UNIFORM APPLICATION
2011

STATE IMPLEMENTATION REPORT
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

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Center for Mental Health Services

Division of State and Community Systems Development
Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

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Please respond by writing an Executive Summary of your current year's application.
Executive Summary (2011 Implementation Report)

The Department of Health and Welfare is designated by statute (Idaho Code Section 39 Chapter 3) as the State Mental Health Authority (SMHA). Most of these responsibilities are carried out by the Department’s Division of Behavioral Health. The Division of Behavioral Health’s Central Office includes Adult Mental Health (AMH), Children’s Mental Health (CMH), Substance Use Disorders (SUD) and a data unit. The Central Office component of the Division of Behavioral Health provides system coordination and leadership, policy and standards development, rule promulgation and interpretation, technical assistance, training, consultation, funding application and regulation, and quality assurance monitoring. A total of seven (7) regions are organized into three service areas or “hubs,” with the DBH management team composed of the hub heads and the unit leads. Idaho’s two (2) state psychiatric hospitals, State Hospital North and State Hospital South, are also under the jurisdiction of the DBH Administrator.

The Idaho Community Mental Health Block Grant Application for SFY 2011 was a one-year plan for both children's and adult mental health services. The statewide mental health system vision and program priorities which guide the Plan were developed by the Idaho State Planning Council on Mental Health and the children's and adult mental health programs. The Idaho State Planning Council on Mental Health 2010 Report to the Governor and State Legislature (July 2010) was an important source of direction for the FFY 2011 Plan. The children's program plan for FFY 2011 continued to focus on transformation to the development of a comprehensive system of care among child-serving agencies. This focus was consistent with the Systems of Care approach to move the entire children's mental health service system toward family-centered, community-based, and interagency collaboration.

The priority service population for adults in SFY 2011 was adults with a serious mental illness who were in crisis and individuals who qualified according to statutory mandates. These included adults referred by a judge under Idaho Code Section 19-2524, which allows a judge to order a substance abuse assessment and/or a mental health examination for certain convicted felons and felony parole violators that appear before the court. Based on the results of an assessment or examination, a judge may order, as a condition of probation, that the defendant undergo treatment consistent with a treatment plan contained in the assessment or examination report. A treatment plan is subject to modification by the court.

A major emphasis of the SFY 2011 mental health plan was system transformation in order to create an outcome driven system of care for persons. Priority areas included maintaining and integrating funding for community mental health services, consumer and family empowerment, accountability, and better integration of treatment for substance use disorders. The SFY 2011 Plan addressed development of information systems and outcomes measures for improved accountability and continuous quality improvement.
II.  SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X Federal FY _____

<table>
<thead>
<tr>
<th>State Expenditures for Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculated FY</td>
</tr>
<tr>
<td>1994</td>
</tr>
<tr>
<td>$538,391</td>
</tr>
</tbody>
</table>

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.
III. MAINTENANCE OF EFFORT (MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State’s Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State’s maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

<table>
<thead>
<tr>
<th>State FY</th>
<th>X</th>
<th>Federal FY</th>
</tr>
</thead>
</table>

State Expenditures for Mental Health Services

<table>
<thead>
<tr>
<th>Actual FY</th>
<th>Actual FY</th>
<th>Actual/Estimate FY</th>
</tr>
</thead>
</table>
MOE Shortfalls
States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions
A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance
If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOE Shortfalls</td>
<td>$23,293,500</td>
<td>$20,430,000</td>
<td>$21,154,300</td>
</tr>
</tbody>
</table>
Adult - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement
Summary of Areas Previously Identified by the State as Needing Improvement

The response to this section reflects the perspective of the Idaho State Planning Council on Mental Health, the Governor’s Behavioral Health Transformation Work Group and the Division of Behavioral Health’s submission for the Combined SAPT/MHBG 2012-2013 Block Grant submission. The SFY 2011 Block Grant Planning Report relied on the Idaho State Planning Council’s Report to the Governor for identification of unmet needs and critical gaps.

Idaho State Planning Council on Mental Health’s Identification of Critical Gaps

The Idaho State Planning Council on Mental Health’s 2011 Report to the Governor and State Legislature: Idaho Mental Health at the Crossroads (June 2011) document identifies critical gaps related to increased suicides, increased use of law enforcement and increased use of hospitals. Recommendations include identification of sustainable funding to support an Idaho Suicide Prevention Hotline; full funding for mental health services and priority on Crisis Intervention Training (CIT) for law enforcement; and adoption of the “...principles of the 10 X 10 SAMHSA Plan to support the need for a full continuum of care for people with mental illness services in their own communities, for both physical and mental health, thereby preventing costly hospitalizations, and supporting the system of recovery.”

Governor’s Behavioral Health Transformation Work Group’s Plan for Transformation

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff’s Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision; “Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery. Goals included the following; 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

The BHTWG’s efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho’s Behavioral Health System (October 28, 2010). This report’s recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council to the State Behavioral Health Council; establish the Behavioral Health Interagency Cooperative to oversee transformation efforts; and adopting the BHTWG’s proposed Array of Core Services “…as the ‘floor’ of services they seek to make...
available in each region; that this array be maintained as the goal for regional planning and capacity building; and that is also be used as a measure by which to indicate progress toward a truly transformed behavioral health system…” The proposed array of core services is outlined in the chart below (p. 16):

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

Governor Otter signed Executive Order 2011-01 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership is at the pleasure of the Governor and includes representation from the Department of Health and Welfare, the Office of Drug Policy, the Department of Correction, the Department of Juvenile Corrections, the State Mental Health Planning Council, Administrator of Idaho Courts, the Superintendent of Public Instruction and one representative of the counties. One purpose is to “d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho’s Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho’s budget, current needs of the agencies, and recommendations of the Idaho Health Care Council.” As of 5/13/11, the IBHIC “to do” list was broken into four phases. Phase 1 included finalizing Phase 1 funding; planning regional behavioral health development boards and state behavioral health planning council (e.g., identifying proposed membership, proposing an implementation timetable, soliciting and reviewing input and drafting legislation to implement regional behavioral health development boards to submit to the 2012 legislature); establishing core services for all regions and drafting 2012 legislation proposals; developing a
transformation work plan, communications protocol and proposed transformation activity funding for SFY 2013; review SUDS treatment services and data report elements and prepare a status report for the Governor. Phase 2 included determining available Phase 2 funding and resources; finalizing core services standards for the transformed behavioral health system; initiating regional transformation efforts, coordinating transformation activities with health care reform activities and preparing a status report for the Governor. Phase 3 included determining available Phase 3 funding and resources; developing a Transformation Implementation Plan that applies to all Cooperative entities; developing regional Transformation Implementation Plans; monitoring and evaluating phase-in and recommending adjustments to State and Regional Transformation Plans; coordinating transformation activities with health care reform activities and preparing a status report for the Governor. Phase 4 included determining available Phase 4 funding and resources; continuing phase-in of transformation, drafting legislation to implement the next phase; coordinating transformation activities with health care reform activities and preparing a status report for the Governor.

Division of Behavioral Health Identified Unmet Service Needs and Critical Gaps

This section reflects the identification of mental health (adults and children) unmet service needs and critical gaps as reported in the Idaho Combined SAPT/MHBG 2012-2013 Block Grant Planning Report. Idaho's behavioral health unmet service needs and critical gaps are based on data from multiple sources. These numbers represent Idaho's best estimate to date of incidence, treated prevalence, and quantitative targets. Data represents our best estimates based on available data and reflects the limitations of our reporting and information systems. In some cases it is not possible to guarantee unduplicated counts. These numbers represent publicly provided and/or funded (including Medicaid) mental health services rendered by the public sector. Some individuals received services from both public mental health system and private sector providers during FY2011. As of July 1, 2011, numbers served for adult mental health and children's mental health were captured in the Division's WITS system.

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

The Web Infrastructure for Treatment Services (WITS) system was implemented 10/1/09 for collection of Adult Mental Health (AMH) data for public services provided through regional mental health center (RMHC) sites. Implemented in SFY 2009, the VistA data infrastructure system is used by State Hospital South (SHS) and State Hospital North (SHN). The Division of Behavioral Health (DBH) has an Interagency
Agreement with the Idaho Division of Vocational Rehabilitation (IDVR), and employment data is also collected from IDVR. The Office of Consumer Affairs (OCFA) provides monthly reports of services for Consumer and Family Advocacy/Education, Peer Specialist Certification and PATH activities provided by PATH peer specialists. Children’s mental health data has historically been collected and reported from the FOCUS system, but DBH is in the process of enhancing the WITS system to allow data collection and report extraction from WITS. Consumer survey information is based on annual and end of service MHSIP and YSS-F survey requests. In an effort to support and crosswalk data from WITS, VistA and SUD data sources, DBH is also working on development of a data warehouse with a target implementation data of SFY 2012. Medicaid data must be requested. Medicaid’s contract with the data management vendor, Molina, began in May 2010. This system handles Medicaid service and billing data.

According to the U.S. Census Bureau data for 2010, Idaho total population estimate was 1,545,801, with an estimate of 1,126,894 aged 18 or older and an estimate of 418,907 under age 18. Based on this data and the SAMHSA/CMHS estimation methodology establishing prevalence for adults at 5.4% for SMI, 2.6% for SPMI, 5% of the estimated SMI population as homeless and 5% for children/adolescents, it may be concluded that there are 60,852 adults in the state of Idaho with serious mental illness, 29,299 adults in the state of Idaho with serious and persistent mental illness, 3,043 adults with SMI who are also homeless and 20,945 children with serious emotional disorder diagnoses.

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

**Suicide:** There is no nationally certified suicide prevention hot line in Idaho. The National Suicide Prevention Lifeline reported 3,700 calls from Idahoans in 2010. The Suicide Prevention Action Network of Idaho (SPAN Idaho) provided a suicide fact sheet in July 2010 based on data from the Idaho Bureau of Vital Records and Health Statistics, the Idaho Department of Health and Welfare, the Centers for Disease Control and Prevention and YRBS Idaho (see attached). According to these statistics, suicide is the 2nd leading cause of death for Idahoans 15-34 and for males 10-14 years of age. The fact sheet reports that in 2009, 307 people completed suicide, with 77% by men, and 58% involving a firearm. Also in 2009, “14.2% of Idaho youth attending traditional high schools reported seriously considering suicide in 2009,” with 6.9% reporting at least one attempt. The State Planning Council on Mental Health identified this as a top June 2011 concern. The Chestnut report of SUD client data from GAIN results for SFY 2010 (January 2011; see attached) indicated that 59% of the sample population
reported co-occurring psychiatric problems, 28% reported major depressive disorder, 22% reported traumatic stress disorder, 61% reported a history of physical, sexual or emotional victimization, and 23% reported homicidal/suicidal thoughts in the past year. The SEOW report for 2010 (see attached, p. 10-11) indicates that “Idaho’s suicide rate (2005) was 45% greater than the national rate.”

**Housing and Homelessness**: Homelessness remains an area of concern in Idaho. The website ([http://www.endhomelessness.org/section/about_homelessness/cost_of_homelessness](http://www.endhomelessness.org/section/about_homelessness/cost_of_homelessness)) for the National Alliance to End Homelessness indicates that Idaho had a 32% increase in homelessness from 2008 to 2009, with an estimated total of 1,939 homeless individuals in 2009. The Idaho Housing and Finance Association’s (IHFA) January 2011 Point in Time count estimates 2,199 homeless individuals statewide. Homeless students in Boise school districts was estimated at 1,717 in the 2009-2010 school year (i.e., Nampa 757; Boise 656; and Meridian 304). In the Coeur d’Alene School District, 248 of the roughly 10,000 total students were identified as homeless in spring 2010. Project Safe Place provides services to teenagers in crisis at 78 locations spread around the greater Coeur d’Alene area. This program’s services include a drop-in center, drug prevention education, crisis intervention and emergency shelter for youth under 18.

Prior to SFY 2011, the Projects for Assistance in Transition from Homelessness (PATH) grant divided PATH funds among seven Regional Mental Health Centers. The Idaho PATH Annual Report for 2009 indicated that, of the estimated (i.e., 5% of estimated SMI) 2,947 adults who were homeless with SMI, there were only 702 PATH clients served with federal, state and other funds (not including federal funds to Idaho Housing and Finance Association or Boise Ada Housing Authority that provide limited assistance to adults with SMI). In SFY 2011, the PATH grant contracted with other providers. The contract with St. Vincent de Paul in Coeur d’Alene was directed to provision of homeless services to adults diagnosed with a serious mental illness in that catchment area. The majority of PATH funds went to a contract with Mountain States Group’s Office of Consumer and Family Affairs (OCAFA) to hire, train and supervise Certified Peer Specialists to provide up to 75% active face to face outreach to homeless adults with SMI. Two PATH Peer Specialists, each working 19 hours per week, were trained and began to provide PATH outreach in April 2011.

The Idaho Home Outreach Program for Empowerment (ID-HOPE) project was funded through a CMHS transformation grant and the evidence based practice of Critical Time Intervention (CTI) began in pilot regions 3 and 4 in March 2011. The ID-HOPE team is composed of a mix of Certified Peer Specialists and bachelors/masters level staff. This team includes specialists in housing and crisis services. In May and June, 2011, PATH and ID-HOPE team members participated in the PATH to Housing phone and webinar technical assistance course offered by the Centers for Social Innovation. Idaho is also in the process of establishing Safe and Sober housing for adolescents in Regions 1, 3 and 4. While there is some concern about funding, initial costs will be covered through the Access to Recovery (ATR) project. Sustainability of these resources is a concern.
The Chestnut study (January 2011) indicated that 39% of the SFY 2010 sample reported environmental stressors related to housing.

While Idaho has homelessness services, safe, decent and affordable Idaho housing resources are more difficult to access and retain for individuals diagnosed with mental health and/or substance use disorders. The Idaho Housing and Finance Association (IHFA) announced in April 2011 that it was no longer accepting applications for Shelter Plus Care, with an anticipated wait of 18 months or more before this resource would again be available. Landlords are often reluctant to rent to individuals with behavioral disorder diagnoses. Adolescent SUD residential facilities and/or transitional living resources have historically included funded from the Division of Behavioral Health and Idaho Division of Juvenile Corrections (DJC). Decreased funding for both programs has made it difficult to support the costs for the number of beds and bed days that are needed.

**Employment:** The Idaho Department of Labor reported an unemployment rate of 9.4% for May 2011, with an estimate of Idaho workers without jobs below 72,000 for the first time in nine months. The June 2011 report described variability in employment among Idaho counties. This report states that “Seventeen primarily rural counties posted double-digit unemployment rates, down from 18 in April. Two major urban counties remained in double-digits.” While jobs are hard to find for the general Idaho populace, they are even harder to find and keep for those with mental health and/or substance use disorder diagnoses.

**Prevention:** Idaho has limited substance use prevention funds and no identified funding for mental health prevention (as of July 2011). Regarding mental health prevention, the Office of Consumer and Family Affairs (OCAFA) provides education on mental health issues, but there are no formal prevention efforts, programs or policies for Adult Mental Health (AMH). While the Children’s Mental Health (CMH) program participates in anti-stigma awareness campaigns and the annual Children’s Mental Health day, there are no ongoing, formal prevention efforts or policies in CMH. Prevention efforts are historically more beneficial and more cost effective than more intense treatment services. In addition to being less stigmatizing, community based services are significantly less expensive than hospitalization, jail or residential options.

**Data Infrastructure:** The Division of Behavioral Health continues to focus on development of a strong data infrastructure system capable of both collecting and extracting required data for local, state and federal reports and producing outcome data to guide resource decisions and best practice. The WITS system was implemented for Adult Mental Health (AMH) in October 2009, with current efforts on developing WITS for Children’s Mental Health (CMH) and Substance Use Disorders (SUD) service needs. Requirements for a data warehouse capable of assisting with the interlinking of behavioral health data with the state hospitals’ VistA and other systems were addressed in SFY 2011, with a planned data warehouse completion in SFY 2012. The WITS system does not link to data systems for Medicaid, courts, criminal justice, primary health, schools, community hospitals or Idaho Vocational Rehabilitation. Specific
requests must be made to access data from these data resources, and their data is not necessarily based on the same data element definitions as that used by the Division of Behavioral Health’s WITS system. As of July 2011, there was no resource that captured co-morbidity data for behavioral health and physical health diagnoses, and this lack of data complicates efforts to accurately assess need.

Access to Care: Additional unmet needs relate to access to care. As of July 1, 2010, the priority population for mental health was adults in crisis and those referred through the court system. Access to behavioral health care for those without criminal charges is difficult in a context of limited funding. Access to primary medical and dental care resources and services can be difficult as well. The rural and frontier nature of Idaho’s geography poses additional challenges with respect to transportation and to attracting and retaining health professionals.

Steven Snow, Executive Director of Idaho’s Council for the Deaf and Hard of Hearing indicates that the deaf and hard of hearing in Idaho don’t have access to services that adequately address deaf and hard of hearing needs. According to Steven, there is only one person in Idaho who signs and provides mental health counseling services. Steven suggests that the lack of access to adequate behavioral health services negatively affects the quality of life for deaf and hard of hearing Idaho citizens. On November 3, 2011, the Council for the Deaf and Hard of Hearing held their first task force meeting to identify needs for mental health, substance use, domestic violence and other issues in SFY 2012.

Idaho is composed primarily of rural and frontier areas, and increased gas prices make it even more difficult for Idaho citizens to keep appointments with service providers that may be up an hour or more away by car. In SFY 2008, there were two major changes in Medicaid. Policy changes expanded eligible locations for service delivery to allow physicians to perform telehealth in any setting in which they are licensed. A benefit was added to allow for family therapy without the client present.

Medicaid cuts in SFY 2011 also impacted access to care for Idaho citizens with mental health diagnoses. In SFY 2011, House Bill 260 reduced State Medicaid spending by $34.6 million, which translated to a total reduction of $100 million with the additional loss of matching federal funds. As of July 2011, Medicaid was pursuing a contract with a managed care organization (MCO) with a target implementation date of 7/1/12 for the administration of mental health benefits. A 1915b waiver will be in place as the funding authority to support the MCO contract. Qualis signed a three year contract renewal with Medicaid in June 2011 to provide case management and utilization management services.

Medicaid is expected to provide the Idaho State legislature with a plan for Medicaid managed care with a focus on high-cost populations in January 2012. The Medicaid managed care plan shall include improved coordination of care through primary care medical homes, improved coordination and case management for high-risk, high-cost disabled adults and children that reduce costs and improve health outcomes and allow for a system that includes independent, standardized, statewide assessment and
evidence-based benefits provided by businesses that meet national accreditation standards. Specific mental health features will include elimination of administrative requirements for a functional and intake assessment and addition of a comprehensive diagnostic assessment addendum; increased criteria for accessing the partial care benefit and restriction to those individuals who have a diagnosis of serious and persistent mental illness; elimination of the requirement for new annual plans; and direction to the Department to develop an effective management tool for psychosocial rehabilitation services.

**Cultural Issues:** Cultural issues are addressed through learning applications on the Department of Health and Welfare’s Knowledge Learning Center (KLC) website, but this does not address specifics related to Native American Tribes or Gay, Lesbian, Transgender and Bisexual populations. The Idaho Minor in Prevention Curriculum includes attention to culture, age and gender. Service information and treatment materials are available in English and Spanish in regional Behavioral Health offices, and other languages can be addressed through translator resources.

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

**Evidence Based Practice for Criminal Justice Involved:** The Division of Behavioral Health’s priority service population is those who are court ordered for treatment. Behavioral health programs strive to provide best practice services, and this could be increased with additional training and implementation of evidence based practices that were specifically designed for criminal justice involved individuals with co-occurring behavioral health diagnoses.

**Recovery and Resilience:** One of the identified BHTWG core services is that of peer support. The BHTWG Plan for the Transformation of Idaho’s Behavioral Health System (October 28, 2010) defines this (p. 35) as “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.” As of July 2011, Certified Peer Specialists were working on teams providing mental health services related to Assertive Community Treatment, Projects for Assistance in Transition from Homelessness (PATH), and Critical Time Intervention (ID-HOPE).

References

Adult - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY
Most Significant Events that Impacted the State Mental Health System in the Previous Fiscal Year

The Idaho mental health service system for children and adults was described in the SFY 2011 Mental Health Block Grant Planning Report and will not be reviewed in this section. Several significant events impacted the Idaho State Mental Health System in SFY 2011 (7/1/10 – 6/30/11). This section will describe significant event highlights related to the efforts of the Governor’s transformation workgroup, organizational and programmatic events, new legislation passed in SFY 2011, Medicaid changes and data activities.

**Governor’s Transformation Workgroup**  Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff’s Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision; “Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery. Goals included the following: 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

The BHTWG’s efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho’s Behavioral Health System (October 28, 2010). This report’s recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council to the State Behavioral Health Council; establishing the Behavioral Health Interagency Cooperative to oversee transformation efforts; and adopting the BHTWG’s proposed Array of Core Services “…as the ‘floor’ of services they seek to make available in each region.” The report recommends, “…that this array be maintained as the goal for regional planning and capacity building; and that is also be used as a measure by which to indicate progress toward a truly transformed behavioral health system…” Core regional services recommended by the BHTWG are 1) Psychiatric Emergency and Crisis Intervention Services, 2) Assessments and Evaluations, 3) Designated Examinations and Dispositions, 4) Inpatient Psychiatric Hospitalization, 5) Medication Management, 6) Case Management Services, 7) ACT, Intensive Case Management, Wraparound Services, 8) Psychotherapy, 9) Intensive Outpatient Services, 10) Drug Screening, 11) Alcohol and Drug Residential Treatment, 12) 24-Hour Out-of-Home Treatment Interventions for Children & Adolescents, 13) Illness Self-Management, 13) Peer Support Services, 14) Prevention Services, 15) Early Intervention Services for Children & Adolescents, 16) Supported Employment, 17) Supported Housing, 18) Transportation, 19) Day Treatment, Partial Care, and 20) Partial Hospitalization

Governor Otter signed Executive Order 2011-01 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. One charge to the IBHIC is to “d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho’s Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho’s budget, current needs of the agencies, and recommendations of the Idaho Health Care Council.”
Organizational and Programmatic Events

Several organizational changes were implemented at the Division of Behavioral Health in SFY 2011. Effective July 1, 2010, the seven (7) Regions were organized into three service areas or “hubs.” The management team for the Division of Behavioral Health (DBH) is composed of the hub heads and the unit leads. The DBH Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). Program Managers in Region 3, Region 4, and Region 5 report to the southwestern hub Administrator. The DBH Administrator at Central Office has oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs.

As of July 1, 2011, the priority adult populations to be served through the public mental health service system was defined as 1) adults who are in crisis, 2) court ordered commitment to the Department (66-329 and 18-211/212), 3) Court ordered evaluation and treatment for offenders sentenced under criminal court (Idaho Code 19-2524), 4) mental health court referred individuals and 5) outpatient services for those who have no insurance or other resources. Regional Mental Health Courts refer individuals to treatment through Assertive Community Treatment (ACT) programs. While regional programs may continue to retain some eligible individuals who have Medicaid and who are unable to be served in the private sector because of challenging needs or behaviors, efforts were made in SFY 2011 to refer all Medicaid eligible individuals to private community resources. The priority children’s populations served through the public mental health system were defined in SFY2011 as 1) children and families in crisis, 2) court ordered evaluation and treatment for juveniles ordered by the court or through Juvenile Mental Health Court (see ID Code 20-511(a), 66-321, 18-211/212, and 3) outpatient services for those who have no other benefits. In SFY 2011, the Division sent representatives to monthly community networking meetings sponsored by the courts for the purpose of exploring the feasibility of creating a veteran’s court. These meetings include representation from the courts, behavioral health treatment providers, the veteran’s administration, law enforcement and other stakeholders. The veteran’s group anticipates implementing a veteran’s court in SFY 2012.

Because Idaho is primarily a rural and frontier state, psychiatric services may be supplemented through telehealth video conferencing to rural and frontier locations. The high definition video conference system is also used for statewide meetings, including meetings of the State Planning Council on Mental Health. In SFY 2011, there was a cost savings for all video conference users (not just the Division of Behavioral Health) of $312,366.00.

Through a contract with the Division of Behavioral Health, the Office of Consumer Affairs took responsibility to develop and implement a Peer Specialist Certification program in Idaho in 2009. This project was funded with Mental Health Block Grant dollars. As of July 2011, there were 83 Peer Specialists who completed the training, and 68 of those Peer Specialists passed the certification exam and are now Certified Peer Specialists. The Office of Consumer Affairs supervises placement of certified Peer Specialists; in each of seven regional Assertive Community Treatment (ACT) teams. Certified Peer Specialists are expected to complete their own Wellness Recovery Action Plans (WRAP) in addition to completing the Peer Specialist Certification training. There are also currently 71 Peer Specialists Trained in WRAP and 16 WRAP Facilitators. There are also 25 Certified Peer Specialists now trained in Peer Support Whole Health. Recovery and resilience are modeled through inclusion of Certified Peer Specialists on regional ACT teams, use of Certified Peer Specialists as outreach providers through the Projects for Assistance in Transition from Homelessness (PATH) program, and use of a mixed bachelors/masters level staff with Certified Peer Specialist staff on the Idaho Home Outreach Program for Empowerment (ID-HOPE) that provides Critical Time Intervention (CTI) services in Regions 3 and 4.
An SFY 2009 federal audit of the Pathways in Transition from Homelessness (PATH) grant provided an opportunity for each region to use feedback to develop an action plan to reflect opportunities for improvement in efforts to provide outreach and prevent homelessness among adults diagnosed with a serious mental illness. While PATH funds were distributed to each of seven regional behavioral health centers in SFY 2010, the SFY 2011 PATH service delivery funds were distributed according to responses to a Request for Proposals (RFP). Results of the RFP process included a subgrant to St. Vincent de Paul for services delivered in northern Idaho, with a special focus on homeless veterans, and a larger subgrant to Mountain States Group. Mountain States Group is a private provider with multiple service programs. The Office of Consumer and Family Affairs (OCAFA) is one of those programs. The majority of PATH funds were directed to OCAFA efforts to hire and supervise two (2) PATH Peer Specialists in each region working 19 hours per week to adults in their region who have a mental health diagnosis and who are literally homeless. This program was implemented in April 2011. Additional PATH funds were allocated equally to each of seven regional Community Mental Health Centers to help with one time rental assistance or security deposits for eligible adults with a serious mental illness who are either homeless or at risk of becoming homeless. In addition to receiving training in evidence based practices related to Supported Housing, Supported Employment and SSI/SSDI Outreach and Recovery (SOAR), PATH Peer Specialists were also trained in Mental Health First Aid in June 2011 through a Center for Social Innovations technical assistance opportunity.

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

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

The Department of Health and Welfare’s Division of Behavioral Health was awarded a Center for Mental Health Services (CMHS) Transformation grant in SFY 2011 (October 2010) to implement the Idaho Home Outreach Program for Empowerment (ID-HOPE) project. This project supports provision of evidence based Critical Time Intervention (CTI) services in pilot Regions 3 and 4, with adaptations that include use of a mixed team of bachelors/masters level and Certified Peer Specialists and the use of 7-14 day intensive intervention services for enrolled ID-HOPE participants in crisis. The ID-HOPE program began accepting referrals in March 2011. As of September 30, 2011, the program had 187 referrals with 101 enrolled ID-HOPE participants.

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

A memorandum between the Division of Behavioral Health’s Children’s Mental Health (CMH) program and Child Welfare describes how services will be coordinated for shared clients. The Department of Health and Welfare’s Service Integration program facilitates family efforts to navigate the range of Department programs and services. This program works with Idaho’s Health Information and Referral Center, or the 211-Idaho CareLine. The CareLine provides referral information (including housing and other resources) through the statewide 211 number. The Bannock Youth Foundation (Pocatello) and Hays Shelter Home (Boise) provide federal grant funded crisis and emergency shelter to runaway and homeless youth; these programs coordinate mental health care needs with CMH. The Division’s CMH program and the Department of Education collaborate with local school districts to implement intensive community and school based programs. Independent Idaho local school districts respond to the Individuals with Disabilities Education Act (IDEA) for eligible children. IDEA services include child find/referral, evaluation/eligibility, individualized education plans (IEP), related services, least restrictive environments, review and re-evaluation, transition requirements and consideration of behavior management needs.

Idaho has implemented many programs and pilots in an effort to better meet the needs of youth in the juvenile justice system. The first example was the creation of the Juvenile Justice/Children’s Mental Health Collaborative Workgroup. (JJCMH) This group includes administrative and direct service personnel. The primary purpose of the group is to resolve obstacles of cooperatively serving youth with an SED that are involved in the juvenile justice system. One project sponsored by the group was the establishment of a Youth Mental Health Court. The court was operating in three counties as of July 2011, and there is statewide interest in expansion. The Youth Mental Health Court has been successful with youth offenders and uses the Wraparound process to facilitate treatment planning and coordination. The Department of Health and Welfare provides one wraparound specialist for this court and training to other agencies, including juvenile probation officers. Another project includes the placement of clinicians in juvenile detention centers to assist with evaluations, referrals to services, crisis counseling and to assist families in accessing community services.

The purpose of the Olmstead Act is to ensure that individuals who no longer need institutional level care are able to move into less restrictive community based settings. As of July 2011, the State of Idaho did not have a formal Olmstead Plan. Over the past three years, Idaho’s allocation of federal Olmstead Grant funding has gone toward supporting the Peer Specialists programs through Mountain States Group. Idaho’s new “Money Follows the Person” Program has similar goals to the Olmstead act with respect to assisting with community placements in lieu of institutions. The program that Idaho is adopting is called the Home Choice Program. This program is federally funded and allows for Transition Managers to help assist adults diagnosed with developmental disabilities or mental illness who no longer need institutional care to transition into the level of community based care that best meet their needs.

**New Legislation Passed in SFY 2011**

**Education**

**S1108** phases out tenure for teachers who have not earned it, replaces it with one or two year contracts and eliminates seniority as a factor in reduction in force decisions. It allows for inclusion of parental feedback as a factor in staff performance evaluations.

**S1110** institutes a pay for performance system and rewards teachers and administrators on a school-wide basis for student achievement as determined by academic growth. Teachers may be rewarded for teaching in hard to fill positions and for taking on leadership roles.
S1208 Youth Challenge Program authorizes the establishment of the National Guard Youth Challenge Program, a multi-phase youth intervention program intended to improve the education, life skills and employment potential of high school dropouts in the state of Idaho. This will be accomplished through military-based discipline and training, combined with educational instruction, experiential learning, and mentoring.

Juvenile Competence and Juvenile Corrections
HO140 Juvenile Competency Law This law establishes standards for the evaluation of a juvenile’s competency. At the present time, any time a juvenile is believed to be incompetent to assist in their defense, the juvenile is evaluated and treated based on Idaho’s adult competency statute, sections 18-210 – 18-212, Idaho Code. Questions of juvenile competency are complicated by issues relating to a youth’s developmental, mental and emotional maturity which are not present in adult cases. Further, the adult statute mandates that the defendant be committed and restoration services be provided in an inpatient facility. Costly restrictive confinement is often unnecessary in the provision of restoration services for juveniles. This legislation maintains the United States Supreme Court’s constitutional standards for determining competency that have been set out for adults but adds factors for the court to consider when applying these constitutional standards to juveniles. Unlike the adult statute, the legislation takes into consideration the unique issues that arise when a juvenile’s alleged incompetency may be the result of a developmental disability and requires that evaluators with specialized expertise perform those evaluations. The legislation also provides greater flexibility in the provision of restoration services for those juveniles determined to be incompetent but restorable allowing for community based restoration services when appropriate which may result in substantial savings as compared with inpatient services.

S1003 Juvenile Corrections Act, Detention This law amends §20-518 to allow juveniles who have been waived to adult court to be placed in the general population of juvenile detention centers rather than be sight and sound separated from other juveniles or from adults in county jail facilities. The Juvenile Corrections Act (JCA) currently prohibits juveniles who have been waived to adult court from being housed in a juvenile detention facility with juveniles adjudicated under the JCA unless those being treated as adults are sight and sound separated. This means that these juveniles, recently as young as 12 or 14 years old, must be housed either segregated from other juveniles in a detention facility or in an adult jail, also with sight and sound isolation. It is in the best interests of these juveniles that they are allowed, at the court’s discretion, to remain with juveniles their own age while awaiting trial, sentencing or other disposition. However, these juveniles may only remain in a juvenile general population if the detention administration determines that the safety and security of the other juveniles is not at risk.

Employment
HO109 amends the Employment Security Law to add an additional temporary total unemployment rate indicator for extended benefits that qualify for one-hundred percent federal funding. For weeks of unemployment beginning on or after January 1, 2011, and ending on December 31, 2011, or the expiration date in section 502 of the tax relief, unemployment insurance reauthorization and job creation act of 2010, P.L. 111-312, as amended, whichever is later, the average rate of seasonally adjusted total unemployment in the state, as determined by the United States secretary of labor, for the three (3) month period referred to in subsection (1)(b)(ii)1. equals or exceeds one hundred ten percent (110%) of such average for any and all of the corresponding three (3) month periods ending in the three (3) preceding calendar years.)

HO122 amends the Employment Security Law to revise the ratios of total base period earnings to the highest quarter earnings. This provision reduces the number of weeks seasonal workers will be able to receive benefits.

Drug/Mental Health Courts
HO225 leaves the prohibition against persons charged with a felony crime of a sex offense from participating in drug court, but allows the admission, in some cases, of persons charged with or convicted
of a crime of violence. Such persons could be admitted to drug court only after consultation with the drug court team and with the consent of the prosecuting attorney. All persons admitted into a drug court would continue to be required to meet the eligibility criteria established by the drug court, which must be consistent with the guidelines established by the Drug Court and Mental Health Court Coordinating Committee. Judges presiding over drug court would continue to exercise their discretion in admission decisions to ensure the safety of staff and of all participants. This measure will enhance the scope and effectiveness of our drug courts, and also facilitate the formation of veterans’ courts, which have been established in more than 20 states and have proven effective in addressing the particular needs and challenges of veterans who come into the criminal justice system.

**HO226** modifies the class of cases in which courts may exercise their discretion to set aside convictions, or reduce felony convictions to misdemeanors. Idaho Code § 19-2604 now permits persons who have been placed on probation to have their convictions set aside if they have at all times complied with the terms of probation, or if they have graduated from a drug court or mental health court and have complied with all the terms of probation during any subsequent period of probation. The court has discretion to grant this relief or not, and the court can set aside the conviction only if it is convinced that such action is compatible with the public interest. Persons who have been placed on retained jurisdiction and later placed on probation may have their felony convictions reduced to misdemeanors if they satisfy these conditions. This bill would remove the requirement that defendants must at all times comply with the terms of probation to be eligible for relief. It would amend the statute to state that a defendant is eligible for relief if the court did not find, and the defendant did not admit, any violation of the terms of probation in a probation violation proceeding. It would also provide courts the option, where a defendant was placed on probation, of reducing the felony conviction to a misdemeanor. The court could grant relief only upon a finding that such action was compatible with the public interest. Providing a chance for such defendants to have their convictions set aside would give them an added incentive to abide by the terms of probation and live law-abiding lives, and would increase their employment and educational opportunities. As provided under the current statute, sex offenders would not be eligible for relief.

**Medicaid Changes**

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

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

Regarding medications, the Department will pay the lesser of the provider's lowest charge to the general public for a drug or the estimated acquisition cost (EAC) plus a dispensing fee. (a) The EAC is defined by
the department as the average acquisition cost (AAC) of the drug, or when no AAC is available, reimbursement will be wholesale acquisition cost (WAC). WAC shall mean the price, paid by a wholesaler for the drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug as published by a recognized compendia of drug pricing on the last day of the calendar quarter that corresponds to the calendar quarter (b) The department shall establish pharmacy dispensing fee payments based on the results of surveys of pharmacies and dispensing rates paid to other payers. The dispensing fee structure will be tiered, with the tiers based on the annual Medicaid claims volume of the enrolled Idaho retail pharmacy. All other pharmacy dispensing fees will be the lowest dispensing fee for the tiered structure. (3) The AAC will be established by the department will utilize periodic by state cost or national surveys to obtain the most accurate pharmacy drug acquisition costs in establishing the pharmacy reimbursement fee schedule for the product. When surveys are requested by the department to Pharmacies participating in the Idaho Medicaid program, they are required to participate in these periodic state cost surveys by disclosing the costs of all drugs net of any special discounts or allowances. Participating pharmacies that refuse to respond to the periodic state surveys will be dis-enrolled as a Medicaid provider.

Medicaid is expected to provide the Idaho State legislature with a plan for Medicaid managed care with a focus on high-cost populations in January 2012. The Medicaid managed care plan shall include improved coordination of care through primary care medical homes, improved coordination and case management for high-risk, high-cost disabled adults and children that reduce costs and improve health outcomes and allow for a system that includes independent, standardized, statewide assessment and evidence-based benefits provided by businesses that meet national accreditation standards. Specific mental health features will include elimination of administrative requirements for a functional and intake assessment and addition of a comprehensive diagnostic assessment addendum; increased criteria for accessing the partial care benefit and restriction to those individuals who have a diagnosis of serious and persistent mental illness; elimination of the requirement for new annual plans; and direction to the Department to develop an effective management tool for psychosocial rehabilitation services.

Data Events
The Division of Behavioral Health’s Adult Mental Health (AMH), Children’s Mental Health (CMH), and Substance Use Disorders (SUD) programs provide information on publicly funded AMH, CMH and SUD services. The AMH program is using WITS for data collection needs. The CMH program is transitioning from use of FOCUS to use of WITS. The State Hospital systems (i.e., State Hospital North (SHN) and State Hospital South (SHS)) provide data on Idaho citizens psychiatrically hospitalized at SHN and SHS using the VistA system. Data on Division of Behavioral Health trainings and SUD prevention is tracked through EXCEL spreadsheets through the Division’s Central Office location.

The Division of Behavioral Health contracts with vendor FEI to develop, train, implement and host the WITS system. The WITS system is capable of tracking service provider locations and other characteristics. This system has been implemented for Adult Mental Health (AMH) services; data element definitions for the National Outcome Measures were built in WITS using the Client Level Reporting Project data element definitions. The Division of Behavioral Health and FEI are in the process of building data elements to collect and report on required data for SUD and for Children’s Mental Health (CMH) program services. The two state hospitals, State Hospital North (SHN) and State Hospital South (SHS) use the VistA data infrastructure system. The Division of Behavioral Health is working on a data warehouse that will allow client data from the VistA system to be crosswalked to the WITS system so that client services can be tracked.

For Division of Behavioral Health purposes, reports are built to look at the identifier and other unidentifiable information. The WITS system does have the ability to aggregate services rendered to the client. As of June 30, 2011, the AMH and CMH programs were able to capture client level data, including
client demographics, characteristics, enrollments (admission/discharge), assessments, & non-Medicaid services (type, provider, duration, amount) through the WITS system. Credible report extraction remained a challenge for these programs and the WITS system did not interlink to the hospitals’ VistA data system. Medicaid client level encounter/claims service and provider data were not available for CMH in July 2011. Non-billed service data is anticipated to be available one year after CMH implemented WITS (July 1, 2011).

As of July 2011, provider and client identifiers in the WITS, VistA and BPA systems did not allow for linkage with Medicaid provider identifiers. Client identification numbers through WITS are generated based on name and birth date. While the WITS system does attempt to capture a consumer’s Medicaid number, this is not required or always known when a client profile is created or updated. The Division of Behavioral Health is working on a data warehouse in an effort to allow linkage to other systems. As of July 2011, WITS was not linked with Medicaid behavioral health data. The WITS system does capture the client's insurance type. If the client is identified in WITS as having Medicaid, some reports could be extracted (e.g., service utilization).

Idaho received a section 3013 grant for development of a health information exchange under the HITECH Act; the Idaho Health Data Exchange (IHDE) is the state designated entity for recipient of the grant funding. IHDE is a statewide health information organization and has been operational as an HIE since 2009. IHDE includes a clinical data repository. Clinical staff at State Hospital North and State Hospital South can access the repository for clinical information, such as lab results, for patients they are treating. Mental health and substance abuse data are not currently included in the exchange. IHDE’s Security and Privacy Committee is reviewing the SAMHSA FAQs related to substance abuse confidentiality and health information exchange to determine IHDE’s next steps in this regard. IHDE, at the invitation of the behavioral health bureau chief, sent a staff member to the SAMHSA-Sponsored 2011 Health Information Technology Regional Forum to learn more about the issues and opportunities in this area.

The Idaho Adult Mental Health system uses the Mental Health Statistics Improvement Program (MHSIP) consumer satisfaction survey and the Children’s Mental Health system uses the Youth Services Survey for Families (YSS-F) to measure child and family satisfaction with mental health service provision. Idaho’s surveys are sent annually in July and at the time of case closures. Survey result data were data entered into the federal site until that site closed in May 2011. After federal site closure, survey results were data entered into an Idaho survey monkey site. Block grant goals for the 2012-2013 plan include establishment of kiosks at regional behavioral health sites that will allow individuals to directly respond to survey questions. This will reduce or eliminate the need for Central Office data entry and will allow respondents to be independent in this effort.

Idaho was awarded a Transformation Transfer Initiative (TTI) grant in SFY 2011 to build a data warehouse to allow improved data extraction and interlinking to the VistA system used by the state psychiatric hospitals. As of October 2011, the Behavioral Health Division data warehouse had all the elements present, but the Information and Technology (IT) Division was still forming linkages to the WITS data dictionary and data extraction of meaningful reports was not yet possible. Plans are to complete these efforts in SFY 2012.
Adult - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.
**Mental Health Block Grant Expenditure - Adults**

<table>
<thead>
<tr>
<th>Adult Mental Health</th>
<th>SFY 2011 Planned Block Grant Budget</th>
<th>Federal SFY 2011 Expenditures to Date - (As of 11/23/2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer/Family Empowerment</td>
<td>$1,205,898</td>
<td>$1,161,857</td>
</tr>
<tr>
<td>1) Consumer/Family Empowerment &amp; Peer Specialists</td>
<td>$153,000</td>
<td>$244,483</td>
</tr>
<tr>
<td>2) Quality Improvement System Development</td>
<td>$25,000</td>
<td>$0</td>
</tr>
<tr>
<td>State Planning Council</td>
<td>$20,000</td>
<td>$16,666</td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Total Adult Services SFY 2011</strong></td>
<td>$1,413,898</td>
<td>$1,433,006</td>
</tr>
</tbody>
</table>

**Children’s Mental Health**

<table>
<thead>
<tr>
<th>CMH Special Projects Contracts:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>- Family Run Organization</td>
<td>$269,267</td>
</tr>
<tr>
<td>- Suicide Prevention Services</td>
<td>$22,854</td>
</tr>
<tr>
<td>- Primary Care Phys Training</td>
<td>$13,125</td>
</tr>
<tr>
<td><strong>Total Children’s Services SFY 2011</strong></td>
<td>$312,121</td>
</tr>
</tbody>
</table>

Administration at 5% | $90,843 | $90,843 |

**Totals; Adult Services, Children’s Services, Administration** | $1,816,862 | $1,787,895 |

The above information shows Idaho’s Planned CMHS Block Grant Expenditures as outlined in the SFY 2011 Planning Report and the Actual SFY 2011 Expenditures as of 11/23/11. All block grant funds pertaining to adult and children’s mental health obtained through SAMHSA and in accordance with PL 102-321 were expended for community based programming.

The Adult Mental Health portion of the Block Grant funds are dedicated to support the State Planning Council on Mental Health ($20,000 planned; $16,666 expended), to support suicide prevention through a contract with Suicide Prevention of Idaho (SPAN-Idaho; $10,000 planned and expended), to fund a contract with Mountain States Group ($153,000 planned; $244,483 expended) to support the Office of Consumer Affairs’ efforts to provide advocacy and education to consumers and family members and to develop and oversee a Peer Specialist Training, Certification, Placement and Supervision program. In SFY 2011, additional funds were directed to supporting the Peer Specialist Certification program, consumer and family outreach and oversight of Certified Peer Specialist training and placements at regional offices providing ACT and PATH services. Although $25,000 was planned to support Quality...
Improvement efforts, there were no block grant funds expended on this in SFY 2011. The remaining $1,161,857 in Federal Adult Mental Health CMHBG funds were placed in the Department of Health and Welfare’s Mental Health Cost Pool and allocated to the seven regional CMHC budgets to fund various community mental health program categories by the use of a Random Moment Time Study. The total Adult Mental Health block grant expenditures as of 11/23/11 was $1,433,006.
Manner in which the State intends to expend the block grant for SFY 2011:

<table>
<thead>
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<td><strong>Totals; Adult Services, Children’s Services, Administration</strong></td>
<td><strong>$ 1,816,862</strong></td>
</tr>
</tbody>
</table>

It is expressly understood, as required by Public Law 102-321, that no Federal CMHBG funds are used for inpatient services. The following projects will be specifically funded with Federal Community Mental Health Block Grant (CMHBG) funds in FY2011:

$153,000 will be used to fund the contract with the Office of Consumer Affairs (through Mountain States Group) for Peer Specialist Training, Certification and supervision at regional ACT work sites. It will also include provision of advocacy and education to consumers and family members throughout Idaho.

$20,000 will be used to support the meetings and activities of the Idaho State Planning Council on Mental Health.

$10,000 will be used to contribute to funding a contact for suicide prevention.

$25,000 will be dedicated to provide funding for implementation of a quality improvement system to ensure best practice service delivery in all adult and children’s mental health services programs.

$1,205,898 in Federal CMHBG funds are placed in the Department of Health and Welfare’s Mental Health Cost Pool and allocated to the seven regional CMHC budgets to fund various community mental health program categories by the use of a Random Moment Time Study.
Child - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement
Summary of Areas Previously Identified by the State as Needing Improvement

The response to this section reflects the perspective of the Idaho State Planning Council on Mental Health, the Governor’s Behavioral Health Transformation Work Group and the Division of Behavioral Health’s submission for the Combined SAPT/MHBG 2012-2013 Block Grant submission. The SFY 2011 Block Grant Planning Report relied on the Idaho State Planning Council’s Report to the Governor for identification of unmet needs and critical gaps.

Idaho State Planning Council on Mental Health’s Identification of Critical Gaps

The Idaho State Planning Council on Mental Health’s 2011 Report to the Governor and State Legislature: Idaho Mental Health at the Crossroads (June 2011) document identifies critical gaps related to increased suicides, increased use of law enforcement and increased use of hospitals. Recommendations include identification of sustainable funding to support an Idaho Suicide Prevention Hotline; full funding for mental health services and priority on Crisis Intervention Training (CIT) for law enforcement; and adoption of the “...principles of the 10 X 10 SAMHSA Plan to support the need for a full continuum of care for people with mental illness services in their own communities, for both physical and mental health, thereby preventing costly hospitalizations, and supporting the system of recovery.”

Governor’s Behavioral Health Transformation Work Group’s Plan for Transformation

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff’s Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision; “Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery. Goals included the following; 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

The BHTWG’s efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho’s Behavioral Health System (October 28, 2010). This report’s recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council to the State Behavioral Health Council; establish the Behavioral Health Interagency Cooperative to oversee transformation efforts; and adopting the BHTWG’s proposed Array of Core Services “...as the ‘floor’ of services they seek to make
available in each region; that this array be maintained as the goal for regional planning and capacity building; and that is also be used as a measure by which to indicate progress toward a truly transformed behavioral health system…” The proposed array of core services is outlined in the chart below (p. 16):

Governor Otter signed Executive Order 2011-01 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership is at the pleasure of the Governor and includes representation from the Department of Health and Welfare, the Office of Drug Policy, the Department of Correction, the Department of Juvenile Corrections, the State Mental Health Planning Council, Administrator of Idaho Courts, the Superintendent of Public Instruction and one representative of the counties. One purpose is to “d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho’s Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho’s budget, current needs of the agencies, and recommendations of the Idaho Health Care Council.” As of 5/13/11, the IBHIC “to do” list was broken into four phases. Phase 1 included finalizing Phase 1 funding; planning regional behavioral health development boards and state behavioral health planning council (e.g., identifying proposed membership, proposing an implementation timetable, soliciting and reviewing input and drafting legislation to implement regional behavioral health development boards to submit to the 2012 legislature); establishing core services for all regions and drafting 2012 legislation proposals; developing a
transformation work plan, communications protocol and proposed transformation activity funding for SFY 2013; review SUDS treatment services and data report elements and prepare a status report for the Governor. Phase 2 included determining available Phase 2 funding and resources; finalizing core services standards for the transformed behavioral health system; initiating regional transformation efforts, coordinating transformation activities with health care reform activities and preparing a status report for the Governor. Phase 3 included determining available Phase 3 funding and resources; developing a Transformation Implementation Plan that applies to all Cooperative entities; developing regional Transformation Implementation Plans; monitoring and evaluating phase-in and recommending adjustments to State and Regional Transformation Plans; coordinating transformation activities with health care reform activities and preparing a status report for the Governor. Phase 4 included determining available Phase 4 funding and resources; continuing phase-in of transformation, drafting legislation to implement the next phase; coordinating transformation activities with health care reform activities and preparing a status report for the Governor.

Division of Behavioral Health Identified Unmet Service Needs and Critical Gaps

This section reflects the identification of mental health (adults and children) unmet service needs and critical gaps as reported in the Idaho Combined SAPT/MHBG 2012-2013 Block Grant Planning Report. Idaho’s behavioral health unmet service needs and critical gaps are based on data from multiple sources. These numbers represent Idaho’s best estimate to date of incidence, treated prevalence, and quantitative targets. Data represents our best estimates based on available data and reflects the limitations of our reporting and information systems. In some cases it is not possible to guarantee unduplicated counts. These numbers represent publicly provided and/or funded (including Medicaid) mental health services rendered by the public sector. Some individuals received services from both public mental health system and private sector providers during FY2011. As of July 1, 2011, numbers served for adult mental health and children's mental health were captured in the Division’s WITS system.

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

The Web Infrastructure for Treatment Services (WITS) system was implemented 10/1/09 for collection of Adult Mental Health (AMH) data for public services provided through regional mental health center (RMHC) sites. Implemented in SFY 2009, the VistA data infrastructure system is used by State Hospital South (SHS) and State Hospital North (SHN). The Division of Behavioral Health (DBH) has an Interagency
Agreement with the Idaho Division of Vocational Rehabilitation (IDVR), and employment data is also collected from IDVR. The Office of Consumer Affairs (OCFA) provides monthly reports of services for Consumer and Family Advocacy/Education, Peer Specialist Certification and PATH activities provided by PATH peer specialists. Children’s mental health data has historically been collected and reported from the FOCUS system, but DBH is in the process of enhancing the WITS system to allow data collection and report extraction from WITS. Consumer survey information is based on annual and end of service MHSIP and YSS-F survey requests. In an effort to support and crosswalk data from WITS, VistA and SUD data sources, DBH is also working on development of a data warehouse with a target implementation data of SFY 2012. Medicaid data must be requested. Medicaid’s contract with the data management vendor, Molina, began in May 2010. This system handles Medicaid service and billing data.

According to the U.S. Census Bureau data for 2010, Idaho total population estimate was 1,545,801, with an estimate of 1,126,894 aged 18 or older and an estimate of 418,907 under age 18. Based on this data and the SAMHSA/CMHS estimation methodology establishing prevalence for adults at 5.4% for SMI, 2.6% for SPMI, 5% of the estimated SMI population as homeless and 5% for children/adolescents, it may be concluded that there are 60,852 adults in the state of Idaho with serious mental illness, 29,299 adults in the state of Idaho with serious and persistent mental illness, 3,043 adults with SMI who are also homeless and 20,945 children with serious emotional disorder diagnoses.

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

**Suicide:** There is no nationally certified suicide prevention hot line in Idaho. The National Suicide Prevention Lifeline reported 3,700 calls from Idahoans in 2010. The Suicide Prevention Action Network of Idaho (SPAN Idaho) provided a suicide fact sheet in July 2010 based on data from the Idaho Bureau of Vital Records and Health Statistics, the Idaho Department of Health and Welfare, the Centers for Disease Control and Prevention and YRBS Idaho (see attached). According to these statistics, suicide is the 2nd leading cause of death for Idahoans 15-34 and for males 10-14 years of age. The fact sheet reports that in 2009, 307 people completed suicide, with 77% by men, and 58% involving a firearm. Also in 2009, “14.2% of Idaho youth attending traditional high schools reported seriously considering suicide in 2009,” with 6.9% reporting at least one attempt. The State Planning Council on Mental Health identified this as a top June 2011 concern. The Chestnut report of SUD client data from GAIN results for SFY 2010 (January 2011; see attached) indicated that 59% of the sample population
reported co-occurring psychiatric problems, 28% reported major depressive disorder, 22% reported traumatic stress disorder, 61% reported a history of physical, sexual or emotional victimization, and 23% reported homicidal/suicidal thoughts in the past year. The SEOW report for 2010 (see attached, p. 10-11) indicates that “Idaho’s suicide rate (2005) was 45% greater than the national rate.”

**Housing and Homelessness:** Homelessness remains an area of concern in Idaho. The website [http://www.endhomelessness.org/section/about_homelessness/cost_of_homelessness](http://www.endhomelessness.org/section/about_homelessness/cost_of_homelessness) for the National Alliance to End Homelessness indicates that Idaho had a 32% increase in homelessness from 2008 to 2009, with an estimated total of 1,939 homeless individuals in 2009. The Idaho Housing and Finance Association’s (IHFA) January 2011 Point in Time count estimates 2,199 homeless individuals statewide. Homeless students in Boise school districts was estimated at 1,717 in the 2009-2010 school year (i.e., Nampa 757; Boise 656; and Meridian 304). In the Coeur d’Alene School District, 248 of the roughly 10,000 total students were identified as homeless in spring 2010. Project Safe Place provides services to teenagers in crisis at 78 locations spread around the greater Coeur d’Alene area. This program’s services include a drop-in center, drug prevention education, crisis intervention and emergency shelter for youth under 18.

Prior to SFY 2011, the Projects for Assistance in Transition from Homelessness (PATH) grant divided PATH funds among seven Regional Mental Health Centers. The Idaho PATH Annual Report for 2009 indicated that, of the estimated (i.e., 5% of estimated SMI) 2,947 adults who were homeless with SMI, there were only 702 PATH clients served with federal, state and other funds (not including federal funds to Idaho Housing and Finance Association or Boise Ada Housing Authority that provide limited assistance to adults with SMI). In SFY 2011, the PATH grant contracted with other providers. The contract with St. Vincent de Paul in Coeur d’Alene was directed to provision of homeless services to adults diagnosed with a serious mental illness in that catchment area. The majority of PATH funds went to a contract with Mountain States Group’s Office of Consumer and Family Affairs (OCAFA) to hire, train and supervise Certified Peer Specialists to provide up to 75% active face to face outreach to homeless adults with SMI. Two PATH Peer Specialists, each working 19 hours per week, were trained and began to provide PATH outreach in April 2011.

The Idaho Home Outreach Program for Empowerment (ID-HOPE) project was funded through a CMHS transformation grant and the evidence based practice of Critical Time Intervention (CTI) began in pilot regions 3 and 4 in March 2011. The ID-HOPE team is composed of a mix of Certified Peer Specialists and bachelors/masters level staff. This team includes specialists in housing and crisis services. In May and June, 2011, PATH and ID-HOPE team members participated in the PATH to Housing phone and webinar technical assistance course offered by the Centers for Social Innovation. Idaho is also in the process of establishing Safe and Sober housing for adolescents in Regions 1, 3 and 4. While there is some concern about funding, initial costs will be covered through the Access to Recovery (ATR) project. Sustainability of these resources is a concern.
The Chestnut study (January 2011) indicated that 39% of the SFY 2010 sample reported environmental stressors related to housing.

While Idaho has homelessness services, safe, decent and affordable Idaho housing resources are more difficult to access and retain for individuals diagnosed with mental health and/or substance use disorders. The Idaho Housing and Finance Association (IHFA) announced in April 2011 that it was no longer accepting applications for Shelter Plus Care, with an anticipated wait of 18 months or more before this resource would again be available. Landlords are often reluctant to rent to individuals with behavioral disorder diagnoses. Adolescent SUD residential facilities and/or transitional living resources have historically included funded from the Division of Behavioral Health and Idaho Division of Juvenile Corrections (DJC). Decreased funding for both programs has made it difficult to support the costs for the number of beds and bed days that are needed.

**Employment:** The Idaho Department of Labor reported an unemployment rate of 9.4% for May 2011, with an estimate of Idaho workers without jobs below 72,000 for the first time in nine months. The June 2011 report described variability in employment among Idaho counties. This report states that “Seventeen primarily rural counties posted double-digit unemployment rates, down from 18 in April. Two major urban counties remained in double-digits.” While jobs are hard to find for the general Idaho populace, they are even harder to find and keep for those with mental health and/or substance use disorder diagnoses.

**Prevention:** Idaho has limited substance use prevention funds and no identified funding for mental health prevention (as of July 2011). Regarding mental health prevention, the Office of Consumer and Family Affairs (OCAFA) provides education on mental health issues, but there are no formal prevention efforts, programs or policies for Adult Mental Health (AMH). While the Children’s Mental Health (CMH) program participates in anti-stigma awareness campaigns and the annual Children’s Mental Health day, there are no ongoing, formal prevention efforts or policies in CMH. Prevention efforts are historically more beneficial and more cost effective than more intense treatment services. In addition to being less stigmatizing, community based services are significantly less expensive than hospitalization, jail or residential options.

**Data Infrastructure:** The Division of Behavioral Health continues to focus on development of a strong data infrastructure system capable of both collecting and extracting required data for local, state and federal reports and producing outcome data to guide resource decisions and best practice. The WITS system was implemented for Adult Mental Health (AMH) in October 2009, with current efforts on developing WITS for Children’s Mental Health (CMH) and Substance Use Disorders (SUD) service needs. Requirements for a data warehouse capable of assisting with the interlinking of behavioral health data with the state hospitals’ VistA and other systems were addressed in SFY 2011, with a planned data warehouse completion in SFY 2012. The WITS system does not link to data systems for Medicaid, courts, criminal justice, primary health, schools, community hospitals or Idaho Vocational Rehabilitation. Specific
requests must be made to access data from these data resources, and their data is not necessarily based on the same data element definitions as that used by the Division of Behavioral Health’s WITS system. As of July 2011, there was no resource that captured co-morbidity data for behavioral health and physical health diagnoses, and this lack of data complicates efforts to accurately assess need.

**Access to Care:** Additional unmet needs relate to access to care. As of July 1, 2010, the priority population for mental health was adults in crisis and those referred through the court system. Access to behavioral health care for those without criminal charges is difficult in a context of limited funding. Access to primary medical and dental care resources and services can be difficult as well. The rural and frontier nature of Idaho’s geography poses additional challenges with respect to transportation and to attracting and retaining health professionals.

Steven Snow, Executive Director of Idaho’s Council for the Deaf and Hard of Hearing indicates that the deaf and hard of hearing in Idaho don’t have access to services that adequately address deaf and hard of hearing needs. According to Steven, there is only one person in Idaho who signs and provides mental health counseling services. Steven suggests that the lack of access to adequate behavioral health services negatively affects the quality of life for deaf and hard of hearing Idaho citizens. The Council for the Deaf and Hard of Hearing has plans to implement a task force to identify needs for mental health, substance use, domestic violence and other issues in SFY 2012.

Idaho is composed primarily of rural and frontier areas, and increased gas prices make it even more difficult for Idaho citizens to keep appointments with service providers that may be up to an hour away by car. In SFY 2008, there were two major changes in Medicaid. Policy changes expanded eligible locations for service delivery to allow physicians to perform telehealth in any setting in which they are licensed. A benefit was added to allow for family therapy without the client present.

**Cultural Issues:** Cultural issues are addressed through learning applications on the Department of Health and Welfare’s Knowledge Learning Center (KLC) website, but this does not address specifics related to Native American Tribes or Gay, Lesbian, Transgender and Bisexual populations. The Idaho Minor in Prevention Curriculum includes attention to culture, age and gender. Service information and treatment materials are available in English and Spanish in regional Behavioral Health offices, and other languages can be addressed through translator resources.

**Transitional Aged Youth:** Transitional aged youth diagnosed with a serious emotional disorder who are served through the Children’s Mental Health system (up to age 18) sometimes continue to require mental health services to ensure stability for recovery and resilience. Idaho’s Children’s Mental Health system requirements are different than the Adult Mental Health system requirements, and the transition from one system to another is sometimes challenging.
**Evidence Based Practice for Criminal Justice Involved:** The Division of Behavioral Health’s priority service population is those who are court ordered for treatment. Behavioral health programs strive to provide best practice services, and this could be increased with additional training and implementation of evidence based practices that were specifically designed for criminal justice involved individuals with co-occurring behavioral health diagnoses.

**Recovery and Resilience:** One of the identified BHTWG core services is that of peer support. The BHTWG Plan for the Transformation of Idaho's Behavioral Health System (October 28, 2010) defines this (p. 35) as “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.” As of July 2011, Certified Peer Specialists were working on teams providing mental health services related to Assertive Community Treatment, Projects for Assistance in Transition from Homelessness (PATH), and Critical Time Intervention (ID-HOPE).

References

Child - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY
Most Significant Events that Impacted the State Mental Health System in the Previous Fiscal Year

The Idaho mental health service system for children and adults was described in the SFY 2011 Mental Health Block Grant Planning Report and will not be reviewed in this section. Several significant events impacted the Idaho State Mental Health System in SFY 2011 (7/1/10 – 6/30/11). This section will describe significant event highlights related to the efforts of the Governor’s transformation workgroup, organizational and programmatic events, new legislation passed in SFY 2011, Medicaid changes and data activities.

**Governor’s Transformation Workgroup.** Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff’s Office, the Department of Education, a private provider, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision; “Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery. Goals included the following: 1) Increase availability of and access to quality services, 2) Establish an infrastructure with clear responsibilities and actions, 3) Create a viable regional and/or local community delivery system, 4) Efficiently use existing and future resources, 5) Increase accountability for services and funding, and 6) Seek and include input from stakeholders and consumers.

The BHTWG’s efforts resulted in the report entitled, Behavioral Health Transformation Work Group: A Plan for the Transformation of Idaho’s Behavioral Health System (October 28, 2010). This report’s recommendations included replacing Regional Mental Health Advisory Boards and Regional Advisory Councils with Regional Behavioral Health Community Development Boards; replacing the State Mental Health Planning Council to the State Behavioral Health Council; establishing the Behavioral Health Interagency Cooperative to oversee transformation efforts; and adopting the BHTWG’s proposed Array of Core Services “…as the ‘floor’ of services they seek to make available in each region.” The report recommends, “…that this array be maintained as the goal for regional planning and capacity building; and that is also be used as a measure by which to indicate progress toward a truly transformed behavioral health system…” Core regional services recommended by the BHTWG are 1) Psychiatric Emergency and Crisis Intervention Services, 2) Assessments and Evaluations, 3) Designated Examinations and Dispositions, 4) Inpatient Psychiatric Hospitalization, 5) Medication Management, 6) Case Management Services, 7) ACT, Intensive Case Management, Wraparound Services, 8) Psychotherapy, 9) Intensive Outpatient Services, 10) Drug Screening, 11) Alcohol and Drug Residential Treatment, 12) 24-Hour Out-of-Home Treatment Interventions for Children & Adolescents, 13) Illness Self-Management, 13) Peer Support Services, 14) Prevention Services, 15) Early Intervention Services for Children & Adolescents, 16) Supported Employment, 17) Supported Housing, 18) Transportation, 19) Day Treatment, Partial Care, and 20) Partial Hospitalization.

Governor Otter signed Executive Order 2011-01 on January 27, 2011, establishing the Idaho Behavioral Health Interagency Cooperative (IBHIC). Membership, at the pleasure of the Governor, includes representation from the 1) Department of Health and Welfare, 2) Office of Drug Policy, 3) Department of Correction, 4) Department of Juvenile Corrections, 5) State Mental Health Planning Council, 6) Administrator of Idaho Courts, 7) Superintendent of Public Instruction and 8) counties. One charge to the IBHIC is to “d. Facilitate transformation efforts as described in the BHTWG Plan for transformation of Idaho’s Behavioral Health System (October 2010), with consideration for fiscal restrictions in Idaho’s budget, current needs of the agencies, and recommendations of the Idaho Health Care Council.”

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Organizational and Programmatic Events  Several organizational changes were implemented at the Division of Behavioral Health in SFY 2011. Effective July 1, 2010, the seven (7) Regions were organized into three service areas or “hubs.” The management team for the Division of Behavioral Health (DBH) is composed of the hub heads and the unit leads. The DBH Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). Program Managers in Region 3, Region 4, and Region 5 report to the southwestern hub Administrator. The DBH Administrator at Central Office has oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs.

As of July 1, 2011, the priority adult populations to be served through the public mental health service system was defined as 1) adults who are in crisis, 2) court ordered commitment to the Department (66-329 and 18-211/212), 3) Court ordered evaluation and treatment for offenders sentenced under criminal court (Idaho Code 19-2524), 4) mental health court referred individuals and 5) outpatient services for those who have no insurance or other resources. Regional Mental Health Courts refer individuals to treatment through Assertive Community Treatment (ACT) programs. While regional programs may continue to retain some eligible individuals who have Medicaid and who are unable to be served in the private sector because of challenging needs or behaviors, efforts were made in SFY 2011 to refer all Medicaid eligible individuals to private community resources. The priority children’s populations served through the public mental health system were defined in SFY2011 as 1) children and families in crisis, 2) court ordered evaluation and treatment for juveniles ordered by the court or through Juvenile Mental Health Court (see ID Code 20-511(a), 66-321, 18-211/212, and 3) outpatient services for those who have no other benefits. In SFY 2011, the Division sent representatives to monthly community networking meetings sponsored by the courts for the purpose of exploring the feasibility of creating a veteran’s court. These meetings include representation from the courts, behavioral health treatment providers, the veteran’s administration, law enforcement and other stakeholders. The veteran’s group anticipates implementing a veteran’s court in SFY 2012.

Because Idaho is primarily a rural and frontier state, psychiatric services may be supplemented through telehealth video conferencing to rural and frontier locations. The high definition video conference system is also used for statewide meetings, including meetings of the State Planning Council on Mental Health. In SFY 2011, there was a cost savings for all video conference users (not just the Division of Behavioral Health) of $312,366.00.

Through a contract with the Division of Behavioral Health, the Office of Consumer Affairs took responsibility to develop and implement a Peer Specialist Certification program in Idaho in 2009. This project was funded with Mental Health Block Grant dollars. As of July 2011, there were 83 Peer Specialists who completed the training, and 68 of those Peer Specialists passed the certification exam and are now Certified Peer Specialists. The Office of Consumer Affairs supervises placement of certified Peer Specialists; in each of seven regional Assertive Community Treatment (ACT) teams. Certified Peer Specialists are expected to complete their own Wellness Recovery Action Plans (WRAP) in addition to completing the Peer Specialist Certification training. There are also currently 71 Peer Specialists Trained in WRAP and 16 WRAP Facilitators. There are also 25 Certified Peer Specialists now trained in Peer Support Whole Health. Recovery and resilience are modeled through inclusion of Certified Peer Specialists on regional ACT teams, use of Certified Peer Specialists as outreach providers through the Projects for Assistance in Transition from Homelessness (PATH) program, and use of a mixed bachelors/masters level staff with Certified Peer Specialist staff on the Idaho Home Outreach Program for Empowerment (ID-HOPE) that provides Critical Time Intervention (CTI) services in Regions 3 and 4.
An SFY 2009 federal audit of the Pathways in Transition from Homelessness (PATH) grant provided an opportunity for each region to use feedback to develop an action plan to reflect opportunities for improvement in efforts to provide outreach and prevent homelessness among adults diagnosed with a serious mental illness. While PATH funds were distributed to each of seven regional behavioral health centers in SFY 2010, the SFY 2011 PATH service delivery funds were distributed according to responses to a Request for Proposals (RFP). Results of the RFP process included a subgrant to St. Vincent de Paul for services delivered in northern Idaho, with a special focus on homeless veterans, and a larger subgrant to Mountain States Group. Mountain States Group is a private provider with multiple service programs. The Office of Consumer and Family Affairs (OCAFA) is one of those programs. The majority of PATH funds were directed to OCAFA efforts to hire and supervise two (2) PATH Peer Specialists in each region working 19 hours per week to adults in their region who have a mental health diagnosis and who are literally homeless. This program was implemented in April 2011. Additional PATH funds were allocated equally to each of seven regional Community Mental Health Centers to help with one time rental assistance or security deposits for eligible adults with a serious mental illness who are either homeless or at risk of becoming homeless. In addition to receiving training in evidence based practices related to Supported Housing, Supported Employment and SSI/SSDI Outreach and Recovery (SOAR), PATH Peer Specialists were also trained in Mental Health First Aid in June 2011 through a Center for Social Innovations technical assistance opportunity.

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

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

The Department of Health and Welfare’s Division of Behavioral Health was awarded a Center for Mental Health Services (CMHS) Transformation grant in SFY 2011 (October 2010) to implement the Idaho Home Outreach Program for Empowerment (ID-HOPE) project. This project supports provision of evidence based Critical Time Intervention (CTI) services in pilot Regions 3 and 4, with adaptations that include use of a mixed team of bachelors/masters level and Certified Peer Specialists and the use of 7-14 day intensive intervention services for enrolled ID-HOPE participants in crisis. The ID-HOPE program began accepting referrals in March 2011. As of September 30, 2011, the program had 187 referrals with 101 enrolled ID-HOPE participants.

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

A memorandum between the Division of Behavioral Health’s Children’s Mental Health (CMH) program and Child Welfare describes how services will be coordinated for shared clients. The Department of Health and Welfare’s Service Integration program facilitates family efforts to navigate the range of Department programs and services. This program works with Idaho’s Health Information and Referral Center, or the 211-Idaho CareLine. The CareLine provides referral information (including housing and other resources) through the statewide 211 number. The Bannock Youth Foundation (Pocatello) and Hays Shelter Home (Boise) provide federal grant funded crisis and emergency shelter to runaway and homeless youth; these programs coordinate mental health care needs with CMH. The Division’s CMH program and the Department of Education collaborate with local school districts to implement intensive community and school based programs. Independent Idaho local school districts respond to the Individuals with Disabilities Education Act (IDEA) for eligible children. IDEA services include child find/referral, evaluation/eligibility, individualized education plans (IEP), related services, least restrictive environments, review and re-evaluation, transition requirements and consideration of behavior management needs.

Idaho has implemented many programs and pilots in an effort to better meet the needs of youth in the juvenile justice system. The first example was the creation of the Juvenile Justice/Children’s Mental Health Collaborative Workgroup. (JBCM) This group includes administrative and direct service personnel. The primary purpose of the group is to resolve obstacles of cooperatively serving youth with an SED that are involved in the juvenile justice system. One project sponsored by the group was the establishment of a Youth Mental Health Court. The court was operating in three counties as of July 2011, and there is statewide interest in expansion. The Youth Mental Health Court has been successful with youth offenders and uses the Wraparound process to facilitate treatment planning and coordination. The Department of Health and Welfare provides one wraparound specialist for this court and training to other agencies, including juvenile probation officers. Another project includes the placement of clinicians in juvenile detention centers to assist with evaluations, referrals to services, crisis counseling and to assist families in accessing community services.

The purpose of the Olmstead Act is to ensure that individuals who no longer need institutional level care are able to move into less restrictive community based settings. As of July 2011, the State of Idaho did not have a formal Olmstead Plan. Over the past three years, Idaho’s allocation of federal Olmstead Grant funding has gone toward supporting the Peer Specialists programs through Mountain States Group. Idaho’s new “Money Follows the Person” Program has similar goals to the Olmstead act with respect to assisting with community placements in lieu of institutions. The program that Idaho is adopting is called the Home Choice Program. This program is federally funded and allows for Transition Managers to help assist adults diagnosed with developmental disabilities or mental illness who no longer need institutional care to transition into the level of community based care that best meet their needs.

**New Legislation Passed in SFY 2011**

**Education**

**S1108** phases out tenure for teachers who have not earned it, replaces it with one or two year contracts and eliminates seniority as a factor in reduction in force decisions. It allows for inclusion of parental feedback as a factor in staff performance evaluations.

**S1110** institutes a pay for performance system and rewards teachers and administrators on a school-wide basis for student achievement as determined by academic growth. Teachers may be rewarded for teaching in hard to fill positions and for taking on leadership roles.
**S1208 Youth Challenge Program** authorizes the establishment of the National Guard Youth Challenge Program, a multi-phase youth intervention program intended to improve the education, life skills and employment potential of high school dropouts in the state of Idaho. This will be accomplished through military-based discipline and training, combined with educational instruction, experiential learning, and mentoring.

**Juvenile Competence and Juvenile Corrections**

**HO140 Juvenile Competency Law** This law establishes standards for the evaluation of a juvenile’s competency. At the present time, any time a juvenile is believed to be incompetent to assist in their defense, the juvenile is evaluated and treated based on Idaho’s adult competency statute, sections 18-210–18-212, Idaho Code. Questions of juvenile competency are complicated by issues relating to a youth’s developmental, mental and emotional maturity which are not present in adult cases. Further, the adult statute mandates that the defendant be committed and restoration services be provided in an inpatient facility. Costly restrictive confinement is often unnecessary in the provision of restoration services for juveniles. This legislation maintains the United States Supreme Court’s constitutional standards for determining competency that have been set out for adults but adds factors for the court to consider when applying these constitutional standards to juveniles. Unlike the adult statute, the legislation takes into consideration the unique issues that arise when a juvenile’s alleged incompetency may be the result of a developmental disability and requires that evaluators with specialized expertise perform those evaluations. The legislation also provides greater flexibility in the provision of restoration services for those juveniles determined to be incompetent but restorable allowing for community based restoration services when appropriate which may result in substantial savings as compared with inpatient services.

**S1003 Juvenile Corrections Act, Detention** This law amends §20-518 to allow juveniles who have been waived to adult court to be placed in the general population of juvenile detention centers rather than be sight and sound separated from other juveniles or from adults in county jail facilities. The Juvenile Corrections Act (JCA) currently prohibits juveniles who have been waived to adult court from being housed in a juvenile detention facility with juveniles adjudicated under the JCA unless those being treated as adults are sight and sound separated. This means that these juveniles, recently as young as 12 or 14 years old, must be housed either segregated from other juveniles in a detention facility or in an adult jail, also with sight and sound isolation. It is in the best interests of these juveniles that they are allowed, at the court’s discretion, to remain with juveniles their own age while awaiting trial, sentencing or other disposition. However, these juveniles may only remain in a juvenile general population if the detention administration determines that the safety and security of the other juveniles is not at risk.

**Employment**

**HO109** amends the Employment Security Law to add an additional temporary total unemployment rate indicator for extended benefits that qualify for one-hundred percent federal funding. For weeks of unemployment beginning on or after January 1, 2011, and ending on December 31, 2011, or the expiration date in section 502 of the tax relief, unemployment insurance reauthorization and job creation act of 2010, P.L. 111-312, as amended, whichever is later, the average rate of seasonally adjusted total unemployment in the state, as determined by the United States secretary of labor, for the three (3) month period referred to in subsection (1)(b)(ii).1. equals or exceeds one hundred ten percent (110%) of such average for any and all of the corresponding three (3) month periods ending in the three (3) preceding calendar years.)

**HO122** amends the Employment Security Law to revise the ratios of total base period earnings to the highest quarter earnings. This provision reduces the number of weeks seasonal workers will be able to receive benefits.

**Drug/Mental Health Courts**

**HO225** leaves the prohibition against persons charged with a felony crime of a sex offense from participating in drug court, but allows the admission, in some cases, of persons charged with or convicted
of a crime of violence. Such persons could be admitted to drug court only after consultation with the drug
court team and with the consent of the prosecuting attorney. All persons admitted into a drug court would
continue to be required to meet the eligibility criteria established by the drug court, which must be
consistent with the guidelines established by the Drug Court and Mental Health Court Coordinating
Committee. Judges presiding over drug court would continue to exercise their discretion in admission
decisions to ensure the safety of staff and of all participants. This measure will enhance the scope and
effectiveness of our drug courts, and also facilitate the formation of veterans’ courts, which have been
established in more than 20 states and have proven effective in addressing the particular needs and
challenges of veterans who come into the criminal justice system.

**HO226** modifies the class of cases in which courts may exercise their discretion to set aside convictions,
or reduce felony convictions to misdemeanors. Idaho Code § 19-2604 now permits persons who have
been placed on probation to have their convictions set aside if they have at all times complied with the
terms of probation, or if they have graduated from a drug court or mental health court and have complied
with all the terms of probation during any subsequent period of probation. The court has discretion to
grant this relief or not, and the court can set aside the conviction only if it is convinced that such action is
compatible with the public interest. Persons who have been placed on retained jurisdiction and later
placed on probation may have their felony convictions reduced to misdemeanors if they satisfy these
conditions. This bill would remove the requirement that defendants must at all times comply with the
terms of probation to be eligible for relief. It would amend the statute to state that a defendant is eligible
for relief if the court did not find, and the defendant did not admit, any violation of the terms of probation
in a probation violation proceeding. It would also provide courts the option, where a defendant was placed
on probation, of reducing the felony conviction to a misdemeanor. The court could grant relief only upon
a finding that such action was compatible with the public interest. Providing a chance for such defendants
to have their convictions set aside would give them an added incentive to abide by the terms of probation
and live law–abiding lives, and would increase their employment and educational opportunities. As
provided under the current statute, sex offenders would not be eligible for relief.

**Medicaid Changes**

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

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

Regarding medications, the Department will pay the lesser of the provider's lowest charge to the general
public for a drug or the estimated acquisition cost (EAC) plus a dispensing fee. (a) The EAC is defined by
the department as the average acquisition cost (AAC) of the drug, or when no AAC is available, reimbursement will be wholesale acquisition cost (WAC). WAC shall mean the price, paid by a wholesaler for the drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug as published by a recognized compendia of drug pricing on the last day of the calendar quarter that corresponds to the calendar quarter (b) The department shall establish pharmacy dispensing fee payments based on the results of surveys of pharmacies and dispensing rates paid to other payers. The dispensing fee structure will be tiered, with the tiers based on the annual Medicaid claims volume of the enrolled Idaho retail pharmacy. All other pharmacy dispensing fees will be the lowest dispensing fee for the tiered structure. (3) The AAC will be established by the department will utilize periodic by state cost or national surveys to obtain the most accurate pharmacy drug acquisition costs in establishing the pharmacy reimbursement fee schedule for the product. When surveys are requested by the department to Pharmacies participating in the Idaho Medicaid program, they are required to participate in these periodic state cost surveys by disclosing the costs of all drugs net of any special discounts or allowances. Participating pharmacies that refuse to respond to the periodic state surveys will be dis-enrolled as a Medicaid provider.

Medicaid is expected to provide the Idaho State legislature with a plan for Medicaid managed care with a focus on high-cost populations in January 2012. The Medicaid managed care plan shall include improved coordination of care through primary care medical homes, improved coordination and case management for high-risk, high-cost disabled adults and children that reduce costs and improve health outcomes and allow for a system that includes independent, standardized, statewide assessment and evidence-based benefits provided by businesses that meet national accreditation standards. Specific mental health features will include elimination of administrative requirements for a functional and intake assessment and addition of a comprehensive diagnostic assessment addendum; increased criteria for accessing the partial care benefit and restriction to those individuals who have a diagnosis of serious and persistent mental illness; elimination of the requirement for new annual plans; and direction to the Department to develop an effective management tool for psychosocial rehabilitation services.

### Data Events

The Division of Behavioral Health’s Adult Mental Health (AMH), Children’s Mental Health (CMH), and Substance Use Disorders (SUD) programs provide information on publicly funded AMH, CMH and SUD services. The AMH program is using WITS for data collection needs. The CMH program is transitioning from use of FOCUS to use of WITS. The State Hospital systems (i.e., State Hospital North (SHN) and State Hospital South (SHS)) provide data on Idaho citizens psychiatrically hospitalized at SHN and SHS using the VistA system. Data on Division of Behavioral Health trainings and SUD prevention is tracked through EXCEL spreadsheets through the Division’s Central Office location.

The Division of Behavioral Health contracts with vendor FEI to develop, train, implement and host the WITS system. The WITS system is capable of tracking service provider locations and other characteristics. This system has been implemented for Adult Mental Health (AMH) services; data element definitions for the National Outcome Measures were built in WITS using the Client Level Reporting Project data element definitions. The Division of Behavioral Health and FEI are in the process of building data elements to collect and report on required data for SUD and for Children’s Mental Health (CMH) program services. The two state hospitals, State Hospital North (SHN) and State Hospital South (SHS) use the VistA data infrastructure system. The Division of Behavioral Health is working on a data warehouse that will allow client data from the VistA system to be crosswalked to the WITS system so that client services can be tracked.

For Division of Behavioral Health purposes, reports are built to look at the identifier and other unidentifiable information. The WITS system does have the ability to aggregate services rendered to the client. As of June 30, 2011, the AMH and CMH programs were able to capture client level data, including
client demographics, characteristics, enrollments (admission/discharge), assessments, & non-Medicaid services (type, provider, duration, amount) through the WITS system. Credible report extraction remained a challenge for these programs and the WITS system did not interlink to the hospitals’ VistA data system. Medicaid client level encounter/claims service and provider data were not available for CMH in July 2011. Non-billed service data is anticipated to be available one year after CMH implemented WITS (July 1, 2011).

As of July 2011, provider and client identifiers in the WITS, VistA and BPA systems did not allow for linkage with Medicaid provider identifiers. Client identification numbers through WITS are generated based on name and birth date. While the WITS system does attempt to capture a consumer’s Medicaid number, this is not required or always known when a client profile is created or updated. The Division of Behavioral Health is working on a data warehouse in an effort to allow linkage to other systems. As of July 2011, WITS was not linked with Medicaid behavioral health data. The WITS system does capture the client's insurance type. If the client is identified in WITS as having Medicaid, some reports could be extracted (e.g., service utilization).

Idaho received a section 3013 grant for development of a health information exchange under the HITECH Act; the Idaho Health Data Exchange (IHDE) is the state designated entity for recipient of the grant funding. IHDE is a statewide health information organization and has been operational as an HIE since 2009. IHDE includes a clinical data repository. Clinical staff at State Hospital North and State Hospital South can access the repository for clinical information, such as lab results, for patients they are treating. Mental health and substance abuse data are not currently included in the exchange. IHDE’s Security and Privacy Committee is reviewing the SAMHSA FAQs related to substance abuse confidentiality and health information exchange to determine IHDE’s next steps in this regard. IHDE, at the invitation of the behavioral health bureau chief, sent a staff member to the SAMHSA-Sponsored 2011 Health Information Technology Regional Forum to learn more about the issues and opportunities in this area.

The Idaho Adult Mental Health system uses the Mental Health Statistics Improvement Program (MHSIP) consumer satisfaction survey and the Children’s Mental Health system uses the Youth Services Survey for Families (YSS-F) to measure child and family satisfaction with mental health service provision. Idaho’s surveys are sent annually in July and at the time of case closures. Survey result data were data entered into the federal site until that site closed in May 2011. After federal site closure, survey results were data entered into an Idaho survey monkey site. Block grant goals for the 2012-2013 plan include establishment of kiosks at regional behavioral health sites that will allow individuals to directly respond to survey questions. This will reduce or eliminate the need for Central Office data entry and will allow respondents to be independent in this effort.

Idaho was awarded a Transformation Transfer Initiative (TTI) grant in SFY 2011 to build a data warehouse to allow improved data extraction and interlinking to the VistA system used by the state psychiatric hospitals. As of October 2011, the Behavioral Health Division data warehouse had all the elements present, but the Information and Technology (IT) Division was still forming linkages to the WITS data dictionary and data extraction of meaningful reports was not yet possible. Plans are to complete these efforts in SFY 2012.
Child - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.
Children's Mental Health

- Contract with Family Run Organization $228,067. This went to the Idaho Federation of Families for a statewide Parent Support and Advocacy Program for parents and families with a child who was SED, and for Respite Care provider training and referral.

- Contract for Suicide Prevention Services $22,854. This was used to contract with Benchmark to do research and suicide prevention services for the State of Idaho.

- Contract for Primary Care Physician Training $13,125. This was to contract with St. Luke's Regional Medical Center to conduct monthly behavioral health trainings for Primary Care Physicians who treat children who also have mental health disorders.

- CMH Special Projects $6- This went to purchase materials for the anti-stigma campaign for children's mental health day.

Total Children's FY2011 $ 264,052
ADULT - IMPLEMENTATION REPORT

Transformation Activities: 

Name of Implementation Report Indicator: Increased Access to Services (Number)

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Table Descriptors:

Goal: Persons with a serious mental illness will have access to SMHA services. While a small number will have Medicaid, the majority served do not have access to Medicaid or other forms of insurance.

Target: Provide state public mental health service access to at least 7,000 eligible persons.

Population: Adults 18 and over w/SMI who are served by the SMHA. While some have Medicaid, the majority do not have access to Medicaid or other forms of insurance. The SFY 2011 priority population is adults w/SMI in crisis and statutory mandate (court ordered).

Criterion: 2:Mental Health System Data Epidemiology 3:Children's Services

Indicator: Total number of adults who received services through the state operated mental health system.

Measure: Total number of adults receiving state operated mental health services.

Sources of Information: WITS

Special Issues: The WITS system for AMH was implemented 10/09; SFY 11 is the first full year of AMH data capture from WITS. This number is based on numbers with intakes and includes enrolled, non-enrolled, assessed and not assessed clients. Enrolled clients are those opened for services in the public mental health system and included in the Department's ongoing caseload count. Non-enrolled clients served are those that received at least one Department provided adult mental health service but are not formally opened or included in the ongoing services caseload count. Non-enrolled clients served are those that received at least one Department provided adult mental health service but are not formally opened or included in ongoing services caseload counts.

Significance: National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model: The data reported on this measure reflects access data for eligible adult individuals who received intakes through the SMHA. The Adult Mental Health program is not able to capture the data of those persons with a serious and persistent mental illness who receive services from private providers. The number of assessments and ongoing cases is significantly lower than the number of intakes.

Target Achieved: The number of intakes provided through the SMHA in SFY 2011 as measured
or through report extraction in the WITS system was 9,732. This target was achieved.
**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2009 Actual</th>
<th>(3) FY 2010 Actual</th>
<th>(4) FY 2011 Target</th>
<th>(5) FY 2011 Actual</th>
<th>(6) FY 2011 Percentage Attained</th>
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<tbody>
<tr>
<td>Performance Indicator</td>
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</table>

**Table Descriptors:**

**Goal:** Adults with a serious and persistent mental illness will be re-hospitalized less often as they will be able to access community based mental health services.

**Target:** Achieve a rate not to exceed 6% for re-admission to the two State Psychiatric Hospitals within 30 days of discharge.

**Population:** Adults with SMI

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Percentage of persons who are re-admitted to any state psychiatric hospital within thirty days of a state hospital discharge.

**Measure:**
Numerator - Number of persons readmitted within thirty days of state hospital discharge
Denominator - Number of persons discharged from a state hospital

**Sources of Information:**
State hospital data system (VistA).

**Special Issues:**
This objective supports the Planning Council's priority on quality, continuum of care and community supports and is a required NOM.

**Significance:**
National Outcome Measure.

**Activities and strategies/changes/innovative or exemplary model:**
An adult mental health program policy requiring that persons discharged from a state psychiatric hospital will be opened (if there are no other providers) for follow up services by the regional CMHC for not less than 30 days, in most cases, allows for consistent and coordinated discharge planning between the hospitals and the CMHC's. A post discharge survey is conducted by regional CMHC staff on all persons discharged from a state psychiatric hospital. The surveys are sent to State Hospital South for data tabulation.

**Target Achieved or Not Achieved/If Not, Explain Why:**
In SFY 2011, 21 individuals were readmitted to a state psychiatric hospital within 30 days out of a total number of 855 discharges. This reflects a 2.46% readmission rate within 30 days. This target was 243.9% achieved.
Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
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<th>(4) FY 2011 Target</th>
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<th>(6) FY 2011 Percentage Attained</th>
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<td>703</td>
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<td>855</td>
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</table>

Table Descriptors:

Goal: Adults with a serious mental illness will be re-hospitalized less often as they will be able to access community based mental health services.

Target: Achieve a rate not to exceed 11% for re-admission to the two State Psychiatric Hospitals within 180 days of discharge.

Population: Adults with a Serious Mental Illness

Criterion:
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

Indicator: Percentage of persons re-admitted to a state psychiatric hospital within 180 days of discharge from a state psychiatric hospital.

Measure:
Numerator - Number of person readmitted within 180 days of discharge.
Denominator - Total number of discharges.

Sources of Information: State hospital data system (VistA)

Special Issues: VistA system implementation during SFY09 for the two state psychiatric hospitals improves Idaho's reporting of the NOMS. The 11% target reflects concerns about increased stressors on Idaho citizens related to the economy and an SFY 2011 priority population of those in crisis and those eligible under statutory mandate (i.e., court ordered).

Significance: National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model: A policy implemented in the adult mental health program requires that persons discharged from a state psychiatric hospital be opened for follow up services by the regional CMHC for not less than 30 days. In most cases, this allows for consistent and coordinated discharge planning between the hospitals and the CMHC's. A post discharge survey is conducted by the regional CMHC staff on all persons discharged from a state psychiatric hospital. The surveys are then sent to State Hospital South for data tabulation.

Target Achieved or Not Achieved/If Not, Explain Why: In SFY 2011, 72 individuals were readmitted to a state hospital within 180 days, out of a total number of 855 discharges. This results in a readmission within 180 days percentage of 8.42%. This target was 130.6% achieved.
**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Number of Practices (Number)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2009 Actual</th>
<th>(3) FY 2010 Actual</th>
<th>(4) FY 2011 Target</th>
<th>(5) FY 2011 Actual</th>
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**Table Descriptors:**

**Goal:** Persons with a serious mental illness will have access to evidence based mental health services.

**Target:** Maintain the number of Evidence-Based Practices in Idaho during SFY 2011.

**Population:** Adults with SMI

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Total number of evidence based practices provided by the SMHA.

**Measure:** Total number of evidence based practices that are implemented by the adult mental health program.

**Sources of Information:** Regional reports, Vocational Rehabilitation (Supported Employment), and WITS.

**Special Issues:** Evidence based practices (EBP) implemented by the SMHA for adults w/SMI in SFY 2011 included ACT, Supported Employment, Supported Housing, Medication Management, Illness Self Management and Integrated Treatment of Co-Occurring Disorders. All regions provide ACT; not all provide all other EBPs. EBP fidelity is measured only for ACT (DACTS). Supported employment is provided through an Interagency Agreement with the Idaho Division of Vocational Rehabilitation. The public mental health system provides AMH services through 7 regionally based community mental health centers across the State. Idaho's SFY 2011 priority population is adults w/SMI in crisis and those referred through statutory mandate (ie, court ordered).

**Significance:** This is a required National Outcome Measure.

**Activities and strategies/changes/innovative or exemplary model:** ACT, MH Court ACT and supported employment services are available in each of seven service regions of the Department of Health and Welfare's Adult Mental Health Program. Most regions provide illness self-management, co-occurring integrated treatment, supported housing and medication management. In SFY 2009, 2010 and 2011, certified peer specialists were placed with ACT teams. Certified Peer Specialists began providing regional PATH outreach services to homeless adults with SMI in SFY 2011.

In SFY 2009, SFY 2010, and SFY 2011, Idaho offered the six evidence based practices of Assertive Community Treatment, Supported Housing, Illness Self Management, Supported Employment, Integrated Treatment for Co-Occurring Disorders (MH/SA) and Medication Management. Family psychoeducation was not available. This target goal was achieved.
**ADULT - IMPLEMENTATION REPORT**

Transformation Activities: __

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
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<td>Denominator</td>
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</table>

**Table Descriptors:**

**Goal:** The goal is to increase independence and housing stability for adult Idaho citizens with SMI who are receiving supportive services from the SMHA and are also living in Shelter Plus Care housing.

**Target:** During SFY 2011, at least 65% of adults with SMI living in Shelter Plus Care housing and receiving supportive services from the SMHA will maintain their housing stability for at least 9 months.

**Population:** Adults with a serious mental illness (SMI) who are living in Shelter Plus Care housing and receiving SMHA supportive services. The percentages does not include those who move out of state or move into other permanent housing during the reporting period.

**Criterion:**

1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:**

Numerator: Adults w/SMI in S+C housing that maintain housing for 9 months.
Denominator: total unduplicated adults in Shelter Plus housing who are receiving SMHA supportive services.

**Measure:** Percentage of adults with a SMI receiving SMHA supportive services who remain in Shelter Plus Care programs for 9 months or longer.

**Sources of Information:** The SFY 2011 Supported Housing data was provided through the Idaho Housing and Finance Association's (IHFA) Homelessness Management Information Services (HMIS) data system.

**Special Issues:**

Six of seven regions collaborate with Idaho Housing and Finance Association (IHFA) to identify eligible Shelter Plus Care individuals. Those who receive Shelter Plus Care housing and who meet SMHA eligibility also receive mental health services (e.g., case management, counseling and other supportive services) from the SMHA. The number of eligible Shelter Plus Care slots is fixed. IHFA stopped accepting new individuals into the Shelter Plus Care program in April 2011 because they were overextended.

**Significance:** Adults with SMI who do not have stable and supported housing are at increased risk of relapse. Adults who remain in Shelter Plus Care programs for 9 months or longer are more likely to stabilize and to demonstrate increased resilience in other areas of their lives.

**Activities and strategies/changes/**

Provision of Supported Housing through Shelter Plus Care programs and supportive services through the SMHA.
innovative or exemplary model:

**Target Achieved or Not Achieved/If Not, Explain Why:**

In SFY 2011, the data reported from IHFA's HMIS system indicated that 100 of 169 adult clients remained in shelter plus care housing for 9 months or longer. This goal was 91% achieved.
## Transformation Activities:

None

### Name of Implementation Report Indicator:

Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

<table>
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<tr>
<th>Fiscal Year</th>
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<th>Denominator</th>
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<tr>
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<td>FY 2011 Actual</td>
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<td>N/A</td>
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</tbody>
</table>

### Table Descriptors:

**Goal:**
The Divisions of Behavioral Health (BH) & Vocational Rehabilitation (VR) collaborate to improve Community Supported Employment services and data capture for SMI adults served through the DHW SMHA service system.

**Target:**
The SFY 2011 target was to provide CSE services to at least 270 adults with a serious mental illness served through the 7 CMHC service sites.

**Population:**
Adults with a serious mental illness who are receiving BH and VR services through regional service programs; this changed to those employed as tracked through the SMHA WITS data system.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:**
Total number of adults employed as tracked through the SMHA's WITS data system (numerator) or through IDVR reports of Rehabilitated Closed cases in SFY 2011.

**Measure:**
Total number of adults employed as tracked through the SMHA's WITS data system (numerator) or through IDVR reports of Rehabilitated Closed cases in SFY 2011.

**Sources of Information:**
Total number of adults employed as tracked through the SMHA's WITS data system (numerator) or through IDVR reports of Rehabilitated Closed cases in SFY 2011.

**Special Issues:**
The Divisions of Behavioral Health and Vocational Rehabilitation (IDVR) have historically collaborated to identify methods to improve CSE data capture and services to eligible adults served through both programs. Data pulled from IDVR was not consistent with SMHA data pulled from WITS. The WITS system was not able to track this data until 4/22/11, so the SFY 2011 employment data pulled from the SMHA's WITS data system tracks only about two months worth of data (4/22/11- 6/30/11). Additional data is provided from the IDVR monthly reports on Rehabilitated Closed data for SFY 2011; this number is low because it does not reflect those individuals with open VR cases who are employed.

**Significance:**
Ongoing collaboration and enhanced data capture will improve supported employment services and access to Idaho adult citizens with a serious mental illness receiving services from regional CMHCs. Capture of supported employment data from the WITS system for a full year in SFY 2012 will increase consistency with data reporting on NOMS and URS.

**Activities and**
See special issues.
strategies/
changes/
innovative or
exemplary model:

Target Achieved  or  Not Achieved/If Not, Explain Why:
The SFY 2011 target was to serve a total number of 270 persons with Supported Employment. The Actual SFY 2011 number (two months) served according to the SMHA's WITS two month data extraction report was 135 adults employed. The number of Rehabilitated Closed cases from IDVR monthly reports indicated that 213 individuals were employed; this number is low because it does not reflect the number of IDVR open cases with employed individuals. According to IDVR data, the target was 79% achieved (please note that this estimate was low because it did not include open employed individuals).
Transformation Activities: 

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2009 Actual</th>
<th>(2) FY 2010 Actual</th>
<th>(3) FY 2011 Target</th>
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<td>Denominator</td>
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<td>9,423</td>
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<td>9,732</td>
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Table Descriptors:
Goal: Priority population persons with a serious mental illness will have access to ACT services.

Target: Provide ACT services to at least 250 persons as measured by total number of ACT clients served during SFY 2011.

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Total number of persons receiving Assertive Community Treatment Services from the SMHA.

Measure: Total number of persons receiving ACT services.

Sources of Information: WITS report extraction for SFY 2011 of ACT and Mental Health Court referred ACT clients served.

Special Issues: This is a required NOM. Assertive Community Treatment teams in Idaho serve traditionally referred and Mental Health Court (MHC) referred clients. Idaho implemented a Peer Specialist Certification program in SFY 2009. Certified peer specialists have been placed with ACT teams across the State of Idaho in an effort to model best practice, recovery and resilience. Idaho's SFY 2011 priority population was adults with SMI in crisis and those referred through statutory mandate (i.e., court ordered).

Significance: Idaho continues to support the implementation of ACT/FACT teams in the public mental health system as a strategy to decrease psychiatric hospitalizations and to maintain persons in their communities with the necessary supports. Additionally, Idaho ACT/FACT teams collaborate with the courts to provide services to eligible individuals referred through regional Mental Health Courts.

Activities and strategies/changes/innovative or exemplary model: ACT staff serve traditionally referred ACT clients and mental health court referred clients in each region. The SFY 2011 priority populations were adults with SMI in crisis and court ordered. Certified peer specialists continued to be placed with regional ACT teams to model best practice, recovery and resilience.

Target Achieved or Not Achieved/If Not, Explain Why:
The total number of ACT/FACT clients served in SFY 2011 was 639 out of a total served of 9,732. This target was achieved.
Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

<table>
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Table Descriptors:

Goal: Implement the WITS data system in SFY 2010 and begin to track the number of adults with SMI served by the SMHA who received Family Psychoeducation to establish a baseline.

Target: Establish a baseline.

Population: Adults with SMI served through the regional SMHA receiving Family Psychoeducation services.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: Adults with SMI served through the regional SMHA receiving Family Psychoeducation services.

Measure: Adults with SMI served through the regional SMHA receiving Family Psychoeducation services.

Sources of Information: WITS data system.

Special Issues: The data system in Idaho has been inadequate to track services. Implementation of the WITS data system helps to track numbers of adults with SMI receiving Family Psychoeducation services through the SMHA. Budget cuts made it difficult to provide the broader range of services that were offered before the economic downturn. Family psychoeducation was not offered by the SMHA in SFY 2011.

Significance: Family Psychoeducation services help to provide a strong resource for recovery and resilience for adults diagnosed with serious mental illness. This is a required NOM.

Activities and strategies/changes/innovative or exemplary model:

Establish a baseline of adults with SMI receiving Family Psychoeducation services through the SMHA in SFY 2011.

Target Achieved or Not Achieved/If Not, Explain Why: There were no identified SMHA clients served with the evidence based practice of Family Psychoeducation in SFY 2011. This may reflect the July 1, 2010 focus population prioritization of adults diagnosed with a serious mental illness in crisis and those who were court ordered under statute. It is not anticipated that Family Psychoeducation will be offered in SFY 2012. Because the SFY 2011 goal was a measure of baseline, this goal was achieved.
**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA) (Percentage)

<table>
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<td>FY 2011 Target</td>
<td>FY 2011 Actual</td>
<td>FY 2011 Percentage Attained</td>
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<td>9,732</td>
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</table>

**Table Descriptors:**

**Goal:** Provide co-occurring, integrated treatment to adults with co-occurring mental illness and substance use disorders to at least 193 adults receiving SMHA services in SFY 2011.

**Target:** The target for SFY 2011 was to provide co-occurring, integrated SMHA treatment services to at least 193 eligible adults with SMI and substance use diagnoses.

**Population:** Eligible adults with co-occurring mental health and substance use disorders receiving SMHA treatment services.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Provision of co-occurring, integrated treatment services to at least 193 individuals with mental illness and substance use disorders receiving SMHA treatment services.

**Measure:** See Indicator.

**Sources of Information:** Regional counts, court data, WITS report extraction.

**Special Issues:** Idaho has worked to standardize the process to capture system data from mental health and substance use programs. Regional ACT teams provide dual diagnosis groups and other dual diagnosis services to adults referred through mental health courts. In SFY 2011, the WITS system report extraction indicated that 595 adults received integrated treatment for co-occurring disorders through the SMHA.

**Significance:** National Outcome Measure. Data for this performance indicator for SFY 2011 was obtained through report extraction from the WITS system.

**Activities and strategies/changes/innovative or exemplary model:**

Dual diagnosis services were provided to mental health court referred clients served by regional ACT or forensic ACT teams.

**Target Achieved or Not Achieved/If Not, Explain Why:** The SFY 2011 target was provision of co-occurring, integrated treatment services provided to at least 193 mental health court referred ACT clients. The total number served according to report extraction from the WITS system for SFY 2011 was 595. This target was achieved and exceeded.
Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

<table>
<thead>
<tr>
<th>(1)</th>
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<th>(5)</th>
<th>(6)</th>
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<tbody>
<tr>
<td>Fiscal Year</td>
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<td>FY 2010 Actual</td>
<td>FY 2011 Target</td>
<td>FY 2011 Actual</td>
<td>FY 2011 Percentage Attained</td>
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<td>--</td>
<td>9,732</td>
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</tr>
</tbody>
</table>

Table Descriptors:

Goal: At least 500 adults receiving SMHA services will also receive Illness Self Management.

Target: Provide Illness Self Management to at least 500 adults with SMI served by the SMHA.

Population: Adults diagnosed with a serious and persistent mental illness receiving Illness Self Management services through the SMHA.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: Numbers of adults with SPMI receiving Illness Self Management through the SMHA.

Measure: Numbers of adults with SPMI receiving Illness Self Management through the SMHA.

Sources of Information: WITS data system.

Special Issues: The WITS system did not track numbers of adults with SMI receiving Illness Self Management through the SMHA in SFY 2011. The public mental health system provides adult mental health services through 7 regionally based community mental health centers. The SFY 2011 priority population was adults with SMI in crisis or court ordered (statutory mandate). The SMHA provides ACT services to those who are court ordered and to some traditionally referred individuals. ACT services include provision of Illness Self Management; data for this EBP is the same as the data for the ACT EBP for SFY 2011.

Significance: This is an evidence based practice and a required NOM.

Activities and strategies/ changes/ innovative or exemplary model:

Track the numbers of adults receiving Illness Self Management services through the SMHA in SFY 2011. Provide Illness Self Management services to ACT and FACT clients served through regional SMHA offices.

Target Achieved or Not Achieved/If Not, Explain Why: Illness Self Management is part of the service package available to SMHA clients receiving ACT services. In SFY 2011, there were 639 individuals receiving SMHA provided ACT services, as measured through WITS data extraction. ACT clients are provided Illness Self Management services, so these 639 ACT clients were also offered Illness Self Management. This target was achieved.
**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2009 Actual</th>
<th>(3) FY 2010 Actual</th>
<th>(4) FY 2011 Target</th>
<th>(5) FY 2011 Actual</th>
<th>(6) FY 2011 Percentage Attained</th>
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</thead>
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<td>Denominator</td>
<td>8,209</td>
<td>9,423</td>
<td>--</td>
<td>9,732</td>
<td>--</td>
</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:** Provide Medication Management services through the SMHA to at least 500 adults with SMI in SFY 2011.

**Target:** Provide Medication Management services through the SMHA to at least 500 adults with SMI in SFY 2011.

**Population:** Adults diagnosed with SPMI receiving Medication Management services through the SMHA in SFY 2011.

**Criterion:**

1: Comprehensive Community-Based Mental Health Service Systems

3: Children's Services

**Indicator:** The numerator is the number receiving Medication Management services. The denominator is the total number receiving SMHA services in SFY 2011.

**Measure:** The numerator is the number receiving Medication Management services. The denominator is the total number receiving SMHA services in SFY 2011.

**Sources of Information:** Report extraction from the WITS system (see Table 17 of the NOMS/URS report for SFY 2011).

**Special Issues:** The WITS data system in SFY 2011 should help to track the numbers of adults with SMI who are receiving medication management services through the SMHA. The public mental health system provides adult mental health services through 7 regionally based community mental health centers. The SFY 2011 priority population was adults with SMI in crisis or through statutory mandate (ie, court ordered).

**Significance:** This is an evidence based practice and a required NOM.

**Activities and strategies/changes/innovative or exemplary model:** Use the WITS system to track the number of adults with SMI receiving medication management services through the SMHA in SFY 2011. Provide medication management services through the SMHA to at least 500 adults with SMI in SFY 2011.

**Target Achieved or Not Achieved/If Not, Explain Why:** According to WITS reports, there were 6,340 served with Medication Management out of a total served of 9,732 in SFY 2011. This target was achieved.
## Name of Implementation Report Indicator: Client Perception of Care (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
<th>FY 2011 Attained</th>
</tr>
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<td>86.40</td>
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<td>Numerator</td>
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<td>667</td>
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<td>642</td>
</tr>
<tr>
<td>Denominator</td>
<td>772</td>
<td>772</td>
<td>--</td>
<td>737</td>
</tr>
</tbody>
</table>

### Table Descriptors:

- **Goal:** Persons receiving SMHA services will report a positive perception of care received from the SMHA.
- **Target:** To achieve an 84% or higher approval rating in consumer's positive satisfaction with services.
- **Population:** Adults with SMI
- **Criterion:**
  1: Comprehensive Community-Based Mental Health Service Systems
  3: Children's Services
- **Indicator:** Percentage of consumers receiving DHW provided mental health services who rate positive general satisfaction with services on the MHSIP survey.
- **Measure:**
  - Numerator: Number of consumers who rate positive satisfaction with services
  - Denominator: Number of completed consumer satisfaction surveys
- **Sources of Information:** MHSIP Adult Consumer Survey
- **Special Issues:** This is a required NOM.
- **Significance:** Measurement of consumer satisfaction is an important component in assessing the overall quality and appropriateness of services. This supports the Planning Council's priorities related to quality.

### Activities and strategies/changes/innovative or exemplary model:

Idaho adopted and implemented the use of the MHSIP Adult Consumer Satisfaction Survey in October 2003. The survey is offered annually and at discharge to all persons receiving ongoing publicly provided adult mental health services for 30 days or more. Consumers are asked to voluntarily complete the survey. Completed paper surveys are sent to central office where they were data entered into the DS2K+ website by support staff. When the DS2K+ site closed in spring 2011, a new internal site was established for the collection of SFY 2011 MHSIP survey results.

### Target Achieved or Not Achieved/If Not, Explain Why:

The target for this Performance Indicator was 84% of consumers responding to the MHSIP consumer survey would report positively about general satisfaction with services. Actual numbers were 642 out of a total of 737 respondents, for 87% reporting positively. This target was achieved.
Transformation Activities: 

Name of Implementation Report Indicator: Adult - Increase/Retained Employment (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2009 Actual</th>
<th>(2) FY 2010 Actual</th>
<th>(3) FY 2011 Target</th>
<th>(4) FY 2011 Actual</th>
<th>(5) FY 2011 Attained</th>
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<tr>
<td>Performance Indicator</td>
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<td>N/A</td>
<td>112</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Numerator</td>
<td>146</td>
<td>149</td>
<td>--</td>
<td>213</td>
<td>--</td>
</tr>
<tr>
<td>Denominator</td>
<td>270</td>
<td>N/A</td>
<td>--</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

Table Descriptors:
Goal: Provide increased and/or retained employment for adults receiving SMHA services.
Target: Provide employment services to at least 16 persons per region for a total of at least 112 persons.
Population: Eligible adults with a serious mental illness who are able to work.
Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
Indicator: Number of adults able to work who are receiving SMHA services and who are employed.
Measure: Number of adults able to work who are receiving SMHA services and who are employed. Measure is VR report of Rehabilitated Closed clients (closed after 90 days of employment).
Sources of Information: Division of Vocational Rehabilitation, Regional information
Special Issues: The Division of Behavioral Health has an Interagency Agreement with Idaho Division of Vocational Rehabilitation (IDVR) to provide vocational services to SMHA adults with a serious and persistent mental illness. The agreement includes data capture and reporting, as well as IDVR presence during weekly ACT team meetings. The SMHA priority populations for SFY 2011 were adults with SMI in crisis and court ordered (ie, statutory mandate).
Significance: The Idaho Division of Vocational Rehabilitation defines Community Supported Employment according to the number of days of ongoing employment. Clients that are able to retain employment for a period of 90 days are determined to be successful, and their case is closed under the Rehabilitations, Closed category. The numbers reported on this Performance Indicator are SMHA clients receiving IDVR services and determined to be Rehabilitated, Closed during SFY 2011. This is a required NOM.
Activities and strategies/ changes/ innovative or exemplary model: The SMHA and IDVR collaborate to increase and retain the number of adults with SMI able to work and that are working and retaining jobs.

Target Achieved or Not Achieved/If the SFY 2011 Performance Indicator was defined as the total number of persons receiving VR services who maintained employment for at least 90 days before their case was closed (Rehab Closed) by VR. The target was 112 individuals; the
Not, Explain Why: SFY 2011 Actual was 213. This target (as measured by the SFY 2011 Rehabilitation Closed data provided in the IDVR monthly reports) was achieved.
Transformation Activities: __

Name of Implementation Report Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2009 Actual</th>
<th>(2) FY 2010 Actual</th>
<th>(3) FY 2011 Target</th>
<th>(4) FY 2011 Actual</th>
<th>(5) FY 2011 Percentage Attained</th>
</tr>
</thead>
<tbody>
<tr>
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<td>93.70</td>
<td>86</td>
<td>10.45</td>
<td>12.15</td>
</tr>
<tr>
<td>Numerator</td>
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<td>684</td>
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<td>56</td>
<td>--</td>
</tr>
<tr>
<td>Denominator</td>
<td>498</td>
<td>730</td>
<td>--</td>
<td>536</td>
<td>--</td>
</tr>
</tbody>
</table>

Table Descriptors:

Goal: Adults receiving SMHA services will report decreased arrests in the prior 12 month period on the MHSIP Consumer Survey.

Target: To achieve 14% or less in arrests reported through the MHSIP system for clients served in the previous 12 month period.

Population: Adults served by regional community mental health programs with SMI and also with criminal justice involvement.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

Indicator: Numbers of consumers responding to MHSIP survey question and indicating that they were not arrested during the previous 12 month period. This includes adults in service for at least 12 months and adults who began MH services during the 12 months of SFY 2011.

Measure: Numbers of consumers responding to MHSIP survey question and indicating that they were not arrested during the previous 12 month period. This includes adults in service for at least 12 months and adults who began MH services during the 12 months of SFY 2011.

Sources of Information: MHSIP consumer survey.

Special Issues: Completion of the MHSIP Consumer Survey is voluntary and anonymous; the reported numbers capture only a subset of the total number of clients served through the mental health service system.

Significance: This is a National Outcome Measure.

Activities and strategies/changes/innovative or exemplary model: Continue to track reported arrests through MHSIP. Continue efforts to develop an internal data infrastructure system to capture arrest data related to clients receiving services through the SMHA.

Target Achieved or Not Achieved/If Not, Explain Why: The SFY 2011 target for this Performance Indicator was that 86% of consumers receiving mental health services that responded to the MHSIP consumer survey would report that they had not been arrested in the previous 12 month period.

There were 536 responses to this question, with 480 adults reporting no arrests in the previous 12 month period. This goal was achieved.
ADULT - IMPLEMENTATION REPORT

Transformation Activities: 

Name of Implementation Report Indicator: Adult - Increased Stability in Housing (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2009 Actual</th>
<th>(3) FY 2010 Actual</th>
<th>(4) FY 2011 Target</th>
<th>(5) FY 2011 Actual</th>
<th>(6) FY 2011 Percentage Attained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>82.61</td>
<td>90</td>
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<td>N/A</td>
</tr>
<tr>
<td>Numerator</td>
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<td>114</td>
<td>--</td>
<td>54</td>
<td>--</td>
</tr>
<tr>
<td>Denominator</td>
<td>450</td>
<td>138</td>
<td>--</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

Table Descriptors:

Goal: The SFY 2011 goal was to increase stability in housing among adults receiving SMHA services who have been homeless or at risk of homelessness.

Target: At least 90 persons who have received homeless services through PATH funds will retain stable housing for at least 3 months; total served in SFY 2010 will be 90.

Population: Adults receiving PATH funded services who have been homeless or at risk of becoming homeless.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

Indicator: Adults receiving SMHA services who have been homeless or at risk of becoming homeless will retain stable housing (i.e., permanent housing) for at least three (3) months as measured by regional PATH reports from 7 regions.

Measure: Adults receiving PATH funded services who have been homeless or at risk of becoming homeless will retain stable housing (i.e., permanent housing) for at least three (3) months as measured by regional PATH reports from 7 regions.

Sources of Information: Regional data sources.

Special Issues: The Idaho Housing and Finance Association has responsibility to manage Idaho’s Homeless Information Management system (HMIS) and this data tracking is not available to the Division of Behavioral Health for PATH tracking. The FY 2011 PATH service dollars were awarded to Mountain States Group; Certified Peer Specialists from that agency report counts of PATH clients. Because the award was late, the program was not able to hire and train PATH Certified Peer Specialists until the end of March 2011. Services began in April, 2011. Data reflects late program start-up for just the months of April, May and June.

Significance: This is a National Outcome Measure.

Activities and strategies/ changes/ innovative or exemplary model: The SFY 2011 goal was for a total of at least 90 PATH clients served through the Mountain States Group contract would maintain housing for at least 3 months, as measured by contractor reports. The PATH Certified Peer Specialists did not begin to provide regional services until April 2011. Data is only from April 2011 through June 2011, and numbers do not meet the goal of 90 individuals.

Target Achieved or Not Achieved/If The SFY 2011 goal was to increase independence and housing stability for adult Idaho citizens with SMI receiving PATH services from the SMHA who maintain housing for at least 3 months. Data from 4/1/11 through 6/30/11 indicate that
Not, Explain Why: there were 54 enrolled PATH clients as of 6/30/11, with 18 of those individuals literally homeless. While this target was not fully achieved by June 30, 2011, the PATH Certified Peer Specialists efforts to provide face to face outreach and case management are a strong addition to the service system for adults with SMI who are homeless or at risk of becoming homeless.
Transformation Activities:  

Name of Implementation Report Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1) Fiscal Year</th>
<th>(2) FY 2009 Actual</th>
<th>(3) FY 2010 Actual</th>
<th>(4) FY 2011 Target</th>
<th>(5) FY 2011 Actual</th>
<th>(6) FY 2011 Percentage Attained</th>
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</thead>
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<tr>
<td>Performance Indicator</td>
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<td>61.77</td>
<td>95.03</td>
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</tr>
<tr>
<td>Numerator</td>
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<td>474</td>
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<td>425</td>
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</tr>
<tr>
<td>Denominator</td>
<td>744</td>
<td>755</td>
<td>--</td>
<td>688</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>

Table Descriptors:

Goal: Adults receiving SMHA services will report a stronger sense of social connectedness.

Target: To achieve a 65% or higher rating on social connectedness.

Population: Adults with a serious mental illness (SMI).

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Responses on consumer survey (MHSIP).

Measure: Responses on consumer survey (MHSIP).

Sources of Information: Consumer survey (MHSIP).

Special Issues: The MHSIP survey is sent to all open consumers once each year and upon case closure. The D2K system Idaho used to support this data closed in spring 2011 and data capture was transferred to an internal system.

Significance: This is a National Outcome Measure.

Activities and strategies/changes/innovative or exemplary model:

Encourage completion and submission of MHSIP consumer surveys. Achieve a rating of at least 65% on MHSIP Consumer Survey positive reports of Social Connectedness in SFY 2011.

Target Achieved or Not Achieved/If Not, Explain Why:

In SFY 2011, there were 688 surveys returned, with 425 of these respondents reporting positively on Social Connectedness. The SFY 2011 target was 65% positive responses on Social Connectedness and this goal was 95% achieved.
Transformation Activities: [ ]

Name of Implementation Report Indicator: Adult - Improved Level of Functioning (Percentage)

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
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<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>FY 2009 Actual</td>
<td>FY 2010 Actual</td>
<td>FY 2011 Target</td>
<td>FY 2011 Actual</td>
<td>FY 2011 Percentage Attained</td>
</tr>
<tr>
<td>Performance Indicator</td>
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<td>64.89</td>
<td>67</td>
<td>60.06</td>
<td>89.64</td>
</tr>
<tr>
<td>Numerator</td>
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<td>486</td>
<td>--</td>
<td>412</td>
<td>--</td>
</tr>
<tr>
<td>Denominator</td>
<td>743</td>
<td>749</td>
<td>--</td>
<td>686</td>
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</tr>
</tbody>
</table>

Table Descriptors:

Goal: Adults receiving SMHA services will report an improved level of functioning as a result of treatment services provided.

Target: To achieve at least 67% or higher report of improved functioning.

Population: Adults with a serious mental illness (SMI).

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children’s Services
4: Targeted Services to Rural and Homeless Populations

Indicator: Subjective report of improved functioning on the MHSIP consumer survey; objective regional reports of increased functioning in areas of psychiatric stability, work, housing, family, etc.

Measure: Subjective report of improved functioning on the MHSIP consumer survey; objective regional reports of increased functioning in areas of psychiatric stability, work, housing, family, etc.

Sources of Information: Consumer survey (MHSIP) and regional data submissions.

Special Issues: The MHSIP survey is sent to all open consumers once each year and upon case closure. The D2K system is no longer hosting the data system to support this data, and the data began to be managed through an internal system in May 2011.

Significance: This is a National Outcome Measure.

Activities and strategies/changes/innovative or exemplary model:

Track and report improved functioning via MHSIP consumer survey responses.

Target Achieved or Not Achieved/If Not, Explain Why:

In SFY 2011, there were 686 surveys returned with responses in the Improved Functioning category. There were 412 who reported Improved Functioning. This target was 89.6% achieved.
**Transformation Activities:** ☑

**Name of Implementation Report Indicator:** ACT Outcomes and Fidelity Measurement

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2009 Actual</th>
<th>(3) FY 2010 Actual</th>
<th>(4) FY 2011 Target</th>
<th>(5) FY 2011 Actual</th>
<th>(6) FY 2011 Percentage Attained</th>
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<tbody>
<tr>
<td>Performance Indicator</td>
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<td>2</td>
<td>3</td>
<td>N/A</td>
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<tr>
<td>Numerator</td>
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<td>--</td>
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</tr>
<tr>
<td>Denominator</td>
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<td>N/A</td>
<td>--</td>
<td>N/A</td>
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</tbody>
</table>

**Table Descriptors:**

**Goal:** The State will continue to provide Assertive Community Treatment (ACT) services and measure fidelity to the model of service for this evidence based practice.

**Target:** The Adult Mental Health Program will conduct ACT fidelity assessment on no less than two existing ACT or forensic ACT teams.

**Population:** Adults with SMI who are receiving ACT or forensic ACT (FACT) services from regional SMHAs.

**Criterion:** 5: Management Systems

**Indicator:** The number of completed ACT or FACT fidelity assessments.

**Measure:** Total number of completed ACT or FACT fidelity assessments conducted during SFY 11.

**Sources of Information:** Adult Mental Health Program DACTS scores/review, regional information.

**Special Issues:** This objective supports the State Planning Council's priorities on quality and continuum of care. While the Dartmouth Assertive Community Treatment Scale (DACTS) is used for determining fidelity, the DACTS does not completely and accurately reflect ACT services in rural and frontier areas, or effectiveness of services provided to mental health court referred clients. For example, one item on the DACTS encourages a low graduation rate. Mental health court referred clients are successful when they graduate from the program.

**Significance:** ACT teams provide community based services to adults with a serious mental illness who require intensive services to maintain in a least restrictive, community setting and forensic ACT services to eligible adults referred through regional Mental Health Courts. Fidelity assessments help to determine fidelity to the model and provide an opportunity for both feedback and sharing of information on best practice service delivery.

**Activities and strategies/changes/innovative or exemplary model:** Data relating to ACT services and to MH Court ACT services will be tracked through WITS in SFY 2011. The Adult Mental Health Program has selected the DACTS Fidelity Scale as the assessment tool to be used to measure the fidelity of the ACT program in Idaho. Assessments were conducted on three regional ACT teams by a team led by the Division office in September 2011. Assessments in September 2011 were done in Caldwell, Boise and Twin Falls.

**Target Achieved or Not Achieved/If Not Achieved/If Not Achieved:** The SFY 11 target was to review ACT fidelity on at least 2 regional ACT teams in SFY 2011 (7/1/2010-6/30/2011). The DACTS fidelity assessments in 3 regions (Boise, Caldwell, Twin Falls) occurred in September 2011, after 6/30/11, but they
Not, Explain Why: did occur. This target was achieved.
Transformation Activities: ☑

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2009 Actual</th>
<th>(2) FY 2010 Actual</th>
<th>(3) FY 2011 Target</th>
<th>(4) FY 2011 Actual</th>
<th>(5) FY 2011 Percentage Attained</th>
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</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Numerator</td>
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</tr>
<tr>
<td>Denominator</td>
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<td>N/A</td>
<td>--</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

Table Descriptors:
Goal: Provide standardized, accurate and timely outcome based data reports for the Adult Mental Health Program.

Target: Enhance report extraction capability in SFY 2011 from the WITS data infrastructure system that was implemented for AMH in October 2009.

Population: Adults with SMI

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Improved WITS data extraction for AMH NOMS/URS by 6/30/11.

Measure: The AMH will extract NOMS/URS data for adults receiving community SMHA services from the WITS system by 6/30/11.

Sources of Information: ITSD, Division of Behavioral Health

Special Issues: The Adult Mental Health program explored requirements in SFY 2008, and implemented the WITS system in October 2009 to support the community mental health center data tracking needs. While data could be entered in SFY 2010, it could not be reliably extracted. Report extraction capability was the goal for SMHA AMH service data for the NOMS/URS in SFY 2011.

Significance: It is critical that the SMHA accurately report and identify the populations being served and the outcomes of services provided. Reliable and valid data is necessary for informed decision making by Health and Welfare, the State Planning Council on Mental Health and the Idaho Legislature.

Activities and strategies/ changes/ innovative or exemplary model: The VistA data system was installed at both state hospitals in July 2007. The Division of Behavioral Health's efforts to identify and implement a more robust data infrastructure were aided by the DIG grant and the CLRP grant. The WITS system was informed by the data element definitions for the NOMS and URS from the CLRP grant. The legislature allocated SFY 2009 funds to support a joint data system to serve the needs of the Adult Mental Health and Substance Use Disorders programs. WITS was implemented for statewide data entry October 1, 2010. WITS report extraction began in November 2011.

Target Achieved or Not Achieved/If Not, Explain Why: The Division of Behavioral Health implemented data entry into the WITS system for community SMHA services to adults in 10/09. Report extraction capability for AMH NOMS/URS from the WITS system was the goal for SFY 2011. Report extraction from WITS for AMH data did occur, albeit with some challenges in SFY 2011. This goal continues to be addressed and continues to evolve. This target was achieved for SFY 2011.
ADULT - IMPLEMENTATION REPORT

Transformation Activities: 🟢

Name of Implementation Report Indicator: Attend Medication Appointment After State Hospital Discharge

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td></td>
<td>FY 2009 Actual</td>
<td>FY 2010 Actual</td>
<td>FY 2011 Target</td>
<td>FY 2011 Actual</td>
<td>FY 2011 Percentage Attained</td>
</tr>
<tr>
<td>Performance Indicator</td>
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<td>75.19</td>
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<td>594</td>
<td>--</td>
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</tr>
<tr>
<td>Denominator</td>
<td>549</td>
<td>684</td>
<td>--</td>
<td>790</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>

Table Descriptors:

Goal: Persons with serious mental illness discharged from a state hospital will have ready access to community-based mental health services.

Target: Achieve a rate of 80% or higher for persons discharged from a state psychiatric hospital who attend their scheduled first medication follow-up appointment with their physician or physician extender.

Population: Adults diagnosed with a serious mental illness.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of persons discharged from a state hospital who keep their first medication follow-up appointment with a physician or physician extender at their community mental health provider.

Measure: Numerator- Number of persons who keep their first medication follow-up appointment with a physician after discharge Denominator- Number of persons discharged from a state hospital as measured by total number of discharge survey results.

Sources of Information: State Hospital data bases, discharge survey.

Special Issues: This objective supports the Planning Council's objective on quality, continuum of care and community supports. This has been a special focus of the SMHA. The state hospitals and community programs have collaborated to improve continuity of care and to refine discharge procedures. Existing challenges for state hospitals include out of state discharges. Typically, the other state will not schedule an appointment with a person planning to discharge until that person is actually in their state. This makes it more difficult to ensure a timely follow up. For purposes of reporting, State Hospital North indicated that 23 of the 340 discharges were out of state in SFY 2011; the numerator will reflect the 317 in state discharges that received a survey from SHN and the 473 that were discharged from State Hospital South for a total denominator of 790.

Significance: Attending the first medication follow-up appointment in the community is a key indicator of successful community reintegration and treatment compliance.

Activities and strategies/changes/innovative or exemplary model: All persons discharged from a state hospital have a medication follow-up appointment with their community mental health provider scheduled prior to their being discharged from the state hospital. A policy was implemented in the AMH program that strongly encourages that all persons discharged from a state psychiatric hospital be opened for follow up services by the regional CMHC for a...
minimum of 30 days to allow for consistent and coordinated discharge planning. A post discharge survey is conducted by the regional CMHC staff on all persons discharged from a state psychiatric hospital. The surveys are sent to State Hospital South for tabulation.

**Target Achieved or Not Achieved/If Not, Explain Why:**

The SFY 2011 target for the Performance Indicator for attending the first medication appointment after state hospital discharge was 80%. In SFY 2011, 594 of 790 returned surveys indicated they attended their medication appointment; this is 75.19%. This target was 93.99% achieved.
### Transformation Activities: 

**Name of Implementation Report Indicator:** Co-Occurring Disorders Training

<table>
<thead>
<tr>
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**Table Descriptors:**

**Goal:** Idaho is developing and implementing a best practice model of integrated treatment to serve those with co-occurring substance use and mental health diagnoses.

**Target:** The Adult Mental Health Program will provide at least one (1) training opportunities for CMHC staff on treatment strategies for co-occurring disorders.

**Population:** Adults with SMI

**Criterion:** 5: Management Systems

**Indicator:** Co-occurring treatment training provided

**Measure:** The number of trainings completed.

**Sources of Information:** Adult Mental Health Program, number of training opportunities on integrated treatment for co-occurring disorders.

**Special Issues:** A primary emphasis of the ACT teams in Idaho is provision of collaborative services to participants in the Idaho Mental Health Court programs. One of the the essential core components is the ability to provide integrated treatment for persons with co-occurring disorders. In an effort to ensure cost-effective training during a context of budget cuts, DHW developed a course based on Tip 42 that is accessible by regional SMHA MH and SUD staff.

**Significance:** This objective supports the Planning Council's priorities on continuum of care as well as the President's New Freedom Recommendations related to Goal 5. This has also been identified as a system training priority by the Adult Mental Health Program Managers. The economic downturn decreased the amount of funds available for outside trainers. The Division of Behavioral Health implemented modules from SAMHSA's TIP 42 on the Department's Knowledge Learning Center website. State employees have access to this training website and continuing education credits are available for completion of each module.

**Activities and strategies/changes/innovative or exemplary model:** The economic downturn affected the ability to continue training with out of state contracts. The Department's Knowledge Learning Center educational website implemented the SAMHSA TIP 42 modules in SFY 2010, with continuing education credits for each completed module. This training opportunity is available at no cost to DHW employees in all seven regions of the State of Idaho.

**Target Achieved or Not Achieved/If Not, Explain Why:** The SAMHSA TIP 42 module of Substance Abuse Treatment for Persons with Co-Occurring Disorders was added to the Department of Health and Welfare's Knowledge Learning Center training website in SFY 2010 and continued to be available through SFY 2011. Material is available in modules, with an exam to
assess competence. Successful completion of modules and exams are documented with certificates and with continuing education credits. This was not an SFY 2011 target area, and descriptions are provided for information only.
**Name of Implementation Report Indicator:** Follow Up Appointment Within 7 Days of Discharge

<table>
<thead>
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<th>Fiscal Year</th>
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**Table Descriptors:**

**Goal:** Adults diagnosed with a serious mental illness discharged from a state hospital will have ready access to community based mental health services.

**Target:** Achieve a rate of 85% or higher for the number of persons seen for a first face to face appointment at their community mental health provider within 7 days of discharge from an Idaho state hospital.

**Population:** Adults diagnosed with a serious and persistent mental illness (SPMI).

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Percentage of persons seen at their community mental health provider within 7 days of discharge from an Idaho state hospital.

**Measure:**
- Numerator: Number of persons seen by their community mental health provider within 7 days of discharge from a state hospital.
- Denominator: Number of persons discharged from a state psychiatric hospital as measured by discharge survey results.

**Sources of Information:** State hospital database, discharge survey.

**Special Issues:**
Existing challenges for state hospitals include out of state discharges. Typically, the other state will not schedule an appointment with a person planning to discharge until that person is actually in their state. This makes it more difficult to ensure a timely follow up. For purposes of reporting, State Hospital North indicated that 23 of the 340 discharges were out of state in SFY 2011; the numerator will reflect the 317 in state discharges that received a survey from SHN and the 473 that were discharged from State Hospital South for a total denominator of 790.

**Significance:** Timely follow-up in the community is a significant indicator for successful community integration and reduction of re-hospitalization. This objective supports the Planning Council priorities on quality, continuum of care and community supports.

**Activities and strategies/changes/innovative or exemplary model:** A post discharge survey is conducted by regional CMHC staff on all persons discharged from a state psychiatric hospital, with surveys sent to SHS for data tabulation. An AMH policy requires that persons discharged from a state psychiatric hospital be opened for follow up services by the regional CMHC for a minimum of 30 days to allow for consistent and coordinated discharge planning.

**Target Achieved or**

The target for this Performance Indicator was that at least 85% of persons would be seen for a first face to face appointment at their community mental health...
Not Achieved/If Not Achieved/If Not, Explain Why: provider within 7 days of discharge from an Idaho state hospital. The actual SFY 2011 numbers were 644 out of 790 returned surveys indicating follow up appointments within 7 days of discharge for a percentage of 81.5%. This target was 95.88% achieved.
**Transformation Activities:**

**Name of Implementation Report Indicator:** Homeless Persons Served

<table>
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<th>(1) Fiscal Year FY 2009 Actual</th>
<th>(2) FY 2010 Actual</th>
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**Table Descriptors:**

**Goal:** Data provided for baseline informational purposes in SFY 2009 suggested that there were 207 homeless persons served through the SMHA. There was not a goal for SFY 2011, and data is provided for information only.

**Target:** Data provided for baseline informational purposes in SFY 2009 suggested that there were 207 homeless persons served through the SMHA. The goal for SFY 2010 was maintenance of that number.

**Population:** Adults diagnosed with a serious and persistent mental illness who are homeless.

**Criterion:** 4: Targeted Services to Rural and Homeless Populations

**Indicator:** The number of persons served by the SMHA who reported living in a homeless shelter as measured by the WITS data system in SFY 2010.

**Measure:** The number of persons served by the SMHA who reported being homeless or living in a homeless shelter as measured by the WITS data system in SFY 2010.

**Sources of Information:** The WITS data system living situation data field for homeless or living in a homeless shelter.

**Special Issues:** The WITS data system was implemented for AMH data needs in October 2009. Report extraction was implemented in October 2010. This is the first year that data from the WITS data system has been used for NOMS/URS and block grant reporting.

**Significance:** Provision of mental health services to eligible individuals who are homeless or who are at risk of homelessness helps to develop recovery, resilience and stabilization.

**Activities and strategies/changes/innovative or exemplary model:** Activities and strategies to serve those who are homeless or at risk of becoming homeless and who have a diagnosis of a serious and persistent mental illness include assessment; linkage to, and collaboration with, other resources and providers; and provision of an array of mental health services that are individualized to the needs of the person.

**Target Achieved or Not Achieved/If Not, Explain Why:** The WITS data system indicates that mental health services were provided to 340 adults who reported living in a homeless shelter at one point in SFY 2010. This information related only to those indicating that they were homeless or that they lived in a homeless shelter during the reporting period; it did not include those who were doubled up or at risk of becoming homeless. Although this was not a goal for SFY 2011, the WITS data system indicates that 582 adults were served.
Name of Implementation Report Indicator: Homeless Services Providers

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<tr>
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</table>

Table Descriptors:

Goal: There was no SFY 2011 goal for homeless services providers. Data provided is for information only.

Target: There was no SFY 2011 goal for homeless services providers. Data provided is for information only.

Population: Adults who are either homeless or at risk of becoming homeless and who have a diagnosis of a serious and persistent mental illness.

Criterion: 4: Targeted Services to Rural and Homeless Populations

Indicator: There are seven regions and each region is responsible to provide outreach activities to those who are homeless and who have a serious mental illness in their regions.

Measure: There are seven regions and each region is responsible to provide outreach activities to those who are homeless and who have a serious mental illness in their regions.

Sources of Information: Regional self report of Point in Time count events and other outreach activities.

Special Issues: Each regional CMHC works collaboratively with local area homeless service providers.

Significance: Providing outreach to homeless services providers improves the availability of quality services for all Idaho citizens who need mental health services.

Activities and strategies/ changes/ innovative or exemplary model: During SFY 2011, Regional CMHCs provided a variety of outreach activities. Activities included regional Point in Time count (aka Homeless Stand Down) of those who were homeless. These events provided assistance to those who were homeless and requested assistance with applying for benefits or services and/or with referrals to other resources. Outreach brochures and mental health service applications were passed out at these events, and participating organizations networked and collaborated to meet the needs of those who attended and needed help.

Target Achieved or Not Achieved/If Not, Explain Why: Regions provided homeless outreach events in SFY 2011. Additionally, 2 half time PATH Certified Peer Specialists per each of 7 regions were hired in SFY 2011 to provide PATH services (began 4/1/2011), with an expectation that at least 75% of their time would be spent in face to face outreach activities. This has significantly increased the numbers of identified adults with SMI who are homeless or at risk of becoming homeless in Idaho.
### Name of Implementation Report Indicator: Increased Access to Independent Housing

<table>
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<tr>
<th>(1) Fiscal Year</th>
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<th>(3) FY 2010 Actual</th>
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#### Table Descriptors:

**Goal:** The SFY 2010 and SFY 2011 Plans did not include a Performance Indicator goal for Increased Access to Independent Housing.

**Target:** The SFY 2010 Plan did not include a Performance Indicator goal for Increased Access to Independent Housing. Numbers provided are for information only.

**Population:** Adults diagnosed with a serious mental illness who report living in a private residence.

**Criterion:**

1: Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Adults with SMI served by the SMHA will demonstrate increased access to Independent Housing as measured by the numbers of clients reporting that they reside in a Private Residence in the WITS data system for SFY 2010.

**Measure:** Adults with a serious mental illness served by the SMHA will demonstrate increased access to Independent Housing as measured by the numbers of clients reporting that they reside in a Private Residence in the WITS data system for SFY 2010.

**Sources of Information:**

WITS system implemented in October 2009; WITS report extraction began in October 2010 and these reports were used for the SFY 2010 NOMS/URS reports and the block grant performance indicator data.

**Special Issues:**

WITS system implemented in October 2009; WITS report extraction began in October 2010 and these reports were used for the SFY 2010 NOMS/URS reports and the block grant performance indicator data. Data from WITS may differ from data reported in previous years; past data reports were derived from a variety of unstable data sources that relied primarily on manual counts. Data from WITS is more credible than data reported in previous years that was gathered from an assortment of less reliable data sources.

**Significance:**

Access and maintenance of independent housing is an important recovery indicator for adults with a serious mental illness. This objective supports the Planning Council’s priorities to provide a continuum of care.

**Activities and strategies/changes/innovative or exemplary model:**

The CMHC provides an array of services (e.g., psychosocial rehabilitation, medications, ACT, etc.) directed to encouraging independence in the community of choice.

**Target Achieved or**

The WITS data system indicates that 5,205 people out of 9,732 served in SFY 2011 reported living in a private residence.
Not Achieved/If Not, Explain Why:
## Name of Implementation Report Indicator: Risk Assessment/Crisis Intervention Training

<table>
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### Table Descriptors:

#### Goal:
The there was not a specific SFY 2010 or SFY 2011 goal for the Performance Indicator related to Risk Assessment/Crisis Intervention training. The data here is for informational purposes.

#### Target:
The there was not a specific SFY 2010 or SFY 2011 goal for the Performance Indicator related to Risk Assessment/Crisis Intervention training. The data here is for informational purposes.

#### Population:
Adults with a diagnosis of a serious mental illness (SMI).

#### Criterion:
5:Management Systems

#### Indicator:
The indicator is the number of risk assessment and/or crisis intervention trainings that were available in the regions in SFY 2010 and SFY 2011.

#### Measure:
The measure is the number of risk assessment and/or crisis intervention trainings that were available in the regions in SFY 2010 and SFY 2011.

#### Sources of Information:
Regional reports of risk assessment and/or crisis intervention training opportunities in their respective regions in SFY 2010 and SFY 2011.

#### Special Issues:
All regions have access to videotaped Designated Examination training. Regions also provide face to face training for designated examination and dispositioner responsibilities.

#### Significance:
Staff that are trained are better able to assess risk and resolve crisis situations in least restrictive and effective ways.

#### Activities and strategies/changes/innovative or exemplary model:
All regions provide designated examination training as needed. Some regions use the Crisis Intervention Training (CIT) in collaboration with law enforcement.

### Target Achieved or Not Achieved/If Not, Explain Why:
In SFY 2011, all regions provided designated examination training opportunities as needed.
Name of Implementation Report Indicator: Increased Access to Services (Number)

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<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
<th>FY 2011 Actual</th>
<th>FY 2011 Percentage Attained</th>
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Table Descriptors:
Goal: To provide an array of mental health services to children representing the (SED) target population.

Target: To serve no less that 1,697 children/youth through the Department's Children's Mental Health program.

Population: Children with SED and meeting eligibility criteria for the CMH program.

Criterion: 2: Mental Health System Data Epidemiology
3: Children's Services

Indicator: The number of children/youth served by the Department of Health and Welfare's Children's Mental Health program.

Measure: Unduplicated count of children served through the Mental Health Authority Children's Mental Health program.

Sources of Information: FOCUS information system.

Special Issues: The reduction in the target number for FY2011 is in response to a reduction in funding for the Children's Mental Health program, the closure of 9 field offices, and a reduction in the number of CMH staff. The calculation of the FY 2011 target of 1,697 children served was made by reducing the FY 2010 projected number of 2,610 children by 35%. The 35% was chosen given that approximately 70% of children served during FY2010 were Medicaid eligible and efforts are underway to assist families requiring lower intensity services to access services through the private sector using Medicaid.

Significance: National Outcomes Measure.

Activities and strategies/ changes/ innovative or exemplary model: The children's mental health authority will explore methods of assisting children and families in accessing community mental health services funded by Medicaid and other third party payers.

Target Achieved or Not Achieved/If Not, Explain Why: This target has been ACHIEVED at 121%. 

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

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<th>(3) Target</th>
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**Table Descriptors:**

**Goal:** Ensure that an array of community-based services are available to children with SED and their families to decrease psychiatric hospitalization and readmissions.

**Target:** Readmission of youth to State Hospital South (SHS) Adolescent Unit will not exceed 3% at 30 days after discharge.

**Population:** Children with SED discharged from State Hospital South.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** The number of children/youth readmitted to SHS at 30 days after discharge from SHS.

**Measure:** Numerator: children (0-18 years) who are readmitted to SHS within 30 days after discharge from SHS. Denominator: total number of children (0-18 years) discharged from SHS during the past year.

**Sources of Information:** State Hospital South (SHS) data.

**Special Issues:** Idaho has only one adolescent state hospital unit, which is a 16 bed facility.

**Significance:** National Outcomes Measure.

**Activities and strategies/changes/innovative or exemplary model:** SHS continues to work toward the reduction of readmissions through thorough discharge planning. For a child/youth to be placed at SHS, the child must be evaluated and followed by a CMH clinician. These clinicians are engaged in case management throughout the hospitalization and assist the child and family with transition. By increasing access to community-based services upon discharge, the child has an improved chance of successful transition back to their home community.

**Target Achieved or Not Achieved/If Not, Explain Why:** This target was ACHIEVED as only 1 out of 90 children discharged from State Hospital South were readmitted within 30 days of discharge (1.1%).
Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

<table>
<thead>
<tr>
<th>(1)</th>
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<tr>
<td>Fiscal Year</td>
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<td>FY 2010 Actual</td>
<td>FY 2011 Target</td>
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<td>Denominator</td>
<td>87</td>
<td>80</td>
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<td>90</td>
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</table>

Table Descriptors:

Goal: To ensure that an array of community-based services are available to children with SED and their families to decrease psychiatric hospitalization.

Target: Readmission of youth to State Hospital South Adolescent Unit will not exceed 9% at 180 days after discharge.

Population: Children with SED hospitalized in State Hospital South.

Criterion:
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

Indicator: The number of children/youth readmitted to SHS at 180 days after discharge.

Measure: Numerator: children (0-18 years) readmitted to SHS within 180 days after discharge. Denominator: children (0-18 years) discharged from SHS during the year.

Sources of Information: SHS data

Special Issues: Idaho has only one (1) State Hospital adolescent unit, which is a 16 bed facility.

Significance: National Outcomes Measure.

Activities and strategies/changes/innovative or exemplary model: SHS continues to work toward the reduction of readmissions through thorough discharge planning. Children/youth placed in SHS must be evaluated and followed by a CMH clinician. These clinicians are engaged in case management throughout the placement and assist the child and family with transition. By increasing the access to community-based services upon discharge, the child has a better chance of successful transition back to their home community.

OMB No.

Target Achieved or Not Achieved/If Not, Explain Why:

This target was ACHIEVED at 200%. With only 4 out of 90 children being readmitted at 180 days this target was achieved. Only 4.44% were readmitted.
### Name of Implementation Report Indicator: Evidence Based - Number of Practices (Number)

<table>
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<th>(2) FY 2010 Actual</th>
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<td>2</td>
<td>3</td>
<td>3</td>
<td>100</td>
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</table>

#### Table Descriptors:
- **Goal:** Provide community-based services that are evidence-based.
- **Target:** Maintain a minimum of 2 Evidence-Based Practices available in Idaho.
- **Population:** Children with SED
- **Criterion:**
  1: Comprehensive Community-Based Mental Health Service Systems
  3: Children’s Services
- **Indicator:** The number of EBPs available through the Idaho CMH System of Care.
- **Measure:** The number of EBPs that are available through the Idaho Children’s Mental Health system to serve children and youth with SED.
- **Sources of Information:** CMH Information System: FOCUS and Regional self-report
- **Special Issues:** Idaho has two (3) EBPs available through the CMH program that are recognized by SAMHSA. One is Treatment or Therapeutic Foster Care, another is Functional Family Therapy, and the other is Parenting with Love and Limits. Even though Idaho does not follow fidelity to an EBP model for TFC, Idaho does have quality assurances for the use of the Idaho model. Idaho contracts with the Idaho Youth Ranch (IYR) for FFT and IYR does adhere to the fidelity of the FFT model. An additional service, Wraparound is available in some areas of Idaho and is considered to be EBPs by many. (not SAMHSA).
- **Significance:** National Outcome Measure

### Activities and strategies/changes/innovative or exemplary model:
Idaho's Treatment/Therapeutic Foster Care program is an Idaho developed system and does not necessarily adhere to the fidelity of the EBP model. The fidelity of Idaho’s TFC system is connected to a set of practice standards that were developed based off of best practices. The adherence to these standards is measured through the use of a case review instrument and quality assurance practices.

### Target Achieved or Not Achieved/If Not, Explain Why:
This target was ACHIEVED at 100%.
Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
<th>FY 2011 Actual</th>
<th>FY 2011 Percentage Attained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Indicator</td>
<td>3.87</td>
<td>2.07</td>
<td>2</td>
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<tr>
<td>Numerator</td>
<td>119</td>
<td>54</td>
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<tr>
<td>Denominator</td>
<td>3,072</td>
<td>2,615</td>
<td>--</td>
<td>2,053</td>
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</tbody>
</table>

Table Descriptors:

Goal: To provide an array of community-based services that are evidence-based and demonstrate achievement of treatment outcomes.

Target: Maintain a minimum percentage of children/youth that receive Therapeutic Foster care in Idaho.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: The percentage of children/youth receiving Children's Mental Health services that receive treatment foster care services.

Measure: Numerator: The total number of children/youth that are placed in treatment foster care by the CMH program. Denominator: The total number of children/youth with SED that receive services through the CMH program.

Sources of Information: Children's Mental Health information system (FOCUS).

Special Issues: The treatment foster care program in Idaho does not follow the fidelity of the EBP program, but has a quality assurance system in place to ensure quality. Idaho has adopted a definition/standard of treatment foster care and begun a training of staff and contractors throughout the state. The target for this indicator is being reduced given the change in the definition of treatment foster care and the change in the population served through the CMH program.

Significance: National Outcome Measures.

Activities and strategies/changes/innovative or exemplary model: Idaho’s Therapeutic Foster Care program is an Idaho developed system and does not necessarily adhere to the fidelity of the EBP model. The fidelity of Idaho’s TFC system is connected to a set of standards that guide the delivery of services. The adherence to these standards is measured through use of a case review instrument and through ongoing quality assurance practices.

Target Achieved or Not Achieved/If Not, Explain Why: This target was not ACHIEVED primarily because of limited capacity of available therapeutric foster care bed space for CMH children. The children who are placed in the therapeutric foster homes usually remain in these placements for long stays, and these placements do not open up quickly. However, if you combine the children served through Children’s Mental Health, Child Welfare, and other referral sources, there were 108 total children being served throughout the state in 2011, rather than just 7. In essence, Idaho children are being served through...
therapeutic foster homes.
Transformation Activities:  
Indicator Data Not Applicable: ✓

**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
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</tr>
<tr>
<td>FY 2009 Actual</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</tr>
<tr>
<td>FY 2010 Actual</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>FY 2011 Target</td>
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<td></td>
</tr>
<tr>
<td>FY 2011 Actual</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>FY 2011 Percentage Attained</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Table Descriptors:**
**Goal:**
**Target:**
**Population:**
**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:**
**Measure:**
**Sources of Information:**
**Special Issues:**
**Significance:**

**Activities and strategies/changes/innovative or exemplary model:**

**Target Achieved**
Multi-Systemic Therapy is not available in Idaho.

or

**Not Achieved/If Not, Explain Why:**
**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

<table>
<thead>
<tr>
<th>(1)</th>
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<th>(6)</th>
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<tbody>
<tr>
<td>Fiscal Year</td>
<td>FY 2009 Actual</td>
<td>FY 2010 Actual</td>
<td>FY 2011 Target</td>
<td>FY 2011 Actual</td>
<td>FY 2011 Percentage Attained</td>
</tr>
<tr>
<td>Performance Indicator</td>
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<td>2.68</td>
<td>2.68</td>
<td>4.24</td>
<td>158.21</td>
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<tr>
<td>Numerator</td>
<td>176</td>
<td>70</td>
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<td>87</td>
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</tr>
<tr>
<td>Denominator</td>
<td>3,072</td>
<td>2,615</td>
<td>--</td>
<td>2,053</td>
<td>--</td>
</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:** Provide an array of community-based services that are evidence-based and demonstrate achievement of treatment outcomes.

**Target:** Maintain or increase the percentage of children/youth that receive FFT in Idaho at a minimum of 2%.

**Population:** Children with SED.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** The percentage of children/youth receiving Functional Family Therapy.

**Measure:**
Numerator: The number of children/youth with SED that receive Functional Family Therapy.
Denominator: The total number of children receiving CMH services.

**Sources of Information:** Reports by contractor.

**Special Issues:** The FFT program provided in Idaho is delivered by the Idaho Youth Ranch, a contractor. The contractor complies with the FFT measures of fidelity as required in the contract.

**Significance:** National Outcome Measure.

**Activities and strategies/changes/innovative or exemplary model:** FFT is available in all seven regions of the state through a contract with the Idaho Youth Ranch. FFT is made available to both CMH and the Department of Juvenile Corrections.

**Target Achieved or Not Achieved/If Not, Explain Why:** This goal was achieved at 158%.
Transformation Activities:  

Name of Implementation Report Indicator: Client Perception of Care (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
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<td>FY 2010 Actual</td>
<td>FY 2011 Target</td>
<td>FY 2011 Actual</td>
<td>FY 2011 Percentage Attained</td>
<td></td>
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<tr>
<td>Performance Indicator</td>
<td>82.72</td>
<td>71.10</td>
<td>50</td>
<td>80.95</td>
<td>161.90</td>
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<tr>
<td>Numerator</td>
<td>158</td>
<td>123</td>
<td>--</td>
<td>102</td>
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<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>191</td>
<td>173</td>
<td>--</td>
<td>126</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>

Table Descriptors:

Goal: Ensure that families of children with SED are full partners in developing, implementing, and evaluating the System of Care.

Target: To remain at or above an average satisfaction score of 50% with the MHSIP Youth Services Survey for Families (YSS-F).

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: The percentage of positive responses to questions related to perception of care on the MHSIP YSS-F.

Measure: Numerator: the number of families responding to the MHSIP YSS-F that rate their perception of care as positive. Denominator: the total number of families responding to the perception of care section of the MHSIP YSS-F.

Sources of Information: MHSIP satisfaction data base. (questions 16, 17, 18, 19, 20, and 21).

Special Issues: Beginning in SFY2008, the children's mental health program implemented a standard that surveys families once a year on July 1st and upon case closure.

Significance: National Outcome Measure.

Activities and strategies/changes/innovative or exemplary model: Idaho uses the MHSIP YSS-F. Surveys are sent to parents of children with an open case on July 1st of each year or upon closure if the case is closed prior to July 1.

Target Achieved or Not Achieved/If Not, Explain Why: This target was ACHIEVED at 162%. 81% of survey respondents reported satisfaction with their involvement in treatment planning and implementation of treatment. This is a 10% increase over last year's percentage.
Name of Implementation Report Indicator: Child - Return to/Stay in School (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td>FY 2009 Actual</td>
<td>72.19</td>
<td>84.91</td>
<td>75</td>
<td>85.37</td>
<td>113.83</td>
</tr>
<tr>
<td>Numerator</td>
<td>FY 2010 Actual</td>
<td>--</td>
<td>90</td>
<td>--</td>
<td>35</td>
<td>--</td>
</tr>
<tr>
<td>Denominator</td>
<td>FY 2011 Target</td>
<td>122</td>
<td>106</td>
<td>--</td>
<td>41</td>
<td>--</td>
</tr>
<tr>
<td>FY 2011 Attained</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table Descriptors:

Goal: Children with Serious Emotional Disturbance are provided necessary mental health services that support their return to/continuation in school.

Target: A minimum of 75% of children/youth will return to/remain in school.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: The percentage of children with SED that returned to/remained in school during and after receiving CMH services as reported on the MHSIP YSS-F.

Measure: Numerator: The number of families reporting that their child returned to/remained in school on the MHSIP YSS-F. Denominator: The total number of families completing the school section of the MHSIP YSS-F.

Sources of Information: MHSIP YSS-F

Special Issues: Beginning in SFY2008, the children's mental health program implemented a standard that surveys families once a year on July 1st and upon case closure.

Significance: National Outcome Measure

Activities and strategies/changes/innovative or exemplary model:

Surveys are sent to all families that are receiving services from the CMH program on July 1st each year. Additionally, if a case is closed prior to July 1, a survey is sent to the family at the time of case closure. This information is used throughout the year as a management instrument and reported annually as a NOM.

Target Achieved or Not Achieved/If Not, Explain Why:

This target was ACHIEVED at 114%. 85% of respondents indicated that their child returned to/remained in school. This is only a 1% increase from last year's data.
**Name of Implementation Report Indicator:** Child - Decreased Criminal Justice Involvement (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2009 Actual</th>
<th>(2) FY 2010 Actual</th>
<th>(3) FY 2011 Target</th>
<th>(4) FY 2011 Actual</th>
<th>(5) FY 2011 Percentage Attained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td>52.05</td>
<td>45.45</td>
<td>35</td>
<td>48.48</td>
<td>138.51</td>
</tr>
<tr>
<td>Numerator</td>
<td>38</td>
<td>35</td>
<td>--</td>
<td>16</td>
<td>--</td>
</tr>
<tr>
<td>Denominator</td>
<td>73</td>
<td>77</td>
<td>--</td>
<td>33</td>
<td>--</td>
</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:** Children with Serious Emotional Disturbance are provided necessary mental health services that decreases their criminal justice involvement.

**Target:** At least 35% of children/youth served through the Children's Mental Health program will have a reduced involvement with the juvenile justice system.

**Population:** Children with SED.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** The percentage of children with SED that have reduced involvement with criminal justice as reported in the MHSIP YSS-F.

**Measure:**
- **Numerator:** The number of families reporting on the MHSIP YSS-F that their child had reduced involvement with criminal justice.
- **Denominator:** The total number of families reporting on criminal justice involvement in the MHSIP YSS-F.

**Sources of Information:**

MHSIP YSS-F.

**Special Issues:**

Idaho law allows for a judge to order the Department of Health and Welfare to provide Children's Mental Health services to youth involved in the juvenile justice system. It can be anticipated that the percentage of youth served through the Children's Mental Health program that have criminal justice involvement will increase. With that increase, it can be anticipated that the percentage of youth with additional involvement with the criminal justice system could increase. In addition, this will be the third year that Idaho has collected this data. Last year was the first year Idaho identified a target. The target for this indicator is being adjusted given additional data and changes in Idaho law related to providing mental health services to children/youth involved in the criminal justice system.

**Significance:**
National Outcome Measure.

**Activities and strategies/changes/innovative or exemplary model:**

Surveys are sent to all families receiving services from the CMH program on July 1st each year and at case closure. This information is used throughout the year as a management instrument and reported annually as a NOM.

**Target Achieved or Not Achieved/If this target was achieved:**
This target was ACHIEVED at 139%. 48% of those families with SED children surveyed had a reduction of contact with the criminal justice system.
Not, Explain Why:
### Name of Implementation Report Indicator: Child - Increased Stability in Housing (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
<th>FY 2011 Attained</th>
<th>FY 2011 Percentage Attained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
<td>1.56</td>
<td>64.10</td>
</tr>
</tbody>
</table>

#### Table Descriptors:

**Goal:** Children with Serious Emotional Disturbance are provided support to increase stability in their living situation.

**Target:** To maintain a homeless rate of less than a 1% among the children/youth served through the Children's Mental Health program

**Population:** Children with SED.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** The percent of children served through the Children's Mental Health program that are reported as homeless on the MHSIP YSS-F.

**Measure:** Numerator: The number of families reporting their living situation as homeless on the MHSIP YSS-F.
Denominator: The total number of families responding to the living situation section of the MHSIP YSS-F.

**Sources of Information:** The MHSIP YSS-F

**Special Issues:** Idaho has a low historical rate of homelessness and particularly with children and youth in the CMH system. The target will be established at a low rate, but considering the current economic conditions, it is difficult to predict the likelihood of an increase in the homeless population.

**Significance:** National Outcome Measure

**Activities and strategies/changes/innovative or exemplary model:**

This is the second year this National Outcome Measure will be implemented. Idaho has a low rate of homelessness, historically. Idaho has attempted several campaigns to reach out to the homeless population of children/youth with SED and their families, but has yet to dramatically reach the homeless population.

**Target Achieved or Not Achieved/If Not Achieved/If Not, Explain Why:**

This target was not achieved but was only attained at 64%. There were 2 homeless children to the 128 families that responded to the survey. Nationally, Idaho has a large per capita homeless rate, and has recently seen an increase in homeless families due to the rise in unemployment.
Name of Implementation Report Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>FY 2011 Percentage Attained</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2009 Actual</td>
<td>73.40</td>
<td>138</td>
<td>188</td>
<td>-</td>
</tr>
<tr>
<td>FY 2010 Actual</td>
<td>70.86</td>
<td>124</td>
<td>175</td>
<td>-</td>
</tr>
<tr>
<td>FY 2011 Target</td>
<td>65</td>
<td>--</td>
<td>--</td>
<td>-</td>
</tr>
<tr>
<td>FY 2011 Actual</td>
<td>72.36</td>
<td>89</td>
<td>123</td>
<td>-</td>
</tr>
<tr>
<td>FY 2011 Percentage Attained</td>
<td>111.32</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Table Descriptors:
Goal: Children with Serious Emotional Disturbance are provided mental health services that support increased social supports/social connectedness.
Target: At least 65% of families receiving Children's Mental Health services will report increased social supports/social connectedness for their child on the MHSIP YSS-F.
Population: Children with SED.
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services
Indicator: The percentage of children with SED experiencing increased social supports/social connectedness as reported on the MHSIP YSS-F.
Measure: Numerator: The number of families reporting that their child has increased social supports/social connectedness on the MHSIP YSS-F. Denominator: The total number of families responding to the social supports/social connectedness section on the MHSIP YSS-F.
Sources of Information: MHSIP YSS-F
Special Issues: This is the third year Idaho has collected this data. This indicator is being adjusted to reflect economic conditions and changes in the system of care.
Significance: National Outcomes Measure.
Activities and strategies/changes/exemplary model:
Surveys are sent to all families receiving services from the CMH program on July 1st each year and at the time of case closure. This information is used throughout the year as a management instrument and reported annually as a NOM.
Target Achieved or Not Achieved/If Not, Explain Why: This target was achieved at 111% 72% of families responded that their child had increased social connectedness/support after receiving CMH services.
**Name of Implementation Report Indicator:** Child - Improved Level of Functioning (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
<th>FY 2011 Actual</th>
<th>FY 2011 Percentage Attained</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Indicator</strong></td>
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<td>55.49</td>
<td>50</td>
<td>47.97</td>
<td>95.94</td>
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<td><strong>Numerator</strong></td>
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<td>96</td>
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<td>59</td>
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</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>186</td>
<td>173</td>
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<td>123</td>
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</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:** Children with Serious Emotional Disturbance are provided mental health services that support an improved level of functioning.

**Target:** A minimum of 50% of families receiving CMH services will report improved levels of functioning for their child.

**Population:** Children with SED.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children’s Services
4: Targeted Services to Rural and Homeless Populations

**Indicator:** The percentage of parents reporting that their child demonstrated improved levels of functioning after receiving CMH services.

**Measure:**
Numerators: The number of families reporting on the MHSIP YSS-F that their child had improved levels of functioning. Denominator: The total number of families completing the level of functioning section on the MHSIP YSS-F.

**Sources of Information:** MHSIP- YSS-F.

**Special Issues:** This will be the fourth year Idaho has collected this data and the third year Idaho had a target.

**Significance:** National Outcome Measure.

**Activities and strategies/changes/innovative or exemplary model:** Surveys are sent to all families receiving services from the CMH program on July 1st each year and at the time of case closure. This information is used throughout the year as a management instrument and reported annually as a NOM.

**Target Achieved or Not Achieved/If Not, Explain Why:**

This target of 50% was not ACHIEVED. It was 95% attained, however. 48% of those reporting on the functioning questions on the MHSIP YSS-F reported positively. This is a 7.5% decrease from last year’s data. It is unclear why this target was not achieved, especially since the CAFAS target (shown in the next table) was achieved at well over 100% of its target goal, showing that the same population did in fact have improved functioning.
Name of Implementation Report Indicator: CAFAS Outcomes

<table>
<thead>
<tr>
<th></th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
<th>FY 2011 Actual</th>
<th>FY 2011 Percentage Attained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>Performance Indicator</td>
<td>66</td>
<td>73</td>
<td>50</td>
<td>68</td>
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<tr>
<td>Numerator</td>
<td>404</td>
<td>563</td>
<td>--</td>
<td>503</td>
<td>--</td>
</tr>
<tr>
<td>Denominator</td>
<td>608</td>
<td>772</td>
<td>--</td>
<td>743</td>
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</tr>
</tbody>
</table>

Table Descriptors:
Goal: Provide an array of effective community-based services to children with SED and their families.

Target: At least 50% of children/youth receiving two (2) or more CAFAS evaluations will reflect a decrease in functional impairment.

Population: Children with SED.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: Percent of children/youth with a CAFAS score reflecting decreased functional impairment over time.

Measure: Numerator: Number of children/youth receiving services with CAFAS scores indicating a decrease in functional impairment. Denominator: Total number of children receiving an initial CAFAS and at least one additional CAFAS following the delivery of services.

Sources of Information: FOCUS information system.

Special Issues: CAFAS is a method to measure a child's overall functional impairment. While the overall score may improve, a child may still experience difficulties in specific functional areas. Additionally, services may terminate prior to the administration of a second CAFAS.

Significance: Improved functioning demonstrates the effectiveness of service interventions that lead to successful community integration.

Activities and strategies/changes/innovative or exemplary model: CMH will strive to meet the target by continuing to implement a continuous quality improvement (CQI) program that addresses the effectiveness of services. The CAFAS will continue to be used to measure functional impairment.

Target Achieved or Not Achieved/If Not, Explain Why: This target has been ACHIEVED at 136%. 68% of youth taking two or more CAFAS reflected decreased functional impairment.
## Transformation Activities:

**Name of Implementation Report Indicator:** Expenditures on Community-Based Systems

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2009 Actual</th>
<th>(2) FY 2010 Actual</th>
<th>(3) FY 2011 Target</th>
<th>(4) FY 2011 Actual</th>
<th>(5) FY 2011 Attained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td>92</td>
<td>92</td>
<td>75</td>
<td>N/A</td>
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</tr>
<tr>
<td>Numerator</td>
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<td>60,140,767</td>
<td>--</td>
<td>51,761,145</td>
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<td>Denominator</td>
<td>77,187,319</td>
<td>65,505,595</td>
<td>--</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

### Table Descriptors:

**Goal:** Prioritize funding for community-based services to ensure appropriate resource allocation of the community-based system and to ensure continuous quality improvement of the service system.

**Target:** At least 75% of all funding for CMH services by DHW will be spent on community-based services.

**Population:** Children with SED.

**Criterion:** 5:Management Systems

**Indicator:** Percentage of total CMH funding, including block grant funds, expended on community-based services.

**Measure:** Numerator: Amount of children's mental health funding for community-based programs (non-hospital care and expenditures). Denominator: Total funds spent on all children's mental health services including State Hospital South and other hospitalizations funded by Medicaid or CMH contracts.

**Sources of Information:** FOCUS information system, Division of Management Services information systems, SHS data, and Medicaid system information.

**Special Issues:** Existing data systems cannot differentiate from hospitalizations that are local and short term versus distant and longer term. For the purposes of this indicator, community-based services are defined as children's mental health services that are less restrictive than hospitalization. The data for medicaid-funded hospitals was not available, therefore, the total number of outpatient services was not reportable.

**Significance:** A community-based service system is a core value for the state as well as being a standard of practice for the field of mental health. Community-based services have been shown to be the most normalized, the most effective, and the most cost effective services.

### Activities and strategies/changes/innovative or exemplary model:

The Department is dedicated to serving children in their home communities whenever possible. Even though children may require services that are not community-based, the focus has been on developing an array of core services in each region of the state.

**Target Achieved or Not Achieved/If Not, Explain Why:**

This target was not able to be identified due to missing medicaid inpatient information. The new information system did not report Medicaid inpatient expenditure cost, so this table was not reportable. The table will be updated when the information is available.
Name of Implementation Report Indicator: Local Council Services

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2009 Actual</th>
<th>(2) FY 2010 Actual</th>
<th>(3) FY 2011 Target</th>
<th>(4) FY 2011 Actual</th>
<th>(5) FY 2011 Percentage Attained</th>
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<tbody>
<tr>
<td>Performance Indicator</td>
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<td>84</td>
<td>75</td>
<td>42</td>
<td>56</td>
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<td>Numerator</td>
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<td>Denominator</td>
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</table>

Table Descriptors:

**Goal:** Provide a system of integrated social services, educational services, juvenile justice services, and substance use services in combination with mental health services.

**Target:** A minimum of 75 families will receive Wraparound services.

**Population:** Children with SED.

**Criterion:** 3: Children's Services

**Indicator:** Number of families receiving Wraparound services through the CMH program.

**Measure:** Unduplicated count of families served through the Wraparound process.

**Sources of Information:** FOCUS information system and reports from Wraparound specialists.

**Special Issues:** The target for this indicator is being reduced given the projected reduction in total cases served through the CMH program. While Wraparound is considered an Evidence-Based Practice (EBP) by some, it is not listed as an EBP by SAMHSA.

**Significance:** The Wraparound model emphasizes interagency collaboration and consumer driven services. This indicator was selected as the Transformation Indicator considering the consumer and family driven components.

**Activities and strategies/changes/innovative or exemplary model:** Wraparound will be the chosen model for all children, youth, and families with high service needs, those at risk of out-of-home placement, and families with children involved in multiple systems.

**Target Achieved or Not Achieved/If Not, Explain Why:** This target was NOT ACHIEVED. It was only attained at 56%. The target for 2011 was set for 75 families to receive Wraparound services. In 2011 only 42 families received Wraparound services. The provision of Wraparound-type services may not be counted as Wraparound because the services are provided within the context of case management services and not counted as a separate service. Consideration will be given to changing this indicator to a percentage of those served through the CMH program.
Transformation Activities: 

Name of Implementation Report Indicator: Services to rural populations

<table>
<thead>
<tr>
<th></th>
<th>FY 2009 Actual</th>
<th>FY 2010 Actual</th>
<th>FY 2011 Target</th>
<th>FY 2011 Actual</th>
<th>FY 2011 Percentage Attained</th>
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<td>Fiscal Year</td>
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<td>Performance Indicator</td>
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<td>1,726</td>
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Table Descriptors:
Goal: Ensure that families residing in rural areas have access to services for their children with a serious emotional disturbance.
Target: A minimum of twenty-five percent (25%) of children served by the Children's Mental Health program will be from rural areas of the state.
Population: Children with SED.
Criterion: 4: Targeted Services to Rural and Homeless Populations
Indicator: The percentage of children receiving CMH services from the MHA that reside in rural areas. The number of children served in a rural service area is defined as those children receiving services through DHW field offices other than the primary regional office.
Measure: Numerator: The number of children/youth receiving Children's Mental Health Services through field offices located in rural areas of the state. Denominator: The total number of children/youth receiving Children's Mental Health services (through all Department of Health and Welfare field offices).
Sources of Information: FOCUS information system, Medicaid Data of youth served by rural and urban zip codes.
Special Issues: The Department of Health and Welfare has previously calculated the number of families residing in rural areas by adding cases served through field offices located in rural areas of the state. Given the recent closure of 9 field offices located in rural areas, this calculation is becoming more difficult. This target becomes increasingly difficult to achieve as it involves the maintenance of the same level of services when rural offices have been closed due to budget limitations. Because Idaho is a state-run system information is gathered based on where the clinical case manager serving the child is located, not where the child lives. Medicaid recently provided data regarding children served divided into rural vs. urban zip codes.
Significance: A significant percentage of Idaho citizens reside in rural areas of the state.
Activities and strategies/changes/innovative or exemplary model: The Department recently gained information from Medicaid data regarding urban and rural children being served divided by zip codes.
Target Achieved or This target was ACHIEVED at 120%. Over 30% of children being served come from rural areas of the state.
Not Achieved/If Not, Explain Why:
Name of Implementation Report Indicator: Target Population Served

<table>
<thead>
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<th>Fiscal Year</th>
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<th>FY 2011 Target</th>
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Table Descriptors:
- **Goal:** To provide youth/children with emotional disturbance access to outpatient mental health services funded by Medicaid.
- **Target:** To provide mental health services to no less than 16,500 children with emotional disturbance through outpatient mental health programs funded by Medicaid.
- **Population:** Children with Emotional Disturbance.
- **Criterion:** 2: Mental Health System Data Epidemiology
- **Indicator:** The number of children/youth that receive Medicaid funded mental health services.
- **Measure:** The total unduplicated number of children/youth that receive a Medicaid funded outpatient mental health service.
- **Sources of Information:** Medicaid Data
- **Special Issues:** Outpatient mental health services funded by Medicaid do not require a SED or specific mental health diagnosis. As a result, some of the unduplicated count of children/youth receiving services may not be SED, though all have a mental health diagnosis and are emotionally impaired.
- **Significance:** Medicaid is the largest funder of mental health services in Idaho. It is necessary to track services and continue to provide effective mental health services to children in Idaho that are SED and those that have not been determined SED.
- **Activities and strategies/changes/innovative or exemplary model:** Medicaid is a major source of payment for community mental health services. As mental health services provided through public agencies are impacted by current economic factors, the number of children and families accessing Medicaid funded services will be expected to increase.

Target Achieved or Not Achieved/If Not, Explain Why: This target was ACHIEVED at 102% of the target.
Idaho State Planning Council on Mental Health
Pete T. Cenarrusa Building, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0036

November 29, 2011

Virginia Simmons
Grants Management Specialist
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Simmons:

The Idaho State Planning Council on Mental Health received the Implementation Report of the State of Idaho FFY 2011 Federal Community Mental Health Services Block Grant. The Idaho State Planning Council’s Executive Committee reviewed the report by conference call and the Implementation Planners reported their findings in detail to the Executive Committee for discussion and comment. The Executive Committee accepted the Implementation Report with recommendations added and provided by the Idaho State Planning Council (Council).

The Council on Mental Health appreciates the opportunity to review and provide comment on the FFY 2011 Implementation Report. The efforts of the Council to educate and advocate will be vital in the coming years as our Nation and States continue to impose cuts in behavioral health services to one of our most vulnerable populations. The impact of these cuts is yet to be realized in terms or lost lives and life lost. As always the Council will continue our efforts to advocate and promote improvement to Idaho’s system of care for individuals with mental health needs.

Sincerely,

Teresa Wolf, Chair
OPTIONAL—Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.