 12 reporting any use of marijuana in the past 30 days	Education
	Percent illicit drug use in the past 12 months	DHW-BRFSS
Lifetime use	Percent of students in grades 9 through 12 reporting any use of methamphetamines in their lifetime	Education
Illicit Drug Consequences		
Drug-related mortality	Number of deaths from illicit drug use per 100,000 population	DHW-VS
Crime	Number of drug/narcotic possession and distribution arrests per 1000 population	ISP
	Number of drug related filings per 1000 population	Courts

Fact Sheets

The following pages contain fact sheets from the Idaho SEOWs various partners. This format has been developed in the interest of providing a clear line of communication between our stakeholder's and the data managers and analysts. With that in mind, stakeholders should feel free to distribute these fact sheets individually or as a package.

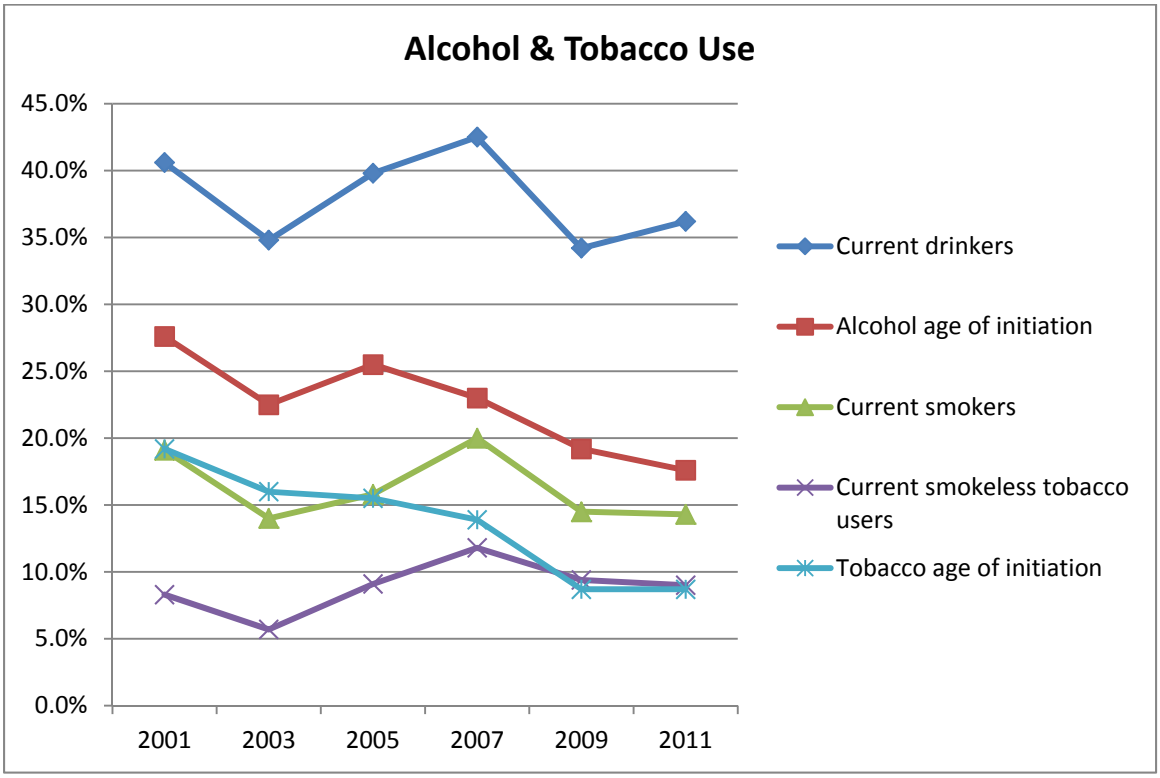
Department of Health & Welfare (DHW) - Behavioral Risk Factor Surveillance System (BRFSS)



"Heavy drinking" is defined as the percent of adults aged 18 and older reporting average daily alcohol consumption greater than 2 (male) drinks or greater than 1 drink (female) per day.

"Cigarette smoking" is defined as the percent of persons aged 18 and older who report smoking 100 or more cigarettes in their lifetime and now smoke cigarettes either every day or on some days.

"Illicit drug use" is defined as the percent of individuals who used illicit drugs in the past 12 months.



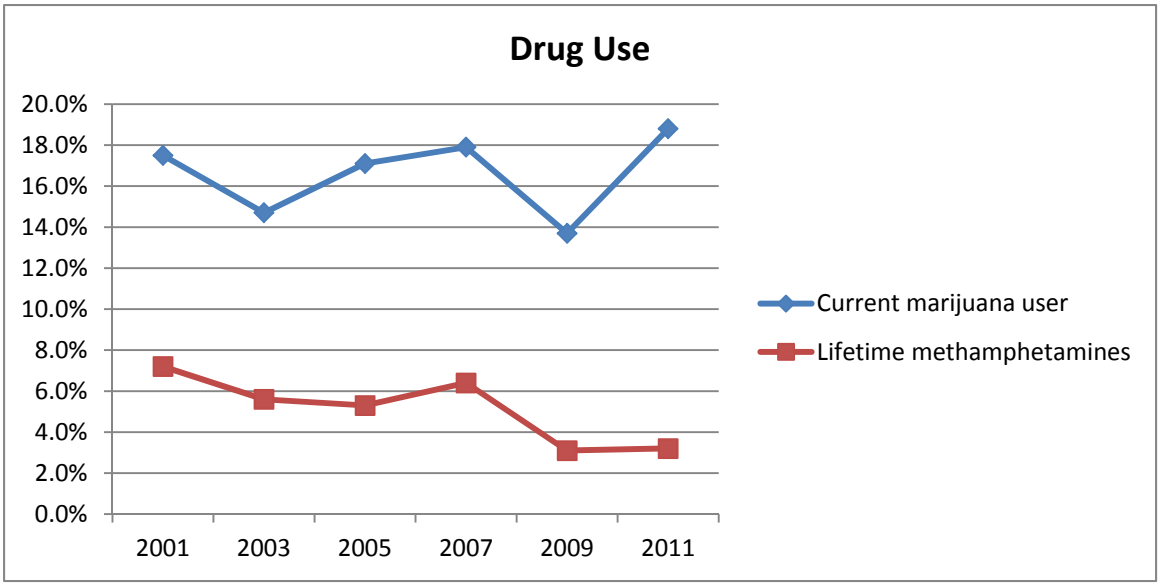
"Current drinkers" is defined as the percentage of Idaho students who had at least one drink of alcohol during the past 30 days. The percentage of Idaho students who had at least one drink of alcohol during the past 30 days did not change significantly from 2001 to 2011.

"Alcohol age of initiation" is defined as the percentage of Idaho students who had their first drink of alcohol other than a few sips before age 13 years. The age of initiation for alcohol (first drink before age 13) has dropped significantly from 27.6% in 2001 to 17.6% in 2011.

"Current smokers" is defined as the percentage of Idaho students reporting any use of cigarettes in the past 30 days. After increasing significantly from 14.0% in 2003 to 20% in 2007, the current smoking rate among Idaho high school students dropped again to a near low of 14.3% in 2011.

"Current smokeless tobacco users" is defined as the percentage of Idaho students reporting any use of smokeless tobacco in the past 30 days. Chewing tobacco use during the previous 30 days peaked in 2007 at 11.8%, but continued to fall to 9.0% in 2011. Past month chewing tobacco use increased significantly from 5.7% in 2003 to 11.8% in 2007.

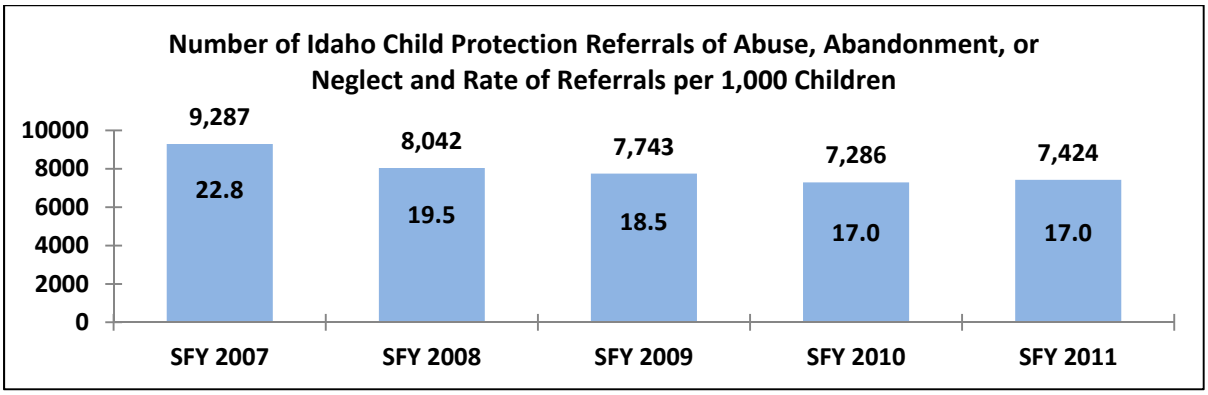
"Tobacco age of initiation" is defined as the percentage of Idaho students initiating tobacco use before age 13. The percentage of Idaho students who smoked a whole cigarette for the first time before the age of 13 decreased significantly from 19.2% in 2001 to 8.7% in 2011.



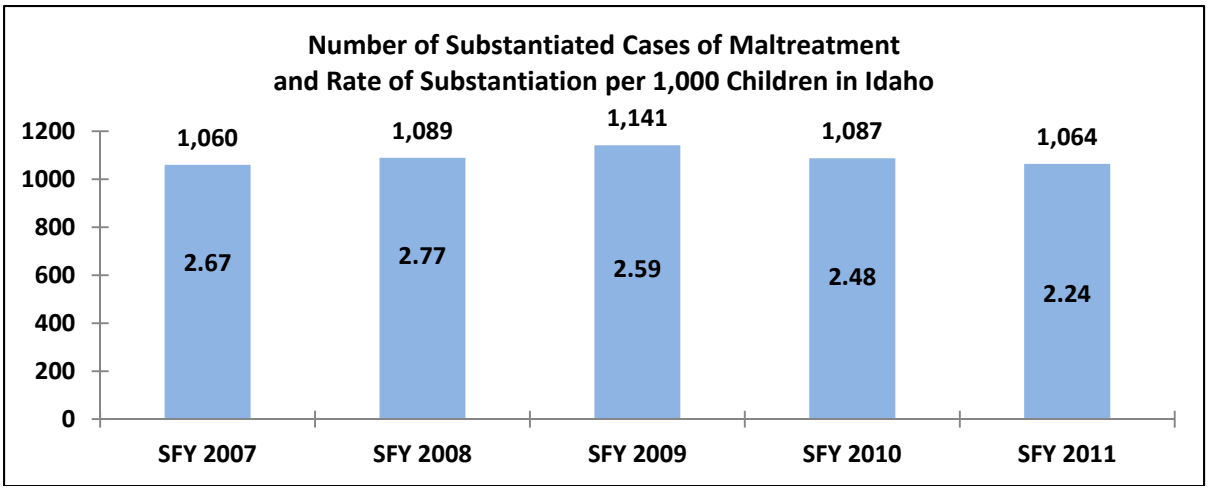
"Current marijuana user" is defined as the percentage of Idaho students reporting any use of marijuana in the past 30 days. The percentage of Idaho students who used marijuana one or more times during the past 30 days has not changed significantly since 2001.

"Lifetime methamphetamines" is defined as the percentage of Idaho students who used methamphetamines one or more times during their life. Lifetime meth use peaked in 2001 at 7.2% and decreased to a low of 3.1% in 2009.

DHW – Division of Family and Community Services (FACS)



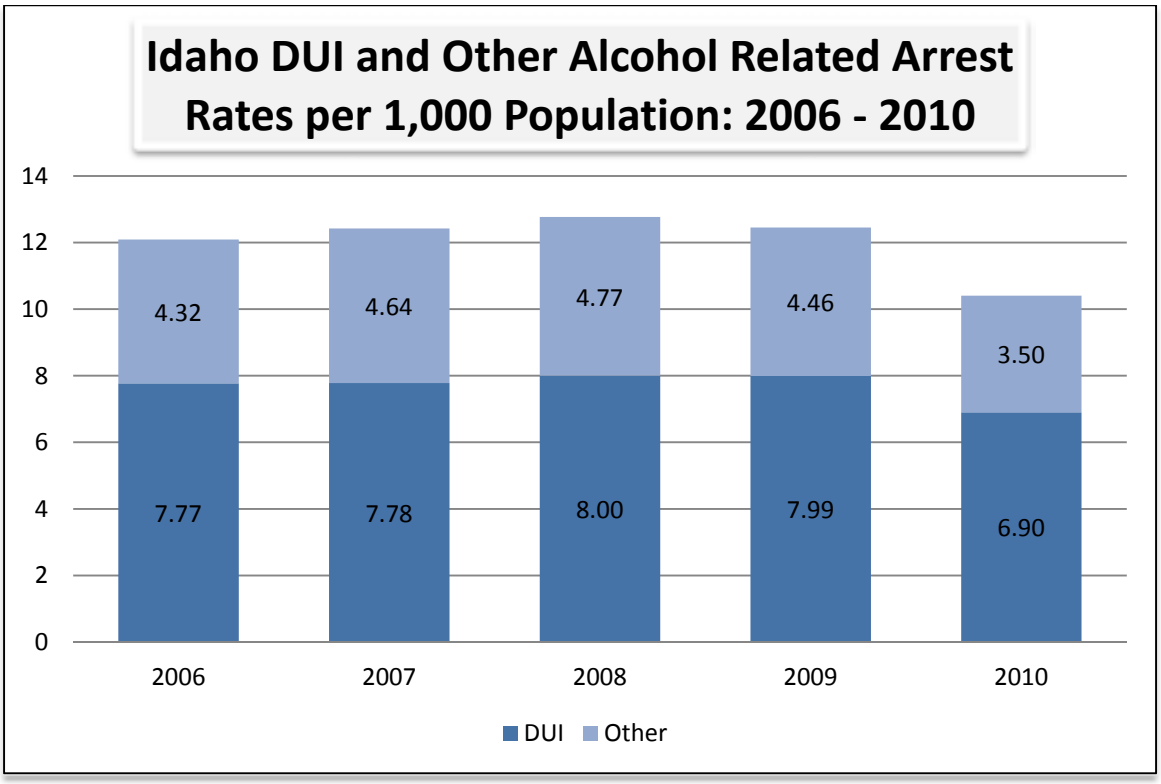
Reporting of Abuse, Abandonment, or Neglect – Idaho Code 16-1605 Section 1: "Any... person having reason to believe that a child under the age of eighteen (18) years has been abused, abandoned or neglected or who observes the child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment or neglect shall report or cause to be reported within twenty-four (24) hours such conditions or circumstances to the proper law enforcement agency or the department". To report child abuse or neglect call the Idaho Careline 2-1-1 or 1-800-926-2588. Referrals shown above do no include: Third Party, Court Ordered Investigation, Information & Referral, or CP Expansion.



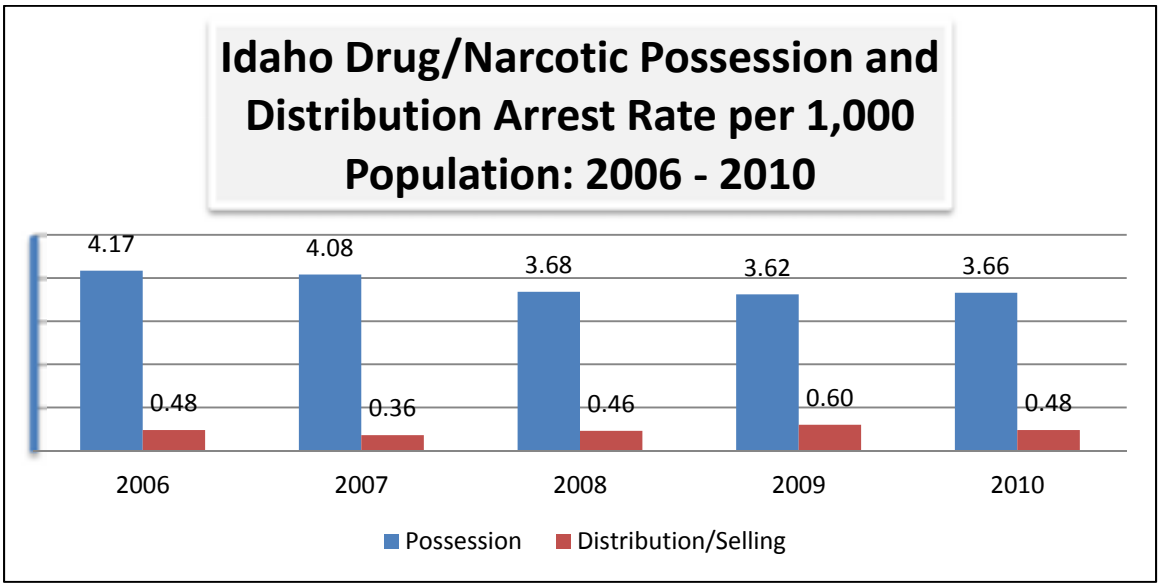
Referrals dispositioned as substantiated are child abuse and neglect reports that are confirmed by one or more of the following: witnessed by a child welfare worker, determined or evaluated by a court at the adjudicatory hearing, a confession, corroborated by physical or medical evidence, or established by evidence that is more likely than not that abuse, neglect, or abandonment occurred. Substantiations shown above do no include: Court Ordered Investigation or CP Expansion.

Source: Kids Count Report in Family Oriented Community User System (FOCUS) and U.S. Census Bureau population estimates

Idaho State Police (ISP)

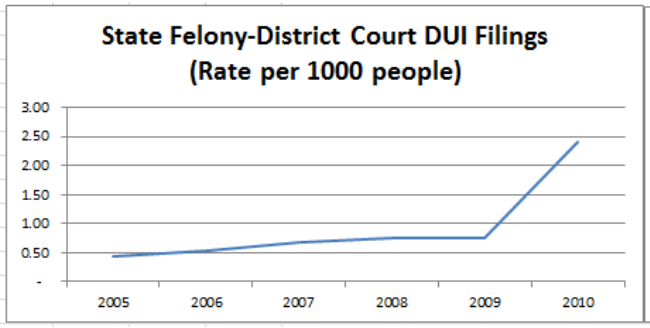


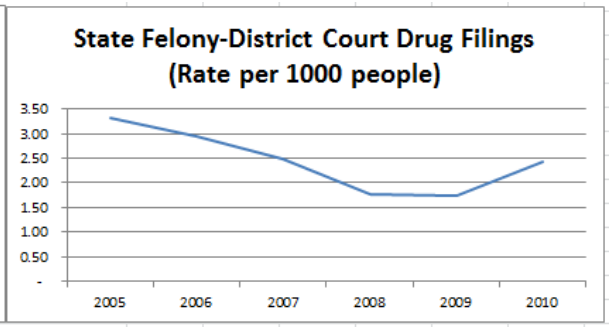
DUI arrests include misdemeanor and felony DUI arrests. While "Other Alcohol Related Arrests" include liquor law violations, public drunkenness, and minor in possession charges.



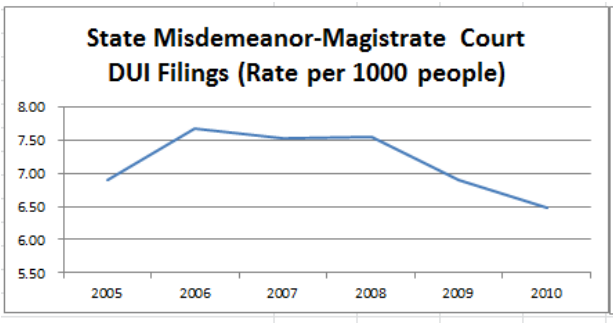
Idaho Supreme Court

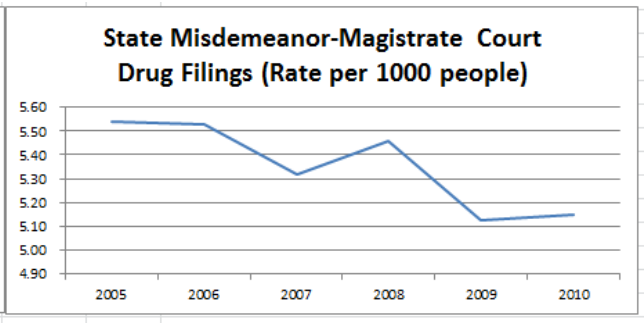
State DUI and Drug Court Filings





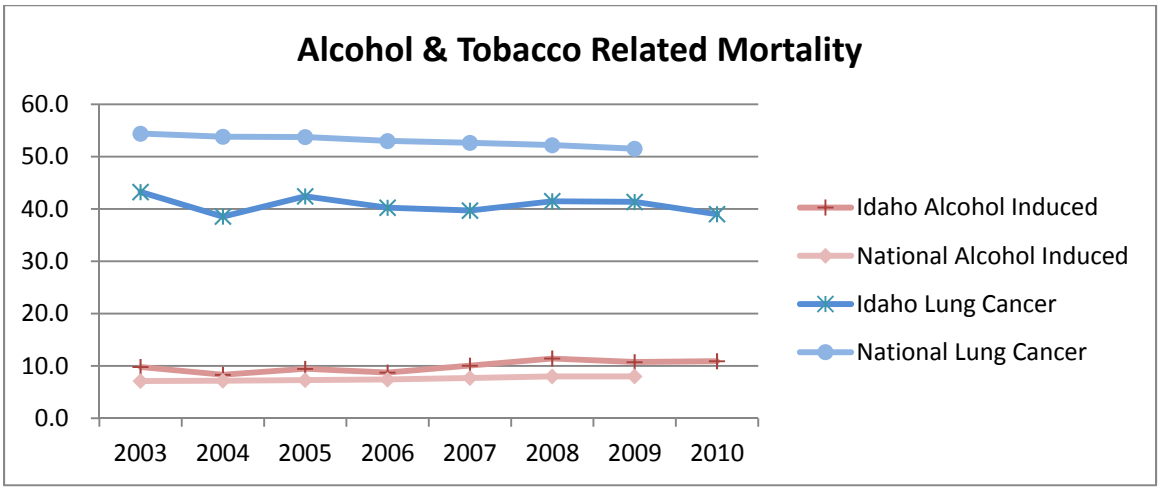
The information above represents the rate of Felony Court Filings in the District Court per 1000 people for the state of Idaho per calendar year.



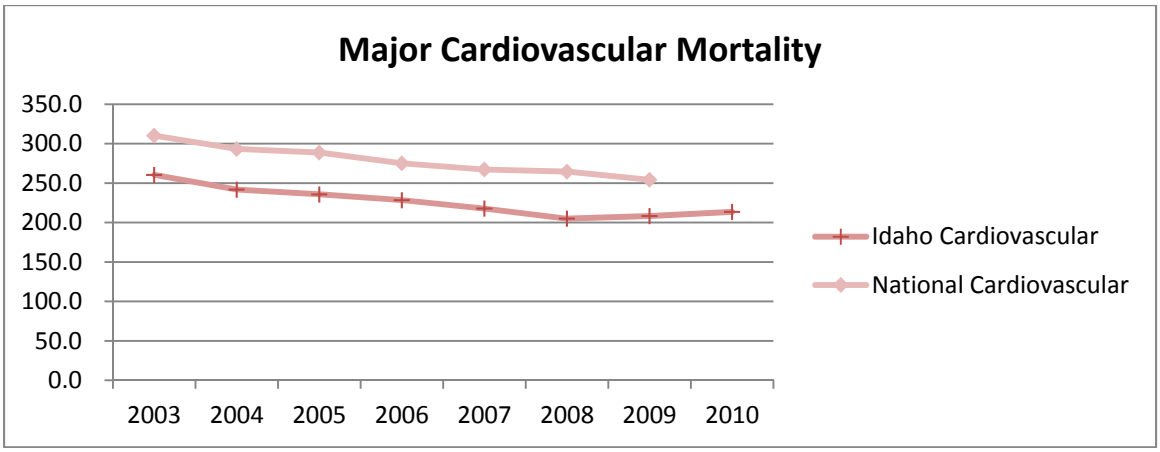


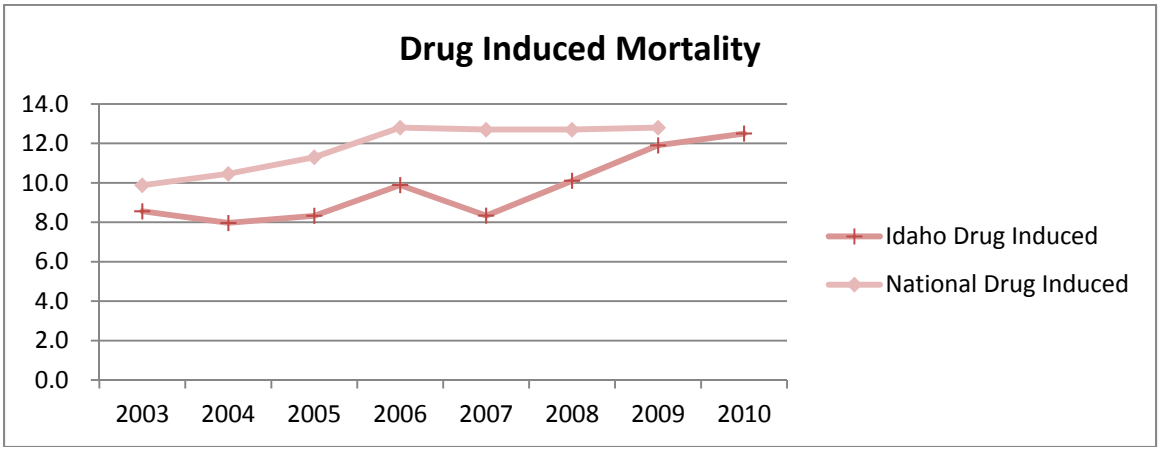
The information above represents the rate of Misdemeanor Court Filings in the Magistrate Court per 1000 people for the state of Idaho per calendar year

DHW – Vital Statistics (VS)



All mortality figures are deaths per 100,000 residents.





Data Limitations & Gaps

On a methodological level, Idaho struggles to collect indicators that directly describe and measure substance abuse rather than aspects related to usage. Among other issues, survey/self-report data has often been exposed as unreliable in a state with a demographic as diverse as Idaho's. Statistical modeling assumes a certain degree of homogeneity that simply is not present. This, coupled with the low funding levels, results in small sample sizes with questionable validity. As a result we've attempted to use capacity measures as a substitute for reliable survey data, but in the future efforts may be undertaken to expand the sample sizes on the NSDUH, BRFSS and YRBS to remedy this issue.

In some cases this issue can be remedied by aggregating data by region, but that creates additional complication. While it is certainly easier to discuss seven regions than it is to discuss 44 counties, a great deal of detail is lost in the conversion to regions. Since only some of our counties are demographically similar to those counties that adjoin them, mean regional scores can mischaracterize trends occurring in the rural and frontier counties that represent the majority of the states land mass.

These issues lead to capacity measures composing a majority of the indicators in this report. But of those capacity measures, the state has a serious gap in coverage. Idaho lacks a hospital discharge database. In many states this is the major source of the morbidity indicators which Idaho lacks in totality. Finally, database cardinality is a persistent issue in many of the systems which report the epidemiological indicators. Particularly in regards to education which lacks even a client level database.

Conclusions

While consumption and many consequences seem to be on the fall there are a couple of notable consequences on the rise. Felony DUI filings have raised sharply over the course of the past 5 years. Additionally drug induced mortality is on the rise.

In the case of felony DUIs, in recent years there was a revision to Idaho statute 18-8005 which guides DUI penalties. A large number of DUIs previously defined as misdemeanor are now being classified as felony as a result of an expanded time window (from five years to ten years) for multiple DUIs. That said, while felony DUIs have been on the rise, misdemeanors have been on the fall. This may indicate a stable DUI rate.

Drug induced mortality is significantly more complicated. While other mortality rate indicators have been on the fall or stagnant, drug induced mortality has risen 51% in the past three years. Nationally this variable has been stagnant. While this variable could be a function of increased awareness and identification of drug mortality pathology, it remains an indicator to monitor in the future and further investigate in the present.

By in large, the preponderance of falling indicators may indicate that community based prevention efforts began in 2006 are beginning to have an effect. Further research to reject possible intervening variables (such as a depressed economy) must be conducted but the initial results contained in this report are encouraging.

Appendices

Appendix A – Sources contact information

Sources	Agency	Individual	Contact Info (email or phone)
DHW-BRFSS	Idaho DHW – Vital Statistics	Christopher Murphy	murphyc@dhw.idaho.gov
Education	Idaho State Department of Education	Matt Hyde	mhyde@sde.idaho.gov
DHW-FACS	Idaho Department of Health & Welfare – Family & Community Services	Sarah Siron	sirons@dhw.idaho.gov
DHW-VS	Idaho DHW – Vital Statistics	Andy Bourne	bournea@dhw.idaho.gov
ISP	Idaho State Police	Janeena Wing	janeena.wing@isp.idaho.gov
Courts	Idaho Supreme Court	Scott Ronan	sronan@idcourts.net

Appendix B – Idaho state map with counties labeled

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.
Page 46 of the Application Guidance
Narrative Question: This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Identification of Data Sources Used to Identify Needs and Gaps

Idaho's behavioral health unmet service needs and critical gaps are based on data from multiple sources, including comments from Idaho citizens who responded to a survey requesting feedback on this issue. These numbers represent Idaho's best estimate to date of incidence, treated prevalence, and quantitative targets. This information represents our best estimates based on available data and reflects the limitations of our reporting and information systems. In some cases it is not possible to guarantee unduplicated counts. These numbers represent publicly provided and/or funded (including Medicaid) mental health services rendered by the public sector. Some individuals received services from both public mental health system and private sector providers during FY2011. As of July 1, 2011, numbers served for adult mental health and children's mental health were captured in the Division's Web Infrastructure for Treatment Services (WITS) system.

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

The WITS system was implemented 10/1/09 for collection of Adult Mental Health (AMH) data for public services provided through regional mental health center (RMHC) sites. Implemented in SFY 2009, the

VistA data infrastructure system is used by State Hospital South (SHS) and State Hospital North (SHN). The Division of Behavioral Health (DBH) has an Interagency Agreement with the Idaho Division of Vocational Rehabilitation (IDVR), and IDVR provides monthly reports on employment services provided to shared clients. Employment data is extracted from WITS for federal reporting on the National Outcome Measures (NOMS). The Office of Consumer Affairs (OCAFA) provides monthly reports of services for Consumer and Family Advocacy/Education, Peer Specialist Certification and Programs for Assistance in Transition from Homelessness (PATH) outreach, engagement and case management activities provided by PATH peer specialists. Children's mental health data is collected and extracted from WITS. Consumer survey information is based on annual and end of service MHSIP and YSS-F survey requests. Regional computer kiosks provided easier access for service recipients to complete these surveys. In an effort to support and crosswalk data from WITS, VistA and SUD data sources, DBH is refining use of a data warehouse. Medicaid data must be requested. Medicaid's contract with the data management vendor, Molina, began in May 2010. This system handles Medicaid service and billing data.

The Substance Use Disorders treatment (SUDS) program also gathers and reports data from several sources. The National Survey on Drug Use and Health (NSDUH) provides Idaho specific data to evaluate incidence and prevalence of substance abuse and to estimate populations in need of substance use disorders treatment services. The Division of Health implements the Youth Behavioral Risk Survey (YRBS) and the Behavior Risk Factor Surveillance System (BRFSS), and this data is useful for substance use disorder treatment needs assessments and planning. Substance use disorder service provider treatment data is collected by the management services contractor, Business Psychology Associates, and uploaded to the Department. A request for proposals was posted on February 1, 2013 with a new management services contract award anticipated on or before July 1, 2013.

The SUD treatment data is used to create a number of standard reports that are utilized for State planning and assessment. Standard reports include State Utilization Management and Grant Data; Level of Care Capacity and Census Management; Budget Tracker; Treatment Completion Data; Length of Stay Report; County/Regional Utilization Report; Pregnant Women With Children (PWWC) Chart Audit Results and Client, Provider & Stakeholder Satisfaction reports. Each of the seven regions in Idaho has a Regional Advisory Committee (RAC) that provides an annual report and updated information to help determine regional and local treatment needs, emerging trends, gaps in service and the need for programs and services in regions throughout the State. An SFY 2013 legislative proposal describes the discontinuation of regional RACS as regional mental health boards and RACS are merged into Regional Behavioral Health boards. During SFY 2014-2015, the Department plans to continue use of the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), YRBS, BRFSS, substance use disorder treatment data and information from regional behavioral health boards to assess SUD treatment needs in Idaho.

The SUD treatment system is working with the vendor, FEI, to develop the WITS system for SUD use. The Department conducted meetings with other state agencies during SFY 2012 -2013 to assess and plan for SUD treatment needs and services. The WITS/GAIN interface is currently being used by contracted network substance use disorders treatment providers for the assessment of state-funded clients. Idaho is in the process of implementing the full WITS system for the SUD Treatment Services Delivery System. Once fully implemented, contracted network treatment providers will be able to use WITS to assess clients, manage treatment, bill for services and collect outcome measurement data in real-time. As of

March 2013, there were twenty providers piloting the full system. Training for all contracted network SUD providers is planned for Spring 2013, with full implementation by July 1, 2013. Starting in July 2013, all contracted network providers will be required to utilize WITS as their electronic health record and to track and submit claims for payment of state funded community substance abuse services. At that time, the managed service contractor will maintain the adjudication process in WITS and providers will be paid based upon the submitted and accepted claims in WITS.

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

The Idaho State Epidemiological Outcomes Workgroup (SEOW) is composed of state agency staff and community stakeholders (Idaho Prevention Fellow, researchers) with an interest in the substance abuse prevention system. In regards to prevention, the SEOW operates as an ad hoc research resource for policy decision makers. Additionally the group maintains a web dissemination resource for more general data related questions.

On the State level, the SEOW is identified as the Idaho Prevention and Treatment Research (PATR) work group. The PATR website at http://patr.idaho.gov/ states that "The Idaho Prevention and Treatment Research (PATR) Workgroup exists to develop a system of substance abuse related data collection, analysis and reporting that reflects substance abuse consumption and consequences throughout Idaho." This public site is accessible to all Idaho stakeholders and reflects 15 prevention risk factors, reported for each of Idaho's 44 counties resulting in a single source for 1,980 data points. Collected at the county level, the PATR website risk factor data (updated at least once every two years as new data is available) is a resource for state organizations, community members, prevention providers, researchers and coalitions needing data to develop substance abuse (including underage drinking) or other plans for their specific needs. Data graphed by county on this site is based on Hawkins and Catalano's (1992) risk factors. Data reflects domains related to school (i.e., incidents of bullying, suspensions, truancies), individual (i.e., adolescent pregnancy, juvenile arrests for alcohol related charges and juvenile arrests for drug related charges), family (child abuse and neglect, heavy drinking, illicit drug use), and community (i.e., adult arrests for alcohol related charges, adult arrests for drug related charges, free or reduced school lunch eligibility (K-12), impaired driving crashes, per capita sales of distilled spirits, unemployment rate). The PATR website uses data provided by the Idaho State Liquor Division, the Idaho State Police and the Idaho Departments of Education, Transportation and Health and Welfare.

The Division of Behavioral Health's substance abuse prevention program contracted with Benchmark Research and Safety, Inc., to serve as the Idaho substance abuse prevention system manager in SFY 2012. Benchmark managed the community based prevention system. This includes annual state and county level needs assessments used to identify at-risk populations and underserved areas. Community based providers and coalitions are able to utilize this data to secure funding for populations that need services in their respective communities. In SFY 2014, prevention responsibilities and funds will be transferred to the Office of Drug Policy (ODP) in the Governor's office. In SFY 2014-2015, the ODP will be responsible to contract for SUD prevention programs.

Other behavioral health assessments were completed by the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) and the Governor's Transformation Workgroup. The ICSA workgroup's assessment resulted in a document entitled "Idaho Substance Use Disorder Prevention and Treatment System: A Collaborative Strategy for 2008-2012. It indicates that "The System addresses individual, community and tribal needs statewide for effective and accessible prevention, education, assessment, early intervention, treatment, recovery support services and post-treatment support," (p. 3). It adds that the "System strives to maintain an uninterrupted, well-coordinated continuum of services to clients and their families within and outside of the criminal justice system." Identified needs in the ICSA plan that were not complete by July 2011 (Appendices, p. 3, pp. 9-11) included collaboration with 1) local and state correctional agencies and detention facilities to develop shared resource methods to ensure effective implementation and delivery of intervention and treatment services to adult and juvenile populations in correctional and detention facilities and 2) the Department of Education to implement core best practice and outcome measures for prevention services in K-12. Other goals included collaboration with the Department of Health and Welfare to 1) assure a provider network to balance service availability and funding throughout the state; 2) identify core evidence based practices by population; and 3) work with the Idaho Department of Correction and Juvenile Corrections and county probation to identify protocols to integrate treatment with probation services.

The Idaho State Planning Council on Mental Health's 2012 Report to the Governor and State Legislature: Idaho Mental Health at the Crossroads (June 2012) document "…highlights the consequences of reduced services and outlines gaps in resources. Documented resulted have been an increase in suicide rates, overburden of law enforcement and depleted medical/community resources." The 2012 Report recommends provision of "…cost effective, efficient services that are client centered and recovery focused. Specific areas of concern included access to community mental health services, affordable housing and services in rural areas.

Unmet Service Needs and Critical Gaps

According to the U.S. Census Bureau data for 2010, Idaho's total population estimate was **1,545,801,** with an estimate of **1,126,894** aged 18 or older and an estimate of **418,907** under age 18. The SAMHSA/CMHS estimation methodology establishing prevalence indicates percentages for adults at 5.4% for Serious Mental Illness (SMI) and 2.6% for Serious and Persistent Mental Illness (SPMI). Five percent of the estimated SMI population is estimated to be homeless. Five percent of children/adolescents are estimated to have serious emotional disorder (SED) diagnoses. Based on these percentage estimates, it may be concluded that there are **60,852** adults in the state of Idaho with serious mental illness, **29,299** adults in the state of Idaho with serious and persistent mental illness, **3,043** adults with SMI who are also homeless and **20,945** children with serious emotional disorder diagnoses. Idaho's TEDS data for 2008

indicates a treatment admission rate of **5,683** aged 12 and older; an estimated **464** admitted per 100,000 population aged 12 and older; **2,110** primary alcohol admissions and **1,712** primary marijuana admissions. This data indicates that, for the total of **5,683** admissions 12 and older in 2008, **48.9%** were regular outpatient and **40.2%** were intensive outpatient; **11.1%** detoxification services were free-standing residential; **5.9%** residential services were short-term and **.03%** were long-term; **1.1%** of opioid treatment was outpatient, **.1%** was detoxification and **.2%** was residential.

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

Suicide: The National Suicide Prevention Lifeline reported 3,700 calls from Idahoans in 2010. The Suicide Prevention Action Network of Idaho (SPAN Idaho) provided a suicide fact sheet in February 2012 based on data from the Idaho Bureau of Vital Records and Health Statistics, the Idaho Department of Health and Welfare, the Centers for Disease Control and Prevention and YRBS Idaho (see attached). According to these statistics, suicide is the 2nd leading cause of death for Idahoans 15-34 and for males 10-14 years of age. The fact sheet reports that in 2010, 290 people completed suicide. Between 2006-2010, 81% of completed suicides were men, and 63% involved use of a firearm. This report indicates that in 2009, "14.2% of Idaho youth attending traditional high schools reported seriously considering suicide in 2009, with 6.9% reporting at least one attempt." The State Planning Council on Mental Health identified this as a top June 2011 concern. The Chestnut report of SUD client data from GAIN results for SFY 2010 (January 2011; see attached) indicated that 59% of the sample population reported co-occurring psychiatric problems, 28% reported major depressive disorder, 22% reported traumatic stress disorder, 61% reported a history of physical, sexual or emotional victimization, and 23% reported homicidal/suicidal thoughts in the past year. The SEOW report for 2010 (see attached, p. 10-11) indicates that "Idaho's suicide rate (2005) was 45% greater than the national rate." In response to these concerns, Idaho established a suicide prevention hot line in SFY 2013. Prior to that, suicide hot line calls were handled through out of state agencies.

Housing and Homelessness: Homelessness remains an area of concern in Idaho. The website state health facts.org at http://www.statehealthfacts.org/profileind.jsp?rep=81&cat=1&rgn=14 indicates that in November 2011, Idaho ranked 24th in foreclosure percentages. The Idaho Housing and Finance Association's (IHFA) January 2011 Point in Time count estimates 2,199 homeless individuals statewide. The number of homeless students in Boise school districts was estimated at 1,717 in the 2009-2010 school year (ie., Nampa 757; Boise 656; and Meridian 304). In the Coeur d'Alene School District, 248 of the roughly 10,000 total students were identified as homeless in spring 2010. Project Safe Place provides services to teenagers in crisis at 78 locations spread around the greater Coeur d'Alene area. This program's services include a drop-in center, drug prevention education, crisis intervention and emergency shelter for youth under 18.

Prior to SFY 2011, the Projects for Assistance in Transition from Homelessness (PATH) grant divided PATH funds among seven Regional Mental Health Centers. The Idaho PATH Annual Report for 2009 indicated that, of the estimated (i.e., 5% of estimated SMI) 2,947 adults who were homeless with SMI, there were only 702 PATH clients served with federal, state and other funds (not including federal funds to Idaho Housing and Finance Association or Boise Ada Housing Authority that provide limited assistance to adults with SMI). As of SFY 2011, the majority of PATH funds went to a contract with Mountain States Group's Office of Consumer and Family Affairs (OCAFA) to hire, train and supervise Certified Peer Specialists to provide up to 75% active face to face outreach to homeless adults with SMI. Two PATH Peer Specialists, each working 19 hours per week, were trained and began to provide PATH outreach in April 2011. Use of PATH Peer Specialists has improved coordination with regional service providers, and increased use of housing assistance funds because of active PATH referrals for eligible PATH participants.

The Idaho Home Outreach Program for Empowerment (ID-HOPE) project was funded through a CMHS transformation grant and the evidence based practice of Critical Time Intervention (CTI) began in pilot regions 3 and 4 in March 2011. The ID-HOPE team is composed of a mix of Certified Peer Specialists and bachelors/masters level staff. This team includes specialists in housing and crisis services. In May and June, 2011, PATH and ID-HOPE team members participated in the PATH to Housing phone and webinar technical assistance course offered by the Centers for Social Innovation. Funding for ID-HOPE was cut 55% in January 2012, and this program operated solely in Region 4 as of May 2012. The ID-HOPE program is seeking solutions to sustainability after grant funding expires. Idaho is also in the process of establishing Safe and Sober housing for adolescents in Regions 1, 3 and 4. While there is some concern about funding, initial costs will be covered through the Access to Recovery (ATR) project. Sustainability of these resources is a concern.

While Idaho has homelessness services, safe, decent and affordable Idaho housing resources are more difficult to access and retain for individuals diagnosed with mental health and/or substance use disorders. The Idaho Housing and Finance Association (IHFA) announced in April 2011 that it was no longer accepting applications for Shelter Plus Care. Limited Shelter Plus Care resources were offered in two regions in January 2013. Landlords are often reluctant to rent to individuals with behavioral disorder diagnoses. Adolescent SUD residential facilities and/or transitional living resources have historically included funding from the Division of Behavioral Health and Idaho Division of Juvenile Corrections (DJC). Decreased funding for both programs has made it difficult to support the costs for the number of beds and bed days that are needed.

Employment: The Idaho Department of Labor reported an unemployment rate of 9.4% for May 2011, with an estimate of Idaho workers without jobs below 72,000 for the first time in nine months. The June 2011 report described variability in employment among Idaho counties. This report states that "Seventeen primarily rural counties posted double-digit unemployment rates, down from 18 in April. Two major urban counties remained in double-digits." The outlook was somewhat improved in 2012. The United States Department of Labor website at http://www.bls.gov/web/laus/laumstrk.htm (retrieved February 17, 2013) reports that, as of December 2012, Idaho ranked 18th in the nation with a 6.6 percent unemployment rate. While jobs are hard to find for the general Idaho populace, they are even harder to find and keep for those with mental health and/or substance use disorder diagnoses.

Prevention: Idaho has limited substance use prevention funds and no identified funding for mental health promotion (as of February 2013). Idaho uses the required 20% of the Substance Abuse Prevention and Treatment (SAPT) block grant to fund a range of Substance Abuse (SA) prevention services, but funds do not meet the need. As of February 2013, there were no other state agencies funding primary substance abuse prevention activities. In SFY 2014, SUD prevention responsibilities will be transferred from the Department of Health and Welfare's Division of Behavioral Health to the Office of Drug Policy (ODP) in the governor's office. The ODP will retain responsibility for SUD prevention activities, data tracking and outcomes reporting for SFY 2014 – SFY 2015.

In Idaho, the Division of Behavioral Health's prevention database has historically identified the location of prevention services. Coalition information is determined from the Community Coalition of Idaho's membership list. According to these data sources, 67% of Idaho cities with populations over 150 have no community-based substance abuse prevention education programs; 47% of school districts have no SA/SUD prevention and 61% of counties have no SA/SUD coalitions. The YRBS results indicate that 24% of 11th grade males reported binge drinking in the past month, over 50% of high school seniors reported past alcohol use and one in three high school students reported that they had tried marijuana in the past. The Chestnut study (January 2011) indicated that results of their sample showed a pattern of weekly substance use (13+/90 days) of alcohol 16%; cannabis 15%; cocaine 1%; opioid 8%; amphetamine 12%; other drugs 4%; needle use 16%; and tobacco 69%.

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

Data Infrastructure: The Division of Behavioral Health (DBH) continues to focus on development of a strong data infrastructure system capable of both collecting and extracting required data for local, state and federal reports and producing outcome data to guide resource decisions and best practice. The Web Infrastructure for Treatment Services (WITS) system was implemented at DBH Regional Mental Health Centers (RMHC) for Adult Mental Health (AMH) in October 2009, and for Children's Mental Health (CMH) in July 2011. State Hospital South and State Hospital North both use the VistA electronic health record system. A data warehouse was developed in SFY 2012 to assist with interlinking data from the WITS and VistA systems.

The Division of Behavioral Health is in the process of adding all publicly funded SUD treatment agencies to the WITS system. The WITS/GAIN interface is currently being used by contracted network substance use disorders treatment providers for the assessment of state-funded clients. Once the WITS system is fully implemented for SUD, contracted network providers will be able to use WITS to assess clients, manage treatment, bill for services and collect outcome measurement data in real-time. There are currently twenty (20) providers that are in the process of piloting the full system. Training for all contracted network SUD treatment providers is planned for Spring 2013, with full implementation by July 1, 2013. Starting in July 2013, all contracted network providers will be required to utilize WITS as their

electronic health record and to track and submit claims for payment of state funded community substance abuse services. At that time, the managed service contractor will maintain the adjudication process in WITS and providers will be paid based upon the submitted and accepted claims in WITS.

Medicaid Managed Care will be responsible for helping Medicaid providers adopt an Electronic Health Record (EHR). The Idaho Department of Health and Welfare (IDHW), Idaho Department of Corrections (IDOC), Idaho Department of Juvenile Corrections (IDJC), and the Idaho Supreme Court (ISC) are responsible to assist SUD agencies with efforts to adopt WITS as an EHR and encounter/claims based billing system.

The WITS system does not link to data systems for Medicaid, courts, criminal justice, primary health, schools, community hospitals or Idaho Vocational Rehabilitation. Specific requests must be made to access data from these data resources, and their data is not necessarily based on the same data element definitions as that used by the Division of Behavioral Health's WITS system. As of February 2013, there was no resource that captured co-morbidity data for behavioral health and physical health diagnoses, and this lack of data complicates efforts to accurately assess need. The substance abuse prevention program uses a web-based system with secure and non-secure portions (see www.preventionidaho.net) to collect data on participant demographics, attendance, pre/post test scores, providers/staff and staff training, and service costs. This site is also used for collection of required block grant and NOMS data, for providing information to contracted prevention providers, for accessing needs assessment reports and for locating funded prevention services.

Two data system challenges in Idaho relate to coordinating data from multiple state agencies with multiple billing systems and plans to implement both the ICD-10 and the DSM5. Barriers for providers include unfamiliarity with EHR systems, lack of Internet connection in rural and frontier areas of Idaho, lack of Information Technology (IT) assistance in small provider shops, insufficient funds to purchase and maintain an EHR, and inability to take advantage of meaningful use incentives. Most providers in Idaho do not have the staffing necessary to be reimbursed through meaningful use.

Access to Care: Additional unmet needs relate to access to care. As of July 1, 2010, the priority population for mental health was adults in crisis and those referred through the court system. The priority population for SA/SUD included pregnant IV drug users and court ordered individuals. Access to behavioral health care for those without criminal charges is difficult in a context of limited funding. Access to primary medical and dental care resources and services can be difficult as well. The rural and frontier nature of Idaho's geography poses additional challenges with respect to transportation and to attracting and retaining health professionals.
The Chestnut study (January 2011; SUD/GAIN sample SFY 2010) results suggested that biomedical common treatment planning needs included risky sex behavior 82%; tobacco cessation 68%; accommodation of medical conditions 39%; medications for physical health problems 26%; and current treatment for medical problem 26%. Some private providers (e.g., Terry Reilly Health Services) provide low or no cost services to those without insurance or means to pay. There are more people who need Medicaid dental services than there are Medicaid dental providers.

Steven Snow, Executive Director of Idaho's Council for the Deaf and Hard of Hearing indicates that the deaf and hard of hearing in Idaho don't have access to services that adequately address deaf and hard of

hearing needs. According to Steven, there is only one person in Idaho who signs and provides mental health counseling services. Steven suggests that the lack of access to adequate behavioral health services negatively affects the quality of life for deaf and hard of hearing Idaho citizens. The Council for the Deaf and Hard of Hearing has plans to implement a task force to identify needs for mental health, substance use, domestic violence and other issues in SFY 2012.

With respect to justice system involvement (JSI), Chestnut (2011) results indicated that the percentage reporting detention/jail for 30+ days was 26%; detention/jail for 14-29 days was 8%; probation/parole for 14+ days with one or more drug screens was 25%; other probation/parole/detention was 16%; other JSI status was 13%; and past arrest/JSI status was 8%. According to Idaho State Police data in the 2011 SEOW report, there were 7.99% Idaho DUI and other alcohol related arrest rates per 1,000 population in 2009, and 8.62% per 1,000 population were arrested for possession of a controlled substance.

Idaho is composed primarily of rural and frontier areas, and increased gas prices make it even more difficult for Idaho citizens to keep appointments with service providers that may be up to an hour away by car. In SFY 2008, there were two major changes in Medicaid. Policy changes expanded eligible locations for service delivery to allow physicians to perform telehealth in any setting in which they are licensed. A benefit was added to allow for family therapy without the client present. Access to prevention care is limited by available funding. In 2012, 20,451 or under 7% of Idaho youth aged 5 – 18 participated in substance abuse prevention education. This leaves a large population unserved.

Cultural Issues: Cultural issues are addressed through learning applications on the Department of Health and Welfare's Knowledge Learning Center (KLC) website, but this does not address specifics related to Native American Tribes. Curriculum on awareness of Gay, Lesbian, Transgender and Bisexual populations was added to the KLC in SFY 2012. The Idaho Minor in Prevention Curriculum includes attention to culture, age and gender. Service information and treatment materials are available in English and Spanish in regional Behavioral Health offices, and other languages can be addressed through translator resources. The substance abuse prevention program works to match providers and staff to the needs of individuals served. If a qualified member of the participant's preferred culture is not available, then Benchmark Research and Safety (Idaho's prevention system manager) works with the provider and the population to be served to identify a person that is mutually acceptable to deliver the service. The annual Idaho Conference on Alcohol and Drug Dependency offers courses in cultural elements or information on specific cultures.

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

Evidence Based Practice for Criminal Justice Involved: The Division of Behavioral Health's priority service population is those who are court ordered for treatment. Behavioral health programs strive to provide best practice services, and this could be increased with additional training and implementation of evidence based practices that were specifically designed for criminal justice involved individuals with co-occurring behavioral health diagnoses. Adolescents involved in Diversion programs who live in areas where the state has a pilot early intervention program are able to access an evidence-based education

program (Project Toward No Drug Abuse) which is partnered with a support group. Also included in this program is an intake and recovery support planning process.

Recovery and Resilience: The Division of Behavioral Health is dedicated to the pursuit of a behavioral health service system that is focused on a philosophy of recovery and resilience. As of February 2013, Certified Peer Specialists were working on teams providing mental health services related to Assertive Community Treatment (ACT), Projects for Assistance in Transition from Homelessness (PATH), and Critical Time Intervention (ID-HOPE). The Substance Use Disorders program has explored the use of Recovery Mentors to model recovery, focus on wellness and encourage engagement in treatment services. In SFY 2013, the Division of Behavioral Health directly hired half-time peers for ACT teams in each of seven regions. State hospitals also have half-time peers that are supervised through a contract with Mountain States Group.

In December 2012, the Department of Health and Welfare was awarded one of ten Transformation Transfer Initiative grants. The Recovery Infrastructure Training for Empowerment Transformation Transfer Initiative (RITE-TTI) project goals are to build a recovery infrastructure for behavioral health that begins to weave together recovery as it relates to those with mental health diagnoses, those with substance use diagnoses and those with both mental health and substance use disorders. The RITE-TTI project plans are to bring teams of peers (MH and SUD treatment), community resource development specialists (CRDS), and other MH and SUD treatment stakeholders from each of seven regions and the state hospitals to 1) develop an action plan toolkit to help identify needs and gaps, identify an issue to address, develop and implement an action plan to address that issue and gather and disseminate outcomes data; 2) develop a recovery toolkit with a trauma focus that can be taken back to the regions to provide education on recovery and trauma; and 3) participate in Recovery Coaching opportunities, with up to fifteen individuals trained as Recovery Coach trainers. Recovery Coaching opportunities will begin to develop an SUD work force that complements the existing Certified Peer Specialist work force in Idaho. Two half time Certified Peer Specialists will be hired through the Division of Behavioral Health's central office to coordinate RITE-TTI project activities, to handle required logistics and reporting and to manage project outcomes.

Input from Idaho Citizens: Several activities were implemented in January/February 2013 in an effort to solicit input from Idaho citizens into the development of the SFY 2014-2015 Combined SAPT/MH Block Grant. The need to develop the plan was presented to the State Planning Council on Mental Health at their January 2013 quarterly meeting, with a request to provide input through a specific block grant survey link on the external Department of Health and Welfare (DHW) website. Regional Division of Behavioral Health program managers were encouraged to respond to the website, and to share the invitation with local providers and regional boards. The Division of Behavioral Health communicated with the Director of the Idaho Division of Vocational Rehabilitation (IDVR) and requested their input into the plan. The IDVR Director also contacted leaders of four Tribes that IDVR works well with, and invited them to also participate in responding to questions posted on the external DHW website. An internal Division of Behavioral Health survey also solicited input on block grant planning for SFY 2014-2015. Responses from the internal and external websites were incorporated into the narrative sections of the SFY 2014 -2015 Plan.

Responses to this section on unmet needs and critical gaps included concerns about behavioral service integration, access to community based services in rural and frontier areas, provision of individualized services, and development of standardized assessments and outcome measures. One respondent expressed concern that SUD and MH programs are not yet fully integrated into a single behavioral health service delivery system. This can result in conflicting recommendations from separate MH and SUD service providers to an individual with a co-occurring diagnosis. One recommendation was that the newly developed Council on Behavioral Health could be responsible to identify matrices to measure the effectiveness of state and community programs, and with the state responsible to collect, analyze and report results that can be used to guide programs and service delivery. One concern was raised that individuals with SUD treatment issues may be treated with MH crisis services and not admitted into the MH service delivery system. This can result in those individuals falling through the cracks and not receiving ongoing and appropriate behavioral health services once the crisis period has passed. One person recommended improved treatment services and reimbursement for those with co-occurring mental health and substance use disorder diagnoses. Requests were documented for improved coordination and funding for transportation, medical care, dental care and increased numbers of critical time intervention programs. Another request was for additional services available to those with incapacitating behavioral health needs who do not meet eligibility criteria because of their diagnoses (e.g., post-traumatic stress disorder).

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II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Evidence-based Programming

Priority Type: SAP

Population (s): Other (Primary Prevention - General Population)

Goal of the priority area:

All recurring services/strategies funded with the Idaho 2014 and 2015 SAPT Block Grant will be from Idaho's Substance Abuse Prevention Evidence-Based Program List.

Strategies to attain the goal:

Priority will be given to funding prevention programs and practices on the approved list.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of programs funded which are on the Idaho approved list.

Baseline Measurement: Percentage of programs funded from list in 2013

First-year target/outcome measurement: 75% of programs funded are on list.

Second-year target/outcome measurement: 100% of programs funded are on list.

Data Source:

Idaho substance abuse prevention data system

Description of Data:

Name of program funded

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Community-based processes

Priority Type: SAP

Population (s): Other

Goal of the priority area:

Idaho will increase the number of underage drinking prevention coalitions by 5% by June 30, 2015.

Strategies to attain the goal:

Provide technical assistance, leadership development training and underage drinking prevention resources to all community groups willing to address underage alcohol use.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Idaho coalitions undertaking underage drinking prevention activities.

Baseline Measurement: Number of active Idaho coalitions as of October 1, 2013, is 15.

First-year target/outcome measurement: Number of active Idaho coalitiosn as of June 1, 2014 will be 18.

Second-year target/outcome measurement: Number of Idaho coalitions undertaking underage drinking activities as of June 1, 2014 will be 21.

Data Source:

Community Coalitions of Idaho activities report.

Description of Data:

Coalition activity Reports

Data issues/caveats that affect outcome measures::

No data issues foreseen.

Priority #: 3

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SAT

Population (s): PWWDC

Goal of the priority area:

Idaho will develop formal tracking systems and reports to record the number of Pregnant Women and Women with Dependent Children receiving specialized care, as established under the SAPT Block Grant and the cost of such care.

Strategies to attain the goal:

Idaho will establish electronic data collection and reporting systems to capture data on PWWC clients.

Priority #: 4

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SAT

Population (s): PWWDC

Goal of the priority area:

Idaho will identify a new specialized Pregnant Women and Women with Dependent Children (PWWC) Provider by June 30, 2014

Strategies to attain the goal:

Idaho will contact providers serving pregnant women and women involved in child protection to identify an agency willing to deliver this specialty service.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase number of PWWC specialty providers
Baseline Measurement:	Number of PWWC specialty providers as of July 1, 2013
First-year target/outcome measurement:	An evaluation of network providers is completed to identify agencies willing and able to meet PWWDC requirements.
Second-year target/outcome measurement:	Select one network and supply technical assistance needed to enable agency to meet all PWWDC requirements.

Data Source:

Operations Unit, Substance Use Disorders (SUD) Report

Description of Data:

Number of SUD providers contacted
Number of PWWC specialty providers

Data issues/caveats that affect outcome measures::

Priority #:	5
Priority Area:	Substance Use Disorder Treatment Clients
Priority Type:	SAT
Population (s):	HIV EIS

Goal of the priority area:

The Division of Behavioral Health will require that all individuals seeking substance use disorder treatment services to be assessed for HIV/AIDs risks.

Strategies to attain the goal:

Require all Division of Behavioral Health-funded providers assess substance use disorder treatment clients for HIV/AIDS.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	All SSA-funded Substance Use Disorders clients are assessed for HIV/AIDS.
Baseline Measurement:	Percentage of clients assessed for HIV/AIDS in Idaho Fiscal Year 2013.
First-year target/outcome measurement:	50% of clients will be assessed for HIV/AIDS.
Second-year target/outcome measurement:	100% of clients assessed for HIV/AIDS.

Data Source:

WITS data system

Description of Data:

Number of clients whose assessment record indicates they were assessed for HIV/AIDs

Data issues/caveats that affect outcome measures::

Priority #:	6
Priority Area:	All Substance Use Disorder Clients
Priority Type:	SAT
Population (s):	TB

Goal of the priority area:

The Division of Behavioral Health will require that all individuals seeking substance use disorder treatment services to be assessed for tuberculosis.

Strategies to attain the goal:

Require all Division of Behavioral Health-funded providers assess substance use disorder treatment clients for tuberculosis.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Percentage of Substance Use Disorders clients who are assessed for TB.
Baseline Measurement:	Percentage of clients assessed for TB in Idaho State Fiscal Year 2013.
First-year target/outcome measurement:	50% of clients assessed for TB in Idaho State Fiscal Year 2014.
Second-year target/outcome measurement:	100 % of clients assessed for TB in Idaho State Fiscal Year 2015.

Data Source:

WITS data system

Description of Data:

Number of clients assessed for TB

Data issues/caveats that affect outcome measures::

Priority #:	7
Priority Area:	IV Drug Users
Priority Type:	SAP
Population (s):	IVDUs

Goal of the priority area:

Idaho will develop a process to ensure that individuals served as IVDU clients meet established requirements by June 30, 2015.

Strategies to attain the goal:

Develop a process for evaluating client intravenous drug use by June 30, 2014.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: A process for evaluating client intravenous drug use is developed by June 30, 2014. 50% of SUD clients will be assessed for IV drug use in FY 2014.

Baseline Measurement: No process exitst

First-year target/outcome measurement: Develop a process for evaluating client intravenous drug use by June 30, 2014.

Second-year target/outcome measurement:

Data Source:

Operations Unit, Substance Use Disorders Report

Description of Data:

Written process is completed.

Data issues/caveats that affect outcome measures::

Priority #: 8

Priority Area:

Priority Type: MHS

Population (s): SMI, SED

Goal of the priority area:

Idaho's suicide hotline will expand its capacity to serve Idaho citizens who are in crisis.

Strategies to attain the goal:

Suicide hotline capacity will be expanded through increased hours of operation and increased staff during peak operating hours.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Suicide hotline days of operation and number of staff per shift.

Baseline Measurement:	Suicide hotline operates for four days a week with two staff as of March 2013.
First-year target/outcome measurement:	Idaho's suicide hotline hours of operation will expand from Monday through Friday, 9 a.m. to 5 p.m. to seven days a week by June 30, 2014.
Second-year target/outcome measurement:	Idaho's suicide hotline number of staff per shift will expand from two to three by June 30, 2015.

Data Source:

Mountain States Group runs the suicide hotline program.

Description of Data:

Mountain States Group will provide information as to suicide hotline hours and days of operation. Mountain States Group will provide information as to number of staff per shift.

Data issues/caveats that affect outcome measures::

NA

Priority #: 9

Priority Area:

Priority Type: MHS

Population (s): SMI

Goal of the priority area:

The Division of Behavioral Health will enhance the implementation of Assertive Community Treatment (ACT) by providing training to ACT staff and community partners.

Strategies to attain the goal:

The Division of Behavioral Health will sponsor an ACT conference to provide evidence based training opportunities for ACT staff and community partners.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator:	Training provided to Assertive Community Treatment staff and community partners.
Baseline Measurement:	No statewide Assertive Community Treatment training has been provided for the past four years.
First-year target/outcome measurement:	The Division of Behavioral Health will implement a statewide Assertive Community Treatment (ACT) conference for behavioral health, corrections and court personnel with workshop tracks related to ACT, recovery and trauma by January 1, 2014.
Second-year target/outcome measurement:	NA

Data Source:

Division of Behavioral Health.

Description of Data:

Implementation of a statewide Assertive Community Treatment (ACT) conference to provide evidence based training opportunities to ACT staff and community partners.

Data issues/caveats that affect outcome measures::

None

Priority #: 10

Priority Area:

Priority Type: MHS

Population (s): SED

Goal of the priority area:

The Division of Behavioral Health will improve the consistency and standardization of Children's Mental Health services delivery to eligible children without payment resources.

Strategies to attain the goal:

The Division of Behavioral Health will contract with a Children's Mental Health Management Services Contractor to provide Children's Mental

Health services to eligible children without payment resources.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The Division of Behavioral Health will contract with a Children's Mental Health (CMH) Management Services Contractor to provide Children's Mental Health services to eligible children with serious emotional disturbance diagnoses who have no insurance or other payment resources .
Baseline Measurement:	As of March 2013, the Division of Behavioral Health did not contract with a CMH Services contractor for CMH services.
First-year target/outcome measurement:	The Division of Behavioral Health will create a Request for Proposals and award a contract to a Children's Mental Health Management Services Contractor to provide Children's Mental Health services to eligible children with serious emotional disturbance diagnoses who have no insurance or other payment resources by January 1, 2014.
Second-year target/outcome measurement:	The Division of Behavioral Health will transition Children's Mental Health service delivery to the Children's Mental Health Services contractor and implement written quality assurance strategies to guide service delivery to eligible children with serious emotional disturbance diagnoses who have no insurance or other payment resources by June 30, 2015.

Data Source:

Division of Behavioral Health and CMH Management Services Contractor.

Description of Data:

Contract with a CMH Management Services Contractor to provide Children's Mental Health services to eligible children without payment resources. The CMH Management Services Contractor will be responsible to track and report on children served.

Data issues/caveats that affect outcome measures::

None.

Priority #: 11

Priority Area: Substance Use Disorders (SUD) Professionals Training

Priority Type: SAT

Population (s): Other

Goal of the priority area:

The Division of Behavioral Health will implement a resource portal to provide treatment professionals with current research and resources on trauma-informed care.

Strategies to attain the goal:

Portal is developed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Portal is available for Substance Use Disorders (SUD) Professionals to access

Baseline Measurement: No portal currently exists

First-year target/outcome measurement: Portal is developed

Second-year target/outcome measurement: Portal is accessable to SUD Professionals

Data Source:

Operations Unit, Substance Use Disorders Activity Report

Description of Data:

Portal accessibility

Data issues/caveats that affect outcome measures::

Priority #: 12

Priority Area:

Priority Type: SAP

Population (s): Other

Goal of the priority area:

The Division of Behavioral Health in collaboration with the Idaho State Police, Office of Drug Policy, Supreme Court, Department of Juvenile Corrections and Department of Education will implement an alcohol and other drug use youth survey system by June 30, 2015.

Strategies to attain the goal:

Survey will be developed and tested
Survey implementation plan with be executed

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Youth survey is implemented

Baseline Measurement: No youth survey exists in Idaho

First-year target/outcome measurement: Survey is developed and tested

Second-year target/outcome measurement: Survey implementation plan is established and survey is implemented

Data Source:

State Epidemiological Outcomes Workgroup Report

Description of Data:

Survey sites and response summary data.

Data issues/caveats that affect outcome measures::

Priority #: 13

Priority Area:

Priority Type: SAT, MHS

Population SMI, SED, Other (Adolescents w/SA and/or MH, adults and children with substance use disorder diagnoses)

(s):

Goal of the priority area:

The Division of Behavioral Health will support the establishment/infrastructure development of a behavioral health planning council and regional behavioral health boards that include representation from both mental health and substance use disorders stakeholders.

Strategies to attain the goal:

The Division of Behavioral Health will provide support and consultation to the State Councils and regional boards as they work to merge into combined behavioral health entities.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Establishment of a behavioral health council and behavioral health regional boards with mental health and substance use disorder representation.
Baseline Measurement:	Separate mental health and substance use disorder councils and regional boards.
First-year target/outcome measurement:	The State Planning Council on Mental Health will transition to the State Behavioral Health Council with representation from mental health and substance use disorders by June 30, 2014.
Second-year target/outcome measurement:	The State Behavioral Health Council will develop readiness criteria to assess Regional Behavioral Health Boards and their ability to provide guidance on behavioral health service delivery in their respective regions, and the Council will assess each regional Board with this criteria by June 30, 2015.

Data Source:

Division of Behavioral Health, Behavioral Health Planning Council, regional behavioral health boards.

Description of Data:

Establishment of council and regional behavioral health boards. Council development of readiness criteria to assess Regional Behavioral Health boards.

Data issues/caveats that affect outcome measures::

None.

Priority #: 14

Priority Area:

Priority Type: SAT, MHS

Population (s):

Goal of the priority area:

The Division of Behavioral Health will provide guidance on screening and referral for those with behavioral and primary health care needs.

Strategies to attain the goal:

The Division of Behavioral Health will develop a policy and procedures for screening and referring those with behavioral and primary health care needs.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Policies for screening and referring those with behavioral and primary health care needs.
Baseline Measurement:	No existing policies for screening and referring those with behavioral and primary health care needs.
First-year target/outcome measurement:	None.
Second-year target/outcome measurement:	The Division of Behavioral Health will develop a policy and procedures for screening and referring those receiving behavioral health care who have primary health care needs to appropriate community resources, and all staff will be trained on this policy by June 30, 2015.

Data Source:

Division of Behavioral Health.

Description of Data:

Written policies and procedures for screening and referring those receiving behavioral health care services who have primary health care needs to appropriate community resources.

Data issues/caveats that affect outcome measures::

None.

Priority #: 15

Priority Area:

Priority Type: SAT, MHS

Population (s): SMI, SED, Other (Adolescents w/SA and/or MH, Adults and children with substance use disorder diagnoses)

Goal of the priority area:

The Division of Behavioral Health will expand system availability of the Web Infrastructure for Treatment Services (WITS) electronic health record system for the Substance Use Disorder (SUD) statewide treatment provider network.

Strategies to attain the goal:

The Division of Behavioral Health will update the WITS user guide, training and data capture for the SUD treatment provider network.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Web Infrastructure for Treatment Services (WITS) user guide and training for SUD treatment providers.

Baseline Measurement: There is a WITS user guide but it is not specific to SUD treatment providers.

First-year target/outcome measurement: The Division of Behavioral Health will update the WITS user guide, training and data capture for SUD treatment providers by June 30, 2014.

Second-year target/outcome measurement: None.

Data Source:

Division of Behavioral Health.

Description of Data:

WITS, WITS User Guide, training events offered to SUD treatment providers.

Data issues/caveats that affect outcome measures::

None.

Priority #: 16

Priority Area:

Priority Type: SAT, MHS

Population (s): SMI, SED, Other (Adolescents w/SA and/or MH, Adults and children with substance use disorder diagnoses)

Goal of the priority area:

The Division of Behavioral Health will be able to report mental health and substance use disorder expenditures by services for block grant reporting.

Strategies to attain the goal:

The Division of Behavioral Health's data, quality assurance and policy units will collaborate to identify and implement a strategy to operationally define and trace service units and expenditures for block grant reporting.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Ability to report mental health and substance use disorder expenditures by service data for block grant reporting.

Baseline Measurement: Idaho is not able to accurately report mental health and substance use disorder expenditures by service data for block grant reporting.

First-year target/outcome measurement: None.

Second-year target/outcome measurement: The Division of Behavioral Health will build capacity for block grant reporting on mental health and substance use disorder expenditures by service data by June 30, 2015.

Data Source:

Division of Behavioral Health.

Description of Data:

Mental health and substance use disorder expenditures by service data for block grant reporting.

Data issues/caveats that affect outcome measures::

None.

Priority #: 17

Priority Area:

Priority Type: SAT, MHS

Population (s): SMI, SED, Other (Adolescents w/SA and/or MH, Adults and children with substance use disorder diagnoses)

Goal of the priority area:

The Division of Behavioral Health's Web Infrastructure for Treatment Services (WITS) system will be adapted to include ICD-10 codes.

Strategies to attain the goal:

The Division of Behavioral Health will work with the vendor FEI to update WITS with ICD-10 codes.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Ability to use ICD-10 codes through the Web Infrastructure for Treatment Services (WITS) data system.

Baseline Measurement: Idaho is not able to use ICD-10 codes through the WITS system.

First-year target/outcome measurement: None.

Second-year target/outcome measurement: The Division of Behavioral Health will work with the vendor FEI to update the Web Infrastructure for Treatment Services (WITS) system with ICD-10 codes by June 30, 2015.

Data Source:

Division of Behavioral Health and WITS.

Description of Data:

ICD-10 code capability through the WITS system.

Data issues/caveats that affect outcome measures::

None.

Priority #: 18

Priority Area:

Priority Type: SAT, MHS

Population (s): SMI, SED, Other (Adolescents w/SA and/or MH, Adults and children with substance use disorder diagnoses)

Goal of the priority area:

The Division of Behavioral Health will build relationships with Idaho's Tribes.

Strategies to attain the goal:

Participate in regularly scheduled meetings with Idaho Tribes.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Inclusion of Tribal input into behavioral health system service delivery.

Baseline Measurement: Ongoing inclusion of Tribal input into behavioral health system service delivery.

First-year target/outcome measurement: THe Division of Behavioral Health Tribal liaison initiates contact with Idaho's tribes to establish relationships with Tribal Leaders.

Second-year target/outcome measurement: The Division of Behavioral Health's Tribal liaison will participate in regularly scheduled meetings with Tribal members to improve Tribal relationships and invite input into behavioral health service planning in Idaho. The Division's Tribal liaison will work to develop relationships with Idaho Tribes by June 30, 2015.

Data Source:

Division of Behavioral Health.

Description of Data:

Number of meetings and number of Tribes involved in joint meetings.

Data issues/caveats that affect outcome measures::

None.

Priority #: 19

Priority Area:

Priority Type: SAT

Population (s): Other (Adolescents w/SA and/or MH, Adults and children with substance use disorder diagnoses)

Goal of the priority area:

Increase substance use disorder (SUDS) program integrity, consistency and standardization.

Strategies to attain the goal:

Establish SUDS program integrity standards and service procedures.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Substance use disorder (SUD) program integrity.

Baseline Measurement: There are no clear, written SUD program integrity standards or service procedures.

First-year target/outcome measurement: The Division of Behavioral Health will establish program integrity standards and service procedures for Substance Use Disorder treatment by June 30, 2014.

Second-year target/outcome measurement: None.

Data Source:

Division of Behavioral Health - policy unit and quality assurance unit.

Description of Data:

Written SUD program integrity standards and service procedures.

Data issues/caveats that affect outcome measures::

None.

Priority #: 20

Priority Area:

Priority Type: SAT, MHS

Population (s): SMI, SED, Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice, Adults and children with substance use disorder diagnoses)

Goal of the priority area:

The Division of Behavioral Health will collaborate with courts and the Idaho Department of Correction (IDOC) to screen offenders for behavioral health diagnoses and link them to available and appropriate behavioral health services.

Strategies to attain the goal:

The Division of Behavioral Health will hire additional staff to collaborate with courts and IDOC to identify strategies to screen offenders and link them to available services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Division of Behavioral Health collaboration with courts and Idaho Department of Correction (IDOC) to screen offenders for behavioral health diagnoses and link them to appropriate behavioral health services.

Baseline Measurement: Division of Behavioral Health staff assigned to collaborate with courts and IDOC and strategies to screen and refer offenders with behavioral health diagnoses.

First-year target/outcome measurement: The Division of Behavioral Health will hire three staff and develop a process to collaborate with courts and IDOC to strategize methods to screen offenders for behavioral health diagnoses and link them to available and appropriate behavioral health services by June 30, 2014.

Second-year target/outcome measurement: None.

Data Source:

Division of Behavioral Health.

Description of Data:

Staff hired to work with courts and IDOC to develop strategies to screen and refer offenders with behavioral health diagnoses. Procedures that are developed for screening and referral.

Data issues/caveats that affect outcome measures::

None.

Priority #: 21

Priority Area:

Priority Type: SAT, MHS

Population (s): SMI, SED, Other (Adolescents w/SA and/or MH, Adults and children with substance use disorder diagnoses)

Goal of the priority area:

The Division of Behavioral Health will develop behavioral health standards for service delivery.

Strategies to attain the goal:

The Division of Behavioral Health will review existing standards manuals and develop behavioral health standards for service delivery.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Behavioral health standards for service delivery.

Baseline Measurement: The Division of Behavioral Health does not have written behavioral health standards for service delivery.

First-year target/outcome measurement: The Division of Behavioral Health will review several existing standards manuals (e.g., Comprehensive Accreditation Manual for Behavioral Health Care, Joint Commission for

Accreditation of Health Organizations, etc.) to develop behavioral health standards for behavioral health services delivery in at least five service areas by June 30, 2014.

Second-year target/outcome measurement: The Division of Behavioral Health will review several existing standards manuals (e.g., Comprehensive Accreditation Manual for Behavioral Health Care, Joint Commission for Accreditation of Health Organizations, etc.) to develop behavioral health standards for behavioral health services delivery in at least eight service areas by June 30, 2015.

Data Source:

Division of Behavioral Health.

Description of Data:

Written behavioral health standards for service delivery.

Data issues/caveats that affect outcome measures::

None.

Priority #: 22

Priority Area:

Priority Type: SAT

Population (s): Other (Adults and children with substance use disorder diagnoses)

Goal of the priority area:

Develop a cadre of individuals with substance use disorder (SUDS) diagnoses who are able to demonstrate recovery and resilience through recovery coaching.

Strategies to attain the goal:

Provide recovery coaching to Idaho citizens with substance use disorders (SUDS).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Individuals with substance use disorder (SUD) diagnoses demonstrating recovery and

resilience through recovery coaching.

Baseline Measurement: There are no SUD diagnosed individuals in Idaho who are trained in recovery coaching.

First-year target/outcome measurement: The Division of Behavioral Health will train at least thirty (30) individuals in recovery coaching by June 30, 2014.

Second-year target/outcome measurement: The Division of Behavioral Health will establish recovery coaching services as a life skills service under Recovery Support Services in all regions by June 30, 2015.

Data Source:

Division of Behavioral Health.

Description of Data:

Numbers of Idaho citizens with SUD diagnoses trained in recovery coaching. Establishment of recovery coaching services as a life skills service under Recovery Support Services in all regions.

Data issues/caveats that affect outcome measures::

None.

Priority #: 23

Priority Area:

Priority Type: SAT, MHS

Population (s): SMI, SED, Other (Adolescents w/SA and/or MH, Adults and children with substance use disorder diagnoses)

Goal of the priority area:

Ensure that Division of Behavioral Health service delivery staff are adequately trained to assess, diagnose and develop treatment plans according to the new Diagnostic and Statistical Manual V (DSM-V) guidelines.

Strategies to attain the goal:

Provide statewide training on DSM-V guidelines.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator:	Division of Behavioral Health staff ability to assess, diagnose and develop treatment plans based on the Diagnostic and Statistical Manual V (DSM-V) guidelines.
Baseline Measurement:	DSM-V has not yet been released and no staff have been trained adequately on DSM-V guidelines.
First-year target/outcome measurement:	None.
Second-year target/outcome measurement:	The Division of Behavioral Health will provide statewide training in assessment, diagnosis and treatment planning according to the new DSM-V guidelines by June 30, 2015.

Data Source:

Division of Behavioral Health.

Description of Data:

Number of regional training events on DSM-V guidelines. Number of staff trained on DSM-IV guidelines.

Data issues/caveats that affect outcome measures::

None.

Priority #: 24

Priority Area:

Priority Type: SAT, MHS

Population (s): Other (Adults and children with substance use disorder diagnoses)

Goal of the priority area:

Newly established regional behavioral health boards will be provided with tools that help them to identify regional gaps and plan ways to address identified issues.

Strategies to attain the goal:

The Division of Behavioral Health will facilitate the development of an Action Plan toolkit curriculum that outlines ways to identify gaps, create action plans to address those gaps, implement action plans and collect outcome data.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Action plan toolkit to facilitate ability to identify gaps, create and implement action plans to address gaps and collect outcome data.
Baseline Measurement:	The Division of Behavioral Health does not have an Action Plan toolkit that can help newly established regional behavioral health boards to actively address identified issues.
First-year target/outcome measurement:	None.
Second-year target/outcome measurement:	The Division of Behavioral Health will create an Action Plan toolkit and will provide training to all seven regional behavioral health boards on use of the Action Plan toolkit by June 30, 2015.

Data Source:

Division of Behavioral Health.

Description of Data:

Action Plan toolkit curriculum.

Data issues/caveats that affect outcome measures::

None.

Priority #: 25

Priority Area:

Priority Type: SAT, MHS

Population (s): SMI, SED, Other (Adults and children with substance use disorder diagnoses)

Goal of the priority area:

The Division of Behavioral Health will provide guidance on cultural awareness expectations for those who deliver behavioral health services.

Strategies to attain the goal:

Develop and provide training on cultural awareness and delivery of behavioral health services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Development of an action plan toolkit curriculum.
Baseline Measurement:	Idaho does not have an action plan curriculum to guide regions in gaps analysis, action plan implementation and outcomes measurement.
First-year target/outcome measurement:	None.
Second-year target/outcome measurement:	The Division of Behavioral Health will create an Action Plan toolkit and will provide training to all seven regional behavioral health boards on the Action Plan toolkit by June 30, 2015.

Data Source:

Division of Behavioral Health

Description of Data:

Action Plan toolkit curriculum and numbers of regional trainings.

Data issues/caveats that affect outcome measures::

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

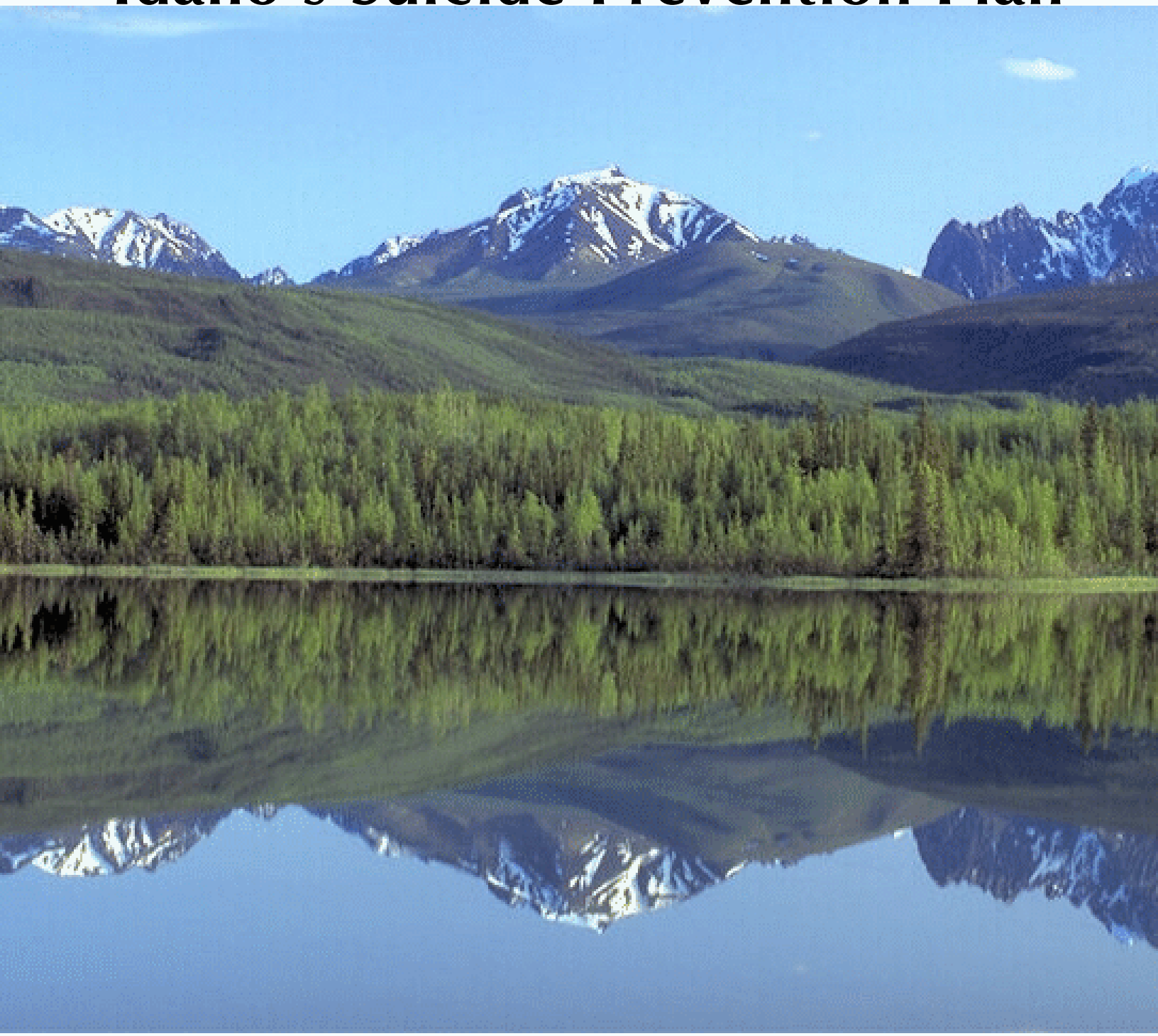
Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$9,305,868		$3,206,400	$5,274,266	$34,202,900	$	$
a. Pregnant Women and Women with Dependent Children*	$1,300,000		$	$	$	$	$
b. All Other	$8,005,868		$3,206,400	$5,274,266	$34,202,900	$	$
2. Substance Abuse Primary Prevention	$3,235,514		$	$	$288,100	$	$
3. Tuberculosis Services	$		$	$	$19,050	$	$
4. HIV Early Intervention Services	$		$	$	$	$	$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	$441,206		$	$1,237,174	$	$	$
11. Total	$12,982,588	$	$3,206,400	$6,511,440	$34,510,050	$	$

* Prevention other than primary prevention

footnote:
This table reflects anticipated SSA funding for SFY 2014 and 2015. SAPT Block grant planned expenditures on all Use of Block Grant Dollars tables are based on Idaho's 2013 block grant award notice.

Idaho's Suicide Prevention Plan



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Introduction

Idaho's suicide prevention plan was developed to help address the problem of suicide in Idaho.

Suicide is a significant problem in the United States and in Idaho. During the years 1990–2000, on average, more than 30,000 individuals died each year in the United States from suicide. Although it is generally agreed that not all suicides are classified as such[1], only unintentional injuries ("accidents") surpassed suicide as the reported leading cause of death for 25–34 year olds in 2000. Suicide trailed unintentional injuries and homicides as the third leading cause of death for 15 to 24 year olds in 2000 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2003).[2]

Idaho consistently has had a higher suicide rate than the United States as a whole. From 1999–2001, 559 Idahoans died from suicide. It was second only to unintentional injury as the leading cause of death for Idahoans aged 15–34, and the ninth leading cause of death overall.[3]

Suicide is a complex problem, resulting from one or more biological, psychological, environmental, social and/or cultural factors. Idaho faces significant challenges in addressing this problem. Known risks include mental disorders, alcohol and substance use disorders, financial or relationship losses, lack of social support, barriers to care, and a sense of hopelessness (Appendix A).[1] Certain protective factors, such as problem-solving and conflict resolution skills, strong family and community connections, and access to effective clinical care for mental, physical and substance abuse disorders, can help counter these risks and challenges (Appendix A).[1]

Numbers and rates are the public face of suicide. Personal pain and the sense of hopelessness leading to suicide, lost futures, and the heartache felt by loved ones left behind are the untold stories. In 1996, Jerry and Elsie Weyrauch of Marietta, Georgia lost their 34-year-old physician daughter to suicide. They channeled their grief into a positive force that ultimately led a national strategy to address suicide.

The 2001 U.S. Department of Health and Human Services Public Health Service blueprint to guide states working to prevent suicide, *National Strategy for Suicide Prevention: Goals and Objectives for Action*,[1] is a testament to the Weyrauchs. They exemplify Margaret Meade's statement: "Never doubt that a small group of thoughtful, committed people can change the world, indeed, it is the only thing that ever has." The Suicide Prevention Action Network (SPAN), a grassroots advocacy organization developed by the Weyrauchs in 1996, drove the public/private partnership that sponsored the National Suicide Prevention Conference in Reno, Nevada, in October, 1998. The Surgeon General's *Call to Action to Prevent Suicide* and the *National Strategy for Suicide Prevention*[1] resulted from this conference. Idaho's Suicide Prevention Plan is the result of an equally dedicated group of individuals who refuse to let the problem go unaddressed here.

Idaho Suicide Facts

Idaho's suicide data reveals four unique populations at higher risk for suicide completions.

- *Young Native American Males*
- *Elderly Males*
- *Working-aged Males*
- *Teenaged Males*

Idaho's suicide rate is higher than that of the United States as a whole. During the three-year period 1999–2001, there were 14.4 suicides in Idaho for every 100,000 citizens, as compared to 10.7 per 100,000 in the United States for the year 2000.[3] Overall rates, though, do not point to the unique populations at risk.

A closer examination of Idaho suicide data reveals four unique populations at higher risk for suicide completions. These include young Native American males (15–24 years of age), elderly males (75 years of age and older), working-aged males (18–64 years of age), and teenaged males (15–17 years of age). Although the overall suicide rate in Idaho during 1999–2001 was 14.4 per 100,000 population, the rate for elderly males was 81.2 per 100,000; for working-aged males was 25.8 per 100,000; for 15–17 year old males was 22.5; and for Native Americans was 21.0 per 100,000. For the 10-year period 1992–2001, Native American males aged 15–17 had the highest suicide rate in Idaho at 115.8 per 100,000 population, with 18–24 year old Native Americans having a rate of 88.1 per 100,000 population.[3] (Note: During the 10-year period 1992–2001, elderly white males had the second highest suicide rate in Idaho at 99.3 per 100,000 population.)[3]

Idaho males are approximately four times as likely to die from suicide as females.[3] This also is true for the United States as a whole.[1] Firearms are the most common method for completed suicides in Idaho. Two out of every three suicides (67%) involved a firearm during the period 1999 – 2001.[3] Nationally in 1998, 57% of all suicides were due to firearms.[1]

Completed suicides are just one part of the problem. Nationally, it has been estimated that 20 individuals visit an emergency room for a suicide attempt for each reported suicide death.[3] Although an emergency room database is not available in Idaho, an estimated 2,330 Idahoans aged 18 years and older attempted suicide within the previous 12 months, as determined by responses to the 2001 Idaho Behavioral Risk Factor Surveillance Survey (BRFSS). Sixty percent of reported attempts for ages 18 and older were made by females.[4] Based on responses to the 2001 Youth Risk Behavior Survey (YRBS), almost 6,000 additional suicide attempts within the previous 12 months were estimated for 15–17 year olds. Almost two-thirds (63%) of reported attempts by 15–17 year olds were by females.[5] Combined estimates from BRFSS and YRBS reveal almost 40 suicide attempts in Idaho, in 2001, for every completed suicide.

It was estimated that there were almost 40 suicide attempts in Idaho in 2001 for every completed suicide.

Suicide Prevention

Suicide prevention requires the effort and coordination of a myriad of agencies, groups, and individuals.

Many suicides can be prevented. Prevention requires a comprehensive approach (Appendices B, C, D, E)[6] that includes both developing protective factors (Appendix A) and concurrently reducing risk factors (Appendix A). No single agency or organization is uniquely qualified to fully address the problem. Suicide prevention requires the effort and coordination of a myriad of organizations, agencies, groups, and individuals. These include mental health providers, health care providers, tribes, schools and universities, law enforcement and judicial agencies, senior services agencies, community-based organizations, faith-based organizations, and survivors groups.

Strategies for suicide prevention fall into three categories:[1]

- **Universal** — Address whole populations. For example, working to improve health insurance coverage.
- **Selective** — Address unique, at risk populations. For example, training gatekeepers (individuals who come into frequent contact with individuals in populations at risk for suicide) to recognize signs that an individual may be contemplating suicide and refer that person for help.
- **Indicated** — Target individuals at risk for suicide. Indicated strategies include crisis intervention and mental health treatment.

Purpose of the Plan

Idaho's suicide prevention plan was developed to address the problem of suicide in Idaho. It is intended to be a guide for agencies, organizations and individuals to follow at state, regional, and local levels when developing their own specific action plans. Because the statewide plan is based on current Idaho activities and needs, it will help to avoid a duplication of efforts at a time when resources are limited. When developing the plan, an attempt was made to link current science for preventing suicide with practical application in the field.

The plan looks beyond agencies and organizations, such as mental health providers, that traditionally have taken responsibility for preventing suicides. If prevention activities are to be accomplished when funding is scarce, prevention efforts must be undertaken by non-traditional providers such as faith-based organizations and organizations working with Idaho's unique populations at higher risk for suicide.

If suicide prevention activities are to be accomplished when funding is scarce, prevention efforts must be undertaken by non-traditional providers.

Development Process

In 1994, in response to a U.S. Public Health Service initiative, a small group of Idahoans met with their counterparts from 10 northwestern states to begin the process of addressing adolescent suicide using a public health approach. Idaho's Adolescent Suicide Prevention Task Force, which evolved into SPAN Idaho, was developed as a result of this meeting.

In November 2002, SPAN Idaho began developing a statewide suicide prevention plan at a meeting in Sun Valley that involved 63 participants from all regions of the state. In March 2003, State Representative Margaret Henbest secured funding to complete the plan development process.

A core planning group met in June 2003 to review work completed by SPAN Idaho and determine the processes to be used to gather additional regional input for the statewide plan. The core group represented SPAN Idaho, Adult and Children's Mental Health (Idaho Department of Health and Welfare), Safe and Drug-Free Schools (Department of Education), NAMI Idaho, Southeastern Public Health District, Red Flags (Idaho State University), Suicide Prevention Services (statewide suicide prevention hotline), Idaho Commission on Aging, the Legislature, First Lady Patricia Kempthorne, and Generation of the Child Initiative staff.

Idaho-specific data, comparative national data, and "best practices" gleaned from the Institute of Medicine's *Reducing Suicide: A National Imperative (2002),*[7] provided background information to revise the SPAN Idaho draft plan. Each member of the core group was responsible for contacting one or more additional key organizations or agencies that represent or provide services to populations at risk for suicide. The expanded group was asked to review and comment on the second draft of the plan.

The expanded planning group included faith-based organizations, Tribes, Hispanic groups, State Mental Health Planning Council, Idaho Federation of Families, Idaho Council on Children's Mental Health, Area Agencies on Aging, Department of Labor, Idaho State Police Post Academy, psychologist, psychiatrist, and physician's organizations, and regional public health departments. Feedback was incorporated into the plan, which was reviewed and prioritized by the core group, creating a third draft.

Regional meetings were held in Coeur d'Alene, Lewiston, Boise, Twin Falls, Pocatello and Idaho Falls to allow public input into the plan. In addition to Idaho-specific suicide data and information on best practices, results of a region-specific resource inventory of suicide prevention activities and services was provided as background at the meetings. The draft plan also was available on the Internet for public comment. Input and feedback from regional meetings and Internet traffic was incorporated into the plan, which again was reviewed and prioritized by the core group to create the final draft.

Idaho's Suicide Prevention Plan was unveiled at the November 2003 SPAN Idaho conference one year after the process was initiated.

Priority Populations

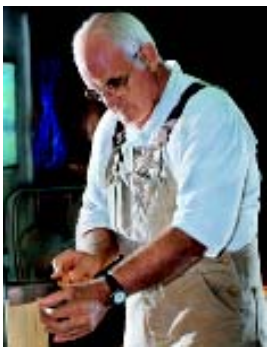
Idaho's Suicide Prevention Plan is intended to reduce risks for both suicide attempts and suicide completions for all Idahoans. Although self-report data indicate that females in Idaho are almost twice as likely to attempt suicide as males[4,5], the following groups are at highest risk for suicide completions.

Working-Aged Males—18–64 years of age:

More than half (55%) of all suicides in Idaho during 1999–2001 were among working-aged males, although they comprised less than one-third (31%) of the population. During 1999–2001, the suicide rate among 18–64 year old males living in Idaho was 25.8 per 100,000.[3]

Although information on employment status of working-aged Idaho males who complete suicide is not collected, national studies associate suicide with unemployment and economic distress.[7],[8],[9] A two-fold increase in the risk of suicide has been noted among the unemployed in the United States.[7] The suicide rate for working aged males in Idaho is almost twice (1.8 times) that of the state overall.[3]

Elderly Males:



Idaho's suicide rate for those aged 75 years and older is second only to that of 15–17 year old Native American males. For the three-year period 1999–2001, elderly men had a suicide rate almost six times higher than for the population as a whole. While the average annual rate in Idaho for the three-year period was 14.4 per 100,000 population, the rate among males aged 75 years and older was 81.2 per 100,000.[3]

Although Idaho-specific information is not available, studies associate suicide among the elderly with risks that include death of a spouse, isolation, depression, and serious medical conditions. Additionally, there is a greater likelihood that death will result from suicide attempts among the elderly because they are more likely to be medically fragile, less likely to be discovered after an attempt because they are more likely to live alone, and they are more likely to use highly fatal methods.[7]

Teenaged Males (15–17 years of age):

Nationally, suicide is the third leading cause of death for teenagers, following unintentional injury and homicide. In Idaho, suicide is the second leading cause of death for teenagers following unintentional injury.[3]

During 1999–2001 in Idaho, 15–17 year old boys completed suicide at about five times the rate of girls the same age (22.5 versus 4.2 per 100,000).[1] The 2001 Idaho Youth Behavior Risk Factor Survey of 9th through 12th graders found that almost twice as many teenaged girls attempted suicide as teenaged boys (63% versus 37%).[5]

Many factors that increase teenagers' risk for suicide are understood: mental disorders, substance abuse, prior suicide attempt, sexual abuse, impulsive and aggressive behavior, and access to firearms.[3] These risks can be addressed using strategies that include building social and problem solving skills, providing self-referral information, training gatekeepers to identify and refer individuals exhibiting signs of potential self-harm, and screening and referring individuals to treatment. Evaluations of the effectiveness of the various approaches have not been completed.[7]

Native Americans:

Young Native American males (15–17 years) have the highest suicide rate in Idaho. At 115.8 per 100, 000 during 1992–2001, the rate was higher than that of elderly white males (99.3 per 100,000). At 88.1 suicides per 100,000 population, Native American males aged 18–24 had the third highest rate in Idaho during the same 10-year period.[3]

The pattern of suicides across the life-span among Native Americans is quite different than other groups.[7] The rate among Native Americans is highest among younger age groups, peaking at age 25–34 nationally and 15–17 in Idaho, then tapering off with increasing age. It is lowest for older males. For other races, there is a dramatic rise among 15–24 year olds, that flattens and holds across the working years, followed by a dramatic increase among older males.

Important Risk & Protective Factors

Several important factors that might increase risk for suicide have been identified. Especially challenging are abuse and a history of suicide in a family or among friends. In addition, several protective factors can help deter suicidal thoughts and actions.

Mental disorders — particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders — can make an individual more at risk for suicide. Also, abuse of alcohol and other substances can be tied to suicide.[3] More than 90% of suicides in the United States are associated with mental illness and/or substance abuse.[7]

Other risk factors for suicide include impulsive and/or aggressive tendencies, a sense of hopelessness, and a history of trauma or abuse. Some major physical illnesses, along with barriers to health care, increase the risk. A previous suicide attempt or family history of suicide also increase risk.[3]

Losses such as a job, financial, relational or social loss increase the risk for suicide, as well as having easy access to lethal means. Local clusters of suicide may have a contagious influence.[3]

Important risks also include social and cultural factors. Lack of social support and a sense of isolation increase a person's risk for suicide. In addition, barriers to timely and appropriate mental health and substance abuse treatment, and the stigma that prevents people from seeking such help, increase risk. Some cultural and religious beliefs, as well as exposure to other who have completed suicide — even exposure through the media — increase risk.[3]

The good news is that there are important protective factors that can help counter suicide risks. Included among these are cultural and religious

beliefs that discourage suicide, problem-solving and conflict resolution skills, skills in handling disputes in a non-violent manner, and strong family and community support.[3]

Effective clinical care for mental, physical, and substance abuse disorders, as well as easy access to care also can help protect against suicide. Support during ongoing medical and mental health care relationships is important, as is support to encourage people to seek care for mental illness and substance abuse disorders.[3]

Plan Format

Idaho's suicide prevention plan is based on Idaho-specific needs and resources. The format mirrors that of the national plan, separating goals (what we want to accomplish), outcomes (the change we expect to see), and strategies (generally, how the changes might be accomplished) into **Awareness, Implementation, Methodology (AIM)** categories.[1] Additionally, Idaho's plan includes development of the infrastructure needed to oversee plan implementation. The four categories are defined as follows:

- **Infrastructure** — Goals, outcomes and strategies addressing the tangible framework needed to secure resources to coordinate and provide information and technical assistance to organizations, agencies, and individuals working to implement goals and strategies within the plan, and to update the plan over time.
- **Awareness —** Goals, outcomes and strategies addressing increasing knowledge on a wide-scale basis.
- **Implementation** — Goals, outcomes and strategies addressing the programs and activities conducted to prevent suicides.
- **Methodology** — Goals, outcomes and strategies addressing program evaluation, surveillance, reporting, and research.

Key elements of a plan include engaging a broad and diverse group of partners, developing a sustainable and functional infrastructure, engaging in appropriate activities and tracking progress.

Goals – Outcomes – Strategies

Infrastructure

The tangible framework needed to coordinate plan implementation, to provide information and technical assistance to organizations, agencies, and individuals working to implement components of the plan, and to update the plan over time.

What we want to accomplish:

#1: Develop a central coordinating body for leadership in implementing suicide prevention efforts in Idaho.

The change we expect to see:

#1: A central coordinating body for leadership and implementing suicide prevention efforts in Idaho will be in place and will have accomplished the following:

a. Resources have been acquired to support state and local infrastructure.
b. Statewide and local planning groups are functioning.
c. Statewide and local action plans are coordinated.
d. Plan implementation oversight is functioning.
e. Resource directories have been developed and are being maintained.
f. Technical assistance is available.
g. Formal and informal information sharing is being accomplished between and among organizations.
h. A mechanism is in place for coordinating with tribal and minority populations on implementation issues so they are consistent with cultural traditions and concerns.
i. Data needs for suicide prevention have been identified.
j. A method is in place for plan updates.

Generally, how the change might be accomplished:

At the state level:

a. Public and private resources are identified for infrastructure development (eg., grants, contracts, volunteers, staff, physical location, equipment etc.).
b. Avoid duplication by utilizing existing group(s), expanding their role(s) and function(s) for statewide coordination.
c. Explore the mechanisms other states have used to implement their suicide prevention plans.
d. Coordinate communication between state and local levels.
e. Hold an annual conference for information sharing.

At the local level (as self defined):

a. Public and private resources are identified for infrastructure development (eg., grants, contracts, volunteers, staff, physical location, equipment etc.).
b. Avoid duplication by utilizing existing group(s), expanding their role(s) and function(s) for local coordination.
c. Coordinate communication between local and state levels.

Awareness

Increased public knowledge of suicide related issues in Idaho, of risks and protective factors for suicide, and of available suicide prevention and intervention resources.

What we want to accomplish:

#2: Increase awareness of suicide as a mental health issue in Idaho.

The changes we expect to see:

#2: Idahoans have increased awareness of the following:

a. Statewide and regional suicide statistics.
b. Risk and protective factors for suicide.
c. Symptoms of depression and mental illness.
d. The connection between depression, substance abuse, mental illness and suicide.
e. Warning signs for suicide.
f. Stigma surrounding mental health, mental illness, and help seeking.
g. Available resources and services.
h. Best methods for suicide prevention.
i. Access to care issues.

Generally, how the changes might be accomplished:

At the state level:

a. Distribute media guidelines to local groups and organizations.
b. Conduct an annual public event to raise awareness of suicide related issues.
c. Provide information to physicians and other health care professionals, mental health professionals, senior centers, business owners, human resources department staff, tribal leaders, educators and school personnel, parent-teacher organizations, clergy, law enforcement, suicide survivor groups, community service groups, gun shop owners, pawn

shop owners, bartenders, Alcoholics Anonymous groups, meals on wheels, mobile health clinics, book mobiles, loan officers working with agricultural people, legislators and others.

d. Develop a mechanism for coordinating with tribal and minority populations on awareness issues so they are consistent with cultural traditions and concerns.
e. Develop a coordinated / collaborative state-level awareness action plan and disseminate to local groups and organizations.
f. Gather and disseminate information on available resources and services using the most appropriate means (eg. website, teleconference etc.).

At the local level (as self defined):

a. Distribute media guidelines to local media outlets.
b. Conduct local public events to raise awareness of suicide related issues.
c. Provide information to physicians and other health care professionals, mental health professionals, senior centers, business owners, human resources department staff, tribal leaders, educators and school personnel, parent-teacher organizations, clergy, law enforcement, suicide survivor groups, community service groups, gun shop owners, pawn shop owners, bartenders, Alcoholics Anonymous, meals on wheels, mobile health clinics, book mobiles, loan officers working with agricultural people, legislators and others.
d. Link to information on national and state events / campaigns related to suicide issues.
e. Develop a coordinated / collaborative local awareness action plan.
f. Gather and disseminate information on available resources and services.

Implementation

Enhance and promote programs, services, and activities, to prevent suicides by promoting protective factors and reducing risks.

What we want to accomplish:

#3: Identify, compile and disseminate best known practices and materials for the following:

a. Promoting protective factors against suicide-related behaviors.
b. Reducing risks for suicide-related behaviors.
c. Crisis response.
d. Working with populations having higher risk for suicide.
e. Working with suicide survivors.
f. Training gatekeepers.
g. Mental health providers.
h. Primary care providers.

The change we expect to see:

#3: Best known practices and materials are available and accessible for designing and developing programs, services, and activities for preventing suicides.

Generally, how the change might be accomplished:

At the state level:

a. Acquire resources to support state activities.
b. Support existing effective programs.
c. Implement state initiative(s) that address suicide prevention by promoting protective factors and resiliency.
d. Educate gatekeepers including: physicians and other health care professionals, mental health professionals, senior centers, business owners, human resources department staff, tribal leaders, educators and school personnel, parent-teacher organizations, clergy, law enforcement, suicide survivor groups, community service groups, gun shop owners, pawn shop owners, bartenders, Alcoholics Anonymous, meals on

wheels, mobile health clinics, book mobiles, loan officers working with agricultural people, legislators and others.

e. Develop toolboxes of best practices for use by service providers, schools, organizations, and others.
f. Develop a mechanism for coordinating with tribal and minority populations so cultural traditions and concerns are addressed in practices and materials available for use by these populations.
g. Provide prevention interventions for high risk populations.

At the local level (as self defined):

a. Acquire resources to support local activities.
b. Support existing effective programs.
c. Implement local initiative(s) that address suicide prevention by promoting protective factors and resiliency.
d. Develop local programs, services, and activities based on best practice toolboxes.
e. Educate local gatekeepers including: physicians and other health care professionals, mental health professionals, senior centers, business owners, human resources department staff, tribal leaders, educators and school personnel, parent-teacher organizations, clergy, law enforcement, suicide survivor groups, community services groups, gun shop owners, pawn shop owners, bartenders, Alcoholics Anonymous, meals on wheels, mobile health clinics, book mobiles, loan officers working with agricultural people, legislators and others..
f. Provide prevention interventions for high risk populations.

Methodology

Gather data to evaluate the effectiveness of programs, activities, and clinical treatments, and conduct suicide-specific surveillance and research.

What we want to accomplish:

#4: Develop and disseminate guidelines for outcome and performance measurement for suicide prevention efforts:

The change we expect to see:

#4: Guidelines and performance measures have been developed and distributed.

Generally, how the changes might be accomplished:

At the state level:

a. Conduct a search for guidelines used by other states and organizations.
b. Conduct a search for performance measures used by other states and organizations.
c. Obtain funding to conduct measurement-related research.

What we want to accomplish:

#5: Identify statewide and local suicide-related needs and resources. Identify gaps in service and barriers to accessing care.

The change we expect to see:

#5: A needs and resource assessment is completed. Gaps in services and barriers to accessing care have been identified.

Generally, how the change might be accomplished:

At the state level:

a. Retain a contractor to conduct a statewide survey.
b. Convene a statewide meeting of service providers and consumers and identify needs and gaps.
c. Serve as a resource for tribes and Hispanic groups as they address their needs.

At the local level (as self defined):

a. Gather local resource information.

What we want to accomplish:

#6: Develop a systematic and repeated method of monitoring suicide-related attitudes, intentions and behaviors.

The change we expect to see:

#6: Regularly collected data are available to guide suicide prevention-related decision making.

Generally, how might the change be accomplished:

At the state level:

a. UtilizeYouth Risk Behaviors Survey data.
b. Fund and utilize data from the Mental Health Module of the Behavioral Risk Factor Surveillance System.
c. Request Emergency Room discharge data from hospitals.
d. Make suicidal behavior a "reportable disease."
e. Develop a depository for all suicide and suicide-related data.
f. Conduct a population-based survey of adult Idahoans.
g. Disseminate data statewide.

At the local level (as self defined):

a. Request Emergency Room discharge data from local hospitals.
b. Disseminate data locally.

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Appendix A

Important Protective Factors for Suicide (Include individual's attitudinal and behavioral characteristics as well as attributes of the environment and culture.)

- Cultural and religious beliefs that discourage suicide and support self-preservation.
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes.
- Strong connections to family and community support.
- Effective clinical care for mental, physical, and substance abuse disorders.
- Easy access to a variety of clinical interventions and support for help-seeking.
- Support through ongoing medical and mental health care relationships.
- Restricted access to highly lethal means of suicide.

Important Risk Factors for Suicide (Some cannot be changed but can alert others to heightened risk during periods of recurrence of mental or substance abuse disorders or following significant stressful life events.)

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance use disorders
- Impulsive and/or aggressive tendencies
- Hopelessness
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

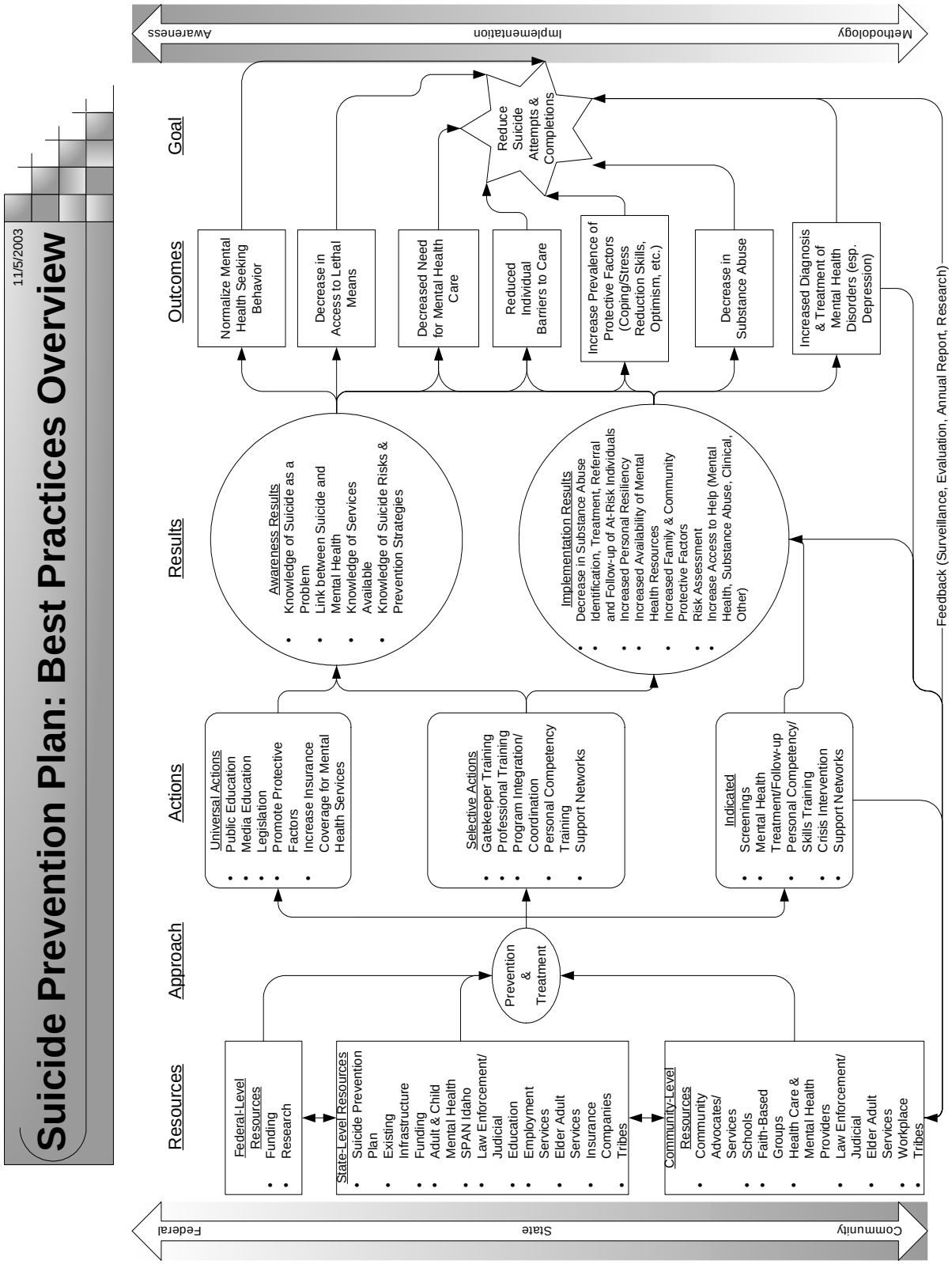
- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Sociocultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of personal dilemma)
- Exposure to, including through media, and influence of others who have died by suicide

Source: National Strategy for Suicide Prevention: Goals and Objectives for Action (2001). U.S. Department of Health and Human Services, Public Health Service. Rockville, MD.

Appendix B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Decrease in Substance Abuse Identification, Treatment, Referral and Follow-up of At-Risk Individuals
Increased Personal Resiliency
Increased Availability of Mental Health Resources
Increased Family & Community Protective Factors
Risk Assessment
Increase Access to Help (Mental Health, Substance Abuse, Clinical, Other)
Normalize Mental Health Seeking Behavior
Decrease in Access to Lethal Means
Decreased Need for Mental Health Care
Reduced Individual Barriers to Care
Increase Prevalence of Protective Factors (Coping/Stress Reduction Skills, Optimism, etc.)
Decrease in Substance Abuse
Increased Diagnosis & Treatment of Mental Health Disorders (esp. Depression)
Reduce Suicide Attempts & Completions
Feedback (Surveillance, Evaluation, Annual Report, Research)
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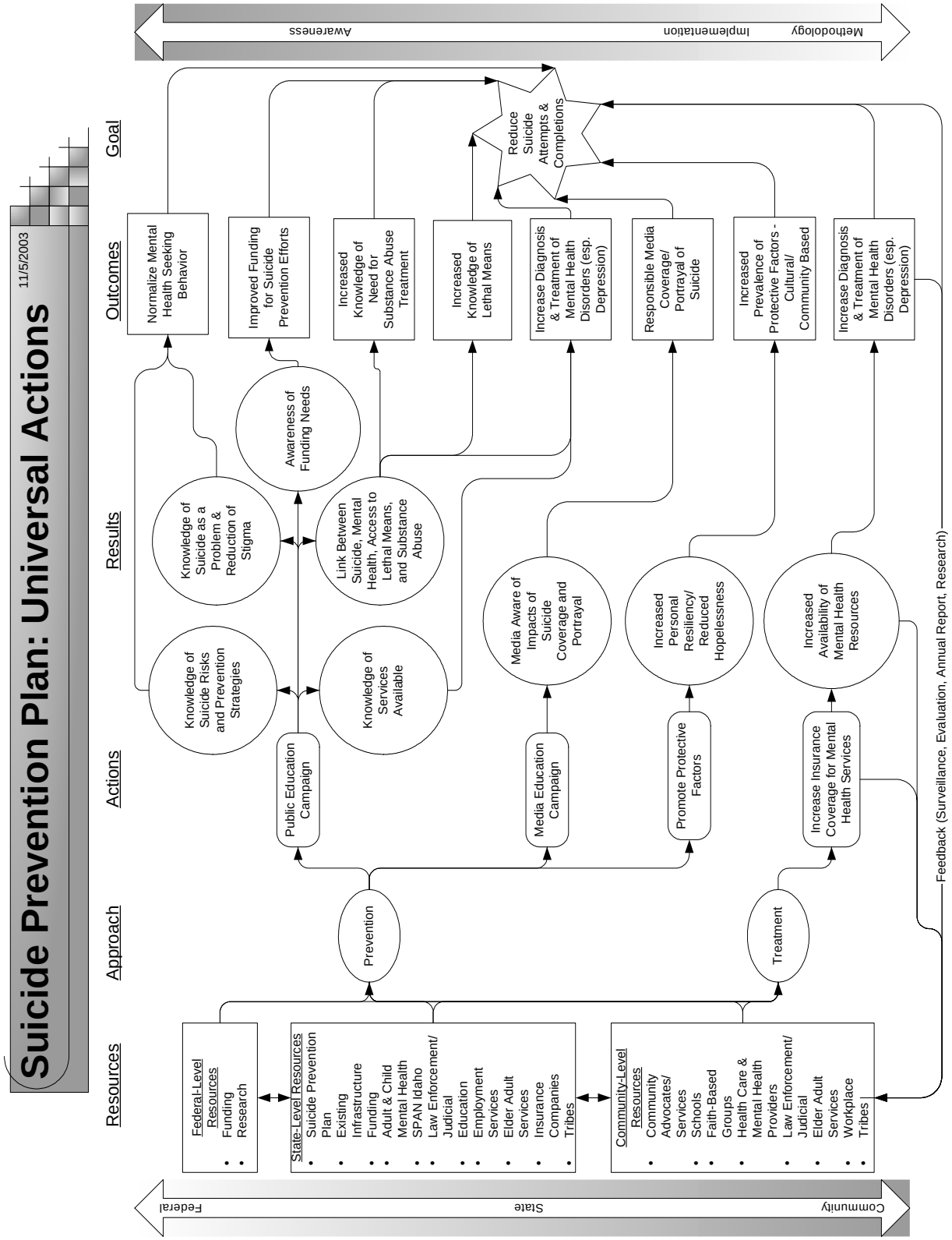
Appendix C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Media Education Campaign
Promote Protective Factors
Increase Insurance Coverage for Mental Health Services
Knowledge of Suicide Risks and Prevention Strategies
Knowledge of Services Available
Knowledge of Suicide as a Problem & Reduction of Stigma
Awareness of Funding Needs
Link Between Suicide, Mental Health, Access to Lethal Means, and Substance Abuse
Media Aware of Impacts of Suicide Coverage and Portrayal
Increased Personal Resiliency/ Reduced Hopelessness
Increased Availability of Mental Health Resources
Normalize Mental Health Seeking Behavior
Improved Funding for Suicide Prevention Efforts
Increased Knowledge of Need for Substance Abuse Treatment
Increased Knowledge of Lethal Means
Increase Diagnosis & Treatment of Mental Health Disorders (esp. Depression)
Responsible Media Coverage/ Portrayal of Suicide
Increased Prevalence of Protective Factors - Cultural/ Community Based
Increase Diagnosis & Treatment of Mental Health Disorders (esp. Depression)
Reduce Suicide Attempts & Completions
Feedback (Surveillance, Evaluation, Annual Report, Research)
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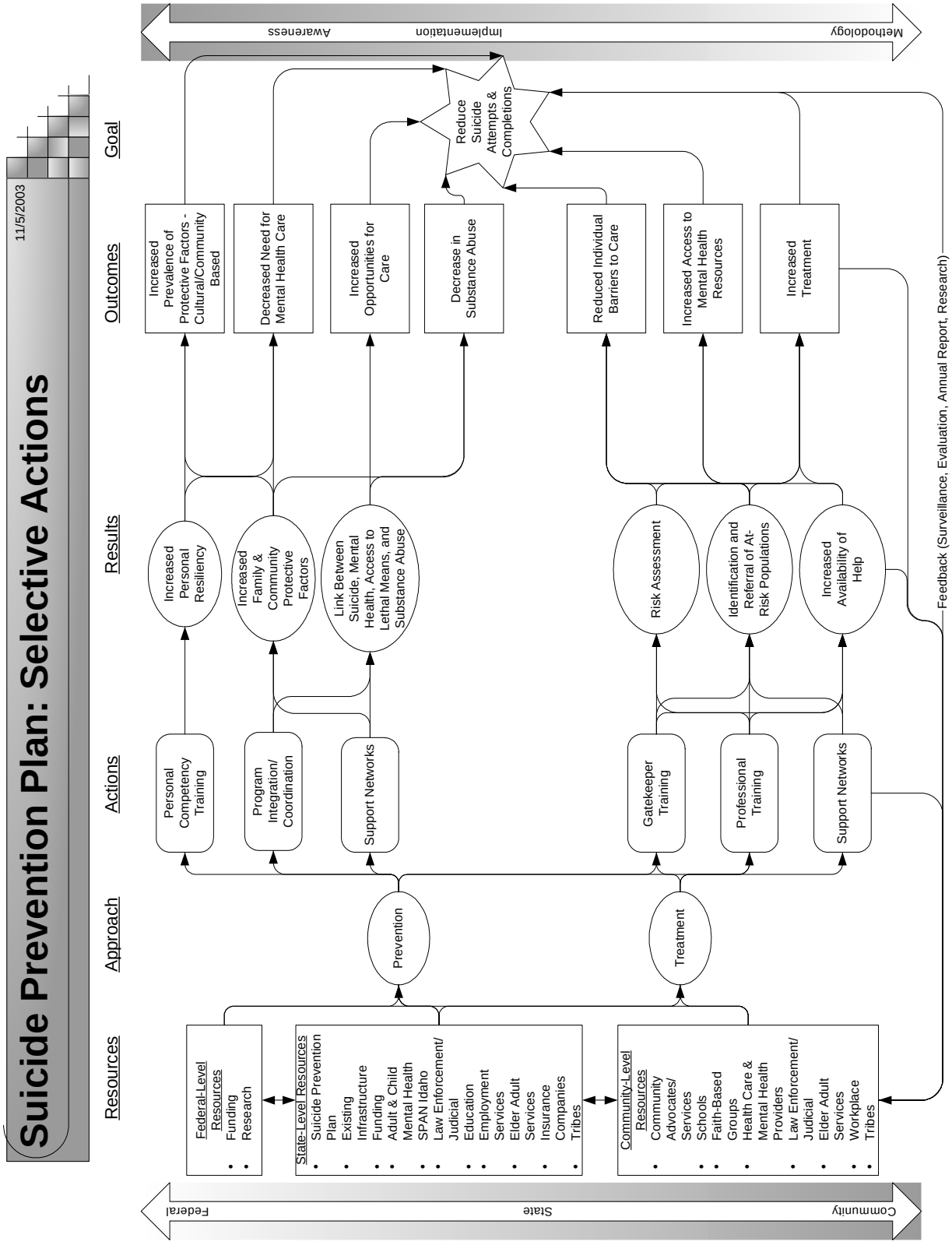
Appendix D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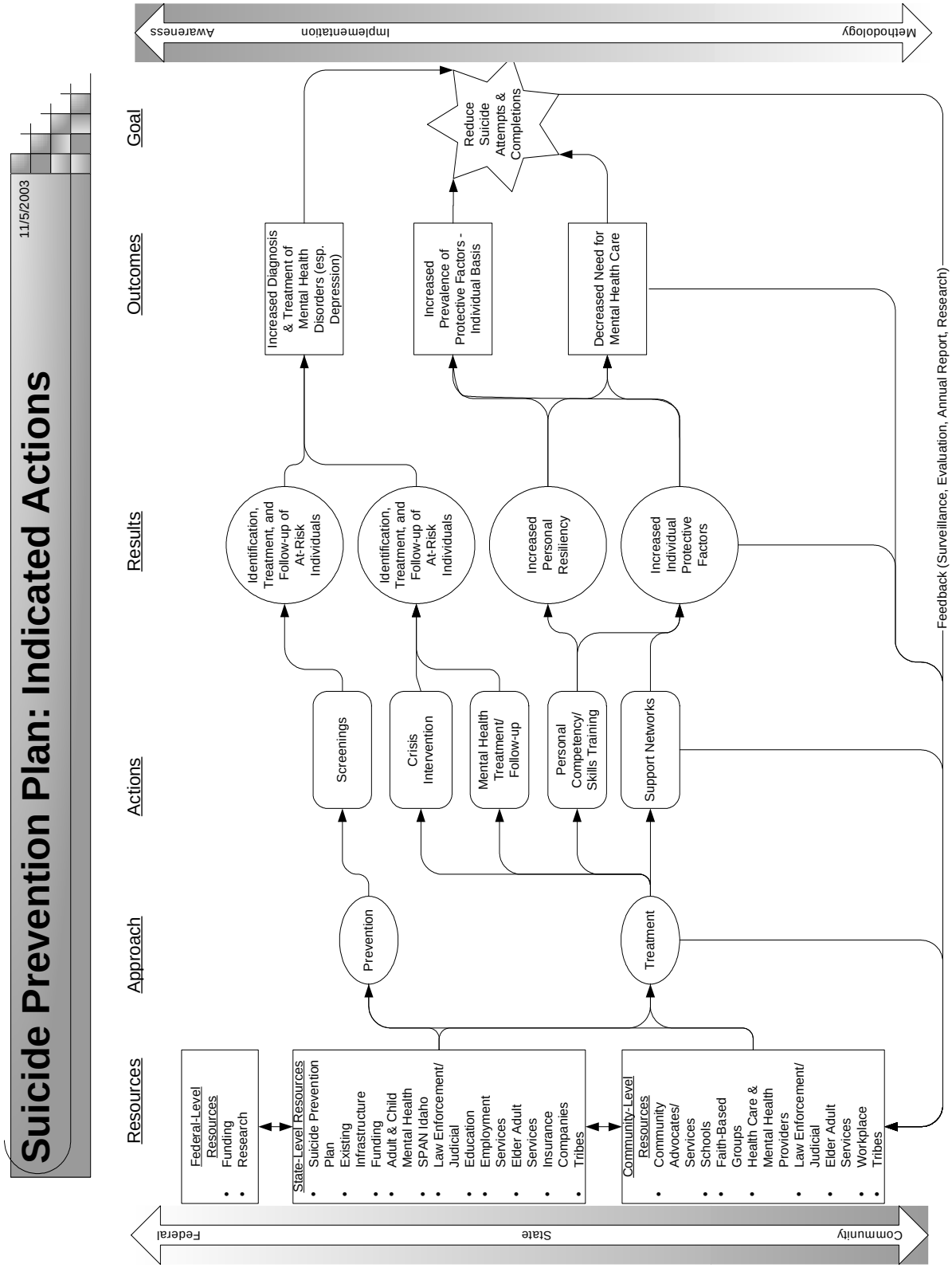
Law Enforcement/ Judicial
Education
Employment Services
Elder Adult Services
Insurance Companies
Tribes
Community-Level Resources
Community Advocates/ Services
Schools
Faith-Based Groups
Health Care & Mental Health Providers
Law Enforcement/ Judicial
Elder Adult Services
Workplace
Tribes
Prevention
Treatment
Personal Competency Training
Program Integration/ Coordination
Support Networks
Gatekeeper Training
Professional Training
Support Networks
Increased Personal Resiliency
Increased Family & Community Protective Factors
Link Between Suicide, Mental Health, Access to Lethal Means, and Substance Abuse
Risk Assessment
Identification and Referral of At-Risk Populations
Increased Availability of Help
Increased Prevalence of Protective Factors - Cultural/Community Based
Decreased Need for Mental Health Care
Increased Opportunities for Care
Decrease in Substance Abuse
Reduced Individual Barriers to Care
Increased Access to Mental Health Resources
Increased Treatment
Reduce Suicide Attempts & Completions
Feedback (Surveillance, Evaluation, Annual Report, Research)
Federal
State
Community
Awareness
Implementation
Methodology

Appendix E


Suicide Prevention Plan: Indicated Actions
11/5/2003
Resources
Approach
Actions
Results
Outcomes
Goal
Federal-Level Resources
Funding
Research
State-Level Resources
Suicide Prevention Plan
Existing Infrastructure Funding
Adult & Child Mental Health SPAN Idaho
Law Enforcement/ Judicial
Education
Employment Services
Elder Adult Services
Insurance Companies
Tribes
Community-Level Resources
Community Advocates/ Services
Schools
Faith-Based Groups
Health Care & Mental Health Providers
Law Enforcement/ Judicial
Elder Adult Services
Workplace
Tribes
Prevention
Treatment
Screenings
Crisis Intervention
Mental Health Treatment/ Follow-up
Personal Competency/ Skills Training
Support Networks
Identification, Treatment, and Follow-up of At-Risk Individuals
Identification, Treatment, and Follow-up of At-Risk Individuals
Increased Personal Resiliency
Increased Individual Protective Factors
Increased Diagnosis & Treatment of Mental Health Disorders (esp. Depression)
Increased Prevalence of Protective Factors - Individual Basis
Decreased Need for Mental Health Care
Reduce Suicide Attempts & Completions
Feedback (Surveillance, Evaluation, Annual Report, Research)
Federal
State
Community
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Glossary

Best Practices — activities or programs that are in keeping with the best available evidence regarding what is effective.

Effective — prevention programs that have been scientifically evaluated and shown to decrease anadverse outcome or increase a beneficial one in the target group more than in a comparison group.

Evaluation — the systematic investigation of the value and impact of an intervention or program.

Gatekeepers — those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

Goal — a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Means — the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).

Outcome — a measurable change in the health of an individual or group of people that is attributable to an intervention.

Protective factors — factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Resource — a source of supply or support (e.g., technical assistance, training, funding, etc.).

Risk Factors — those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Social Support — assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Stigma — an object, idea, or label associated with disgrace or reproach.

Strategy — a method or approach for achieving an end.

Suicidal Ideation — self-reported thoughts of engaging in suicide-related behavior.

Suicide Attempt — a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicide — death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.

Suicide Attempt Survivors — individuals who have survived a prior suicide attempt.

Suicide Survivors — family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance — the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

Technical Assistance — consultation to provide special knowledge, training, data products, etc.

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III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$13,277,400	$	$33,483,000	$	$6,181,400
6. Other 24 Hour Care		$	$	$	$5,575,400	$	$
7. Ambulatory/Community Non -24 Hour Care		$3,325,600	$2,277,800	$7,863,600	$37,622,800	$	$485,800
8. Mental Health Primary Prevention		$27,400	$	$	$	$	$
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		$	$	$	$	$	$
10. Administration (Excluding Program and Provider Level)		$233,800	$	$695,600	$940,000	$	$20,400
11. Total	$	$3,586,800	$15,555,200	$8,559,200	$77,621,200	$	$6,687,600

* Prevention other than primary prevention

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			$	$
Specialized Outpatient Medical Services			$	$
Acute Primary Care			$	$
General Health Screens, Tests and Immunizations			$	$
Comprehensive Care Management			$	$
Care coordination and Health Promotion			$	$
Comprehensive Transitional Care			$	$
Individual and Family Support			$	$
Referral to Community Services Dissemination			$	$
Prevention (Including Promotion)			$	$
Screening, Brief Intervention and Referral to Treatment	0	0.00	$	$

Brief Motivational Interviews	0	0.00	$	$
Screening and Brief Intervention for Tobacco Cessation	0	0.00	$	$
Parent Training			$	$
Facilitated Referrals	0	0.00	$	$
Relapse Prevention/Wellness Recovery Support	0	0.00	$	$
Warm Line	0	0.00	$	$
Substance Abuse (Primary Prevention)			$2,352,068	$
Classroom and/or small group sessions (Education)	39054		$1,072,764	$
Media campaigns (Information Dissemination)	58630		$402,000	$
Systematic Planning/Coalition and Community Team Building(Community Based Process)	4368		$14,736	$
Parenting and family management (Education)	2156		$545,910	$
Education programs for youth groups (Education)			$	$
Community Service Activities (Alternatives)	1526		$101,858	$
Student Assistance Programs (Problem Identification and Referral)	6508		$107,724	$
Employee Assistance programs (Problem Identification and Referral)			$	$

Community Team Building (Community Based Process)			$	$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)	9620		$107,076	$
Engagement Services			$851,084	$
Assessment	5036		$851,084	$
Specialized Evaluations (Psychological and Neurological)	0	0.00	$	$
Service Planning (including crisis planning)	0	0.00	$	$
Consumer/Family Education	0	0.00	$	$
Outreach	0	0.00	$	$
Outpatient Services			$4,423,456	$
Evidenced-based Therapies			$	$
Group Therapy	4036		$4,423,456	$
Family Therapy			$	$
Multi-family Therapy			$	$
Consultation to Caregivers			$	$
Medication Services			$	$

Medication Management			$	$
Pharmacotherapy (including MAT)			$	$
Laboratory services			$	$
Community Support (Rehabilitative)			$739,900	$
Parent/Caregiver Support	0	0.00	$	$
Skill Building (social, daily living, cognitive)	100		$20,900	$
Case Management	3000		$281,000	$
Behavior Management	0	0.00	$	$
Supported Employment	0	0.00	$	$
Permanent Supported Housing	0	0.00	$	$
Recovery Housing	600		$438,000	$
Therapeutic Mentoring	0	0.00	$	$
Traditional Healing Services	0	0.00	$	$
Recovery Supports			$	$
Peer Support			$	$
Recovery Support Coaching			$	$

Recovery Support Center Services			$	$
Supports for Self-directed Care			$	$
Other Supports (Habilitative)			$451,000	$
Personal Care	0	0.00	$	$
Homemaker	0	0.00	$	$
Respite	0	0.00	$	$
Supported Education	0	0.00	$	$
Transportation	1000		$451,000	$
Assisted Living Services	0	0.00	$	$
Recreational Services	0	0.00	$	$
Trained Behavioral Health Interpreters	0	0.00	$	$
Interactive Communication Technology Devices	0	0.00	$	$
Intensive Support Services			$284,054	$
Substance Abuse Intensive Outpatient (IOP)	2600		$284,054	$
Partial Hospital	0	0.00	$	$

Assertive Community Treatment	0	0.00	$	$
Intensive Home-based Services	0	0.00	$	$
Multi-systemic Therapy	0	0.00	$	$
Intensive Case Management	0	0.00	$	$
Out-of-Home Residential Services			$252,990	$
Children's Mental Health Residential Services	0	0.00	$	$
Crisis Residential/Stabilization	0	0.00	$	$
Clinically Managed 24 Hour Care (SA)	0	0.00	$	$
Clinically Managed Medium Intensity Care (SA)	0	0.00	$	$
Adult Mental Health Residential	0	0.00	$	$
Youth Substance Abuse Residential Services	30		$252,990	$
Therapeutic Foster Care	0	0.00	$	$
Acute Intensive Services			$	$
Mobile Crisis			$	$
Peer-based Crisis Services			$	$

Urgent Care			$	$
23-hour Observation Bed			$	$
Medically Monitored Intensive Inpatient (SA)			$	$
24/7 Crisis Hotline Services			$	$
Other (please list)			$81,900	$
Drug Testing	450		$81,900	$

footnote:

The Substance Use Disorder Expenditures are for Idaho State Fiscal Year 2014.

Idaho is unable to track MHBG expenditures by service at this time (III. Table 3)

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$5,515,082	
2 . Substance Abuse Primary Prevention	$1,617,757	
3 . Tuberculosis Services		
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	$220,603	
6. Total	$7,353,442	

* Prevention other than primary prevention

** HIV Early Intervention Services

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$131,411	
	Selective		
	Indicated		
	Unspecified		
	Total	$131,411	
Education	Universal	$750,000	
	Selective	$150,000	
	Indicated		
	Unspecified		
	Total	$900,000	
Alternatives	Universal	$25,000	
	Selective		
	Indicated		
	Unspecified		
	Total	$25,000	
Problem Identification and Referral	Universal		
	Selective	$20,000	
	Indicated		
	Unspecified		

	Total	$20,000	
Community-Based Process	Universal	$22,000	
	Selective		
	Indicated		
	Unspecified		
	Total	$22,000	
Environmental	Universal	$40,000	
	Selective		
	Indicated		
	Unspecified		
	Total	$40,000	
Section 1926 Tobacco	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Other	Universal		
	Selective		
	Indicated		
	Unspecified	$479,346	
	Total	$479,346	
Total Prevention Expenditures	$1,617,757		
Total SABG Award*	$7,353,442		
Planned Primary Prevention Percentage	22.00 %		

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$968,411	
Universal Indirect	$479,346	
Selective	$170,000	
Indicated		
Column Total	$1,617,757	
Total SABG Award*	$7,353,442	
Planned Primary Prevention Percentage	22.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

footnote:
Please note headings on Table 5b vary from those on Table 5a. To account for the variation, the amount reported as Unspecified on Table 5a, as recorded in the Universal Indirect column on Table 5b

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	c
Heroin	c
Inhalants	c
Methamphetamine	c
Synthetic Drugs (i.e. Bath salts, Spice, K2)	c
Targeted Populations	
Students in College	c
Military Families	b
LGBTQ	c
American Indians/Alaska Natives	b
African American	c
Hispanic	b
Homeless	c
Native Hawaiian/Other Pacific Islanders	c
Asian	c
Rural	b
Underserved Racial and Ethnic Minorities	b

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	328182.00			$328,182	17573.00			
2. Quality Assurance	224190.00	603802.00		$827,992	15762.00	341901.00		
3. Training (Post-Employment)	73876.00			$73,876	5853.00			
4. Education (Pre-Employment)								
5. Program Development	184690.00			$184,690	5254.00			
6. Research and Evaluation	73876.00			$73,876	2652.00			
7. Information Systems	73878.00	18000.00		$91,878	5642.00	169000.00		
8. Enrollment and Provider Business Practices (3 percent of BG award)		194739.00		$194,739				
9. Total	$958,692	$816,541		$1,775,233				

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	$
MHA Planning Council Activities	$ 20,000
MHA Administration	$
MHA Data Collection/Reporting	$
Enrollment and Provider Business Practices (3 percent of total award)	$ 68,358
MHA Activities Other Than Those Above	$ 455,121
Total Non-Direct Services	$543479

Comments on Data:

$20,000 = 1 year for Planning Council
$68,358= 1 year for 3% of total MHBG award for Enrollment and Provider Business Practices; see SABG for 3% detail on this item.
$455,121= 1 year for 1) suicide prevention ($32,854), 2) peer specialist/family empowerment contract ($153,000) and 3) program development w/Federation of Families ($269,267).

footnote:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

IV: Narrative Plan

C Coverage M/SUD Services

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Narrative Question: Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Exchange) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Identify which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014

Identification of services covered by Medicaid or QHPs on January 1, 2014 is contingent upon Idaho's insurance exchange decision and on decisions that are made with Medicaid. In the event that Idaho does set up an Idaho health insurance exchange, it is anticipated that the Division of Behavioral Health may be one of the mechanisms used to monitor this exchange, but details on this issue are not yet clear and are contingent on policy decisions made by the legislature in SFY 2013.

Does Idaho have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

Development of a plan to monitor whether individuals and families have access to mental health and substance use disorder services offered through QHPs and Medicaid is contingent on policy decisions made by the legislature in SFY 2013.

Who in Idaho is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.

Identification of who is responsible to monitor access to mental health and substance use services by the QHPs in Idaho is not yet decided. These determinations will be contingent on policy decisions made by the legislature in SFY 2013.

Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

SMHA and SSA involvement in reviewing any complaints or possible violations or MHPAEA will be determined and contingent on policy decisions made by the legislature in SFY 2013.

What specific changes will the state make in what is bought given the coverage offered in the state's EHB package?

This is assuming we have an exchange implemented. Depending on the outcome of the SFY 2013 legislature, the state of Idaho may defer to the federal government for recommendations on this topic.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

IV: Narrative Plan

D Affordable Insurance Exchange

Page 67 of the application Guidance

Narrative Question: Affordable Insurance Exchanges (Exchanges) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance. QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Description of how Idaho will evaluate the impact that its outreach, eligibility determination, enrollment and re-enrollment systems will have on eligible individuals with behavioral health conditions.

Implementation of Affordable Care Exchanges in Idaho has not yet been fully planned. One option within the Behavioral Health System would be to use Medicaid Managed Care enrollment numbers to correlate the impact to populations served through the SMHA and SSA. Medicaid Managed Care will get a fixed premium per consumer per month as an incentive to keep the maximum number of people enrolled in Medicaid. Results may be confounded if Medicaid does not expand for the adult populations, but mandated expansion (woodwork effect) is likely to be seen in the children's population. Multi-year comparisons of National Outcome Measure/Uniform Reporting System (NOMS/URS) table changes may provide basic data to consider when evaluating the impact of outreach, eligibility determination, enrollment and re-enrollment systems on eligible individuals with behavioral health conditions.

Description of how Idaho will work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled.

The Division of Behavioral Health (DBH) will work with its partners to ensure that services are responsive to the needs of individuals with behavioral health diagnoses. In Idaho, Community Resource Development Specialists (CRDS) in each region assist citizens to understand and negotiate system resources in their communities, and they will continue to provide this assistance to those with behavioral health diagnoses. Individuals receiving Substance Use Disorder (SUD) treatment and recovery support services through the management services contractor will receive evaluations from that contractor to assess and assist eligible individuals to apply for Medicaid or other benefits that they may qualify to receive. Idaho has a strong SSI/SSDI Outreach, Access and Recovery (SOAR) program with SOAR trained staff in each region of the state, and these SOAR trainers will also help individuals to access benefits that they are entitled to receive.

The Division of Behavioral Health could partner with the Family and Community Services (FACS) Navigators to promote and advocate for an initiative to ensure the 211 Careline information is current and regularly updated. The Medicaid Managed Care contractor will be paid per enrolled member per month, and they are expected to use multiple methods to market services (e.g., website, 800 number, local representatives).

Description of how Idaho will ensure that providers are screening for eligibility, assisting with enrollment, and billing third party Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services.

The Division of Behavioral Health is in the process of contracting for a new management services contractor for the substance use delivery system. Assurance that providers are screened for eligibility, assistance with enrollment and billing third party or other insurance prior to drawing down block grant dollars for services will be a requirement of the new management services contract, and therefore part of their subcontract with network providers.

Information about a health insurance exchange in Idaho will be clearer after the legislature concludes in March or April 2013. Without knowing what type of exchange will be funded, it is difficult to extrapolate details of a system beyond the concept that the Division of Behavioral Health services will continue to serve as the backstop for those between or without benefits. The Division of Behavioral Health will continue to be a partner in the process. Medicaid Managed Care is expected to be an active partner in the eligibility process, and they are also expected to become a major portal for individuals seeking services and linkage to an assortment of benefits and resources. Children's Mental Health Block grant dollars will continue to provide some funding to the family organization contract (Federation of Families), and this agency may assist families to identify ways to maximize benefits that support services to their children.

Description of how Idaho will ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how the state will assist its providers in enrolling in the networks.

The Division of Behavioral Health is in the process of contracting for a new management services provider for the substance use delivery system. The management services contractor will be responsible to ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and they will work actively to enroll and monitor an array of network providers. The SUD treatment rules are also being revised to include a broader range of licensed and certified professionals eligible to deliver treatment and recovery support services.

Medicaid will also be a key partner in ensuring that there is adequate community behavioral health provider participation in QHP networks. The new Medicaid Managed Care entity will collaborate with the Division of Behavioral Health with respect to implementing activities that encourage network enrollment. The Division of Behavioral Health's Behavioral Health System Redesign Plan will serve as a critical map to outline the structure. While the Medicaid Managed Care contractor will likely be primarily responsible for provider enrollment, the Division is anticipated to be primarily responsible for quality assurance oversight of services provided through the system.

Provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

First, assuming uninsured means persons lacking private insurance for SABG-funded SUD treatment clients the answer is 100%. Part of the process to qualify for state funded SUD treatment services is a financial resource review. If an individual has private health insurance, they are not eligible for state funded treatment services. The SUD Treatment management services contract requirement and treatment client data system were used to make this determination. In SFY 2012, 3,800 individuals received SUD

treatment services funded wholly or in part by SABG funds. In SFY 2013, it is estimated that Idaho's SUD system will serve the same or slightly more clients, depending on the impact of sequestration on the SABG.

The Division of Behavioral Health has been actively working on improving its data system for the past several years. The Web Infrastructure for Treatment Services (WITS) system was implemented for adult mental health in October 2009, and for children's mental health in July 2011. Report extraction for adult mental health in SFY 2009 was only available for nine months. The average number of uninsured Idaho citizens served by the mental health block grant in SFY 2010, 2011 and 2012 is 11,478. This is the projected number to be served by the mental health block grant in SFY 2013, 2014 and 2015.

Provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

This number is estimated to remain the same as in SFY 2013. The answer is 100% because the contract with the SUD treatment managed care providers will continue to require a financial screen that includes private insurance review. If individuals have private insurance, they will not be eligible for SABG-funded services. Based on SFY 2012 data and anticipated funding levels, Idaho anticipates serving approximately 3,800 individuals supported wholly or in part by SABG funds.

The Division of Behavioral Health has been actively working on improving its data system for the past several years. The Web Infrastructure for Treatment Services (WITS) system was implemented for adult mental health in October 2009, and for children's mental health in July 2011. Report extraction for adult mental health in SFY 2009 was only available for nine months. The average number of uninsured Idaho citizens served by the mental health block grant in SFY 2010, 2011 and 2012 is 11,478. This is the projected number to be served by the mental health block grant in SFY 2013, 2014 and 2015.

For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

During the December 2012/January 2013 Request for Proposal (RFP) review process for Medicaid Managed Care, the Medicaid representative indicated that there were 700 enrolled Medicaid providers. There may be some fluctuation month to month as new providers are enrolled and other providers are removed.

Provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

The Idaho Medicaid Division recently completed a bidding process for a Medicaid Managed Care contractor. This contractor will be responsible to 'create' their network. It is anticipated that they will take over the existing network and build a relationship with existing providers. It is difficult to estimate specific numbers of enrolled Medicaid providers for SFY 2014 and SFY 2015 at this date. The best estimate at this time would be to maintain the estimate of 700 providers enrolled in Medicaid as of February 2013.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
   a. Budget review;
   b. Claims/payment adjudication;
   c. Expenditure report analysis;
   d. Compliance reviews;
   e. Encounter/utilization/performance analysis; and
   f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

IV: Narrative Plan

E Program Integrity

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Narrative Question: The Affordable Care Act directs the Secretary of HHS to define Essential Health Benefits (EHBs). Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a -typical employer plan in that state as required by the Affordable Care Act. At this point in time, many states will know which mental health and substance abuse services are covered in their benchmark plans offered by QHPs and Medicaid programs. SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc. States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

Does the state have a program integrity plan regarding the SABG and MHBG?

Idaho has not completed the plan for health care services as required by the Affordable Care Act. For the present, Idaho will use existing resources to address program integrity requirements for Substance Use Disorders (SUD) treatment and SUD prevention. For SUD treatment, the SUD Management Services Contractor (MSC) will be responsible to screen all SUD service applications. As a part of the screening process, the MSC will determine if the individual has access to private or other public health care services such as Medicaid, Medicare or TRICARE. Individuals having private insurance will be referred to their provider. Individuals with no insurance will be covered by the Substance Abuse Block Grant (SABG) funds. The SUD MSC will also be responsible for initial compliance review, service utilization reviews and authorization, and complaint resolution. Complaints not resolved by the management services contractor will be referred to the Single State Authority (SSA) for review and resolution. Finally, the SUD MSC will conduct onsite monitoring on all agencies serving SSA funded clients. The monitoring will include review of records for completeness, appropriateness of treatment plan based on intake assessment and recovery plans.

Program integrity is also monitored on all funded recurring Substance Abuse Prevention services. The Substance Abuse Prevention management contractor review begins by evaluating funding applications to determine if the proposed program is appropriate for the identified risk factors and target population(s). Program integrity reviews continue through onsite monitoring of prevention providers. Prevention management contractor staff review provider records to determine if the target population is being served as proposed, if the evidence-based prevention program is being delivered in accordance with program protocols and if program outcomes are consistent with published research.

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

Idaho's Division of Medicaid includes a Medicaid Program Integrity Unit, that oversees Medicaid service programs. As of July 2011, Medicaid was pursuing a contract with a managed care organization (MCO) with a target implementation date of 7/1/12 for the administration of mental health benefits. This was delayed and the Request for Proposal was only available in fall of 2012. A 1915b waiver will be in place as the funding authority to support the MCO contract. The Medicaid MCO contract was offered to OptumHealth in February 2013. Qualis signed a three year contract renewal with Medicaid in June 2011 to provide case management and utilization management services.

The Idaho Medicaid Managed Care Organization (i.e., likely OptumHealth) will provide an integrated oversight of all behavioral health Medicaid services (mental health and substance use disorder) to adults and children in the state of Idaho. Eligible services are expected to start with currently available Medicaid behavioral health services. Depending on the final decision as to who ends up with the contract award, there may be enhancements in the areas of crisis, prevention and service access. Program integrity will be a key aspect of the Medicaid MCO contract responsibilities.

The Division of Behavioral Health's Quality Assurance (QA) unit is responsible to provide oversight of mental health services provided to adults and children through the Division of Behavioral Health's Regional Mental Health Centers. The QA unit monitors regional quality of care and service utilization. The Division of Behavioral Health also measures consumer satisfaction through annual MHSIP and YSS-F satisfaction survey requests of service participants.

Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

For the substance abuse prevention services, Idaho has a three tiered approach. The substance abuse prevention management contract manager, regional staff and Idaho's National Prevention Network (NPN) conduct integrity reviews at three levels. The initial program integrity activities are conducted by the prevention management contract manager and focus on the application for substance abuse prevention funding. Entities must propose to use an evidence-based program that has been proven effective for their target population. The evaluation of the application includes a review of the proposed program and target population. If the proposed population or their risk factors have not been documented to be impacted by the proposed program, they will not be funded. The second level evaluation is conducted by the NPN who reviews the proposed service plan and focuses on the evidence used to document program effectiveness as well as the target population and risk factors. The third level review is conducted by the prevention management regional staff during provider site visits. They review provider records and staff to ensure the program is being delivered to the target population as approved for funding. They also review outcome data to determine if the program is getting results that are reasonable based on the program's research, the population served and the length of the program.

The Substance Use Disorder management services contractor is responsible to ensure that all provider network staff are adequately trained to provide contracted services that are evidence based and monitored continuously for opportunities to improve. They are responsible to ensure trainings contain cultural competence components; updates on new developments in the field of SUD treatment and Recovery Support Services (RSS); technical assistance on implementing evidence based treatment strategies and technical assistance on implementing quality improvement strategies for each program. They must keep records of the training received by all network providers. The Substance Use Disorder management services contract lead and regional staff are responsible for these activities.

The Medicaid Program Integrity Unit is responsible for program integrity issues for Idaho citizens receiving Medicaid services. The Division of Behavioral Health's QA unit provides this service for citizens that receive behavioral health services through the Division's Regional Mental Health Centers.

What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:

a. Budget review; The Department of Health and Welfare's Division of Support Services includes a Bureau of Financial Services. Financial Services provides a quarterly review of expenditures from Division of Behavioral Health programs. In addition, budget review for SUD treatment services is conducted quarterly by Behavioral Staff during site visits to the SUD treatment management services contractor. Expenditures are reviewed in total and by target population expenditures. The substance abuse prevention activity expenditures are also reviewed quarterly during contract monitoring meetings the Behavioral Health staff hold with the substance abuse prevention management contractor.

b. Claims/payment adjudication; The Department of Health and Welfare's Division of Support Services' Bureau of Financial Services tracks and provides oversight of Division of Behavioral Health claims and payments. The SUD treatment management services contractor is responsible for oversight of all treatment services delivered under their contract. This is done through a three part model. First, the SUD treatment management services contractor screens all clients for treatment needs and authorizes those who qualify for state funded services for a full assessment. Based on the assessment, the SUD treatment management services contractor authorizes specific types and amounts of services for a defined period for each client. This contractor is also responsible for claims/ payment adjudication for approved treatment programs within their provider network. They review claims to determine if they are provided by an individual qualified to deliver the services and in compliance with the services and length of stay authorized for the client. Those claims that fall within the authorization are paid, all others are denied. The SUD treatment management services contractor also has a formal adjudication process for denied claims. As a final option, claimants may appeal to the Division of Behavioral Health.

For the substance abuse prevention services, the management contractor is responsible for claims and payment adjudication. They review claims for payment to determine if the services invoiced were approved for delivery under the contract, individuals delivering the services met the contract-established qualifications and if required data elements were entered into the substance abuse prevention data system prior to submission of the invoice. The substance abuse prevention management contractor has a formal process for adjudication of denied claims, and as with treatment, a final appeal may be submitted to the Division of Behavioral Health.

c. Expenditure report analysis; The Department of Health and Welfare's Division of Support Services' Bureau of Financial Services collaborates with Division of Behavioral Health to analyze expenditure reports during quarterly budget reviews. The SUDS treatment expenditures are monitored two times per month after the Division receives a service invoice from the SUD treatment management services

contractor. Expenditure reports for substance abuse prevention are also monitored two times per month on or after the first and the fifteenth of the month when the prevention activity invoice is received.

d. Compliance reviews; The Division of Behavioral Health's Quality Assurance (QA) unit implements compliance reviews for each Regional Mental Health Center. Compliance reviews are also conducted by Behavioral Health staff as a part of quarterly contract monitoring activities on the SUD treatment management services contractor and the substance abuse prevention management contractor. At the provider level, the SUDS treatment management services contractor is responsible for conducting onsite monitoring of providers within the network to ensure compliance with contract requirements. Likewise, the substance abuse prevention management contractor is responsible for conducting onsite monitoring of prevention providers and coalitions within their network to ensure compliance with block grant and contract requirements.

e. Encounter/utilization/performance analysis; The Division of Behavioral Health's Quality Assurance (QA) unit conducts utilization/performance reviews for each Regional Mental Health Center. SUD treatment encounter/utilization/performance analysis first reviewed by the SUD treatment management services contractor, as detailed above, to ensure the invoice service was authorized and appropriate. A second analysis is conducted by the Division of Behavioral Health data unit after the receipt of each treatment services invoice as well as during contract monitoring site visits.

f. Audits: The Division of Behavioral Health's Operations unit monitors Division contract activities. The QA team can conduct root cause analyses of critical incident situations. Legislative auditors are responsible to audit Division programs. The Random Moment Time Study (RMTS) provides a snapshot of staff activities at the time that RMTS data is requested. Medicaid auditors audit programs that provide Medicaid services. Audits are conducted on the substance abuse prevention management contractor invoices during regular contract monitoring visits. A random sample of provider billings are selected by region from invoices submitted after the previous audit. The SUD prevention services management contractor is responsible to provide documentation verifying the service occurred on the date invoiced.

How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

The Department of Health and Welfare maintains consistent fiscal policies and mechanisms for all Department of Health and Welfare programs, (e.g., Division of Behavioral Health, Medicaid, food stamps). The Division of Support Services provides oversight of fiscal policies and mechanisms. The Division of Behavioral Health establishes standard fee for service rates for allowable Substance Use Disorders treatment and recovery support services. These rates are established based on a comparison of private provider fees, standard insurance rates and Medicaid reimbursement rates. The rates are included in the contract the Division of Behavioral Health holds with the substance use disorders treatment management services contractor. Rates for the delivery of prevention activities are negotiated annually as a part of the funding application and award process. As a part of the funding application, prevention providers and community coalitions must identify the activity(ies) that they propose to implement. Rates vary based on the cost of evidence-based programs and practices, the distance the provider/coalition will need to travel to deliver the activity, staff/facilitator costs, facility costs and other costs associated with implementation. The substance abuse prevention management contractor negotiates with the agency on any cost that appears to be excessive or unnecessary. Once the two entities have agreed upon activity costs, a fee for service is established. These fees are reviewed and approved by the Division of Behavioral Health's prevention services manager.

How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

The Idaho Department of Health and Welfare assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards in several ways. In order to qualify to deliver Division of Behavioral Health-funded services, substance use disorders treatment agencies must be certified by the Division. In order to successfully complete a facility review, facilities must address a variety of quality of care and safety standards. These standards are located online at http://adminrules.idaho.gov/rules/current/16/0720.pdf. Additional requirements specific to services delivered to state-funded substance disorder treatment clients are established in the SUDS treatment management services contract. The SUDS Treatment Management Services Contractor is solely responsible to ensure compliance with facility standards and contract requirements for all enrolled SUDS treatment providers. Compliance with standards is monitored during SUDS treatment management services contractor treatment provider monitoring site visits. The substance abuse prevention management contractor is responsible for ensuring all entities receiving SAPT block grant primary prevention funds meet quality and safety standards and requirements established within their contract. The initial quality requirements focus on the delivery of evidence-based programs and practices. Entities that have paid staff delivering prevention activities must provide documentation that the proposed staff meet the minimum qualified prevention professional requirements. These requirements as well as safety requirements are established in the Substance Abuse Prevention Provider and Coalition standards located on the internet at http://www.preventionidaho.net/Benchmark.aspx. The Medicaid Managed Care Organization will be responsible to do the same for Medicaid enrolled providers. The Division of Behavioral Health's Policy unit develops and trains Division of Behavioral Health service providers on program requirements, and the Division's QA unit ensures compliance through QA reviews.

How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?
The Department of Health and Welfare's Division of Behavioral Health uses Block Grant funds and state dollars to pay for Idaho citizens who are uninsured and for services that are not covered by private insurance and/or Medicaid. Comprehensive assessments evaluate proposed service recipients' financial and insurance status. Mental health block grant dollars are used to fund service delivery personnel at Division of Behavioral Health Regional Mental Health Centers and contracts (e.g., Federation of Families and Office of Consumer and Family Affairs).

*SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

   a) What information did you use?

   b) What information was most useful?

3) How have you used information regarding evidence-based practices?

   a) Educating State Medicaid agencies and other purchasers regarding this information?

   b) Making decisions about what you buy with funds that are under your control?

Footnotes:

IV: Narrative Plan

F Use of Evidence in Purchasing Decisions

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Narrative Question: SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions? a) What information did you use? b) What information was most useful?
  - 3) How have you used information regarding evidence-based practices? a) Educating State Medicaid agencies and other purchasers regarding this information? b) Making decisions about what you buy with funds that are under your control?

The Division of Behavioral Health (DBH) encourages use of evidence based or promising practices. Several DBH staff are responsible to track and disseminate information regarding evidence-based or promising practices. The Department of Health and Welfare maintains an on-line learning system. The Knowledge Learning Center (KLC) provides a multitude of courses for Department staff, with many courses offering Continuing Education Units (CEU's). DBH staff have contributed to the development of several courses, including Motivational Interviewing, SAMHSA's Tip 42 and a unit on Gay, Lesbian, Bisexual, Transgender and Questioning (GLBTQ) awareness.

Specific evidence based or promising practices are available in Idaho. Regional Mental Health Centers (RMHC) provide Assertive Community Treatment (ACT) services. Each ACT team includes a Certified Peer Specialist who models recovery and resilience. Data on ACT services and outcomes is tracked through the DBH WITS data system and disseminated through state and federal reporting.

Projects for Assistance in Transition from Homelessness (PATH) programs use PATH Certified Peer Specialists to provide outreach, engagement and case management to adults with serious mental illness who are either homeless or at risk of becoming homeless. Data on these services is tracked and reported through monthly service reports from the contractor (Mountain States Group's Office of Consumer and Family Affairs) and through the PATH Annual Report. The PATH supervisor at Mountain States Group also provides updates on PATH services to the State Planning Council.

The Idaho Home Outreach Program for Empowerment (ID-HOPE) provides the evidence based practice of Critical Time Intervention, with adaptations that include the use of a team with bachelors/masters staff and Certified Peer Specialists. This program also offers seven to fourteen day, community based crisis intervention to ID-HOPE participants as an alternative to hospitalization. Data on services provided, consumer satisfaction and outcomes is collected and reported monthly by the contractor (Human Supports of Idaho) to the Project Director at DBH. Human Supports also works closely with the ID-HOPE Advisory Board, and information on services and outcomes are provided at their quarterly meetings. Monthly reports are also available to Board members. Since November 2012, the ID-HOPE program has received regular technical assistance consultation on sustainability ideas from SAMHSA's William Hudock.

The Recovery Infrastructure Training for Empowerment Transformation Transfer Initiative grant project will work to build a recovery oriented infrastructure for the behavioral health (mental health and substance use)

system. This will be done by building a cadre of Substance Use Disorder (SUD) Recovery Coaches, developing a recovery/trauma toolkit to disseminate in each region, and developing and implementing an action plan toolkit for statewide use. It is hoped that the action plan toolkit will be useful for regional boards to identify critical behavioral health service gaps, develop and implement plans to address those gaps and disseminate information as to the outcomes of those action plans. The RITE-TTI project will be facilitated by two half-time Certified Peer Specialists, who will be responsible to track data and outcomes, complete monthly reports, coordinate project activities and disseminate information about the project's progress and outcomes. The DBH is working closely with the National Association of Mental Health Project Directors (NASMHPD) to develop the RITE-TTI as a promising or evidence based practice that may be used in other states and territories.

Information regarding evidence-based or promising practices has been used in purchasing or policy decisions. Historically, Certified Peer Specialists placed with RMHC ACT teams were hired and supervised through a contract with Mountain States Group's Office of Consumer and Family Affairs. RMHC programs found peers to be a useful addition to ACT teams, and these individuals were directly hired by the Department of Health and Welfare, effective November 19, 2012.

Information regarding evidence-based practices has been used in several ways. Evidence based program information is available to Department staff on the KLC. State Medicaid agencies have been educated on evidence based programs. The State Planning Council includes representation from Medicaid. A key Medicaid behavioral health staff member is an active member of the ID-HOPE board. Critical time intervention and use of peers were included as possible services in the Medicaid Managed Care Request for Proposals.

Regarding purchases, the DBH does use data on service outcomes to make decisions about purchases with funds that they control. Clear data on successful and cost effective service outcomes is increasingly important in a context of limited behavioral health funding. Services that demonstrate good outcomes and cost savings are more likely to be funded.

The substance abuse prevention specialist is responsible for ensuring that all recurring services delivered by community-based prevention providers are appropriate for the target population and have scientific research documenting positive outcomes. Idaho maintains a list of evidence-based programs that are eligible for SSA substance abuse prevention funds. As a part of the application for funds, community-based groups must identify their target population and proposed program. Only organizations proposing to deliver an evidence-based program appropriate for their target population are funded. For community coalitions, funding focuses on the support of community-based and environmental strategies. The most often used community-based strategy is Communities that Care. Environmental strategies recognized by SAMHSA are also eligible activities for coalitions. Compliance with the evidence-based requirement for prevention evaluated annually with the prevention management contractor reviews prevention funding applications. Final approval is made when the SSA prevention specialist reviews the SUD prevention management contractor's proposed funding plan.

Idaho uses the program evaluations located within the National Registry of Evidence-based Programs and Practices as well as previous program outcomes to determine if programs are evidence-based. In order to be included on the Idaho Evidence-based Program list, a program either has to score higher than an average 2.67 on Quality of Research measures and a 3.0 on Readiness to Disseminate measures, or if it is listed on NREPP but has a lower score, the program has to have documented positive outcomes with the population served in Idaho. Community-based processes and environmental strategies are evaluated by reduction in negative behaviors in the community, increased community member awareness and increased coalition participation.

The SSA has shared information on these requirements with the Idaho Office of Drug Policy and other state agencies and branches of government as well as with community coalitions. In order to receive SAPT Block Grant prevention funds, an organization or coalition must propose to use an evidence-based program.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

IV: Narrative Plan

G Quality

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Narrative Question: Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
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Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections – Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

The Data Infrastructure Grant (DIG) notes sent in an e-mail in February 2013 state the following:

"SAMHSA Barometer Update:
The guidelines for the Mental Health Block Grant application indicated that states need to refer to the SAMHSA Barometer for Needs Assessment, which is a report on selected population indicators derived from the NSTA Survey. When the guidelines were developed, it was assumed that the Barometer would be finalized; however, it is not yet finalized. Because it is incomplete at this time, states do not need to refer to the Barometer in their Mental Health Block Grant Applications."

Idaho's responses to this narrative section will be based on best understood information as of February 2013.

What additional measures will your state focus on in developing your State BG Plan (up to three)?

The Division of Behavioral Health proposes to address measures related to prevention and behavioral health (i.e., substance use and mental health) categories. With respect to prevention, the Division will develop and implement a plan to promote annual National Depression Screening day. The Division will also develop and implement a recovery based behavioral health outcomes tool and improve reporting capability on this outcomes tool measure.

Please provide information on any additional measures identified outside of the core measures and state barometer.

The Division of Behavioral Health will use the County Health Rankings and Roadmaps website produced by University of Wisconsin Population Health Institute (funded by the Robert Wood Johnson Foundation and posted annually) to monitor the average number of reports of mentally unhealthy days,

the ratio of population to mental health providers, and the years of potential life lost before age 75 per 100,000 by State and by County. Results will be used to inform the behavioral health planning process.

What are your state's specific priority areas to address the issues identified by the data?

The priority areas identified by the Division of Behavioral Health include 1) access to care, 2) recovery and trauma informed care and 3) integration of behavioral health and primary care services.

What are the milestones and plans for addressing each of your priority areas?

As of February 2013, there were no specific milestones or plans to address each of the identified priority areas. Additional information will be forthcoming at the end of the legislative session in March or April, 2013.

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

IV: Narrative Plan

H Trauma

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Narrative Question: In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Does your state have any policies directing providers to screen clients for a personal history of trauma?

As of February 2013, the Division of Behavioral Health had no formal policies directing providers to screen clients for a personal history of trauma. There are local and state efforts to improve the trauma awareness and capability of behavioral health service providers. The Juvenile Justice Children's Mental Health (JJCMH) group is addressing and educating youth service providers on trauma. All clients receiving publically-funded Substance Use Disorder (SUD) treatment in Idaho must receive a GAIN I assessment. The GAIN I includes a section on assessment of trauma. The Office of Consumer and Family Affairs facilitated trauma workshops in three regions by SAMHSA technical assistance trainers in January 2013. The Recovery Infrastructure Training for Empowerment Transformation Transfer initiative grant project is designed to build a recovery oriented infrastructure for Idaho's behavioral health system. One aspect of this project is a requirement to develop a recovery and trauma curriculum that will be shared with all regional boards and other regional stakeholders.

The Division of Behavioral Health plans to develop standards of care by SFY 2015 that will include trauma. Primary principles of trauma informed care addressed in these proposed standards will include the following:

1) Understanding trauma and its impact
2) Promoting safety
3) Ensuring cultural competence
4) Supporting consumer control
5) Sharing power and governance
6) Integrating care
7) Healing happens
8) Recovery is possible

The Idaho Division of Behavioral Health actively supports the primary principles of trauma-informed care and plans to communicate the core values through the development of policy by the end of SFY 2015 to ensure that all individuals are treated with compassion and respect. The policy will include requirements for screening all individuals seeking treatment for their personal history of trauma. Training will offered to all staff on trauma-informed principles, theory and on trauma-informed practice.

Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

As of February 2013, the Division of Behavioral Health had no formal policies designed to connect individuals with trauma histories to trauma-focused therapy. While there is no formal policy, SUD providers are expected to cover all GAIN I focus areas in the client's individualized service plan. If trauma is an identified concern and the SUD provider does not have trauma-informed care expertise, there is an expectation that the provider will refer to another provider who does have that expertise.

Does your state have any policies that promote the provision of trauma-informed care?

As of February 2013, the Division of Behavioral Health had no formal policies promoting the provision of trauma-informed care.

What types of evidence-based trauma-specific interventions does your state offer across the life-span?

There are local and state efforts to improve the trauma awareness and capability of behavioral health service providers. The Juvenile Justice Children's Mental Health (JJCMH) group is addressing and educating youth service providers on trauma. The Office of Consumer and Family Affairs facilitated trauma workshops in three regions by SAMHSA technical assistance trainers in January 2013. Trauma and other training is coordinated by the SUD treatment Management Services Coordinator for their providers. The Recovery Infrastructure Training for Empowerment Transformation Transfer initiative grant project is designed to build a recovery oriented infrastructure for Idaho's behavioral health system. One aspect of this project is a requirement to develop a recovery and trauma curriculum that will be shared with all regional boards and other regional stakeholders.

What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

There are local and state efforts to improve the trauma awareness and capability of behavioral health service providers. The Juvenile Justice Children's Mental Health (JJCMH) group is addressing and educating youth service providers on trauma. The Office of Consumer and Family Affairs facilitated trauma workshops in three regions by SAMHSA technical assistance trainers in January 2013. Trauma and other training is coordinated by the SUD Management Services Coordinator for SUD providers. The Recovery Infrastructure Training for Empowerment Transformation Transfer initiative grant project is designed to build a recovery oriented infrastructure for Idaho's behavioral health system. One aspect of this project is a requirement to develop a recovery and trauma curriculum that will be shared with all regional boards and other regional stakeholders. The substance abuse prevention providers have been provided access to webinars on early childhood trauma and the SSA and the Office of Drug Policy are working on development of a webinar library which enable prevention professionals as well as community members to access this information at their earliest convenience.

Input from Idaho Citizens: Several activities were implemented in January/February 2013 in an effort to solicit input from Idaho citizens into the development of the SFY 2014-2015 Combined SAPT/MH Block Grant. The need to develop the plan was presented to the State Planning Council on Mental Health at their January 2013 quarterly meeting, with a request to provide input through a specific block grant survey link on the external Department of Health and Welfare (DHW) website. Regional Division of Behavioral Health program managers were encouraged to respond to the website, and to share the invitation with local providers and, regional boards. The Division of Behavioral Health communicated with the Director of the Idaho Division of Vocational Rehabilitation (IDVR) and requested their input into the plan. The IDVR Director also contacted leaders of four Tribes that IDVR works well with, and invited them to also participate in responding to questions posted on the external DHW website. An internal Division of Behavioral Health survey also solicited input on block grant planning for SFY 2014-2015. Responses from the internal and external websites were incorporated into the narrative sections of the SFY 2014 -2015 Plan.

There were several citizen responses to the trauma questions on the external website. Recommendations were made to use existing materials (e.g., Seeking Safety, STEPPS and Cognitive Behavioral Therapy) for time limited and repeated groups, and to follow the National Child Traumatic Stress Network guidelines for service delivery. One person expressed a concern that "Unfortunately the Idaho legislature voted to remove funding for Collateral Contact, which enables family members to be encouraged to participate in treatment plans." Another suggested that training be developed to fit different practice levels (e.g., assisted living care, psychosocial rehabilitation, peer support, clinical therapy), regional training be provided on a regular basis and patient outcomes be tracked to assess the effectiveness of each approach. An Idaho provider indicated that "The ISU Better Todays/Better Tomorrows gatekeeper education program provides a base for understanding child trauma. ISU also has provided several webinars that were accessible to Idaho clinicians on trauma treatments. More funding is needed to continue and expand these training opportunities." One citizen emphasized the importance of including trauma education for emergency room personnel and state and local law enforcement and another stressed that financial support to provide and attend trauma training events must be identified.

Several comments were made about trauma policies. Citizens indicated that trauma informed care training should be provided before policies are developed. One individual suggested that it might be useful to add a trauma training aspect to provider licensing requirements. Another recommended working with colleges and universities to train students on trauma informed care before they go to work in the field. Use of a fidelity scale in credentialing reviews was also recommended.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. [42,43] Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

IV: Narrative Plan

I Justice

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Narrative Question: The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. [42,43] Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44] A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

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Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

Idaho has not yet determined if they are going to expand Medicaid. Therefore, detailed plans are not developed. Preliminary work has started to evaluate the criminal/juvenile justice populations covered under an expanded Medicaid and how those potentially eligible individuals would be enrolled. The Division of Behavioral Health collaborates regularly with the adult and juvenile justice systems on how best to resource the necessary care and treatment of Idaho's offender population. Idaho Code dictates that the State Mental Health Authority (SMHA) and Single State Authority (SSA) have a defined role in the planning, coordination and delivery of behavioral health services to the criminal justice population under alternative community sentences.

As of February 2013, plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as part of coverage expansions were not clear. Juvenile justice does not access 4E funding. There may be additional information available on this issue at the end of the SFY 2013 legislative session in April 2013.

Describe the screening and services that are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders.

For adults, Idaho Code authorizes judges to refer clients prior to adjudication for Substance Use Disorders (SUD) and Mental Health (MH) assessments (see Idaho Statutes19-2524, 18-211/212). With respect to juveniles, Idaho judges and prosecutors have the option to order a 20-511A assessment for mental illness and treatment services at any point in the legal process when they believe a juvenile may have a mental illness diagnosis that may interfere with their ability to comply with the law. The 20-511A process requires the Department of Health and Welfare to complete a mental health assessment and report the findings of that assessment to the court. The court may order a plan of treatment for the youth if it determines that such a need exists. Idaho Code is currently being revised to implement evaluation for all felons prior to sentencing and treatment as indicated by the evaluation if a community sentence.

The Division of Behavioral Health transfers funds annually to Department of Juvenile Corrections (DJC) to support a project that places a clinician in each of the juvenile detention facilities. Juveniles admitted to an Idaho juvenile detention facility are required to complete the Alaska Screener assessment tool. Depending on the results of this assessment, a follow-up communication may occur with the family and the youth to determine if additional assistance is required.

Idaho is piloting an early intervention program which in some districts serves adolescents in diversion programs. This program includes a GAIN short screener in the assessment process which is used to determine appropriateness for this level of care.

Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

The Idaho State Mental Health Authority (SMHA) and Single State Authority (SSA) coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental health and/or substance use disorders through mental health and drug court processes. Each region of the state of Idaho has at least one mental health court. Participants often have both mental health and substance use disorder diagnoses.

Coordination between the SMHA, the SSA and the criminal and juvenile justice system for behavioral health services provided in correctional facilities is identified in statutes (i.e., 19-2524, 18-211, 18-212). The governor appointed members of the Behavioral Health Interagency Committee charged with transforming Idaho's behavioral health system includes representation from adult corrections, juvenile corrections and the courts. The Juvenile Justice Children's Mental Health group meets regularly, with representation from the Division of Behavioral Health. This group has some influence on policy development for shared populations. The Department of Juvenile Corrections has funding and authority to provide substance use and mental health treatment services to youth in their care. Treatment services include both direct treatment as well as re-entry prevention programs. The Access to Recovery (ATR) program provides treatment services to adult misdemeanants that are supervised through the adult corrections system. The Department of Health and Welfare and the courts collaborate in ensuring that there is no duplication of treatment services and in problem solving identified gaps in service delivery. In

addition the SSA's prevention intervention program is partnering with juvenile probation and the courts in several locations in Idaho. This program has been offered to youth in diversion in an effort to keep them from escalating their substance use and negative behaviors. The program components include an intake assessment, education program, support group and recovery support plan. For 2014 this level of care will be expanded and made available to all adolescents served by the SSA.

Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

Idaho efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems. Judges can order mental health and/or substance use assessments and treatment. Individuals may enter the system through several avenues. These include probation, mental health courts, drug courts and other diversion courts (e.g., juvenile, veterans). Decisions made in the SFY 2013 legislature regarding health care reform and establishment of health insurance exchanges may also impact future enrollment and care coordination efforts for these individuals.

What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

The Division of Behavioral Health participates in Crisis Intervention Training (CIT) in many areas of the state. The CIT program involves cross-training of first responders from law enforcement and behavioral health. The Division produced a first responders training curriculum for law enforcement officers responding to behavioral health related situations. Training on behavioral health topics is offered in the law enforcement pre-service academy. The Idaho Department of Correction and the Idaho Department of Health and Welfare collaborate in an effort to provide better care to offenders with behavioral health diagnoses. These efforts include a significant investment in problem-solving courts (e.g., mental health courts, drug courts, juvenile courts and veteran's courts).

The private substance use disorder (SUD) treatment provider network works with both criminal justice and non-criminal justice clients to seek training and supervision covering both populations. The annual Idaho Conference on Alcohol and Drug Dependencies (ICADD) provides training tracks for behavioral health and criminal/juvenile justice personnel and treatment providers. Clinicians placed at juvenile detention facilities provide in-service training to juvenile justice personnel on ways to recognize and work with youth who are diagnosed with a mental illness or serious emotional disorder. Regional mental health staff coordinate treatment for shared individuals with adult and juvenile corrections programs, and sometimes have office space in corrections facilities. Education and collaboration are common among line staff and leadership of these organizations. Services include training, consultation and treatment.

Input from Idaho Citizens: Several activities were implemented in January/February 2013 in an effort to solicit input from Idaho citizens into the development of the SFY 2014-2015 Combined SAPT/MH Block Grant. The need to develop the plan was presented to the State Planning Council on Mental Health at their January 2013 quarterly meeting, with a request to provide input through a specific block grant survey link on the external Department of Health and Welfare (DHW) website. Regional Division of Behavioral Health program managers were encouraged to respond to the website, and to share the invitation with local providers and regional boards. The Division of Behavioral Health communicated with the Director of the Idaho Division of Vocational Rehabilitation (IDVR) and requested their input into the plan. The IDVR Director also contacted leaders of four Tribes that IDVR works well with, and invited them to also participate in responding to questions posted on the external DHW website. An internal Division of Behavioral Health survey also solicited input on block grant planning for SFY 2014-

2015. Responses from the internal and external websites were incorporated into the narrative sections of the SFY 2014 -2015 Plan.

There were several citizen responses to the justice section of the block grant application. One individual said that "At one time, there were court ordered assessments provided to the juvenile court judge in the area. It was felt this was too costly and was stopped. Later, they began a screening assessment. The difficulty with screening assessments is that it is a cursory snapshot of the individual and does not cross check data or effectively gather data from multiple sources. Until screening tools are replaced by in depth assessment, the material gathered…will be very limited in truthfulness or usability. A whole person assessment is ideal." Another commented that "Screening and appropriate services need to be available and provided to children long before they are facing adjudication and/or sentencing. We are addressing these issues far too late. What are we doing to ensure universal screening of children/youth in primary care before they get in trouble with the law? What are we doing to reduce self-inflicted injury among children/youth?"

One respondent noted that "The Department of Health & Welfare is virtually the only interface with the Judiciary in our present system of care. It would be helpful if people were able to access care long before they end up as clients of the courts or the inpatient facilities. That said, people that are served by the court system need access to the wide range of community supports for their mental health. It appears that people without Medicaid are limited to what the state provided mental health system is able to provide." Another citizen expressed his or her opinion that "Without a fundamental understanding of mental illness and substance abuse as physiological and psychological and preventable and treatable, government entities will continue to basically criminalize symptoms and to thus perpetuate such occurrences."

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

IV: Narrative Plan

J Parity Education

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Narrative Question: SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Describe how Idaho can or will use their dollars to develop communication plans to educate and raise awareness about parity

The Idaho State Behavioral Health Authority (SBHA; formerly SMHA and SSA) has not yet developed communication plans to educate and raise awareness about parity. Decisions about how Idaho will use funds to develop communication plans to educate and raise awareness about parity will be affected by decisions made in the SFY 2013 legislature. One legislative proposal, SB 1114, would allow for establishment of a state Behavioral Health Planning Council and Regional Behavioral Health Boards. The Council will be charged with advocating for citizens with behavioral health diagnoses; advising the state behavioral health authority on concerns, policies and programs; providing input into the state's behavioral health systems plan; monitoring and evaluating allocation and adequacy of behavioral health services and state laws; ensuring those with behavioral health diagnoses have access to prevention and treatment services; and presenting an annual report to the Governor. The described SB 1114 role for Regional Behavioral Health Centers is to "…provide or arrange for the delivery of services that…will lead to the establishment of a comprehensive regional behavioral system of care. If the proposed legislation passes, it is conceivable that the Behavioral Health Planning Council, the Regional Behavioral Health Boards and the Division of Behavioral Health will collaborate to develop communication plans about parity.

Describe how Idaho can or will coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.)

Proposed legislation (SB 1114), if approved, will create governmental Regional Behavioral Health Boards in each of the seven regions of the state. These Regional Behavioral Health Boards will have a role in their communities to educate and raise awareness and understanding about benefits. Details on this issue have yet to be determined because Idaho has not embraced the Affordable Care Act (ACA).

The Division of Behavioral Health uses block grant funds to contract with the Federation of Families. The Federation disseminates a web based newsletter that includes information about awareness and understanding of benefits. The efforts of regionally trained SSI/SSDI Outreach, Access and Recovery (SOAR) staff have significantly increased the number of individuals accessing benefits to which they are eligible and entitled. The Projects for Assistance in Transition from Homelessness (PATH) Certified Peer Specialists provide outreach and case management to those who have a serious mental illness and who are at risk of becoming homeless. The Idaho Home Outreach Program for Empowerment (ID-HOPE) program uses a staff mix of Certified Peer Specialists and bachelors/masters level staff to provide Critical Time Intervention (CTI) services. PATH Peer Specialists and ID-HOPE staff are SOAR trained, and they use these skills to assist program participants applying for benefits.

The Managed Care Organization (MCO) is expected to be implemented according to the Per Member Per Month (PMPM) model, which translates to the idea that maximum provider enrollment equals maximum potential for benefits and profit. Efforts to maximize provider enrollment offer an incentive for the MCO to provide education to an assortment of public and private sector agencies on benefits and options.

Describe the steps and processes that can be taken to ensure that a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity

Several steps and processes may be taken to ensure that broad and well planned outreach activities are offered to relevant audiences that are directly impacted by parity, however these plans and activities are on hold until Idaho determines how to proceed with ACA implementation. Detailed plans for strategic outreach may also be impacted by the emerging role of the Regional Behavioral Health Planning Council and the Regional Behavioral Health Boards, if SB 1114 proposed legislation is approved. The Federation of Families offers a monthly web-based newsletter. This newsletter reaches a wide audience and may include information on benefits or opportunities to learn more about benefits. Another project that may assist with this is the Recovery Infrastructure Training for Empowerment Transformation Transfer Initiative (RITE-TTI) project that was awarded to the Department in December 2012. The RITE-TTI project seeks to build an infrastructure for a recovery oriented system of behavioral health care across the state of Idaho. The RITE-TTI project will train representatives from each region in Recovery Coaching, with a cadre of participants trained as trainers. Participants will be recruited from each region to participate in two toolkit development teams. The Recovery/Trauma toolkit team will build on existing recovery and trauma research to develop a recovery/trauma curriculum for Idaho. The Action Plan toolkit team will be tasked with developing a curriculum that will outline steps for regional boards or other groups to take to help them to identify gaps, develop and implement action plans to address those needs and to track and disseminate data on action plan outcomes. Each team will be responsible to share curriculums and training with their respective regional boards and other stakeholders.

Input from Idaho Citizens: Several activities were implemented in January/February 2013 in an effort to solicit input from Idaho citizens into the development of the SFY 2014-2015 Combined SAPT/MH Block Grant. The need to develop the plan was presented to the State Planning Council on Mental Health at their January 2013 quarterly meeting, with a request to provide input through a specific block grant survey link on the external Department of Health and Welfare (DHW) website. Regional Division of Behavioral Health program managers were encouraged to respond to the website, and to share the invitation with local providers and regional boards. The Division of Behavioral Health communicated with the Director of the Idaho Division of Vocational Rehabilitation (IDVR) and requested their input into the plan. The IDVR Director also contacted leaders of four Tribes that IDVR works well with, and invited them to also participate in responding to questions posted on the external DHW website. An internal Division of Behavioral Health survey also solicited input on block grant planning for SFY 2014-2015. Responses from the internal and external websites were incorporated into the narrative sections of the SFY 2014 - 2015 Plan.

Concerns were expressed about the lack of communication networks in rural communities. One respondent noted that "In the rural areas, there are not enough people who know how to seek assistance or to drive the financial needs to have rural areas paid much attention." Another commented on the importance of including education and awareness-building about parity in all communication about insurance exchanges. One person suggested that SAMHSA could use market research results to "…create camera-ready…materials…and make them available for states to customize."

Another recommended that states survey citizens to assess parity needs. This person added concerns about access to care, especially in health professional shortage areas of the state that have difficulty attracting and retaining providers. One suggestion was to market information about parity through newsletters, public meetings and announcements. More specifically, one person stated that "Representatives will need to get out into the communities and hold forums to educate, identify barriers, learn of unintended consequences and develop policy that is congruent with the needs of stakeholders."

Requests were made to ensure that family members were involved in the process, and that they be educated so that they could assist with advocacy and support efforts. There was a specific comment about including families of inmates, adjudicated persons, mental health court and screened individuals. Idaho's National Alliance for the Mentally Ill (NAMI) provides family education and support, and one citizen recommended that judges require attendance at NAMI events in the same way they require AA participation. One person recommended expansion and publication of the NAMI 'In Our Voice' program, and use of public television to schedule NAMI materials.

Suggestions were made to develop a strategic plan to provide parity education before starting to create tools. Understanding the market allows for development and implementation of a more successful plan to meet the unique needs of Idaho citizens. One comment was that "The process should be focused in each state to meet the unique needs of its residents. As people start to learn about insurance exchanges, information about parity should be visible and clear. If I buy xx insurance, I will get yy coverage for mental health. In addition, most people do not know what "parity" is and understand they are entitled to it. Surveying the public, preferably by state, would identify the needs of the target audience and better frame any messages developed." One individual recommended a publication that clearly identifies direct and indirect costs to the state and to counties that are related to mental health issues of those without health care.

Communication was recommended as a means of sharing information about parity. One individual said, "An example of a positive effort is several presentations by Ross Edmunds to the Regional Boards and RACS on the redesign of the Community Development boards. These meetings went a long way to develop support for the shift and learn about concerns." Another stated that "The stigma of going to behavioral health services is drastically reduced if the patient can briefly meet and initiate a relationship with a particular service provider." Yet another recommended collaborations with private providers, schools and disability organizations (e.g., such as the State Independent Living Council or the Consortium of Idahoans with Disabilities).

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

6. Describe how your behavioral health providers are screening and referring for:

   a. heart disease,

   b. hypertension,

   c. high cholesterol, and/or

   d. diabetes.

Footnotes:

IV: Narrative Plan

K Primary and Behavioral Health Care Integration Activities

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Narrative Question: Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Describe your involvement in the various coordinated care initiatives that your state is pursuing

Information about a health insurance exchange in Idaho will be clearer after the legislature concludes in March or April 2013. Without knowing what type of exchange will be funded, it is difficult to extrapolate details of a system beyond the concept that the Division of Behavioral Health services will continue to serve as the backstop for those between or without benefits. The Division of Behavioral Health will continue to be a partner in the process. The Medicaid Managed Care Organization (MCO) contract was awarded to OptumHealth in February 2013. The Division of Behavioral Health anticipates opportunities to collaborate with the Medicaid MCO to implement a range of coordinated care initiatives in Idaho. The State Behavioral Health Authority (SBHA; formerly SMHA and SSA) falls under the same Department as Medicaid. The SBHA is fully engaged with Medicaid in the initiatives listed above.

The Division of Behavioral Health is in the process of contracting for a new management services contractor for the substance use delivery system. Assurance that providers are screened for eligibility, assistance with enrollment and billing third party or other insurance prior to drawing down block grant dollars for services will be a requirement of the new management services contract, and therefore part of their subcontract with network providers. The SUD Management Services Contractor will be responsible to track participant demographics and to work with enrolled providers to provide appropriate services and referrals for participating individuals.

Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

As of February 2013, there were no specific coordinated care initiatives being developed or implemented, other than those described above.

Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

Many of these critical processes and coordination fall under the Affordable Care Act (ACA) and Idaho has not yet embraced the ACA. In Idaho, Community Resource Development Specialists (CRDS) in each region assist citizens to understand and negotiate system resources in their communities, and they will continue to provide this assistance to those with behavioral health diagnoses. Individuals receiving Substance Use Disorder (SUD) treatment and recovery support services through the management services contractor will receive evaluations from that contractor to assess and assist eligible individuals to apply for Medicaid or other benefits that they may qualify to receive. Idaho has a strong SSI/SSDI Outreach, Access and Recovery (SOAR) program with SOAR trained staff in each region of the state, and these SOAR trainers will also help individuals to access benefits that they are entitled to receive.

The Children's Health Improvement Collaborative (CHIC) five year Centers for Medicare and Medicaid grant allows for a partnership between Idaho and Utah to "…improve health outcomes and satisfaction among children and families in both states." This project has already worked with health centers, health districts, hospitals and private practices to provide learning collaborative opportunities related to asthma, with plans to implement another on immunization rates. The project also supports a patient centered medical home demonstration project with Primary Health Medical Group (Boise), St. Luke's Developmental Pediatrics (Boise) and Coeur d'Alene Pediatrics (Coeur d'Alene, Hayden, Post Falls). For further information on this project, go to http://www.healthandwelfare.idaho.gov/Medical/Medicaid/ChildrensHealthcareImprovementCollaboration/tabid/1894/Default.aspx .

Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

The Division of Public Health's Tobacco Prevention site provides data on Idaho tobacco use, health hazards and expectations after smoking cessation. The Department of Health and Welfare's Division of Public Health Tobacco Prevention site can be accessed at the following link: http://www.healthandwelfare.idaho.gov/Health/TobaccoPreventionandControl/tabid/324/Default.aspx. The site also provides information on free resources to help with smoking cessation. Resources include a link to the website Quitnow.net/Idaho, access to free nicotine replacement therapy products and links to the Project Filter Cessation Brochure and the "Going Smokefree Toolkit. In 2013, Idaho will send packets to all SUD treatment providers covering the cessation resources available through the Division of Public Health. The packet will include a fact sheet on accessing the resources as well as materials that can be given to clients to enable them to receive the free resources.

Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

Currently, the SSA uses the Global Appraisal of Individual Needs (GAIN) tool to assess service needs for all incoming SUD treatment clients. The GAIN includes a section which assesses tobacco use. Idaho will continue to use this tool to evaluate need for tobacco cessation services. Tobacco cessation resource materials will be made available for clients with tobacco addictions.

Describe how your behavioral health providers are screening and referring for a. heart disease, b. hypertension, c. high cholesterol, and/or d. diabetes.

Division of Behavioral Health service providers are required to use the Common Assessment tool. The Common Assessment assesses information related to health. The Behavioral Risk Factor Surveillance System (BRFSS) questions are also used on the MHSIP adult consumer survey. Assessment data is used to guide referrals for physical health issues. The Behavioral Health Medication Management program assesses basic physical health concerns during regularly scheduled medication check-up appointments. If necessary, an assigned case manager may follow-up with a referral to a primary health care provider. Both State Hospital South and State Hospital North provide thorough physical and dental assessments for hospitalized individuals. The state hospitals collaborate with Regional Mental Health Centers (RMHC) to ensure community based referrals to appropriate primary health care resources after hospital discharge.

Input from Idaho Citizens: Several activities were implemented in January/February 2013 in an effort to solicit input from Idaho citizens into the development of the SFY 2014-2015 Combined SAPT/MH Block Grant. The need to develop the plan was presented to the State Planning Council on Mental Health at their

January 2013 quarterly meeting, with a request to provide input through a specific block grant survey link on the external Department of Health and Welfare (DHW) website. Regional Division of Behavioral Health program managers were encouraged to respond to the website, and to share the invitation with local providers and regional boards. The Division of Behavioral Health communicated with the Director of the Idaho Division of Vocational Rehabilitation (IDVR) and requested their input into the plan. The IDVR Director also contacted leaders of four Tribes that IDVR works well with, and invited them to also participate in responding to questions posted on the external DHW website. An internal Division of Behavioral Health survey also solicited input on block grant planning for SFY 2014-2015. Responses from the internal and external websites were incorporated into the narrative sections of the SFY 2014 -2015 Plan.

On the topic of primary and behavioral health care integration activities, Idaho citizens offered several thoughts. One parent offered that "I am my son's care coordinator. No one else is provided by insurance, government, or private means. I participate on my regional behavioral health board, am active in addressing concerns through the legislature and am active in provider organizations. I will be involved and affected by Medicaid Managed Care." With respect to tobacco use, one parent indicated that "…my son was encouraged to develop the habit of smoking while in mental health facilities…mental health professionals claim that smoking satisfies a medication need and don't fully commit to its eradication in our culture."

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

IV: Narrative Plan

L Health Disparities

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Narrative Question: In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities. While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Describe how Idaho will track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age

Data on access or enrollment in services, types of services and outcomes by race, ethnicity, gender, age and LGBTQ will be tracked in several ways. State Mental Health Authority (SMHA) services provided through Regional Mental Health Centers (RMHC) will be tracked through comprehensive intakes and assessments that have data entered into the Division of Behavioral Health's Web Infrastructure for Treatment Services (WITS) electronic health record system. Substance use disorders treatment services will be tracked by the Substance Use Disorder (SUD) Treatment Management Services contractor identified in the current Request for Proposal process. Individuals receiving Medicaid services will be tracked by the Medicaid Managed Care organization. Access to substance abuse prevention services will be tracked through demographic data on individuals participating in recurring services and through funding applications identifying specific populations to be served in single service activities.

Describe how Idaho will identify, address and track the language needs of disparity-vulnerable subpopulations

Data on language needs of disparity-vulnerable subpopulations will be tracked in several ways. SMHA services provided through Regional Mental Health Centers (RMHC) will be tracked through comprehensive intakes and assessments that have data entered into the Division of Behavioral Health's Web Infrastructure for Treatment Services (WITS) electronic health record system. Substance use disorder treatment services will be tracked by the Substance Use Disorder (SUD) Treatment Management Services contractor identified in the current Request for Proposal process. Individuals receiving Medicaid services will be tracked by the Medicaid Managed Care organization. Language needs for individuals in substance abuse prevention services are tracked through two processes. The funding applications must identify the population(s) to be served and the language in which services will be delivered. In addition, substance abuse prevention providers are required to notify the contract manager if they have a client with special language needs which includes not only speaking languages other than English, but also need for sign language.

Describe how Idaho will develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations

Efforts to address and eventually reduce disparities in access, service use and outcomes for the above disparity vulnerable subpopulations will be addressed through collaboration between several agencies. The Division of Behavioral Health's RMHCs offer services and materials in English and Spanish, and also offer translator services in other languages. Regions have access to Telecommunications Devices for the Deaf (TDD) technology to help communicate with those who are deaf or hard of hearing, and some regions have staff who sign. While the major second language in Idaho is Spanish, Idaho is also home to many refugees who speak other languages. Collaboration with refugee agencies and resources will be key to providing good services to these individuals. The SUD Treatment Management Services Contractor will be responsible to track client demographics and to work with enrolled providers to provide appropriate services to each individual. The Medicaid Managed Care organization will be responsible to do the same for enrolled Medicaid participants. Idaho will continue to address language needs for individuals in substance abuse prevention services using two processes. Annual review of language needs will enable the substance abuse prevention system to identify new needs and additional resources.

Describe how Idaho will use Block Grant funds to measure, track and respond to these disparities

The Division of Behavioral Health's (DBH) WITS data system tracks demographic data to all who receive adult and children's behavioral health services through DBH Regional Mental Health Centers. By SFY 2014, all SUD Treatment providers will be required to enter data into the WITS system as well. For substance abuse prevention services, the Division will continue to collect language needs as a part of funding applications as well as through tracking participant requests for language assistance including sign language. As disparities are identified from data reports as to service access and outcomes, the Division of Behavioral Health will use block grant funds to identify service improvements designed to reduce these disparities and improve access and services to those identified subpopulations.

Input from Idaho Citizens: Several activities were implemented in January/February 2013 in an effort to solicit input from Idaho citizens into the development of the SFY 2014-2015 Combined SAPT/MH Block Grant. The need to develop the plan was presented to the State Planning Council on Mental Health at their January 2013 quarterly meeting, with a request to provide input through a specific block grant survey link on the external Department of Health and Welfare (DHW) website. Regional Division of Behavioral Health program managers were encouraged to respond to the website, and to share the invitation with local providers and regional boards. The Division of Behavioral Health communicated with the Director of the Idaho Division of Vocational Rehabilitation (IDVR) and requested their input into the plan. The IDVR Director also contacted leaders of four Tribes that IDVR works well with, and invited them to also participate in responding to questions posted on the external DHW website. The Office of Drug Policy, which will be taking over management of substance abuse prevention services in 2014, collected input from members of the Community Coalitions of Idaho, the Strategic State Prevention Workgroup and other state agencies including Department of Education, Specialized Student Services. An internal Division of Behavioral Health survey also solicited input on block grant planning for SFY 2014-2015. Responses from the internal and external websites were incorporated into the narrative sections of the SFY 2014 -2015 Plan.

There were several comments from Idaho citizens in response to questions about health disparities. One individual noted that some individuals have learning disabilities that may require adaptation of treatment materials to help them learn. Another recommended additional providers that are fluent in Spanish as

well as bi-culturally competent, especially in southwest, south central and eastern Idaho. Consideration of nutrition, on-line treatment and alternative therapies was suggested by one individual. Another suggested that Medicaid support the costs of using interpreters at a rate that "…recognizes the administrative costs to billing the services and provides a rate the supports the needs of quality interpreters (such as travel time and missed appointments due to client no-shows). The DBH could extend this reimbursement to non-Medicaid services..." One respondent noted the importance of integrating behavioral and primary health providers in community settings, and another recommended additional work with refugee and tribal groups.

One citizen identified service disparities related to rural and frontier areas of the state that have fewer resources and increased transportation burdens. It was recommended that "First, the state should advocate with SAMHSA to insert "rural" and "frontier" into its list of health disparity populations! Reducing disparities should be done at the local level. The state should support and facilitate communities in identifying the needs, gaps and barriers and designing local approaches to address health disparity populations. As is true in answering all the questions in this survey, the state can identify the need based on data, but the state's role should then shift to facilitating community solutions." It was suggested that media could be better used to provide community education and awareness that recovery is possible.

It was noted by one respondent that disparities differ, and it is best to meet the person where they are and "make 'any door the right door' by locating providers from different fields in the same location. Evaluation also plays a key role here in identifying ongoing barriers to access, service use and outcomes…" One person suggested collaborations with the Human Rights Commission, senior centers and GLTBQ organizations in each community. Another recommended working with community leaders and disparity communities to identify strengths and service gaps, and then working with them to identify and implement solutions to the challenge areas. One citizen indicated that "The approach has to be multi-level. Disparities should be tracked at the patient, the program and the system levels…another important consideration is integrating information across databases…[to]…help research and evaluations.."

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

IV: Narrative Plan

M Recovery

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Narrative Question: SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

As of February 2013, Idaho did not have a definition of recovery and a set of recovery values and/or principles that were vetted with key stakeholders, including people in recovery. The Division of Behavioral Health is dedicated to creating a recovery oriented system of behavioral health care. The Division was awarded one of ten Transformation Transfer Initiative grants in December 2012. The Recovery Infrastructure Training for Empowerment Transformation Transfer Initiative (RITE-TTI) grant project is designed to help build a recovery infrastructure in Idaho. This project will provide Recovery Coaching training to develop a cadre of those in SUD recovery to complement the existing and growing group of MH Certified Peer Specialists; it will recruit a team of MH and SUD stakeholders and Community Resource Development Specialists from each region to work on a Recovery/Trauma toolkit development team and another to work on an Action Plan development team. The toolkit teams will be expected to research existing materials and develop curriculums that are adapted for use in Idaho. This project is fully sustainable, as Recovery Coaching Trainers will be able to provide additional training after the grant ends, and toolkit teams can share their curriculums with regional boards and other stakeholders. Once a strong recovery infrastructure has been established, it is hoped that the next steps will be to develop and adopt a definition of recovery and a set of recovery values and principles.

Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

The Office of Consumer and Family Affairs (OCAFA) has a director who has lived experience with recovery. She is the director of OCAFA and also the current chair of the State Planning Council on Mental Health. OCAFA established the Peer Specialist Certification Program (based on the Appalachian group model) in October 2009. Since then, over 130 peers have been trained and certified. Certified peer specialists work in several programs. The Projects for Assistance in Transition from Homelessness (PATH) program uses two half time peers per region to provide PATH outreach, engagement and case management. Peer specialists are also placed at the two state hospitals, where they help with discharge planning for those who may be at risk of becoming homeless upon discharge. The Idaho Home Outreach Program for Empowerment (ID-HOPE) program provides evidence based Critical Time Intervention (CTI) services in Region 4 through a Centers for Mental Health Services (CMHS) Transformation grant. The CTI model for ID-HOPE is adapted in two ways. The team is composed of a mix of bachelors/masters level staff and Certified Peer Specialists. ID-HOPE participants who have a crisis may receive 7-14 days of intensive, community based crisis intervention services by ID-HOPE staff as an alternative to hospitalization. As of November 19, 2012, the half-time Certified Peer Specialists that were hired by OCAFA to work on Assertive Community Treatment (ACT) teams were directly hired by regional Division of Behavioral Health programs in each region of the state. The RITE-TTI project (see first question and response) will be facilitated by two half-time Certified Peer Specialists.

Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Idaho's behavioral health system promotes the use of person centered planning and participant directed care. The Division of Behavioral Health's Regional Mental Health Centers are directed to ensure that program participants are actively involved in treatment planning and development. The Substance Use Disorders (SUD) Management Services Contractor has expectations that enrolled and approved SUD service providers must engage participants in person centered planning.

All youth receiving services in state-approved substance use disorder treatment programs must have an individualized treatment plan that addresses the substance use, co-occurring mental health disorders, physical health as well as other problems affecting the youth's major life areas. The development of a treatment plan must be a collaborative process involving the youth, family members, and other support and service systems. All youth receiving Behavioral Health-funded substance use disorders treatment are assessed using the GAIN which assesses all life areas, not only substance use, thus ensuring the youth and their clinician have the information they need to develop a comprehensive care plan.

Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

Idaho's Division of Behavioral Health is engaged in a process of developing a behavioral health system of care that offers a variety of recovery supports and services to meet the holistic needs of those seeking or in recovery. Community Resource Development Specialists (CRDS's) are available in every region to help citizens navigate through community resource options. Certified peer specialist training is offered twice a year, with individuals with mental health diagnoses recruited from each region for each training opportunity. The Recovery Infrastructure Training for Empowerment Transformation Transfer Initiative (RITE-TTI) project includes the training of SUD peers in Recovery Coaching, which will allow SUD peers similar opportunities to work and model recovery and resilience. Another aspect of the RITE-TTI project is the development of a Recovery/Trauma toolkit curriculum that can be used to educate and raise awareness of these issues across the state of Idaho. The Peer Run Center for Hope in Region 4 offers opportunities for those with behavioral health diagnoses in recovery to socialize with others and to participate in the learning and fun activities that the Center offers. The Center is run solely by peers. Idaho was without a suicide hotline until fall 2012. At that time, a suicide hotline was established through a contract with Mountain States Group. The National Alliance for the Mentally Ill (NAMI) provides a variety of family member education and support services, including the Family to Family education training. The OCAFA arranges for regular education opportunities for consumers. Past training events have included Mental Health First Aid, Wellness Recovery Action Planning, Trauma Informed Care and SSI/SSDI Outreach Access and Recovery (SOAR) training events.

Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Idaho's plan does not specifically include strategies to implement peer-delivered services tailored to specific populations such as veterans, people with trauma, members of racial/ethnic groups, LGBT populations and families/significant others.

Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

The Division of Behavioral Health has provided training for professional workers at Regional Mental Health Centers on recovery principles and recovery-oriented practice and systems, and the new SUDS Management Services Contractor is expected to do the same for enrolled SUDS service providers. The RITE-TTI project activities are designed to build a recovery oriented infrastructure for the Idaho behavioral health system, with final deliverables that include SUD peers trained in Recovery Coaching, a Recovery/Trauma toolkit curriculum and an Action Plan toolkit curriculum. The Division's Regional Mental Health Centers directly hired their own part-time Certified Peer Specialists to work on regional Assertive Community Treatment teams in November 2012.

Does the state have an accreditation program, certification program, or standards for peer-run services?

Idaho does have a 40 hour Certified Peer Specialist training and certification program that is modeled on the Appalachian Group's training and certification. Certified Peer Specialists are also encouraged to take Wellness Recovery Action Plan (WRAP) training, and to use personal WRAPS to help with personal recovery goals. As of February 2013, there were no written standards for peer-run services.

Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

The Division was awarded one of ten Transformation Transfer Initiative grants in December 2012. The Recovery Infrastructure Training for Empowerment Transformation Transfer Initiative (RITE-TTI) grant project is designed to help build a recovery infrastructure in Idaho. This project will provide Recovery Coaching training to develop a cadre of those in SUD recovery to complement the existing and growing group of MH Certified Peer Specialists; it will recruit a team of MH and SUD stakeholders and Community Resource Development Specialists from each region to work on a Recovery/Trauma toolkit development team and another to work on an Action Plan development team. The toolkit teams will be expected to research existing materials and develop curriculums that are adapted for use in Idaho. This project is fully sustainable, as Recovery Coaching Trainers will be able to provide additional training after the grant ends, and toolkit teams can share their curriculums with regional boards and other stakeholders. RITE-TTI project activities will be facilitated by two half time Certified Peer Specialists.

The Office of Consumer and Family Affairs (OCAFA) established the Peer Specialist Certification Program (based on the Appalachian group model) in October 2009. Since then, over 130 peers have been trained and certified. Certified peer specialists work in several programs. The Projects for Assistance in Transition from Homelessness (PATH) program uses two half time peers per region to provide PATH outreach, engagement and case management. Peer specialists are also placed at the two

state hospitals, where they help with discharge planning for those who may be at risk of becoming homeless upon discharge. The Idaho Home Outreach Program for Empowerment (ID-HOPE) program provides evidence based Critical Time Intervention (CTI) services in Region 4 through a Centers for Mental Health Services (CMHS) Transformation grant. The CTI model for ID-HOPE is adapted in two ways. The team is composed of a mix of bachelors/masters level staff and Certified Peer Specialists. ID-HOPE participants who have a crisis may receive 7-14 days of intensive, community based crisis intervention services by ID-HOPE staff as an alternative to hospitalization. As of November 19, 2012, the half-time Certified Peer Specialists that were hired by OCAFA to work on Assertive Community Treatment (ACT) teams were directly hired by regional Division of Behavioral Health programs in each region of the state.

Involvement of Individuals and Families; Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

Individuals in recovery and family members are utilized to evaluate planning, delivery and evaluation of behavioral health services in several ways. Those receiving services through Regional Mental Health Centers are encouraged to complete annual MHSIP or YSS-F satisfaction surveys. Individuals in recovery and family members are represented on regional boards and state councils. The ID-HOPE project has an Advisory Board that includes two consumers and two family members. The ID-HOPE board meets at least quarterly to provide input into project planning, service delivery and evaluation. The PATH program contracts with OCAFA through Mountain States Group to hire and supervise two half time Certified Peer Specialists in each region to provide PATH outreach, engagement and case management to adults with a serious mental illness who are either homeless or at risk of becoming homeless. This contract also allows for one Certified Peer Specialist to work at State Hospital South and another at State Hospital North to coordinate hospital discharge planning with regional PATH Certified Peer Specialists. The Peer Run Center for Hope in Region 4 is completely peer run. The National Alliance for the Mentally Ill (NAMI) and OCAFA provide input into proposed behavioral health legislation. The RITE-TTI project will train individuals in recovery from SUD in Recovery Coaching, and will allow the development and dissemination of Recovery/Trauma toolkit curriculums in each region of the state. It will also allow for the development of an Action Plan toolkit curriculum that may be useful to newly established Regional Behavioral Health Boards as they seek to identify relevant behavioral health service gaps and needs and to develop and implement action plans to address those needs. Regional Advisory Boards provide feedback and recommendations on behavioral health planning, service delivery and evaluation. The State Planning Council on Mental Health (this may become the State Behavioral Health Planning Council) provides input into the Idaho Block Grant Planning and Implementation Reports. The State Council also submits an annual letter to the Governor on their perceptions of behavioral health system strengths, challenges and recommendations.

Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

The Juvenile Justice Children's Mental Health (JJCMH) meetings could address specific issues and work to problem solve system solutions. The Regional Mental Health Boards could also provide a forum for identifying and problem solving individual and family member issues and needs. The State Council on

Mental Health includes at least fifty percent representation by individuals in recovery and family members, and this group also works to develop plans to address identified issues and concerns related to the behavioral health service system. The block grant also funds a contract with the Idaho Federation of Families. The Federation sends a representative to all of the above mentioned groups.

How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

Individuals and family members are presented with opportunities to proactively engage the behavioral health service delivery system through regional boards and the state Planning Council. Opportunities to participate in treatment and recovery planning, shared decision making and direction of ongoing care and support are expectations of services provided through Regional Mental Health Centers and by SUD providers enrolled by the SUD Management Services Contractor.

How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Idaho's Division of Behavioral Health is dedicated to supporting and helping to strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks and recovery oriented services. The Division contracts with the Office of Consumer and Family Affairs (OCAFA) through Mountain States Group to provide consumer and family member education and advocacy; twice annual Certified Peer Specialist training and certification opportunities and supervision of PATH peer specialists in each region. The director of the OCAFA is also the chair of the State Planning Council and a member of the ID-HOPE Advisory Board. NAMI leaders regularly provide feedback to the Division on issues that they identify and on their recommendations. Grants such as PATH, ID-HOPE and the RITE-TTI project include efforts to strengthen and expand recovery-oriented services and use of Certified Peer Specialists in the behavioral health work force array.

Housing

What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

Idaho's Division of Behavioral Health strives to identify housing opportunities for persons served that are located in least restrictive settings. Regional Mental Health Centers receive $8, 000 per region of PATH housing assistance funds. These funds are utilized by eligible PATH participants receiving services at the centers or by eligible PATH participants that are referred by PATH Certified Peer Specialists. Regional Mental Health Centers participate in the Shelter Plus Care program facilitated by the Idaho Housing and Finance Authority (IHFA). Regional programs gather and submit monthly Shelter Plus Care data on services that provide match for IHFA's housing resources. Idaho has several SSI-SSDI Outreach, Access and Recovery (SOAR) trainers in each region. SOAR trainers help citizens to access benefits that they are eligible to receive.

What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

As of February 2013, there were no specific plans to address housing needs of persons served to ensure they are incorporated into a supportive community. Housing remains a concern for Idaho's behavioral

health system, and challenges are higher in rural and frontier areas where transportation to available resources can be difficult.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

IV: Narrative Plan

N Prevention

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Narrative Question: As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

The State of Idaho employs a management contractor to oversee the delivery of substance abuse prevention services. As a part of their contract, they are responsible to conduct an annual state and county-level needs assessment based on Hawkins and Catalano's risk factors. The 2013 needs assessment is posted on the www.preventionidaho.net website. In addition, past needs assessments from 2011 and 2012 are available on the assessment page (http://www.preventionidaho.net/NeedsAssessments.htm).

In addition, with the support of the State Epidemiological Outcomes Workgroup staff, Idaho has created the Prevention and Treatment Research website. Currently, the site focuses on substance abuse prevention data. The data is based on Hawkins and Catalano's risk factors and includes a variety of archival and survey data reported at the state and county level. This site was designed to provide the resources and data that community coalitions could use in community planning as well as grant applications. The web address is http://patr.idaho.gov/. The plan is to expand the site over time to include mental health and substance use data.

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

The State of Idaho has established a list of evidence-based programs and practices that are eligible for SAPT block grant funding. All recurring programs funded by the State of Idaho must be on the list. Decisions to include an evidence based program on the list are based on National Registry of Evidence-based Programs and Practices ratings and Idaho outcome data. The national registry ratings used to evaluate programs are pasted below. National registry-listed programs that have shown positive

outcomes with Idaho populations which do not meet the ratings requirements may be funded in areas where the program has proven effective.

Quality of Research	Indicator	Rating
1	Reliability of Measures	2
2	Validity of Measures	2.5
3	Intervention Fidelity	3
4	Missing Data and Attrition	2.5
5	Potential Confounding Variables	3
6	Appropriateness of Analysis	3
	Total	16
	Average	2.67

Readiness for Dissemination	Indicator	Rating
1	Availability of Implementation Materials	3
2	Availability of Training and Support Resources	3
3	Availability of Quality Assurance Procedures	3
	Total	9
	Average	3

The challenge comes in finding evidence-based environmental strategies. Few are listed on National Registry of Evidence-based Programs and Practices, and even less have comprehensive implementation materials that are comparable to the recurring education programs. Currently, Idaho funds media campaigns; community meetings and awareness events; youth projects related to substance abuse prevention or education, and prescription take back events. The Single State Authority (SSA) does not fund underage alcohol buyer activities with prevention funds because the Enforcing Underage Drinking Laws Grant managed by the Department of Juvenile Corrections covers that activity. In addition, the 2012 Legislature fully funded staffing for the Idaho State Police Beverage Control Unit, bringing them back to full force, so they are now taking the lead on underage buys. Likewise, because the Idaho Tobacco Project includes a comprehensive enforcement system with underage buyers for tobacco, the SSA does not fund underage tobacco buys.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

Idaho's funding for substance abuse primary prevention is limited to the set aside within the SAPT block grant. While prevention services are distributed throughout communities within Idaho, no community has a comprehensive system of prevention. Given the limited funding, Idaho is focusing on the development of infrastructure to support community coalition-based substance abuse prevention initiatives. For this effort, Idaho has a three-pronged approach. The first prong focuses on normalizing the use of evidence-based prevention activities. This was started by prioritizing evidence-based programming for funding and by providing training on evidence-based programs. The second prong centers on developing systems to evaluate outcomes. This initiative included the development of the www.patr.idaho.gov website which is constantly updating data sets as new data is available to create a historical picture of behavior/risk factor changes within counties. The site enables community coalitions to evaluate environmental strategies by reviewing changes in archival and survey data tied to the targeted risk factor and population. Also a part of this initiative is a partnership with Idaho's SEOW staff and the Center for Substance Abuse Prevention's Collaborative for the Application of Prevention Technologies West Resource Team.

The partnership has developed a youth alcohol, tobacco and other drugs/mental health (ATOD/MH) survey for each county to generate accurate county-level data for community and state planning as well as outcome evaluation. Implementation of this survey is planned for 2014. The third and final prong of this undertaking focuses on prevention, provider staff and community coalition member training and development. Idaho is a large, mountainous state with most of the communities located in rural and frontier counties. In addition, most prevention providers and almost all coalition members have other jobs. Very few prevention provider staff are employed full time delivering prevention services. In recognition of the multiple responsibilities of prevention provider staff, Idaho has developed a two track plan for training and skill development. The first track is currently in place and is a part of the annual Idaho Conference on Alcohol Drug Dependency and Prevention. Idaho has added two tracks to this conference. One track focuses on coalition development and one targets prevention professionals. These tracks have enabled Idaho to offer updates of current research, effective programs and practices and cultural issues. Unfortunately, neither Idaho nor the prevention providers and coalitions have the resources to ensure everyone undertaking substance abuse prevention activities can attend the conference. To that end, Idaho is working to develop an online webinar library that prevention professionals and coalition members could access at any time. This would enable individuals to review the materials at their convenience and as the topic becomes relevant to them.

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

The SSA uses the substance abuse prevention data system to collect participant demographic data. It also collects attendance data and pre/post test data on individuals participating in recurring session prevention programs. Pre/post test scores are used to determine 1) if program implementation results in intended outcomes, 2) provider technical assistance needs and 3) utility of the program to serve specific populations within Idaho. The SSA is also receiving technical assistance from the Center for Substance Abuse Prevention to develop a standard pre/post test for all recurring adolescent education programs. Currently, the tools provided with the evidence-based programs are used to evaluate outcomes. This leaves Idaho with the ability to evaluate specific program outcomes but does not enable cross program/population evaluation. In addition, some pre/posttests do not clearly measure data related to the risk-factor the program was intended to address. A standard instrument will enable Idaho to evaluate across programs and populations to determine if the program is addressing the prioritized risk factor and to generate system data. Finally Idaho has worked with Center for Substance Abuse Prevention's Collaborative for the Application of Prevention Technologies West Resource Team to develop a youth ATOD/MH survey that will collect sufficient surveys in each county to generate accurate county-level outcome evaluation data. Implementation of this survey is planned for 2014. This combined with the archival data collected on the PATR website will enable Idaho to measure the effectiveness of environmental practices.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

The only state funds provided by Idaho to support the implementation of the Strategic Prevention Framework include $288,100 to support the Governor's Office of Drug Policy which is charged with managing SABG prevention dollars beginning July 1, 2013. Other than this minimal funding, Idaho does not provide any additional state funds for the support or delivery of substance abuse prevention activities or the strategic prevention framework. However, as of August 1, 2013, Idaho was awarded a SPF SIG grant which will be used to implement the Strategic Prevention Framework at both the community and state levels.

Currently, Idaho uses SAPT Block Grant funds for all substance abuse prevention activities including the development of the state's prevention framework. Framework activities include an annual needs assessment, priority funding for evidence-based programs and practices, development of community coalitions, a data system and the Prevention and Treatment Research website. The annual needs assessment identifies population and service needs. By giving priority to funding for evidence-based programs and practices, Idaho has moved to a research-based, effective prevention system. The focus on development of community coalitions supporting ongoing prevention efforts enables Idaho to sustain prevention activities in the face of falling federal funding. The prevention data system collects participant demographic, attendance and pre/post test data for individuals attending multi-session programs as well as prevention professional qualifications and training information. Finally, the Prevention and Treatment Research (PATR) website collects archival and survey data to evaluate state and county population change over time and enable community coalitions to make data-driven decisions.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
Seventy-one percent (71%) of Idaho's primary prevention set-aside is expended supporting community-based services delivered by community organizations and coalitions. The other 29% currently goes to the state for resource development.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.
One hundred percent (100%) of Idaho's primary prevention set-aside that goes to community organizations is expended supporting evidence-based programs and practices and environmental strategies. The programs and practices approved for funding are listed in the table below. The following table also identifies the approved environmental strategies.

Idaho Approved Evidence-based Substance Abuse Prevention Programs & Practices

Key for Evidence-based Programs

M/J	Middle/Junior High School Students
HS	High School Students
ES	Elementary School Students
P/G	Parents/Guardians
PS	Preschool Students
CO	Communities

	Programs and Practices	Population
1	Across Ages	M/J
2	Active Parenting	P/G
3	All Stars	ES
4	Als Pals	PS
5	ATLAS (Athletes Training and Learning To Avoid Steroids)	HS Males
6	Big Brothers/Big Sisters	ES, M/J, HS
7	Brief Strategic Family Therapy	P/G
8	Building Skills	ES
9	Class Action	HS
10	Communities Mobilizing for Change on Alcohol	CO
11	Familias Unidas - Hispanic	P/G
12	Families and Schools Together	P/G

13	Family Matters	P/G
14	Good Behavior Game	ES
15	Life Skills Training Program	ES
16	Nurturing Program	P/G
17	Positive Action	ES
18	Project Action	ES
19	Project Alert	M/J
20	Project Northland	HS, M/J
21	Project SUCCESS	HS, M/J
22	Project Toward No Drug Abuse	HS, M/J
23	Promoting Alternative Thinking Strengths (PATHS)	ES, PS
24	SAFE Children	P/G
25	Second Step A Violence Prevention Curriculum	M/J, ES
26	SPORT	HS, M/J
27	STARS for Families	P/G
28	Strengthening Families Program (10 - 14)	P/G
29	Too Good for Drugs	M/J
Idaho Approved Environmental Strategies		
1	Media Campaign/Media Advocacy	
2	Community Meetings	
3	Community Awareness/Education Activities	
4	Responsible Server Training	
5	Public Policy/Local Ordinance Initiatives a. bans on home delivery b. alcohol restrictions at public events c. advertising restrictions d. local option taxes on tobacco or alcohol e. open container restrictions f. social host liability	
6	Prescription Medication Take-back Programs	
7	Legislative Forums and Advocacy	

N.1.: ODP Response:
For Question 1, please indicate how Idaho is using its needs assessments and available data to identify the types of primary prevention services that are needed.

The Idaho Office of Drug Policy is using its needs assessments and available data to identify the types of primary prevention services that are needed by:

1. Establishing Regional Grant Review Boards to identify priority target populations, risk and protective factors and service types for substance abuse prevention funding. In SFY 2014, the Office of Drug Policy utilized data collected by the current contractor, Benchmark Research & Safety, Inc., to guide all funding decisions. Regional needs assessments provided the foundation for individualized Regional Substance Abuse Prevention Strategic Plans in each of Idaho's seven service areas. Target Populations (the types of people whose attitudes, knowledge, skills, risk/protective factors, and behaviors who could benefit from substance abuse prevention program or initiatives); Risk Factors (attributes or conditions individual, families, schools or communities that increase the likelihood of substance use/abuse problems); Protective Factors (attributes or conditions that buffer an individual from the influence of risk factors or reduce the likelihood of use); Prevention Strategies (method or mechanisms of substance abuse prevention delivery); and, Prevention Services were charted. Program awards were based on the presenting data. For example: in Region I, students in Upper Elementary School, Junior High School, and High School were identified as target populations. Because of that prioritization, the decision not to fund prevention programs in grade K-3, in that region, was made based on the available data.

2. Making data, its analysis, and pertinent reports easily accessible and understandable to the general public. Regional Substance Abuse Prevention Needs Assessments for each of the seven Idaho Department of Health & Welfare regions are posted to the state's prevention services website: www.preventionidaho.net. Additionally, Idaho's Prevention and Treatment Research Website (PATR) is a data source available to prevention providers and the public for use in program planning and outcome evaluation. Updated reports, as well as findings from the biannual Youth Behavior Risk Survey (YRBS), are distributed to prevention providers. This provides them with the appropriate data to allow them to target their prevention efforts in their local communities.

3. Providing training and technical assistance to individual communities and prevention providers related to reviewing, analyzing and accessing available data for use in substance abuse prevention efforts to insure that services and programs are provided to appropriate groups who need prevention services the most. *Community Assessment* and Data *and Evaluation* sessions will be added to the agenda at the annual Idaho Conference on Alcohol and Drug Dependency in May 2014 to further assist prevention providers in these areas.

Response is attached under the title N 1 ODP response

Page 1

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5%)

Narrative Question: States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Response: At least 5% of Idaho's MHBG funds will be allocated in SFY 2014 to implement evidence based prevention and treatment approaches with a focus on promotion, prevention and early intervention. Block grant funds have historically been allocated for the purpose of providing education and advocacy services to adults with a serious mental illness. Mountain States Group is the agency that was awarded the contract to provide these services through their consumer run Office of Consumer and Family Affairs (OCAFA). Educational materials are disseminated to consumers and family members across Idaho. Block grant funds have also been historically allocated to an Idaho agency to provide parent education and support and youth education and support. The Federation of Families has provided these services in the past.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

IV: Narrative Plan

O Children and Adolescents Behavioral Health Services

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Narrative Question: Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders. SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Description of how Idaho will establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders

The state of Idaho will establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental health and substance use disorder diagnoses in several ways. The Division of Behavioral Health's Policy Unit will be responsible to create clinical practice standards. The Division's Quality Assurance (QA) Unit will provide quality assurance oversight on provider implementation of clinical practice standards. The QA unit is in the process of developing a comprehensive Idaho quality improvement plan that will include a description of the children's system and the consumer perspective. It is anticipated that the Medicaid Managed Care organization will become a key partner in the planning process, and with respect to collecting and evaluating system data to help guide system activities. The Federation of Families contracts with the Division to provide supportive services for children and families. The Federation is expected to provide input into the establishment of a system of care in Idaho. The Substance Use Disorder Treatment (SUD) Management Services contractor will oversee the delivery of treatment and recovery support services to youth addicted to alcohol or other drugs. The intake process, using the GAIN assessment, will provide the care manager with the information needed to make a diagnosis as well as identify other service needs. The SUD Treatment provider assigned to treat the youth will be responsible for delivery of treatment services. The SUD Treatment provider may also provide case management or the service may be provided by a different organization. In any case, the case manager is responsible to ensure youth receive all services they and their family need to support and sustain a full recovery.

Describe the guidelines that Idaho has or will establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders

The Division of Behavioral Health has policies that describe guidelines for individualized care planning for Regional Mental Health Centers (RMHC). The Division's Quality Assurance team provides RMHC reviews of regional cases to determine the impact of policy on individualized care planning in each region. The Medicaid Managed Care contractor will be responsible to ensure individualized care planning from Medicaid service providers of care to Medicaid funded children. All youth receiving services in state-approved substance use disorder treatment programs must have an individualized treatment plan that addresses the substance use, co-occurring mental health disorders, physical health as well as other problems affecting the youth's major life areas. The development of a treatment plan must

be a collaborative process involving the youth, family members, and other support and service systems. All youth receiving Behavioral Health-funded substance use disorders treatment are assessed using the GAIN, which assesses all life areas, not only substance use thus ensuring the youth and their clinician have the information they need to develop a comprehensive care plan.

Describe how Idaho has established collaboration with other child and youth serving agencies to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)

Idaho has established collaboration with other child and youth serving agencies to address behavioral health needs in several ways. The governor appointed Behavioral Health Integration Committee is developing a memorandum of understanding for collaboration between key child and youth serving agencies. The Juvenile Justice Children's Mental Health (JJCMH) workgroup includes representation from regional mental health programs, the Idaho Division of Juvenile Corrections, county probation and the Federation of Families. The JJCMH meets regularly to address system issues and to identify shared policy goals between agencies. Recent accomplishments include the Family Engagement white paper and implementation of juvenile competency statute 20-519. The Special Education Advisory Board (SEAP) is a federally funded policy group, with fifty percent of its members composed of parents of youth with special education needs. One of the tasks that this group works to address is directed to youth with emotional disturbance related disabilities. Recent accomplishments include public comment on restraint and seclusion rules proposed in SFY 2012 and advice to the Department of Education on ways to solicit feedback from consumers of Special Education services.

The Division of Behavioral Health also collaborates with Utah to advance public health for youth in Idaho. Mental Health is one component of focus for the group currently looking to address depression screening among all populations and exploring how to become more trauma-sensitive. Madison School District is currently in their fourth year of a six year grant. The Division of Behavioral Health participates on the federal technical assistance calls related to this project and works to coordinate statewide service efforts with the goals of the Madison project. Despite having a specific geographic focus, Madison has initiated a variety of programs designed to increase awareness of behavioral health issues among Idaho children and youth, and several educational kits on these topics are available for use across child-serving systems of care.

The Division of Behavioral Health-funded Substance Use Disorders Treatment providers are required to conduct a GAIN assessment on all youth referred for treatment services. This assessment evaluates a broad range of areas related to the youths' life areas. As a part of this process SUD Treatment providers must either directly provide case management services or partner with a care management agency to ensure all service needs identified in the assessment are addressed. Some services, such as transportation, life skills and family therapy are covered by the Division of Behavioral Health. Other services such as mentoring, parenting education, tutoring, behavioral management, and health care are provided by other agencies within the community. To meet clients' needs, the SUD Treatment providers have developed relationships with a broad range of community organizations including health care providers, public health districts, school districts, faith-based and recovery support groups, law enforcement agencies, battered women and crisis shelters, child protection agencies and youth organizations.

Describe how Idaho will provide training in evidence based mental health and substance abuse prevention, treatment and recovery services to children/adolescents and their families

The Division of Behavioral Health's Operations Unit will be constructing a three year training plan in SFY 2013. The Division is responsible for only a segment of the Behavioral Health System, and therefore plans to collaborate with other partners to identify methods to provide training in evidence based mental health and recovery services. The substance abuse prevention services have been collaborative with a

broad range of community providers, sharing CSAP and other organization developed evidence or research-based webinars, providing written materials and videos through the Idaho RADAR Center and participating in cross-training activities with Juvenile Corrections and Education. The SSA will continue to support two prevention tracks in the annual Idaho Conference on Alcohol and Drug Dependency. One track focuses on prevention professional development and has had speakers on adolescent development, identifying drug-endangered children, providing youth with emotional support, and risk and protective factors. The second track focuses on coalition development and includes current research on youth engagement, preventing underage drinking and community planning for healthy youth. In addition, the annual conference provides cutting edge research on topics of multi-disciplinary interest include ethics, culturally appropriate care, adolescent brain development, child trauma and healthy child development. A variety of training tools are used to disseminate current research and information on evidence-based programming for SUD Treatment and Recovery support services. Idaho's current training initiatives for SUD treatment professionals focus on GAIN Site Interviewer Training, recovery support service skill development, adolescent treatment via telehealth and trauma focused cognitive behavioral therapy for adolescents.

Describe how Idaho will monitor and track service utilization, costs and outcomes for children and youth with mental health, substance use and co-occurring disorders

Idaho has plans to monitor and track service utilization, costs and outcomes for children and youth with mental health, substance use and co-occurring diagnoses. The Medicaid Managed Care Contractor will be responsible to ensure monitoring, tracking and data collection for children and youth receiving Medicaid reimbursable services. There is currently a Request for Proposal (RFP) to identify a Substance Use Disorders (SUD) Treatment management services contractor to oversee the substance use delivery system. Once the contract has been awarded, the contracted SUD Management Services Contractor will have responsibility for monitoring and tracking SUD Treatment provider services in Idaho. The Web Infrastructure for Treatment Services (WITS) electronic health record system used by the Division will provide data that will help with monitoring and tracking service utilization, costs and outcomes. The SUD Treatment system use of WITS across multiple governmental agencies (e.g., IDHW, IDOC, IDJC, ISC) will also be beneficial in this effort. With respect to assessment tools, children's state funded services are monitored in some areas with the CAFAS, and the ASAM can be used to measure level of care needs for youth with SUD diagnoses. During SFY 2014-2015, Idaho plans to move to a managed care model, and this is expected to facilitate the development of a coordinated state outcome and utilization tracking plan.

Input from Idaho Citizens: Several activities were implemented in January/February 2013 in an effort to solicit input from Idaho citizens into the development of the SFY 2014-2015 Combined SAPT/MH Block Grant. The need to develop the plan was presented to the State Planning Council on Mental Health at their January 2013 quarterly meeting, with a request to provide input through a specific block grant survey link on the external Department of Health and Welfare (DHW) website. Regional Division of Behavioral Health program managers were encouraged to respond to the website, and to share the invitation with local providers and regional boards. The Division of Behavioral Health communicated with the Director of the Idaho Division of Vocational Rehabilitation (IDVR) and requested their input into the plan. The IDVR Director also contacted leaders of four Tribes that IDVR works well with, and invited them to also participate in responding to questions posted on the external DHW website. An internal Division of Behavioral Health survey also solicited input on block grant planning for SFY 2014-2015. Responses from the internal and external websites were incorporated into the narrative sections of the SFY 2014 -2015 Plan.

Regarding ideas to establish and monitor a system of care approach for children, citizens had several ideas. One individual recommended increased "…community based activities and provisions to support families with troubled youth…especially…in rural areas." Another comment was that "It should start with medical providers and with teachers and be proactive and educational as opposed to punitive." Yet another citizen responded that "Currently the mistake is putting too much power into the hands of the juvenile justice system. Allow the professionals to address this on an individual basis."

On the topic of guidelines that the state might establish for individualized care planning, website respondents suggested that it would be important to "Adopt a person centered planning philosophy and monitor provider performance through credentialing processes." With respect to collaboration with child and youth serving agencies, one citizen cited involvement with the local juvenile justice council and expressed interest in grant funding to address co-occurring needs of youth. This individual indicated that collaboration with other child serving agencies was important, and also challenging to do in a consistent manner, especially in rural and frontier areas of the state.

In response to the question about training on evidence based treatment, prevention and recovery, one citizen suggested that "It could be provided through agencies that are regional in nature and are looked at as a hub for resources. it could also potentially be provided through organizations such as the ministerial associations. Partnering between colleges, juvenile justice, psychiatric hospitals, and state agencies would also allow for facilitation and allow for very low cost to those looking to attend." Another indicated that, "Making services accessible is one factor…[and]…another important factor is evaluation. Not all evidence-based programs will meet the needs of Idaho's unique populations. The best approach is to combine training in cost-effective evidence-based practices with approaches that already exist in the community." Another said that, "This should be addressed by the licensing agencies."

With regard to ways Idaho could monitor and track service utilization, costs and outcomes, citizens had several suggestions. One stated that, "First we need to identify the data points we want to measure…This is a job for the Council on Behavioral Health and regional behavioral health boards to address." Another comment was that "The best system to track service utilization is the claims management system. Idaho recently hired Molina to process claims; perhaps they can provide access to service utilization data for Medicaid and [the SUD management services contractor] for state funded substance abuse services?" Yet another person stated that "…a multilevel approach tracking the patient, the program and the system in these key areas." One individual indicated disagreement with the state's use of the GAIN assessment tool, and another complained about the cumbersomeness of using the WITS data system.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

IV: Narrative Plan

P Consultation with Tribes

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Narrative Questions: SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Idaho's six federally recognized tribes are the Shoshone Bannock, the Northwest Band of the Shoshone, the Nez Perce, the Coeur d'Alene, the Kootenai and the Duck Valley (Shoshone Paiute) Tribes. The Division of Behavioral Health's Substance Use Disorder provider network includes the tribally owned Benewah Medical and Wellness Center in northern Idaho (Plummer). Interaction with the Division on SUD treatment services is limited to the facility renewal process. The Division's prevention services and Idaho Tobacco Project have worked with Tribal members and organizations serving tribal members for more than fourteen years. The Division's substance abuse prevention management contractor, Benchmark Research Safety, Inc. contracts with tribal organizations, school districts on Tribal lands or serving tribal members and social service organizations serving Tribal members to deliver prevention education, coalition support and community awareness activities. In SFY 2013, prevention responsibilities and funds were reallocated to the Office of Drug Policy (ODP) in the Governor's office. In SFY 2014-2015, the ODP will be responsible to oversee the management of the substance abuse prevention program. In addition, the Idaho Tobacco Project has met with members of the Shoshone Bannock Tribe to discuss sharing of resources to prevent minors' access to tobacco products. This is an ongoing conversation that includes the Idaho Tax Commission.

During SFY 2012, the Division of Behavioral Health spoke to tribal representatives attending a quarterly Medicaid meeting and invited them to participate in efforts to plan a behavioral health service system that met the needs of all Idaho citizens. On January 31, 2013, the Division was offered an introduction by the Director of the Idaho Division of Vocational Rehabilitation to leaders from four Idaho tribes. These leaders indicated a willingness to work with the Division of Behavioral Health. An e-mail was sent to each with an invitation to access an external website that provided a survey opportunity to provide input into the narrative categories of the Idaho 2014-2015 Combined SAPT/MH Block grant application and plan.

Behavioral Health efforts to engage Tribal leaders are anticipated to involve meetings between the Division of Behavioral Health and Tribal Mental Health and Substance Use Disorder programs. The Division of Behavioral Health values the development of opportunities to collaborate with Tribal leaders. The Division formally identified a representative to serve as an active liaison to leaders of Idaho tribes.

This liaison will work with the Department of Health and Welfare's Tribal Relations Manager to build relationships with Tribal leaders from each Tribe, and to invite ongoing input into behavioral health planning and service implementation.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

IV: Narrative Plan

Q Data and Information Technology

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Narrative Question: In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data; list and briefly describe all unique information technology systems maintained and/or utilized by the state agency; provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and identify the specific technical assistance needs the state may have regarding data and information technology.

Description of Idaho's Division of Behavioral Health (DBH) plan, process, needed resources and timeline to develop the capacity to provide unique client-level data and description of information technology systems utilized

The Division of Behavioral Health's Adult Mental Health (AMH), Children's Mental Health (CMH), and Substance Use Disorders Treatment (SUD) programs provide information on publicly funded AMH, CMH and SUD Treatment services. The Division of Behavioral Health (DBH) contracts with vendor FEI to develop, train, implement and host the Web Infrastructure for Treatment Services (WITS) system. The WITS system is capable of tracking service provider locations and other characteristics. This system has been implemented for Adult Mental Health (AMH) services (October 2010) and for Children's Mental Health (CMH; July 2011). Data element definitions for the National Outcome Measures were built in WITS using the Client Level Reporting Project data element definitions. Data on Division of Behavioral Health trainings and SUD prevention is tracked through EXCEL spreadsheets through the Division's Central Office location.

The Division of Behavioral Health is in the process of adding all publicly funded SUD agencies to the WITS system. The WITS/GAIN interface is currently being used by contracted network substance use disorders treatment providers for the assessment of state-funded clients. Once the WITS system is fully implemented for SUD Treatment, contracted network providers will be able to use WITS to assess clients, manage treatment, bill for services and collect outcome measurement data in real-time. There are currently twenty (20) providers that are in the process of piloting the full system. Training for all contracted network SUD Treatment providers is planned for Spring 2013, with full implementation by July 1, 2013. Starting in July 2013, all contracted network providers will be required to utilize WITS as their electronic health record and to track and submit claims for payment of state funded community substance use disorder treatment services. At that time, the management services contractor will maintain the adjudication process in WITS and providers will be paid based upon the submitted and accepted claims in WITS.

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

The WITS system uses a unique client identifier based on a numerical value assigned to the letters of the first and last name, the date of birth (DOB), and the Social Security Number (SSN). The identifiers cannot be duplicated in any given provider agency. In theory, extracting information for unduplicated clients can

be pulled by identifier. Realistically, there could be the possibility of the same client being assigned multiple identifiers in WITS if the information used to assign the identifier is entered differently (e.g., a client DOB entered differently in Region 1 than in Region 2 will result in two different identifiers). For Division of Behavioral Health purposes, reports are built to look at the identifier and other unidentifiable information. The WITS system does have the ability to aggregate services rendered to the client. Division of Behavioral Health SUD Treatment/AMH/CMH providers (excluding Medicaid) do not have to obtain national provider identifiers. The WITS system is capable of collecting and reporting national provider identifiers.

The two state hospitals, State Hospital North (SHN) and State Hospital South (SHS), use the VistA data infrastructure system. The Division of Behavioral Health implemented a data warehouse in SFY 2012 to allow client data from the VistA system to be crosswalked to the WITS system so that client services can be tracked.

Regarding use of specific systems, the SUD Treatment program uses the Global Appraisal of Individual Needs (GAIN) tool for assessments. The data collected from the GAIN is maintained by Chestnut Health Services and is not accessible through the Division of Behavioral Health's WITS system. Chestnut submits monthly and quarterly GAIN aggregate data to the Division of Behavioral Health and to individual providers in the SUD Treatment provider network. The Division of Behavioral Health uses WITS, VistA, Drug Assistant Software, LOCUS/CALOCUS and CAFAS/PECAFAS to track prescription drug utilization for AMH and CMH. Data pertaining to prescription drug utilization for SUD Treatment is not available. WITS is also linked to FAS Outcomes for the eCAFAS and ePECFAS (CMH instruments). WITS is stage one meaningful use certified.

Idaho participates in the Data Infrastructure Grant (DIG) project. The Division of Behavioral Health is in the process of completing a client level data submission representing all those served by the State Mental Health Authority (SMHA) during SFY13.

Idaho received a section 3013 grant for development of a health information exchange under the HITECH Act. The Idaho Health Data Exchange (IHDE) is the state designated entity receiving the grant funding. IHDE is a statewide health information organization and has been operational as an HIE since 2009. IHDE includes a clinical data repository. Clinical staff at State Hospital North and State Hospital South can access the repository for clinical information, such as lab results, for patients they are treating. Mental health and substance use disorder treatment data are not currently included in the exchange. IHDE's Security and Privacy Committee is reviewing the SAMHSA FAQs related to substance use disorder treatment confidentiality and health information exchange to determine IHDE's next steps in this regard. IHDE, at the invitation of the behavioral health bureau chief, sent a staff member to the SAMHSA-Sponsored 2011 Health Information Technology Regional Forum to learn more about the issues and opportunities in this area.

Medicaid Managed Care will be responsible for helping Medicaid providers adopt an Electronic Health Record (EHR). The Idaho Department of Health and Welfare (IDHW), Idaho Department of Corrections (IDOC), Idaho Department of Juvenile Corrections (IDJC), and the Idaho Supreme Court (ISC) are responsible to assist SUD Treatment agencies with efforts to adopt WITS as an EHR and encounter/claims based billing system.

Description of the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and identification of the specific technical assistance needs the state may have regarding data and information technology

The WITS system does not link to data systems for Medicaid, courts, criminal justice, primary health, schools, community hospitals or Idaho Vocational Rehabilitation. Specific requests must be made to access data from these data resources, and their data is not necessarily based on the same data element definitions as that used by the Division of Behavioral Health's WITS system. As of February 2013, there was no resource that captured co-morbidity data for behavioral health and physical health diagnoses, and this lack of data complicates efforts to accurately assess need. The substance abuse prevention program uses a web-based system with secure and non-secure portions (see www.preventionidaho.net) to collect prevention services data. The system collects attendance data on all prevention participants as well as providers/staff qualification and training data. Participants in recurring programs are assigned a unique identification number which is used to collect demographic data, attendance data and pre/posttest scores. This site is also used for collection of required block grant and NOMS data, for providing information to contracted prevention providers, for hosting needs assessment reports and for locating funded prevention services.

Two data system challenges in Idaho relate to coordinating data from multiple state agencies with multiple billing systems and plans to implement both the ICD-10 and the DSM-V. Barriers for providers include unfamiliarity with EHR systems, lack of Internet connection in rural and frontier areas of Idaho, lack of Information Technology (IT) assistance in small provider shops, insufficient funds to purchase and maintain an EHR, and inability to take advantage of meaningful use incentives. Most providers in Idaho do not have the staffing necessary to be reimbursed through meaningful use.

There are several possible areas of information technology related technical assistance that the Idaho Department of Health and Welfare could benefit from. It would be helpful to have technical assistance to improve interlinking and interoperability between multiple systems. It would be helpful to have guidance on implementation of the ICD-10 and the DSM-V. Technical assistance in resolving accessibility issues in rural and frontier areas and for small providers without the funds to purchase electronic health record systems would be useful.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

Quality Improvement Work Plan

Idaho Division of

Behavioral Health

Services

1/01/2013-updated 3/13/13

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INTRODUCTION

The goals of the Idaho Division of Behavioral Health (IDBH) Quality Improvement Work Plan are guided by the healthcare quality improvement aims identified by the Institute of Medicine's (IOM) report: *"Crossing the Quality Chasm*". The targeted IOM quality improvement aims for all healthcare services are to be safe, client-centered, effective, timely, efficient and equitable. These IOM aims are interwoven throughout the Quality Improvement Work Plan. In addition the QIWP is based on the Idaho Department of Health and Welfare's values, mission statement, and strategic plan.

IDBH Values:

- Integrity
- High quality customer service
- Compassion

Quality Improvement Process

IDBH has adopted a continuous quality improvement (CQI) model for producing improvement in key service and clinical areas. This model encompasses a systematic series of activities, organization-wide, which focus on improving the quality of identified key treatment, service and administrative functions.

The overall objective of the quality improvement process is to ensure that quality improvement is built into the performance of all IDBH functions. This objective is met through a commitment to quality from the administration, QI/QA staff, and clients, family members, and providers. The quality improvement process is incorporated internally into all service areas of IDBH. It is applied when examining the care and services delivered by the IDBH network of providers, programs, and facilities.

Mission Statement:

To actively promote and protect the economic, mental, and physical health and safety of all Idahoans

Strategic Plan:

Goal 1: Improve the Health Status of Idahoans

Goal 2: Increase the Safety and Self-Sufficiency of Individuals and Families

Goal 3: Enhance the Delivery of Health and Human Services

Client and Family Involvement in Quality Improvement

Consistent with our values of involving clients and family members in the quality improvement process, QIWP activities shall be based on input from clients and family members

The goal is to involve clients, family members, providers and stakeholders in the planning, operations, and monitoring of our quality improvement efforts. Their input will come from a wide variety of sources including the boards, community coalitions, client and family focus groups, client satisfaction surveys, client advocacy groups, complaints, and grievances.

QUALITY IMPROVEMENT WORK PLAN- Jan 2013- June 2014

Developing the Quality Improvement Work Plan (QIWP)

The purpose of the IDBH Quality Improvement Work Plan (QIWP) is to establish the framework for evaluating how the Quality Improvement Program (QIP) contributed to meaningful improvement in client outcomes, clinical care that is strengths based and recovery oriented, and effective and efficient administrative services**.** The QIWP defines the specific areas of quality of services, both clinical and administrative, that IDBH will evaluate .

The QIWP defines the 1) goals, 2) objectives, 3) methodology, and the 4) timelines for completion. The QIWP will be monitored and may be revised throughout the year, as needed. The IDBH QIWP will be updated a least annually.

Annual Evaluation of Quality Improvement Work Plan Effectiveness

IDBH shall evaluate the QIWP at least annually in order to ensure that it is effective and remains current with overall goals and objectives. This evaluation will be the Annual QIWP Evaluation. The evaluation will include a summary of completed and in-process quality improvement activities, the impact the process has had, and the identified need for any process revisions and modifications. Whenever possible Lean Six Sigma tools may be used.

Quality Improvement Work Plan

Goals

The Quality Improvement Work Plan Goals define targeted measures by which Behavioral Health can objectively evaluate the quality of services, both clinical and administrative, provided to clients and families. Some of the goals are process goals while others are measurable objectives.

Statewide Quality Improvement Work Plan Targets for Jan 2013, to June 2014

The first three statewide targets have been established as:

- Implementation of Regional Consumer Quality Review Teams
- Development of Regional Quality Improvement Work Plans
- Selection of Outcomes Tools

Goals, objectives, methodology and timelines have been determined and are summarized in the attached tables.

#1 QIWP: Regional Consumer Quality Review Teams (RCQRT)

#	Goal	Objective	Methodology:	Proposed timeline for completion
1.1	Develop Regional Consumer Quality Review Teams- at least one team per region/hub	Identify who will participate on the Regional Consumer Review Teams	1) Discuss current RMQT meetings as possible option for RCQRT 2) Identify Regional leads for project and implement workgroup 3) Communicate goal to NAMI- Idaho, Office of Family and Consumer Affairs, Substance Use Disorder Management Services contractor, Regional Advisory Committees, Mental Health Boards, and other MH/SUD Agencies and other local regional entities to identify who could participate on the Regional Teams 4) Finalize plans for how regional meetings will be held- on-site, web meetings, etc. 5) Establish guidelines/meeting rules	1) Jan 2013 2) Jan 2013 Revised to Feb 2-13 3) March/April 2013 4) April 2013 5) May 2013 6) June 2013
1.2	Implement Regional Consumer Quality Review Teams	Start Regional Team Meetings	1) Hold first regional meetings a. Communicate guidelines/ meeting rules b. Supply staff for minutes c. Establish Team Leadership 2) Identify processes for documenting consumer/family input 3) RCQRT's to report progress	1) July – Dec 2013 2) Sept- Dec 2013 3) Dec 2013
1.3	Identify areas of service for Teams to focus on	Focus on five areas of service quality: availability, accessibility, acceptability, appropriateness, and adequacy and choose what specific items will be reviewed in each area	1) Teams to consider conducting face-to-face interviews with consumers family members and providers to identify areas to focus on 2) Teams to consider conducting other types of interviews/surveys with consumers family members and providers to identify areas to focus on	1) Jan- June 2014 2) Jan-June 2014
1.4	Reporting of outcomes of reviews	Determine what types of reports will be developed, how often they will produced	1) Project Lead and leads for each region/hub to define types of reports 2) Develop draft reports	1) Jan – Feb 2014 2) March- April 2014
1.5	Use of data for improvement across programs	Determine who reports will be used by	1) Communication to regions regarding planned use for reports 2) Draft reports to be distributed to DBH administration 3) Finalized reports to be distributed to identified parties	1) March 2014 2) May 2014 3) July 2014
	Reviews are completed on a quarterly basis by the Regional Consumer Quality Review Team			July 2014

#2 QIWP: Regional Quality Improvement Work Plan (RQIWP)

#	Goal	Objective	Methodology:	Proposed timeline for completion
2.1	Development of plan for Performance Indicators that focus primarily on quality of service, appropriateness of services and the pattern of utilization of services	Work with regions to develop plan for QI Work Plans	1) Discuss current strategic plans, operational plans as option for RQIWP 2) Identify Regional leads 3) Communicate with Regional Mental Health Centers (RMHC) and Private Substance Use Providers (SUD) about project 4) Meet with Regional Mental Health Centers (RMHC) and Private Substance Use Providers (SUD) to discuss the plan for the development of Regional Quality Improvement Plans 5) Develop survey to be distributed	1) Jan 2013 2) March 2013 3) March/ April 2013 4) May- June 2013 5) June 2013
2.2	Determine what should be included in Quality Improvement Work Plans	Ensure QI Work Plans are focused on meaningful outcome data SUD to focus on prevention/education, recognition, treatment and maintenance. MH to focus on access, process, and outcomes	1) Survey stakeholders for what data is needed for quality improvement 2) Identify National Benchmarks for comparison 3) Review Benchmarking study by Institute for Behavioral Healthcare 4) Research SAMHSA, HEDIS, NCQA, AHRQ	1) July – Dec 2013 2) July – Sept 2013 3) July - Sept 2013 4) July- Sept 2013
2.3	Data collection for QI Work Plans	Determine a methodology for collection of identified data elements	1) Determine what data can be reported out of WITS 2) Look at other sources 3) Consider developing new systems for data collection	1) Oct 2013 2) Oct 2013 3) Oct-Dec 2013
2.4	Regional Quality Improvement Work Plans Drafted	Ensure that Regional Quality Improvement Work Plans will meet expectations	1) Drafts reviewed by Regional Quality Improvement Teams 2) Drafts finalized	1) March 2014 2) June 2014
2.5	Regional Quality Improvement Work Plans turned in to DBH	Completion of DBH QI Work Plan	1) Regional Quality Improvement Work Plans finalized	July 2014
	Regional Quality Improvement Plans are completed			**July 2014**

#3 QIWP: Integrated Outcomes Tools

#	Goal	Objective	Methodology:	Proposed timeline for completion
3.1	Identify reliable and valid tools for measuring outcomes	Implement outcome tools across statewide programs to ensure that outcomes can be reported as needed to legislature, boards, etc.	1) Discuss any current tools being used to track outcomes 2) Identify Regional leads for project 3) Research current tools being used by SAMHSA, HEDIS, NCQA, AHRQ, and other national benchmarks 4) Implement use of 1 standardized recovery measurement tool, such as the RSA to establish a baseline	1) Jan 2013 2) Jan 2013 Revised to March 2013 3) March- April 2013 4) April 2013
3.2	Involve stakeholders in the process	Ensure buy-in by involving stakeholders in the process of choosing the outcome tools	1) Central QA to implement a workgroup 2) Workgroup to develop communications plan with regional stakeholders 3) Review selected tools from above noted research or may be based on other methods for selecting tools	1) March – July 2013 2) March – Sept 2013 3) Sept –Dec 2013
3.3	Pilot the chosen tools	Ensure that the tools can be used in the field	1) Choose 3-5 programs to pilot the use of the tool 2) Review input from programs on the use of the tool	1) Oct –Dec 2013 2) Jan- Feb 2014
3.4	Implement the chosen tool	Begin using chosen tools	1) Communicate to providers which tools have ben chosen 2) Provide Training to providers on the use of the tool 3) Follow up training as needed	1) March- April 2014 2) May- June 2014 3) July – Dec 2014
3.5	Reporting of outcome data	Determine what types of reports will be developed, how often they will produced	1) Develop draft reports 2) Distribute for input 3) Finalize reports	1) March 2014 2) April- May 2014 3) June 2014
3.6	Use of data for improvement across programs	Determine who reports will be used by	Review reports in Regional Consumer Quality Review Teams	July 2014
	Outcome monitoring tool is selected and implemented Statewide for MH/SUD under the direction of the IDBH			**July 2014**

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

Footnotes:

IV: Narrative Plan

S Suicide Prevention

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Narrative Question: In the FY 2012/2013 Block Grant application, SAMHSA asked states to provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan. States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website **here**.

Suicide Prevention

Until SFY 2013, there was no nationally certified suicide prevention hotline in Idaho. The National Suicide Prevention Lifeline reported 3,700 calls from Idahoans in 2010. The Suicide Prevention Action Network of Idaho (SPAN Idaho) provided a suicide fact sheet in July 2010 based on data from the Idaho Bureau of Vital Records and Health Statistics, the Idaho Department of Health and Welfare, the Centers for Disease Control and Prevention and YRBS Idaho (see attached). According to these statistics, suicide is the 2nd leading cause of death for Idahoans 15-34 and for males 10-14 years of age. The fact sheet reports that in 2009, 307 people completed suicide, with 77% by men, and 58% involving a firearm. Also in 2009, "14.2% of Idaho youth attending traditional high schools reported seriously considering suicide in 2009," with 6.9% reporting at least one attempt. The State Planning Council on Mental Health identified this as a top June 2011 concern.

The Department of Health and Welfare contracted with Idaho State University's Institute of Rural Health to assess the need and viability of establishing an Idaho Suicide Hotline. This report can be accessed at www.isu.edu/irh/publications/Hotline_Report_2010_web_pwp.pdf. While a suicide hotline was a recognized need, there were challenges in identifying funding sources to establish and maintain operations for this type of resource. The Idaho Suicide Prevention Hotline was created as a result of collaborative efforts between multiple entities, including the Idaho Council on Suicide Prevention, the Suicide Prevention Action Network of Idaho, Idaho State University Institute of Rural Health, the Department of Veterans Affairs (Boise), the Idaho National Guard, the Idaho Department of Health and Welfare and Mountain States Group, Inc. Funding contributors to this project included United Way (Kootenai County, Southeast Idaho, and Treasure Valley), the Idaho State Legislature, the Idaho Department of Health and Welfare, Wells Fargo Bank, the Saint Alphonsus Health System, the Jeret 'Speedy' Peterson Foundation, Citi Cards, the Ada County Paramedics Association, the Suicide Prevention Action Network of Idaho and the Idaho National Guard.

Mountain States Group was awarded the contract to implement a suicide hotline in Idaho in SFY 2013. The hotline uses trained volunteers, and was launched on November 26, 2012. The program tracks caller demographics and general call information. There were 115 calls from November 26th through early January 2013. Of these, 36% received a scheduled follow up call.

Idaho's Suicide Prevention Council developed a suicide prevention plan in 2003 (go to website http://healthandwelfare.idaho.gov/Portals/0/Children/DocumentsSrtView.pdf). In an effort to update this plan, a Suicide Prevention Plan Development Group met in July and August 2010 to discuss new suicide prevention challenges and collaboration opportunities. Representation included former legislators, survivors, mental health consumers and their families, aging and adult care providers, youth and school

services, public and private mental health providers and veteran's mental health services, Native Americans, Hispanics and advocates for lesbian, gay, bisexual, and transgender (LGBT) persons. The Idaho Suicide Prevention Plan: An Action Guide (2011) is accessible at http://www.spanidaho.org/ispplan.pdf .

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

IV: Narrative Plan

T Use of Technology

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Narrative Question: In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe strategies the state has deployed to support recovery in ways that leverage ICT and requests are to update this information. Information requested includes a description of specific application of ICTs the State BG Plans to promote over the next two years; incentives the state is planning to put in place to encourage their use; support system the State BG Plans to provide to encourage their use; barriers to implementing these strategies and how the State BG Plans to address them; how the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine; how the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and what measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

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

The Department of Health and Welfare maintains a website. This website includes the use of dynamic forms that can be updated when there are changes. This site includes the availability of MHSIP and YSS-F Consumer Surveys that can be completed through key survey. Additionally, computer kiosks were established in SFY 2012 at each DBH Regional Mental Health Center (RMHC) site to allow consumers easier access to confidentially complete MHSIP and YSS-F surveys. As surveys may be filled out in conjunction with other appointments, this increases ease of use and likelihood of a higher consumer survey response rate. Increased consumer survey response feedback will help to guide services toward improved outcomes.

The Division of Behavioral Health (DBH) encourages use of evidence based or promising practices. Several DBH staff are responsible to track and disseminate information regarding evidence-based or promising practices. The Department of Health and Welfare maintains an on-line learning system. The Knowledge Learning Center (KLC) provides a multitude of courses for Department staff, with many courses offering Continuing Education Units (CEU's). DBH staff have contributed to the development of several courses, including Motivational Interviewing, SAMHSA's Tip 42 and a unit on Gay, Lesbian, Bisexual, Transgender and Questioning (GLBTQ) awareness.

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

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

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

As of February 2013, the Division of Behavioral Health did not have a formal plan to work with organizations such as FQHCs, hospitals, community based organizations and other local service providers to identify ways that ICTs could support the integration of mental health and addiction treatment services with primary care and emergency medicine.

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

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

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

IV: Narrative Plan

U Technical Assistance Needs

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Narrative Question: States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources. 1. What areas of technical assistance is the state currently receiving? 2. What are the sources of technical assistance? 3. What technical assistance is most needed by state staff? 4. What technical assistance is most needed by behavioral health providers?

Technical assistance the state receives and sources of technical assistance

Use of peers as service providers can empower the peer, model recovery and serve as a cost effective paraprofessional service modality. As of July 2011, Certified Peer Specialists were working on Assertive Community Treatment (ACT) teams, Projects for Assistance in Transition from Homelessness (PATH) teams and on the Idaho Home Outreach Program for Empowerment (ID-HOPE) Critical Time Intervention (CTI) team. In December 2012, the Division of Behavioral Health was awarded one of ten Recovery Infrastructure Training for Empowerment Transformation Transfer Initiative (RITE-TTI) grants from the National Association of Mental Health Project Directors (NASMHPD). The purpose of the RITE-TTI project is to build a recovery oriented system of behavioral health care through training in Recovery Coaching and development of two toolkits for statewide use. Both toolkit teams will be composed of mental health and substance use representatives from all seven regions. The recovery toolkit with a trauma focus will be shared with regional boards and other stakeholders. The action plan toolkit will provide a clear curriculum to help regional boards to identify issues and service gaps; to develop and implement an action plan to address those gaps, and to track and disseminate information on action plan outcomes. NASMHPD plans to provide ongoing technical assistance and support through monthly conference calls as the RITE-TTI project is implemented.

Regarding technical assistance provided, the Centers for Social Innovations provided technical assistance in SFY 2011to PATH Certified Peer Specialists in Mental Health First Aid, Data, Outcomes and the PATH to Housing course. Some of the ID-HOPE staff also participated in the PATH to Housing course. The ID-HOPE project was chosen as a research site for teaching Critical Time Intervention skills, and this training occurred in June 2011. SAMHSA provided technical assistance to the ID-HOPE Advisory Board on ID-HOPE sustainability planning in SFY 2013 through consultation from William Hudock.

Both CSAP and the CAPTUS are providing technical assistance to Idaho on substance abuse prevention issues. CSAP is currently working with Idaho to develop a standard pre/posttest for adolescents participating in multi-session prevention education programs. They are also providing technical assistance on methods to identify resources and needs of children of deployed military members and Native Americans and impact of early childhood trauma on youth of Idaho and training resources for prevention providers. Finally, in order to better assist the community coalitions working on population level change, the state is working with CSAP to gather a list and implementation guides for evidence based environmental strategies. Because of the effectiveness of these types of strategies, their comparatively low cost, and their sustainability, it will be increasingly important to encourage prevention providers to implement these types of activities and provide them with the necessary information to do so effectively. The CAPTUS is assisting Idaho in developing a youth ATOD/MH survey. With the loss of the Safe and Drug Free Schools program, Idaho no longer had financial resources to conduct a youth

survey. This leaves coalitions without data they need for planning and evaluation and for DFC grant reporting. The youth survey is designed to be limited to behavioral health issues and the plan is to gather sufficient data in each county so that Idaho will have county-level data for community planning.

Technical assistance needed by state staff and behavioral health providers

Idaho's technical assistance needs relate to data, collaboration with primary medical and dental agencies and use of technology to enhance the existing service delivery system, especially in rural and frontier areas. As of February 2013, the Division of Behavioral Health's Web Infrastructure for Treatment Services (WITS) system was used for Adult Mental Health and Children's Mental Health data needs, with a tentative implementation target date for the Substance Use Disorders (SUD) services by the end of SFY 2013. A data warehouse was implemented in SFY 2012, and work is in progress to determine capability to allow a crosswalk of WITS and VistA data (used by both state hospitals). The WITS system does not link to data systems for Medicaid, courts, criminal justice, primary health, schools, community hospitals or Idaho Vocational Rehabilitation. Specific requests must be made to access data from these data resources, and their data is not necessarily based on the same data element definitions as that used by the Division of Behavioral Health's WITS system. As of February 2013, there was no resource that captured co-morbidity data for behavioral health and physical health diagnoses, and this lack of data complicates efforts to accurately assess need.

Other data system challenges in Idaho relate to coordinating data from multiple state agencies with multiple billing systems and plans to implement both the ICD-10 and the DSM-V. Barriers for providers include unfamiliarity with EHR systems, lack of Internet connection in rural and frontier areas of Idaho, lack of Information Technology (IT) assistance in small provider shops, insufficient funds to purchase and maintain an EHR, and inability to take advantage of meaningful use incentives. Most providers in Idaho do not have the staffing necessary to be reimbursed through meaningful use. It would be helpful to have technical assistance to improve interlinking and interoperability between multiple data systems. It would be helpful to have guidance on implementation of the ICD-10 and the DSM-V. Technical assistance in resolving accessibility issues in rural and frontier areas and for small providers without the funds to purchase electronic health record systems would be useful.

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

The U.S. Census Bureau (2010) indicates that Idaho's population is 1,567,582, with 9 rural counties (i.e., no population center of 20,000 or more and six or more persons per square mile), 17 frontier counties (i.e., less than six per square mile) and 18 urban counties. Local SMHA service delivery is based on seven geographical Department of Health and Welfare service areas. Publicly funded Adult Mental Health (AMH) and Children's Mental Health (CMH) services are provided through Regional DBH center sites, with one Regional Program Manager responsible to oversee service delivery and quality for both programs. In an effort to expand psychiatric services to rural and frontier areas that are unable to attract or retain a psychiatrist, the Idaho system has used video conferencing to provide psychiatric services through tele-health. The high definition video conference system is also used for statewide meetings, including meetings of the State Planning Council on Mental Health. In SFY 2011, there was a cost savings for all video conference users (not just the Division of Behavioral Health) of $312,366.00. The SFY 2012 cost savings was $438,710.05. The SUDS system has been exploring the use of social media as an additional cost effective method of expanding treatment services. Technical assistance in this area may be helpful.

Additional technical assistance that may benefit persons receiving services, persons in recovery and families may include training in 1) advocacy techniques, 2) education, 3) combating stigma, 4) trauma, 5)

service access in rural and frontier areas, 6) housing, and 7) peer operated programs, supports and other services that model recovery and resilience.

After years of oversight by the Idaho Department of Health and Welfare, responsibility for Idaho's prevention system is transitioning to the Governor's Office of Drug Policy (ODP) beginning July 1, 2013. Therefore, to minimize disruption to the state's prevention system and to ensure compliance with Federal requirements, technical assistance will be requested to educate ODP staff on Federal reporting requirements, timelines, and other compliance issues.

In addition, due to the rural setting of the majority of Idaho communities, ODP would like training or technical assistance regarding the use of on-line or other network systems in providing distance education to prevention providers and community coalitions throughout the state. Specific information regarding systems that other states have found useful or effective, participant response to these systems, and participant ability to learn or retain information provided through this education modality. This information will allow ODP to determine if this type of training will best suit the needs of our state.

Idaho's community coalitions will benefit from continued Certified Alcohol and Drug Counseling (CADC) community development training and workshop. Also because Idaho is a large state with many isolated communities and few full-time prevention providers, Idaho would benefit from the development of an online webinar library that would enable providers and coalitions to have access to cutting edge research. This system would also enable individuals to access the information when it is pertinent to what they are doing and when they have time to listen.

Input from Idaho Citizens: Several activities were implemented in January/February 2013 in an effort to solicit input from Idaho citizens into the development of the SFY 2014-2015 Combined SAPT/MH Block Grant. The need to develop the plan was presented to the State Planning Council on Mental Health at their January 2013 quarterly meeting, with a request to provide input through a specific block grant survey link on the external Department of Health and Welfare (DHW) website. Regional Division of Behavioral Health program managers were encouraged to respond to the website, and to share the invitation with local providers and, regional boards. The Division of Behavioral Health communicated with the Director of the Idaho Division of Vocational Rehabilitation (IDVR) and requested their input into the plan. The IDVR Director also contacted leaders of four Tribes that IDVR works well with, and invited them to also participate in responding to questions posted on the external DHW website. An internal Division of Behavioral Health survey also solicited input on block grant planning for SFY 2014-2015. Responses from the internal and external websites were incorporated into the narrative sections of the SFY 2014 -2015 Plan.

Recommendations documented on the internal and external websites in response to the request for input on technical assistance needs were varied. One individual suggested improvements to computer systems and assistance in problem solving service access and transportation challenges in rural and frontier communities. Requests for assistance in building effective community supports and aftercare were submitted. Additional comments identified a need to cross train courts, corrections and behavioral health systems. Suicide prevention was mentioned, with a request to hire a suicide prevention coordinator. Data needs were identified as a high priority, with a focus on behavioral and primary care services, outcomes and interventions. Concerns were expressed about statewide health and mental health professional shortage areas, with a request for assistance in identifying methods to fill those service gaps.

State Planning Council Technical Assistance Needs

In February 2013, the Division of Behavioral Health collaborated with the State Planning Council on Mental Health to submit a request to SAMHSA for technical assistance. The Council

has identified several specific issues, concerns and challenges that impact its ability to transition to a Behavioral Health Planning Council (BHPC).

The state of Idaho consists primarily of rural and frontier areas. Efforts to ensure face to face representation from the entire state often require Council members to travel and an overnight stay for quarterly meetings. For some, this requires leaving families and taking time off of work.

The Council supplements two face to face meetings per year with two video conferenced meetings. Video conferencing is helpful with respect to allowing members to communicate, but members must travel to a central regional site to participate in video conference meetings, and turnout is not always good. While the quality of the video conference equipment is good, it is not the same as the quality of communication available through face to face meetings.

There are limited funds available to support Council activities. Historically, the $20,000 allocation has not covered much beyond the costs of two three day face to face meetings. Transportation costs for travel, lodging and meals can be expensive. The Division of Behavioral Health provides administrative support at no cost to the Council.

The Council has had challenges with recruitment. For example, it is difficult to recruit and retain Tribal representatives from any of the six Idaho identified Tribes.

Managing meetings can sometimes be difficult, as some members tend to monopolize the meeting with long stories that may or may not be relevant to the issues being addressed by the Council. Respectful facilitation of these meetings can be challenging.

The existing Council does not have expertise on SUD issues. Cross training on the Idaho SUD infrastructure, system and issues will be integral to transforming the Council into an effective BHPC.

The existing Council does not have the knowledge, skills or expertise to smoothly transition to an integrated BHPC. There is no clear plan to 1) recruit SUD representatives from all regions of the state, 2) cross train existing members in SUD systems and issues, 3) cross train new SUD representatives in MH systems and issues, 4) ensure a balanced BHPC representation of Council members, 5) identify agendas and issues that are relevant to all BHPC members, 6) integrate BHPC members into a productive Council with clear goals and objectives, 7) identify funding to support the costs of an expanded BHPC, 8) expand and integrate the Council while preserving consumer and family member voices and representation, or 9) transition to a BHPC with a focus on developing an integrated, recovery oriented system of behavioral health care. The request for technical assistance was based on the following objectives, strategies and projected timelines:

Council Objective	TA Strategy/TA Activity	Proposed TA Provider	Timeline
Objective 1: Develop a recruitment plan that will ensure a full and balanced behavioral health representation on the Council and Regional Boards	Strategy 1; Identify ways that other Councils and Boards have recruited a balanced membership on behavioral health councils	SAMHSA – To be identified	6/2013
	Strategy 2: Identify mandatory Council and Board membership roles and possible individuals that could meet those requirements	SAMHSA – To be identified	6/2013

	Strategy 3: Prepare a descriptive package that defines expectations for Council and Board members to share with possible new recruits	SAMHSA – To be identified	8/2013
Objective 2: Identify funding to support the expanded Council and Regional Boards	Strategy 1: Identify best practices related to how other states are funding expanded behavioral health councils	SAMHSA – To be identified	8/2013
Objective 3: Educate Council and Regional Board members on both mental health and substance use disorder issues, concerns, systems and resources	Strategy 1: Educate on mental health and substance use disorder issues, concerns, systems and resources	SAMHSA – To be identified	8/2013
	Strategy 2: Educate on impact of Affordable Care Act and other national initiatives on behavioral health systems	SAMHSA – To be identified	8/2013
	Strategy 3: Educate Council and Boards on Medicaid Managed Care impact on behavioral health systems	SAMHSA – To be identified	8/2013
Objective 4: Identify agendas, procedures and issues to address a broader behavioral health perspective.	Strategy 1: Identify best practice business training specific for Council and Regional Board needs	SAMHSA – To be identified	8/2013
	Strategy 2: Identify ways to screen, assess and evaluate needed reports for local, state and federal requirements	SAMHSA – To be identified	8/2013

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.[45] This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

STATE DEPARTMENT OF EDUCATION

P.O. BOX 83720
BOISE, IDAHO 83720-0027

TOM LUNA
STATE SUPERINTENDENT
PUBLIC INSTRUCTION

March 4, 2013

Ross Edmunds
Idaho Department of Health and Welfare
Division of Behavioral Health
PO Box 83720
Boise, ID 83702

Dear Mr. Edmunds,

The intent of this letter is to express support for the SFY 2014-2015 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant. As you have described, the block grant goals of promoting improved services and implementing evidence-based practices for youth with emotional and behavioral disturbances, substance abuse issues, and/or co-occurring disorders are congruent with our department goals.

Successful collaborative efforts between the Department of Education and the Division of Behavioral Health (DBH) currently include examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe and supported in their social-emotional development. For those youth at-risk of emotional, behavioral and substance use disorders, we partner to ensure they have the services and supports needed to succeed academically, and socially as well. The Division's Children's Mental Health (CMH) program and the Department of Education collaborate with local school districts to implement intensive community and school-based programs for children and youth with serious emotional disorders (SED). The Department of Health and Welfare provides technical assistance and professional subject matter expertise on youth with serious emotional and/or social disorders.

The Department of Education hopes to continue these collaborative efforts with the Division of Behavioral Health, as well as future partnering opportunities toward achieving the block grant goals. This collaboration will facilitate efforts to help children, youth and families navigate the system of care continuum, reduce out of home placements, and improve educational outcomes.

Feel free to contact me for more clarification on the State Department of Education's support of this effort.

Respectfully,

Matt

Matt McCarter, Director
Student Engagement & Postsecondary Readiness
State Department of Education
(208)332-6961
mamccarter@sde.idaho.gov

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

ROBERT B. LUCE – Administrator
DIVISION OF FAMILY AND COMMUNITY SERVICES
450 West State Street, 5th Floor
P.O. Box 83720, Boise, ID 83720-0036
PHONE 208-334-0641
FAX 208-332-7330

March 4, 2013

Ross Edmunds
Idaho Department of Health and Welfare
Division of Behavioral Health
PO Box 83720
Boise, ID 83702

Dear Mr. Edmunds:

The Division of Family and Community Services (FACS) supports Idaho's SFY 2014-2015 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant application. The block grant goals to improve services and implement evidence-based practices for youth with emotional and behavioral disturbances, substance abuse issues, and/or co-occurring disorders are in line with our Division goals.

The Division of Family and Community Services has a history of collaborating with the Division of Behavioral Health (DBH) in an effort to provide best practice services to Idaho citizens. The Idaho FACS programs address child welfare and protection, foster care, and adoption. The DBH Children's Mental Health programs work with local child welfare agencies to resolve family issues that may put children at risk for maltreatment, out-of-home placement, and involvement with the foster care system. A Memorandum of Understanding (MOU) between the DBH and FACS (April 2011) outlines shared efforts regarding infant and early childhood mental health services. Another MOU describes the service coordination process for children served in both programs. The Department's service integration program works with Idaho's Health Information and Referral Center to facilitate family efforts to navigate the range of Department programs and services. The Substance Use Disorders (SUD) program has established child protection drug courts in Idaho. The Division of Behavioral Health has agreed to consult with FACS on use of IV-E funding for post-adoption services.

FACS plans to continue to collaborate and explore future partnering opportunities with DBH in support of the block grant goals to help youth and families navigate the continuum of care system, prevent out-of-home placements, and facilitate smooth transitions back into the community.

Sincerely,

Robert B. Luce, Division Administrator
Division of Family and Community Services

RBL/cc

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

ELKE SHAW-TULLOCH, MHS – ADMINISTRATOR
DIVISION OF PUBLIC HEALTH
450 West State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
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FAX 208-334-6581
EMAIL ShawE@dhw.idaho.gov

March 4, 2013

Ross Edmunds
Idaho Department of Health and Welfare
Division of Behavioral Health
P.O. Box 83720
Boise, ID 83702

Dear Mr. Edmunds:

The Idaho Division of Public Health supports the Division of Behavioral Health's SFY 2014-2015 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant. The block grant goals to promote improved services and implement evidence-based practices for youth and/or adults with behavioral health diagnoses and to improve linkages between primary health and behavioral health are in line with the goals of the Division of Public Health.

The Division of Public Health and the Division of Behavioral Health have a history of collaboration. Eligible children and families may access medical and preventative health services through the Idaho Department of Health and Welfare's seven regional offices; through Idaho's seven local public health districts (through contracts with the Division of Public Health); and through other regionally based organizations and providers. Local public health services may include: clinical and home health nursing (family planning, immunizations, school-based nursing); WIC (supplemental nutrition program for women, infants and children); emergency medical services; chronic disease prevention and control; suicide prevention; and school-based services (oral health education, fluoride treatments, and sealants as well as coordinated school health efforts such as physical activity, nutrition, tobacco prevention). Past collaborative efforts include the SFY 2010 H1N1 Response Workgroup, the Substance Use Prevention and Treatment Tobacco Project and joint support and participation in the Idaho Council on Suicide Prevention and the development of the Idaho Suicide Prevention Hotline.

The Division of Public Health welcomes opportunities and linkages that encourage the provision of quality primary and behavioral health care for Idaho citizens.

Sincerely,

Elke Shaw-Tulloch, MHS, Administrator
Division of Public Health

Cc: Dieuwke Dizney-Spencer, MHS, RN, Deputy Division Administrator

Idaho Department of Juvenile Corrections

954 W Jefferson Street P.O. Box 83720 Boise, ID 83720-0285 Phone: (208) 334-5100 Fax: (208) 334-5120

Telecommunications Relay Service (TRS) 1 800 377-3529

C.L. "BUTCH" OTTER
Governor

SHARON HARRIGFELD
Director

March 5, 2013

Mr. Ross Edmunds
Idaho Department Health and Welfare
Division of Behavioral Health
P O Box 83720
Boise, ID 83720-0036

Dear Mr. Edmunds:

The Idaho Department of Juvenile Corrections (IDJC) is supportive of the 2014-2015 Combined SAPT/Mental Health Block Grant. As you have described, the Block Grant goals of promoting improved services and implementing Evidence-Based Practices, for youth with emotional and behavioral disturbances, substance abuse issues, and/or co-occurring disorders are in line with our Department goals.

To date, there have been several successful collaborative efforts between the Division of Behavioral Health (DBH) and IDJC. The Department of Health and Welfare (H&W) has Memoranda of Agreement with IDJC and all of the county administered juvenile detention facilities in the state for placement of clinicians in the facilities. These clinicians assist with services for juveniles detained with mental health issues. The state of Idaho uses some Children's Mental Health program general funds to support the cost of these clinicians. Another effort with DBH includes the Juvenile Justice Children's Mental Health (JJCMH) meetings. The JJCMH, which includes members from state, county, court, and consumer stakeholders, meets quarterly to resolve obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored dissemination on the implementation of a Youth Mental Health Court, which uses the wraparound service model, in three counties with interest in expansion to other counties. Another collaborative effort includes the Strengthening Families Round Table, which is a diverse group of stakeholders, who meet every other month to brainstorm innovative ideas for family empowerment and support. IDJC and DBH are finalizing a Memorandum of Understanding along with the courts for coordination of substance abuse services, as well as each partner's roles and responsibilities for their shared populations in their respective programs.

The Department of Juvenile Corrections hopes to continue to collaborate with the Division of Behavioral Health. IDJC looks forward to future partnering opportunities toward achieving the Block Grant goals including collaborating with the courts to help youth and families navigate the continuum of care system, prevent or divert incarcerations, and facilitate smooth transitions back into the community.

Sincerely,

Sharon Harrigfeld
Director

SH:sn

An active partnership with communities

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

PAUL J. LEARY - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

March 6, 2013

Mr. Ross Edmunds, Administrator
Division of Behavioral Health
Idaho Department of Health and Welfare
P O Box 83720
Boise, ID 83702-0036

Dear Mr. Edmunds,

As the Division of Medicaid we are supportive of the 2014-2015 Combined Mental Health and Substance Abuse Block Grant. As you have described, the Block Grant goals of promoting improved services and implementing Evidence-Based Practices for youth with emotional and behavioral disturbances, adults with serious mental illnesses, substance abuse issues, and/or co-occurring disorders are in line with our Division goals. We look forward to ongoing partnering with your Division to implement the Block Grant goals in the upcoming years.

Many collaborative efforts already exist between our two Divisions. The Division of Behavioral Health has participated in several Medicaid workgroups to improve the Medicaid mental health benefits package based upon client need. The Division of Medicaid collaborates with the Division of Behavioral Health's State Mental Health Authority (SMHA) and Single State Authority (SSA) in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the Medicaid population. The Division of Behavioral Health is the Medicaid provider for Substance Use Disorder (SUD) treatment services in Idaho. which are handled through a SUD Management Services Contract. The Division of Medicaid contracts with private providers for delivery of mental health services to Idaho children and adults. The Divisions are collaborating with consumers and other state agencies for the "Money Follows the Person" Home Choice Program. As of March 2013, Medicaid is close to awarding a managed care contract with a target implementation date of July 1, 2013, for the administration of mental health benefits. The Division of Behavioral Health provided input into the request for proposal for the managed care contract.

The Division of Medicaid appreciates the opportunities to collaborate with the Division of Behavioral Health and hopes to continue to partner toward achieving the Block Grant goals and future efforts to implement the identified behavioral health transformation plan.

Sincerely,

PAUL J. LEARY
Administrator

PJL/ksl

IDAHO DEPARTMENT OF CORRECTION

"Protecting Idaho through Safety, Accountability, Partnerships, and Opportunities for Offender Change"

C. L. "BUTCH" OTTER
Governor

BRENT D. REINKE
Director

March 4, 2013

Ross Edmunds
Idaho Department of Health and Welfare
Division of Behavioral Health
PO Box 83720
Boise, ID 83702

Dear Mr. Edmunds,

The mission of the Idaho Department of Correction (IDOC) is to protect Idaho through safety, accountability, partnerships and providing opportunities for offender change. Our mission is best accomplished by establishing partnerships with stakeholders who share our commitment to the community. As such, the Idaho Department of Correction (IDOC) is supportive of the Division of Behavioral Health's (DBH) Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant for SFY 2014-2015.

As you have described, the block grant goals of promoting improved services and implementing evidence-based practices for adults with serious mental illness, substance abuse issues, and/or co-occurring disorders are in line with our Department goals. Successful collaborative efforts between the Department of Correction and the Division of Behavioral Health (DBH) already include service to individuals referred through mental health and drug diversion courts. Mental health courts frequently refer individuals to DBH for treatment.

The model used to support mental health court referrals is Assertive Community Treatment (ACT). ACT teams work with court representatives to develop individualized treatment plans for court referred participants. Treatment plans are designed to help participants stabilize, learn life management skills and avoid additional criminal activities. ACT staff attend weekly court sponsored meetings to discuss progress and needs of mental health court referred clients.

The Department of Correction values its partnership with the Division of Behavioral Health. These collaborative efforts help individuals navigate the system of care continuum, prevent or divert incarceration, and facilitate smooth transitions back into the community.

Sincerely,

Brent Reinke, Director
Idaho Department of Correction

C.L. "Butch" Otter

Governor

Elisha Figueroa

Administrator

304 N 8th Street, Room 455

Boise, ID 83702

208-854-3042

208-854-3041

State of Idaho

Office of Drug Policy

Executive Office of the Governor

March 12, 2013

Idaho Department Health and Welfare
Division of Behavioral Health
P O Box 83720
Boise, ID 83702

Dear Mr. Edmunds,

The Idaho Office of Drug Policy supports Idaho's 2014-2015 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant application. The Block Grant goals to focus on the prevention of underage drinking, prescription drug abuse and normalizing marijuana use are consistent with our organization's goals.

The Office of Drug Policy has a history of collaborating with the Division of Behavioral Health in an effort to support development of strong positive family values and implement needs-based services to Idaho citizens. The Idaho Office of Drug Policy's mission is to lead Idaho's substance abuse policy and prevention efforts by developing and implementing strategic action plans and collaborative partnerships to reduce drug use and related crime, thereby improving the health and safety of all Idahoans. The Division of Behavioral Health programs work with my staff to support community coalitions and cross agency planning to prevent alcohol and drug abuse. A designated Division program specialist serves as a liaison to my office to support comprehensive planning and ensure no duplication of efforts. Representatives from Division participated in the State Strategic Prevention Planning Committee and assisted with the development of the state's prevention plan. The Division's State Epidemiological Outcomes Workgroup staff have provided necessary data resources for development of the state prevention plan as well as developing websites designed to support community-level planning.

The Office of Drug Policy will expand its collaborative efforts with Division on 2014 by taking on management of the primary prevention set-aside within the Substance Abuse Prevention and Treatment Block Grant. This partnership will enable Idaho to unite all prevention efforts under one unit within state government and ensure there is no duplication of effort. Based on the resources the Division has established to date, Idaho is well placed to continue delivering effective prevention programming.

Sincerely,

Elisha Figueroa, Administrator

IV: Narrative Plan

V Support of State Partners

Page 84 of the application Guidance

Narrative Question: The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information exchanges (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.[45] This could include, but is not limited to:

- **The State Medicaid Agency** agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- **The state justice system** authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- **The state education agency** examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- **The state child welfare/human services department**, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- **The state public health authority** that provides epidemiology data and/or provides or leads prevention services and activities.

Support of State Partners

Idaho has been in the process of reviewing the public behavioral health service system (i.e., mental health and substance use prevention and treatment) for several years, with a focus on transforming the system such that "Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery." Governor Otter signed Executive Order 2011-01 on January 27, 2011, which established the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) Counties. One charge to the IBHIC is to "d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho's Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho's budget, current needs of the agencies, and recommendations of the Idaho Health Care Council."

State Education Agency

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

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

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

The SSA also partners with state and local education agencies on the delivery of prevention education and afterschool programming, provision of prevention materials and videos and youth surveys. This partnership has provided youth with prevention services they would not have received as well as providing the SSA with youth-based data needed for community-level planning.

State Medicaid Agency

The Division of Behavioral Health is the Medicaid provider for Substance Use Disorder (SUD) treatment services in Idaho. Local substance use disorders (SUD) services for adults and children are provided through an array of private treatment providers. A Management Services Contractor is responsible to manage this array of SUD treatment providers, prior authorize services, conduct SUD utilization reviews and provide data to the Division for state and federal reporting. The Division is in the process of identifying a contractor through a Request for Proposal (RFP) process to manage the treatment service delivery through a network of Department approved treatment providers for SFY 2014. This contractor will also be responsible to provide care management utilization review. Care Management responsibilities include 1) use of a statewide 1-800 number for eligibility screenings, 2) making an initial ASAM PPC-2R level of care determination and 3) prior authorizing units of service. The Division of Medicaid contracts with private providers for delivery of mental health services to Idaho children and adults.

The Medicaid managed care organization (MCO) contract was offered to OptumHealth in February 2013. A 1915b waiver will be in place as the funding authority to support the MCO contract. Qualis signed a three year contract renewal with Medicaid in June 2011 to provide case management and utilization management services. The agency that is awarded the contract to implement Medicaid Managed Care will provide an integrated oversight of all behavioral health Medicaid services (mental health and substance

use) to adults and children in the state of Idaho. Eligible services are expected to start with currently available Medicaid behavioral health services. Depending on the MCO focus, there may be enhancements in the areas of crisis, prevention and service access.

The Divisions of Behavioral Health and Medicaid collaborate with consumers and other state agencies to implement the "Money Follows the Person" Home Choice Program. In SFY 2012-2013, the Division of Medicaid will consult with the Division of Behavioral Health's SMHA and SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.

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

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

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

Health Insurance and Health Information Exchanges

In March 2010, the new health reform law (Patient Protection and Affordable Care Act; also called ACA) was enacted. It provides new options for coverage by expanding Medicaid eligibility to more low-income people and creating state-based health insurance "exchanges" through which insurance coverage can be purchased. The State of Idaho's Department of Insurance (DOI) obtained a grant for Health Insurance Exchange planning in October 2010. This has been a controversial issue in Idaho. As of February 2013, the Governor and legislature had not committed to the development of an Idaho health insurance exchange. Additional information is anticipated by the end of the legislative session in March or April of 2013.

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

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

State Department of Justice

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

As of February 2013, there were several established formats for collaboration between the Division of Behavioral Health and Juvenile Corrections. The Department of Health and Welfare has Memorandums of Agreement with the Department of Juvenile Corrections that describe placement of clinicians in all of the county administered juvenile detention center facilities in the state. Clinicians placed at juvenile detention centers assist with evaluations, service referrals and crisis counseling for both mental health and substance abuse. The State of Idaho uses some of the state general funds allocated to the Children's Mental Health program to support the costs of those placements. Other collaborative efforts with the Department of Juvenile Corrections include the Juvenile Justice Children's Mental Health (JJCMH) meetings and Strengthening Families Round Table meetings. The JJCMH, which includes members from county probation, Department of Juvenile Corrections, Department of Education, parent advocates, the court system, Department of Health and Welfare and outside providers, meets quarterly to resolve obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored dissemination on the implementation of a Youth Mental Health Court in three counties (as of July 2011) with interest in expansion to other counties. The Youth Mental Health Court uses the wraparound service model to facilitate treatment planning and coordination. The workgroup has adopted a definition of family involvement and is working on specific strategies for family involvement across systems. The JJCMH group is also working on a white paper outlining multi-agency implementation of trauma informed care. The Strengthening Families Round Table meets every other month to brainstorm innovative ideas for family empowerment and support.

Department of Correction and courts collaborate to provide services to individuals referred through mental health courts. The Division of Behavioral Health's Adult Mental Health program serves eligible mental health court referred clients primarily through Assertive Community Treatment (ACT) teams in each region. ACT staff work closely with court representatives to develop individualized treatment plans for shared clients. Treatment plans are designed to help participants stabilize and learn additional life management skills (e.g., taking medications, ending drug/alcohol abuse, avoiding criminal activities). ACT staff attend weekly court sponsored meetings to discuss progress and needs of mental health court

referred clients. During SFY 2012, Mental Health Court Utilization operated at approximately 86% of capacity. The Division of Behavioral Health's Substance Use Disorders (SUD) program has Memorandums of Understanding with Idaho Department of Correction, Idaho Department of Juvenile Corrections and the courts for coordination of the delivery of SUD treatment services to their respective populations.

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

The 2012-2013 MH/SAPT Block Grant focused on mental health and substance abuse prevention and treatment for children and adults, and the 2014-2015 plan will do the same. The Division of Behavioral Health will continue to collaborate with the Departments of Correction and Juvenile Corrections and the courts to help individuals and families navigate the system of care continuum, prevent or divert from incarceration and facilitate smooth transitions for incarcerated individuals back into the community of choice.

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

Medical services for children with SED may be funded by Medicaid, the Children's Health Insurance Program (CHIP), private insurance, county welfare services or private pay modalities. House Bill 376 (2003) directs that medical coverage be provided for children and adults with income between 150-185% of the Federal Poverty Guidelines. In response to this legislation, CHIP-B provides low cost health coverage to children without insurance who do not not qualify for either Medicaid or regular CHIP services.

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

Districts respond to local service needs, with some resource and service variation among districts and through contracts with the Department of Health and Welfare. Services may include community and home health nursing (i.e., family planning, immunizations, school-based nursing); environmental health; Women with Infants and Children's (WIC) supplemental nutrition program for women, infants and children; and school-based oral health services (i.e., education, fluoride mouth rinse, fluoride varnish and sealants). Other partners, such as Delta Dental and Terry Reiley Health Services, provide oral health services. While few Idaho dentists accept Medicaid, there are Idaho dentists that donate time to provide free dental care for children and low-income families. The Idaho Oral Health Alliance, a not-for-profit organization, is also working toward increased access to oral health care.

The Division of Public Health's Bureau of Community and Environmental Health conducts a variety of health education and health promotion programs directed to encouraging healthy choices and healthy behaviors. Programs include adolescent pregnancy prevention , comprehensive cancer control, coordinated school health, diabetes prevention and control, environmental health (including a public listing of properties seized as clandestine drug laboratories), Fit and Fall Proof™ (fall prevention exercise for seniors), heart disease and stroke prevention, tobacco prevention and cessation, sexual violence

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

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

The Division of Behavioral Health's Idaho Tobacco Project works with the Division of Public Health's Tobacco Prevention and Cessation Program. Both organizations respond to public inquiries and provide information on available resources. The SSA's WSN representative also serves on the Public Health's Maternal, Infant, and Early Childhood Home Visiting Program board. Information on substance use disorder treatment and substance abuse prevention resources as well as cross training have been provided to board members and to community organizations delivering the home visiting services.

State Child Welfare/Human Services Department

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

The Division of Behavioral Health consults and collaborates with FACS on issues related to accessing mental health services for children served through the child protection and adoption programs. The two Divisions collaborated on the design of a Treatment Foster Care program and an associated program to train Treatment Foster parents. Staff from both Divisions were trained on the Treatment Foster Care model and the training program for foster parents. In SFY 2012, the two Divisions collaborated on addressing use of poly pharmaceuticals with children in foster care.

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

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

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45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

IV: Narrative Plan

W State Behavioral Health Advisory Council

Page 85 of the application Guidance

Narrative Question: Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. SAMHSA encourages states to expand and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.). Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council. There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

State Planning Council Members as of February 2013 (see also forms on BGAS)

Name	Type of Membership	Agency or Organization Represented
Rep. Sharon Block	Agency	Legislature
Kathie Garrett	Agency	Idaho Council on Suicide Prevention
Pat Martelle (Guidry)	Agency	Division of Medicaid
Gary Hamilton	Agency	Division of Vocational Rehabilitation
Julie Williams	Agency	Housing
Teresa Wolf	Agency	Social Services
Lisa Koltes, MD	Board Member	Region III MH Board
Dr. Linda Hatzenbuehler	Board Member	Region VI MH Board
Kim Jardine-Dickerson	Agency	Division of Education
Stan Calder	Consumer	Region I Consumer
Jennifer Griffis	Family	Region II Family
Martha Ekhoff	Consumer	Region IV Consumer
Rick Huber	Consumer	Region V Consumer
Linda Johann	Family	Region I Family
Captain Rick Capell	Agency	Law Enforcement

Lynne Whiting	Family	Region VII Family

Requirements For SPC Membership Per Proposed Legislation

1. No less than (50%) family members and consumers

Current Members of SPC		
Name	Type of Membership	Agency or Organization
Rep. Sharon Block	Agency	Legislature
Kathie Garrett	Agency	Idaho Council on Suicide Prevention
Pat Martelle	Agency	Division of Medicaid
Gary Hamilton	Agency	Division of Vocational Rehabilitation
Julie Williams	Agency	Housing
Teresa Wolf	Agency	Social Services
Captain Rick Capell	Agency	Law Enforcement
Kim Jardine Dickerson	Agency	Division of Education
Dr. Linda Hatzenbuehler	Board Member	Region VI MH Board
Lisa Koltes, MD	Board Member	Region III MH Board
Stan Calder	Consumer	Region I Consumer
Martha Ekhoff	Consumer	Region IV Consumer
Rick Huber	Consumer	Region V Consumer
Jennifer Griffis	Family	Region II Family
Linda Johann	Family	Region I Family
Lynne Whiting	Family	Region VII Family

2. Membership shall also reflect to the extent possible the collective demographic characteristics of Idaho's citizens.
http://quickfacts.census.gov/qfd/states/16000.html

Idaho Population, 2012		1,595,728
Ethnicity	**Idaho**	**U.S.**
White persons, percent, 2011 (a)	93.90%	78.10%
Black persons, percent, 2011 (a)	0.80%	13.10%

American Indian and Alaska Native persons, percent, 2011 (a)	1.70%	1.20%
Asian persons, percent, 2011 (a)	1.30%	5.00%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.20%	0.20%
Persons reporting two or more races, percent, 2011	2.10%	2.30%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	11.50%	16.70%
White persons not Hispanic, percent, 2011	83.60%	63.40%

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories

3. The planning council membership shall strive to include representation from:

Consumers	Stan Calder	Region I consumer
	Martha Ekhoff	Region IV Consumer
	Rick Huber	Region V Consumer
Families of Adult Individuals	Linda Johann	Region I Family
	Lynne Whiting	Region VII Family
Families of Children	Jennifer Griffis	Region II Family
Principal State Agencies Judicial Branch	No members	
Education	Kim Jardine Dickerson	Division of Education
Vocational	Gary Hamilton	Vocational Rehabilitation
Criminal Justice	Captain Rick Capell*	Law Enforcement

Adult Correction/Juvenile

Title XIX of social Security	No members

*Does Capell count as both Adult Corrections and juvenile Justice?

4. Public and Private Entities concerned with the need, planning, operation, funding and use of Mental health Services or Substance use disorders, and related support services.

Public/Private Entities	Kathie Garrett	Idaho Council on Suicide Prevention
	Julie Williams	Housing

5. The Regional Mental Health Board in each department of Health and Welfare region as provided for in section 39-31302, Idaho Code.

This is the only Proposed Legislation requirement where SPC members overlap

Region I Advisory Board	Stan Calder Linda Johann
Region II Advisory Board	Jennifer Griffis Teresa Wolf *Ex Officio
Region III Advisory Board	Lisa Koltes
Region IV Advisory Board	Martha Ekhoff
Region V Advisory Board	Rick Huber
Region VI Advisory Board	Linda Hatzenbuehler
Region VII Advisory Board	Lynne Whiting Kim Jardine-Dickerson

6. The Planning Council may include members of the legislature and the state judiciary.

Legislature	Rep. Sharon Block

States must consider the following:

Describe the planning mechanism that the state uses to plan and implement substance abuse services. Describe how these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services:

From 2007-2011 the Interagency Committee on Substance Abuse Prevention and Treatment was responsible to provide support and guidance regarding Substance Use Disorder (SUD) treatment and prevention. The committee representation included entities whose clients used publically-funded treatment, community members and consumer representatives. This committee sunsetted in June 2012 and was replaced by a similar cooperative. The State Mental Health Planning Council is composed of representative consumers, family members, representatives from education, employment, housing, etc. The State Mental Health Planning Council provides input into the block grant and provides feedback to the State Mental Health Authority (SMHA) on mental health issues of concern.

One legislative proposal, SB 1114, would allow for establishment of a state Behavioral Health Planning Council and Regional Behavioral Health Boards. The Council will be charged with advocating for citizens with behavioral health diagnoses; advising the state behavioral health authority on concerns, policies and programs; providing input into the state's behavioral health systems plan; monitoring and evaluating allocation and adequacy of behavioral health services and state laws; ensuring those with behavioral health diagnoses have access to prevention and treatment services; and presenting an annual report to the Governor. The described SB 1114 role for Regional Behavioral Health Centers is to "…provide or arrange for the delivery of services that…will lead to the establishment of a comprehensive regional behavioral system of care." Some regions have already begun the process of merging mental health and substance use into one behavioral health board.

The Division of Behavioral Health is in the process of identifying a Substance Use Disorder (SUD) Management Services Contractor who will be responsible for enrollment and management of Idaho SUD services providers. Substance use services will be tracked by the SUD Management Services contractor identified in the current Request for Proposal process. Individuals receiving Medicaid services will be tracked by the Medicaid Managed Care organization.

Please describe how the Council was actively involved in developing the State Combined MH/SAPT Block Grant Plan for SFY 2014-2015:

Several activities were implemented in January/February 2013 in an effort to solicit input from Idaho citizens into the development of the SFY 2014-2015 Combined SAPT/MH Block Grant. The need to develop the plan was presented to the State Planning Council on Mental Health at their January 2013 quarterly meeting, with a request to provide input through a specific block grant survey link on the external Department of Health and Welfare (DHW) website. Regional Division of Behavioral Health program managers were encouraged to respond to the website, and to share the invitation with local providers and regional boards. The Division of Behavioral Health communicated with the Director of the Idaho Division of Vocational Rehabilitation (IDVR) and requested their input into the plan. The IDVR Director also contacted leaders of four Tribes that IDVR works well with, and invited them to participate in responding to questions posted on the external DHW website. An internal Division of Behavioral Health survey also solicited input on block grant planning for SFY 2014-2015. Responses from the internal and external websites were incorporated into the narrative sections of the SFY 2014 -

2015 Plan. The Executive Committee of the State Planning Council also reviewed the Plan and wrote a letter of support in March 2013.

Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?

From 2007-2011 the Interagency Committee on Substance Abuse Prevention and Treatment was responsible to provide support and guidance regarding Substance Use Disorder (SUD) treatment and prevention. The committee representation included entities whose clients used publically-funded treatment, community members and consumer representatives. This committee sunsetted in June 2012 and was replaced by a similar cooperative.

One legislative proposal, SB 1114, would allow for establishment of a state Behavioral Health Planning Council and Regional Behavioral Health Boards. The Council will be charged with advocating for citizens with behavioral health diagnoses; advising the state behavioral health authority on concerns, policies and programs; providing input into the state's behavioral health systems plan; monitoring and evaluating allocation and adequacy of behavioral health services and state laws; ensuring those with behavioral health diagnoses have access to prevention and treatment services; and presenting an annual report to the Governor. The described SB 1114 role for Regional Behavioral Health Centers is to "…provide or arrange for the delivery of services that…will lead to the establishment of a comprehensive regional behavioral system of care." Some regions have already begun the process of merging mental health and substance use into one behavioral health board.

Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Membership is defined by legislation, and includes efforts to ensure representation of service area populations with respect to ethnic, cultural, linguistic, rural, suburban, urban, older adults and families with young children.

Please describe the duties and responsibilities of the Council.

One legislative proposal, SB 1114, would allow for establishment of a state Behavioral Health Planning Council and Regional Behavioral Health Boards. The Council will be charged with advocating for citizens with behavioral health diagnoses; advising the state behavioral health authority on concerns, policies and programs; providing input into the state's behavioral health systems plan; monitoring and evaluating allocation and adequacy of behavioral health services and state laws; ensuring those with behavioral health diagnoses have access to prevention and treatment services; and presenting an annual report to the Governor. The described SB 1114 role for Regional Behavioral Health Centers is to "…provide or arrange for the delivery of services that…will lead to the establishment of a comprehensive regional behavioral system of care.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year: 2014

End Year: 2015

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Martha Ekhoff	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1720 Jefferson Boise, ID 83702 PH: 208-336-5533	
Rick Capell	State Employees		P.O. Box 2877 Pocatello, ID 83205-2877	rcapell@pocatello.us
Kathie Garrett	State Employees		ID PH: 208-344-5838	kgarrettidaho@aol.com
Gary Hamilton	State Employees		ID PH: 208-769-1441	ghamilton@vr.idaho.gov
Kim Jardine-Dickerson	State Employees		PH: 208-282-1102	Jardsvsa@ISU.edu
Lisa Koltes	State Employees		PH: 208-453-9470	koltesL@dhw.idaho.gov
Pat Martelle	State Employees		3232 Elder St. Boise, ID 83720 PH: 208-346-1813	martellep@dhw.idaho.gov
Julie Williams	State Employees		P.O. Box 7899 Boise, ID 83707-1899 PH: 208-799-3095	juliew@ihfa.org
Teresa Wolf	State Employees		P.O. Box 896 Boise, ID 83501 PH: 208-799-3095	teresawolf@co.nezperce.id.us
Stan Calder	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1785 Windsor Coeur d'Alene, ID 83815 PH: 208-620-1118	stanleysteamer51@yahoo.com
Jennifer Griffis	Parents of children with SED		155 Cheyenne Drive Grangeville, ID 83530 PH: 208-507-1754	jengriffis@gmail.com
Linda Hatzenbuehler	Others (Not State employees or providers)		BOX 8090-CD 186 Pocatello, ID 83209 PH: 208-282-3992	hatzlind@isu.edu
Rick Huber	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		309 Pashermakay Court #7 Rupert, ID 83350 PH: 208-436-1841	rick2727272000@yahoo.com
Linda Johann	Family Members of Individuals in Recovery (to include family members of adults with SMI)		11655 W. Manitoba Court Post Falls, ID 83854 PH: 208-773-2778	ljohann@air-pipe.com
			160 N. Shilling	

Lynne Whiting	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Ave. Blackfoot, ID 83221 PH: 208-403-9140	Lynniem57@hotmail.com

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year: 2014

End Year: 2015

Type of Membership	Number	Percentage
Total Membership	16	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	1	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	8	50%
State Employees	8	
Providers	0	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	8	50%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

Narrative X – Improving Enrollment and Business Practices, Including Billing – This change inserts the following new language: "Improving enrollment processes and provider business practices Each state is asked to set-aside three percent each of its SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Response: Integration of consumer and participant health information data, eligibility and enrollments are integral parts of the Division of Behavioral Health's plan to increase access to appropriate care and better treatment outcomes. As such, the state plans to use at least three percent (3%) of each of the mental health and substance abuse block grants to support capacity and infrastructure for provider use of electronic health records including billing and client eligibility services by using the Web Infrastructure for Treatment Services (WITS) platform already adopted in many states and counties.

Funding will assist in state efforts to encourage public and private providers to undertake meaningful use of certified electronic health record (EHR) across the behavioral health service settings. WITS has the capabilities to follow clients across a variety of service and treatment settings statewide (i.e. public mental health, substance use treatment, court ordered services, etc.), including tracking of descriptives, treatment episodes, billable services, service notes and outcomes of care. Additionally, WITS will facilitate the coordination of participant benefits across the system via the use of a statewide adopted E.H.R. that is capable of communicating across agency and funder boundaries. All Substance Use Disorders treatment service providers, delivering services funded by the SSA, will be trained on the use of the electronic health record system. After training is completed, the providers will be required to enter consumer demographic and diagnostic data, service plan and record of services provided. This process will include training for public and private provider staff on the use of electronic records. FEi.com is our contracted builder of additional functionalities and our contractor for staff training, secured hosting and maintenance. Set aside funding from both block grants will be used to support contracted services, efforts to increase coordination of benefits and other EHR related implementation and maintenance activities in Idaho's Behavioral Health system.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

IV: Narrative Plan

X Comment on the State BG Plan

Page 90 of the application Guidance

Narrative Questions; Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Input from Idaho Citizens: Several activities were implemented in January/February 2013 in an effort to solicit input from Idaho citizens into the development of the SFY 2014-2015 Combined SAPT/MH Block Grant. The need to develop the plan was presented to the State Planning Council on Mental Health at their January 2013 quarterly meeting, with a request to provide input through a specific block grant survey link on the external Department of Health and Welfare (DHW) website. Regional Division of Behavioral Health program managers were encouraged to respond to the website, and to share the invitation with local providers and regional boards. The Division of Behavioral Health communicated with the Director of the Idaho Division of Vocational Rehabilitation (IDVR) and requested their input into the plan. The IDVR Director also contacted leaders of four Tribes that IDVR works well with, and invited them to also participate in responding to questions posted on the external DHW website. The Office of Drug Policy, who will be responsible for managing substance abuse prevention funds in 2014 also secured input from the Strategic State Prevention Planning Committee, other state agencies serving youth and families and the Community Coalitions of Idaho, a coalition of community groups dedicated to preventing substance abuse and underage drinking. An internal Division of Behavioral Health survey also solicited input on block grant planning for SFY 2014-2015. Responses from the internal and external websites were incorporated into the narrative sections of the SFY 2014 -2015 Plan.

Idaho State Planning Council on Mental Health

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

MEMBERSHIP

Stan Calder
Rick Capell
Martha Ekhoff
Kim Jardine-Dickerson
Kathie Garrett
Jennifer Griffis
Gary Hamilton
Linda Hatzenbuehler
Michael Hinman
Pam Hirsch
Rick Huber
Linda Johann
Patricia Martelle
Lynne Whiting
Julie Williams
Teresa Wolf

March 26, 2013

Barbara Orlando
Office of Program Services, Division of Grant Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

RE: State of Idaho Combined Substance Abuse Prevention and Treatment (SAPT) and Mental Health (MH) Block Grant Application for SFY 2014-SFY 2015
Dear Ms. Orlando:

The Idaho State Planning Council on Mental Health (Council) reviewed, discussed and provided comment to the proposed Combined SAPT and MH block grant application for SFY 2014-2015 at our Council meetings on August 14 – 16, 2012 and January 15 – 17, 2013.

The federal block grant plays a key role in the provision of mental health and substance use disorders services in Idaho, especially in times of fiscally restrained budgets. The Idaho State Planning Council continues to monitor the legislature as they struggle with decisions impacting Idaho's most vulnerable populations. The Council remains attentive in monitoring budget reductions and the reorganization of services for children, youth, families, and individuals. We believe our role as Council members is more important then ever as we continue to inform and educate our elected officials and the regional mental health boards.

Providing appropriate mental health services to individuals in Idaho is a perennial challenge for our State and we offer the following information related to Idaho's Mental Health system of care.

- The Council has actively participated in the discussion about the Department of Health and Welfare Division of Behavioral Health's desire to merge the regional mental health boards and the regional advisory councils (substance use disorders) into regional behavioral health boards. During the January 2013 meeting, the Council voted to support the legislation that the Division of Behavioral Health would be introducing in the 2013 Legislative sessions. The Idaho State Planning Council on Mental Health was awarded an opportunity from the Substance Abuse and Mental Health Services Administration

(SAMHSA) to receive technical assistance in the area of planning steps to take to create a merged State Behavioral Health Planning Council.

- Informing our Legislature on the continued need to have available quality mental health services is of great importance to the Council. The Council presented testimony to the Legislative Healthcare Task Force on the letter to the governor, which addressed concerns about the impact of current and future budget cuts to services and to individuals receiving services.

- The Council remains informed about and monitors the progress of Medicaid Managed Care in Idaho. The Council has a Medicaid representative as one of its members.

- The Council participated in Idaho Department of Health and Welfare's external survey pertaining to the Block Grant to encourage input from the Council and the general public.

- Hosting the annual legislative event and award ceremony expands our opportunity to inform and educate the public and our elected officials. The 2013 Legislative event presented awards to recipients from the media, the judiciary, legislators, law enforcement, and community advocates for their exemplary work. The general focus of the event was to put a face on the many challenges that individuals have in navigating the mental health system.

The Idaho State Planning Council on Mental Health is comprised of a dedicated group of champions providing a voice for many of our citizens. Our goal is to keep the Governor, our State Legislature and elected officials in Idaho's communities acutely aware of the need for providing quality mental health services to our citizens. We are committed to improving services for all individuals affected by mental illness and to promoting that recovery is possible for individuals who have a behavioral health diagnosis. The Council is in support of the Division's block grant application for SFY 2014-2015.

Sincerely,

Martha Ekhoff, Chair
Idaho State Planning Council on Mental Health

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - GOVERNOR
RICHARD M. ARMSTRONG - DIRECTOR

OFFICE OF THE DIRECTOR
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-5500
FAX 208-334-6558

August 27, 2013

Pamela S. Hyde, JD, Administrator
Substance Abuse and Mental Health Administration
1 Choke Cherry Road, Room 8-1065
Rockville, Maryland 20857

RE: FY2014-2015 Combined Substance Abuse and Mental Health Block Grant Behavioral Health Assessment and Plan

Dear Dr. Hyde:

On behalf of the Governor of the State of Idaho, it is my privilege to submit to you Idaho's FY2014-2015 Combined Substance Abuse and Mental Health Block Grant Behavioral Health Assessment and Plan. The Substance Abuse and Mental Health block grants enable Idaho to implement community-based prevention activities, substance use disorder treatment and mental health services.

If you have any questions about this document please contact Cynthia Clapper for questions related to Children or Adult Mental Health. Ms. Clapper may be reached at (208) 334-5527 or via email at clapperc@dhw.idaho.gov. If the questions are related to Substance Abuse Prevention or Treatment contact Terry Pappin. Her phone number is (208) 334-6542 and her email address is pappint@dhw.idaho.gov.

Sincerely,

RICHARD M. ARMSTRONG
Director

RMA/tgp

Enclosures

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including 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 the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

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14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name: Richard M. Armstrong

Title: Director

Organization: Idaho Department of Health and Welfare

Signature: _____ Date: 8/28/13

Footnotes:

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I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Section	Title	Chapter
Title XIX, Part B, Subpart I of the Public Health Service Act		
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

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I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee	Richard M. Armstrong
Title	Director

Signature of CEO or Designee[1] _____ Date: 8/28/13

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

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I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Section	Title	Chapter
Title XIX, Part B, Subpart II of the Public Health Service Act		
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**

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Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee: Richard M. Armstrong

Title: Director

Signature of CEO or Designee[1]: _____ Date: 8/28/13

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

Please see attachments section of this application for signed certifications and assurances.

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I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

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Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Richard M. Armstrong
Title	Director
Organization	Idaho Department of Health and Welfare

Signature: Date: 8/18/13

Footnotes:

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I: State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name: Richard M. Armstrong

Title: Director

Organization: Idaho Department of Health and Welfare

Signature: Date: 8/28/13

Footnotes:

Idaho
OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016