

**Region 2
Behavioral Health Stakeholder Meeting
Regional Structure Proposal Report
November 15, 2011**

Background

In response to the request by the Behavioral Health Interagency Cooperative (Cooperative) made in August 2011 for Regions 2 and 7 to propose a regional structure that the Region thinks would most meaningfully lead the coordination of community-based behavioral health services, Region 2 behavioral health stakeholders met two times to draft such a proposal. The group met a third time in Lewiston on November 15 to consider the Cooperative's response to their proposal and articulate next steps.

A list of meeting participants is included as Attachment A. Facilitator Marsha Bracke maintained meeting discussion notes on flip charts, a transcription of which is included as Attachment B. The summaries of the October 20 and September 15 Region 2 meetings, including the proposed structure reflected in the October 20 summary, are included as Attachments C and D respectively.

Stakeholders reviewed the notes of the November 2, 2011 Cooperative meeting, after which Ross Edmunds, Administrator of the Department of Health and Welfare Division of Behavioral Health, discussed those results with the group.

During the course of the discussion:

- Ross Edmunds provided background about the transformation effort that brought the Cooperative to this place where it is asking the regions for a proposed structure, clarifying that he is there as a member of the Cooperative's subcommittee but not as a spokesperson for the Cooperative.
- Stakeholders discussed the Cooperative's response to their proposed structure, learning the Cooperative finds a pilot not realistic given the statutory requirements necessary to generate an entity with fiscal capacity (a question the group had been asking themselves already), and the lack of funding to do something distinctly different in order to evaluate its effectiveness.
- Explored and articulated opportunities for and concerns about moving forward with the development of a regional entity.

The Cooperative's draft meeting summary of November 2, 2011 and the Cooperative's matrix of core services with services identified for potential regional delivery were made available to the group. That material is included with this report as Attachments E and F.

Conclusions

Region 2 stakeholders seek the Cooperative's support in pursuing legislation to create the structure they proposed on October 20, with more attention devoted to their relationship with the Medicaid Managed Care Organization (proposing even that the MCO have a contractual requirement to work with the regional entity) and to ensure a strong collective regional voice. They seek additional clarity in terms of their scope - which was discussed at this and previous meetings as focusing primarily on prevention, early education and intervention. They are also looking for the Cooperative entities to provide their sideboards or parameters for delivering community-based services services, and to continue this dialogue as the process proceeds and details materialize.

In the near term, Region 2 stakeholders want to pursue the coordination of their mental health and substance abuse disorder roles, and work collaboratively to pursue grants to help get them started. They would look to the PHD to work as a fiscal agent when they need one, and model their coordination effort around that structure.

One proposed that working with the PHD now could function as a pilot with the addition of three individuals (two legislative appointees and a behavioral health representative) to the PHD Board. He also said the separate behavioral health entity proposed by the region may not be necessary, if the region chose to fold the function within the PHD existing infrastructure, assuming a common mission to "promote, prevent, protect." There are some stakeholders who are concerned that the behavioral health system would be lost within the PHD structure, but are supportive of the structure as a model for behavioral health.

Region 2 stakeholders expressed concern about funding to get started, and questioned the commitment of the Cooperative and the Governor in moving this process forward. They seek evidence of that commitment. One individual did not support moving forward given lack of confidence in funding, commitment, statutory ability, and question about scope. A couple questioned why the Cooperative members themselves weren't having this discussion with the group.

Next Steps

In a round robin format, each stakeholder articulated their opinion and concerns respective to their next steps. All but one said they want to move forward. Each participant's comments were recorded on flip chart notes and warrant reference and follow-up in subsequent discussions and entity development. Those notes can be found in Attachment B - Flip Chart Notes, pages 5-6.

Marsha will prepare documentation summarizing the discussion and presenting the stakeholder group results regarding the near term strategy and proposed structure. Marsha was asked to try to report this information on a single page in a series of a few paragraphs so that it is easily retrieved and understood (that summation is the "conclusions" section on page 1 of this report). Marsha asked the group to read and revise the draft material, as it is the region's product, providing clarification where needed.

The material will be presented to the Cooperative at its November 21, 2011 meeting. Stakeholders are specifically invited to that meeting if they are interested in presenting the material themselves and/or engaging in a discussion directly with the Cooperative. After that meeting, Marsha will communicate with the group about the Cooperative meeting outcome.

**Region 2
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November 15, 2011
List of Participants**

Name	Affiliation	Phone	E-mail
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**Region 2
Behavioral Health Stakeholder Meeting
Regional Structure Proposal Report
November 15, 2011
Flip Chart Notes**

PURPOSE

- To discuss the Cooperative's thinking about the proposed structure and articulate opportunities to pursue the regional entity.

AGENDA

- Meeting Overview
- Introductions
- Seek understanding of Cooperative discussion
- Articulate opportunities for regional structure
- Wrap Up

PRINCIPLES OF MEETING CONDUCT

- Participate!
- Listen! Seek to understand
- Be open minded
- Be solutions oriented
- Challenge issues, respect people
- Honor time constraints
- One person speaks at a time
- Turn off electronics

INITIAL DISCUSSION/RESPONSE

- Meeting budgets and meeting needs are two different things
- How do you transform without a Director of Transformation - a champion - central person driving the process?
- Cooperative interested in preservation not transformation - haven't proposed a process
- Intent do transform? Or not? Ask them
- Maintain preference for public health model
- Feel helpless in trying to shape where we're headed
- Want community voice in directing service
- Offended that we have to "demonstrate readiness"
- Outcome of dialogue ... collaboratively enter into a process so you know it's a fit (sideboards/readiness)
- How do you make that happen?
- Need expressed intent by Governor's office
- Don't see how regional group can affect change given managed care
- Leverage the kind of things we can do when we come together
- Structure ourselves to do that more
- PHD legislation - done statewide at once
- What's missing that could benefit community - not emergency room
- Prevention, Promoting Health
- "Promote, Prevent, Protect" - motto of public health - good role for us
- What has changed politically and where does it leave us?
- If this is such a big deal to the Cooperative, why are none of them here?

SUGGESTED NEXT STEPS

- Propose to Cooperative what you want / establish the group
- Work with Cooperative to generate the entity
- Establish a voice for Behavioral Health in Region 2 - have a coordinated, single voice
- Seek legislative funding for entity (grant example, private funding ideas)
- Contract for service
- Regional entity to inform the Medicaid contract, network and service
- Recommend that a condition of the RFP be to assist in the development of regional Behavioral Health entities" - demonstrates states interests in transformation - Representative Rusche
- Scope of services akin to "Promote, Prevent, Protect"
- Cooperative establish sideboards - what's the criteria?
 - What will work for you
 - How much funding is available to develop?
 - What are the rules of engagement?

SHORT TERM

- Use PHD or other entity to be a fiscal agent for grants
 - Transitional
 - Use as pilot, has legs, ready to function, needs funding
 - Potential entity with additions to Board?
- Cooperative - come back and help us define services
- Readiness - infrastructure exists that is ready to manage
- Need statutory entity to accept funding
- Need seed money
- Use PHD to start

NEXT STEPS

- Jim R. - be involved with Medicaid Managed Care - provide information, want to influence now and be involved later. Move forward.
- Ron - Regarding Medicaid - our group could structure a couple sentences to deliver to the RFP; If Cooperative agrees with our proposal and presents to legislature it has more potential weight. Move forward. Need funding.
- Brian - need to move forward. Nothing's changed politically. Governor's response indicates and evolution and devolving responsibility to the Regions. Afraid resources won't be available. Worry about losing services. Great structure; voice of regional Managed Care entity; can apply for other funds (DJCS); build funding (grants/DHW) to hire staff
- Dianne - move forward. Ask Cooperative if they would personally be more involved at a regional level. Help establish parameters. Use our time better.
- Steve - move forward. At what point do we have to say which services we are responsible for? How move forward?
- Jim C. - move forward. Would like to hear that Governor has reviewed the proposed structure and sees need to provide Cooperative more direction to provide guidelines/parameters and funding.
- John R. - Absolutely essential that Governor and Cooperative show that they believe in transformation - need some demonstration. Funding from legislature unlikely unless Governor asks; if not use Medicaid as a vehicle to help figure out how to organize and use services more effectively
- Sabrina - what's Governor's accountability? How to motivate him to want this?
- Lisa M - More forward. Support. How will managed care affect Courts / wraparound? Be aware and have input.
- Vicki - move forward. Like Representative Rusche's suggestion to include managed care contract language regarding this entity.

- Ken - Thursday meeting had lack of clarity around DHW position. Ross clarified; validation of committee work; what are next steps. Move forward.
- John T - on fence. Historically practice of inertia without outcomes; what is purpose: Scope of duties? Just prevention? Don't know that I want input on State Hospital North. What will we change into? No funding, no legislation, concept without scope.
- Scott - Support -move forward; integrate Boards; value in combining. We need to figure out expectations (do we manage or deliver? Voice with the ability to provide feedback?)
- Bev - like to see more provider involvement; understand what we do; appreciate DHW management/administrative visits to region - clarification of rules
- Lisa T - appreciate background, support moving forward but don't know details or how we can think of them. Missing line workers.
- Diana - move forward. 2prongs - response to WICHE integration of SUDs/MH; more local control with regional boards to offer services; City services don't apply here
- Brain B - supportive; need clarity, not enough detail, what about funding?; does Governor support?
- Jerry - more urgency with Medicaid; get some piece in place, clarity can come

OTHER

- Do a succinct summary including concerns about funding, commitment of Cooperative and Governor
- Marsha send Medicaid RFP link

**Region 2
Behavioral Health Structure Scoping Meeting
Summary Results
October 20, 2011**

In an effort to describe potential structures for an effective, regionally based behavioral health system, the Behavioral Health Interagency Cooperative asked stakeholders in Region 2 to participate in a discussion process. The outcome of the process would be a proposed regional structure that the Region thinks would most meaningfully lead the coordination of community-based behavioral health services. Region 2's product is intended to inform the Cooperative's discussion at its November 2, 2011 meeting. At that time, the Cooperative will consider whether it is possible to pursue a pilot project to test the proposed structure.

The Cooperative is undertaking a similar process in Region 7 as well.

The process for developing the structure includes:

1. Meeting 1: to present the invitation and collect initial thoughts in response to the Cooperative's questions about a structure;
2. Reflect stakeholder comments in a draft document and circulate it electronically with participants for further reflection and regional input and development; and
3. Meeting 2: Refine the proposal and prepare it for presentation to the Cooperative on November 2.

Meeting process included:

- Introductions by each of the participants,
- A power point presentation made by the Facilitator, providing the status of the discussion process relative to the questions presented at the previous meeting, ,
- A round robin discussion presenting each participant's suggestions and preferences regarding the development of that draft,
- A facilitated discussion to capture the group conclusions,
- A presentation of a Regional Mental Health Board subcommittee draft organization chart,
- A discussion to align that chart with the group conclusions, and
- A detailed discussion about the composition of the proposed regional board.

Flip chart notes maintained by the Facilitator to document the group record have been transcribed and are included as Attachment B.

Using the inputs provided at the meeting, the Facilitator will generate a **revised draft** proposal for the Region 2 behavioral health entity. This document is included as Attachment C. This draft specifically reflects the conclusions of the second meeting as revised from the earlier draft document. Participants have been asked to review this material and ensure it reflects the group's collective thought. The document will be distributed to the Cooperative for discussion at its November 2 meeting, and Region 2 stakeholders who are interested are specifically invited to attend and participate in that presentation.

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Behavioral Health Structure Scoping Meeting
Summary Results
October 20, 2011
List of Participants**

Name	Affiliation	Phone	E-mail
Beecher, Ron	Department of Health and Welfare	208-816-2230	beecherr@dhw.idaho.gov
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**Region 2
Behavioral Health Structure Scoping Meeting
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Flip Chart Notes**

FEEDBACK PER LAST MEETING

- Emphasize need for Medicaid on team
- Do we even want to do this?
- If we do – SAMSHA grant? Need that funding.
- Legislative authority early so we can apply for funds...need support for grant writer
- Do it right
- Would like to see us try something – see mental health board ideas
- Missing the boat if you don't tie child protection to it – impacts behavioral health – include everything to get meaningful change
- A lot to bite off bit by bit – do we have the “counsel” needed to know where we're going / do it correctly?
- Bottom line is money – group should focus on what we can do without funding – look hard and fast at those areas
- Brings us together to streamline – get things in the open
- Even with no services, it helps us as a community
- Will see a lot more vets – need to gear up for that. How many? Maybe big and co-occurring (MH and SUDs)
- Sustainability – can develop a lot of great programs, but they are worthless if we can't sustain them. Need funding stream.
- Sit on a lot of boards – lots of planning and paper but no programs – what's' different? Real help? Frustrated.
- Anxious to see end result – how Cooperative can move forward
- Support moving forward – can't answer sustainability question unless we move forward
- Community partnerships – community effort (CP, MH, SUD) – have that be at the forefront
- Consumers, families, parents integral
- Client care at top of pyramid
- Careful to not create more bureaucracy
- Capitalize on minimizing overhead costs
- Ideal world – intervene early – outreach – Community Action Agency, Food Bank – get folks plugged in
- Disappointed legislators aren't here
- Significance of consumer involvement
- How fit with managed care/Medicaid?
- Region 2 commitment
- Always react to state funding
- They ask for our input, blend it into the state mix, comes back and doesn't fit us – we adapt. We know what we need.
- Reliable funding
- We need a plan that makes sense to use that we can act on
- As a starting place – prevention and early intervention
- Variety of stakeholders – one board to address the variety of behavioral health needs in the community
- Huge positive to bring together

- Need to think about how much we're willing to and capable of biting off
- Funding and sustainability to continue
- Voice for region 2 – true issues
- Like public health district model but concerned that behavioral health will be swallowed up.
- Can central office release control and how? Timeline? What comes next?
- What needs to be done? How will state help?
- Evaluate and continue to make sure we are doing better/adding value
- Personal fears – jobs, benefits, raises
- Fears for communities
- Fears at all levels, address fear
- Consumer and advocates need to help build system
- In awe of knowledge and passion in this group
- Flexibility – comes with funding
- Dow hat we're doing better by being local
- Not in public health district but model it
- Thoughtful board regarding Medicaid – consultative, not service, have input in development of contract, coordination and communicate

STRUCTURE DISCUSSION

- Regional Behavioral Health Board
 - Includes child protection, mental health, substance abuse disorders, agencies that fund them, consumers and advocates, Medicaid
 - Coordinates efforts identifies and addresses community issues across sectors
 - Input/coordination with Medicaid and managed care
 - Regional voice, identifies issues i.e. Vets
 - Executive Community – potentially funding entities comprised of people who make decisions
 - Even with nothing more – this adds value
 - Ad a minimum – legislation to establish this Board
- Infrastructure
 - Need funding to Act
 - Legislative authority to purse funding, hire staff, contract
 - With staff, work to fill gaps in the community based on client needs, potentially starting with prevention and early identification
 - Look at what we can do without funding
 - Need to start with grants/counties match
 - Grant writer – need funding to support
 - SAMSHA grant
 - With transition of funding for community based services from DWH
 - With transition of “more-to-all?” behavioral health services
 - Monitor, evaluate, improve
- Concerns
 - Funding – need some funding
 - Sustainability
 - Fear – personal, community, county, region, state agencies, legislators

 - Discussion
 - Two layers – executive – funding decision-makers
 - Regional Advisory Board – diverse

- Governing Board Discussion
 - Education, IDJC, IDOC, DHW, Judiciary, Counties (Commissioner or designee), Medicaid, Families and Consumers (13)
 - Representative from each county – not necessarily a commissioner
 - Designation to commission – delegate
 - State agencies not locally accountable
 - State on Board? Pros and Cons – “devolving responsibilities, integral partner, no local accountability, test question for pilot?”
 - Governor appoints someone to represent state
 - Legislative delegation appoints 1 republican and 1 democrat for state representation – model in other activity
- Advisory Board – doers
 - Where the work is
 - State agencies – in code
 - Consumers and families – in code
 - Medical professionals/providers
- Governing Board
 - Five County Commissioners / delegate
 - Legislators appoint one republican, one democrat
 - Chair of Advisory Board (vote and/or ex officio)
- Feedback
 - See child protection differently -don't know how it fits
 - Impressioned in home, make them a part of the solution – control the front door
 - Child protection on Board – start the discussion, pursue referral process
 - Need a plan to review and evaluate
 - Frustrated that we won't get our own proposal in on time
 - Create a Board most responsive to our needs – poise to get SAMSA grant
 - Welfare needs to be more involved in health
 - Concern that this is an exercise in futility and no ability to move forward
 - Legislature won't fund anything new

NOVEMBER AGENDA

- Funding for a regional board to act

MESSAGES/SUGGESTIONS

- It's all about choice
- Present a plan and see if we can sell it.
- Have the numbers
- Develop a proposal with specific funding request (if we don't ask we certainly won't get it) – RAC has some Bring money with pilot

CONCLUSIONS

- Yes – we want to proceed with pilot
- Yes – we want legislation that enables us to pursue SAMSHA funding

Proposal
Region 2 Proposed Behavioral Health Structure
October 20, 2011

This is a draft document prepared by the Facilitator intended to represent the thinking of the group as reflected at the October 20, 2011 Region 2 Stakeholder meeting, building upon the work as documented in the September 15, 2011 meeting. This material is intended for consideration by the Behavioral Health Interagency Cooperative, with the understanding that additional opportunities exist to work with the Cooperative to provide further focus and clarification as a pilot process is considered.

Region 2 behavioral health stakeholders intentionally confirmed their interest in participating in this pilot process (with questions about how it could actually be piloted) and/or to moving toward the proposed configuration, as well as their desire to secure a grant-writer in order to pursue funding opportunities, as soon as possible.

Proposed Legal Form

Region 2 behavioral health stakeholders propose the development of a regional behavioral health entity, established through statute, which features a small, efficient governing body and a regional advisory board featuring a broad spectrum of behavioral health stakeholders.

Specifically, Region 2 proposes a Regional Behavioral Health Governing Body that includes:

- A County Commissioner delegate from each of the five Counties in the Region, and
- Two delegates identified by state legislators, one from the Republican and a second from the Democrat perspective.

The Chair of the Behavioral Health Advisory Board would also participate on the governing body, in either an ex officio or voting capacity, still to be determined.

The Regional Behavioral Health Advisory Board is proposed to feature the participation of a broad range of stakeholders articulated in state code to ensure the range of representation, to include:

- Representatives from agencies which have funding (DOC, IDJC, DHW, Medicaid, SDE, Judiciary, Counties, Veterans, Vocational Rehabilitation)
- Consumers, Families and Advocates
- Providers
- Law Enforcement
- Juvenile Justice
- Public Health District
- Representing: Youth and Adult
- Representing: Mental Health, Substance Use Disorder, Child Protection
- And others.

Specific numbers and construct are still to be determined.

The entity would eliminate the need for the existing Regional Mental Health Advisory Board and Regional Advisory Council structure. Stakeholders embrace the idea of the increasingly integrated approach in order to more effectively discuss and coordinate regional efforts.

Structure

The regional entity would have the capacity to hire, contract, and secure funding. Stakeholders are eager to generate this capacity as early in the legislative session as possible in order to pursue SAMSHA grants to support regional efforts.

Stakeholders seek funding from the outset in order to secure the services of a grant-writer to aggressively pursuing grant opportunities. An Executive Director and staff support are also envisioned for the entity.

The Regional Board would be part of a State Board of Regional Behavioral Health Boards affording them the opportunity to coordinate on the state level and identify and address issues of mutual concern.

Region 2 stakeholders have produced a visual of the new structure, included on the last page of this proposal.

Role and Responsibility

The regional entity will have the ability to pursue funding, hire staff, and contract for services. It will:

- Identify and work fill gaps in the community based on client needs, potentially starting with prevention and early identification;
- Secure the services of a grant-writer and pursue grants;
- Prepare to contract with funding agencies for the provision of community based and other services, as appropriate;
- Monitor, evaluate and improve the system, maintaining accurate/compatible data and reporting on outcomes (including customer, contractor, provider satisfaction)
- Have the authority and flexibility to make adjustments to the system, direct funding, and develop capacity in a manner both proactive and responsive to local needs, leveraging what already works well;
- Work to generate and integrate quality mental health and substance abuse services now and continue that effort to integrate behavioral health with physical health;
- Work to ensure that there is a continuum of services across the life span, providing for supports in those areas where funding restrictions or eligibility process leave consumers and families without supports for periods of time;
- Pay specific attention to finding ways to fill the service needs in rural areas;
- Develop good working relationships and partnerships within the community;
- Generate a system that is easily accessible to consumers and families;
- Provide community education and secure community input;
- Utilize a managed care model;
- Be fiscally accountable.

Core Services

Region 2 stakeholders are less concerned about the list of core services than they are working to ensure that services are provided based on the consumer's need. They see prevention, early intervention and education and transitions as an immediate opportunity, and they see a need to look at the whole system and all categories of service. They continue to emphasize the import of the pending Medicaid managed care contract and the anticipated 2014 adjustments to eligibility requirements. Knowing that providers

support all payers of services, including Medicaid, state and private insurers, and that Medicaid is prevalent, coordination with Medicaid is imperative in order to ensure an effective provider pool. They recommend another column on the list of core services which indicates private insurers.

Funding

Region 2 stakeholders emphasize that they need funding in order to act, and want funding to come with the pilot in order to help position them for success. Existing RAC funding, while minimum, was identified as an initial source. Their first step would be to secure a grant-writer to pursue immediate SAMSHA grant opportunities in order to support the development of the system.

The group confirmed their desire to:

- Minimize funding spent on administration and put as much as possible into programs and services;
- Contract with funding agencies for servicing their clients as appropriate;
- Reinvest savings back into the behavioral health system.

Region 2 stakeholders see an opportunity to focus efforts on prevention and intervention, acknowledging that re-alignments of how some existing services are delivered and pursuing opportunities and efficiencies without funding might comprise initial efforts. And while they discussed the reality that they may need to pursue unfunded initiatives, that if they can make the case for their approach they should make it and sell it.

Concerns and Considerations

- The availability of funding and the sustainability of the effort is a significant concern.
- Stakeholders want to see their efforts go into a program and into the community rather than something on paper that they share in another meeting.
- There is an acknowledgement of the fear of change – personally and by the community, counties, region, state agencies, and elected officials.
- There is a concern that the state is seeking to “devolve” itself of its responsibility, and a desire that the funding agencies are directly involved and engaged at the regional level. Articulating that, as well as the broad representation of the Advisory Board, is a help to address that concern.
- Stakeholders reiterated the need for a common language, and emphasized the use of the term "behavioral health" instead of "mental health" and "substance use disorder," to facilitate the integration of the system. Much of the discussion kept coming back to "mental health" even though it may have intended "behavioral health," and there is a need to be intentional about ensuring that both are addressed and that it truly becomes an integrated system.
- Multiple providers (not one state provider) are required to support the behavioral health system, which also spans multiple payers.
- A question was asked about the implications of the Jeff D lawsuit respective to this work and responsibility as a regional entity.
- A clear delineation of state and regional roles is necessary and helpful, identifying also what services remain with the state and what services come to the region.
- Stakeholders seek clear accountability in state rule regarding the regional role and responsibility. Specifically mentioned was the responsibility to collect needs, comply with the state mental health plan, and determine state requirements respective to the funding so that the region is clear on what it has to deliver.

- There is a recognition that providers support private, state and Medicaid clients to be viable, and this fact must be considered in the proposal and implementation process.
- The Medicaid Managed Care RFP and contract will move forward. Stakeholders seek a meaningful way to interact and coordinate with that effort.
- Stakeholders continue to question how such a structure can be piloted.
- Some stakeholders expressed concern that the region gets asked for its input and what works best for the region, that input goes to the state or the legislature, and then it comes back to them as something else. Then they adapt.

The following materials under “Vision” are intentionally carried over from the September 15, 2011 meeting for the group's future reference.

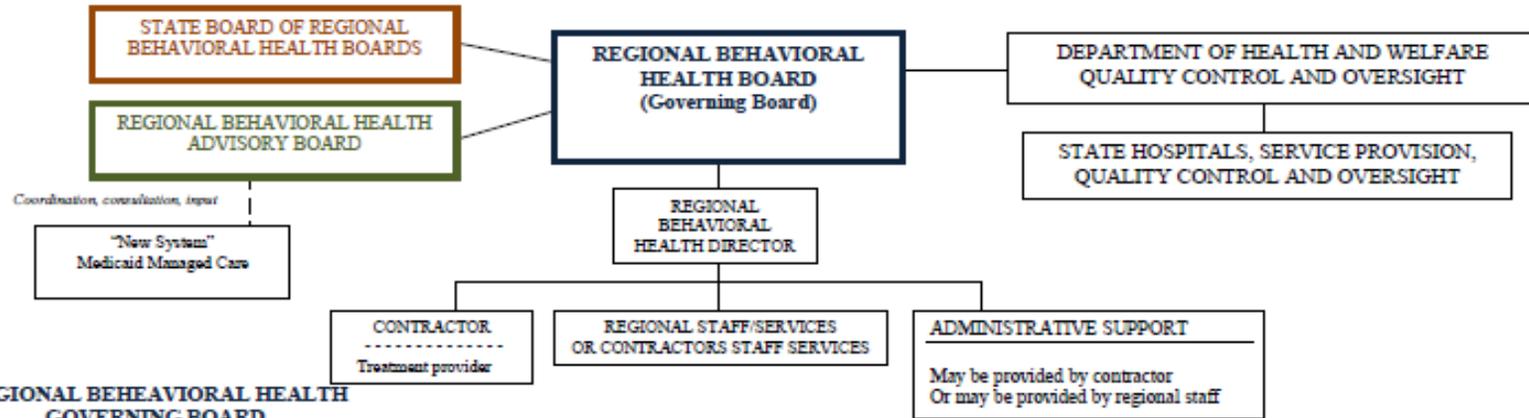
VISION

Region 2 stakeholders expressed their individual visions for a regional behavioral health system that:

- Integrates mental health, substance abuse and physical health and emphasizes prevention;
- Features education, prevention, early identification and support services;
- Is easily and simply accessible and available where consumers are without stigma and the need for criminalization;
- Features an integrated continuum of care that provides high quality care regardless of people's ability to pay;
- Makes quality services accessible to rural areas;
- Is a coordinated, integrated program across age and services;
- Is sustainable, comprehensive, and integrated across life span and Region 2 geography;
- Provides an infrastructure that supports people doing the work;
- Is collaborative - all elements of the system work together and work to meet the gaps;
- Is funded;
- Provides vital lifelines and stability;
- Provides the flexibility to do what will work in the region and the rural area, building on regional strengths.

THIS DOCUMENT IS FOR INFORMATIONAL PURPOSES ONLY

Region 2 Proposed Structure
IDAHO REGIONAL BEHAVIORAL HEALTH SYSTEM
 October 20, 2011



REGIONAL BEHAVIORAL HEALTH GOVERNING BOARD

- ♦ 1 County Commissioner/designee from each County in the Region (5)
- ♦ 2 Legislative delegates (1 Republican, 1 Democrat)
- ♦ Chair of the Regional Advisory Board (ex officio or vote?)

REGIONAL BEHAVIORAL HEALTH ADVISORY BOARD

- ♦ Representatives from agencies which have funding (DOC, IDJC, DHW, Medicaid, SDE, Judiciary, Counties, Veterans, Vocational Rehabilitation)
- ♦ Consumers, Families and Advocates
- ♦ Providers
- ♦ Law Enforcement
- ♦ Juvenile Justice
- ♦ Public Health District
- ♦ Representing: Youth and Adult
- ♦ Representing: Mental Health, Substance Use Disorder, Child Protection

STATE BOARD OF

- REGIONAL BEHAVIORAL HEALTH BOARDS**
- ♦ Chair of Regional Behavioral Health Board from each Region

REGIONAL BEHAVIORAL HEALTH BOARD RESPONSIBILITIES

- ♦ Appoints Chairperson
- ♦ Hires staff, pursues funding, contracts for services
- ♦ Responsible for local policies, procedures, finances and programs
- ♦ Provides for quality improvement
- ♦ Meets legislative intent
- ♦ Maintains accurate, compatible data
- ♦ Reports on outcomes (include customer, contractor, provider satisfaction)
- ♦ Identifies needs and gaps, works to address them
- ♦ Provides community education and solicits community input
- ♦ Provides services consistent with statewide standards
- ♦ Develops collaborate efforts, working relationships, and partnerships

FEATURES OF THE NEW SYSTEM

- ♦ Ability to use carryover funds
- ♦ More flexibility in community decisions
- ♦ Integrated with emphasis on prevention, consistency, early identification, accessible across life span
- ♦ Ability to contract for services
- ♦ Uses existing best practices
- ♦ Baseline policy set by state authority
- ♦ Consistent procedures
- ♦ Community collaboration and awareness (education and anti-stigma)
- ♦ Continuum of care
- ♦ Training
- ♦ Single point of entry/local responsiveness
- ♦ Decentralized/ representation

**Region 2
Behavioral Health Structure Scoping Meeting
Summary Results
September 15, 2011**

In an effort to describe potential structures for an effective, regionally based behavioral health system, the Behavioral Health Interagency Cooperative asked stakeholders in Region 2 to participate in a discussion process. The outcome of the process would be a proposed regional structure that the Region thinks would most meaningfully lead the coordination of community-based behavioral health services. Region 2's product is intended to inform the Cooperative's discussion at its November 2, 2011 meeting. At that time, the Cooperative will consider whether it is possible to pursue a pilot project to test the proposed structure.

The Cooperative is undertaking a similar process in Region 7 as well.

The process for developing the structure includes:

1. Meeting 1: to present the invitation and collect initial thoughts in response to the Cooperative's questions about a structure;
2. Reflect stakeholder comments in a draft document and circulate it electronically with participants for further reflection and regional input and development; and
3. Meeting 2: Refine the proposal and prepare it for presentation to the Cooperative on November 2.

Region 2 stakeholders met on Thursday, September 15, 2011 from 9 to noon in the Lewiston State Office Building 3rd Floor Large Conference Room in Lewiston, Idaho. Invitees were identified to ensure a range of perspective, as indicated by the Cooperative and as coordinated by DHW Mental Health Program Manager Vicki Malone. Others in the region reflected an interest in the effort are invited to provide their input to this draft product. The list of participants is included as Attachment A. The meeting was facilitated by Marsha Bracke, Bracke and Associates, Inc., who also facilitates the Cooperative.

Meeting process included:

- Introductions by each of the participants via round robin format, including an invitation for each to share with the group their individual visions for behavioral health in the Region,
- A power point presentation made by the Facilitator, providing the background respective to the Cooperative, the purpose of this inquiry, and discussion questions to inform the development of a proposed regional structure,
- An open discussion about what Core Services for which the Region may want to be responsible or pilot,
- A facilitated process of collecting individual suggestions around questions related to regional entity characteristics, legal form, structure and representation, and
- A discussion about next steps.

Hand written contributions of the participants and the flip chart notes maintained by the Facilitator have been transcribed and are included as Attachment B.

Using the inputs provided at the meeting, the Facilitator has generated a ***draft*** proposal for the Region 2 behavioral health entity for further consideration and refinement. This document is included as Attachment C.

Provided as a separate attachment are chapters out of Idaho State Code Title 39 Chapter Four describing elements of the Public Health Districts, provided at participants' request to inform their discussion of the Public Health District structure and how that can inform the proposal under development.

This draft is specifically intended as a straw man that present the inputs in a consolidated format, and it is specifically subject to regional review and refinement. Comments and suggestions are invited immediately upon the distribution of the document to meeting participants, who are invited to share the material with their constituents and peers. Comments can be submitted to the Facilitator, and they will be collected and provided at the October 20, 2011 meeting of the group for consideration and refinement by regional stakeholders.

**Region 2
Behavioral Health Structure Scoping Meeting
Summary Results
September 15, 2011
List of Participants**

Name	Affiliation	Phone	E-mail
Beecher, Ron	Department of Health and Welfare	208-816-2230	beecherr@dhw.idaho.gov
Bernatz, Kevin	Idaho Department of Juvenile Corrections	208-799-3332	kevin.bernatz@idjc.idaho.gov
Button, Steve	Lewiston School District	208-305-9633	sbutton@lewistonschools.net
Cooley, Zoe	Advocate/member of NAMI and affiliates	208-835-3071	jimzoe@cpinternet.com
Davis, Randy	St. Joseph Regional Medical Center Mental Health Services	208-799-5750	rdavis@sjrhc.org
Douglass, Scott	Idaho Department of Correction, District 2 Probation and Parole	208-799-5030 x 103	sdouglas@idoc.idaho.gov
Downey, Eleanor	Resource Advisory Council and Lewis-Clark State College	208-792-2266	epdowney@lcsc.edu
Dulin, Brian	Latah County Probation and Youth Services	208-883-2277	bdulin@latah.id.us
Fowler, Beverly	ChangePoint	208-759-1000	bevchange@gmail.com
Goetz, Chris	Clearwater County Sheriff	208-476-4521	cgoetz@clearwatercounty.org
Harrigfeld, Sharon	Director, Idaho Department of Juvenile Corrections	208-577-5404	sharon.harrigfeld@idjc.idaho.gov
Kauffman, Barb	Consumer Representative	208-743-4708	bkauffman1951@q.com
Malone, Vicki	Department of Health and Welfare Program Manager, Region 2 Behavioral Health	208-799-4440	malonev@dhw.idaho.gov
Martin, Lisa	Idaho Supreme Court Problem Solving Courts	208-790-1748	d2pscourts@cableone.net
Marugg, Ed	Public Health - Idaho North Central District	208-799-0356	emarugg@phd2.idaho.gov
Pals, Diana	Mental Health Providers	208-882-7848	dianapals@hotmail.com
Phillips, Jim	Phillips Agency	208-746-7266	jimbobp@clearwire.net
Rusche, John	Representative, Idaho House	208-750-6048	jrusche@house.idaho.gov
Schmidt, Keicia	Problem Solving Courts	208-816-3363	keiciaschmidt@u.boisestate.edu
Stensrude, Kris	Nez Perce County Court Services - Clinical Department	208-750-2037	kriss@co.nezperce.id.us
Stroschein, Tom	Latah County Commissioner	509-330-1137	toms@moscow.com
Suesz, Jerry	Idaho Department of Vocational Rehabilitation, Rivercity Mental Health	208-799-4448	jsuesz@idaho.gov
Taylor, Lisa	Nez Perce County Court Services	208-799-3177	lisataylor@co.nezperce.id.us
Wakefield, Sabrina	MSW Intern with John Rusche and Eleanor Downey	208-790-3653	sabrinawakefield@u.boisestate.edu
Webley, Terri	Peer Support Specialist	208-476-3405	trwebl@aol.com
Wilson, Marsha	Consumer Representative	208-791-4985	Mdwilson793@lcmail.lcsc.edu
Wolf, Teresa	Nez Perce County	208-799-3095	teresawolf@fco.nezperce.id.us

**Region 2
Behavioral Health Structure Scoping Meeting
Summary Results
September 15, 2011
Flip Chart Notes**

WELCOME

- Region 2 Behavioral Health
- September 15, 2011

INTRODUCTIONS

- Name
- Affiliation
- Role in behavioral health
- Your Vision for Region 2

PRINCIPLES OF MEETING CONDUCT

- Participate!
- Listen! Seek to understand
- Be solutions oriented
- Be open to new ideas
- One person speaks at a time
- Avoid side conversation
- Honor time constraints
- Use electronics responsibly

VISION

- Walk into door and get help needed
- Infrastructure that supports people doing the work - integrated/supported system of care
- Mental Health and Substance Abuse services are enhanced and available
- System that relies on regional strengths that bridges scope of behavioral health needs
- System meets the gaps - work together
- Integrated continuum of care that provides high quality care regardless of people's ability to pay
- Quality services accessible to rural areas - services work and are accessible to family members
- Standardized flow, system from contact with law enforcement and thereafter
- Funding to support system
- Sustainable, comprehensive, integrated system across life span and geography
- Vital lifelines exist (clinicians, peer support specialists)
- Services are not stigmatized - comfortable to access them
- Services available where people are - outreach and intervention
- Kids get what they need without having to be criminalized
- Increase availability and effectiveness in whole system
- Education
- More cohesive way to go through and open to all (not just crisis)
- Coordinated, integrated program across age and services

- Stability to get to work and work maintains stability
- Maintain local control of some type to address rural challenges
- Early identification and support/services
- Integrate mental health, substance abuse and physical health emphasizing prevention
- Freedom to design what will work in our rural area
- Look at on a regional basis
- Coordinated Services
- Early intervention
- Holistic system
- De-stigmatized
- A system available beyond crisis to everyone in need

CORE SERVICES

Discussion question: For what community-based behavioral health services would a Region 2 behavioral health entity want to be responsible?

- Concern - going to be big changes in how services are funded in 2014/parity
- If we look just at funded programs, we aren't looking at the whole system - need to look across funding streams and service categories
- Add column to matrix of private insured
- If DHW funding went to regional entity - probably more flexibility
- Need to keep what is working well - take some infrastructure with us (medication monitoring)
- Logistics support required
- More focus on prevention and education
- Look broader
- Providers - use all
- Address transitions
- Have some play in all categories - detail to be decided by region
- At a minimum - what state is providing
- This is minimum list - currently funded

DESIRED CHARACTERISTICS

Discussion Question: What are the desired characteristics of a Region 2 Behavioral Health Entity?

- Federal, state and county funded
- Flexible funding
- Flexible spending
- Some autonomy
- Flexible
- Adequate funding
- Proactive - adjust based on needs and/or funding
- Informed
- Flexible (within parameters)
- Ability to act
- Open to all
- Integrated with medicine
- Serves the entire age span
- Flexible, adaptable, comprehensive
- Control over \$, decisions
- Forward thinking

- A menu of services that meet the spectrum of behavioral health/mental health needs with all entities providing their division of labor and recipients having user friendly access
- Flexibility
- Continuum of care - prevention/early intervention - crisis - chronic care
- Integrated communication capabilities between ALL providers
- Ease of accessibility for consumers
- Flexibility
- Policy Board
- Funded by state/counties, federal contracts, insurers, fees
- Addressing co-occurring
- Holistic approach
- Integrated services that are available to everyone, regardless of the cost for services
- Managed care model
- Crisis services available
- Mental Health Training for providers
- Cost efficient
- Highest Quality
- Collaborative for further cost efficiency
- Supportive of service delivery experts (inclusive)
- Providing continuum of services which clients and families can navigate to meet full range of needs
- Integrated services, comprehensive
- Flexible
- Accountable
- Data Driven
- Transparent
- Integrating local delivery and funding, strengths
- Availability of services - rural
- Experience with lean budget
- Experience with oppositional government
- Strong mental health board
- Good relationship between agencies
- Addressing rural-ness
- Develop good working relationships and partnerships within the community
- Stakeholders from mental health and substance use disorder providers
- Co-occurring cross training

Group Discussion (as transcribed on flip chart notes)

- Accountability: financial decisions, determining and servicing the needs of the area, helps determine the legal form
- All apply

LEGAL FORM

Discussion Question: What legal form should be used for the regional entity if it intends to enter into contracts, hire staff, and/or own property?

Individual Inputs (participants provided on post-its)
(comments in parenthesis reflect follow-up discussion/clarification)

- Contract for cost efficiency
- DHW for oversight, support and crisis services

- Adequate funding
- Intergovernmental agreements depending on funding sources
- Similar to Health Department - body politic with statutory powers and duties
- Like public health districts?
- 501(c)3
- Cooperative with Governing Board
- Not for profit - private
- As needed
- Non-profit
- Attorney - nonprofit?
- Non Profit
- Cooperative
- Cooperative
- 39-400 Idaho Code (Describes Health Districts)
- Corporation with a governing board
- The most cost effective, biggest bang for the buck (quality)
- Similar to mental health board with added paid professional administrator to support board on contract and monitor
- Independent enough to address identified service needs
- Representatives from all stakeholders including political, providers, consumers, law enforcement, courts, schools, state DHW, voc rehab, medical, hospitals with freedom/flexibility to operate and funds go directly to Board
- Legal form should provide a clear level of what agency or level of government will be responsible to provide specific services
- Legal, by statute - legislative funding source to each state department and regional government (state, county, city jurisdiction)

Group Discussion (as transcribed on flip chart notes)

- Need entity
- Statue - describe responsibilities
 - Board
 - Public Health District Model
 - Practice prevention and education
 - Questions about Treatment
 - Body Politic - look at legal definition in code
 - Is the exiting Board representative?
- Fold into Public Health District
 - Will this get too big?
 - Another division within?
- Have another body like the health district / mimic

STRUCTURE

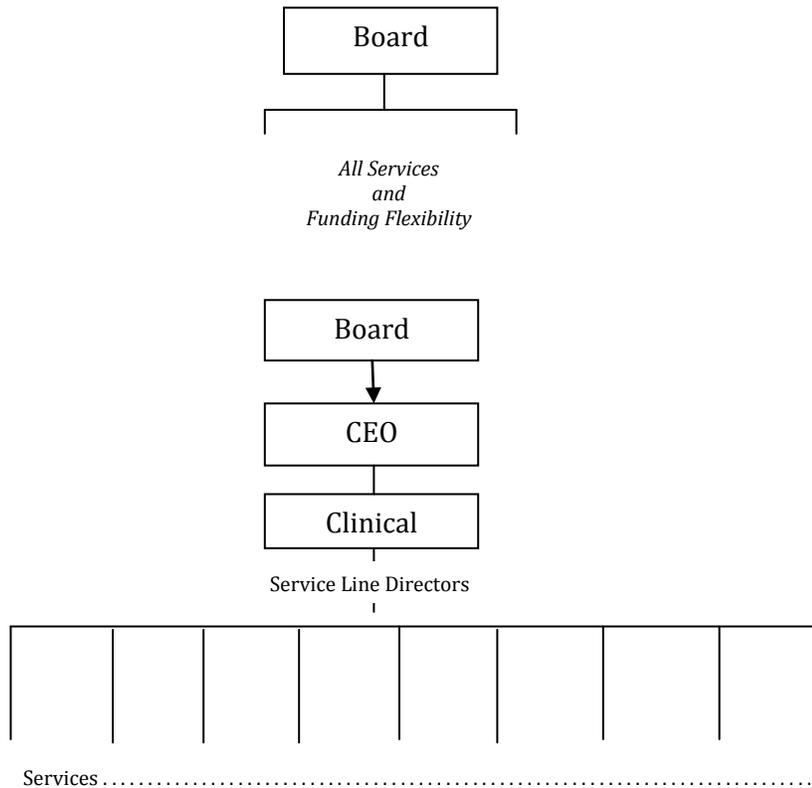
Discussion Question: How should it be structured (e.g. governing board, staff, committees, contractors, etc.)?

Individual Inputs (individuals provided on post-its)

(comments in parenthesis reflect follow-up discussion/clarification)

- Regional Board with employees
- Regional Board - committees

- Combination of a Board and subcommittees
- Recipient empowered access - mentor/escort driven
- Paid CEO, Director and staff
- Management follows Board developed policy - also there is a coordinator role for overseeing
- Managing Board supported by statute, rules and law
- Board - regional hire administrator, committees, support staff
- Regional Board, hired/contracted administrator
- Each region should have a governing board, with multi disciplines represented to provide input
- Representative from substance abuse, mental health and justice systems along with health care and education - under 20 people
- Board - people that have authority to make decisions about money. Can use a combination of staff and contractors.
- Policy Board made up of representatives from local governments (Counties). Staff who actively manage contracts/programs.
- Board, Director, Staff
- Regional Board, Administrator
- Adequately staffed - staff to include some case management/quality control.
- Board, contractors, committees
- Committees, contractors
- Board and committees
- Board (?elected, appointed by electeds) Full time executive and staff, contact managers - quality, data managers, perhaps service delivery
- Set up like public health is currently



Group Discussion (as transcribed on flip chart notes)

- Representative Board
- Authority to make decisions about spending money
- Public Health Districts have County Representatives on Board - commissioners and designees
- Governance Board
- Elected officials
- Small
- Secure consumer and family voice at this level
- Technical Advisory Board
- Regional Advisory Council/Regional Mental Health Boards together
- Consumer and Family
- Providers
- Executive Director
- Quality Manager/Data Management functions - measure outcomes
- Grant Writing/Contract Management
- Administrative Assistant
- Do eligibility determination and case management - that is, following and helping a client through the system when and when not covered
- Could be employee/contract
- Case manager would help get someone set up (rather than after being eligible) and fill in the gaps

RERESENTATION

Discussion Question: How should the regional board ensure adequate regional stakeholder representation while being nimble enough to efficiently address operational and business issues?

Individual Inputs (individuals provided on post-its)

- Board should be comprised of individuals who can make financial and contract decisions, supported by subcommittees of family, consumer, providers, etc.
- Board needs to have representation from community with expertise in business models for non-profit organization and the board needs representation of community stakeholders 12-20 members
- Business leaders
- Board that is represented by local government and/or interested citizen appointees
- Strong private provider representation
- Representation from juvenile justice, Department of Correction, schools
- Cross-training
- Business people to help (LCSC?)
- Needs a paid director with input from Board
- Invited multiple government representation for each regional board. Similar to this meeting today. Both public and private agencies to be represented.
- Stakeholders have input to Board
- All stakeholders in region with equal vote
- Include consumers and families for representation. Legal and executives for business and operations.
- Local residents, elected officials appoint most, some professional expertise, clearly defined state vs. local roles.
- Transparency
- Include all service providers to problem-solve and assure efficiency
- Limit board members (8-12), careful selection of board members, active members region
- Representation from each district from different agencies
- Ensure all entities are represented in all communities

- Current Board make-up
- Multidisciplinary

Group Discussion (incorporated in earlier sections)

SUBCOMMITTEE

- Regional Mental Health Board meeting to continue conversation
- Folks at this meeting invited
- Regional Advisory Council members invited

Initial Draft
Region 2 Proposed Behavioral Health Structure
September 15, 2011

This is a draft document prepared by the Facilitator intended to represent the thinking of the group as reflected at the September 15, 2011 Region 2 Stakeholder meeting. It is also intended to be subject to review, discussion, study and refinement by stakeholders present at that meeting and others with an interest in the effort. Please provide comments to: Marsha Bracke, Facilitator, 208-472-8841 or marsha@marshabracke.com by close of business Friday, October 14, 2011.

VISION

Region 2 stakeholders expressed their individual visions for a regional behavioral health system that:

- Integrates mental health, substance abuse and physical health and emphasizes prevention;
- Features education, prevention, early identification and support services;
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- Is funded;
- Provides vital lifelines and stability;
- Provides the flexibility to do what will work in the region and the rural area, building on regional strengths.

REGIONAL ENTITY

Role and Responsibility

A Region 2 behavioral health entity would:

- Be the recipient of pooled state, county, federal funds and grant funding as appropriate and use and leverage that funding in a way that best meets the regional need;
- Have the authority and flexibility to make adjustments to the system, direct funding, and develop capacity in a manner both proactive and responsive to local needs, leveraging what already works well;
- Work to generate and integrate quality mental health and substance abuse services now and continue that effort to integrate behavioral health with physical health;
- Work to ensure that there is a continuum of services across the life span, providing for supports in those areas where funding restrictions or eligibility process leave consumers and families without supports for periods of time;
- Pay specific attention to finding ways to fill the service needs in rural areas;
- Develop good working relationships and partnerships within the community;
- Generate a system that is easily accessible to consumers and families;
- Utilize a managed care model;
- Be fiscally accountable.

Core Services

Region 2 stakeholders will continue their discussion about which core services the regional entity should be responsible. They indicated that at a minimum, they should have a role in what the state is funding now, but also noted that they should have some play in all categories of service, noting that if they look only at funded programs, they aren't looking at the whole system. Stakeholders indicated an interest in looking across funding streams and service categories, capitalizing on what is working well, bringing some existing infrastructure along, using all providers, providing more focus on prevention, early intervention and education, and addressing transitions. They asked what will continue to be state run and what will they manage, noting the pending Medicaid managed care contract and the fact that providers support all payers of services, including Medicaid, state and private insurers. To sustain or generate a provider pool that can meet the need requires consideration of this reality. To that end, they recommended another funding column on the matrix of core services that identified private insurers.

Legal Form

Of the several legal forms proposed by Region 2 stakeholders, including a private non-profit, Cooperative, Corporation, Public Health District-like structure, or folding the effort within the existing Public Health District structure, Region 2 stakeholders propose continued discussion around a Public Health District-like form. While folding the entity into the Public Health District remains a popular notion among many in the group, particularly given the Health District's important role in prevention and education and that it is already a proven structure and entity, concern exists that the behavioral health function may be diluted in the larger organization, the addition of treatment services to the Health District's existing functions, and that consumers and families and other stakeholders may not have an adequate voice.

Idaho Statutes provided as a separate attachment provide information about how the Public Health District is formed to inform the group's study and recommendation for a behavioral health entity. Discussion regarding this legal form reflected the opportunity to have legislators sit on the Board who can directly inform the state legislature about the needs and activities of the system, as well as a corresponding concern about having elected officials serve on a board whose interest may potentially be conflicted between their elected position vs. meeting behavioral health needs. It was acknowledged that among the body politic, elected officials may likely be able to designate their board responsibility.

The legal form would be supported and substantiated by state statute and rules.

Structure, including Representation

The structure features a small governing board, potentially of only 7 people should the Region decide on the Public Health District model. This Board would include representatives from local County Governments, who may be able to delegate their role. There is an interest by some in securing consumer and family representation at the Board level.

The behavioral health entity would hire a full time Executive Director, who would also employ someone to manage quality and data, someone to do grant writing and contract management, and an administrative assistant. Contractors would also be utilized. One of the responsibilities of the staff or a contractor would be case management - a way to assist, follow and help a client through the system whether or not the client is covered and during those times there are gaps in service similar to the model currently in Children's Mental Health.

The Board and Staff would be supported and advised by a Technical Advisory Committee, which would be a representative group (a combination of the existing Regional Mental Health Board and Regional Advisory Council), to include consumer and family and provider representation. Region 2 stakeholders intend to take more time to discuss the specifics of this committee.

Funding

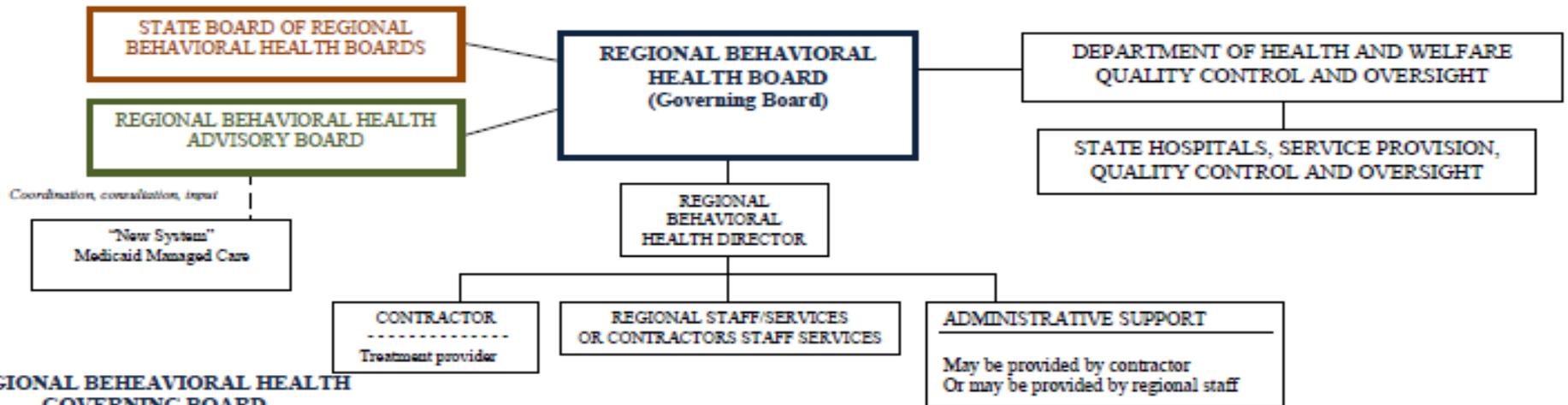
Funding would be pooled in the regional entity depending on the stakeholder decision respective to Core Services. The regional entity would pursue grants for additional funding as part of its function.

Concerns and Comments

- There is a concern about the continuation of state and federal funding and what vulnerabilities that poses to the regional entity.
- Stakeholders reiterated the need for a common language, and emphasized the use of the term "behavioral health" instead of "mental health" and "substance use disorder," to facilitate the integration of the system. Much of the discussion kept coming back to "mental health" even though it may have intended "behavioral health," and there is a need to be intentional about ensuring that both are addressed and that it truly becomes an integrated system.
- There is a desire to ensure the full representation of all stakeholders at all levels of the structure.
- There is a desire to continue to emphasize prevention and education.
- Multiple providers (not one state provider) are required to support the behavioral health system, which also spans multiple payers.
- A question was asked about the implications of the Jeff D lawsuit respective to this work and responsibility as a regional entity.
- A clear delineation of state and regional roles is necessary and helpful, identifying also what services remain with the state and what services come to the region.
- Stakeholders seek clear accountability in state rule regarding the regional role and responsibility. Specifically mentioned was the responsibility to collect needs, comply with the state mental health plan, and determine state requirements respective to the funding so that the region is clear on what it has to deliver.
- There is a recognition that providers support private, state and Medicaid clients to be viable, and this fact must be considered in the proposal and implementation process.
- The Medicaid Managed Care RFP and contract will move forward. Stakeholders seek a meaningful way to interact and coordinate with that effort.
- The question was asked how such a structure can be piloted.

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Region 2 Proposed Structure
IDAHO REGIONAL BEHAVIORAL HEALTH SYSTEM
 October 20, 2011



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REGIONAL BEHAVIORAL HEALTH BOARDS

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- ◆ Reports on outcomes (include customer, contractor, provider satisfaction)
- ◆ Identifies needs and gaps, works to address them
- ◆ Provides community education and solicits community input
- ◆ Provides services consistent with statewide standards
- ◆ Develops collaborate efforts, working relationships, and partnerships

FEATURES OF THE NEW SYSTEM

- ◆ Ability to use carryover funds
- ◆ More flexibility in community decisions
- ◆ Integrated with emphasis on prevention, consistency, early identification, accessible across life span
- ◆ Ability to contract for services
- ◆ Uses existing best practices
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- ◆ Consistent procedures
- ◆ Community collaboration and awareness (education and anti-stigma)
- ◆ Continuum of care
- ◆ Training
- ◆ Single point of entry/local responsiveness
- ◆ Decentralized/ representation



Idaho Behavioral Health Interagency Cooperative

Meeting Summary Draft
November 2, 2011

COOPERATIVE MEMBERS PRESENT:

- Director Richard Armstrong, Department of Health and Welfare
- Director Sharon Harrigfeld, Idaho Department of Juvenile Corrections
- Patti Tobias, Administrator of the Idaho Courts
- Teresa Wolf, State Mental Health Planning Council
- Rich Henderson, Idaho Department of Education
- Angenie McCleary, County Representative

ALTERNATES PRESENT:

- Tammy Perkins, Office of the Governor
- Frank Riley, Idaho Department of Juvenile Corrections
- Kathie Garrett, NAMI Idaho
- Scott Ronan, Idaho Courts
- Dr. Melanie Reese, Idaho Department of Education
- Shane Evans, Idaho Department of Correction

OTHER:

- Danielle Miller, Department of Health and Welfare
- Leslie Clement, Department of Health and Welfare
- Ross Edmunds, Department of Health and Welfare
- Caitlin Zak, Office of Drug Policy
- Rochelle Kubinski, BPA
- Tony Poinelli, Idaho Association of Counties
- Pat Guidry, Department of Health and Welfare
- Amy Jeppesen, Recovery for Life
- Matt Ellsworth, Legislative Services Office

FACILITATOR

- Marsha Bracke, Bracke and Associates, Inc.

ACTION ITEMS:

1. Marsha and Danielle will produce and distribute the meeting summary by Monday, November 7, 2011.
2. The SGS Subcommittee will continue to develop outcomes reporting ASAP, and present a proposed report format for an anticipated December/January report to JFAC at the November 23 meeting.
3. The SGS Subcommittee will assist Marsha in generating the table of SUDs funding status to include in the draft Report to the Governor.
4. DOC, IDJC and the Courts will send an edit of the paragraph describing their SUDs funding efforts to Marsha as soon as possible and no later than Friday, November 4, 2011.
5. Marsha will convene a third series of meetings with Regions 2 and 7. The primary discussion will be about the Cooperative's thinking respective to the structure proposals,

and to help articulate and confirm next steps. Ross Edmunds will be present to participate in these discussions.

6. Marsha will revise the existing State Behavioral Health Planning Council proposal to reference the regional entities in a manner that reflects what structure exists now and what that structure might potentially look like in the future.
7. Cooperative members will review and comment on draft Report materials as they are distributed, and come to the November 21, 2011 meeting prepared to edit a final version of the document.

REFERENCE MATERIALS:

On October 31, 2011 the following materials were distributed to inform and support meeting discussion:

1. The agenda for the November 2, 2011 meeting
2. The September 23, 2011 draft meeting summary documentation
3. The Region 7 structure proposal, dated October 3, 2011
4. The Region 2 structure proposal, dated October 20, 2011
5. The Core Services matrix, as it exists to date
6. The Planning Council Proposal of September 1, 2011
7. The SGS Subcommittee meeting summary notes of Friday, October 7, 2011
8. The SGS Subcommittee meeting summary notes of Wednesday, October 12, 2011
9. A revised draft Report to the Governor, dated October 31, 2011.

Other handouts provided at the meeting included a summary of SUDs funding status from the Courts, IDJC and DHW. Shane Evans, DOC, provided a verbal report and will follow-up with a written copy electronically.

The Facilitator maintained notes of discussion points on Flip Charts, which have been transcribed and are included as Attachment A.

AGENDA ITEMS - CONCLUSIONS

September 23, 2011 Follow-Up

Approve Meeting Summary Documentation

The Meeting Summary was distributed and reviewed.

Marsha and Danielle will make a few grammatical corrections to the summary.

- Summary approved per corrections to grammatical errors

Regional Structure Proposal - Development

Regional Summary

The Cooperative reviewed and focused their initial discussion on seeking to understand the structure proposals generated by Region 2 and 7. The proposals were very similar for their interest in having diverse representation and involvement in the regional entity's activities; seeking flexibility with what funding they may be able to manage so they can generate efficiencies according to their local context and consumer and family needs; work to emphasize prevention, intervention, education and recovery; reinvest any savings into the delivery system; coordinate and communicate with the Medicaid managed care system; secure the robust involvement of the funded entities in the coordination process; have staff

to administer the regional entity and seek private and grant funding to help support their efforts; and have a voice throughout the regional and the state level. Both regions expressed concern about start-up and sustained funding combined with a priority to minimize administrative expenses and get as much funding as possible into services. Both structures are proposed to be established legislatively.

The distinguishing difference between the two proposals was the entity itself. Both proposals involve a combining or integration of the existing Regional Mental Health Boards and Regional Advisory Councils (one proposed moving the little bit of existing RAC funding to the new entity). Both require the services of an Administrator and potential additional staff to oversee the operation and contracts. Region 2, however, proposed that its advisory board feature a governing body similar to that of the Public Health Districts, where County Commissioners designate a representative serve local interests, and legislators appoint two representatives to bring a broader perspective to the governing body (one Democrat, one Republican). A larger advisory board would be comprised of a broad and diverse range of stakeholders in the region, and that board would advise the governing body. The proposal also features a state-level Board of regional entity chairs to coordinate and work across regions.

Region 7 featured the same combination of the existing boards, with a Joint Powers Agreement of all 10 counties in the region to demonstrate their commitment to and designate a representative to sit on the Board. Within that structure, each of the counties would designate an individual that brings a needed perspective to the Board. The required Board representation could be articulated in statute.

Both regions questioned how such a structure can be piloted.

SGS Subcommittee Discussion

At the September 23, 2011 meeting of the Cooperative, the SGS Subcommittee was tasked to review the Core Services and indicate which of those services that could potentially be contracted with a regional entity in the near and long-term. Ross Edmunds, DHW, reported that a number of services are already contracted out and others could be, contingent on an entity's demonstration of their readiness and ability to provide those services in a manner that meets the entity's needs. Ross pointed out there are specific things the regions could do better at a regional level; among them recovery support services, housing, employment, prevention, etc.

What the group also learned through the process is that, given the structural proposals and the systems change that needs to occur in order to make them a reality, a pilot is not possible. Rather, if regions form themselves into the entity they desire to be and demonstrate readiness for managing the services they seek to manage, the funding agencies will then have the option of contracting with them. Elements of this discussion included the following comments and observations:

- Different regions may not come together and demonstrate readiness at the same pace. In response to a question about whether a given region proves to never be ready, the group considered that the structure and delivery may not have to look the same in all regions.
- The funding agencies have an obligation to communicate what their sideboards and target populations are so a Region can plan readiness according to a known target. Within that structure there is flexibility and autonomy so that the regions

have the ability to address local needs and emphasize prevention, intervention and recovery in a manner they find most effective.

- The approach furthers the concept of braiding (not blending) funding to facilitate services. The braided funding approach was articulated as the preferred approach in the previous transformation work group recommendation.
- The approach leverages a number of concerns and opportunities, including establishing the independence and authority of the regional entity, the choice of the funding entity to contract as appropriate to their need, the capacity for braiding funding within a regional context, and the ability of a region to pursue private and grant funding - and serve any population - on its own initiative.
- The approach supports regional interests in being a single place where someone can go to access a broader system. The entity could facilitate and align services based on consumer needs and what services are available in the region. This approach was likened to an MSC.
- Medicaid is moving to a managed care approach. There is interest among the regions of coordinating within that context, and concern regarding what it means given the program's predominance in service delivery. The suggestion is that the Cooperative and the regional entities will have to evaluate how to move forward within the rest of the delivery system as that model comes into existence.
- It is important to regional entities to have all funding entities' regional counterparts at the table.
- Region 2 specifically discussed that even without funding, there is value in coming and working together as a behavioral health community.
- The structure would feature enabling legislation, perpetuate best practice, secure regional flexibility, and demonstrate readiness for contracting within sideboards shared by the funding agencies.
- Patti Tobias expressed her sincere gratitude to the two regions for their efforts in generating the proposed structures.

Draft Proposal

Pending further discussion with the regions, the Cooperative **may be willing to recommend** that the state legislature create enabling legislation, empowering regions to form an entity that meets regional needs to coordinate and deliver behavioral health services. Funding entities are to communicate the sideboards they require in order to be able to contract for services, and will have the option to so contract once the regional entities demonstrate readiness. The structure is intended to 1) foster flexibility within those sideboards to best meet the needs of consumers and families in the region, 2) enable the regions to reinvest savings into the system, and 3) facilitate local and regional coordination, creativity and the pursuit of private funding opportunities. **It was requested that the Cooperative's proposal be documented in writing after further discussion with the Regions.**

In a round robin format, all members of the Cooperative confirmed their support to **pursue another discussion with the regions regarding their response to the proposed regional structures. The results of those discussions will be considered by the Cooperative at its next meetings.** Specific comments as recorded on Flip Chart Notes are included on page 8 of Attachment A - Flip Chart Notes.

Next Steps

The Cooperative's discussion and proposal will be documented for Cooperative review. There is great appreciation for the regions' efforts, and a desire to continue the discussion and development of the regional entities. Marsha has tentatively scheduled meetings November 8 in Region 7 and November 15 in Region 2. The Cooperative confirmed that schedule. Ross Edmunds will participate in those meetings to discuss with the regions their proposal and the Cooperative's response, and generate a sense of the appropriate next steps given those discussions. Members of the Cooperative and the SGS Subcommittee are also specifically invited to attend and participate in this discussion. As these conclusions are developed, Marsha will continue to update information about the regional outreach effort and reflect that in the Draft Report to the Governor.

Planning Council Proposal

At the last meeting of the Cooperative, it was asked if members want to forward the State Behavioral Health Planning Council proposal for legislative action this year. In a round robin format Marsha confirmed with the group their desire to move forward with the legislation. This process included a confirmation from both Teresa Wolf and Kathie Garrett that the Planning Council encourages the proposal and its movement in the next session, and the legislation can move forward as a standalone document. Dick Armstrong and Patti Tobias pointed out the need to change the reference to "Regional Behavioral Health Community Development Boards," since those won't be in place at the time this proposal is made. Marsha was asked to change the language to reflect the current and an anticipated regional entity structure. The recommendation for the legislation will be included in the Draft Report to the Governor.

Operational Guidelines: Outcomes Reporting

On behalf of the SGS Subcommittee and with their input, Ross Edmunds reviewed the SGS Subcommittee notes on Outcome Reporting and sought feedback from the Cooperative relative to the document's ongoing development. Ross pointed out the group is concentrating on what is common among them first. Feedback included the need to secure a definition for "recidivism," and to bring to the next meeting a proposed final format that can be used in December/January presentations to JFAC.

Draft Status Report

Cooperative members took a few minutes to review the draft Report, providing the following feedback:

- DOC, IDJC and the Courts will review and refine the paragraphs devoted to their work and progress with SUDs funding by Friday, November 4, 2011;
- Reference to populations might be more broadly defined, rather than as "specific populations,"
- Include the proposed chart reflecting the collective status of Substance Abuse funding at a simple, high level (Marsha will use the SGS Subcommittee to help generate this chart).

Other comments and suggestions are invited electronically. Given that the Report is to be finalized at the November 21, 2011 meeting, members of the Cooperative will make a point of reviewing drafts sent electronically so completing the report at that meeting is possible.

SUDs Status Reports

The Courts, IDJC and DHW each provided a written summary of their SUDs funding and data to date. DOC provided an oral report (a hard copy of which will be delivered as soon as it is available).

Other

Marsha reported there was an inquiry on the website from a provider who wanted to share with the group her experience with new changes regarding SUDs funding. The Cooperative asked for more specific information in order to more meaningfully coordinate that inquiry and request.



Idaho Behavioral Health Interagency Cooperative

Attachment A – Flip Chart Transcript
November 2, 2011

Agenda

- Approve Meeting Summary
- Address Regional Structure Proposals and Next Steps
- Decide on Planning Council and Next Steps
- Input: Operational Guidelines/Draft Report
- Status Report: SUDs
- Wrap Up

Principles of Meeting Conduct

- Participate
- Listen - Seek to Understand
- Be solutions oriented
- Be open to new ideas
- One person speaks at a time
- Use electronics responsibly

Regional Structure: Discussion Process

1. Understand proposal
2. Understand what core services can be contracted out
 - Short term
 - Long term
 - By entity
3. Summarize Subcommittee Discussion
4. Open Discussion
5. Articulate Next Steps

Discussion: Regional Structure

- Would a county decide who they appointment? (Region 7)
 - Concerned about conflict in County designation/ county responsibility for funding
 - 2 County Representatives
- Money is a Policy Decision

SGS Subcommittee Status

- As regions demonstrate readiness, contract as appropriate
- Expectation - Coordination
- One place to go – All things facilitated aligned
- Guarantors have minimum requirements

- Like MSC
- But no additional funds
- Minimize administrative costs
- Be clear about target population(s)
- Stick to operational guidelines
- Regions create entities
- Decide to use it
- Court contracts w/ entities for SUD treatment for drug court offenders
- Substance abuse treatment
- FOCUS: Braided Funding
- How does this line up with managed care services?
- Evaluate to move forward with our system in a world where Medicaid is managed care

Proposal

- Cooperative recommend legislation empower the creation of an entity that
 - Meets the regions needs
 - Demonstrates readiness
 - Individual entities can decide how to use them
- There will be enabling legislation
- Model we create within the state
- Not for profit
- Best Practice/our requirements/side boards/prerequisites
- Flexibility with regard to how it is done
- Side Boards

Proposal: Round Robin

- Teresa – proving readiness eliminates failure, indicate commitment
- Dick – very comfortable, consistent with existing business practice can move forward
- Patti – Gratitude to 2 districts; in response to the proposals we are thinking differently; want to see proposal in writing, share with 2 and 7
- Angenie – Likes concept of readiness; need to define readiness, wants empowerment also to help them become ready; transformation –are we going there? Evolution over time, not opposed
- Shane – Support proposal; defer to Director; focus to embrace what advocates promote, meet our responsibility in statute; readiness important, respect evolution; learn about true collaborative approach as we move through.
- Tammy – Likes it
- Sharon – Supportive of it; provides local community to have the autonomy to go forward; agency – flexibility and choice
- Melanie – generally ok

Next Steps

- Document Proposal
 - Informal
- Discuss with Regions
 - Still at the table and engaged
- Develop response
- Develop recommendations/proposal

- Legislative Draft
- Proposed Duties
- Collaborative or Cooperative
- Can be added into report with the Governor

Regional Meetings

- Nov 8th H&W Idaho Falls on Shoup 1-4
- Nov 15th State Office Lewiston 9-12 - 3rd Floor

Operational Guidelines: Outcomes Reporting

- Feedback Outcomes Reporting
 - Recidivism – Coordinate with Criminal Justice Commission
 - What can we present in Dec to JFAC

Draft Status Report

- SUDS Funding Feedback
- Courts, IDJC, DOC Revisions – Send to Marsha
- Funds have been allocated to 4 entities for populations
- Allocation of services
- Yes, Funding Chart SUDS

Parking Lot

None

	Definition	Evidence Based Interventions	Best Practices	Eligibility/Target Population	Service Intensity	Duration	Accessibility	Statutory Citation (CMH)	Statutory Citation (AMH)	Statutory Citation (SUD)	Currently Funded DHW-DBH	Long Term	Pilot	Currently Funded DHW-Medicaid	Currently Funded DJC**	Long Term	Pilot	Currently Funded DOC****	Long Term	Pilot	Currently Funded Courts	Long Term	Pilot	Currently Funded Counties***	Long Term	Pilot	Currently Funded Education	Long Term	Pilot	
Behavioral Health Services																														
													See below			Already contracting with Counties; may be opportunity to contract community SUDs and MH funding with Board; need county JJ involvement		Could contract for some services		Already contracting with Counties; may be opportunity to contract with Board; requires legislation				Potential willingness to redirect from in-patient; may be some short-term opportunities with willing County(s); coordination with Courts and IDJC						
Treatment Services																														
Assessment/Evaluation								16-2402	39-3128	39-306	X			X	XX			X			X								X****	
Case Mgmt											X			X	XX			X			X									
Intensive Case Mgmt											X							X												
Wraparound											X				XX			X			X									
Assertive Community Treatment									39-3128		X			X(+/-)																
Medication Mgmt									39-3128		X	Voluntary Populations		X	XX															
Drug Screening											X				XX			X			X									
Psychotherapy (Outpatient)								16-2402	39-3128	39-304	X			X	XX			X			X									
Intensive Outpatient									39-3128	39-304	X			X	XX			X			X									
Day Treatment								16-2402			X							X												
Partial Hospitalization									39-3128					X				X												
CMH Out-of-Home Care								16-2407, 16-2402			X																			
Alcohol & Drug Residential Treatment										39-304	X				X			X			X									
Inpatient Psychiatric Hospitalization								16-2407, 16-2402	329		X			X				X						X						
Crisis Services																														
Crisis Assessment/Evaluation									39-3128		X			X				X						X						
Crisis Intervention								16-2402	39-3128		X			x																
Designated Exams & Dispositions								16-2412	66-329		X																			
Recovery Support Services																														
Peer/Family Support Services								16-2402		39-304	X				X			X			X									
Early Intervention Services														X				X												
Illness Self-Management and Recovery Services											X	Voluntary Populations	Voluntary Populations																	
Supported Employment																														
Supported Housing								39-3128	39-3128	39-3128	X							X			X			X						
Transportation											X			X				X			X			X						
Prevention Services																														
Substance Use Disorders Prevention											X	Voluntary Populations	Voluntary Populations		X															
Mental Health Prevention																														
Additional Services in Statute																														
Emergency Detox by Medical Hospital (39-304)											X			X							X			X						
Community Detox (39-304)											X																			
Community Consultation and Education (39-3128)											X																			
Precare/Postcare for State Hospitals (39-3128)											X																			
Training of MH Personnel (39-3128)											X																			
Research and Evaluation (39-3128)											X																			

** Funded by IDJC through appropriations or grants for services for juveniles not in IDJC custody, served at the community level. Does not include all IDJC behavioral health funding used in facilities.

***Under Treatment Services, the Counties do offer some of these, but only when they receive funding from the Department of Juvenile Corrections, the Department of Corrections, or through the Jail. These are not indicated here because they will be reported as funded by the other State agencies. The only exception is the Counties do fund Inpatient Psychiatric Hospitalization through the commitment process. Under Emergency Services, the Counties fund Crisis Assessment/Evaluation related to the commitment process and Counties fund Designated Exams and Dispositions. Under Recovery Support Services, some counties fund public transportation and contribute to community/affordable housing organizations. However, this funding is not specific to people with substance abuse or mental health problems and not done by all the counties. No Prevention Services are funded and under Additional Services the only one funded is Community Detox (39-304) and this is just in some counties.

**** Education - as relates to educational needs, so the funding is academically related, that creates an advance XXX in learning that requires specially designed instruction.

*****Department of Correction - still requires departmental QA