Idaho Behavioral Health Planning Council

Wednesday, April 25th, 2018
Hampton Inn
495 S Capitol Blvd, Boise, ID 83702

8:30 – 8:45	Welcome and Introductions	DBH & IHFA
8:45 – 8:50	Brief Overview of Planning Council and Behavioral Health Board Structure	Rosie Andueza Federal money is received through the block grant and as a requirement, the Planning Council was created. There are Regional Behavioral Health Boards as well. There are seven regions. At the community level, the boards analyze the needs in each specific community and report back to the Planning Council. Each year, the Planning Council puts together a report based on the reported gaps and needs from each region. Housing is consistently an issue in each of the regions.
8:50 – 9:50	PowerPoint: Regional Behavioral Health Board Updates: • Resources in the region • TBH update • Available programs and services • Specific regional housing needs	Regional Behavioral Health Board Representatives Region 1 – Marilyn Miller In the rural areas outside of the more populated centers in the region, housing is a major issue, and the concern is also heavily placed on felon probation housing as well. Region 1 has a recovery center that provides a large number of services. The heaviest populated area is within Kootenai County. There are currently only two providers in Region 1 that will provide TBH at this point. Region 2 – Lisa Martin Crisis Intervention training is very prominent in the region, as are suicide prevention and mental health first aide.

		TBH is used predominately by veterans' services in this region. The community hospitals also have TBH, and there is currently one provider who also offers TBH. Housing is a big challenge in Lewiston; average rent is around $750, which is high for such small communities. There are currently people using the jail and tent cities as their permanent housing. There is also currently Oxford housing in Lewiston. Region 3 – Brian Lindner A crisis center is currently in the works and should open in Nampa in December. There are currently no local providers for TBH in Region 3. The housing market is very tight in Region 3 and finding affordable housing for those on Medicaid/assistance is very difficult. The Region is working on certified family homes for those with mental illness. The Region would also like to see HART homes become the standard type of facility funded through Medicaid. Region 4 – Ken Widick The housing market is very difficult right now. Region 4 just recently opened a crisis center in Boise, and have found it to be a very, very valuable agency as a housing provider. There is also a very active recovery center in Boise. There is currently one provider for TBH. Region 5 – Angenie Region 5 does have a crisis center. The Walker Center offers TBH, but is currently the only provider. There is a need for transitional housing, and some male sober housing. The number one housing issue is finding affordable housing in general, there for finding specialized housing becomes even more problematic. A lot of funds are utilized in helping people without Medicaid benefit pay for voluntary treatment, so if perhaps that was more readily available, funding could be more easily put towards housing. Region 6 – Mark Gunning The hope is to have a crisis center in the region soon. There are currently no agencies in the region providing TBH. Housing issues include transitional and residential long-term housing. Region 7 – Michelle Osmond The Region does have a crisis center in Idaho Falls as well as several homeless shelters. There are

		still a lot of rural and frontier areas not being served. TBH is used at the State Hospital every day. The TBH contract in place does require the offsite doctors to come on site a specific, set amount of time in order to best understand the issues of the community. **<u>Questions:</u>** **Are there still churches working to assist with housing in Region 3?** Yes. Churches and the faith based communities are a valuable resource that should be remembered
9:55 – 10:00	PowerPoint/Handout: SOAR Overview and Upcoming Trainings	Crystal Campbell SOAR is a model used to help people who have a mental health challenge and who are currently experiencing or are at risk of homelessness. There are case managers throughout the state, but there is not funding so it is very limited. There is one point of contact in each of the hubs to find a local SOAR Case Manager. Training will be offered three times a year, or there is an online training option where training is done with a cohort. A list of the SOAR hub leads is available on the website.
10:00 - 10:15	Break	
10:15 – 10:25	PowerPoint: Structure of IHCC and Regional Homeless Coalitions	HUD sets certain goals at a national level and that translates into the scoring that is seen in the application for funding as well as the scoring that occurs in the pursuit of the funding. There is more and more a push for data driven funding and sometimes there is a difference between HUD's structure and the local level community perception and needs. Region 1 – Jon Bruning – St. Vincent de Paul They currently operate two shelters and have roughly 200 units of housing. Everything is full.

		Region 2 – Steve Bonner – Average waitlist in this region is 12-18 months. The region has struggled to maintain housing and has suffered losses of shelters and trailer court areas. The region is currently applying for grants in an effort to provide additional beds specifically for veterans in need of housing. Region 3 – Nancy Tuttle – The region has suffered a loss of transitional housing. There is a huge need for low and affordable cost housing, and while there are builders willing to help build low income housing, the community isn't supportive of it. Region 4 – Misty McEwan- While the region has a lower unemployment rate, housing is still an issue. Funding was lost for transitional housing. Region 5 – There are multiple resources available in the greater Pocatello areas, as well as a couple crisis centers. However, from one year to the next, the region lost 100 beds, and there continues to be a challenge with having enough housing. There is a house that is opening up for emergency family housing in conjunction with a local Presbyterian church. They also recruited the local chair of the Idaho Home Builder's Association to participate and have discussions about affordable housing. There is a Homelessness tab on the IHFA website for extra resources. The IHCC meets throughout the year. HMIS – Homelessness Management Information System This information is not shared outside of Idaho. HUD programs are required to use it, PATH providers are as well, and a few other agencies. There are also voluntary users – those who don't received HUD funding, but use it and help create a better picture across the state. CMIS is the Community Management Information System. This is totally separate from the HMIS and each provider has their own grouping. It is locked and the information is not shared at all in order to comply with the rules around privacy, etc. The data is collected and shared, dependent upon the community needs. There is also a link to the community reports for this year and last on the website (Helping Idaho's Homeless).

		A point in time (PIT) count is done the last Wednesday of January to capture a snapshot of homelessness across Idaho. This is done in the winter as it becomes incredibly difficult to count those who are truly homeless during the warmer camping weather. The last PIT, the unsheltered count was almost equal to the sheltered count. State funding for homelessness is not an option at this point. Idaho is one of the few where state funding is not provided. The numbers include all ages, however, numbers showing serious mental illness or substance abuse are adults only, and this number is self-reported. Training for participation in the PIT are always offered during the day, making it difficult for those who work during the day to participate. This feedback will be shared.
10:25 – 10:40	PowerPoint: Homeless Connect (Coordinated Entry)	Dana Wiemiller IHFA is the administrator of the system, and they work in collaboration with IHCC. When a unit comes available within a region, the access point is contacted, and the highest priority client is identified. This also includes case conferencing. Assessments are done, and can be done in person or over the phone, so there is not a requirement that the person come in to have the assessment done. There are six levels of prioritization considered, and then within those categories, there are also prioritization "tie breakers" based on HUD and other criteria.
10:40 – 10:50	New Initiatives	
10:50 – 11:10	Housing Offered and Services Provided	
11:10 – 12:00	Joint Discussion Q & A	In Region 1, additional men's shelters are definitely needed. There are shelters in the main county, but additional options are needed. In Region 2, Clearwater County (Orofino) is the highest area of need. IDOC provides some funding for those re-entering, but it only covers 30 days and is not enough. In Latah County, housing is too expensive. In Region 3, there is a need for housing for people coming out the State Hospital. There are some

		facilities that can house women in that situation, but there is a large need for transitional housing for men. In Region 5, there is a need for housing where treatment can also occur (i.e. in transitional housing, etc). In Region 6, the issue of "not in my neighborhood" is becoming more and more of a challenge. In Region 7, the largest struggle is finding resources in the smaller counties due to the abundance of rural and frontier areas.
12:00 – 12:30	Working Lunch: Welcome and Introductions – Behavioral Health Planning Council – Move to the Boise Meeting Room	Tammy Rubino/Crystal Campbell
12:30 – 1:00	Morning Wrap-Up/Discussion	Tammy Rubino/Crystal Campbell The morning was very beneficial and full of very good information. The discussion was unfortunately cut short this morning as time ran out. Crystal will reach out to the boards for follow up. Judy added that one of the challenges for those experiencing homelessness is also ensuring prescriptions as well. Regions could have an opportunity to look into possible solutions to help people obtain the medications they need, especially when housing is a challenge as well. It would be helpful to have further discussions about people coming out jail, prison, or hospital, and in need of housing. It was noticed that the overall discussion in the morning didn't really address this sort of homelessness. IDOC does provide a 30-day supply and a prescription, but that must be paid for. IDOC does provide for 30-day housing, having spent roughly 650k last year, with another roughly 600k for safe and sober housing. Nobody leaves DOC without a 30-day housing plan, but 30 days goes by extremely quick. A SOAR application can be done in jail, but there are some differing guidelines and challenges. The question arose regarding what homelessness costs the state, as being able to discuss and utilize that information would be influential and helpful in having dialogue with the state legislators. The question was asked if the 30-day period could be extended. IDOC had requested an extension

		for transitional housing at this year's legislature, but the request was denied. Housing can be a factor in why people are entering the penal system, but it isn't tracked specifically. There are multiple layers to the solution, and several programs are showing some good results, but the demand is higher than the resources available to meet them. To move forward, Crystal will work with the regional representatives to determine next steps. Overall, connecting the two groups this morning was very beneficial, and a great place to start the partnerships between the Behavioral Health Planning Council and other agencies. DBH is working on an enhanced safe and sober housing model – there is a recovery coach on site, meds are allowed, and it creates a stable environment where the person can stay for six months. It is more expensive than basic safe and stable housing, but the idea is that the expense up front will be worth it in the long term. The goal will be to open a similar house for women as well. The housing is specifically for those coming out of state hospital. State hospital cost per day is roughly $650 whereas prison is roughly $55 and these houses are approximately $45.
1:00 – 1:30	PowerPoint/Handout: Block Grant Update	Jon Meyer Terry Pappin was previously the person who would provide block grant information, but she has retired, so Jon Meyer will be heading it up going forward along with Kim Nealey, who will be monitoring the mental health side of the block grant. On even number years, the block grant application is a really large combined application for mental health and substance use disorders. The application has been approved and we are currently just waiting to hear when the funds will be disbursed. This year, a much smaller application will be due on September 1st. At almost the same time, the block grant report will be due. There is no indication that the amount of the award will change this year, but we have not yet been informed of the amount. Work is done very closely with Marianne and the Office of Drug Policy to do all the necessary reporting. The formula for the annual awards is established by federal code. We are no longer required to report upon the tuberculosis expenditures, but we will still be completing them. There are specific requirements for the Planning Council to meet, including membership where 50% of the council must be individuals, their families and advocates. The Governor's Report is a big part of what is done to prepare the grant each year, as it must identify and address gaps and needs and what is being done to meet them. Typically, the grant

		application is done in May or early June, and is due in September. It is usually delivered to the finance department by July and is also sent out to the Planning Council around the same time. A letter is also required from the chair stating that a review was done. The actual submission does not require a letter from the Council. Last year's application was approximately 300 pages. The Council will be notified of the report in approximately October. Most of the funding goes directly into treatment on the SUD side. The 20% that goes to ODP is typically to providers for specific programs. Jon showed the links available on the website. www.Mentalhealth.idaho.gov. Then follow the links on the left-hand side to the Planning Council where all the block grant documents can be found in the menus on the right-hand side, including archived information. For website questions and updates, please reach out to Jon or Mindy. Jon.Meyer@dhw.idaho.gov Questions (Kim and Jon will follow up): *Does the formula for the annual awards ever change?* *Is there a minimum allotment level that we are limited to through the formula?*
1:30 – 1:45	Break	
1:45 – 2:15	Handout: Upcoming Mental Health Awareness Month	Crystal Campbell/Regional Board Representatives The 2nd annual Mental Health Awareness event is occurring next Friday, May 4th. Crystal would love to have additional coordination between the Planning Council and the Regional Behavioral Health Boards. The event takes place in Boise at the Capitol, in the Lincoln Auditorium. The event will also be live-streamed for those who cannot attend in person. There is a social media campaign being done with Optum for #mymentalhealthidaho in an effort to reduce stigma and encourage dialogue about mental health across the state. Optum is putting together a Green Glow event that evening, including businesses that will be

		lighting up in green for mental health awareness. There is a lot going on in the other regions and can be found on the website calendar for Behavioral Health Events.
2:15 – 3:15	PowerPoint: YES Update – Wraparound in Idaho	Candace Falsetti, Brooke Rizor, Venecia Anderson, Suzette Driscoll Brooke Rizor, LCSW, Director of the System of Care Institute at Portland State University Wraparound is very family and youth driven, and works to bring together family and youth perspectives. The model follows very specific phases and activities, and that is part of what makes wraparound different from just a really good therapist or service. It builds on actual strengths that aren't always immediately apparent. Wraparound is individualized, and will be different from one child to another. Wraparound is not something that should be aged out of, wraparound should be approached with an end in sight. The timelines will be different for each individual, typically engagement and team preparation can take place anywhere between 2 and 30 days, dependent upon what can be done in person and how the family operates. Implementation can take around six months to a year. Nearly every state has implemented wraparound in at least one jurisdiction. Candace Falsetti, Venecia Anderson, Suzette Driscoll We do have some kids who are beginning wraparound services, and training classes are being conducted to continue the implementation. There are currently nine people who have been through the training and are actively working with families. The next training will include fifteen DBH staff to continue the wraparound efforts. The expectation is that by June of 2019 there will be about 250 families receiving wraparound, and this will continue to ramp up as training and coaching continues. It is important that the state of Idaho is able to sustain this, and not always have Portland State come in and conduct the training. By June of 2020 the goal is to have 1250 families in wraparound. Children who meet class membership are still getting services; there are approximately 20,000 that meet membership, whereas there are approximately 1350 who would need wraparound services. These kids are likely already getting services from a multitude of areas. From the beginning the plan has been to make this work in Idaho, and to make sure that the ongoing training, support, and implementation in all areas of the state can be done and sustained without ongoing support from Portland State. At the statewide level we need to be able to identify and address the gaps that are occurring. There is a Workforce Development team in place under the YES project that is working to identify

		these gaps and needs. <u>Questions:</u> Have the wraparound services the Idaho used to provide been considered and reviewed? Yes, prior to coming to Idaho, the prior services being offered were reviewed and discovered, and some things were pulled from those prior services, ideas, and experiences. Things that worked, things that didn't, were all reviewed, and used as the Idaho model of wraparound was created. Were there any key take-aways from that review? It was determined that some of the elements didn't work because it wasn't necessarily approached from a statewide manner. Should there be concern that the funding for YES will go away?
3:15 – 3:30	Membership Update	Mindy OldenKamp
3:30 – 4:30	Planning Council Strategic Planning	Tammy Rubino Membership needs to be a top priority as the Council moves forward. The main focus in regard to the strategic planning is to come up with ideas for the October meeting and plan the agenda. Housing is to be a top priority for the coming year. Regionally, transportation and access to services continues to be an issue. The suggestion was to create a vision for the next five years; the intent is to have a facilitator come in and work with the Planning Council on the strategic plan at the next meeting. It is fine to have a facilitator come in, but the essential element will be to identify top priorities that can actually be worked on and tangible. The strategic plan should live through the Governor's Report and provide an outline/roadmap of where the council is going complete with deliverables and goals met. The issue becomes that the Planning Council is an advisory board, not an actionable board. There may be resources available through other states or at the national level. The problem lies in the fact that the Planning Council does not have a plan or goal going forward now that the Behavioral Health Boards have been established. There are overlaps between the council that Empower Idaho has and the Planning Council, as far as

		membership and objectives are concerned. The Empower Idaho council can advocate, whereas this Planning Council cannot. There should likely be a member of the Planning Council on the Empower Idaho Council. This Planning Council is meant to be advisory to Division of Behavioral Health and Health and Welfare as well as to the Regional Behavioral Health Boards. The Planning Council has the opportunity not to advocate for specific measures, but rather to advocate for sweeping, broad elements instead. This Planning Council should also be a cheerleader for the boards. It would be very beneficial to have continued representation from the board chairs or a designated member of the health boards at the Planning Council meetings. It would be very helpful to have a candid conversation with the boards to determine what is working well, what is not, how they are structured, and the variances that may be occurring from region to region.

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Thursday, April 26th, 2018
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8:30 – 9:00	Breakfast Meet and Greet	
9:00 – 9:45	Handouts: IROC Update	Rosie Andueza Last year, 2 million dollars was received to target the opioid crisis. There was a four-prong approach, including medication assisted treatment, which is now available across the state. There are now prescriber reports to help track and report prescribed opioids. We have contracted with Recovery Idaho to provide peer to peer services, including working with emergency departments who will call when they have someone in who is in crisis or is seeking drugs. Funding was used for naloxone and was going to be used for prescription take back boxes as well. Funding was already provided for the take back boxes from another source, so all the funding was moved to provide additional naloxone. It was targeted for rural areas, and places that are more than an hour away from treatment. There are questions as to where the doses can be kept as to if they've been exposed to extreme temperatures. This has been the first year of this program and there will be several areas of focus for the coming second year. There will not be additional naloxone kits purchased with the grant this year as not all the funds were spent last year. This is a single year, potentially repeating grant. There is a state-wide opioid misuse committee being put on by ODP that is growing tremendously. Drug induced deaths have increased nearly 30% over the last five years in Idaho. The past year has seen positive momentum within the statehouse regarding addressing the opioid

		crisis and the discussion on how to provide funding. While most measures haven't been passed yet, there are many more positive discussions happening.
9:45 – 10:00	Probation and Parole Idaho Security Medical Program Update	Rosie Andueza Probation and Parole: Felony Probation and Parole Mental Health Treatment is a new service available in Idaho. We have contracted with CHCNI, and there is now at least one clinic in every region that will provide these services. The amount initially funded was less that what was forecast as needed, but DBH has been working with IDOC to create a program that will work with the funding available. There is no time limit on when these services can be utilized. These services are referred by the parole or probation officer. Funding for this is now in the base budget. The question was asked about what happens once the person is no longer on probation – do they no longer have access to the services? Idaho Security Medical Program: There are currently three beds at the maximum-security facility for people who fall within this category. IDOC has committed to increase the beds from 3 to 9, and only charge for the medication costs. The adolescent unit is moving from State Hospital South to the Treasure Valley, and that will free up additional beds there as well.
10:00 – 10:30	Handout: HART Update	Anne Bloxham Homes with Adult Residential Treatment (HART) is a pilot program being sponsored by DBH to integrate residential treatment services with behavioral health services. This pilot is a result of the issue that some clients are not best treated in typical residential treatment scenarios. The HART provider must be contracted with OPTUM to provide services. The goal is that better treatment will be able to be provided to the individual in crisis in a more timely manner. There are currently three contracts – two in Boise (Curtis and Hillcrest) and one in Hayden (Harmony House). Curtis House is male only, Hillcrest will accept males and females. Harmony House will accept both males and females. The facilities are all open, as they were existing homes. For the house in Hayden, residential treatments are available, and the OPTUM credentialing is pending. A facility in Pocatello has been identified and will be under contract within the next few months. Referrals should be made in partnership, and any discharges should be done with collaboration with DBH as well.

		Beds are already being filled. The pilot is set to go through this December of this year, at which point it will be evaluated to determine what is working and what may not be. The money was permanently added to the base budget, so the hope is to grow additional HART models and gain new beds and have beds and placings more appropriate for the needs of these clients. Long term, the hope is that Medicaid will raise the rates and we'll be able to do more HARTS. Anne shared the anecdotal experience she had where upon visiting a client who had previously been a struggle to simply get up and get going, she experienced him inviting her in to see his treatment plan and share what he was working on. This is not a time limited benefit. There are no time limits in the contract. There may be people who live in a HART for a long or permanent period of time, and there may be people who only need be there for a few months. This model requires the individual to be actively engaged. There is a maximum of two people per bedroom. <u>Questions:</u> If the patient has a prescriber that they have been working with and likes, can they continue with them within the HART? Yes, that would still be allowed within the treatment plan. The expectation of the HART provider is that they be actively involved, completing the following and being actively engaged. Do the clinicians in the current HART places take care of patients other than the HART clients? Currently everyone in the facility is a HART client, so that is all they are handling at this point. There are positions that must be available 24 hours a day, and there are clinicians that are required to be available on call. Do a lot of these clients have severe physical disabilities or developmental disabilities? No, most of these are simply adults with a serious mental illness.
10:30 – 10:45	Break	
10:45 – 11:15	PowerPoint Suicide Prevention Update: Idaho Lives Project	Judy Gabert Idaho is always above the average as a state for deaths by suicide. In 2016 we ranked #8 in the nation. In 2016 the national rate was 13.9 whereas Idaho's rate was 20.8. It is important to drive home that suicide is not that common, as the more it becomes "normalized"

		the more people will think it's an option. Idaho sees higher rates of suicide due to multiple factors like ease of access to guns, stigma, and difficulty of accessing treatment. Idaho has been working hard to combat suicide rates and implement prevention tactics. It's important to note that we'll never change people's minds about suicide unless we change people's minds about mental health. Most states do not have an office of Suicide Prevention, and those that do don't have the level of staffing that Idaho does. 74 schools have been trained in sources of strength. Three regional coordinators are coming on board to help schools in the aftermath of a death within a community. This will begin in July. Training focuses on Sources of Strength and teaches kids about healthy activities and where they can find help. It also focuses on normalizing mental health and thinking of it just as another kind of health. Brain research shows that there are multiple 'little' things that can be easily done to help create positivity. Start by being kind to yourself, including self-talk. You speak to yourself at roughly 100 words a minute, and if you can change your own inner dialogue, it'll change the world around you as well. Keep positivity and gratitude at the forefront. There are additional materials available through the Department of Health and Welfare's website: https://healthandwelfare.idaho.gov/Families/SuicidePreventionProgram/tabid/486/Default.aspx More information can be found on the Idaho Lives Project website: www.idaholives.org
11:15 – 12:00	October Meeting Plan and Agenda Discussion	Tammy Rubino Mindy OldenKamp Potential agenda items for October: Discuss the relationship and strategic plans of the Empower Idaho Council and this Planning Council. Regional BHB membership serving on the board – are they voting/attending members, how do they fill the roles, is there anything that prohibits or limits this? Regional board reps should present and provide input on current strengths and weaknesses. Governor's Report, Gaps and Needs analysis, board reporting on successes Ross attend and provide update Revisit Planning Council subcommittees and determine purpose or need. The overall structure of the Planning Council needs to be addressed. Is there still an executive

		committee, or need for a prevention subcommittee? The bylaws should be addressed and revisited to determine actual membership and committee. Perhaps discuss a legislative committee again. Presentation from Empower Idaho and the Behavioral Health Council in existence there. Jason will provide a 15 – 20 minute update from IDJC. Follow up from the IHFA and the homeless coalition information presented at this meeting. YES update (standing agenda item). Kim Hokanson will review the statutes and rules applying to the structure and subcommittees required for the Planning Council. Scheduling – feedback shows that Wednesday/Thursdays work well. Tentative dates: October 17th and 18th
12:00	Dismissal	