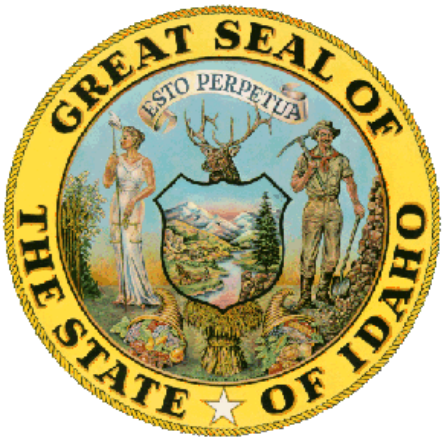
Governor's
Behavioral Health Transformation Work Group



Interim Status Report

January 19, 2010

Governor's Behavioral Health Transformation Work Group

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Introduction

Purpose of the Interim Status Report

Executive Order No. 2009-04 tasks the Behavioral Health Transformation Work Group (BHTWG) with "developing a plan for a coordinated, efficient state behavioral health infrastructure with clear responsibilities, leadership authority and action," and to "provide for stakeholder participation in the development of the plan."

This is an **Interim Status Report** of the BHTWG's effort to date. Having articulated a vision and goals for the future and studied and articulated the first real step of a phased in approach to achieve it, the group also recognizes the clear necessity to do so in a way that enables the state and regions to build the infrastructure and capacity to support transformation. This report represents the thoughtful efforts of the group to not just recommend change, but a studied effort to both move in that direction while allowing for the evolution of systems and structures to support it.

BHTWG
Interim Status Report

The BHTWG Interim Status Report presents the results of the group's effort to date. It outlines its vision for the future, proposed steps for moving in that direction, and process for developing its final strategic plan.

This Interim Status Report presents:

1. The Vision, Goals and conceptual structure the BHTWG proposes to achieve,
2. An initial change to the system that moves the state in that direction, with a conceptual evolution of the system to follow behind it,
3. A description of the next steps the BHTWG proposes to take to inform the development of Idaho's Coordinated Behavioral Health Strategic Plan, which will outline in more detail the evolution of this transformation with the benefit of broad public inputs, and
4. Results to date of elements that support that development, including an initial inventory of funding figures and draft core services.

Background

Effectively serving people with mental illness and substance abuse disorders requires a community, cross-systems effort. Children are likely to first present their symptoms in a school setting. Sometimes youth or adult mental illness is first identified when an individual encounters the justice system. Many people are served by the Department of Health and

Welfare (DHW) in initial, voluntary stages as well as when needing critical hospitalization services. Voluntary and involuntary systems exist; public and private resources are utilized; and co-occurring disorders are prevalent. Millions of dollars are spent in the state by state agencies, county governments, private contributions, and more to support people with mental illness and substance abuse disorders. The situation is further compounded because, in some cases, different state agencies find themselves purchasing the same services from the same providers at different rates.

There have been numerous efforts over the years to address this challenge. Stakeholder groups have worked collaboratively at many levels to study structures and propose systems that deliver services in the most meaningful way. Table 1 presents a series of products generated by some entities that have made efforts to best serve this important population.

Comprehensive Statewide Mental Health Transformation Action Plan 2007
Statement of Needs and Gaps (Region II Mental Health Board, February 2008)
Legislative Council Interim committee – Mental Health and Substance Abuse Treatment Delivery System
Mental Health Substance Abuse Workgroup
Juvenile Justice Children's Mental Health Strategic Plan
Mental Health Stakeholder Implementation Plan (NAMI-Boise Mental Health Association)
Interagency Work Group on Mental Health Services
Western Interstate Commission for Higher Education Study 2008
Western Interstate Commission for Higher Education Report April 29, 2009
Western Interstate Commission for Higher Education Draft Idaho Behavioral Health System Proposal and Request for Information, July 2009
Other reports and products

Table 1: These products and work groups are a number of many whose work informs the effort to address challenges associated with serving people with mental illness and substance abuse across systems and in their communities.

Moving toward an ideal service delivery system that effectively crosses systems, is both outcome-oriented and accountable, and provides adequate community supports in a recovery-oriented environment is a long process. Over the years efforts have been made to generate a transformed system. Such action is reflected in the creation of the Division of Behavioral Health to facilitate the integration of mental health and substance abuse services, as well as to the provision of mental health clinicians at juvenile detention centers in order to more effectively assess and meet youth's mental health needs at this critical juncture. Idaho continues to pursue transformation by working to generate cross-system capacity in a manner conducive to meeting actual need.

The need is great. The economic reality is sobering. The Department of Health and Welfare, which offers the largest funding source in the state for helping people with mental illness and substance abuse, faces an estimated shortfall of $133 million in general funds and a total shortfall of potentially $515 million for fiscal year 2011 (while this reflects a department-wide shortfall, the majority of the funding is Medicaid). Other agencies and private entities make significant contributions, and also face budgetary challenges.

Appendix A presents a spreadsheet reflecting the BHTWG's continuing attempt to understand regional expenditures on mental health and substance abuse by the various public and private BHTWG stakeholders. Finding a way to coordinate and leverage these resources is critical to maximizing the use of shrinking dollars while trying to more effectively serve and support this important population in their regions and their own communities. Budget realities notwithstanding, the BHTWG is committed to generating the most effective and efficient system possible.

Vision, Goals and Structure

The BHTWG adopted a Vision for behavioral health in Idaho that is informed and driven by Idaho's history of reports, studies and collaborative efforts. The group has affirmed by unanimous vote at its December 2, 2009 meeting the intent to work to realize this vision, and to proceed with a phased-in approach to achieve it, generating measures and data that will inform its further development.

BHTWG Commitment

The BHTWG affirms their intent to work to realize this vision, and to proceed with a phased-in approach to achieve it, generating measures and data that will inform its further development.

Vision

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

Goals

1. Increase the availability of, and access to, quality services.
2. Establish a coordinated, efficient state and community infrastructure throughout the entire mental health and substance abuse system with clear responsibilities and leadership authority and action.
3. Create a comprehensive, viable regional or local community delivery system.
4. Make efficient use of existing and future resources.
5. Increase accountability for services and funding.
6. Provide authentic stakeholder participation in the development, implementation and evaluation of the system.

Structure

A final structure for the Behavioral Health system is informed by the studies and reports generated by the Western Interstate Commission for Higher Education WICHE Report April, 2009. Using that material as its foundation, the BHTWG works to create a system where mental health and substance abuse services are integrated. While many of the specific details of the structure are yet to be developed, pending public input and results generated through regional capacity building, features of the system as envisioned include the following elements:

Conceptualized structure

- Integrated mental health and substance abuse
- Core services - a continuum for children and adults is available in a regional delivery system
- Seven regional entities have regional authority, responsibility, accountability
- Braided funding
- Managed care
- State guarantor: establish standards, measure outcomes, ensure accountability, gather and report data
- ICSA-like state coordination body

- The Department of Health and Welfare will serve as a guarantor of services, establishing service standards in an out-come based system, ensuring accountability to the same, and gathering and reporting data. DHW will coordinate with the regions regarding information sharing and service delivery options.
- A regional delivery system which includes no less than seven (7) regional boards that can also operate as business entities to identify needs and gaps, develop and coordinate community services within the community and amongst the various agencies, work to augment funding, and direct their resources consistent with the needs of their respective regions (this could be similar to the system already established for health districts);
- A braided funding system is utilized. Funding amounts for all entities using the system are known, responsibilities accounted for, and distributions are made consistent with each entities' responsibility;
- A continuum of core services are required and available within each region;
- A managed care system exists to provide for controlled, consistent costs with providers capable of assuming risk in that regard;
- A statewide body, similar to the Interagency Committee on Substance Abuse, exists to coordinate and perpetuate the transformed system.

The Path Forward

The shared vision exists and the first steps toward generating the ultimate structure exists. But the act of moving from present day to ultimate structure is complex. The envisioned structure requires that:

- Statewide standards for service delivery be established,
- A body of core services be developed and available within each region,
- Regional entities be restructured to manage the business of ensuring core services are available and operating according to their regional needs,
- That data gathered enables the effective establishment of a managed care approach that is outcome-based, leverages state resources, and enables providers to be able to assume both the responsibility for and risk of their new services.
- The development of an oversight entity to ensure system implementation and sustainability.

Moving from the existing system to the envisioned system warrants a methodical approach. There is no ideal model to adopt; there is a structure to generate that accomplishes the vision and goals specific to Idaho and customized to Idaho's needs, populations and resources.

The approach proposed in the following pages offers Idaho a significant system change toward transformation, and provides a platform from which subsequent phases can continue to evolve until the ultimate structure is achieved.

Phased-in Approach

What differentiates this proposal from previous studies and recommendations is not a substantial difference in the end result - as many point to relatively similar conclusions. What differentiates this proposal is proposed action to move forward.

Phase One

The BHTWG proposes that Phase One begins with a reorganization initiated and completed by the Department of Health and Welfare. That reorganization would be complimented by regional authority, responsibility and accountability for the Regional Mental Health Boards. Phase One is considered implementable in the near term, offering a methodical and measurable first step toward a system consistent with that guided by the BHTWG Vision and Goals. Details include:

- DHW would organize administratively by three regions. A single inpatient and outpatient services Administrator would manage the Department's mental health services in each of the three regions, overseeing the provision of crisis and clinical services. The initiative addresses system transition gaps between inpatient and

outpatient services by offering regional management of both systems by the same Administrator. (Supports Goals 1-5)

- The state would, through the Department of Administration, contract with a network of providers in each of the three regions utilizing an outcomes-based, measureable approach. All entities contracting for services could utilize this regional single-network provider, enabling a consistent reimbursement for the same services. (Supports Goals 1-5)
- Data, collected and tracked on a regional and cross-systems basis, enables the generation of efficiencies, accountability practices, and is a foundation to establishing a meaningful managed care environment. (Supports Goals 1-5)
- Seven Regional Mental Health Board's would be authorized to and accountable for developing regional capacity for the full continuum of proposed core services, including community supports. Regional Mental Health Board membership would be modified to include representatives of school districts and others that reflect that core, community-based delivery system. This work will enable regional entities to expand their responsibilities and capacity incrementally and methodically. (Supports Goals 1-6)
- The role of the State Mental Health Planning Council would be expanded to oversee the development of regional capacity-building efforts and the development and implementation of the BHTWG Strategic Plan. This experience can inform the future development of an ICSA-like statewide coordination body to oversee the system. (Supports Goals 1-6)
- This is a statewide systems change. To be effective, other state agencies and local entities would need to organize around and participate in the regionalized structure according to their respective roles and responsibilities. (Supports Goals 1-5)
- By utilizing the same regional network of providers, common sets of data would be collected and shared for use as a guide in capacity building by Regional Mental Health Boards and to evaluate the risk burden of potential providers. (Supports Goals 1-5)

An illustration of the Phase One organization is depicted on Graph 1 on the next page. It is important to note that as the system evolves, it is anticipated that the entities on the left side of the chart will strengthen in capacity, authority and accountability.

What differentiates this plan from other recommendations is proposed action to move forward.

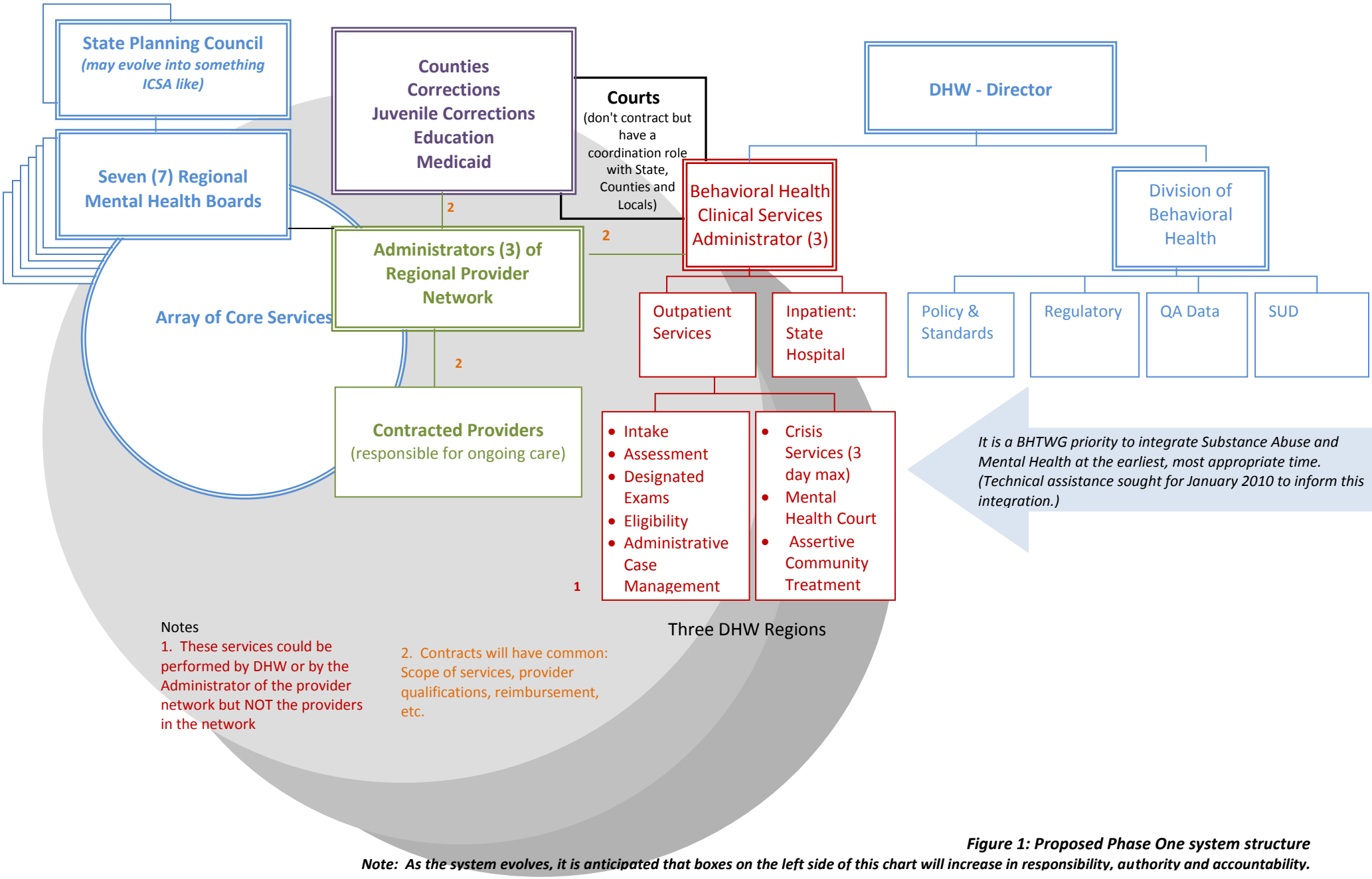

Figure 1: Proposed Phase One system structure

Note: As the system evolves, it is anticipated that boxes on the left side of this chart will increase in responsibility, authority and accountability.

Development Considerations

Integration of Mental Health and Substance Abuse. The Phase One reorganization focuses on DHW's mental health program, even while recognizing that patients present both mental health and substance abuse concerns. In practice integration must and will occur. Already the Assertive Community Treatment (ACT) Teams include substance abuse expertise as part of their composition, and that practice will continue. The group is seeking technical assistance for as early as January 2010 to determine how and when to best integrate the two services.

DHW Evaluation. DHW will need to continue to evaluate the process from a funding and staffing perspective in the short term; results of that evaluation may factor into the process and design of the proposed reorganization.

Sustainability. There is a desire to avoid letting Phase One become the first and last phase of transformation, particularly in a challenging economic environment. Ensuring the continued development of the plan and the ongoing implementation and evolution of the system is prominent. Ensuring that oversight responsibility for the state's transformation as proposed and the development of regional capacity is key to perpetuating this initiative. Potential revisions to State Code respective to the State Mental Health Planning Council (or the eventual establishment of an ICSA-like coordination body), as well as the Regional Mental Health Boards are one way to provide infrastructure to system change. The Council would potentially have responsibility for oversight of the regional capacity building effort and implementation of the Strategic Plan; the Regional Mental Health Boards will have the authority and accountability to develop capacity and augment it through their own regional authority.

Provider Network Development. A contracted arrangement with a network of providers provides a method for controlling costs collectively across entities, and informs a potential initiative to eventually capitate State funds. This also helps to more efficiently share resources traditionally held separate (insurance companies and the public system having different network qualifications).

Technical Assistance. Technical assistance will be sought to inform the development of phases as appropriate. Specifically, the WICHE Request for Information document can be used as a tool to explore regional capacity and help build subsequent phases of development.

Methodical, Measurable Approach. Methodically pursued, implemented and measured, Phase One will inform the development of subsequent phases as regions work to build their capacity for services and the state ensures the availability of crisis and critical services as the system evolves.

Workforce Development. The group also recognizes a need to work with graduate schools to train and develop a workforce to help generate service capacity throughout the state.

Next Steps

As the BHTWG continues its work to develop its Strategic Plan in 2010, it will be more fully describing conceptual and anticipated phases to this initial first step. But given the need to generate an infrastructure to support a regional delivery system, and the practical necessity to do so in a meaningful and methodical way, the BHTWG anticipates that subsequent phases will feature:

1. The development and deployment of a data gathering system to support an outcome-based system, identify and track rates, costs, needs and more for the purposes of generating increased understanding of the population and system and establishing a foundation for a managed care system;
2. The generation of statewide quality standards within that outcome-based system in order to ensure quality care and system-wide accountability;
3. The evolution of existing regional bodies into ones with the responsibility for the regional behavioral health system from both a business and service delivery perspective, and to create the capacity to ensure the breadth of core services are available at the most local level possible;
4. The development of a diverse statewide oversight and coordination body who ensures the ongoing implementation of the strategic plan and ensures the continuing progress of the developmental phases of the transformed system as designed.
5. The potential deployment of a pilot project in one region to test the envisioned system and use those lessons learned to ensure effective development of future refinements and regional responsibility.

Public Process and Plan Delivery

During early 2010, the BHTWG will further refine its proposal and specifically the follow-up phases, and then be seeking input from legislators, stakeholders, the public at large, local entities, county governments and regional entities on its draft plan. The group has generated a draft public involvement plan for implementation. That input will inform the generation of a Strategic Plan, which is intended for delivery to the Governor prior to October 1, 2010.

Subsequent phases are anticipated to generate infrastructure, data and experience, to include:

- an effective data gathering system
- statewide quality standards for an outcome-based system
- evolution of regional bodies and capacity, and
- a pilot project in one region to inform the effective implementation of future efforts.

DRAFT Estimated Expenditures on Mental Health and Substance Abuse in Idaho

Note: This data is in draft form only and still under development. It is intended to provide a snapshot of expenditures on mental health and substance abuse efforts across the state and on a regional basis, but is it is in development and is not presented as an actual and accurate count at the time of this printing.

Mental Health

Services		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Statewide / Total	*Does the total DHW expenditure include statewide staff?*
DHW Behavioral Health: Mental Health	Adult Mental Health	$ 2,271,945	$ 1,820,581	$ 2,803,162	$ 3,727,059	$ 2,100,543	$ 2,421,743	$ 2,264,933	$17,409,966	
	Children's Mental Health	$ 1,784,440	$ 1,085,441	$ 1,877,304	$ 2,107,707	$ 1,332,457	$ 1,261,865	$ 1,661,740	$11,110,954	
	Community Hospital	$ 370,550	$ 129,900	$ 916,096	$ 1,043,733	$ 670,541	$ 422,959	$ 98,367	$ 3,652,146	
	State Hospital North	$ 2,741,256	$ 1,026,084	$ 2,497,500	$ 2,021,088	$ 22,200	$ -	$ -	$ 8,308,128	
	State Hospital South	$ 1,793,933	$ 1,313,090	$ 721,458	$8,022,693	$ 2,435,931	$ 4,846,558	$ 2,421,913	$21,555,576	
	Medicaid (Adult)	$ 2,002,489	$ 4,825,231	$10,033,298	$17,800,907	$ 7,725,409	$10,308,262	$13,897,787	$ 76,593,383	*Federal and State*
	Medicaid (Child)	$12,245,837	$ 4,344,691	$11,818,805	$14,297,889	$ 9,086,861	$14,697,781	$21,632,389	$ 88,124,253	*Federal and State*
State Catastrophic Fund	Voluntary	$ 388,704	$ 54,554	$ 22,101	$ 6,241	$ 451,230	$ -	$ -	$ 922,830	*CAT Funds are a combination of state and county funds.*
	Involuntary	$ 360,845	$ 102,470	$ 1,197,531	$ 1,747,096	$ 72,416	$ 196,992	$ 38,889	$ 3,716,239	
County	Jail							$ 149,800	$ 149,800	*working*
	Other								$ 1,200,000	*approximate*
Juvenile Corrections	Individual contracts	$ 50,250	$ 648	$ 291,895	$ 44,898	$ -	$ 153,300	$ 207,621	$ 748,612	*FY09*
	Detention Facility Contracts	$ 145,655	$ 43,791	$ 105,655	$ 78,919	$ 74,063	$ 65,904	109,669	$ 623,656	*FY09*

Department of Corrections	**Mental Health (incarcerated only)**								$ 1,605,800	*YEnd09 (Includes staffing and contract services only)*
School Districts	**(2008 SED)**	$ -	$ 263,176	$ 432,686	$ 713,483	$ 704,840	$ 58,223	$ 159,259	$ 2,327,312	
Voc Rehab	**Services for SMPI**	$ 55,827	$ 62,182	$ 57,704	$ 57,704	$ 57,704	$ 61,526	$ 66,175	$ 418,822	
HUD										
Mental Health Court Testing	**Adult Mental Health**	$ 24,000	$ 14,882	$ 13,463	$ 23,992	$ 14,942	$ 12,174	$ 26,734	$ 130,186	
	Juvenile Mental Health							$ 11,013	$ 11,013	
Private contributions	**Pharmaceutical companies / value of meds provided**	$ 706,739	$ 485,715	$3,576,944	$3,666,883	$ 653,188	$ 1,082,598	$2,426,135	$12,598,202	
Hospital charity care (cost shift to local hospitals)	**SARMC**								$ 2,050,000	*Figures provided by Dr. Novak*
	IMH								$ 2,050,000	May-09
	SLRMC								$ 500,000	*The question has been asked whether these costs eventually get reimbursed by Medicaid. Need to answer that question.*
	Mercy Med									
	West Valley									
		$34,942,470	$15,572,436	$36,365,602	$55,360,292	$25,402,325	$35,589,885	$45,172,424	$255,806,878	

Substance Use Disorders

DHW Division of Behavioral Health: Substance Use	**SUD: Adult**	$ 1,354,072	$ 997,118	$ 2,285,241	$ 2,519,613	$ 1,208,659	$ 2,276,670	$ 1 ,870,957	$ 12,512,330	
	SUD: Child	$ 429,443	$ 130,306	$ 343,757	$ 525,892	$ 472,600	$ 543,174	$ 331,979	$ 2,777,151	
Safe & Drug Free Schools	**State**	$ 18,761	$ 3,463	$ 36,802	$ 124,833	$ 62,762	$ 10,441	$ 24,161	$ 281,223	*Substance abuse prevention education, early intervention, violence prevention education and programming*
	Federal	$ 2,590	$ 3,816	$ 33,608	$ 7,631	$ 18,496	$ 6,400	$ 7,958	$ 80,499	

	Other	$ 21,120	$ 47,200	$ 1,238		$ 7,949	$ 16,200	$ 20,241	$ 113,948
Department of Corrections	**Substance Use Disorder (incarcerated/ community)**								$ 2,261,194
Drug Court Testing	**Adult Drug Court**	$ 63,494	$ 41,971	$ 59,787	$ 140,183	$ 83,467	$ 46,013	$ 132,768	$ 567,683
	Juvenile Drug Court Testing	$ 9,488	$ 6,251	$ 8,934	$ 20,947	$ 12,472	$ 7,025	$ 19,839	$ 84,956
		$ 1,898,968	$ 1,230,125	$2,769,367	$ 3,339,099	$1,866,405	$2,905,923	$ 2,407,903	$ 18,678,984