

# **Behavioral Health Transformation Work Group**



## **A Plan for the Transformation of Idaho's Behavioral Health System**

**October 28, 2010**

# Behavioral Health Transformation Work Group 2009-2010

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# Summary List of Recommendations

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## **Director of Transformation**

BHTWG recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislature that establishes the Behavioral Health Transformation Office (BHTO) and the position of Director of Transformation to direct that office in a manner consistent with the roles and responsibilities outlined in the Director of Transformation job description presented in the BHTWG Plan for the Transformation of Idaho's Behavioral Health System, October 28, 2010. The Director of Transformation is specifically intended to act as a daily and continuous champion for the transformation effort on a local, regional and state level.

Furthermore, BHTWG recommends that the BHTWG, Cooperative, and Interagency Committee on Substance Abuse Prevention and Treatment forward the names of prospective candidates who meet the requirements of the position for appointment by the Governor.

The BHTO and the Director of Transformation function are recommended for review in 2016, with a potential sunset or continuation of the Office and position depending on the outcome of that review.

## **Regional Behavioral Health Community Development Boards**

BHTWG recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislature, in anticipation that Regional Behavioral Health Community Development Boards be established and populated during 2011 and functional by December 2011. The establishment of Regional Behavioral Health Community Development Boards eliminates the need for the existing Regional Mental Health Advisory Boards and the Regional Advisory Councils.

## **State Behavioral Health Planning Council**

BHTWG recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislature in order to modify the role of the State Mental Health Planning Council to one that has a behavioral health focus and is called the State Behavioral Health Planning Council, fulfills the requirements of federal law, includes representation from each of the Regional Boards, and limits the group's membership to a representative but efficient number.

## **Statewide Behavioral Health Interagency Cooperative**

BHTWG recommends that the Governor's Office issue an Executive Order to activate the Statewide Behavioral Health Cooperative and its responsibilities in response to the delivery of this Plan.

This action ensures that the momentum generated by the BHTWG and the completion of specific activities as proposed in this Plan are accomplished. These activities include identifying prospective candidates as the Director of Transformation, reviewing and supporting draft legislation to implement the transformation structure, and serving as a point of contact and information for regional stakeholders until that time the Director of Transformation is secured. The Executive Order is recommended to require a review of the need for the Cooperative again in 2016, with a potential sunset or continuation of the Cooperative depending on the outcome of that review.

BHTWG also recommends that legislation be drafted and presented to the 2011 session of the Idaho State Legislature to legislatively enact the Cooperative as described by the Executive Order concurrently with the sunset of ICSA in June.

### **State Behavioral Health Authority**

BHTWG recommends that the Idaho Department of Health and Welfare continue to function as the State Behavioral Health Authority, and to coordinate and communicate the status of that effort and scope as described in the BHTWG Plan for the Transformation of Idaho's Behavioral Health System October 28, 2010 within the context of the Cooperative.

### **Regional Provider Networks**

BHTWG recommends that the structure proposed to be established via Executive Order in 2010 and Legislation in 2011 be so established, tasking that structure with the continued development of transformation and the associated standards, data, need, priorities and funding coordination that will further inform the development of a delivery system featuring Regional Provider Networks.

### **Array of Core Services**

BHTWG recommends that the regions and the state adopt the Array of Core Services proposed in the BHTWG's Plan for the Transformation of Idaho's Behavioral Health System October 28, 2010 as the "floor" of services they seek to make available in each region; that this array be maintained as the goal for regional planning and capacity building; and that it also be used as a measure by which to indicate progress toward a truly transformed behavioral health system over the long term.

# Introduction

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The Behavioral Health Transformation Work Group (BHTWG) was tasked in Executive Orders 2009-04 and 2010-01 to generate 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 and evaluation of the plan."

This initiative was undertaken in response to issues associated with the existing mental health and substance use disorder systems which feature inconsistent service standards, reliance on the use of high cost crisis and hospitalization services or incarceration given the lack of adequate community supports, and the recognition that 50 to 70 percent of people with mental health or substance use disorders have co-occurring symptoms. The existing systems, already costly, suffer even more because the two systems are operated separately, creating fragmentation of services and duplication of efforts. Additionally, the ability to meet mental health and substance use disorder needs, already challenging, is even more difficult in current economic times featuring shrinking state and personal resources.

Consumers and families already suffer from the lack of services and service providers, closing of Department of Health and Welfare (DHW) offices, and short Medicaid resources. Given the current economic downturn, they fear even greater loss. Stakeholders are frustrated by their inability to understand the collective need and manage the cost of that need, as well as by their inability to leverage their collective resources in the most meaningful way.

The BHTWG proposes a structure and process that moves the state toward an accessible, consistent and effective system in spite of the current economic situation and in a manner that generates a more robust system should the economy recover. What's more, BHTWG recognizes that Health Care Reform will likely produce a substantive increase of people with access to behavioral health services in 2016, and Idaho needs to generate the capacity and systems to support that possibility.

From May 2009 through October 2010 the BHTWG worked to generate this Plan that commits the State of Idaho to the process of developing an efficient and effective client-centered system. Rather than starting over, BHTWG specifically opted to use the results and recommendations of previous work in this area to inform their proposed action. BHTWG's Plan pursues the vision and goals that reflect the collective recommendations from that body of work. BHTWG's effort differs from previous efforts in that it proposes a specific transformation structure and action, rather than once again, studying the need for transformation itself.

BHTWG reviewed and used as a foundation for their effort recommendations generated by other studies and outreach efforts. Specifically, BHTWG efforts were informed by a Western Interstate Commission for Higher Education (WICHE) study commissioned by the Idaho State Legislature, which was conducted in 2009. This report provided the basis of the vision, goals and direction the BHTWG pursued. The WICHE process included a statewide public survey, to which WICHE received the input and response of more than 550 individuals from around the state. The input of approximately 160 individuals through in-person interviews also informed the study. WICHE's outreach process is described in their report on page 43. The WICHE report can be found in its entirety at [http://www.legislature.idaho.gov/sessioninfo/2008/interim/mentalhealth\\_WICHE.pdf](http://www.legislature.idaho.gov/sessioninfo/2008/interim/mentalhealth_WICHE.pdf). WICHE's findings and recommendations helped guide the BHTWG's work.

BHTWG reviewed and reflected on the work of other inputs and recommendations generated through previous processes. These include the 2006 Final Report of the Legislative Council Interim Committee on Mental Health and Substance Abuse; the December 15, 2006 Comprehensive Statewide Mental Health Transformation Action Plan 2007: The First Steps; annual reports of the State Mental Health Planning Council; and initiatives of the Interagency Committee on Substance Abuse Prevention and Treatment. Furthermore, BHTWG submitted an early version of their proposal to a technical panel of experts who have guided and experienced transformation, and whose advice substantively enhanced the focus and direction of BHTWGS draft. That report can be found at <http://www.marshabracke.com./BHTWG.docs.htm>.

The BHTWG also considered a proposal by Division of Financial Management Administrator Wayne Hammon, who responded to the Governor's request to conduct an objective assessment about how to best manage the 2011 sunset of the Interagency Committee on Substance Abuse Prevention and Treatment and the role of the Office of Drug Policy. Hammon conducted that study and generated a recommendation to the Governor, which proposes that the Director of Transformation direct the work of a Behavioral Health Transformation Office.<sup>1</sup> The BHTWG recommendations are consistent with many elements of Hammon's proposal.

A special session was convened to gather the observations and insights of the judiciary. The judiciary articulated the unique characteristics of juvenile and criminal justice populations with behavioral health needs, requiring the specialized competence of providers and communication, transition and planning across behavioral health, criminal justice and juvenile justice systems.

BHTWG communicated with state legislators and Regional Mental Health Board and Resource Advisory Council chairs and members. BHTWG meetings included the participation by a range of stakeholders who provided input inside and outside the meeting setting. BHTWG conducted a statewide stakeholder, public and consumer-specific outreach process. This process featured the presentation of the BHTWG recommended structure directly to approximately 400 people, whose concerns, suggestions and sentiments were collected and reviewed. The Stakeholder, Family and Consumer report contains all of this input. The results of the BHTWG outreach process have been summarized in the BHTWG Outreach Thematic Summary, and responses to those comments are documented in there as well. These materials can all be found at <http://www.marshabracke.com/BHTWG.docs.htm>.

All of that input influenced the development of this Plan. The BHTWG will deliver that material to the Director of Transformation and the State Behavioral Health Interagency Cooperative, as they will want to continue to examine and utilize the information provided in this process to incorporate in transformation implementation.

Assumptions on which this plan is based include the BHTWG's intent to:

- Integrate mental health and substance use disorder systems;
- Provide for a core array of services that span prevention through recovery in each region, with a phased-in approach to develop them based on community need, regional resources and readiness and contingent upon the structure of health care reform as adopted by the State of Idaho;

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<sup>1</sup> Next Steps in Behavioral Health / Drug Policy: Draft Discussion Paper. Wayne Hammon, Administrator, Division of Financial Management. August 11, 2010.

- Generate outcome-based results that are best for consumers and families;
- Leverage the state's purchasing power, ensuring that consumers and families receive the best service at a cost that reflects the best use of taxpayer dollars;
- Assure that cost sharing is a reality as the system becomes fully integrated and regionalized, and that cost shifting does not occur;
- Establish consistent statewide standards for the quality of services;
- Provide for effective data gathering, sharing and reporting processes amongst providers and agencies to ensure sound decision-making;
- Present an implementation strategy for moving toward the transformed system; and
- Ensure collaboration and cooperation across existing mental health and substance use disorder systems.

The BHTWG is pleased to present this Plan for the Transformation of Idaho's Behavioral Health System (Plan). The Plan guides the development of a "coordinated, efficient state behavioral health infrastructure with clear responsibilities, leadership authority and action." The Plan recommends a structure that streamlines and integrates existing mental health and substance abuse disorder entities and efforts into a single *behavioral health system*. The structure features regional empowerment, and it provides the platform to improve access, enhance quality, develop consistent service delivery standards, generate outcome-based services and data-driven decision-making – all of which will increase efficiencies and accountabilities.

## Vision and Goals

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Using the body of input and material generated in years prior to and during the work of the BHTWG, the following are the Vision and Goals the BHTWG seeks to achieve for the behavioral health system.

### *Vision*

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

### *Goals*

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

# Organizational Structure

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The BHTWG proposes an organizational structure which is specifically intended to integrate mental health and substance use disorder systems and services, improve access, enhance quality, create efficiencies, clarify roles and responsibilities, support the development of increasingly viable regional delivery systems, and provide for continuous consumer and family involvement, all with a goal to create a consumer-focused recovery-oriented behavioral health system.

A description of each element of the structure follows. A table that indicates the differences between the existing and the transformed structure is included in Attachment A.

## *Director of Transformation*

Lessons learned from other states clearly show that having one individual and office with the single responsibility to champion transformation on a daily basis by coordinating, facilitating and supporting the generation of the transformed system is essential to making transformation a reality. BHTWG agrees. With the variety of agency interests and requirements associated with behavioral health needs, and the unique and important interests and functions of the regions and their Regional Boards, the BHTWG recognizes the important role of one individual with the authority and capacity to make transformation a reality.

The Director of Transformation as proposed by the BHTWG will be the one official in the state designated to oversee and execute the coordination of the transformation of Idaho's existing mental health and substance use disorder systems into a single, effective, recovery-oriented behavioral health system. The Director of Transformation will:

- Lead the implementation of the BHTWG Transformation Plan (2010) and Behavioral Health Interagency Cooperative Transformation Implementation Plan (to be developed in 2011);
- Chair the Behavioral Health Transformation Cooperative, coordinating their respective, equitable participation in the transformation process;
- Serve as the liaison to the Regional Boards, helping to facilitate the development of a viable regional and/or local community Transformation Implementation Plans and delivery system while honoring entity and agency roles, responsibilities and accountabilities;
- Ensure that the inputs and priorities of the Regional Boards and the Cooperative are effectively used to guide the development of regional provider networks which deliver services based on regional priorities and consistent statewide standards;
- Coordinate the development of a statewide or series of contracts in a manner that reflects regional priorities, meets agency accountability and reporting requirements, reflects consistent statewide standards, and maximizes the use of the taxpayer dollar;
- Refine and focus the transformation effort over time as implementation lessons are learned, research and best practices are identified, considered and applied as appropriate, and data and performance measures inform strategic direction;
- Represent the Behavioral Health Cooperative in statewide efforts to coordinate health care reform implementation.

The individual who secures the position of Director of Transformation requires the following minimum qualifications, to include:

- Considerable knowledge of policy and procedures for all three branches of government;
- Demonstrated understanding and/or experience with government systems, judicial processes and systems change;
- Demonstrated understanding and/or experience with public health delivery system and consumer and family needs;
- Considerable knowledge of quality, outcome-based, cost effective treatment for a behavioral health system of care, including mental illness and substance use disorders;
- Demonstrated leadership skills;
- Competency in management; and
- Demonstrated ability to:
  - Hire and supervise staff,
  - Interpret and apply laws, rules and regulations,
  - Develop and implement new policy and procedures,
  - Facilitate, coordinate and communicate effectively with diverse groups of stakeholders and the public,
  - Support contractual and fiscal responsibilities,
  - Manage complex projects, and
  - Solve problems.

Subject to available funding, the Director shall have the authority to hire staff to assist in the performance of the Director's responsibility. Each member of the Statewide Behavioral Health Interagency Cooperative will support transformation by using existing staff to work in coordination with the transformation effort.

BHTWG has produced a job description for the Director of Transformation that reflects these responsibilities and qualifications. This document is included as Attachment B.

***BHTWG Recommendation:***

*BHTWG recommends that legislation be drafted for and presented to the 2011 of the Idaho State Legislature that establishes the Behavioral Health Transformation Office (BHTO) and the position of Director of Transformation to direct that office in a manner consistent with the roles and responsibilities outlined in the Director of Transformation job description (included as Attachment B). The Director of Transformation is specifically intended to act as a daily and continuous champion for the transformation effort on a local, regional and state level.*

*Furthermore, BHTWG recommends that the BHTWG, Cooperative, and Interagency Committee on Substance Abuse Prevention and Treatment forward the names of prospective candidates who meet the requirements of the position for appointment by the Governor.*

*The BHTO and the Director of Transformation function are recommended for review in 2016, with a potential sunset or continuation of the Office and position depending on the outcome of that review.*

## *Regional Behavioral Health Community Development Boards*

Creating a viable regional behavioral health delivery system is a specific transformation goal. It is imperative that the delivery system be locally accessible and effectively meet consumer and family needs. Coordination of that delivery system and building the capacity to support it is a critically important function. BHTWG recommends a regionally based system that is responsive to regional needs and is driven by regional leadership.

BHTWG proposes integrating the existing Regional Mental Health Boards and Regional Advisory Councils function. Regional Behavioral Health Community Development Boards (Regional Boards) would be formed to enable regions to focus on behavioral health needs, capacity and services in the region. The Regional Boards will:

- Feature a small and efficiently organized management team which capitalizes on robust subcommittee efforts to inform their work, specifically including a consumer and family subcommittee and a provider subcommittee;
- Develop a regionally focused Transformation Implementation Plan that specifically describes the region's goals, objectives, strategies and progress toward making available the array of core services (that span prevention through recovery) to be approved by the Cooperative;
- Be knowledgeable about the amount and intended use of the collective resources available to the region, knowing that the process would start using a braided funding approach;
- Address regional issues associated with workforce capacity and development;
- Have the ability to pursue funding and do contracting;
- Deliver an annual update of the Transformation Implementation Plan and report on its progress to the Director of Transformation and the Cooperative;
- Have a representative serve on the State Behavioral Health Planning Council;
- Identify regional priorities and inform Regional Provider Network contract development and evaluation processes in coordination with the Director of Transformation; and
- Demonstrate readiness for contracting for behavioral health services according to criteria established by the Cooperative.

Membership proposed for the Regional Boards include representatives from:

- Counties,
- Law Enforcement,
- Courts,
- Schools,
- Two professionals from the Provider Network/Provider Subcommittee which may be a psychiatrist or physician and a behavioral health care professional, ensuring both mental health and substance use disorder services are represented,
- Public Health Districts,
- Consumer and Family Subcommittee, and
- Regionally based agency representation from IDOC, IDJC and DHW.

While most participants on the Regional Boards are anticipated to be volunteers who serve because behavioral health is related to their work, a responsibility they have to their clients, or an important aspect of their lives, the BHTWG recognizes that, with this focused responsibility, support staff for the

Regional Boards is critically important. The issue of resources is one that the BHTWG acknowledges and discusses later in this report.

***BHTWG Recommendation:***

*BHTWG recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislature, in anticipation that Regional Behavioral Health Community Development Boards be established and populated during 2011 and functional by December 2011. The establishment of Regional Behavioral Health Community Development Boards eliminates the need for the existing Regional Mental Health Advisory Boards and the Regional Advisory Councils.*

### *State Behavioral Health Planning Council*

The purpose of the existing State Mental Health Planning Council is to review the State Mental Health Systems Plan, serve as an advocate for adults and children, and to evaluate on an annual basis the allocation and adequacy of mental health services within the state (Idaho Code 29-3125). The Council's work is key to securing the Community Block Grant which helps fund these services, as described in U.S. Code (Title 42, Chapter 6A, Subchapter XVII, Part B-Block Grants Regarding Mental Health and Substance abuse, subpart i).

The BHTWG proposes that the Planning Council's membership be consistent with that required by federal law as follows:

(c) Membership

(1) In general

A condition under subsection (a) of this section for a Council is that the Council be composed of residents of the State, including representatives of—

(A) The principal State agencies with respect to—

- (i) Mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
- (ii) The development of the plan submitted pursuant to title XIX of the Social Security Act [42 U.S.C. 1396 et seq.];

(B) Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) Adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) The families of such adults or families of children with emotional disturbance.

(2) Certain requirements

A condition under subsection (a) of this section for a Council is that—

(A) With respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) Not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Within that configuration, BHTWG recommends that membership on the Council:

- Include comparable representation from individuals bringing substance use disorder and suicide prevention expertise and experience to the Council in order to facilitate the integration of the mental health and substance use disorder systems;
- Include one representative from each of the seven Regional Boards to secure representation by the Boards at a state level and facilitate the development of a seamless behavioral health system statewide;
- Include the ex officio participation of members from both the House and Senate Health and Welfare Committees and a member of the Judiciary branches of government;
- Include one specific seat for a representative from an advocacy organization; and
- To ensure efficiency and effectiveness, work to limit the total number of members on the Council and generate subcommittee or ex officio involvement as needed to secure the representative participation needs of the Council at any given point in time.

### ***BHTWG Recommendation***

*BHTWG recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislature in order to modify the role of the State Mental Health Planning Council to one that has a behavioral health focus and is called the State Behavioral Health Planning Council, fulfills the requirements of federal law, includes representation from each of the Regional Boards, and limits the group's membership to a representative but efficient number.*

### ***Statewide Behavioral Health Interagency Cooperative***

A number of agencies are legislatively funded to provide or authorized to order behavioral health services for consumers and families. Clearly the Department of Health and Welfare has the greatest portion of that budget and responsibility, including Medicaid. Other agencies and counties also have funding and important responsibilities for providing services. For example, counties support indigent clients; the Idaho Department of Juvenile Corrections, in partnership with counties, has funding to appropriately serve juveniles with mental health needs in the community; schools work to find services for students with behavioral health needs; and the Idaho Department of Correction works to transition offenders from IDOC facilities back to the community. The Courts order assessments and services provided by the Department of Health and Welfare.

In order to generate an effective system that is truly client-focused and maximizes the use taxpayer dollars, these agencies must partner to ensure that monies are being best spent, and that clients needs are most effectively met, *across* systems. Working together, these purchasers and users of services can enhance the system in a manner that generates more effective results. Braided funding (see Attachment C for a description of braided funding and its advantages), shared data and information, coordinated contracting, consistent standards – all are opportunities for the agencies to better serve the client and get the best use of limited resources.

To that end, the Statewide Behavioral Health Interagency Cooperative is to be a small, action-oriented group comprised of government entities that are purchasers and users of services. A representative from the State Behavioral Health Planning Council would sit on the Council to advocate for consumers and families in this forum.

Each Member of the Cooperative would assume shared responsibility to achieve transformation. The Cooperative will:

- Work in coordination with local and state government, the judiciary, and specifically with the Office of the Governor and members of the Senate and House Committees on Health and Welfare;
- Provide input to draft legislation regarding transformation of the behavioral health system as it is under development and worked through the legislative process;
- Review and confirm recommendations, statewide standards, guidelines, contract templates, core services, and other elements of the behavioral health system as they are developed by respective entities;
- Ensure the implementation of the transformation effort as described in the BHTWG Plan for Transformation of Idaho's Behavioral Health System (October 2010), by providing for efficient and effective interagency coordination of systems, operations, services, and funding;
- Produce and present a status report of their interagency efforts and accomplishments to the Office of the Governor, the Chief Justice of the Idaho Supreme Court, counties, and members of the Senate and House Committees on Health and Welfare on an annual basis; and
- Develop, annually update and commit to implementing a Transformation Implementation Plan that is equally applicable to all entities involved with the Cooperative. The Transformation Implementation Plan will address:
  - Overall policies, strategies, steps, and timelines related to transformation implementation
  - Strategies for coordination, cooperation, collaboration, forging partnerships and understandings between behavioral health, education and justice systems;
  - Agreement on the agency staff responsible for specific duties related to the transformation and operation of the behavioral health system as well as a system to ensure accountability to the plan;
  - Statewide behavioral health needs and gaps;
  - A braided funding strategy which coordinates budgets, establishes priorities and addresses issues of funding availability;
  - Data and information sharing, reports and functionality;
  - Coordinated approaches for the delivery of behavioral health services and the elimination of duplicative services among relevant agencies;
  - Readiness criteria for regional contracting;
  - Workforce development and training for public and private providers, including multidisciplinary approaches;
  - Best practices;
  - Ongoing communication strategies;
  - System performance and evaluation and outcome-based performance measures; and
  - The role of behavioral health in Health Care Reform.

The Cooperative will:

- Identify and forward prospective candidates for the position of Director of Transformation;
- Collect and share data needs and requirements and propose how data can be effectively coordinated/cross-walked across agencies;
- Quantify total state funding across entities so that regions and the state can plan for the most effective use of taxpayer dollars;

- Share funding information on a regional scale with regional boards so that they can provide informed input about their needs and priorities;
- Participate in a braided funding scenario where funding streams from various sources are coordinated to support a broad continuum of behavioral health services;
- Articulate their respective needs and requirements for use in Regional Provider Network contracting and evaluation processes;
- Confirm a shared understanding of service standards developed by DHW, which operates as the State Behavioral Health Authority and who will monitor for performance based on consistent service standards statewide; and
- Purchase services through the Regional Provider Networks through contractual arrangement(s) which articulate shared service standards, collects and shares system-wide data, meets reporting requirements of state and federal funding entities, provides for the best use of the taxpayer dollar, and secures the best outcomes for the family and consumer.

Members of the Cooperative shall be appointed by and serve at the pleasure of the Governor, and are proposed to include the:

- Director, Department of Health and Welfare;
- Director, Department of Correction;
- Director, Department of Juvenile Corrections;
- Superintendent of Public Instruction;
- Administrative Director of Idaho Courts;
- One representative from among the Counties;
- One representative from the State Planning Council.

The Cooperative will meet monthly or more frequently as necessary to achieve its goals. The Director of Transformation, with responsibilities as described in this Plan, will chair the Cooperative. A draft Executive Order to establish the Cooperative is included as Attachment D.

***BHTWG Recommendation:***

*BHTWG recommends that the Governor's Office issue an Executive Order to activate the Statewide Behavioral Health Cooperative and its responsibilities in response to the delivery of this Plan.*

*This action ensures that the momentum generated by the BHTWG and the completion of specific activities as proposed in this Plan are accomplished. These activities include identifying prospective candidates as the Director of Transformation, reviewing and supporting draft legislation to implement the transformation structure, and serving as a point of contact and information for regional stakeholders until that time the Director of Transformation is secured. The Executive Order is recommended to require a review of the need for the Cooperative again in 2016, with a potential sunset or continuation of the Cooperative depending on the outcome of that review.*

*BHTWG also recommends that legislation be drafted for and presented to the 2011 session of the Idaho State Legislation to legislatively enact the Cooperative as described by the Executive Order concurrently with the sunset of ICOSA in June.*

## *State Behavioral Health Authority*

Increasing quality and accountability are two transformation goals specifically addressed through the establishment of a State Behavioral Health Authority (Authority). As the designated Authority, the Idaho Department of Health and Welfare will:

- Develop and confirm statewide service and delivery standards;
- Integrate standards into Regional Provider Network contract(s) requirements;
- Monitor the performance measures/outcomes outlined in the contracted arrangement;
- Generate and implement a provider certification process (including appropriate workforce credentials and requirements);
- Explore and if possible secure a Medicaid Waiver;
- Continue to enhance the data reporting process to support transformation objectives;
- Step in and provide regional leadership on behalf of the Regional Boards should a Board find itself unable to function (but not in place of providers of services); and
- Facilitate the data reporting process to enable informed regional planning and input processes which can be used to generate continuous improvement to the system.

The State Behavioral Health Authority will measure the effectiveness of the behavioral health service delivery system in coordination with members of the Cooperative by examining quality of life measures, criminogenic need assessments, as well as other standardized out-come based instruments as determined by the Authority and confirmed by the Cooperative.

Ultimately, the Authority function provides for accountability and quality assurance respective to the delivery of services according to the standards and performance measures generated and applied to those services.

### ***BHTWG Recommendation:***

*BHTWG recommends that the Idaho Department of Health and Welfare continue to function as the State Behavioral Health Authority, and to coordinate and communicate the status of that effort and scope as described in this Plan within the context of the Cooperative.*

## *Regional Provider Networks*

Providers are essential to delivering services to consumers and families. The existing system relies on providers from throughout the state; the transformed system will do the same. The transformed system will create an opportunity for a level of service delivery that doesn't currently exist. The establishment of statewide standards of care provides the professional providers who maintain a certain level of quality and higher to be featured within the system. All purchasers and users of this system will know that each service achieves a specific standard which is consistently provided by any provider throughout the state. Under a contractual arrangement, many providers can be available to serve the range of clients to whom the state provides benefits. Within this structure, providers will have the initiative and incentive to maximize the use of community based services, deliberately move clients toward recovery, and document the practices and the measurements that got them there. Providers have a critically important role in ensuring that a client-focused delivery system exists, regardless of which agency is paying the bill, or in which region of the state the client lives.

The BHTWG acknowledges that currently there are shortages of mental health and substance use disorder providers statewide. In a transformed, integrated behavioral health system, additional providers will be needed. These providers may need additional education and certifications in order to provide services that meet contractual requirements. As these standards are developed and implemented, higher education institutions must be responsive to these workforce demands.

The structure proposed by the BHTWG is designed to support the development and implementation of Regional Provider Networks. These Networks are anticipated to be comprised of a grouping or groupings of private providers within a region that gather contractually with a commitment to serve the client-focused needs of the region and meet statewide standards for service delivery. Given the braided funding scenario by which the payers will be operating, the Regional Networks will bill and the payers will pay using consistent contract vehicle(s).

It is anticipated that the Regional Networks will:

- Supply a significant number of the services identified in the array of the core services proposed for the system;
- Provide recovery-focused, evidence-based based services with contractually required outcome reporting;
- Be a community partner, working to foster a strong and responsive community based resource;
- Have a medical professional representative participate on the Regional Board;
- Be incentivized to provide quality community-based care; and
- Meet the requirements of the contract under which the Regional Provider Networks are authorized and formed.

Given that 1) statewide standards are just in initial stages of development, 2) the standards and regional and payer priorities are to be reflected in the eventual contract, and 3) the complexity of any given contracting process, realizing a regionally organized and based service delivery system will take time. Doing so will require the involvement and input of the Regional Boards and Cooperative in coordination with the Director of Transformation as well as the provider community.

***BHTWG Recommendation:***

*BHTWG recommends that the structure proposed to be established via Executive Order in 2010 and Legislation in 2011 be so established, tasking that structure with the continued development of transformation and the associated standards, data, need, priorities and funding coordination that will further inform the development of a delivery system featuring Regional Provider Networks.*

## Array of Core Services

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To ensure a meaningful and efficient system of care in the State of Idaho, an array of behavioral health services that span prevention to recovery must be available on as local a level as possible.

In this plan, *core services* are defined as an array of services including those that are community based, emergent, medically necessary, and required by law. They provide a “floor” of services intended to be developed and available in each region that span prevention, intervention, treatment and recovery.

With transformation, the goal is to redirect supports from the more expensive emergent and medically necessary services to more effective and less costly prevention, intervention and recovery services.

In this context, core services will be provided in accordance with statewide standards which will include, at minimum, monitoring for quality, consistency and effectiveness. These services will be delivered from a client-centered perspective. Effectiveness of service delivery will be determined by examining quality of life measures as well as other standardized outcome-based instruments. The core services will be provided for in a way that:

- Is outcome oriented;
- Features accessibility on as local a level possible;
- Is integrated and coordinated across responsible agencies and entities;
- Distinguishes between, accommodates the differences, and meaningfully supports the child, the adult, and the transition between them;
- Recognizes the importance of family involvement and utilization of natural support systems; and
- Fosters the involvement of qualified and experienced psychiatric care providers or psychiatrists.

The array of core services are described generically; specific programs or methods for delivering the service are not defined. The intent is to identify the fundamental focus of the service and to provide flexibility in delivery mechanisms.

Clearly the development of an array of core services in each region will take time. Providing a range of services that exceed the array of core services proposed here is a welcome initiative. During transformation, there are a number of considerations to be taken into account. Specifically:

- Each region features a different mix of professional expertise and community volunteerism - the array of services might be achieved through different venues or have a different configuration from one region to another;
- Core services are intended to be available in all regions, but the prevalence of any core service may vary among regions as appropriate to reflect the needs of a region's targeted populations;
- Regions will develop local access standards using their own demographics, geography and availability of services within pocketed areas of their region;
- Some regions might look to their neighboring regions to help make a service available that is not available in their own;
- The goal is for regions to be able to deliver this array of services without depending upon the state to provide the same services;
- Regions have the authority and flexibility to build their service delivery systems in good faith, making reasonable attempts to make all core services available;
- It is intended that regions be poised to succeed in ultimately delivering the complete array of core services;
- This array of core services is intended to provide a consistent "floor" of services for individuals throughout Idaho -- regions may opt to provide an array of services that exceed those proposed here, and that such an initiative is desirable;
- The development of the regional system will occur in a transitional manner, potentially learning from the experience of a pilot region and/or by a phased-in approach to making the array of services available; and
- Some services currently provided by the state may be phased into regional responsibility.

Recognizing that 1) there may be an inclination to provide emergent and medically necessary services as a priority over other services, and 2) the delivery of preventative and community-based services can in some cases be provided at relatively low cost and more effectively enhance an individual's quality of life, *it is the specific intent of transformation to emphasize prevention, intervention and recovery services in regional systems.*

Core services are to be targeted to citizens of the state of Idaho on a sliding fee scale basis (to be determined) and will include adults and children with mental health and substance use disorders.

Definitions of each of the core services identified in the table below are included as Attachment E. The array of core services may evolve over time. This list will be managed by the Cooperative; Transformation Implementation Plans produced on the state and regional level will be designed with the goal to develop the services.

**BHTWG Recommendation:**

*BHTWG recommends that the regions and the state adopt this array of core services as the "floor" of services they seek to make available in each region, that this array be maintained as the goal for regional planning and capacity building, and that it also be used as a measure by which to indicate progress toward a truly transformed behavioral health system over the long term.*

No.	Core Service	Emergent	Medically Necessary	Structurally Necessary	Community-Based (non-institutional)	Medicaid covered	Substance use	Mental Health	Adult	Child
1.	Assertive Community Treatment (ACT), Intensive Case Management Services and Wraparound	X	X		X	+/-	X	X	X	X
2.	Assessments and Evaluations	X	X	X	X	+/-	X	X	X	X
3.	Case Management Services		X		X	X	X	X	X	X
4.	Designated Examinations and Dispositions	X	X	X	X			X	X	X
5.	Intensive Outpatient Treatment				X	+/-	X	X	X	X
6.	Illness Self-Management and Recovery Services				X		X	X	X	
7.	Inpatient Psychiatric Hospitalization	X	X			X	X	X	X	X
8.	Medication Management		X	X	X	X	X	X	X	X
9.	Drug Screening	X	X		X	X	X	X	X	X
10.	Peer Support Services				X		X	X	X	X
11.	Prevention Services				X		X	X	X	X
12.	Early Intervention Services for Children and Adolescents				X		X	X		X
13.	Psychiatric Emergency and Crisis Intervention services (24/7 with open door access)	X	X	X	X	+/-	X	X	X	X
14.	Psychotherapy (including trauma-informed care and cognitive behavioral therapy)		X		X	X	X	X	X	X
15.	Alcohol and Drug Residential Treatment	X	X				X		X	X
16.	Supported employment				X		X	X	X	X
17.	Supported housing				X		X	X	X	
18.	Transformation		X		X	X	X	X	X	X
19.	24-Hour Out-Of-Home Treatment Interventions For Children And Adolescents	X		X			X	X		X
20.	Day Treatment, Partial Care and Partial Hospitalization			X	X	X	X	X	X	X

**Table 1: Core Services**

## Funding and Resources

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The reality is that funding and resources are limited. The economic situation has forced the closure of several Department of Health and Welfare offices. Medicaid dollars are likely to become tighter in this economic climate and as other agencies and counties face budget cuts and challenges meeting the demand for mental health and substance use disorder treatment. With the shrinking pool of dollars, Idaho has already, unfortunately, seen an increased use of high cost crisis services and cost-shifting – a situation unlikely to change as this economic downturn lingers. The BHTWG’s intent is to assure that cost sharing is a reality and as the system becomes fully integrated and regionalized, that cost shifting does not occur.

Without change, the existing situation will get even worse.

The BHTWG has been asked how it can propose to transform a system that the state already cannot afford. Regional stakeholders, regardless of how eager they may or may not be to assume a leadership role for their regional delivery system, wonder how they can resource the effort it will take to identify needs, generate a regionally focused transformation implementation plan, build work force capacity, and secure community supports. Agencies participating on the BHTWG ask themselves the same question – with the existing budget realities how do they generate new responsibilities, help support the efforts of the Behavioral Health Transformation Office, or divert resources without cutting already pared services? The situation is further complicated by the lack of providers in rural areas and a disinclination of many providers to support Medicare and Medicaid clients.

The reality is that the impetus for transforming the behavioral health system has been underway for years. Many groups have proposed a transformed system. The fact that BHTWG has been asked to develop a plan to achieve it at a time when DHW has had to close some of its offices is coincidental, unfortunate, and unrelated. However, DHW and other entities that fund behavioral health services are working to ensure whatever adjustments they make because of the economy line up as much as possible with a structure consistent with a transformed environment. By using the lack of resources as a reason to make no change, the existing situation will get predictably worse; higher cost crisis services will become the stop gap for escalating issues avoided by the availability of early intervention and prevention services.

Stakeholders, consumers and families have made suggestions for how to resource transformation. Some of these include reassigning existing state staff, generating a tax on beer and wine, and legislating additional funding. Whether any of these are possible remains a question.

BHTWG has spent time collecting and discussing the dollars spent on mental health and substance use disorders services and systems across the state. This effort has generated an understanding of what is collectively spent; but what is spent on behavioral health does not answer important questions: What is the actual need? And what is the cost of that need?

To answer these questions, and to use what funding the state does have most effectively, there is much more work to do. It will be incumbent upon the Behavioral Health Interagency Cooperative to continue to explore how to best leverage the taxpayer dollar to get the most appropriate services to consumers and families at the most appropriate time, location and cost. BHTWG is committed, even in these

economic times, to work to create the most effective client-focused system it can now, and position itself for an increasingly accessible and effective system in the future.

Idaho's experience indicates how cooperating to meet needs can generate more effective services and cost savings. For example:

#### Detention Clinician Project

The Detention Clinician Project authorized by the Idaho Legislature in 2008 continues as a partnership among DHW, counties and the Idaho Department of Juvenile Corrections (IDJC), using state funds to place a clinician in each of the twelve juvenile detention centers around the state. Some of the findings from a research study completed by Dr. Ted McDonald of Boise State University reveal the following:

- Three out of four juveniles (75%) entering detention facilities have a mental health issue and/or substance use disorder;
- Over half of the juveniles who are recommended for community-based mental health and/or substance use disorder services after an evaluation by a detention clinician accessed those services within 15-30 days post release;
- Eighty-five percent (85%) of probation officers and judges reported that information from the clinician had an impact on case disposition and service planning;
- One hundred percent (100%) of judges and probation officers indicated a strong desire to see the clinician program continue; and
- Nearly seventy-five percent (75%) of parents reported that their child had received at least one of the services recommended by the clinician.

Data collected by IDJC during juvenile detention facility inspections reveals a drop in critical incidents as well as admissions. During a presentation of this report on February 2, 2010, Juvenile Detention Administrators credited the drop in incidents and admissions to the presence of clinicians in the facilities. They also reported increased morale, confidence, and competence of facility staff due to the training and support provided by clinicians.

#### Contracting Initiatives

IDJC funds a program to support the community based treatment of juveniles at risk of commitment and for those leaving a period of commitment. One of the evidence-based services offered within this program is Functional Family Therapy (FFT). Rates of reimbursement for FFT services varied depending upon the overall level of service indicated in the service plan and were in many cases different. IDJC was able to achieve the same cost of FFT services to the common rate paid by IDHW.

#### Reductions in Community Hospitalization Costs

Home Recovery Team (HRT) is an innovative public-private partnership that was formed in DHW Region 4 in February 2009. This team focused on the provision of community supports as an alternative to hospitalization for those in crisis, with services provided by a combined HRT staff mix of two professionals and two Certified Peer Specialists. At a cost of approximately \$200,000 per year, the Home Recovery Team (HRT) provided short-term (i.e., 7-14 days) intervention, daily in-home support and treatment for at risk individuals. The savings from diverted hospitalizations in the first year of HRT operation was

approximately \$600,000. Despite the success of the HRT pilot, this project was discontinued in May 2010 because of budget cuts.

In addition to the reduction in hospitalization realized through the HRT, the Division of Behavioral Health also implemented a new process for admissions and discharges to the state hospitals. The new process established a protocol to identify the coordination of regional and hospital responsibilities for the admission and discharge processes. Through the creation of the new policy, the Department saved an estimated 1.2 million dollars in Community Hospitalization funds over the previous fiscal year.

To start, the structure proposed by the BHTWG offers some opportunity for transformation in a cost-neutral manner. As proposed, the Behavioral Health Transformation Office and the Director of Transformation can be funded by a redirection of funds currently supporting the Office of Drug Policy. Funds are not available for additional staffing of that office, but efforts to identify and secure grant funding to support transformation are underway, and coordination of existing resources within state agencies through the Cooperative might be found to support transformation activities.

Currently two sets of regional bodies work to address mental health and substance use disorders in each of the regions. The structure proposed by the BHTWG streamlines that effort by integrating the two and forming one, smaller, action-oriented body to work on behalf of the regions utilizing an intentional subcommittee effort to inform their activities. Regional Board members are anticipated to be volunteers whose participation is directly relevant to their work. Still, the BHTWG recognizes that support staff to help the Regional Boards is a necessity with its new responsibilities and accountabilities, and that specific funding to provide that support is not available. In coordination with the Director of Transformation, regions may be able to secure grant funding to help support such a position. Participants in the system can continue to study how to resource this function.

Early intervention and prevention efforts and community supports are less expensive and more positive services than crisis, hospitalization and incarceration. As regional capacity grows, the ability to emphasize these services over the more expensive options will begin to generate a savings in the cost of supporting individual needs and reduce cost-shifting. With the eventual implementation of outcomes-based measurements and monitoring, adjustments can be made to the services and the system to maximize the results for the client and the taxpayer.

The braided funding scenario also provides an opportunity for funding agencies to leverage their resources. With a contractual arrangement that enables all payers of services to purchase services that are consistently delivered at a known cost, the payers achieve purchasing power at a level that doesn't currently exist.

Key to any cost-savings to be achieved by the transformed system, however, now or in the future, is the commitment that all monies saved will be *reinvested* in the system rather than redirected for other uses. Only through that reinvestment can the gains achieved by the more effective system become increasingly helpful to serving consumers and families, and can the system sustain its decreasing reliance on high cost services.

BHTWG recognizes that Medicaid is a primary funder of this system. With Health Care Reform Idaho is likely to see a greater number of individuals on Medicaid. By taking deliberate action now, Idaho can position itself to support an increased number of clients and benefits throughout the state.

Health Care Reform will also perpetuate the movement to integrate mental health and substance use disorders with physical health. Today's movement to a behavioral health system in Idaho is a first important step toward what is anticipated to be a truly integrated health system in years to come. It is important for Idaho to plan for this eventuality, and to look strategically toward an integration that continues a client-centered and effective system.

Clearly, with adequate resources the structural components described here could mobilize the envisioned system much more quickly than they will be able to without those resources. The issue of resources is one with which the state and the regions will continue to grapple. Still, BHTWG recommends that the state position itself to support consumer and family service needs in the most efficient and effective manner. The structure proposed here puts that action in motion and empowers the regions to begin to generate their strategy and capacity for when increased funding is a reality.

The financial support for behavioral health services in the braided funding environment shall be provided by state appropriations for mental health and substance use disorder funding for the entities on the Cooperative, county mental health funding, client co-payments and insurance, federal funding, and by whatever grant funding is secured by the regions or the state.

## Attachment A: Structure Table

BHTWG's Plan guides the development of a "coordinated, efficient state behavioral health infrastructure with clear responsibilities, leadership authority and action." It establishes a specific structure for generating the transformed system it describes, and it puts in motion the process for developing that system over time.

The structure enables individuals involved on a local, regional and state level to continue to contribute more concrete thinking and action to transformation.

Differences between the existing and proposed structure, with action steps to get there, are reflected on the table below.

Element	Existing	Recommended	Action Steps
<b>Systems</b>	<ul style="list-style-type: none"> <li>▪ Substance use disorders</li> <li>▪ Mental Health</li> </ul>	<ul style="list-style-type: none"> <li>▪ Behavioral Health</li> </ul>	Generate an integrated structure which can then pursue behavioral health work
<b>Funding</b>	<ul style="list-style-type: none"> <li>▪ Siloed</li> </ul>	<ul style="list-style-type: none"> <li>▪ Braided</li> </ul>	Develop a plan to integrate funding streams and begin to position funders to pay the same amount for the same service with consistent standards.
<b>Regional Leadership</b>	<ul style="list-style-type: none"> <li>▪ Regional Advisory Councils (substance use disorders only)</li> <li>▪ Regional Mental Health Boards (mental health only)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Regional Behavioral Health Community Development Boards</li> <li>▪ Robust Subcommittee involvement (specifically including Consumers and Families)</li> </ul>	Pursue legislation in 2011 to develop Regional Behavioral Health Community Development Boards.
<b>State Level Coordination</b>	<ul style="list-style-type: none"> <li>▪ State Mental Health Planning Council (mental health only)</li> <li>▪ Interagency Committee on Substance Abuse and Treatment Prevention (substance use disorders only)</li> <li>▪ Department of Health and Welfare</li> <li>▪ Idaho Department of Juvenile Corrections</li> <li>▪ Idaho Department of Correction</li> <li>▪ State Department of Education</li> <li>▪ Office of Drug Policy</li> <li>▪ Courts</li> <li>▪ Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ State Behavioral Health Planning Council</li> <li>▪ Statewide Behavioral Health Cooperative</li> </ul>	<p>Pursue legislation in 2011 to develop the Statewide Behavioral Health Planning Council.</p> <p>With the delivery of this plan (October 2010), issue an Executive Order to establish the Statewide Behavioral Health Cooperative to coordinate the operational elements of transformation. To be followed by legislation in 2011.</p>
<b>Director of Transformation</b>	<ul style="list-style-type: none"> <li>▪ No single point of leadership for the coordination and delivery of services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Director of Transformation – a cabinet level professional responsible for oversight of the transformation</li> </ul>	Pursue legislation in 2011 to establish the position of the Director of Transformation describing roles, responsibilities, accountabilities.
<b>Data</b>	<ul style="list-style-type: none"> <li>▪ Insufficient and disparate data collection</li> </ul>	<ul style="list-style-type: none"> <li>▪ Standardized data collection with common core measures across systems</li> </ul>	Identify core measures and integrate into new and existing data collection methods



# Attachment B: Director of Transformation Job Description

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## **DIRECTOR OF TRANSFORMATION**

### **PRINCIPLE ACCOUNTABILITIES**

The Director of Transformation is the state official designated to oversee and execute the coordination of the transformation of Idaho's existing mental health and substance use disorder systems into a single, effective, outcome-based and recovery-oriented behavioral health system. The behavioral health system is intended to be one where Idaho citizens and their families have appropriate access to quality services provided through a system that is coordinated, efficient, accountable, and focused on recovery.

The Director of Transformation directs the efforts of the Behavioral Health Transformation Office. The Director of Transformation champions the transformation effort, and has the daily responsibility and accountability for achieving the transformed system working in coordination with the Interagency Behavioral Health Transformation Cooperative. The Director of Transformation will:

- Lead the implementation of the BHTWG Transformation Plan (2010) and Behavioral Health Interagency Cooperative Transformation Implementation Plan (to be developed in 2011);
- Chair of the Behavioral Health Transformation Cooperative, coordinating their respective, equitable participation in the transformation process;
- Serve as the liaison to the Regional Boards, helping to facilitate the development of a viable regional and/or local community Transformation Implementation Plans and delivery system while honoring entity and agency roles, responsibilities and accountabilities;
- Ensure that the inputs and priorities of the Regional Boards and the Cooperative are effectively used to guide the development of regional provider networks which deliver services based on regional priorities and consistent statewide standards;
- Coordinate the development of a statewide or series of contracts in a manner that reflects regional priorities, meets agency accountability and reporting requirements, reflects consistent statewide standards, and maximizes the use of the taxpayer dollar;
- Refine and focus the transformation effort over time as implementation lessons are learned, research and best practices are identified, considered and applied as appropriate, and data and performance measures inform strategic direction; and
- Represent the Behavioral Health Cooperative in statewide efforts to coordinate health care reform implementation.

### **MINIMUM QUALIFICATIONS**

The individual who secures the position of Director of Transformation would require the following minimum qualifications, to include:

- Considerable knowledge of policy and procedures for all branches of state and local government;
- Demonstrated understanding and/or experience with government systems, judicial processes, and experience with systems change;

- Demonstrated understanding and/or experience with public health delivery system and consumer and family needs;
- Considerable knowledge of quality, outcome-based, cost effective treatment for a behavioral health system of care and providing for adults and children with mental health and substance abuse disorders;
- Demonstrated leadership skills;
- Competency in management; and
- Demonstrated ability to:
  - Hire and supervise staff,
  - Interpret and apply laws, rules and regulations,
  - Develop and implement new policy and procedures,
  - Facilitate, coordinate and communicate effectively with diverse groups of stakeholders and the public,
  - Support contractual and fiscal responsibilities,
  - Manage complex projects, and
  - Solve problems.

## Attachment C: Definition of Blended and Braided Funding

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*treatment needs, providers, and State public mental health system design and financing has focused on experiences in a small number of States. Given the inherent differences of State Medicaid and mental health delivery systems, the findings of these studies are not easily generalizable. Additional research in both the private and public sectors is needed to better inform purchasers about the relative effects of different risk-sharing approaches to make choices about system design and purchasing decisions.*

### **B. Blending and Braiding Funding Streams in Managed Mental Health Care**

**Question:** Should funding streams from multiple public and private sector payors of managed mental health care services be combined? If so, is blending or braiding a better way to combine these funding streams, and what are the requirements for their long-term success?

**Answer:** Yes. Several evaluations (largely based on expert opinion) of systems that use multiple funding sources have found that respondents believe that combining multiple funding streams across service sectors using blending or braiding techniques is a desirable way to overcome fragmented multiple mental health treatment systems. Further, respondents believe that braiding funds, rather than blending them, allows better tracking and accountability for each agency's financial and programmatic contributions. Combining funding in these ways enhances flexibility to provide access to a coordinated array of mental health, medical, and social services that result in better outcomes. Successful approaches are characterized by involving stakeholders early in the planning process, obtaining leadership commitment, and imple-

menting ongoing monitoring systems for financial and outcomes accountability.

#### **1. Definitions of "Blending" and "Braiding" Funding Streams**

Although the goals of both blending and braiding funding streams are essentially the same, the two are different in the manner in which they are structured and managed.

With blended funding streams, funds from multiple sources (e.g., Medicaid, mental health, child welfare, and education) are combined into a single pool that is used to pay providers. Essentially, blended funding combines funds at the "front end" by first combining funds from multiple sources into a single pool. An often-cited example of a blended funding approach is Wraparound Milwaukee in Milwaukee County, Wisconsin.<sup>19</sup>

With braided funding streams, the funds from various sources are not pooled into a single account; rather, a separate administrative entity such as a fiscal agent monitors and tracks the relative distribution of the levels of each participating agency's responsibility for treatment service delivery and then authorizes payment to providers. Thus, braided funding combines funds at the "back end," when payments to providers are made (Flynn & Hayes, 2003; Koyanagi, 2003a; Koyanagi, 2003b). An often-cited example of a braided funding approach is the Dawn Project in Marion County, Indiana<sup>20</sup> (Koyanagi, 2003a; Pires, 2002).

#### **2. Rationales for Blending or Braiding Funding Streams**

There are many Federal, State, local, and private sector funding streams that have been developed over the years that include resources for paying for mental health treatment services. Each funding source has its

own requirements for which services are provided and who is eligible to provide and receive them. In addition to private sector health insurance, public sector examples include Medicaid, SCHIP, Temporary Assistance for Needy Families (TANF), child welfare, juvenile justice, education, social services, maternal and child health, and State and local mental health programs, each of which is governed by different statutory and regulatory requirements (Burns, Costello, Angold, & Tweed, 1995; Hodges, Nesman, & Hernandez, 1998; Koyanagi, 2003b; Pires, 2002).

One of the effects of these multiple sources of funding has been the development of a generally fragmented service delivery system. This system is often confusing and difficult to navigate for children with mental health care needs and their families. There is widespread recognition that the successful treatment of SEDs among children and adolescents requires access to comprehensive, integrated, and coordinated community-based services that include not only mental health care services, but also medical and social support services (Hanson, Deere, Lee, Lewin, & Seval, 2001; Koppelman, 2004; Seltzer, 2003; Stroul, Pires, Armstrong, & Zaro, 2002).

Beginning in the late 1980s, States and localities developed holistic approaches to creating more seamless delivery systems that are founded on a “system of care” concept. This concept emphasizes availability of an array of services, individualized care, services provided in the least restrictive environment, full participation of families, coordination among child-serving agencies and programs, and cultural competence (Stroul, 2002; SAMHSA, 2005).

The financial boundaries and requirements of the many available funding sources must

be “bridged” to provide for their most effective and efficient use. The use of blended or braided financing mechanisms represents a way to bridge these boundaries by providing centralized points of expertise and accountability to better manage financial resources across service sectors (California Center for Research on Women & Families [CCRWF], 2001; Flynn & Hayes, 2003; Koyanagi, 2003a). The benefits of such an approach, as documented in evaluations of ongoing programs that use pooled funding streams, include—

- Identifying and filling gaps in services;
- Eliminating duplicative services;
- Increasing flexibility in the use of existing and expanded services; and
- Promoting interagency collaboration to improve service coordination (Edelman, 1998; Hodges, Nesman, & Hernandez, 1998; Koyanagi, 2003a; O’Brien, 1997).

### *3. Considerations Regarding Whether to Blend or Braid Funding Streams*

The research approach taken in describing and evaluating pooled funding streams was predominantly based on qualitative methods such as interviews with key stakeholder experts in sites that have implemented this financing approach, site visits, and document analyses. Authors then compared and contrasted findings across sites to identify common themes, challenges, and successes. These reports described the pros and cons of pooling funding streams in general, and then, once pooled, distinguished between blending or braiding of funds and the respective programmatic and financial issues that sites have identified and techniques deployed to address them.

Analyses that have evaluated pooled funding systems report that the choice of whether

to blend or braid funding streams involves several considerations, including—

- How State agencies are organized and financed;
- Stakeholders' willingness to collaborate; and
- The costs of creating an expert management information system that can accurately track all expenditures and ensure that all legal requirements contained in funding authorities are met.

Blending funding streams may require overcoming reluctance on the part of agency heads who, through pooling of funds, may feel that they are losing control over how their funds, for which they are accountable, will be spent. Thus, the amounts they may be willing to offer may be lower than what could be achieved through a braided funding approach that retains more individual agency control. Braiding funding streams requires developing and financing a complex and potentially expensive fiscal monitoring system to ensure a single point of accountability for assessing appropriate delivery of services and allocations of costs across funding streams (Crowell, DelliQuadri, & Austin, 1995; Hodges, Nesman, & Hernandez, 1998; Koyanagi, 2003a; Koyanagi & Feres-Merchant, 2000; O'Brien, 1997; Orland & Foley, 1996; Pires, 2002; Potter & Mulkern, 2004).

#### 4. *Blending or Braiding Funding Streams: Key Elements for Success*

In both blended and braided funding approaches, there are several key elements that support their successful creation and implementation. Figure 8 summarizes these common themes and recommendations as identified in numerous studies and evaluations in the literature.

*Summary of the Literature: The nature of the literature regarding the use of pooled funding streams is primarily qualitative evaluations based on interviews with key stakeholder experts, by conducting site visits, administering surveys, and document content analyses. Blending or braiding multiple funding streams across service sectors is a desirable way to (1) overcome fragmented multiple mental health treatment systems; and (2) enhance flexibility to provide access to a coordinated array of mental health, medical, and social services that result in better outcomes for children and families with mental health needs. Both approaches require a high level of collaboration and coordination among stakeholders. Merging funds in these ways also requires the development of sophisticated financial and health outcomes monitoring systems to document adherence to fiscal and legal integrity requirements, as well as to document improvements in health status and system viability.*



## Attachment D: Draft Executive Order

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THE OFFICE OF THE GOVERNOR EXECUTIVE DEPARTMENT STATE OF IDAHO BOISE

EXECUTIVE ORDER NO. 2011-XX

### ESTABLISHING THE BEHAVIORAL HEALTH INTERAGENCY COOPERATIVE

Whereas, Idaho citizens and their families should have appropriate access to quality services provided through the public mental health and substance use disorders systems that are coordinated, efficient and accountable; and

Whereas, the Behavioral Health Transformation Work Group established by Executive Order 2010-01 was tasked to develop a plan for a coordinated, efficient state behavioral health infrastructure with clear responsibilities, leadership authority and action;

Whereas, the Behavioral Health Transformation Work Group has worked diligently to develop an integrated structure and coordinated delivery system;

Whereas, the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) codified in section 39-303 Idaho State Code, is set to sunset on June 30, 2011;

Whereas, ICSA has made progress in bringing about open communication between stakeholders and providers resulting in meaningful reform of the state's substance use disorders system and this effort should continue; and

Now, therefore I, C.L. "Butch" Otter, Governor of the State of Idaho, by the authority vested in me under the Constitution and laws of this state do hereby create the Behavioral Health Interagency Cooperative (Cooperative).

1. Members of the Cooperative shall be appointed or approved by (as appropriate) and serve at the pleasure of the Governor.
2. The Chair of the Cooperative shall be appointed by and serve at the pleasure of the Governor.
3. The members of the Cooperative shall include but are not limited to:
  - a. Director, Department of Health and Welfare;
  - b. Director, Department of Correction;
  - c. Director, Department of Juvenile Corrections;
  - d. Superintendent of Public Instruction;
  - e. Administrative Director of Idaho Courts;

- f. One representative from among the Counties;
- g. One representative from the State Planning Council.

4. The Cooperative shall:

- a. Work in coordination with the Director of Transformation, once appointed, to secure a coordinated and effective system (who will chair the Cooperative once appointed);
- b. Work in close coordination with local and state government, the judiciary, and specifically with the Office of the Governor and members of the Senate and House Committees on Health and Welfare;
- c. Provide input to draft legislation regarding transformation of the behavioral health system as it is under development and worked through the legislative process;
- d. Review and confirm recommendations, statewide standards, guidelines, contract templates, core services, and other elements of the behavioral health system as they are developed by respective entities;
- e. Ensure the implementation of the transformation of as described in the BHTWG Plan for Transformation of Idaho's Behavioral Health System (October 2010), by providing for efficient and effective interagency coordination of systems, operations, services, and a braided funding process;
- f. Produce and present a status report of their interagency efforts and accomplishments to the Office of the Governor and members of the Senate and House Committees on Health and Welfare on an annual basis;
- g. Meet on a monthly basis, or more frequently as needed to meet the needs of the group;
- h. Develop, annually update, and commit to implementing the Statewide Behavioral Health Cooperative Transformation Implementation Plan that is equally applicable to all entities involved with the Cooperative. The Transformation Implementation Plan will address:
  - Overall policies, strategies, steps, and timelines related to transformation implementation;
  - Strategies for coordination, cooperation, collaboration, forging partnerships and understandings between behavioral health, education and justice systems;
  - Agreement on the agency staff responsible for specific duties related to the transformation and operation of the behavioral health system as well as a system to ensure accountability to the plan;
  - Statewide behavioral health needs and gaps;
  - A braided funding strategy which coordinates budgets, establishes priorities and addresses issues of funding availability;
  - Data and information sharing, reports and functionality;
  - Coordinated approaches for the delivery of behavioral health services and the elimination of duplication of services among relevant agencies;

- Readiness criteria for regional contracting;
- Workforce development and training for public and private providers, including multidisciplinary approaches;
- Best practices;
- Ongoing communication strategies;
- System performance and evaluation and outcome-based performance measures; and
- The role of behavioral health in Health Care Reform.

g. The Cooperative will:

- Identify and forward prospective candidates for the position of Director of Transformation;
- Collect and share data needs and requirements and propose how data can be effectively coordinated/cross-walked across agencies;
- Quantify total state funding across entities so that regions and the state can plan for the most effective use of taxpayer dollars;
- Share funding information on a regional scale with regional boards so that they can provide informed input about their needs and priorities;
- Participate in a braided funding scenario where funding streams from various sources are coordinated to support a broad continuum of behavioral health services;
- Articulate their respective needs and requirements for use in Regional Provider Network contracting and evaluation processes;
- Confirm a shared understanding of service standards developed by DHW, which operates as the State Behavioral Health Authority and who will monitor for performance based on consistent service standards statewide; and
- Purchase services through the Regional Provider Networks through contractual arrangement(s) which articulate shared service standards, collects and shares system-wide data, meets reporting requirements of state and federal funding entities, provides for the best use of the taxpayer dollar, and secures the best outcomes for the family and consumer.

5. An Office of Performance Evaluation review will be delivered on January 1, 2016. Authority for the Cooperative shall sunset on June 30, 2016, pending the result of the January 1, 2016 report.

In Witness Whereof, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho in Boise on this \_\_\_\_ day of \_\_\_\_ in the year of our Lord two thousand and \_\_\_\_ and of the Independence of the United States of American the two hundred \_\_\_\_ and of the Statehood of Idaho the one hundred \_\_\_\_.



## Attachment E: Definitions of Core Services

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### **Assertive Community Treatment (ACT), Intensive Case Management Services and Wraparound**

#### Assertive Community Treatment (ACT)

ACT consists of proactive interventions with serious, disabling mental illness for the purpose of increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology, and ensuring a satisfactory quality of life. Services include the provision and coordination of treatments and services delivered by multidisciplinary teams using an active, assertive outreach approach and including comprehensive assessment and the development of a community support plan, ongoing monitoring and support, medication management, skill development, crisis resolution, and accessing needed community resources and supports.

#### Intensive Case Management

Intensive case management is an intensive community rehabilitation service for individuals at-risk of hospitalization or for crisis residential or high acuity substance use disorders services. Services include: crisis assessment and intervention; individual restorative interventions for the development of interpersonal, community coping and independent living skills; development of symptom monitoring and management skills; medication prescription, administration and monitoring; and treatment for substance use disorders or other co-occurring disorders. Intensive case management also includes coordinating services, referral, follow-up, and advocacy to link the individual to the service system. Services can be provided to individuals in their home, work or other community settings. Services may be provided by a team or by an individual case manager.

#### Wraparound

Wraparound is an intensive and individualized care management process. During the wraparound process, a team of individuals who are relevant to the well-being of the individual (e.g., family members, other natural supports, service providers, and agency representatives) collaboratively develop an individualized plan of care, implement this plan, and evaluate success over time. The wraparound plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family's social networks. The team convenes frequently to measure the plan's components against relevant indicators of success. Plan components and strategies are revised when outcomes are not being achieved.

### **Assessment and Evaluation**

Assessment and evaluation define or delineate the individual's mental health/substance use disorders diagnosis and related service needs. Assessments and evaluations are expected to be timely and of high quality and provided by trained and experienced professionals. Assessment and evaluation services are used to document the nature of the individual's behavioral health status in terms of interpersonal, situational, social, familial, economic, psychological, substance use disorder and other related factors. These services include at least two major components: 1) screening and evaluation (including medical, bio-psychosocial history; home, family, and work environment assessment; and physical and laboratory studies/testing and psychological testing as appropriate); and 2) a written report on the evaluation results to impart the evaluator's professional judgment as to the nature, degree of severity, social-psychological functioning, and recommendations for treatment alternatives.

**Case Management (service coordination)** (case load capacity to be determined by an acuity-based formula)

This service provides supportive interventions to assist individuals to gain access to necessary medical, habilitative, rehabilitative and support services to reduce psychiatric symptoms, address substance use disorders, and develop optimal community living skills. Service Coordination needs are assessed and documented on the comprehensive treatment plan to meet the individual's specific needs. Service Coordination services may include coordinating services, referral, follow-up, and advocacy to link the individual to the service system and to coordinate the various system components to assure that the multiple service needs of the individual are met. Service Coordination may also provide assistance for obtaining needed services and resources from multiple agencies (e.g., Social Security, Medicaid, Prescription Assistance Programs, food stamps, housing assistance, health and mental health care, child welfare, special education, etc.), advocating for services, and monitoring care. Case management also assists in the transition of adolescent consumers as they age out of the children's system and into the adult system and the transition to adulthood.

### **Designated Examinations and Dispositions**

A designated examination is a personal examination of a proposed patient to determine if the proposed patient is: (i) mentally ill; (ii) likely to injure himself or others or is gravely disabled due to mental illness; and (iii) lacks capacity to make informed decisions about treatment and should be involuntarily committed to the Department of Health and Welfare (Department). A designated examiner must be a psychiatrist, psychologist, psychiatric nurse, social worker or other mental health professional designated in rule and specially qualified by training and experience in the diagnosis and treatment of mental illness. A dispositioner is a designated examiner employed by or under contract with the Department to determine the least restrictive appropriate location for care and treatment of involuntary patients.

### **Intensive Outpatient Treatment**

#### Home-Based Mental Health Services

Intensive home-based treatments are time-limited intensive therapeutic and supportive interventions delivered in the home. They are intended to prevent hospitalization. These services are available twenty-four hours a day, seven days a week. Services are multi-faceted in nature and include: situation management, environmental assessment interventions to improve individual and family interactions, skills training, self and family management, and independent living skills training.

#### Intensive Outpatient Substance Use Disorder Treatment

This service provides a time limited, multi-faceted approach treatment for persons who require structure and support to achieve and sustain recovery. Intensive outpatient treatment consists of group and family counseling, job preparedness, relapse prevention, and education.

### **Illness Self-Management and Recovery Services**

Illness self-management uses structured techniques and strategies for managing mental illness/substance use disorders and ongoing self-assessment and self-monitoring to facilitate recovery from mental illnesses/substance use disorders. Several manualized self-management programs have been developed in recent years, including programs designed to help participants identify internal and

external resources for facilitating recovery, and then use these tools to create their own, individualized plan for successful living.

### **Inpatient Psychiatric Hospitalization**

The goal of inpatient care is to stabilize the individual displaying the acute symptoms. This service is available for individuals who are in direct danger to self or others, and/or in acute crisis, including substance use withdrawal. This service provides twenty-four (24) hour care in a hospital requiring short-term, intensive, medically supervised treatment, consistent with the individual's needs. Services provided in an acute psychiatric hospital include, but are not limited to, psychiatric care, monitoring of medication, health assessment, nutrition, therapeutic interventions, observation, case management and professional consultation.

### **Medication Management**

#### Medication Management/Pharmacotherapy

Medication management is a pharmacotherapy service provided by a psychiatrist, physician or other individual licensed to prescribe medications to assess and evaluate the individual's presenting conditions and symptoms, medical status, medication needs and/or substance use disorders status. This includes evaluating the necessity of pharmacotherapy or other alternative treatments, prescribing, preparing, dispensing, and administering oral or injectable medication. Informed consent must be obtained for each medication prescribed.

#### Medication Administration/Monitoring

Medication services are goal-directed interventions to administer and monitor pharmacological treatment. Oral, injectable, intravenous, or topical medications and treatments are administered and their positive and negative effects monitored. This includes medications used to treat substance use disorders or addiction. There is a focus on educating and teaching individuals and members of their support system as to the effects of medication and its impact on alcohol/drug abuse/dependence and/or mental illness. Counseling related to medication management and case coordination with other practitioners involved with the individual is necessary to assure continuity of care. These are primarily face-to-face services contacts, rendered as both facility-based and "in vivo."

### **Drug Screenings**

Laboratory screenings are used to treat behavioral health and medical disorders and provide pharmacologic management. Tests may include, but are not limited to: urinalysis, other formal drug screenings and blood tests.

### **Peer Support Services**

Peer support services provide an opportunity for individuals to direct their own recovery and advocacy process and to teach and support each other in the acquisition and exercise of skills needed for management of symptoms and for utilization of natural resources within the community. This service provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of other natural supports, and maintenance of community living skills. Trained and certified consumers actively participate in decision-making and the operation of the programmatic supports.

## **Prevention Services**

The goal of this service is to prevent suicide, mental illness, and/or substance use disorders. Prevention activities include various strategies aimed at educating the community at large and selective educational and informational strategies for certain individuals who are at greatest risk for suicide, mental illness and/or substance use disorders. A system of prevention involves clear boundaries and expectations, and a comprehensive scope of pro-social activities and educational services designed to increase protective factors and reduce risk factors among all in a community (universal). One of the keys to prevention of suicide, mental illness and substance use disorders is training "gatekeepers" in how to recognize the early signs and symptoms. Gatekeepers are those individuals that have frequent contact with moderate to high risk populations.

## **Early Intervention Services for Children and Adolescents**

Early intervention services are designed to address problems or risk factors that are related to mental illness and substance use disorders. These services are designed to provide information, referral and education regarding symptoms and treatment to assist the individual in recognizing the risk factors for mental illness and substance use disorders. Early intervention and education is an organized service that may be delivered in a wide variety of settings. Early intervention may include time-limited respite care services.

## **Psychiatric Emergency and Crisis Intervention Services (24/7 with open door access)**

### Crisis Intervention/Mobile Crisis

Crisis intervention services are immediate, crisis-oriented services designed to ameliorate or minimize an acute crisis episode and to prevent inpatient psychiatric hospitalization or medical detoxification. Services are provided to adults, adolescents and their families or support systems who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors or moods. The services are characterized by the need for highly coordinated services across a range of service systems. Crisis intervention services should be available on a 24-hour, seven-day per week basis. Services can be provided by a mobile team or by a crisis program in a facility or clinic. Crisis intervention services include: crisis prevention, acute crisis services, and support services.

### Crisis Residential Treatment/Respite Care Services

Crisis residential treatment services provide 24 hour supports for adults for the purpose of ameliorating a crisis in the least restrictive setting while trying to maintain the person's linkages with their community support system. Services include: continuous and close supervision, medical, nursing and psychiatric services and referral to community-based services. Crisis residential treatment services are provided in non-hospital setting. Crisis residential lengths of stay generally should not exceed 10 days.

## **Psychotherapy (including trauma-informed care, cognitive behavioral therapy and outpatient substance use disorders treatment.)**

### Individual

Individual counseling consists of various evidence-based professional therapeutic interventions and is used to address an individual's alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, connecting with and utilizing

natural supports, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various settings.

#### Group

Group psychotherapy consists of therapeutic interventions provided to a group of children, adolescents or adults to address an individual's alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various settings. Group size should be at least three or more, but fewer than 10 individuals.

#### Family Psychotherapy for Children and Adolescents

Interventions directed toward an individual and family to address emotional or cognitive problems which may be causative/exacerbating of the primary mental disorder or have been triggered by the stress related to coping with mental and physical illness, alcohol and drug abuse, and psychosocial dysfunction. Personal trauma, family conflicts, family dysfunction, self-concept responses to medication, and other life adjustments reflect a few of the issues that may be addressed. Includes Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Parenting with Love and Limits (PLL).

#### **Alcohol and Drug Residential Treatment**

This service is a twenty-four hour residential rehabilitation treatment for adults or adolescents with chronic alcoholism or drug dependency who lack an adequate social support system and need supervised treatment to achieve a substance-free lifestyle and explore and instill ways of functioning in a work setting, within the family, and in the community in accordance with the individual's treatment plan. Services include: medication administration, case management and monitoring and individual and group recovery-based services. Some individuals may be experiencing and be monitored for minor detoxification.

#### **Supported Employment, including Vocational Rehabilitation when needed**

##### Supported Employment

Supported employment provides on the job supports in an integrated work setting with ongoing support services for adults with the most severe disabilities for whom competitive employment: a) has not traditionally occurred; b) has been interrupted or intermittent as a result of severe disability; and c) who, because of the nature and severity of their disability, need intensive supported employment services in order to perform work. Activities are performed by a job coach and/or job specialist/case manager in conjunction with a job developer to achieve a successful employment outcome.

##### Job Preparedness

Job preparedness consists of activities directed at assisting individuals to develop skills to gain and maintain employment. Job preparedness services include: providing instruction in the areas of resume writing, job application preparation, and appropriate job interview responses. These activities also emphasize the importance of being ready to seek and hold employment is discussed, including proper nutrition, cleanliness, and physical appearance, allocating daily costs, and taking prescribed medication.

### **Supported Housing (housing first, etc.)**

Supported housing is a safe and secure place to reside which is affordable to consumers and permanent as long as the consumer pays the rent and honors the conditions of the lease. In some models, consumers **are not** required to participate in services to keep their housing, although they are encouraged to use services. Supported housing should be individualized services available when the consumer needs them and where the consumer lives.

### **Transformation**

Transformation services are used to move individuals to and from covered medically necessary medical or behavioral health examinations, treatment and services. This service may be provided in staff-driven vehicles, or by assistance with the cost or process of arranging for and/or using public or private transformation.

### **24-hour Out-of-Home Treatment Interventions for Children and Adolescents**

#### Residential Treatment

Time limited services are designed to assist children or adolescents to develop skills necessary for successful reintegration into the family or transition into the community. Residential treatment centers provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to eligible recipients. Services provided in this setting include: individual, groups and family therapy, behavior management, skill building and recreational activities. Services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment.

#### Treatment Foster Care

Time limited community based treatment services provided to children or adolescents who are placed in 24-hour supervised, trained and surrogate family settings. Intensive therapeutic foster care services incorporate clinical treatment services, which are behavioral, psychological and psychosocial in orientation. Services must include clinical interventions by the specialized therapeutic foster parent(s) and a clinical staff person. Services included in individualized care plans are designed to assist the child or adolescent to develop skills necessary for successful reintegration into the natural family or transition into the community. The family living experience is the core treatment service.

### **Day Treatment/Partial Care Services and Partial Hospitalization**

#### a. Day Treatment and Partial Care for Children and Adolescents

A non-residential treatment program designed for children and adolescents who may be at high risk of out-of-home placement. Therapeutic Day Treatment services are a coordinated and intensive set of therapeutic, individual, family, multi-family and group services and social recreational services. Day Treatment Services provide a minimum of three hours of structured programming per day, two-to-five times a week, based on acuity.

#### b. Partial Hospitalization for Adults

A distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care that is reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization.

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