WICHE

Western Interstate Commission
for Higher Education
Mental Health Program

ALASKA

ARIZONA

CALIFORNIA

COLORADO

COMMONWEALTH OF THE
NORTHERN MARIANA ISLANDS

GUAM

HAWAI'I

IDAHO

MONTANA

NEVADA

NEW MEXICO

NORTH DAKOTA

OREGON

SOUTH DAKOTA

UTAH

WASHINGTON

WYOMING

www.wiche.edu/mentalhealth

# System Redesign Status Update and Mental Health Service Array Assessment 2018


Liza Tupa, PhD
*ltupa@wiche.edu*

Hannah Koch, PsyD
*hkoch@wiche.edu*



WICHE
Western Interstate Commission
for Higher Education
Mental Health Program

# Table of Contents

## Introduction

The Legislature of the State of Idaho, understanding that the current mental health and substance abuse systems were falling short in their ability to effectively meet the needs of adults, children and their families, passed Senate Concurrent Resolution Number 108 in 2007, which implemented a review of Idaho's current mental health and substance abuse treatment delivery system and the development of recommendations to improve the system. The Department of Health and Welfare (DHW) subsequently engaged the Western Interstate Commission for Higher Education's Mental Health Program (WICHE MHP) to perform a third-party assessment and provide recommendations for a redesign of Idaho's mental health and substance use treatment delivery system. Founded in 1953, WICHE is a collaborative interstate compact with 15 western states, and a regional governmental entity. Idaho was a founding member of the WICHE Interstate Compact. The WICHE MHP, established in 1955, is one of the oldest WICHE programs. The WICHE MHP provides workforce development, program evaluation, and behavioral health system consultation across the WICHE member states.

A 2008 report "Idaho Behavioral Health System Redesign: Findings and Recommendations for the Idaho State Legislature" (the 2008 Report) resulted from that review. The report included thirty recommendations for the following issues:

1. Executive Branch Structure/Transforming the Structure and Roles of the Division of Behavioral Health (DBH)
2. Creating Regional Authorities
3. Identifying Gaps in the Intersection of the Justice Systems
4. Increasing Access to Care through Eligibility and Waivers
5. Enhancing the Efficiency of the State's Hospital Capacity
6. Increasing Accountability through Data
7. Enhancing Workforce Capacity

The current report, System Redesign Status Update and Mental Health Service Array Assessment 2018, reflects the two-pronged wish of the Division of Behavioral Health:

1. To understand the status of each of the recommendations in the 2008 Report and facilitate planning for updated action on any of the recommendations.
2. To engage third party consultation in regard to maximizing the efficiency and efficacy of mental health funding for Idaho adults with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI) via the configuration of DBH-funded mental health services. This task was circumscribed to primarily mental health services (with less of an emphasis on substance use services) for primarily adults with SMI and SPMI.

### The 2008 Report

At the time of the 2008 Report, Idaho's mental health and substance abuse systems were severely fragmented, with a significant lack of clarity – and consensus – regarding the roles and responsibilities of various system stakeholders. This fragmentation existed between the child and adult systems, the Medicaid and non-Medicaid eligible, the mental health and substance abuse systems, and the executive branch agencies. The review identified some of the main challenges (or weaknesses) facing Idaho's public mental health and substance abuse systems, as well as some of the opportunities (or strengths) that exist, via key stakeholder interviews and communications, and from quantitative and qualitative data gathered through a web-based survey over the following issue areas:

1. Management structure
2. Existing efforts of system integration and transformation
3. Delivery systems, including access to services and system capacity for adults and children
4. System accountability
5. State hospital and forensic mental health bed needs and capacity
6. Data systems and information sharing
7. Financing
8. Workforce

The 2008 Report, found that Idaho's system was uniquely challenged in several ways:

- Numerous recent and new initiatives aimed at reform in a number of allied systems, which were not necessarily part of a larger, strategic plan.
- A long history of failed – or perceived failure of – collaborations or discussions regarding improving or transforming the related systems.
- Lack of a coordinated, comprehensive, community operated, accountable community mental health system.
- Significant system distinctions and differences between adult and children's mental health, as well as those between the mental health and substance abuse systems.
- A large amount of risk to the State, particularly due to the following reasons:
  **Legal.** State employees were a key part of both deciding which persons were involuntarily admitted to the state hospitals, and, particularly for adults, for delivering the care in the community. This risk was exceptionally high regarding those persons who were receiving services from the state employees – services that may not have met the person's clinical needs. There was no clear oversight of the quality of services delivered by the State, which was an exposure to risk. Further, there was almost no oversight of other community providers.
  **Cost.** There was a significant amount of cost shifting between public systems, where the cost of failing to provide adequate services (or to provide quality services at the most appropriate time) resulted in a person accruing costs in more than one publicly-funded system.

## Changing Idaho Behavioral Health Systems Landscape since 2008

Since the 2008 Report, several significant changes (partly as a result of the recommendations and partly from other forces of change) have occurred within the overall behavioral health service delivery system which require that the 2008 recommendations be interpreted through a different lens. The most notable of these changes is the shift to a managed care model of Medicaid service provision, with Optum as the managed care organization. While the 2008 Report encouraged a similar change, several of the recommendations assumed the status quo of the time.

Another major and more recent system change is the establishment of the Youth Empowerment Services plan (YES) as result of the settlement of the Jeff D. lawsuit. This settlement has necessitated the adoption of numerous children's mental health system changes and improvements. Most of these improvements, have not been implemented similarly for the adult behavioral health service delivery system, however, some similar services will be available for Medicaid enrollees via the Idaho State Plan.

Lastly, the national recession that began just as the 2008 Report was finalized took a significant toll on behavioral health funding in the state,

with most stakeholders reporting that overall funding has not "caught up" to the trajectory prior to the recession.

## Approach

### *Idaho Department of Health and Welfare*

The WICHE MHP staff had several meetings with the leadership of the DBH to understand the history behind the request for this project and to get their perspectives on the 2008 Report recommendations and the actions that had been taken in response to those recommendations.

### *Stakeholder Input Groups*

For both parts of this project, the WICHE MHP staff held stakeholder inputs groups in-person, via video conference, and via teleconference. The WICHE MHP staff met with a variety of stakeholders, including the Regional Behavioral Health Boards (RBHBs), State Hospital Leadership, Optum representatives, the Idaho Health Summit, and others. See a list of these groups in Appendix A. Stakeholders were asked about the status of key recommendations from the 2008 Report, including those for which status was unclear or might vary based upon the perspective of the stakeholder, and about the current service array, what was working, what was not, and any gaps observed.

### *Stakeholder Input Survey*

An online survey was distributed to a wide variety of relevant state employees, providers, RBHB members, and other stakeholders with similar questions to those that the input groups were asked, to cast a wider net for input and give respondents the chance to both reflect on their answers and answer with anonymity.

### *Information Review*

The WICHE MHP staff reviewed a wide variety of documents and information to assist in both parts of this project, including policies, meeting minutes, state reports, recent legislation, and other information on state websites.

### *Best Practices*

Best practices were reviewed for service array recommendations. Most best practice information targets individual practice, with relatively little written about service array, but the Substance Abuse and Mental Health Administration's (SAMHSA's) on-line topic windows shed a light on the most salient components, as do service array recommendations in other states.

# Part One: System Redesign Recommendations Status Update

For ease of use, the 2008 Report recommendations, along with their respective status updates are presented below in table form. While most of the WICHE MHP's research was focused on these issue areas specified by DBH (mental health for adults with SMI/SPMI), many stakeholders and respondents had insight into substance use services, non SMI/SPMI adults, and the children's system, which was shared as appropriate, especially when it related to an interface with the original focus areas. One example is prevention services as they may relate to fewer individuals developing SMI/SPMI.

## System Redesign Recommendations Status Summary

The following overarching findings emerged as a result of the system redesign recommendations status update:

- DBH carefully reviewed and considered the 30 recommendations in the 2008 Report.
- Some of the recommendations were rendered less applicable or inapplicable to Idaho's system given other changes (such as the Optum Medicaid contract and the Jeff D. settlement and resulting YES system) and "progress" or activity there must be considered within this context.

- Significant activity and progress has been made overall for those recommendations that were adopted by DBH. The most notable of these include:
    - Development of HART homes to increase residential capacity.
    - Opening of the regional Crisis Centers.
    - Increased and coordinated mental health services through federally qualified health centers for individuals on felony probation and parole.
    - The inception of the RBHBs (while not individual behavioral health authorities as recommended in the 2008 Report, the RBHBs provide a vehicle for regional input and planning).
    - Coordination of transformative state activities via the Behavioral Health Transformation Workgroup.
    - The contract with Optum as Medicaid-funded treatment providers.
- While numerous positive changes have been made to the mental health service delivery system in Idaho, the overall system remains fragmented within DBH and across agencies, resulting in inefficiencies in service delivery.

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| **Recommendation 1.1**: Transform the Division of Behavioral Health (DBH) into a Division that directly and promptly improves the quality of care at the 'point of care.' This transformation will include:<br><br>1. Becoming a guarantor of care rather than a deliverer of care by administering, monitoring and ensuring the quality of care;<br>2. Leading collaborative efforts that include key community stakeholders and other departments, divisions and agencies to improve systems; and,<br>3. An integration of operations within DBH; across divisions within the Department; and amongst executive branch agencies, including the Office of Drug Policy (ODP). | **1.1.1 Moderate action in response to this recommendation.** While the enactment of the Regional Behavioral Health Boards (RBHBs) push some planning, coordination and input functions out to the various regions, DBH declined to completely divest from centrally contracting for and providing care for adults with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI). This decision was due to many factors including: political issues, lack of Medicaid expansion, the need to remain the providers of the "safety net" of care, the need to ensure a stable rural workforce, and the ability to act as "gate-keepers" for the state hospitals. DBH does not currently plan to transition from being a provider of care. With the changes accompanying the establishment of the Youth Empowerment System (YES), the DBH Children's Mental Health Program is working toward divesting from providing direct care services and putting a robust quality monitoring system in place for child, adolescent and family treatment and services.<br><br>DBH has placed more emphasis on care quality, however. A Quality Assurance (QA) Unit was established within DBH to monitor a variety of types and levels of care. An internal Transformation Sub-Committee within DBH provides some QA oversight of network providers on a voluntary basis. DBH is unable to directly monitor the quality of Medicaid-funded and Optum-provided care and lacks authority to make changes or improvements specifically within the Medicaid system and network. However, as a part of the Medicaid Idaho Behavioral Health Plan (IBHP), DBH and Optum do collaborate on some aspects of monitoring quality of care.<br><br>Additionally, quality management and quality improvement activities within the child behavioral health system are monitored using the Quality Management Improvement and Accountability (QMIA) plan, which the state describes as the children's system's "collaborative, cross-system, practice, performance monitoring and clinical quality improvement system."<br><br>**1.1.2. Significant action in response to this recommendation.** While the RBHBs are a key accomplishment for this recommendation (their role along with DBH administrative contributions to recent crisis center planning are good examples, as is DBH's involvement in |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| | the State Innovation Models integration grant, and the children's systems QMIA plan), DBH leadership feels that DBH could do more in leading these efforts. DBH did establish and does participate in the multi-agency, multi-stakeholder Idaho Behavioral Health Cooperative (established in 2016 per legislative direction [39-3124]), which is charged with improving coordination of behavioral healthcare across Department of Health and Welfare (DHW), the Idaho state judiciary, the Idaho Department of Corrections (IDOC), the Idaho Department of Juvenile Corrections (IDJC), the ODP, the Idaho Association of Counties (IAC), the State Behavioral Health Planning Council (BHPC), and the State Department of Education (SDE). This cooperative is directed to meet quarterly.<br><br>**1.1.3. Significant action in response to this recommendation.** See response to 1.1.2. above; with the additions of the QA section within DBH, QMIA, and the RBHBs. DBH staff and stakeholders report increased satisfaction with processes within DBH. Regarding coordination across executive agencies, the Idaho Behavioral Health Cooperative is meant to bring these agencies together at least once per quarter, but the Cooperative may lack either the political will or the high-level decision makers to enact more impactful and transformative changes to the behavioral health service delivery system. The ODP administers the prevention portion of the Substance Abuse and Mental Health Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG) for the state. Both DBH and the ODP report increased communication and coordination with one another, especially around substance use prevention and treatment issues. The ODB does report that communication is sometimes hampered by the need to work with multiple entities within DBH which may not be sharing information with one another as efficiently as possible, and which may, despite best intentions, not always result in action leading to identified deliverables. |
| **Recommendation 1.2:** Create a statewide 'transformation workgroup' to identify and address barriers to transformation by utilizing an existing collaborative, such as the | **1.2. Recommendation enacted.** Governor Otter created the Behavioral Health Transformation Workgroup (BHTW) through Executive Order in 2009. The purpose of the BHTW was, in part, to recommend strategies for implementing recommendations in the WICHE MHP report. From May 2009 through October 2010 the BHTW worked to generate a |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| Interagency Substance Abuse Prevention and Treatment Committee. | plan that would guide the overall transformation of Idaho's behavioral health system. The BHTW "sunsetted" in 2011. Currently, the Idaho Behavioral Health Cooperative could and arguably should, continue to serve this function. |
| **Recommendation 1.3:** Consolidate statutory requirements regarding designated evaluations for involuntary commitment into a single-step, community-based evaluation and determination process. | **1.3 Significant action in response to this recommendation**, with DBH decision not to fully enact it. With the RBHBs not being individual behavioral health authorities, DBH has kept administration of this process more centralized. In 2007, the Sub-Committee on Mental Health of the Health Care Task Force conducted a study of the involuntary commitment statutes of Idaho. Changes to the statute (§66-329) related to Designated Evaluations were passed in 2008 as a result. In 2010, DBH promulgated rules for appointment of Designated Examiners and Designated Dispositioners [Idaho Administrative Code (IDAPA) 16.07.39 "Appointment of Designated Examiners and Designated Dispositioners"]. The rule chapter defines the qualifications, appointment requirements, and appointment process. Additional statute changes were made to provide for outpatient commitment. DBH is planning to review the DE system again in 2018 to identify opportunities for increasing efficiency and simplicity of the system. |
| **Recommendation 1.4:** Establish new staff positions to invest in a transformed Division:<br>1. Clinical: A medical director (psychiatrist or licensed psychologist), either as a state employee or on contract, and additional clinical staff;<br>2. Policy planning staff; and Data/evaluation staff. | **1.4.1. Significant action on this recommendation**. Due in large part to workforce shortages and competing staffing demands, DBH has not yet hired a central Medical Director, however, all but one regional "hub" has a medical doctor (MD) that serves in the capacity of Medical Director, typically while serving in other capacities as well such as direct service. Regional hubs 3-4-5 have a contracted physician consultant to assist with medical direction and leadership. DBH is requesting a position and funding to hire a central Medical Director.<br><br>**1.4.2. Significant action in response to this recommendation**. Policy and Operations positions were created within DBH.<br><br>**1.4.3. Significant action in response to this recommendation.** The Web Infrastructure for Treatment Services (WITS) Help Desk was established during a DBH reorganization in 2011, and dedicated staff were increased for automation of data and other data and evaluation |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| | functions. Robust oversight and monitoring of community behavioral health provider data reporting remains a gap. |
| **Recommendation 1.5:** Formalize the criteria for the current community grants, which must include an official method for selecting programs; and adjust the community grants program to ensure its use as a mechanism for funding innovative programs and practices. | **1.5. Significant action in response to this recommendation**, with some modification. The RBHBs were developed and funded in part to serve this coordinating function. The community grants as described in the 2008 Report are no longer in place, although each RBHB does receive approximately $55,000, in part to use their respective public health offices as an administrative support and coordination partner, with the remaining funds often being used to write for external grants. RBHBs serve a slightly different role from one another based upon community needs, thus, pursuance of grant funding is a higher priority for RBHBs in some regions than in others. |
| **Recommendation 2.1:** Create a regionally operated, integrated mental health and substance abuse authority – or district – in each of the existing seven regions to plan, administer, and manage and/or deliver services for children and adults. | **2.1 Significant action in response to this recommendation**, with DBH decision not to push full authority out to RBHBs.<br><br>The Regional Mental Health Services Act did create the RBHBs in 2014 (Idaho Code 39-3121). However, DBH remains the Behavioral Health Authority ultimately responsible for DBH-funded behavioral health services. RBHBs have local authority to coordinate and plan services, provide input to central DBH administration, and potentially to provide community family support and recovery support services. |
| **Recommendation 2.2:** Ensure that the boards of the regional behavioral health authorities/ districts comprise of members who represent the various stakeholders; and ensure that the membership of the boards does not exceed fifty percent elected officials, providers and other professionals. | **2.2 Moderate action in response to this recommendation**. The Regional Behavioral Health Services Act prescribes board membership makeup in a different way – prescribing specific types/categories of members versus percentages of types of members, and that prescription does not equate to the recommended 50% non-elected officials, providers, and other professionals. Of the twenty-two members listed in statute, thirteen would be considered elected officials, providers or other professionals, and eight (36%) would not. These eight are defined as: "(1) parent of a child with a serious emotional disturbance; one (1) parent of a child with a substance use disorder; a law enforcement officer; one (1) adult mental health services consumer representative; one (1) mental health advocate; one (1) substance use disorder advocate; one (1) adult substance use disorder services consumer representative; |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| | one (1) family member of an adult mental health services consumer; one (1) family member of an adult substance use disorder services consumer" (Idaho Code 39-3134). Nevertheless, typical board membership and participation by stakeholders not defined as elected officials, providers or other professionals such as the tends to fall even lower than 36%. Even when one stakeholder may meet the definition of more than one of those referenced above, this group remains underrepresented in the RBHBs.<br><br>https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH31/SECT39-3134/ |
| **Recommendation 2.3:** Collaboratively establish a statewide, prioritized package of services to be delivered within regional behavioral health authorities/districts. | **2.3 Significant action in response to this recommendation**. As described in the status update for Recommendation 2.1, while the RBHBs are not independently delivering these services, DBH, with assistance from the Behavioral Health Transformation Workgroup, did develop a prioritized package of services, or Core Services (Idaho Code 39-3131) for adults with SMI and SPMI. These are: crisis services, hospital evaluations, criminal justice clients, and voluntary clients. Knowledge and understanding of this service package varies across DBH staff, partners, and stakeholders, with higher level state staff demonstrating a fairly uniform understanding of it.<br><br>https://legislature.idaho.gov/statutesrules/idstat/title39/t39ch31/sect39-3131/ |
| **Recommendation 2.4:** Transform the existing county behavioral health funding (e.g., Catastrophic Healthcare CAT Fund) and general funds currently expended on behavioral health services) into a fixed match that preserves a maintenance of the current funding for the regional behavioral health authorities. | **2.4 Minimal to moderate action in response to this recommendation**. This recommendation was not fully accepted for enactment by DBH. While county indigent funds do assume a risk of up to $10,000 per patient before general funds are used for community services, a fixed match has not been established. DBH does continue to look for ways to best leverage CAT and County Indigent funds. With expected general fund saving via the establishment of crisis centers across the state, DBH does plan to look for more effective use of CAT and County Indigent funds and maximize federal funding. |
| **Recommendation 2.5:** Use a transformed DBH to fund regional behavioral health authorities | **2.5 Moderate action in response to this recommendation.** While RBHBs are not behavioral health authorities, DBH does fund them for some activities and some provision of services. |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| utilizing formulized funding, based on factors including historical utilization and population. | The appropriation process for these funds has not been updated in some time; but it does have some individualization based on several factors, but little formulization based upon past or predicted future expenditures. |
| **Recommendation 3.1:** Review the mental health and substance abuse programs within the criminal and juvenile justice systems to ensure integration with regionally-based behavioral health authorities. | **3.1 Moderate action in response to this recommendation**, with current decision not to fully adapt and out of DBH's sole scope of control. While a great deal of effort has gone into creating and coordinating services for individuals with co-occurring disorders, criminal and juvenile systems also spend significant funds on mental health and substance use treatment, and these funding streams could be more streamlined. Despite recent efforts (2511A), they are actually less integrated currently. DBH did<br>establish and does participate in the multi-agency, multi-stakeholder Idaho Behavioral Health Cooperative, (established in 2016 per legislative direction [39-3124]), which is charged with improving coordination of behavioral healthcare across DHW, the Idaho state judiciary, IDOC, IDJC, ODP, IAC, the BHPC; but the body may lack either the political will or the high-level decision makers to enact more impactful and transformative changes to the behavioral health service delivery system. |
| **Recommendation 3.2:** Collect and share regional practices that have resulted in providing appropriate care to children in the custody of juvenile corrections. | **3.2 Significant action in response to this recommendation**. With the Jeff D. settlement in 2015, the children's behavioral healthcare system has undergone a major overhaul, with improved access to services a central focus. The resulting new system of care, known as YES was authorized by DHW as part of the settlement resulting from the Class Action lawsuit and is charged, in part, with establishing best practices for care.<br><br>http://youthempowermentservices.idaho.gov/ |
| **Recommendation 4.1:** Identify clinical and financial eligibility criteria that support the delivery of timely, quality, cost-effective screening, assessment, early intervention and prevention services. | **4.1 Minimal to moderate action in response to this recommendation**. The current configuration of prioritized DBH-funded services and associated eligibility criteria does not include prevention and early intervention, with the exception of Federally-specified Block Grant set-aside projects such as First Episode Psychosis (FEP). Without Medicaid expansion, the state has been limited in its ability to provide more universal screening or early intervention for indigent clients. However, some screening costs are reimbursable from |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| | Medicaid, and Medicaid provides some other services that can trigger reimbursed behavioral health services. The new crisis centers will help to some extent with early intervention of adult onset SMI, but not in any systematic way. Similarly, the State Healthcare Innovation Plan (SHIP) grant activities in the state would hopefully encourage more widespread screening for conditions such as depression, suicidality, and anxiety.<br><br>The YES system of care will provide for some early identification and referral for children, a notable improvement, but this process appears to be on a case-by-case basis rather than an early and coordinated screening program. |
| **Recommendation 4.2:** Amend eligibility criteria for public mental health and substance abuse services to support access to screening, assessment, early intervention, and recovery. | **See 4.1 above. Minimal action in response to this recommendation.** While IDOC does currently have funding for these types of activities for persons in their custody, the DBH has limited funds for assessments only. However, IDOC reports that there remains a large gap ($9,479,170) between the numbers of moderate to high risk individuals that are in need of mental health and/or substance use treatment and the funding that IDOC needs to provide those services. While SHIP grant activities will involve some limited pilots of screening in primary care practices, screening for depression is not one of the four Clinical Quality Measures (CQM) currently embraced (although it is one of the additional 12 CQMs currently under review for inclusion). Outcome:<br><br>https://www.idoc.idaho.gov/content/about_us/idaho_justice_reinvestment_initiative<br><br>http://healthandwelfare.idaho.gov/Portals/0/Medical/SHIP/IdahoSHIP.pdf<br><br>http://ship.idaho.gov/ |
| **Recommendation 4.3:** Continue the current effort to identify possible waiver or demonstration programs, including those that will result in integrated providers (mental health and substance abuse); in continuing these efforts, conduct a study of the per capita | **4.3 Moderate action in response to this recommendation**. The IBHP was implemented in 2013 via waiver (1915B[1]), with United Behavioral Health (dba Optum Idaho) as the administrating managed care contractor. While there were expected “hiccups” in provider and consumer adjustment, with efforts by the state and by Optum Idaho to remediate, the current general consensus from the vast majority of individuals that we interviewed or |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| costs of providing appropriate services, basing this study on any new eligibility criteria and including services funded by Medicaid. | otherwise sought input from is that significant access problems still remain for Medicaid enrolled individuals.<br><br>There are no current DBH plans to conduct a study of per capita costs of providing appropriate services based on new eligibility criteria and services funded by Medicaid, although as a managed care company, Optum reviews this type of information regularly. |
| **Recommendation 4.4:** Integrate the current efforts towards credentialing providers with the transformed DBH and regionally-based behavioral health authorities. | **4.4 Minimal action in response to this recommendation**. DBH has recently released a Request for Proposals for an entity to administer a peer credentialing program. Credentialing and monitoring efforts remain at the State level and systems remain separate for mental health and substance use. |
| **Recommendation 4.5**: Consider reinstituting targeted funds for the school-based counseling program. | **4.5 Moderate action in response to this recommendation**. Medicaid eligible children with documented disabilities can receive school-based services prescribed/approved by their physician as part of an Individual Education Plan (IEP). |
| **Recommendation 4.6:** Revise the existing eligibility screening and service delivery contracts for substance abuse to:<br><br>1. Create an adequate, risk-based contract for service delivery, preferably a capitated style contract with more local planning and control of service delivery;<br>2. Clarify eligibility requirements by removing any uncertainty on eligibility decisions; and, | **4.6.1. Minimal action in response to this recommendation**, largely due to less perceived need for this change. While the RBHBs do have input into identifying substance use needs and planning for service delivery in their regions, DBH's contract with BPA Health to manage the provision of substance use DBH-funded services is not risk-based. Additionally, Medicaid/Optum now covers some substance abuse services through their own risk-based managed care contract.<br><br>**4.6.2**. **Significant action in response to this recommendation**. Stakeholders fairly uniformly reported that the eligibility requirements are clear in regard to substance use services; they did also report, however, that funding for substance use services was severely insufficient, and that available services change depending upon how much of the Substance Use Disorder (SUD) funding budget has been expended. Certain higher cost services may be suspended for parts of the year due to budget considerations, so eligibility becomes somewhat confusing and/or moot. |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| Separate the eligibility determination function from the service assessment, planning and financing functions. | **4.6.3. Moderate action in response to this recommendation.** Currently, BPA Health handles eligibility, and clinical assessments are performed by their provider subcontractors. While at the time of the Idaho Behavioral Health System Redesign: Findings and Recommendations for the Idaho State Legislature" (the 2008 Report) there were numerous concerns about this issue, as well as BPA Health performance and processes, the general stakeholder consensus at this time is that BPA Health has significantly improved its efficiency. The more salient related issue at this time, however, is that providers must frequently juggle various eligibility, assessment, and service requirements from IDOC, the Idaho Court System, Medicaid, and DBH. |
| **Recommendation 5.1:** Conduct a review of State Hospital utilization data (both sites) to identify:<br>1. Valid mean (average) and median lengths of stay by age group and by region over a year;<br>2. The number of individuals who would benefit from community-based services and the types of services required;<br>3. The costs accrued per day by these individuals in the state hospitals; and,<br>4. The potential State Hospital cost avoidance that could be realized by decreasing inpatient stays and increasing community tenure. | **5.1.1 Moderate action in response to this recommendation**. While both state hospital regularly calculate average length of stay (LOS), the WICHE MHP was not able to procure a report with LOS calculated by age. Both state hospitals do report on LOS by Region, with is a valuable metric regarding region planning and needs.<br><br>**5.1.2.** Both state hospitals have a clear understanding of the individuals in their care who may be able to make use of a less restrictive setting, yet the common tension between a state hospital and its community still remains, with community providers sometimes lacking appropriate, less restrictive care settings. Conversely, waiting lists for civil beds vary to some extent but are typically long, with court-ordered admissions taking precedence. State Hospital South (SHS) especially has worked hard to decrease their LOS to provide capacity for both civil and court-ordered admissions.<br><br>**5.1.3.** Costs per day are routinely examined and used in budget planning as well as exploring the best ways and various levels of care to meet the needs of SMI and SPMI adults in the state.<br><br>**5.2.4.** Cost avoidance by LOS has been examined by the state hospitals, although LOS has actually increased for State Hospital North (SHN) since FY2014 and has vacillated for SHS. Both state hospitals, as well as DBH administration see few remedies to the issue of waiting lists and lengths of stay with the shortage of appropriate community placements and the |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| | increase of court ordered admissions, much of which has historically been beyond their control. |
| **Recommendation 5.2:** Allocate specific, acute bed capacity to the regional behavioral health authorities. | **5.2 Moderate action in response to this recommendation**, due to state population needs and the fact that RBHBs are not technically individual behavioral health authorities and there is no allocation methodology for the individual regions. Currently, there is a referral process implemented that utilizes State Hospitals largely geographically, with SHN for Regions 1, 2 and 3 and SHS for Regions 5, 6, and 7. Region 4 uses both state hospitals based upon need and availability. |
| **Recommendation 5.3:** Achieve and maintain accreditation for both state hospitals. | **5.3 Moderate action in response to this recommendation**, due to cost/benefit analysis indicating that this may not be in the best interest of SHN. SHS has successfully maintained the Joint Commission (TJC, formerly JCAHO) accreditation. SHN administration has researched the option of obtaining TJC hospital accreditation on at least two occasions since the 2008 report, and both times determined that the benefits of accreditation did not outweigh the monetary and staff time costs to achieve accreditation. At such time as the Centers for Medicare and Medicaid (CMS) eliminate the Institute of Mental Disease exclusion, SHN will likely reexamine the issue of accreditation (TJC and CMS) to be able to open additional beds that can be billed to Medicaid. |
| **Recommendation 5.4:** Utilize deliberate planning and program development in secure facilities, ensuring that civilly committed persons treated in these facilities are served in the least restrictive settings based on their clinical and legal circumstances. | **5.4 Moderate action in response to this recommendation**. SHS does continue to co-mingle forensic and civil patients (based largely upon diagnosis, treatment needs, and bed availability) and has not experienced this practice to be detrimental to patient progress or hospital safety. However, both state hospitals now have a referral option and process whereby they can request transfer of a small number of patients identified as Dangerously Mentally Ill to secure beds in IDOC. |
| **Recommendation 6.1:** Fully implement the recent budget initiative to design and implement a statewide data system that: | **6.1 Moderate to significant action in response to this recommendation**. Since the 2008 report, DHW developed and implemented the Web Infrastructure for Treatment Services, commonly known as the WITS system. |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| 1. Has utility at the 'point of care' (e.g., is helpful in clinical planning and treatment);<br>2. Collaboratively addresses and incorporates 'legacy' systems (systems in use currently by providers and other public agencies) currently in use by stakeholders; and, Moderate to significant activity in response to this recommendation. Since the 2008 report, DHW developed and implemented the Web Infrastructure for Treatment Services, commonly known as the WITS system.<br>3. Supports the implementation of electronic medical records. | **6.1.1.** While the WITS system was designed to have some point-of-care utility, primarily only DBH Adult Mental Health staff use it as such. For DBH staff, the WITS system serves a variety of functions, including procurement of forms, billing assistance, assessment, and alerts. The large majority of contracted or sub-contracted providers (substance use services) do not use it as such. A few of the smaller providers in the state do use WITS to assist in treatment planning and record keeping. Most contracted or sub-contracted providers use is as a portal or vehicle to submit required data to DBH.<br><br>**6.1.2.** This has not occurred, and typically takes a great deal of planning and continual adjustment.<br><br>**6.1.3.** While most providers do utilize electronic medical records (EMRs), the WITS system does not interface or extract data out of EMRs. Providers report that they must enter similar data twice, once into<br>their own records (EMR or in some cases, written) and once into WITS. |
| **Recommendation 6.2:** Conduct a study to determine 'population in need,' i.e. those who have serious mental illness or substance abuse/use disorder who are in need of publicly funded, community services. | **6.2 Minimal action in response to this recommendation**. To date, there has not been a "Population in Need" (PIN) study preformed in Idaho since the 2008 report. DBH leadership has, however, had some discussions around implementing such a study, possibly in partnership with a local University. A PIN study would provide DBH with valuable information about areas of greatest need (in addition to metro areas) and any regional trends. |
| **Recommendation 6.3:** Revamp and improve the accessibility and utility of the DHW website. | **6.3 Moderate to significant action in response to this recommendation**. A new website was established since the 2008 report. Stakeholders vary significantly in their frequency and intensity of use of the DBH portion of the website. A majority of the stakeholders who do access the website felt that it was easier to navigate, with the information they needed more accessible. Some did comment, however, that is was still difficult to navigate and not very helpful. |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| | Stakeholders and DBH staff also commented that the new YES website was simple to use and informative.<br><br>http://healthandwelfare.idaho.gov/ |
| **Recommendation 6.4:** Implement a system of evaluation and reporting for transformation activities, with an emphasis on identifying and analyzing the impacts of change on service recipients. | **6.4 Moderate action in response to this recommendation**. Governor Otter created the BHTW through Executive Order in 2009. During the time that the BHTW (comprised of a variety of government departments, including DHW and other stakeholders) was active, they provided an interim report and a final report of their goals, activities, and accomplishments. Currently, there is no central location or process by which the DHW or DBH report on their numerous transformation activities, although numerous separate work groups and task forces do report on their activities. DBH leadership plans to explore the use of a process to record these activities and accomplishments similar to that used by YES, which has made some advances in organizing this type of information necessitated by the Jeff. D lawsuit settlement. |
| **Recommendation 7.1:** Create a Workforce Collaborative to manage and coordinate a statewide behavioral health workforce study which will inform the development of a statewide strategic workforce plan. | **7.1 Moderate action in response to this recommendation**. As a part of the YES framework, a workforce analysis for children's behavioral health services is being conducted by Boise State University, but no such study has been conducted for services for all ages or adults in particular. Stakeholders almost unanimously agreed that a behavioral health workforce shortage exists across the state. |
| **Recommendation 7.2:** Design and implement applied mental health and substance abuse educational programs that translate into a job in the public behavioral health system. | **7.2 Minimal action in response to this recommendation**. With the exception of significant Health Resources and Services Administration (HRSA) involvement with various state and local agencies and healthcare providers to engage in recruitment and other general healthcare workforce activities, and some sporadic provider agency tuition reimbursement programs for their employees, no formal mental health and/or substance abuse educational programs that can develop into a job in the public behavioral health system (or well-fitting job opportunities thereafter) have been created. |

| WICHE MHP 2008 Recommendation | Status |
|---|---|
| | Currently, DBH has requested Governor's budget funds to assist with the development and establishment of an accredited psychology internship consortium as a method to keep Idaho psychology graduate students in the state and attract out-of-state graduate students to the state to work and live. |
| **Recommendation 7.3:** Increase availability of applied training opportunities in behavioral health professional settings. | **7.3 Moderate activity in response to this recommendation**. With the establishment of the RBHBs, regions have a mechanism by which to identify and plan for behavioral health workforce training needs, although funding is often piecemeal or collaborative between agencies. Additionally, Optum, in their Medicaid managed care role, has had the resources to identify training needs and provide training to providers in their networks, and sometimes beyond. Stakeholders reported that they occasionally have access to high-quality trainings, but to date there have been no systematized, ongoing efforts by DBH to assess the need for and provide trainings for the behavioral health workforce. This is not to say, however, that DBH hasn't identified and provided much needed training to their workforce at times. |
| **Recommendation 7.4:** Provide incentives for the recruitment and retention of behavioral health professionals trained to deliver evidence-based treatment interventions. | **7.4 Moderate activity in response to the recommendation.** In 2014, legislation was amended (I.C. §67-5339) to add an education loan repayment program to draw medical doctors, psychiatrists, nurse practitioners and physician assistants to the two state hospitals. From the behavioral health perspective, these incentives only cover psychiatrists, who, in busy locations where they are in short supply, have little to no time to provide any services other than medication evaluation and medication management. While the state hospital loan repayment program is an important help to state hospital recruitment, there is currently no other systematized, ongoing, DHW sponsored or funded recruitment and retention incentive program. Such an effort, however, could likely only be successfully undertaken after a behavioral workforce analysis has identified the most impactful workforce trends and needs. |

# Part Two: Adult Mental Health Service Array Assessment and Recommendations

## History

Part Two of this project involved engaging third party consultation in regard to maximizing the efficiency and efficacy of mental health funding for Idaho adults with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI) via the configuration of Division of Behavioral Health (DBH)-funded mental health services via the approach described in the introduction section of this report.

## Input groups and survey findings summary

As there was a high degree of overlap among the findings from stakeholder input groups and stakeholder survey findings, the overall combined results for stakeholder perceptions of the strengths, weaknesses/challenges, and gaps are presented below. Specific results by region are presented in Appendix B. Note also that some results may conflict with one another, as stakeholders frequently presented strengths about the service array but also ways in which they felt strongly that the services could and should be improved.

## Stakeholder input groups and survey results:

1. **What about the current <u>DBH-funded</u> service array is working? i.e., what needs are consistently being met?**

    - Regional Behavioral Health Boards (RBHBs) provide a good framework for meeting regional needs and providing regional input.
    - Assertive Community Treatment (ACT) teams were nearly unanimously described as valuable and effective.
    - Regional hospital liaisons are helpful for clients discharging from one of the two state hospitals.
    - Crisis Intervention (CIT) training was nearly unanimously described as very helpful for police responding to individuals with SMI or SPMI or those in crisis.
    - Specialty Mental Health Courts are effective in getting individuals needed services.
    - Designated Examiner system works well, especially as a gatekeeper to help ensure appropriate state hospital admissions.
    - Many stakeholders are hopeful that crisis centers will have an impact and report that the initial results are encouraging.
    - Medication management services are helpful in helping clients maintain stability in the community and access to these services is generally good, especially in more populated areas.

2. **What about the current DBH-funded service array is not working? (i.e., what needs are not consistently being met)?** (*Note: barriers to service delivery that were often mentioned in response to this question are reported under the Barriers to Service Question #5*)

    - Lack of transitional housing and lack of supportive housing, including permanent supportive housing, was one of the most frequently mentioned services/supports that was inadequate and/or not meeting the needs of the population.
    - The lack or inconsistency of services in rural areas was frequently mentioned, specifically in terms of access and lack of mobile crisis services.
    - Even though bed census can vary somewhat from time to time, the

current number of psychiatric hospital beds is inadequate for the need.

- Inadequate and inconsistent funding for community- based rehabilitation services (CBRS) was mentioned frequently, including the need to provide prosocial socialization and engagement opportunities and other recovery supports to avoid a "revolving door" with the inpatient hospitals. (Note: the Department of Health and Welfare (DHW) push to reduce the number of CBRS hours for Medicaid enrollees in the state achieved that goal without leading to increased use of higher, more restrictive levels of care[1]).
- Inadequate resources and future resource planning for Idaho's aging population, including a lack of treatment options to prevent inappropriate state hospital admissions (dementia versus psychiatric illnesses), a lack of trained providers to expertly and effectively serve this population, and a lack of access to services, especially in rural areas.
- Psychiatric hospital discharge planning and follow-up. Discharges from private hospitals, while having improved with the hospital liaisons, remain the most problematic.
- While the perception that services are more readily available for individuals that have been charged with a crime and/or jailed versus for individuals who have not has decreased, it nevertheless persists, especially outside of Region 4.
- The availability of peer support services is inadequate to meet demand.
- Residents are not aware of many programs and services.
- A large proportion of resources currently go to crisis centers versus to case management and individual psychotherapy where they are also badly needed.
- Outpatient commitment law is thought by some to lack enforcement power but is also understood and applied inconsistently across regions.
- A lack of substance use disorder services does exist, including the lack of a full continuum of care, early intervention, residential treatment, and detox, especially medical detox facilities.
- In general, there is a lack of early intervention, early identification and referral services.

**3. What about the current Medicaid-funded Optum-provided service array is working (i.e., what needs are consistently being met)?**

- Members do have access to services with typically good outcomes, and providers get authorizations easily, especially outpatient individual and family psychotherapy.
- Many stakeholders appreciate Optum's focus on Evidence Based Practices.
- Outpatient Behavioral Health services now have open authorization for individual and family therapy—deemed as preventative.
- Optum provides effective services for adults with mild to moderate mental illness in more urban areas for short to medium term and has several services that can be effectively wrapped around a client.
- Optum field care coordinators are helpful with hospital discharges.
- Optum has placed a focus on education and training of their workforce.

- Optum appears to be meeting their goal of controlling behavioral healthcare costs.
- Optum is contracted to pursue primary care integration initiatives and practices.

**4. What about the current Medicaid-funded, Optum-provided service array is not working (i.e., what needs are not consistently being met)?**

- Access for adults with SPMI has improved but most are still not getting all of the services they need to remain successfully in the community even with field care coordinators.
- One of the most frequent responses was that Optum's version of high-intensity services (somewhat akin to DBH ACT services) does not have the capacity nor is it robust enough to keep adults with SPMI out of inpatient treatment.
- Many stakeholders remarked that Medicaid enrolled clients who are discharged from psychiatric inpatient treatment do not receive the discharge follow-up necessary to remain in the community; treatment recommendations go unmet, and appointment availability with prescribers upon psychiatric inpatient hospital discharge can take up to several weeks. Several stakeholders stated that Optum "leaves it to the regions" to manage inpatient hospital discharge transitions.
- There is a lack of support services to compliment individual psychotherapy to keep adults with SMI and SPMI in the community and out of more restrictive institutions. The services include the types of services and supports that traditional ACT and CBRS (in part) services would provide, including home visits, collateral contacts, and more intensive case management.
- Optum lacks sufficient peer support/recovery coaching services.
- Optum is unable or unwilling to provide the three services/supports that best help individuals with SMI or SPMI remain successfully in the community: housing, medication and medication management, jobs (job placement, supported employment).
- It is difficult for Medicaid enrolled clients to access various levels of substance use disorder (SUD) treatment; Optum Medicaid benefits specialists do not always seem to have accurate information about rates and coverage.

**5. What, if any, barriers to service delivery do providers face, or what major challenges do they have in serving the target population?**

The most frequent barriers cited were a lack of funding, workforce capacity, access, transportation for clients to services, stigma and awareness about mental health, siloed systems leading to difficulty with communication and coordination, Medicaid processes, telemedicine, lack of care beds, and lack of jail diversion programs.

**Lack of funding, lack of flexible and/or braided funding models.** Many stakeholders cited the lack of adequate funding as the primary barrier to adults with SMI and SPMI receiving the services and supports they need. Other variations of this response included a lack of agreement with the current priorities for funding and a lack of braided funding models. Stakeholders stressed the need for more

pooled or braided funding models, especially for co-occurring (mental health and substance use) treatment and within integrated care.

**Workforce**. Workforce capacity and training were both cited as major barriers to service delivery as frequently as funding inadequacy. Stakeholders almost unanimously responded that the lack of behavioral health providers in rural areas of the state made effective service delivery difficult if not impossible. Additionally, workforce training and expertise was often mentioned as a barrier to the provision of quality care. Several aspects of the workforce shortage were expressed, including a lack of competitive pay leading to vacancies and turnover across almost all disciplines, but primarily peer specialists, psychiatric nursing, psychology, and psychiatry. Another frequently cited example was the low payment for medication management services adds to the lack of provider capacity for these services.

**Access**. While there is general agreement that access has improved somewhat over the last 5-8 years, consensus remains that access to services remains a primary barrier to treatment. This includes provider capacity, ability of clients to physically access services, and inpatient hospital bed space.

**Transportation**. The lack of transportation to get clients to the services they need was repeatedly cited as a significant barrier. Especially in rural areas, even when clients gain access to/eligibility for services, they are frequently unable to get to where these services and supports are delivered due to transportation problems. The same is true for crisis response and intervention, with most rural providers and other stakeholders reporting that the rural nature of much of the state precluded mobile crisis response teams or behavioral health clinicians corresponding with law enforcement/paramedics from responding to clients in their homes.

**Stigma and awareness**. Even when services are available, residents in need may not seek them due to lack of knowledge about the services or fear of the stigma of having a mental health issue.

**Siloed systems**. Stakeholders report that the separate mental health, substance use, child-adolescent, and adult systems tax already limited resources, and this phenomenon is compounded by the varied payor sources and delivery systems including DBH, Medicaid, and judicial, and correctional systems. This complexity and the differing requirements of the systems lead to significant administrative burdens for providers.

**Medicaid processes**. Eligibility and enrollment processes were frequently cited as barriers to services, with stakeholders reporting that enrollment is a difficult and time-consuming process. The billing complexities within integrated care (for example, with a primary medical versus primary mental health diagnosis) are also seen as a barrier. Some providers reported that the administrative burden of being a Medicaid provider is burdensome to the point of affecting their ability to operate.

**Telemedicine**. The state needs to find ways to approve more telemedicine, especially for prescribers, but also in crisis situations.

**Care beds**. A lack of most types of care beds, including inpatient psychiatric, skilled nursing plus psychiatric, step down and

transitional housing, permanent supportive housing, sober living homes, and supportive group homes, were cited as barriers to helping clients achieve and maintain their highest levels of community functioning. The initiation of expansion of Homes with Adult Residential Treatment (HART) group homes is welcomed by most stakeholders.

**Jail Diversion programs**. Many stakeholders reported that Idaho county jails continue to hold a high proportion of inmates whose primary needs are for behavioral health treatment. There is a need for more formal jail diversion programs across the state.

6. **Do you feel that adequate resources exist in your region for individuals experiencing a crisis?**

Despite the establishment of regional crisis centers in some areas and plans for additional crisis centers, stakeholders overwhelmingly reported that there are not enough resources for individuals experiencing a crisis in their regions. They largely attributed this to a lack of capacity in the existing centers along with the centers' inability to provide a wider spectrum of services including on-site prescribers, more intensive case management, and a lack of referral options.

**Additional input included:**

- Region 7 has not seen a reduction in mental health holds since their crisis center has opened.
- CIT training for law enforcement has been helpful.
- Transportation to the crisis centers was mentioned by several stakeholders as a problem.
- The general public is not well-informed about the crisis centers or other system services.
- The crisis centers are a good start; but many areas of the state need more mobile crisis.
- Crisis centers do not work as well for individuals who end up needing to be placed on a mental health hold.
- Law enforcement extends too much manpower in transporting to crisis centers and other locations such as Emergency Departments.
- Optum does not provide consistent or robust crisis services after hours or on weekends.

7. **What resources are lacking for individuals in a crisis?**

The most frequently mentioned resources that the behavioral health service delivery system lacks for individuals in a crisis were:

- Housing, both transitional and permanent
- Prescribers, along with affordable and accessible medication
- Case management, including case management service via phone or text
- Counseling

8. **What services/supports are missing in the current overall service array?**

As might be expected, responses to this question were widely varied. Stakeholders most frequently responded that increased rural services, housing options, and peer services were needed in the state. Below are the most frequently mentioned needs or issues.

- More and more accessible rural services
- Transportation to access services and supports
- Housing options including more step-down beds (post inpatient discharge)

- Overall increased capacity, overall increased workforce, including most involved professional disciplines
- Peer services, including peer specialists, family navigators/advocates and recovery coaches
- Additional ACT capacity
- Public awareness and stigma reduction for those seeking behavioral health help
- Telehealth options
- Expansion of First Episode Psychosis (FEP)
- Coordination of efforts across the state
- Supported employment programs to assist in the recovery

**9. How would you describe the current system capacity to meet all the needs of these populations?**

Stakeholders overwhelmingly responded that the current system capacity is inadequate to meet the needs of adults with SMI and SPMI.

For example, 71% of survey respondents indicated that the system is "seriously compromised" or only "somewhat unable" of accommodating all individuals in need of services or supports, while only 28.8% of respondents indicated that the system is "somewhat able" or "able" to meet the needs of all individuals in need of services or supports.

Specific issues cited that contribute to capacity problems included:

- Shortage of providers of all disciplines
- Long waiting lists for inpatient hospital bed
- Lack of prevention and early intervention services leads to later treatment capacity problems
- Medicaid reimbursement rates that encourage providers become part of the network
- State system resources are skewed to designated examinations (DEs) and crisis services
- Lack of integration between mental health and substance use services

## Regional differences in stakeholder input groups and survey results

Though there was a high degree of overlap between regions in the findings from stakeholder input groups and the stakeholder survey, specific results by region are presented here. As in the summary data above, some results may conflict with one another, as stakeholders frequently presented strengths of the service array while also describing areas for improvement.

***Crisis services***

In regard to crisis services, the opinions differed based on the rural nature of the region. Stakeholders reported that in more urban areas (Boise in Region 4 and Coeur d'Alene in Region 1, for example) crisis centers are working relatively well and are helpful.

Furthermore, stakeholders from Region 4 also agreed that mobile crisis was relatively effective, especially in partnership with law enforcement and local agencies. The Psychiatric Evaluation Teams (PET) of paramedics and clinicians in urban areas of the state were reported to be very efficient in avoiding unnecessary mental health holds and in getting individuals the help they need. The general consensus across the state is that existing crisis resources are working relatively well, but that more are still needed. For example, stakeholders reported that in rural areas more

widespread mobile crisis is necessary, particularly in Region 1.

On the other hand, there is general consensus (particularly in Region 1 and Region 2) that even though the crisis services seem to be effective, resources are skewed toward crisis service provision and thus away from other services. Representatives from Region 4 concur, saying they feel "overwhelmed" with crisis management, along with conducting DEs. Therefore, across the state, but particularly in Region 4, the perception is "no one is doing early intervention because everyone is in crisis." One state-wide organization mentioned that the system needs to get off the "crisis treadmill" and funnel more resources into prevention and early intervention.

***Transportation***

Regarding transportation, again comments split on a rural/urban divide. Stakeholders reported that in rural areas of regions such as 1, 3, 7, and even rural areas of Region 4, the burden of transportation to crisis centers falls on law enforcement, which stretches their already thin resources. Furthermore, stakeholders report that in rural areas across the state (but especially in Region 1), transportation in general is a challenge, as it is hard for rural residents to reach appointments.

***Access***

Additionally, most regions mentioned access to services as a challenge. Representatives from Region 2 cited access to services as a particularly strong challenge, and representatives from Region 4 echoed this barrier for their outlying areas. Interestingly, data from Optum Idaho indicates that 99.8% of enrolled residents have access to a mental health professional except for some in very rural areas and zip codes, but not necessarily to all kinds of services.

***Specific Programs***

Many stakeholders, particularly in Region 4 and 7, are hopeful about the recent establishment and anticipated expansion of Homes with Adult Residential Treatment, HART Homes, staffed group homes with the capacity to house and support adults with SPMI and SMI. Stakeholders from Region 4 and 7 also stated that FEP programs are very helpful when available.

***Workforce***

A key challenge identified across the state was workforce shortage. This issue was particularly emphasized in Region 1, with representatives saying that they have immense challenges in filling open positions. Region 2 mentioned a shortage of providers at every level. Region 3 highlighted the lack of peer and family support professionals, and Regions 4 and 7 mentioned a lack of psychiatric coverage. An important regional difference is that stakeholders from Region 4 hypothesized that their workforce shortage was due in large part to lack of competitive pay, given the high cost of living in their urban areas. Representatives from other regions (Region 1, for example) hypothesized that their difficulty was in recruiting qualified staff in addition to lack of competitive wages.

## Current DBH Adult Mental Health Funding Priorities

The current DBH adult mental health system funding priorities are shown below.

**Current DBH Adult Mental Health Service Priorities**

| Priority #1<br>Crisis | Priority #2<br>Court Ordered Services | Priority #3<br>Mental Health Court | Priority #4<br>Voluntary |
|---|---|---|---|
| A situation in which the individual perceives a sudden loss of his or her ability to use effective problem-solving and coping skills that lead to a risk of self-harm, risk of harm to others, or decompensation to the point of a person's inability to protect themselves from harm. | Court ordered evaluation, treatment recommendations, and possible treatment provision for offenders being sentenced under criminal court. See Idaho Code 19-2524 for Statutory Definition. | Mental health courts are an alternative sentencing program whereby the court closely supervises and monitors mentally ill adult offenders and oversee their treatment. | Time Limited Outpatient Mental Health Therapeutic Treatment Services for indigent populations. |

These prioritized services appear to reflect an attempt to respond to several influences and pressures external to the DHW while at the same time minimizing the risk of catastrophic outcomes for adults with SMI or SPMI and members of their communities. The "evolution" of this set of priorities is certainly understandable given the economic limitations and pressures that Idaho, as well as many other states, have faced over the past ten to twelve years.

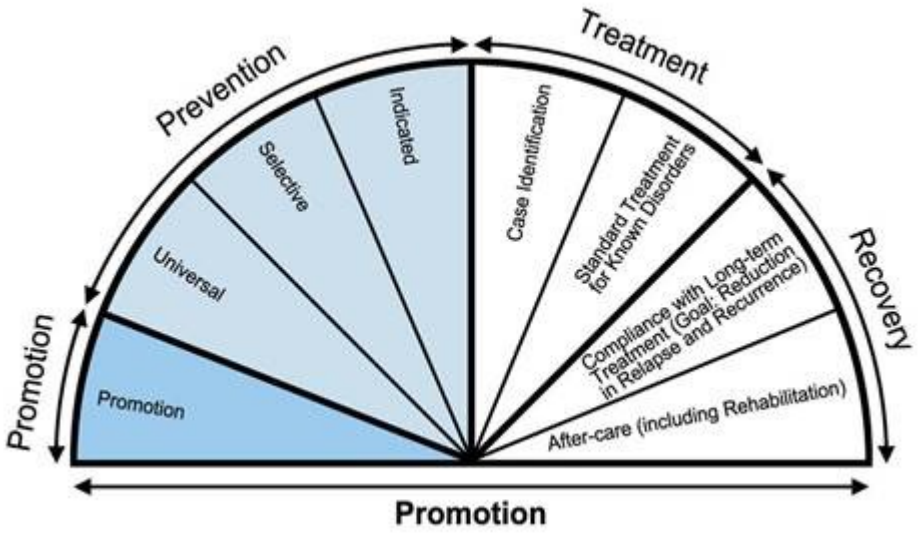
The current package focuses resources "downstream" in terms of the behavioral health needs of adults with SMI and SPMI. This focus, while likely seeming necessary due to limited resources, places the "safety net" a long way down along the continuum of care, and could provide more to prevent a fall earlier on. Additionally, crisis centers are typically most effective when an array of services exists to which individuals in crisis can be referred.[1]

## Recommended DBH Adult Mental Health Funding Priorities

The WICHE MHP recommends that DBH adopt a service delivery approach that more closely reflects the continuum of care as recommended by Substance Abuse and Mental Health Administration (SAMHSA). This continuum, shown in the illustration below (please see Figure 1), encompasses services, supports, and interventions that span promotion, prevention, early intervention, treatment, and recovery:

[1] Substance Abuse and Mental Health Services Administration. (2014). *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies*. (HHS Publication No. (SMA)-14-4848.) Rockville, MD: Substance Abuse and Mental Health Services Administration.

**Figure 1**




From National Research Council and Institute of Medicine. (2009). Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

## The major components of the service continuum "protractor" are described below:

***Promotion***

These activities are designed to create environments and conditions that universally support and promote behavioral health and coping skills along the entire continuum of behavioral health services. Such activities include public awareness campaigns, stigma reduction campaigns and activities, and wellness initiatives.

***Prevention***

These activities are intended to prevent or reduce the risk of developing a behavioral health problem, such as major depression, prescription drug misuse and abuse, or suicide. These activities can and should be carried out at a variety of levels across the behavioral health system landscape and include programs and approaches such as Social Emotional Learning curricula in schools, screening for depression, psychoeducation for universal or targeted populations, and wellness initiatives targeted to subpopulations found to be at risk, based upon social determinants of health.

***Treatment***

Traditional treatment services are for people diagnosed with a behavioral health disorder. They are ideally evidence-based, client centered (i.e., tailored to meet individual needs), and offered in sufficient variety as to meet the varied needs of as many individuals as possible. Such activities include FEP programs, ACT teams, traditional outpatient therapies, intensive outpatient and inpatient treatments.

***Recovery***

These activities support individuals to live productive lives in the community while minimizing the risk of relapse or recurrence. Such activities include sober living homes, supported employment, public transportation training, peer check-ins and problem-solving assistance, and other rehabilitative services.

DBH currently funds many services, supports, and interventions that fall along this continuum, and the WICHE MHP recommends that DBH use

this concept and illustration as a guiding framework for future service array planning for specific DBH-funded services, as well as state behavioral health planning as a whole. While it is likely not feasible for DBH to provide comprehensive services within each of the continuum components and subcomponents, the model can nevertheless show where gaps exist for consideration and, conversely, where services are in place that reflect more comprehensive coverage.

## Recommended Service Array for Idaho Adult Mental Health

After information gathering on gaps and needs specific to the state of Idaho as described in the Approach section above and taking into consideration a full-service array model, the WICHE MHP recommends DBH consider the following service array. For ease of reference, the table below illustrates both current and recommended DBH-funded services as shown along the service array continuum illustrated above.

**Current and Recommended DBH Funded Adult SMI/SPMI Services by Continuum Framework**

| Framework Category/Subcategory | Current DBH Service(s) | Recommended Expansion, Additional Service(s), Initiatives |
|---|---|---|
| Promotion | | Statewide Public Awareness and stigma campaign |
| | | Expand Targeted Mental Health First Aid |
| Prevention/Universal | Integrated Care screening, limited | Expand screenings for substance use, depression, anxiety and suicide[2] |
| Prevention/Selective | | |
| Prevention/Indicated | | |
| Treatment/Case Identification | Assessment | Establish additional triggers and avenues for early identification and assessment |
| | First Episode Psychosis (FEP) programs | Expand FEP to broader areas of the state |
| Treatment/Standard Treatment | Assertive Community Services | Expand ACT services across state with rural modifications |
| | Case Management | Expand case management services |
| | | Expand peer navigation services |
| | Medication Management | |
| | Psychiatric Services | |

[2] United Healthcare Community Plan. *Clinical Practice Guidelines*. Retrieved March 1, 2018 from https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/clinicalguidelines/WA_BH_Screening_Assessment_Treatment_Clinical_Practice_Guidelines.pdf.

| Framework Category/Subcategory | Current DBH Service(s) | Recommended Expansion, Additional Service(s), Initiatives |
|---|---|---|
| | Outpatient Services | Expand outpatient services to prevent crisis and hospitalization<br>Create additional capacity for co-occurring mental illness and substance use disorder treatment |
| | Residential Care | Create residential care options, including for the elderly and individuals transitioning from inpatient treatment. |
| Treatment/Acute | Crisis Intervention | Work with Medicaid and Optum to increase crisis services for Medicaid-enrolled individuals |
| | | Fund transportation options to enable individuals to make use of the behavioral health services offered |
| | Mobile Crisis | Expand mobile crisis, especially in rural areas, consider various models including use of peer specialist, training of Emergency Medical Technicians (EMTs), co-responding |
| Treatment/Compliance-reduce relapse | | Supported employment and volunteer programs for individuals in recovery |
| | | Fund transportation options to enable individuals to maintain treatment gains and level of functioning |
| Recovery/Aftercare | Rehabilitative and Community-Based Services | Review services to identify those with the best outcomes and expand |
| | Residential Care | Transitional and Permanent Supportive Housing |

**A note on Prevention and Early Intervention in Idaho**

The WICHE MHP recognizes that adult mental health and prevention and early intervention is by no means within the sole purview of DBH adult services. Comprehensive and effective prevention strategies must begin before adulthood and should not be limited solely to either substance use or mental illness. Therefore, they require the coordination of a variety of state agencies and other local partners such as the education system. This report does not inventory all such programs and efforts in Idaho.

**Each recommendation in the table above is addressed further here:**

## Promotion

***Statewide public awareness and stigma reduction campaign***

Science shows and Idaho stakeholder input supports that western and rural residents tend to resist seeking help because of a lack of information and/or understanding about available services and because of a fear of being stigmatized. Stigma reduction campaigns are especially important in areas with high suicide rates, such as Idaho.

***Targeted Mental Health First Aid***

Educating residents, especially those who may interface frequently with groups at risk for mental health issues (such as teachers, Boys and Girls Club leaders, coaches, forest rangers, senior outreach volunteers) about the basics of mental health and how to respond if they suspect an individual has a mental health issue, may serve as both stigma reduction and an informal early identification system.

## Prevention, Universal

***Expand screenings for substance use, depression, anxiety and suicide***

Thought by prevention experts to be the "gold standard" of early identification for adults, universal screening is widely recommended for primary care and other care settings. Early identification can enable individuals to get less expensive help sooner. Evidence-based programs such as Screening, Brief Intervention and Referral to Treatment are widely used and heavily supported by SAMHSA and other entities.

## Treatment, Case Identification

Establish additional triggers and avenues for early identification and assessment. Currently, many clients of the DBH-funded system enter it through the criminal justice and judicial systems. Expanding screenings as described above may help individuals get the treatment they need before coming to the attention of law enforcement.

## Treatment, Standard Treatment

***Expand FEP to broader areas of the state***

FEP programs are evidence-based and serve as early intervention, standard treatment, and acute treatment. Identifying, effectively treating, and educating individuals with first episode psychosis can greatly improve the outcome of the often-devastating mental illnesses associated with psychotic symptoms.[3] Currently only three of seven regions have this important early identification treatment.

***Expand ACT services across state with rural modifications***

Stakeholders almost uniformly praised DBH-funded ACT as a mechanism for preventing relapse and hospitalization among Idaho adults with SPMI. They also frequently commented that Optum lacked ACT teams and that enrolled clients experienced more problems, including rehospitalization, because of it. While Medicaid may not reimburse for all components of ACT treatment, the WICHE MHP recommends that DBH work with Optum to find ways to fund and otherwise enable ACT-type services for enrolled adults with SPMI, such as seeking reimbursement and maximizing ACT team treatment Medicaid reimbursability, perhaps with DBH funding the non-reimbursable elements such as team meetings and travel time for home visits.

***Expand case management services, expand peer navigation services***

One way to expand some case management services would be to employ more peer navigators who could serve as "extenders" of Case Managers, although not necessarily in the Medicaid reimbursement sense. These peers could provide basic guidance and assistance to adults in need, alerting Case Managers when more complex issues arise.

[3] Heinssen, R.K., Goldstein, A.B., Azrin, S.T. (2014). *Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care*. *Recovery After an Initial Schizophrenia Episode (RA1SE)*. Bethesda, MD. National Institute of Mental Health.

***Expand outpatient services to prevent crisis and hospitalization***

Preventing a crisis is always preferable to managing a crisis. Additional capacity for outpatient treatment, especially voluntary treatment, may reduce the need for crisis management and thus crisis center usage and/or higher levels of treatment intensity.

Create residential care options, including for the elderly and individuals transitioning from inpatient treatment. Given both Idaho's aging population[4] and reports of insufficient inpatient psychiatric beds in the state, residential care and transitional beds (both step down and step up) can be provided at lower cost than inpatient treatment and will likely relieve some of the burden on the state hospitals and private inpatient units.

***Create additional capacity for co-occurring mental illness and substance use disorder treatment***

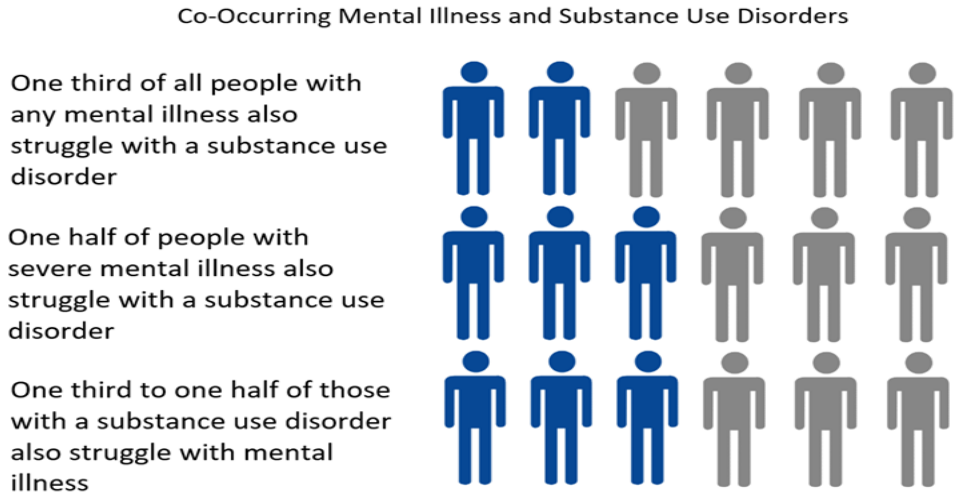
During the time that substance abuse treatment models and systems were developing in the western United States, popular theory postulated that one treatment must come before the other (typically, substance use treatment before mental illness treatment), and the two systems developed separately. Scholarly and applied research, however, has clearly demonstrated the superiority of treating both mental illness and substance use concurrently using evidence-based treatments in individuals with co-occurring disorders.[5][6] National estimates are that approximately one third of all people with any mental illness and approximately half of people with severe mental illnesses are also struggling with substance abuse (see Figure 2).

[4] U.S. Census Bureau (2015). Demographic Data 2010-2015. Retrieved from https://lmi.idaho.gov/census.

[5] Kelly T.M. & Daley D.C. (2013). Integrated Treatment of Substance Use and Psychiatric Disorders. *Social Work Public Health*. *28*(0), 388-406. doi:10.1080/19371918.2013.774673.

[6] Torrens M., Rossi P.C., Martinez-Riera R., Martinez-Sanvisens D., & Bulbena A. (2012). Psychiatric co-morbidity and substance use disorders: treatment in parallel systems or in one integrated system? *Substance Use Misuse*. *47*(8-9), 1005-1014. doi:10.3109/10826084.2012.663296.

**Figure 2**




Similarly, among individuals diagnosed with a substance use disorder, one third to one half report having a mental illness as well.[7] Building co-occurring treatment capacity can be challenging in systems where mental health and substance use treatment systems and thus payment/reimbursement systems have traditionally been siloed. However, high quality, evidence-based treatment for individuals with co-occurring disorders is most effective and may even be more cost-effective. Traditional substance use treatment providers who have developed a niche and who may not have the staff credentialed or trained to treat co-occurring disorders may be especially challenged to provide this type of treatment, but their traditional services do still remain valuable for individuals with SUDs without co-occurring mental illness.

## Treatment, Acute

Work with Medicaid and Optum to increase crisis services for Medicaid-enrolled individuals. Many stakeholders reported that Optum's after hours services, required by contract, were insufficient. Encouraging Optum to provide after hour services as contracted, along with seeking Medicaid reimbursement in place for all applicable crisis center services, may increase sustainability of the crisis centers.

***Fund transportation options to enable individuals to make use of the behavioral health services offered***

Transportation was one of the most frequently cited barriers to treatment by all stakeholder groups that the WICHE MHP addressed as well as by survey respondents, and has long been a barrier in rural areas.[8] Transportation issues included the burden on law enforcement of transporting individuals to emergency

[7] National Alliance on Mental Illness. (2015). *Dual Diagnosis*. Retrieved March 16 from https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/Dual-Diagnosis-FS.pdf.

[8] Arcury T.A., Gesler W.M., Preisser J.S., Sherman J., Spencer J., Perin J. (2005). The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region. *Health Services Research*. *40*(1), 135-156. doi:10.1111/j.1475-6773.2005.00346.x.

departments and other acute settings, and the inability of many Idaho residents, especially those in rural areas, to get to and from needed treatments and services. While providing on demand transportation can be an expensive endeavor. The WICHE MHP recommends that DBH partner with other agencies and entities to explore creative and efficient solutions to this significant barrier to treatment.

***Expand mobile crisis (especially in rural areas), consider and/or expand various models including use of peer specialists, training of EMTs, and increase co-responding***

In close relation to the general issue of transportation described above, stakeholders resoundingly reported that rural areas lack mobile crisis services. Mobile crisis is potentially one of the least expensive ways to provide crisis intervention. Provision of mobile crisis services in rural areas is more challenging than provision of mobile crisis in more urban areas, but it is not impossible.

## Treatment, Compliance - Reduce Relapse

***Supported employment and volunteer programs for individuals in recovery***

Assisting adults with SPMI in engaging in employment or volunteer opportunities, in an evidence-based and client-centered way, helps them maintain their progress made in treatment and avoid relapse and rehospitalization.

***Fund transportation options to enable individuals to maintain treatment gains and level of functioning***

It is vital that adults with SMI and SPMI be able to access follow-up support, medication management, and meaningful activities to avoid relapse and rehospitalization.

## Recovery, Aftercare Options

***Review services to identify and expand those with the best outcomes***

Given the varying stakeholder opinions about the Community Based Rehabilitation Services offered by DBH, the WICHE MHP recommends examining the outcomes associated with this package of services, either quantitatively or via literature review, and consider focusing on and even expanding those services most associated with better outcomes.

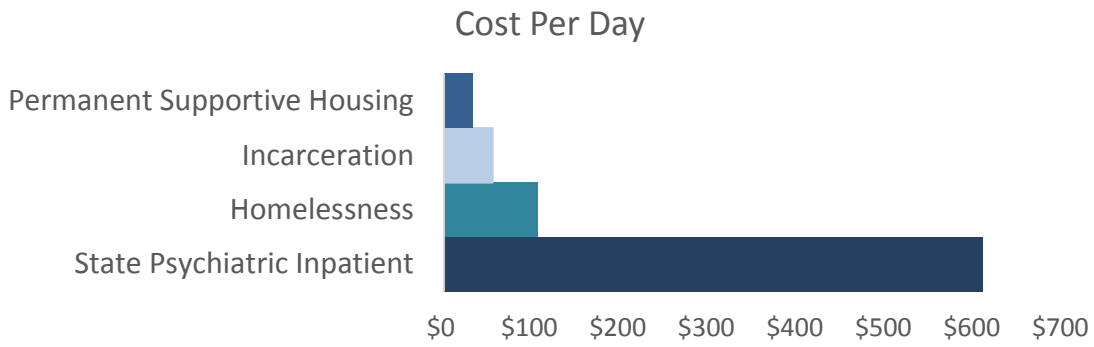
***Transitional and Permanent Supportive Housing***

Housing options are critical to lessening the burdens on Emergency Departments, inpatient hospitals, and law enforcement of responding to the acute needs of adults with SPMI. Permanent Supportive Housing programs use client-centered and evidenced-based processes and interventions to help adults with SPMI maintain safe and stable community living. Permanent Supportive Housing Programs are typically much lower cost than most of the alternatives for adults with SPMI.

Homelessness has been estimated nationally to cost taxpayers $38 - $40 thousand dollars per year per individual, or approximately $106 per day, due to individuals cycling in and out of emergency health care, jails, the criminal justice system, shelters, and psychiatric inpatient treatment when the homeless struggle with SPMI illness (please see Figure 3).[9]

[9] Moorhead, M. (2012, March 2). "HUD secretary says a homeless person costs taxpayers $40,000 a year." Retrieved from http://www.politifact.com/truth-o-meter/statements/2012/mar/12/shaun-donovan/hud-secretary-says-homeless-person-costs-taxpayers.

**Figure 3**




Idaho state psychiatric inpatient costs are currently an average of $609 per day; Idaho prison incarceration costs are $55 dollars per day,[10] and the average cost per day to provide permanent supportive housing is approximately $32 dollars per day while providing opportunities to learn life skills with support, receive appropriate treatment, and receiving rehabilitative services such as job skills training and placement assistance.

Additionally, as stated previously, given reports of insufficient inpatient psychiatric beds in the state, transitional residential beds (both step down and step up) can be provided at lower cost than inpatient treatment and will likely relieve some of the burden on the state hospitals and private inpatient units. Myriad resources and development partners exist to assist with the financing, planning, and execution of permanent supportive housing models, even in more rural areas, and the WICHE MHP recommends that DBH partner with city and state housing authorities to explore these resources and options.

The WICHE MHP appreciates that these service array recommendations would be fiscally impossible to enact in totality within the current DBH budget, and prioritization must be given to the various service array component changes. However, these recommendations are important to improve outcomes for Idaho adults with SPMI and to protect public safety, so the WICHE MHP would certainly recommend pursuing additional funding for those prioritized items. Consideration of the additional recommendations below may allow DBH and other state agencies to best coordinate and leverage available funding.

## Recommendations to Facilitate Service Array Improvements:

The WICHE MHP has several system recommendations to help facilitate the recommended service array improvements.

1. Expand system capacity via behavioral health workforce development by:

    1.1 Initiating and/or expanding workforce development programs for various behavioral health disciplines. This may be accomplished through activities such as:

        1.1.1 Encouraging or incentivizing tuition reimbursement programs and or training-to-job programs

[10] Idaho Department of Corrections. (2013). *FAQ*. Retrieved from https://www.idoc.idaho.gov/content/prisons/faq.

within provider and other agencies.

1.1.2 Partnering with higher education institutions and provider agencies to arrange for increased student practicums and internships, especially in more rural areas.

1.1.3 Exploring Health Resources and Services Administration (HRSA) workforce development grants and resources, including high school outreach resources.

1.2 The state is in need of a position, such as a Director of Behavioral Health Workforce Development, to focus on strategic implementation of impactful processes and programs and to partner with other public and private entities to make an impact on the continuing behavioral healthcare provider shortage in Idaho. This position, with increased dedicated time, could also take the lead inidentifying and coordinating behavioral health workforce training needs.

2. Decrease the number of court ordered mental health evaluations by:

2.1 Collaborating with the judicial system on processes and procedures to identify the most appropriate referrals, enacting statutory changes if necessary.

2.2 Expanding and enacting more jail diversion programs.

3. Improve the sustainability of the newer crisis centers by:

3.1 Working with Medicaid and third-party payors to maximize reimbursement for applicable crisis center services.

3.2 Expanding “upstream” services such as outpatient psychotherapy and supports.

3.3 Training and employing peer navigators for lower level case management needs.

4. “Ramp up” service array improvements by sponsoring smaller scale pilots for recommended types of programs, evaluating their effectiveness and efficiency (including possible savings) and then scaling up the pilots that show good outcomes and return on investment. Pilots such as these are excellent opportunities to partner with private agencies to get new and innovative programs “off the ground.”

5. “Right size” regional funding by examining the regional DBH funding allocation methodology. While several useful demographic indicators are used for this system, program managers and RBHB board members indicate that some regions are frequently over budget (or find their budgets to be inadequate) while others are frequently underspending. Data driven, county and regional level indicators such as prior spending, suicide rates, inpatient hospitalization rates, and psychiatric emergency department visits could also be incorporated into an allocation formula.

6. Align the many commendable and promising efforts to impact and improve the behavioral health of Idaho residents by identifying a specific state position to inventory and understand efforts across the state. This staff member could inform DHW and others about these efforts (so as not to silo potentially valuable resources and information), provide information and guidance to interested partners and agencies regarding behavioral health needs and priorities within the state, identify private agencies with which to partner and

leverage those opportunities for the benefit of the behavioral health system and consumers overall, and work with various partners and agencies to avoid redundancy. One example of this type of coordination would be working with private hospitals to increase and improve basic medical services at the regional crisis centers. This position would not need to replace DBH and other state agency staff that might sit on various boards or otherwise advise or work with such partner agencies and organizations, but would serve a central coordinating/understanding role and could interface as well with any higher-level coordinating position within the Governor's Office.

7. Increase capacity to serve complex co-occurring disorders by facilitating and encouraging providers with this expertise.

8. Streamline the burden of the multiple administrative processes that service providers face when delivering services funded by various state agencies by partnering with providers and other state agencies to review administrative processes and requirements and streamline wherever appropriate. Coordination of authorizations, assessments and reports may ease that administrative burden for providers and ultimately allow them to provide more billable hours, helping with capacity issues as well as provider relations.

9. With RBHB and other stakeholder input, clarify and delineate the role of the RBHBs. While regional differences in RBHB priorities are understandable and likely even encouraged, the WICHE MHP impressions were that the RBHBs varied significantly in both their activities, capabilities, and functions. Standardized expectations, processes, and performance metrics potentiate increased achievements and higher-level responsibilities for the RBHBs.

## Conclusion

This report, System Redesign Status Update and Mental Health Service Array Assessment 2018, covers the dual objectives of the Idaho DBH to determine the status of each recommendation in the 2008 WICHE MHP Behavioral Health System Redesign Study Report and to obtain consultation in regard to maximizing the efficiency and efficacy of mental health funding for Idaho adults with SMI and SPMI via the configuration of DBH-funded mental health services. This task was circumscribed to primarily mental health services (looking less at substance use services) for adults with SMI and SPMI.

**Part One** of the report, the 2008 Report recommendations status update, indicates that DBH carefully reviewed and considered the 30 recommendations in the 2008 Report. Some of the recommendations were rendered less applicable or inapplicable to Idaho's system given other changes (such as the Optum Medicaid contract and the Jeff D. settlement and resulting YES system) and "progress" or activity there must be considered within this context. For those recommendations that were adopted by DBH, significant activity and progress has been made overall. The most notable of these include development of HART homes to increase residential capacity, opening of the regional Crisis Centers, increased and coordinated mental health services through federally qualified health centers for individuals on felony probation and parole, the inception of the RBHBs (while not individual behavioral health authorities as recommended in the 2008 Report, the RBHBs provide a vehicle for regional

input and planning), coordination of transformative state activities via the Behavioral Health Transformation Workgroup, and the contract with Optum as Medicaid-funded treatment providers. While numerous positive changes have been made to the mental health service delivery system in Idaho, the overall system remains fragmented within DBH and across agencies, resulting in inefficiencies in service delivery.

**Part Two** of this report introduces a full continuum model of behavioral health services and supports to guide future planning for service provision. It incorporates nationally recognized best practices to "fill in" the continuum of services and supports currently offered for Idaho adults with SMI and SPMI, selected based upon the unique challenges that the Idaho behavioral health system faces, including its largely rural nature, high suicide rate, individualistic frontier culture, and funding structure. Overall, the WICHE MHP recommends that DBH use this service continuum model to develop a comprehensive set of services and supports for adults with SMI and SPMI to maximize their chances for living in recovery and in the least restrictive settings possible. Recommendations about additional services and a shifting or, more accurately, levelling of priorities are made. These recommendations are based on a review of best practices, and also incorporate input from a variety of partners, including on-the-ground stakeholders and DBH leadership.

Lastly, the report makes several additional recommendations that, if adopted, would likely facilitate DBH's ability to act on the recommended service array. Some of these are based upon recommendations from the 2008 Report and work that remains relevant and necessary, while others reflect the changes that the Idaho behavioral health system has undergone since that report.

## Appendix A. Focus Group Summary

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| **ID Department of Health and Welfare Region 1 Behavioral Health Board** | | | | | | | |
| | | | -Covering telehealth would be good | | | -Housing-clients come out of ER and are back on streets or shelter<br>-Transportation | -Resources skewed to Designated Examinations (DEs) and Crisis |
| **ID Department of Health and Welfare Region 2 Behavioral Health Board** | | | | | | | |
| -Division of Behavioral Health (DBH) is doing well at providing designated examinations (DE)<br>-Specialty and Mental Health (MH) court going well | -Discharge planning into community | -When providers available, able to get med management, counseling | -Need more Community Based Rehabilitation Services (CBRS) hours to be approved<br>-Do not pay enough for med management | -Lack of workforce<br>-Role confusion between community partners and DBH<br>-Need more money | -Giant swaths of Region 2 have no crisis—only 911/police/ paramedics<br>-Do not really have 24-hour crisis | -Access, particularly in rural areas | -Access and money<br>-Medicaid should reimburse at rate that encourages providers to take it<br>-Shortage of providers at every level<br>-Need statewide effort to recruit psychiatrists<br>-Should reach out to hospitals to fill gaps in continuum of care |

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| | | | | | | | -Resources skewed to DEs and Crisis |
| **ID Department of Health and Welfare Region 3 Behavioral Health Board** | | | | | | | |
| -Making partnerships with other agencies<br>-Resource array has grown<br>-CIT training<br>-MH court works well | -Differences in funding (public/private) make partnerships challenging<br>-Funding for prevention in schools<br>-Services depend on where live, what resources available—not consistent<br>-Resource array has grown, problem is access (especially rural)<br>-Failure to follow through on discharge | -Outpatient behavioral health (BH) services now have open authorization for individual and family therapy—deemed as preventative<br>-Have discharge coordinators | | -Conservative legislature does not want to deal with BH issues<br>-Siloed payor sources make it tough | -Crisis centers are good, but transportation to them from rural areas is a challenge<br>-Boise is resourced—do not always have access | -ACT, expanding FEP<br>-Increasing access<br>-Specialized services<br>-Housing for SPMI<br>-Transportation<br>-Supportive employment<br>-Step down services | |

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| | plans—limited follow up when private hospitalization (small number of frequent flyers land in field care coordination, but need consistent system)<br>-Incorporating outpatient and inpatient Medicaid for a single provider—help coordination<br>-Burden is often on Law Enforcement (LE) | | | | | | |
| **ID Department of Health and Welfare Region 4 Behavioral Health Board** | | | | | | | |
| -Crisis centers<br>-PET and mobile crisis<br>-CIT | -Some places do not have mobile crisis | -Primary care integrated BH<br>-Works for those lucky enough to | -Follow up appointments are weeks out | -Do not have good transition to Intensive Outpatient (IOP) | -LE extends too much manpower in transporting | -Crisis services in rural areas | -Need to increase capacity |

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| -Specialty courts—MH court | | get Optum services | -Need psychiatrists<br>-Can bill in integrated settings if primary medical diagnosis, but not if primary MH<br>-Difficult to access SUD treatment<br>-Lack of support for basics like housing, food, support services | or partial hospitalization<br>-Need better integrated approach not shotgun approach<br>-Opioid treatment | | | -Need to stress preventative services |
| **ID Department of Health and Welfare Region 6 Behavioral Health Board** | | | | | | | |
| -Good access for those eligible for Medicaid<br>-ACT is great | -Get better services in jail<br>-Lack of housing<br>-Lack of CBRS<br>-Lack of providers (no private MH providers that are loan repayment)<br>-There is more access in | | | -Not enough housing<br>-Four entities competing for funding rather than one entity competing with legislature for funding<br>-Accessibility for rural population | -Crisis center becomes a homeless shelter | -Lack of reimbursement for collateral contacts | |

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| | substance use disorder (SUDS) world, MH | | | -"State of Ada" – resources go to Boise then trickle down | | | |
| **ID Department of Health and Welfare Region 7 Behavioral Health Board** | | | | | | | |
| -ACT<br>-Behavioral Health (BH) boards<br>-Specialty courts—MH court | -Lots of resources go to crisis and not case management or individual counseling | | -Need ACT services<br>-Lack transition from hospitalization<br>-Follow up appointments are weeks out<br>-Those on MH drugs "blacklisted" in nursing homes and Skilled Nursing Facilities (SNFs)<br>-Lack of support for basics like housing, food, support services | -Jails full of those who should be inpatient<br>-Not enough beds - especially disabled or elderly (closing of Safe Haven in Pocatello b/c of fire)<br>-Transportation<br>-Do not have good transition to IOP or partial hospitalization<br>-Housing<br>-Need better integrated approach not shotgun approach<br>-Right now children's system | -Crisis works well in large cities, inadequate in rural areas<br>-Crisis centers work really well for someone that does not meet criteria for protective custody—cross line to someone who needs inpatient—system breaks down<br>-Optum does not provide good crisis services after | -Lack of psychiatrists<br>-Providers do not take responsibility for patients—wait until "train wreck" instead of stepping in earlier<br>-Transitional services out of hospitals<br>-Lack of recovery support | -Do not have capacity for aging/dementia/ Alzheimer's—not enough facilities |

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| | | | | getting all the attention because of Jeff D<br>-Need flexible/blended funding for co-occurring treatment, same with medical side (medical and BH)<br>-Better training in MH systems for doctors | hours or on weekends | | |
| **ID Department of Health and Welfare State Hospital North** | | | | | | | |
| -SHN doing well—"Club North"<br>-Regions doing well as gatekeepers for involuntary commitment<br>-Ability to discharge to a "live body" in the regions for 30-day follow up | -Not able to handle delirium patients—20% inappropriate hospitalizations<br>-Need housing<br>-Outpatient follow up (optimistic about Heart Homes) | -Do more with less here in Idaho<br>-Optum doing well at cutting costs | -"Optum has been a disaster"<br>-Hard to get people qualified<br>-Organized but rigid<br>-Optum misses the three pillars of "housing, medication, jobs"<br>-Are not engaged in hospital | -Lack of competitive salaries<br>-Transportation<br>-Access<br>-Telemedicine (rural nature of Idaho) | -Crisis centers need to mature a little more<br>-Region 2 is worst in whole state<br>-Crisis bumps into Division of Health and Welfare (DHW) and LE and funnels to us | -System lacking mid-level support/step down<br>-We limit access to care to major metropolitan areas—need small town offices | -Need access to recovery and SUD services<br>-Do not have enough inpatient beds |

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| -MH court working well<br>-ACT teams doing well | | | discharge-punted it to regions | | | | |
| **ID Department of Health and Welfare State Hospital South** | | | | | | | |
| -If they have a payor source, needs met well<br>-Regions work well<br>-Regions have hospital liaisons that are helpful<br>-ACT teams | -Outpatient commitment law is weak ("doesn't have teeth")<br>-Inconsistencies in commitment process<br>-Not enough community beds<br>-LE complains transporting all over the place—up to Coeur d'Alene | -Heart Homes starting—like group home but higher level of care<br>-Optum has done nice job wrapping services around | -Optum is good for those who have a payor source<br>-Need ACT teams | -Resources, money and workforce (not high enough salaries)<br>-Good recruiting new nurses, then they leave (no way to pay based on experience)<br>-Not enough housing | -Crisis centers are helpful but not enough<br>-Have not seen reduction in holds despite Idaho Falls Crisis Center<br>-CIT training for LE has been helpful | -Peers<br>-Step down—hope Heart Homes will work as proposed (but need Medicaid) | -Long waiting list<br>-Have to mix civil and forensic—hurts the milieu |
| **Optum Idaho and Idaho Medicaid** | | | | | | | |
| | | -Members have access to services, good outcomes, | -Ongoing support to keep out of hospital or prison | -Pushing hard to be able to bill for telemedicine | -Crisis centers are a good start | -Need more workforce – residencies in psychiatry | -Our data says 99.8% have access to MH professional except for some |

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| | | get authorizations easily<br>-Use of EBPs<br>-Huge focus on education and training | that is not therapy<br>-Inpatient adult services<br>-CBRS type services<br>-Peer support/recovery coaching | | -Need more statewide awareness about MH crisis<br>-Wish we had mobile crisis unit | -Need social workers the most<br>-Need better coordination of care<br>-ACT teams<br>-public awareness campaign for MH<br>-Integrating outpatient (OP) and inpatient (IP)<br>-Telehealth<br>-Support for peer-run recovery centers | very rural areas and zip codes, but not necessarily access to all kinds of services |
| **BPA Health** | | | | | | | |
| -Crisis<br>-ACT<br>-MH Court<br>-Voluntary | -Too much happening in emergency rooms | -Basic outpatient short-medium term is accessible for Medicaid population | -SUD not as accessible as we thought it would be—discrepancy in rates, lack of understanding of SUD as covered, | -Workforce issue—need to concentrate on early intervention or keeping people healthy after | -Need to get from "crisis treadmill" to investing in people on a long- term basis | -Recovery coaching, family support specialists, peers | -Would be better to have MH and SUD integrated. Some MH are open to it, some do not want to touch it |

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| -Eligibility intake is good—even if tell someone "no" know what is going on | -Need more early intervention<br>-Help keeping healthy once stabilized<br>-Housing is a gap<br>-Need positive things for people to do during the day if they cannot work<br>-For SUD—do not have full continuum of care—do not have early intervention/residential/social detox not medical detox—cannot give patients what they need clinically—"holes in continuum" | | so everything gets turned into a MH disorder<br>-System is set up to have inpatient separated—chunking up the continuum<br>-People think of Medicaid as a MH benefit not a BH benefit<br>-e.g. Mom with kids—Medicaid will pay for mom but not kids so BPA covers cost of transporting kids | intensive treatment<br>-Chasing after funding thus prioritizing the crisis cases<br>-Better communication | -Need more rural crisis – rely a lot on LE<br>-Need more field offices<br>-Need workforce with broader training and relationship with LE | | -BPA supplements Medicaid funding for "dually funded" clients<br>-Problem that we create our own Idaho-specific criteria rather than using national criteria for various things (peers, GAIN certifications, etc.) |

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| **ID Department of Health and Welfare Division of Behavioral Health Central Office and Regional Program Managers** | | | | | | | |
| -Meet needs of court (Region 2)<br>-Get DEs done (Region 2)<br>-"When people hit our system, we do a good job" (Region 2)<br>-ACT (Regions 5 and 7)<br>-MH court (Regions 5 and 7)<br>-FEP (Region 7)<br>-Med management (Regions 5 and 7)<br>-CIT<br>-Mobile crisis, mobile response (Region 4)<br>-Do a good job with | -Do not do well with ongoing case management outside of ACT team, do not do well with ongoing individual therapy (Regions 1, 2, and 7)<br>-Do not do well with catching people early (Region 2)<br>-Could do better with following up after crisis (Regions 3 and 4)<br>-Do need to be better with follow up care once discharged (Region 3) | -Works well for mild SMI in urban areas (all regions)<br>-Service array focuses on talk therapy (all regions)<br>-Good job integrating field care coordinators with hospital discharges (Region 3)<br>-Do good job once client sticks (Regions 6 and 7)<br>-Will provide services based on provider availability (Regions 5 and 6) | -Lots of lip service, no action (Region 1)<br>-Lack of providers (Region 1) | -Residential care facilities are de-incentivized to take mentally ill folks (Region 3)<br>-Shortage of providers (Region 2)<br>-Transportation (Region 4) | -Do not really have mobile crisis except in region 4 (Region 1)<br>-Do have a 24 hour crisis line in all the regions (all regions) | -Budget does not take into account what region needs—region 1 is over what region 4 is short (Regions 1 and 4)<br>-Trustee and benefit money has decreased (all regions)<br>-Need small field offices (all regions)<br>-Central office focused on Child system not as much on adult system (Regions 1 and 2) | -Not adequately resourced for true safety net population – spread thin unless client has Medicaid (Regions 2 and 4)<br>-No staff in rural areas (Regions 1, 2 and 4)<br>-Would be helpful to allow professionals in community to make decisions around DEs—lessen load on DBH staff (Regions 1, 4, and 5) |

| What about the current DBH service array is working? | What about the current DBH service array is not working | What about current Optum service array is working | What about current Optum service array is not working | Barriers to service delivery or major challenge serving the target population? | Adequate resources for individuals experiencing a crisis? | What services or supports are missing in the current service array? | Current system capacity to meet the needs of these populations? |
|---|---|---|---|---|---|---|---|
| partnerships (Regions 1, 2, and 4).<br>-Helpful to video conference with state hospital (Region 4)<br>-Staff is really good (Region 4) | -Need better recovery support—need housing, revolving door with state hospital and homeless shelters (Region 4)<br>-Need more peer support (Region 4)<br>-Need more rural services (Regions 1 and 2) | | | | | | |

## Appendix B Regional Differences Tables and Charts

141 survey responses were received. We excluded from the analyses any responses that were just to the first 1 question, any respondents who responded to just the first question and "No" to the second question, as well as one survey that just responded to the first question and "unsure" to the third and fourth question (a total of 60 responses), leaving a total of 81 surveys that were included in the analyses.

Table 1. Barriers to service delivery by region, from stakeholder survey (n=71)

| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 and 6 | Region 7 |
|---|---|---|---|---|---|---|
| Lack of adequate funding | 75% | 63% | 57% | 66% | 50% | 100% |
| Lack of flexible funding | 25% | 50% | 57% | 55% | 50% | 60% |
| Workforce shortage | 75% | 38% | 86% | 53% | 75% | 100% |
| Workforce training needs | 0% | 50% | 71% | 40% | 25% | 40% |
| Client access problems | 75% | 50% | 86% | 64% | 50% | 60% |

Figure 1. Barriers to service delivery by region, from stakeholder survey (n=71)

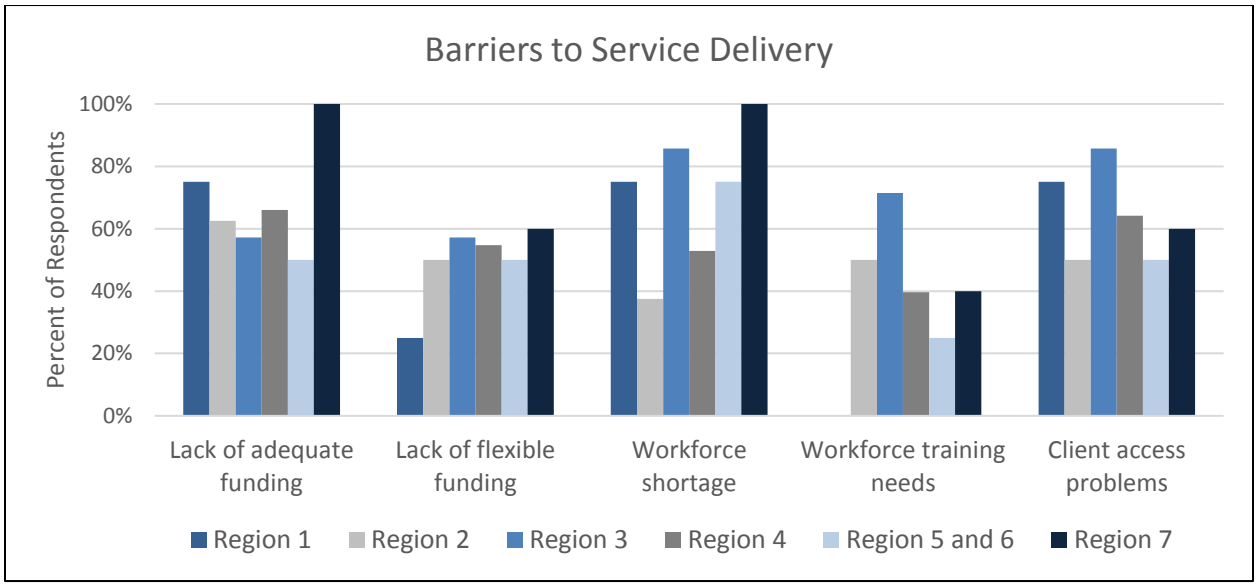


Table 2. Adequate crisis resources by region, from stakeholder survey (n=71)

| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 and 6 | Region 7 |
|---|---|---|---|---|---|---|
| Yes | 25% | 13% | 0% | 23% | 25% | 40% |
| No | 75% | 50% | 100% | 66% | 50% | 60% |

Figure 2. Adequate crisis resources by region, from stakeholder survey (n=71)

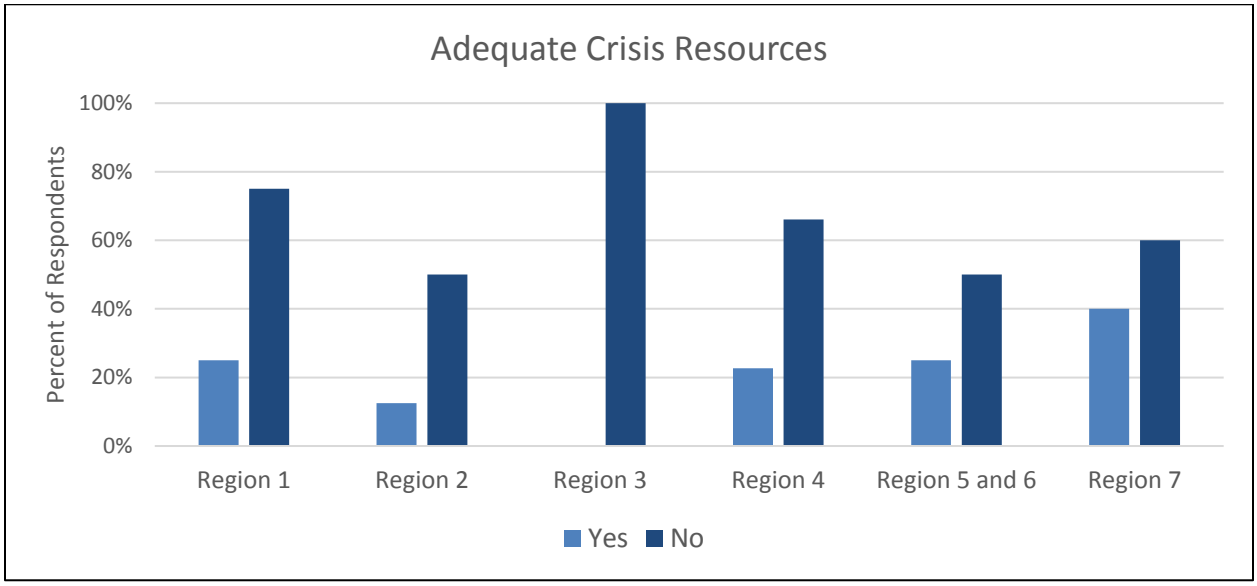


Table 3. What resources are lacking by region, from stakeholder survey (n=53)

| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 and 6 | Region 7 |
|---|---|---|---|---|---|---|
| Crisis Counselors | 25% | 50% | 57% | 38% | 25% | 20% |
| Prescribers | 50% | 25% | 43% | 45% | 50% | 60% |
| Physical crisis center locations | 0% | 50% | 100% | 32% | 50% | 40% |
| Case management | 75% | 25% | 57% | 34% | 50% | 20% |
| Transitional housing | 75% | 50% | 100% | 53% | 50% | 40% |
| Permanent housing | 50% | 50% | 57% | 49% | 25% | 40% |
| Sufficient counseling sessions | 0% | 38% | 29% | 23% | 0% | 0% |
| Linking to social service supports like food assistance | 25% | 25% | 43% | 21% | 0% | 0% |

Figure 3. What resources are lacking by region, from stakeholder survey (n=53)

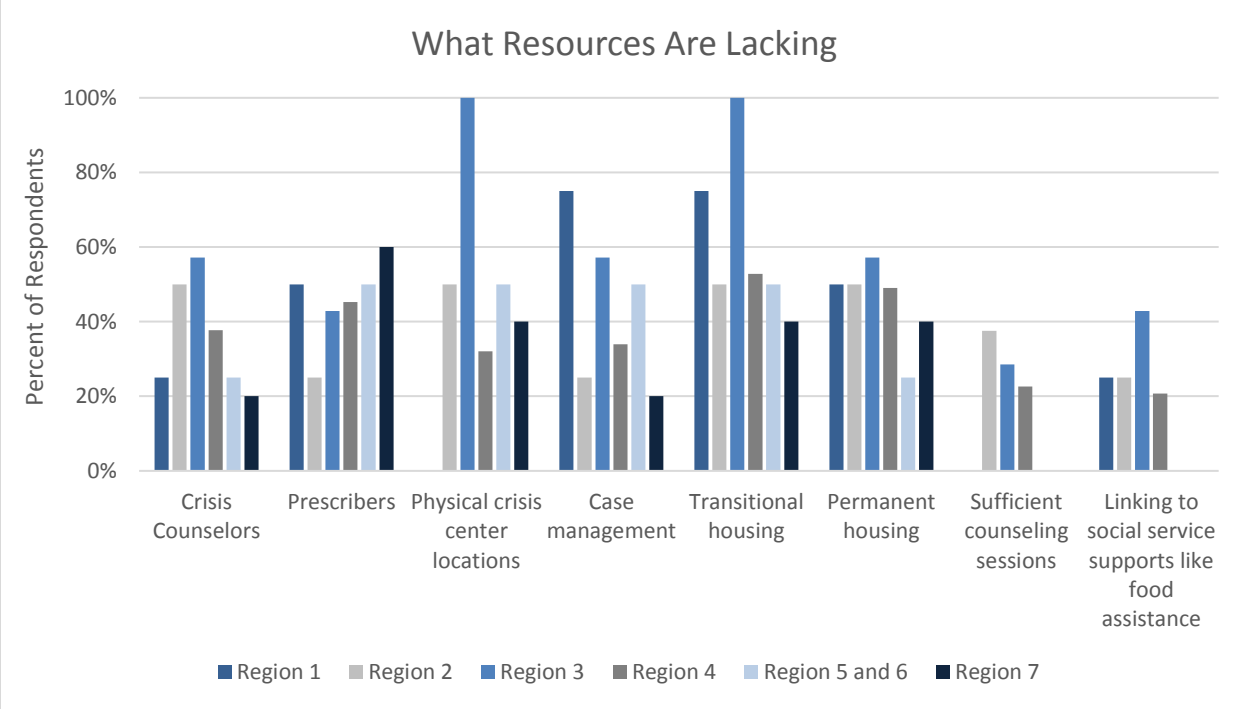


Table 4. Do eligibility criteria support effective services by region, from stakeholder survey (n=67)

| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 and 6 | Region 7 |
|---|---|---|---|---|---|---|
| Yes | 0% | 13% | 14% | 21% | 0% | 20% |
| No | 75% | 50% | 86% | 62% | 75% | 80% |

Figure 4. Do eligibility criteria support effective services by region, from stakeholder survey (n=67)

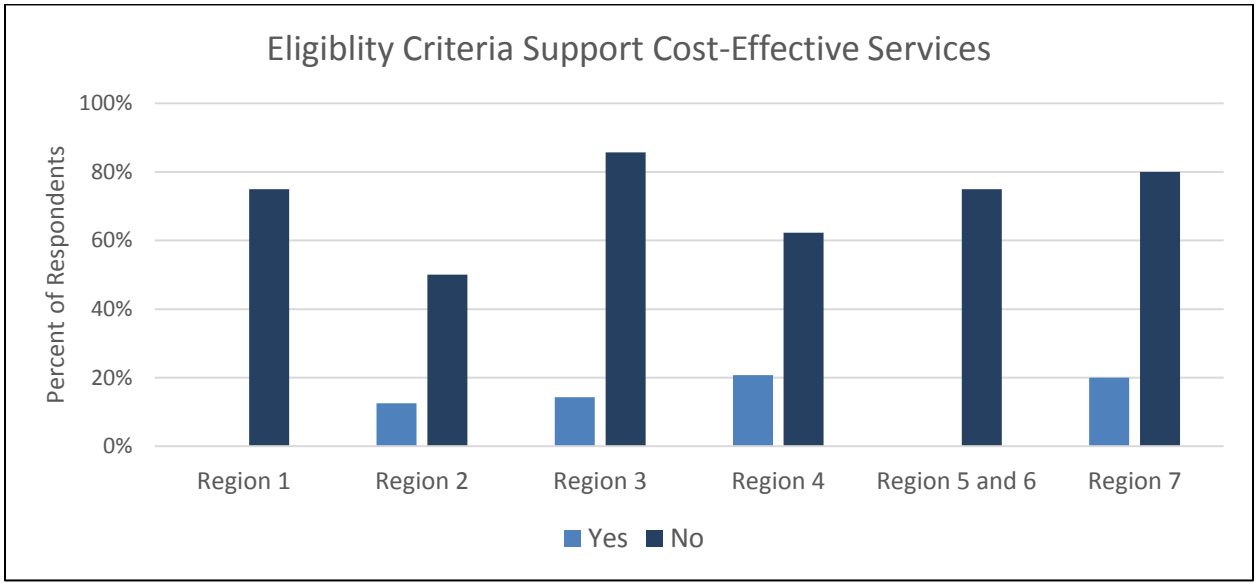


Table 5. Views on System Capacity by region, from stakeholder survey (n=66)

| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 and 6 | Region 7 |
|---|---|---|---|---|---|---|
| Seriously compromised | 50% | 13% | 14% | 30% | 25% | 0% |
| Somewhat unable to accommodate all individuals in need of services or supports | 50% | 38% | 29% | 28% | 25% | 60% |
| Somewhat capable of accommodating all individuals in need of services or supports | 0% | 13% | 43% | 19% | 25% | 40% |
| Can accommodate all individuals in need of services or supports | 0% | 0% | 0% | 4% | 0% | 0% |
| More than able to accommodate all individuals in need of services or supports | 0% | 0% | 0% | 0% | 0% | 0% |
| Total respondents who provided an answer | 100% | 63% | 86% | 81% | 75% | 100% |

Figure 5. Views on System Capacity by region, from stakeholder survey (n=66)

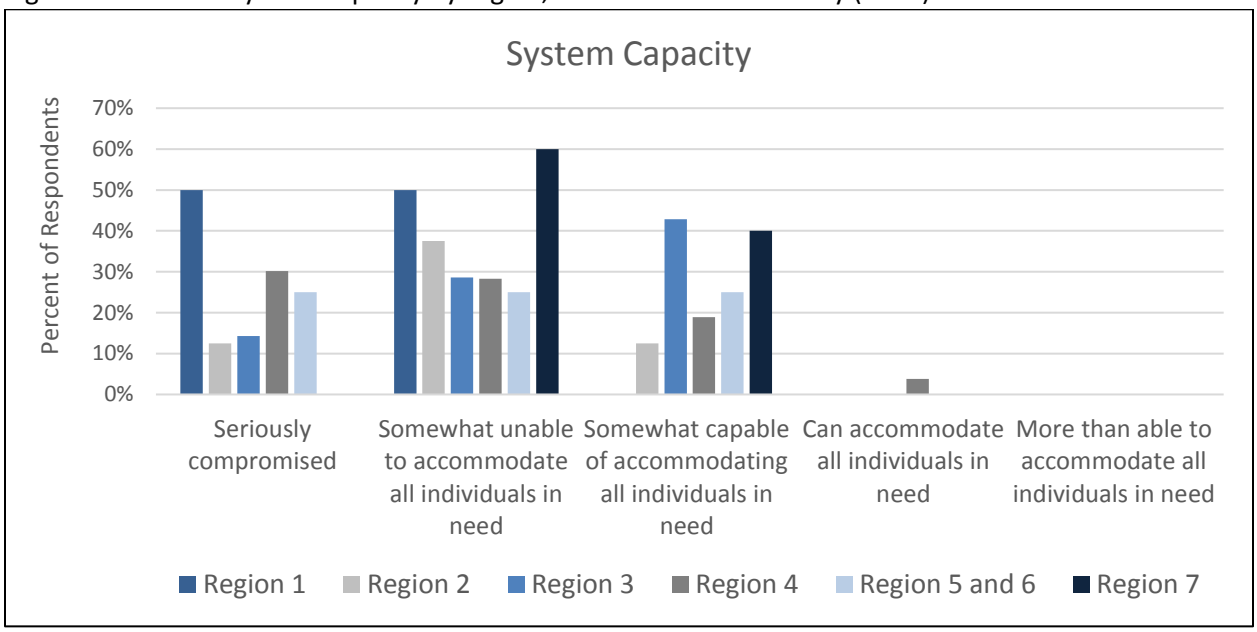
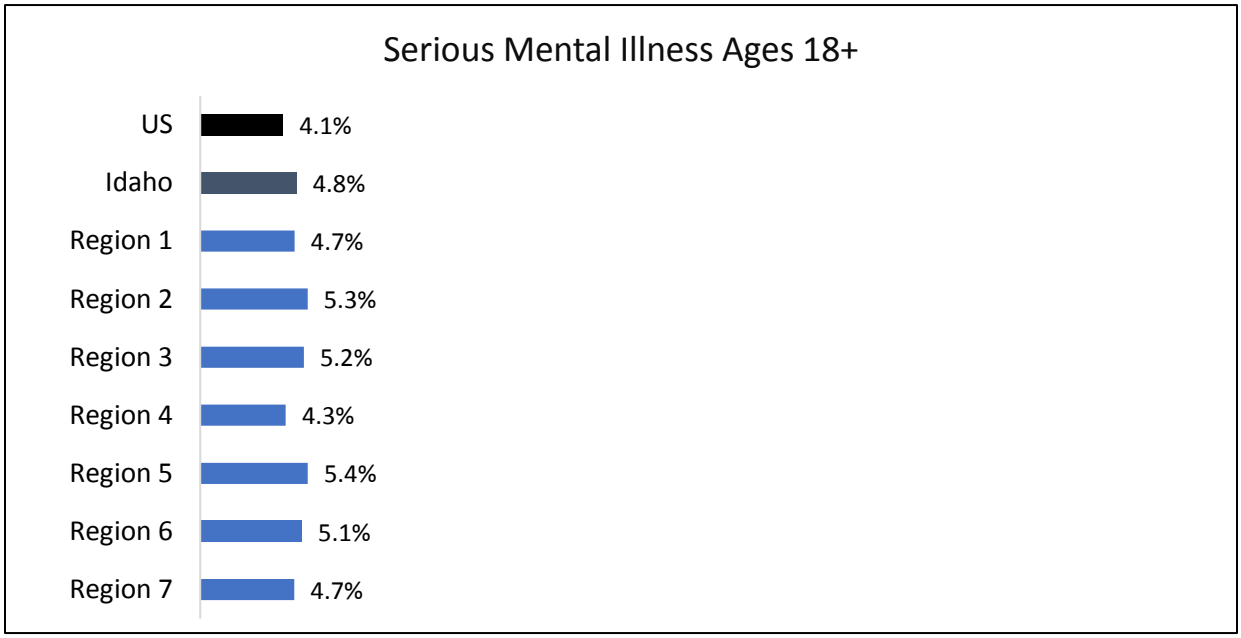
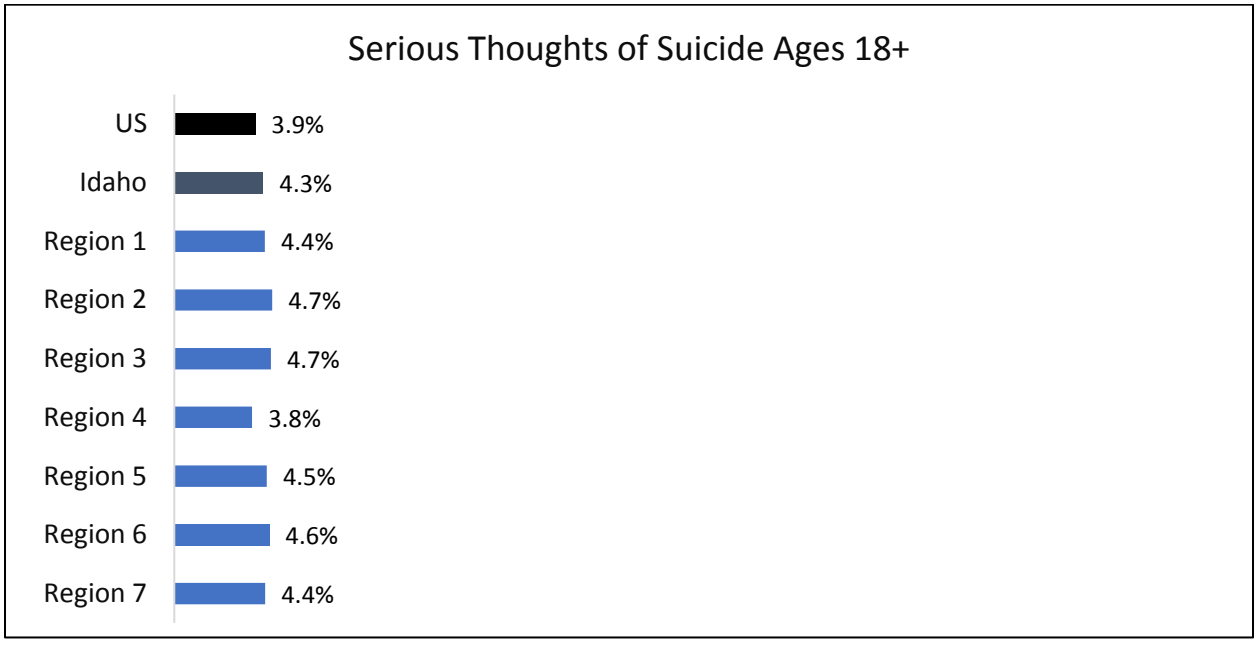


Figure 6. Rates of Serious Mental Illness by Region




Data Source: National Survey on Drug Use and Health. Annual averages based on 2012, 2013, and 2014 data.
Data notes: Timeframe is in the past 12 months. Based on Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) classifications. SMI is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder and includes individuals with diagnoses resulting in serious functional impairment

Figure 7. Rates of Serious Thoughts of Suicide by Region



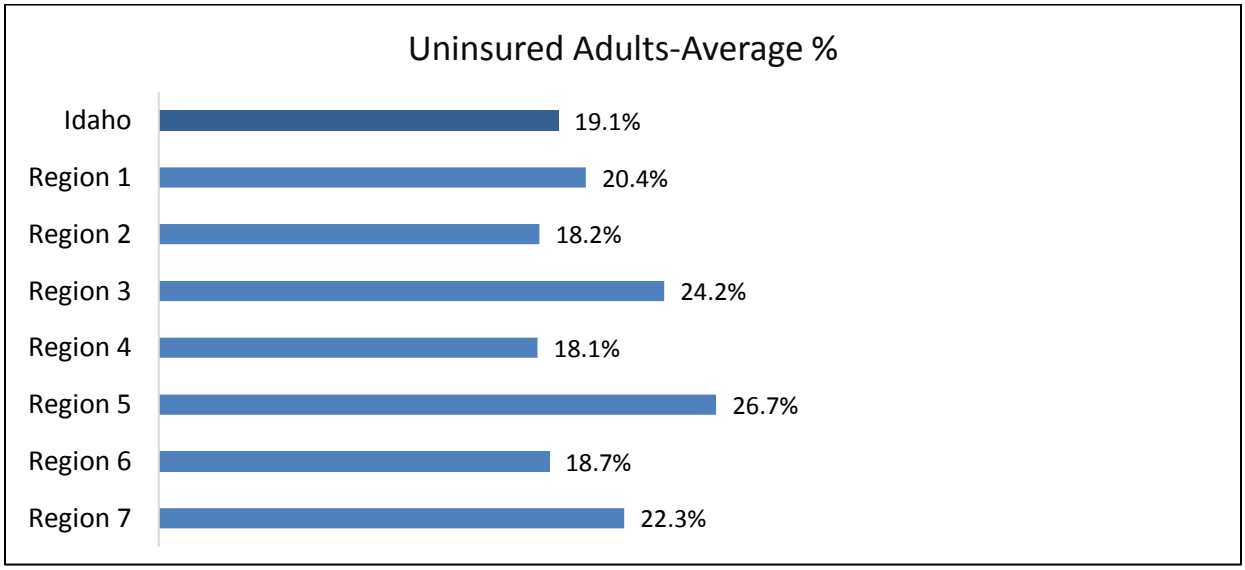

Data Source: National Survey on Drug Use and Health. Annual averages based on 2012, 2013, and 2014 data.
Data notes: Timeframe is in the past 12 months.

Table 6. Average, Total, Percent, and Rate of Mental Health Providers by Region

| | Average # of Mental Health Providers | Total # Mental Health Providers | Percent of Statewide Mental Health Providers | Mental Health Provider Rate |
|---|---|---|---|---|
| Idaho | 2993.0 | 2995 | 100% | 181.0 |
| Region 1 | 77.6 | 388 | 13.0% | 172.4 |
| Region 2 | 33.6 | 168 | 5.6% | 156.4 |
| Region 3 | 47.7 | 286 | 9.5% | 105.0 |
| Region 4 | 286.5 | 1146 | 38.3% | 240.1 |
| Region 5 | 45.0 | 270 | 9.0% | 145.1 |
| Region 6 | 53.7 | 322 | 10.8% | 265.2 |
| Region 7 | 46.1 | 415 | 13.9% | 162.7 |

Data source: Data Source: University of Wisconsin Population Health Institute. County Health Rankings 2017, which used data from the 2016 CMS National Provider Identification File.
Data notes: Mental health providers includes psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care. Rate was created using 2016 CMS data and 2015 Census Population Estimates from County Health Rankings 2017. Some counties in Regions 5 and 7 did not have available data. These counties were excluded from the average # and the rate.

Figure 8. Percentage of Uninsured Adults by Region




Data Source: University of Wisconsin Population Health Institute. County Health Rankings 2017, which used data from the US Census Bureau's 2014 Small Area Health Insurance Estimates.
Data notes: County level percentages were averaged to create percentages for each mental health region. Uninsured Adults is the percentage of the population ages 18 to 64 that has no health insurance.