Idaho

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/02/2017 5.45.10 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

NOT FINAL

State Information

State Information

Plan Year

Start Year	2017
End Year	2018

State SAPT DUNS Number

Number	825201486
Expiration Date	

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name	Idaho Department of Health and Welfare
Organizational Unit	Division of Behavioral Health
Mailing Address	POB 83720/3rd
City	Boise
Zip Code	83720-0036

II. Contact Person for the SAPT Grantee of the Block Grant

First Name	Rosie
Last Name	Andueza
Agency Name	Idaho Department of Health and Welfare
Mailing Address	POB 83720/3rd
City	Boise
Zip Code	83720-0036
Telephone	208-334-5553
Fax	208-332-7305
Email Address	anduezar@dhw.idaho.gov

State CMHS DUNS Number

Number	825201486
Expiration Date	

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	Idaho Department of Health and Welfare
Organizational Unit	Division of Behavioral Health
Mailing Address	POB 83720/3rd
City	Boise
Zip Code	83720-0036

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Ross
Last Name	Edmunds
Agency Name	Idaho Department of Health and Welfare
Mailing Address	POB 83720/3rd

NOT FINAL

City	Boise
Zip Code	83720-0036
Telephone	208-334-5726
Fax	208-334-7305
Email Address	edmundsr@dhw.idaho.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Jonathon
Last Name	Meyer
Telephone	(208) 334-6682
Fax	(208) 334-5998
Email Address	Jonathon.Meyer@dhw.idaho.gov

Footnotes:

NOT FINAL

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: RUSSELL S. BARRON

Signature of CEO or Designee[1]: _____

Title: Director, Department of Health & Welfare

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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as required by
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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
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I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: RUSSELL S. BARRON

Signature of CEO or Designee[1]: _____

Title: Director, Department of Health & Welfare

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

RUSSELL S. BARRON

Title

Director

Organization

Idaho Department of Health and Welfare

Signature:

Date:

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

NOT FINAL

Primary Prevention Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Overview of the State's Prevention Support System
(this step should also include how these systems address the needs of diverse populations in the state)

Idaho Department of Health and Welfare (IDHW) is the Single State Authority (SSA) for substance abuse in Idaho. In SFY 2014, the oversight of SABG primary prevention funds was transferred to the Office of Drug Policy (ODP) within the Governor's office. ODP is responsible for the substance abuse prevention efforts, as well as drug policy, in the State of Idaho. In addition, the Office participates as a member of the State Behavioral Health Planning Council, the Idaho Criminal Justice Commission, the Idaho Conference on Alcohol and Drug Dependency, the Idaho Impaired Driving Task Force, and the Idaho Behavioral Health Board Leadership Committee. The Office also facilitates the Prescription Drug Workgroup, the Alcohol Health Outcomes Workgroup, and the Marijuana Use Workgroup to coordinate substance abuse prevention activities around these specific priority areas as identified by the state's needs assessment. In April 2017, ODP convened and facilitated Idaho's first Opioid Misuse and Overdose Workgroup whose mission is to implement a comprehensive strategic plan to the emerging opioid epidemic in Idaho. These workgroups include representation from the Governor's Office, the Idaho Legislature, law enforcement agencies, health care providers, state licensing boards, healthcare associations, public health districts, family members, prevention organizations, prosecutors, and educators. The Office also oversees and directs the work of the State Epidemiological Outcomes Workgroup (SEOW) and the Evidence Based Practices (EBP) Workgroup.

The SABG serves as the cornerstone of the state's substance abuse primary prevention efforts. Employing the five-step Strategic Prevention Framework (SPF) developed by SAMHSA's Center for Substance Abuse Prevention (CSAP), ODP plans prevention and early intervention services in the state, awards funding annually to providers through a competitive grant application process, and funds more than 45 community based programs that offer a variety of evidence-based curricula for children, adolescents, parents/guardians, and families to reduce substance abuse related problems in the communities they serve. Grant applications are reviewed and the sub-recipient awards made with input from Regional Review Committees comprised of substance abuse experts in each of Idaho's seven regions. In FY17, SABG sub-recipients statewide included: state institutions of higher education, school districts, community coalitions, parent/youth organizations, and faith based agencies. ODP monitors these grant awards, provides on-going technical assistance to all sub-recipient agencies and organizations, and oversees outcome evaluations for each program. ODP is also responsible for a prevention workforce training and development initiative designed to: 1) increase the number of Certified Prevention Specialists (CPS) in the state delivering prevention services; and, 2) promote and train on evidence based programs.

Additionally, ODP oversees the state's SPF-SIG grant, which was awarded in 2013. Using SPF-SIG funds, ODP identified 17 community-based prevention coalitions for the provision of prevention programs with a focus on environmental strategies. All SPF-SIG funded coalitions and programs focus their efforts on addressing the prevention priority areas and indicators identified in the State Strategic Prevention Plan:

- Prescription Drug-Use
- One or both of the following: Alcohol Health Outcomes/Marijuana Use

The populations served with primary prevention funds are "*individuals who do not require treatment for substance abuse.*" ODP develops and supports community-based prevention education and early intervention services using the Institute of Medicine (IOM) Classifications for Prevention:

NOT FINAL

1. Universal: where media messages and written information are provided statewide and across communities to all citizens;
2. Selective: where programs of information and skill development are provided to groups of individuals at some risk; and
3. Indicated: where programs of information, skill development and behavioral changes are promoted to identify individuals most at risk.

All six prevention strategies promoted by the Center for Substance Abuse Prevention (CSAP) are currently supported by SABG funds through ODP. These include: information dissemination; prevention education; alternative activities; community-based process; environmental strategies; and problem identification and referral.

Information Dissemination is conducted through distribution of the Idaho RADAR Network Center's materials and video library to community members, coalitions, schools, prevention/treatment programs, social services/health care providers and other stakeholders. Additionally, ODP manages two statewide media and education campaigns. The first, *Be the Parents (*http://betheparents.org/ *)*, is designed to prevent and reduce underage drinking in Idaho by providing parents and guardians with information about the harmful effects of alcohol on the developing teen brain, along with proven skills for preventing underage alcohol use.. The second, *Lock Your Meds Idaho* (http://www.lockyourmedsidaho.org/), is a multi-media public health campaign designed to reduce prescription drug abuse by making adults aware that they are often the "unwitting suppliers" of prescription medications being used in unintended ways, especially by young people, and to encourage the proper storage and disposal of all medications. Each campaign was recently expanded to address the needs of Idaho's Hispanic and Native American populations.

Prevention Education occurs with the delivery of evidence-based direct service programs by community prevention providers to universal, selective and indicated audiences (see https://prevention.odp.idaho.gov/ for provider and program details). ODP currently funds direct service providers who implement thirteen (13) different evidence-based curricula to youth, parents and families across the state.

Alternative Activities are funded based on needs assessment identified risks. Community based providers funded with SABG set-aside funds offer drug free activities and support services to universal or selective youth and families (e.g., mentoring programs, drop-in recreational programs; after-school activities; and community service activities).

Problem Identification and Referral services are also delivered by community-based providers with the goal of identifying at-risk children and families early and referring them to services needed to reduce their risk of substance use.

Community coalitions are funded to undertake **Community-based Processes** and **Environmental Strategies.**

All above recurring services are evaluated using pre and posttests. Community-based and environmental strategies are evaluated using strategy specific data including participation data, media reach data, and other appropriate measures identified by ODP's state evaluator.

How the System Addresses the Needs of Diverse Populations in the State

Idaho is a geographically large state with vast frontier expanses and relatively few heavily populated areas. The state of Idaho is predominantly rural in character and culture, reflecting traditional morals, values, and lifestyles, with pockets of cultural and ethnic diversity. According to the United States Census

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Bureau, Idaho's largest metropolitan area, the Treasure Valley which includes both Ada and Canyon Counties, contains over 38% of the state's population. Idaho's urban, suburban, rural, and tribal lands have very different historical, social, and cultural features. Each community's needs and perspectives regarding alcohol, tobacco, and other drugs (ATOD) may differ from those of other groups and cultures. Within these communities, prevention efforts must focus on the role social and economic conditions play in problems associated with ATOD (e.g., poverty, inequity, inequality), and the need to engage community leaders and networks in prevention.

Sub-recipients are required to describe in their grant application how programs and activities delivered with SABG funds ensure target population access. All ODP-funded prevention service providers (both direct service providers and community coalitions) are required to assure compliance with State laws, rules, regulations and executive orders with regard to equal opportunity and discrimination. Adherence to these standards is monitored as a component of the annual site visit conducted by ODP.

Recent Census data provides a snapshot of the racial and cultural make-up of Idaho's population. In 2016, Idaho was 93.3% white, with little variation across counties. Statewide, 12.3% of Idahoans were Hispanic or Latino, 1.5% Asian, 1.8% were American Indian or Alaska Native, 0.8% were Black or African-American, and 2.4% described themselves as being two or more races. The percent of foreign born persons, 2011– 2015, was estimated at 6.1%, a reflection of Idaho's developing refugee population.

Idaho has a higher prevalence of American Indians or Alaska Natives than the national average. Idaho has a lower prevalence of Hispanic or Latinos, veterans, individuals 18 to 25, and individuals 25 or older with a bachelor's degree or higher than the national average. ODP has identified the following specific populations as focus populations for SABG funded prevention services: American Indian; Hispanic or Latino; Rural; and the underserved racial and ethnic population of refugees.

There are six federally recognized tribes located in Idaho and building positive relationships with representatives from the tribes has been of paramount importance to ODP. Tribal representatives now participate as members of various workgroups. Risk factors related to alcohol and other drug misuse by youth on our reservations are far more prevalent than in other areas of the State and underscore the need for targeted prevention programming that incorporate native tradition and heritage. SABG funds were used to provide intensive training and technical assistance on the evidence-based program specifically for American Indian youth titled *Project Venture*. As a result, Idaho's Nez Perce and Shoshone-Paiute tribes will be implementing *Project Venture* in FY2018.

The Hispanic population in Idaho continues to grow and thrive. ODP has worked closely with the Idaho Hispanic Commission which has participated in regional grant reviews as well as a member of ODP workgroups. The Commission has also offered assistance to the Office on a number of occasions to ensure prevention materials are accurately translated into Spanish and is assisting with the development of parental focus groups to assess how we are doing in addressing the needs of Hispanic families in the state.

Idaho's rural and frontier communities are consistently identified as high need communities with limited capacity and resources to maintain prevention programs. In response, ODP is taking advantage of emerging technologies to better promote program delivery and outreach, as well as the delivery of monthly training and technical assistance opportunities. Recently ODP contracted with Community Anti-Drug Coalitions of America (CADCA) to provide a series of webinar trainings on the Prevention Specialist domains (Planning and Evaluation; Prevention Education and Service Delivery; Communication; Community Organization; Public Policy and Environmental Change, and Professional Growth). A listing of Training and Events can be found at: https://prevention.odp.idaho.gov/training-and-events/ .

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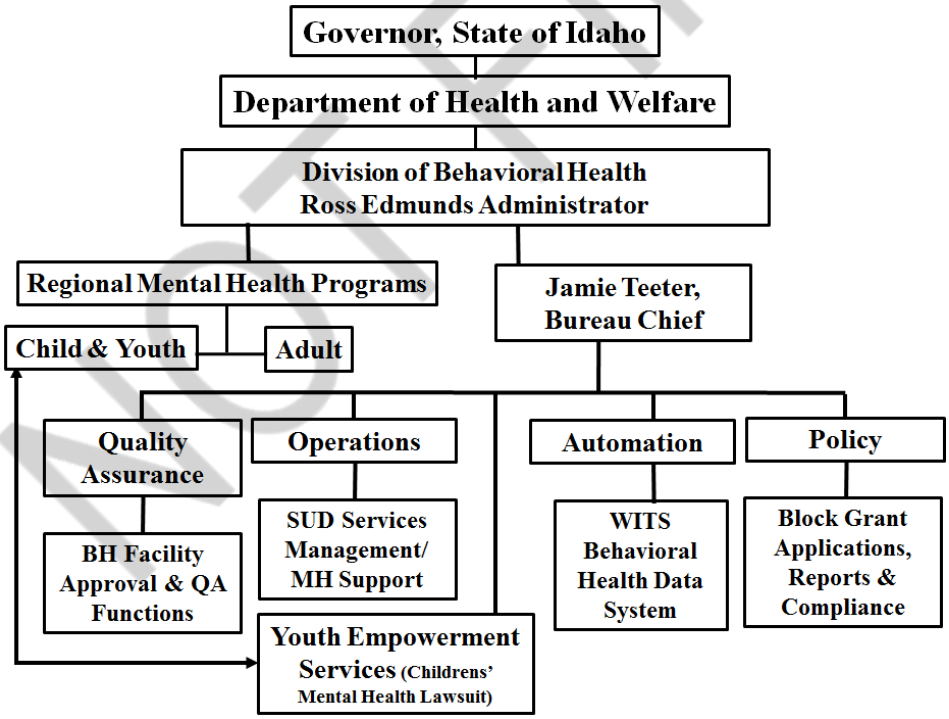
Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Division of Behavioral Health Services

The Idaho Legislature has designated the Department of Health and Welfare's Division of Behavioral Health (Division) as the Single State Agency for Substance Abuse and the State Mental Health Authority. The Division is solely responsible for compliance with the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants requirements and the delivery of services funded with these monies.

The Division's organization chart, found below, depicts the organization of the state's management system and documents Idaho's move toward integrating the mental health and substance use disorders systems. As depicted in the chart below, the Quality Assurance, Automation and Policy Programs work on both substance use disorders and mental health programming, funding, policies, evaluation, data and compliance. The Operations Program is also expanding their scope to cover activities to support mental health services. These activities include SOAR, increasing mental health awareness and assistance with the Youth Empowerment Services. The mental health services for adults as well as children and youth, are managed by the Division's Regional Behavioral Health Offices.



Idaho uses a statewide system for delivering substance abuse prevention and substance use disorder treatment and recovery support services system. The Division of Behavioral Health contracts with an intermediary for the management of a community-based substance use disorder provider network. The substance abuse prevention services are awarded directly to community based providers and coalitions to deliver primary prevention services. The Division has sub-granted the Substance Abuse Prevention and Treatment block grant primary prevention set-aside to the Office

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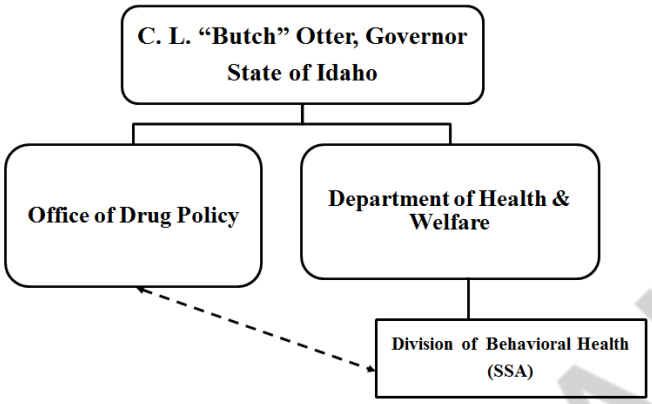
of Drug Policy located within the Idaho Office of the Governor. The chart below depicts the relationship between the Office of Drug Policy and the Division of Behavioral Health.



The Office of Drug Policy (ODP) is responsible for compliance with all requirements related to the primary prevention set-aside. While ODP and the Division are located in separate buildings, staff continuously work together on block grant compliance issues and issues of joint concern. The Office of Drug Policy has provided a separate response to "Step 1. Assess the strengths and organizational capacity of the service system to address the specific populations" which is a separate attachment in this section.

The Division of Behavioral Health focuses on the delivery of early intervention, clinical and recovery support services for individuals with a behavioral health diagnosis. The Division's substance use disorders services are delivery by community based providers. The Division's adult mental health services are delivered by Division staff located in regional offices throughout the state of Idaho. The Division's children's and adolescent's mental health services are managed by Division staff located in the same regional offices, however services are generally delivered by community providers based on each child/adolescent's needs. For both systems, individuals must been diagnostic and financial needs criteria to qualify for state-funded services. Individuals with Medicaid are served under a separate system.

The Division of Behavioral Health serves all individuals, regardless of race, language, ethnicity, sexual preference, religion, age and gender with equal access to care. The only requirements for receiving care are diagnostic and financial criteria. Federal priority clients are given preferred access to care when demand exceeds capacity to cover cost. For both programs, if parents are unable to pay their share of service costs, the Division will cover all costs to ensure children and adolescents have timely access to needed care.

Community-based Recovery Support Services

Idaho has also implemented community based and controlled recovery support services. Crisis centers focus on supporting an individual through a crisis with the goal of regaining stability. Recovery Community Centers focus on sustaining recovery by providing resources to assist recovering individuals with maintaining themselves in a community setting. Anyone can seek assistance at these facilities, these is no means testing to qualify for these services.

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Crisis and recovery support services are also made available by non-profit organizations throughout the state. The Idaho Legislature provides seed monies to support the development of the services, but it is the responsibility of local communities to sustain these services. There are currently 3 Crisis Centers, located throughout Idaho. A fourth is under development. The Centers provide a mix of professional and peer services. The Crisis Centers serve individuals with mental and substance use disorders who are in crisis. Participation in Center services is voluntary and provides an alternative to hospitalization or incarceration. Center services vary based on location and resources, but all Centers are staffed 24/7/365 with a variety of peer behavioral health professional and medical staff onsite or readily available. In addition to responding to the immediate responses, the Crisis Centers also provide assistance with accessing behavioral or medical, food, housing, legal, needs.

Recovery Community Centers were established in Idaho to provide ongoing support to sustain recovery. There are currently eight (8) Recovery Community Centers across Idaho that exist to provide free peer-based recovery support services to individuals with substance use and/or co-occurring behavioral health issues. The state provided seed funding to support the development of recovery community centers with the goal that communities would provide the funding to sustain the centers. These centers are staffed primarily by peers and hours vary by community. Volunteers coach participants to independently identify needs and access resources. In addition, peer specialists advocate for their peers in treatment settings and within the community. The volunteers work to motivate participants through positive means, highlighting strengths and resources. They can facilitate change through goal setting, education, and skills building.

Adult and Children's Mental Health Behavioral Health Prevention, Early Identification and Recovery Support

The Division of Behavioral Health's "Transformation Legislation" was approved by the 2014 Idaho Legislature. The resulting Regional Behavioral Health Services Act is intended to transform Idaho's mental health and substance use services into an Integrated Behavioral Health System of Care. The Statute includes requirements to integrate mental health and substance use treatment through the creation of a governor appointed State Behavioral Health Planning Council (Planning Council) and Regional Behavioral Health Boards (Regional Boards), designated the Department of Health and Welfare as the State behavioral health authority and defines the priory populations to be served by the state operated regional behavioral health centers.
The Planning Council is tasked with monitoring and evaluating the statewide behavioral health system of care and the laws that govern that system and is responsible for establishing readiness and performance criteria for the Regional Boards as well as monitoring the readiness of the Regional Boards to provide local support services within their regions of the state. The Planning Council is charged with working with the Regional Boards in monitoring and evaluating the effectiveness of the state behavioral health service delivery system.

Regional Boards have the responsibility to work with local communities to recommend behavioral health services, identify service gaps and promote plans for improvement through communication with the Council and the Department. Regional Boards may facilitate community-based recovery support services by partnering with entities such as Public Heath Districts, form a private nonprofit organization or remain as an advisory only entity. Once the infrastructure is established the Regional Board my contract to organize and deliver locally driven Recovery Support Services (e.g.,

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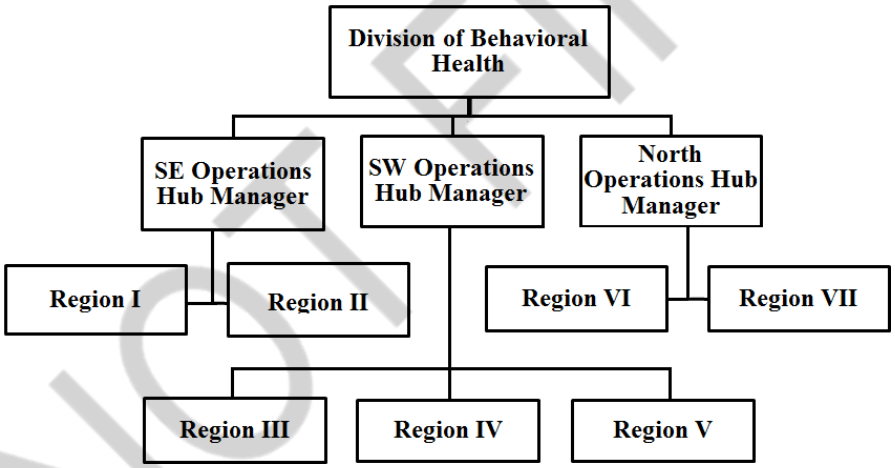
community education, housing assistance, employment, transportation, prevention) further enhancing the local behavioral health service delivery system allowing individuals with behavioral health diagnoses greater opportunities to live in their community of choice and avoid hospitalization.

The Regional Behavioral Health Centers operated through the Department's Division of Behavioral Health will retain responsibility for recovery support services until Regional Boards are ready to oversee these services. Readiness includes identification of adequate state and federal pass-through and grant funding to support Regional Board service administration. Once Regional Boards are funded and independent, the Regional Behavioral Health Centers will provide services that are complementary to those provided by the Council and Regional Boards in an effort to implement a statewide, comprehensive behavioral health system of care.

Mental health service delivery is based on the seven geographical Department of Health and Welfare service regions. The Division employs a multi-level management system for the delivery of mental health services managed by state employees. The chart below depicts the mental health management organization. In most rural and frontier locations, psychiatric services are supplemented using tele-health video conferencing systems. A high definition video conference system is also used for statewide meetings, including meetings of the State Planning Council on Mental Health.



Publicly funded Adult Mental Health (AMH) and Children's Mental Health (CMH) services are provided through Regional DBH center sites, with one Regional Program Manager responsible to oversee service delivery and quality for both programs. The chart below depicts the regional program separation of adult and children's services.

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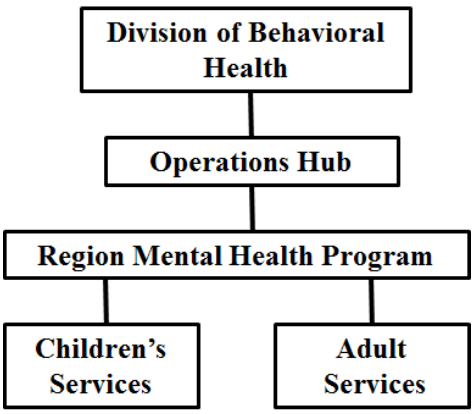

All regions have offices in multiple locations. Psychiatric services may be supplemented through tele-health video conferencing to rural and frontier locations where there is insufficient demand for services to warrant an office. The map below depicts the seven regions and the location of offices within each region.

Priority local services for AMH and CMH are directed toward crisis and court-ordered clients, with voluntary clients served as there is availability in the system. Efforts are made to refer Medicaid

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eligible clients to Medicaid eligible private provider resources. The Division of Behavioral Health regional staff conduct mental health screenings and comprehensive assessments. These staff also partner with the adult or child/family to develop treatment plans, provide case management and deliver outpatient treatment services.

Adult and Children's Mental Health services and SUD services are provided in each of the seven (7) IDHW geographically defined regions. The SMHA services are offered through state operated community behavioral health centers in each region. There are five statutorily mandated priority populations within the adult mental health program:

1. Emergency psychiatric services (I.C.39-3128 which encompasses crisis intervention, designated exams and police holds.
2. Individuals committed to state custody (I.C. 66-329 and 18-212)
3. Court ordered clients (I.C. 19-2524) providing outpatient services for offenders on supervised probation.
4. Mental Health Court participants (I.C. 19-5603) providing forensic community treatment.
5. Voluntary clients without benefits (I.C. 39-3128).

There are three priority populations within the children's mental health program, these include:

1. Emergency psychiatric services (I.C. 39-2128
2. Court ordered clients (I.C. 39-20511a, 6-2416, 21-519b)
3. Voluntary clients without benefits (I.C. 39-3128)

Treatment services include crisis response, assessment, individualized treatment planning, case management and a range of mental health services available to eligible adults with serious mental illness, children with serious emotional disorders and their families. Idaho's two (2) state psychiatric hospitals, State Hospital North and State Hospital South, are also under the jurisdiction of the DBH Administrator. State Hospital North serves adults only, while State Hospital South serves both adults and adolescents. One facility is in north Idaho and the other is in southeastern Idaho. Individuals needing a higher level of hospital services than are available in the Division's facilities receive services in primary care hospitals until such time as they are sufficiently stable to discharge to a lower level of care. For individuals needing specialty services or residential care, the Division contracts with non-government providers to deliver the needed services. There are also several local psychiatric hospitals which are utilized for emergency and short term hospitalizations.

The CMH system's comprehensive system of care includes assessment, case management, family support (e.g., family preservation, counseling, transportation, parent skills training and education, flexible funding and peer support) and family respite. The Division contracts with a private provider to provide statewide family and youth education and support groups, a statewide respite information and referral center, and to recruit and train respite care providers. The CMH program also provides foster care, crisis response, outpatient services, residential and hospitalization. State Hospital South's 16-bed Adolescent Unit provides inpatient stabilization and treatment, with average lengths of stay of 45 to 90 days. Longer term treatment may be provided by foster parents and residential facilities. Some unique aspects of the CMH program that are not available in the community or through existing benefit packages include provision of the evidence based Parenting with Love and Limits (PLL) intensive outpatient program, wraparound and clinical case management. Few services are available to parents with mental illness who have dependent

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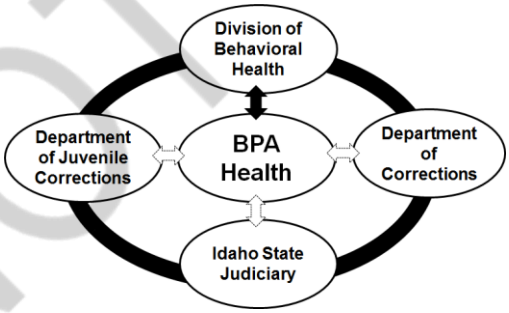
children. Youth 15 years and under are required to have parental consent for services, while those 16 and older can access treatment services without parental consent. Services for children and youth who are diagnosed with SED and a substance use disorder (SUD) are delivered by two different Division of Behavioral Health programs. The CMH comprehensive assessment includes assessment of substance use and service recommendations. The majority of CMH services (mental health and substance abuse) are delivered by private providers. For children and youth diagnosed with SED and a developmental disability, services are coordinated through the Department's Division of Behavioral Health and Division of Family and Community Services.

The Division of Behavioral Health continues to make significant efforts to integrate Idaho's mental health and substance use disorders (SUD) service systems into a unified behavioral health system of care. Recognizing the benefit and necessity of uniform requirements for behavioral health programs, DBH made the decision to propose changes to IDAPA rules that established a process and requirements for community mental health and SUD agencies to obtain State approval as a behavioral health program. While SUD treatment providers in the public network are required to obtain the approval mental health providers may apply for program approval on a voluntary basis. These rules became effective in July 2016. Twenty-nine behavioral health program sites have been approved as of July 2017.

Substance Use Disorders Services (SUD)

The State of Idaho has established a state agency/branch of government partnership for the delivery of SUD treatment services. The Idaho Departments of Corrections, Health and Welfare's Division of Behavioral Health and Juvenile Corrections as well as the Supreme Court's Problem Solving Court Program compose this partnership. The four entities coordinate populations served and all use the services of BPA Health to manage a community-based provider network delivery treatment and recovery services.



The Department of Health and Welfare's Division of Behavioral Health holds the contract with BPA Health and the remaining entities include their service requirements in the contract. Contract management and monitoring activities are jointly conducted. The individuals served under this contract vary by entity and cover a broad spectrum of populations within Idaho. All entities cover SUS services for clients without regard to sex, race, ethnicity, gender-identity, religion, nation of origin, disability, physical health, education or employment-status.

All SAPT block grant requirements related to priority populations, the delivery of SUD services, participation in peer review, client confidentiality and training for staff delivering SAPT block grant funded SUS services are included in this contract. The chart below details the SUD priority

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populations whose services are funded by the aforementioned partnering agencies and branch of Idaho government.

State SUD Priority Clients by State Agency/Branch of Government

State Organization	Type of Client	Description of Client
Division of Behavioral Health	Pregnant Women	Women who are currently pregnant
	Pregnant Women/ Women with Dependent Children	Women who are pregnant and women with dependent children willing to receive services from a PWWDC specialty client.
	IDHW Misdemeanant	Problem Solving Court clients, non-imprisoned individuals, DBH covers part of services received.
	IDHW AMH Referred	Adult co-occurring behavioral health clients referred by a IDHW Adult Mental Health clinician. (SUD treatment only)
	IDHW Adolescent	Non-criminal justice adolescents that do not meet eligibility for any other IDHW priority population.
	Child Protection/SUD	Clients entering treatment services through a Child Protection/SUD liaison. These clients must have an open Child Protection case.
	State Hospital	Clients entering directly from state hospitals (Dual-disorders SUD treatment only)
	IDHW Adult	Voluntary population who earn less than 100% Federal Poverty Guideline (FPG) and meet clinical guidelines.
	IDHW Domestic Violence Court	Individuals who have pled guilty to domestic violence crime and agree to participate in domestic violence problem solving court. Offenders admitted to a problem-solving court would receive SUD services as necessary.
	Idaho's Response to the Opioid Crisis (IROC)	Individuals who identify opioids as their primary substance and are 18 or older or are eligible for IROC funding when questions in the Eligibility Screener are answered according to the eligibility rules.
	IVDU	Reported a demonstrated IV use as primary and sustained with specific IV use within the last 30 days.
	Temporary Assistance for Families in Idaho (TAFI)/SUD	TAFI applicants/recipients
Idaho Supreme Court	Problem Solving Courts	Individuals that have pled guilty and agreed to participate in a problem-solving court. Participants admitted to a problem-solving court would receive SUD services as necessary.
Department of Juvenile Corrections	Justice Involved Juveniles	Justice-involved juveniles requiring SUD services at 1.0 or higher who are not engaged in a Juvenile Drug Court.
Department of Correction	19-2524	Adult felons under active IDOC supervision granted access to state funded SUD services via IC 19-2524.
	Risk to Revocate	Adult felons under active IDOC supervision with drug/alcohol use within the previous 90 day period.
	Reentry	Adult felons with history of drug/alcohol use reentering the community on active IDOC supervision after a period of IDOC incarceration.

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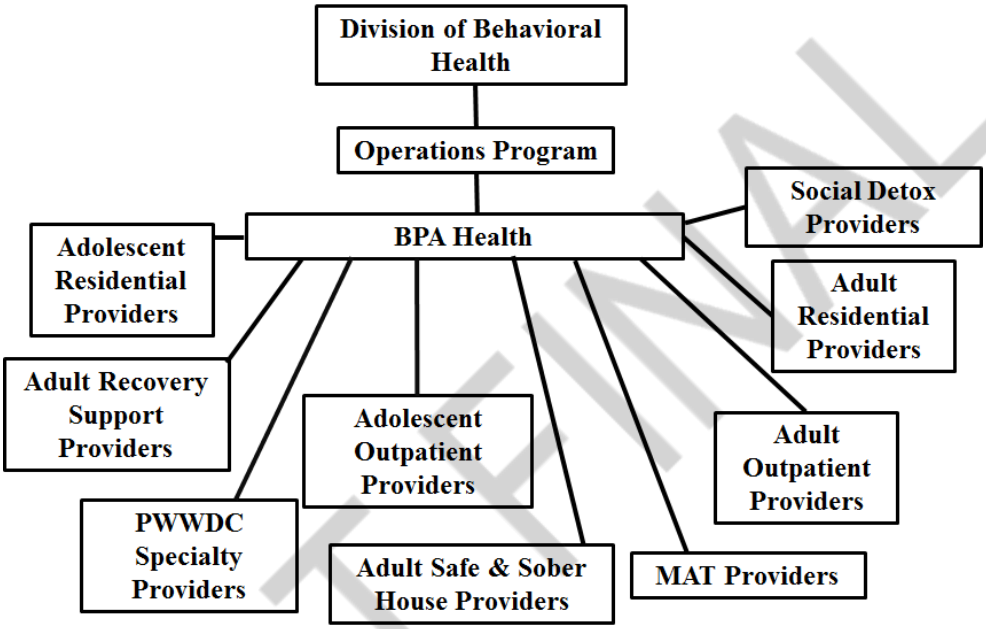
Under their contract with the Division, BPA Health is solely responsible for maintaining a statewide network of SUD providers. The network is designed to meet the all needs of the populations funded under the contract. One provider may delivery more than on service type and all outpatient providers also delivery intensive outpatient services. With the receipt of the "State Targeted Response to the Opioid Crisis Grant," BPA Health is in the process of identifying and qualifying MAT specialty providers. For the Division, this includes the provider types depicted below. Please note one agency may deliver more than one type of the services depicted. For instance, an outpatient provider may provide MAT services and a PWWDC specialty program as well as deliver adult outpatient services.



For the Division, BPA Health qualifies applicants for care, and manages the delivery of SUD treatment and recovery support services. Other than screening and referral, BPA Health provides no direct client services. All treatment and recovery services are delivered by the community-based providers in the BPA Health network. All SUD providers delivering SAPT funded services have successfully completed the Division of Behavioral Health program approval process as well as met BPA Health program requirements prior to delivery of services.

BPA Health directly screens all applicants to determine authorization for care. BPA makes a 1-800 number available for applicants to call to be screened for care. During the phone call, clinical and financial eligibility for care are determined. In addition to questions about alcohol and drug use and consequences, applicants are questioned about age, route of administration, HIV risk, minor children in the home and for women only, pregnancy status. This information, along with fiscal data is used to determine eligibility for SAPT block grant funded care. The information is also used to identify options for treatment providers.

Adolescents are only referred to providers who have met the criteria to deliver services to this population. These providers must have experience and education specific to adolescent risks, needs and community resources. They also must meet minimum standards established by the

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intermediary. Adolescent residential services are provided in separate facilities from those serving adults to ensure the adolescents' safety.

The BPA Health network currently includes 7 providers in their PWWDC specialty network. These providers are located throughout the State of Idaho. As indicated in the goals in Table, the Division is working to expand this network. All pregnant women and women with minor children under the age of 5 are given the preferred option of a PWWDC specialty provider or another provider of their choosing. These women are strongly encouraged to attend a specialty provider because of the additional services available to the women and children. The providers in the network directly provide gender-specific SUD services, case management, child care and transportation, other required PWWDC services women and children are delivered by community-based providers with BPA-Health serving as the payor of last resort.

All providers have the capacity to deliver services to injection drug users. So anyone indicating that route of administration is given information on the providers that best meet they other needs. As with women clients, these individuals are given free choice to select the provider they want to delivery their treatment services.

The receipt of the "State Targeted Response to the Opioid Crisis Grant" has enabled Idaho to establish a special program for opioid user, injection or otherwise. Idaho's Response to the Opioid Crisis (IROC) project will use a multifaceted approach to expand access to Medication Assisted Treatment (MAT), reduce access to opioids through prevention efforts, enhance the recovery oriented system of care, and reduce deaths. IROC will provide opioid specific treatment and recovery support services to individuals with an Opioid Use Disorder (OUD). Treatment services will include access to both Methadone and Suboxone/Buprenorphine MAT. IROC will also increase accessibility to resources to reduce the incidences of opioid misuse by reducing access and preventing overdose deaths. Methods include using prescriber report cards to create social norms of decreased opioid prescribing; reducing diversion of opioids by establishing drop-box programs in pharmacies statewide; and educating prescribers on use of the Prescription Drug Monitoring Program. Finally, IROC will provide community-based services that connect individuals with an OUD to peer supports and sober living activities.

During the admission process, all clients are assessed for TB. Those who are at risk are referred for testing treatment. By placing the TB screening at the provider level, client follow-up can occur. Most clients are referred to Idaho's Public Health Districts which provide education, preventative therapy, testing and treatment of active disease cases. Their fees are based on income.

Recovery support services are available based on client need and type. Recovery support services include case management, alcohol/drug testing, life skills, recovery coaching and transportation. Recovery support services also include child care, prenatal/pediatric care, and -children's therapy for PWWDC clients only

Regional, County and Local Entities that Provide Behavioral Health Services or Contribute Resources

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Idaho subscribes to an integrated service delivery system. Service components include mental health, social services, education, health, vocational services and corrections. Recognizing that services are provided by multiple public and private agencies, the Division continues to seek cooperative agreements with other departments and providers as well as contracting with consumer and family advocacy organizations.

The CMH Division of Behavioral Health program works closely with the Department of Health and Welfare's Child Welfare Program and with the Department of Education. A memorandum between CMH and Child Welfare describes how services will be coordinated for shared clients. The Department's Service Integration program facilitates family efforts to navigate the range of Department programs and services. The Service Integration program works with Idaho's Health Information and Referral Center, or the 211-Idaho CareLine. The CareLine provides referral information (including housing and other resources) through the statewide 211 number. The Bannock Youth Foundation (Pocatello) and Hays Shelter Home (Boise) provide federal grant funded crisis and emergency shelter to runaway and homeless youth; these programs coordinate mental health care needs with CMH. The Division's CMH program and the Department of Education collaborate with local school districts to implement intensive community and school based programs. All 115 independent Idaho local school districts respond to the Individuals with Disabilities Education Act (IDEA) for eligible children. IDEA services include child find/referral, evaluation/eligibility, individualized education plans (IEP), related services, least restrictive environments, review and re-evaluation, transition requirements and consideration of behavior management needs.

The Division works collaboratively with juvenile corrections programs in several ways. The Division allocates funding to the Department of Juvenile Corrections to fund the placement of licensed Clinicians in each juvenile detention center to assist with evaluations, service referrals and crisis counseling. The Juvenile Justice/Children's Mental Health (JJCMH) collaborative workgroup focuses on resolving obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored implementation of Youth Mental Health Court. The Youth Mental Health Court uses the wraparound service model to facilitate treatment planning and coordination. The SUD prevention staff also participates on the juvenile corrections sponsored Enforcing Underage Drinking Laws workgroup. This partnership enables Idaho to reduce duplication and increase effectiveness in service delivery to this population.

The Division of Medicaid within the Department of Health and Welfare provides comprehensive medical coverage in accordance with Titles XIX and XXI of the Social Security Act and state statute. Medicaid participants have access to covered medical and dental benefits through three benefit plans that align with health needs. The Medicaid benefits plans, including the Medicaid Basic Plan Benefits, the Medicaid Enhanced Plan Benefits and the Medicare/Medicaid Coordinated Plan Benefits were effective as of July 1, 2006. Blue Cross of Idaho, under contract with Idaho Medicaid has administered the True Blue Special Needs Plan since 2006. Medicaid eligible locations for service delivery were expanded in SFY 2008 to allow physicians to perform tele-health in any setting in which they are licensed.

Medicaid's state plan amendment to support behavioral health managed care and the 1915b waiver were approved and the Department entered into a contract with United Healthcare, doing business

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as Optum Idaho in April, 2013. Optum Idaho's administration of Medicaid behavioral health benefits, known as the Idaho Behavioral Health Plan (IBHP), began in September 2013. Medicaid continues to work closely with Optum Idaho to implement the IBHP which includes recruitment, enrollment, and training of a provider network; development of electronic information and claims payment systems; and development of related communications and disbursement of information materials. Optum Idaho provides integrated oversight of all behavioral health Medicaid services (mental health and substance use disorder) to adults and children in the state of Idaho.

The Division of Behavioral Health is able to extend services through an assortment of federal SAMHSA grants. The SUD program's Access to Recovery (ATR) grant serves military (includes veterans, military reserves and Idaho National Guard), adolescents re-entering the community from state and county institutions (e.g., juvenile detention, state run correctional, hospitals) and adult supervised misdemeanants. Services include intensive SUD outpatient, safe and sober housing for adults and adolescents, case management, drug testing, transportation, child care, and life skills education. The Projects for Assistance in Transition from Homelessness (PATH) grant allows for outreach to adults with serious mental illness who are homeless. Idaho's prevention data capacity has been significantly increased by the State Epidemiological Outcomes Workgroup (SEOW) grant, which funded the Division's development of the Idaho Prevention and Treatment Research website (www.patr.idaho.gov). This website provides county level risk-factor data to enable community coalitions and other interested individuals and groups to easily access substance abuse-related data.

The Idaho Legislature has approved funding for four behavioral health crisis centers around the state, including one in Boise that's expected to open in 2017. The Division of Behavioral Health contracts with outside organizations such as hospitals or the Health District to operate the crisis centers. The other three crisis center are in Idaho Falls, Twin Falls and Coeur d'Alene. Behavioral Health Crisis Centers are designed to be short term community resources that fill the gap for individuals experiencing a crisis that may otherwise end up in jail or the emergency room. The crisis center serves as a link to the existing behavioral health services available in the community. Locations are selected on several factors including community readiness, project proposal, community involvement, and legislative support.

The Division of Behavioral Health collaborates with the Social Security Administration to encourage collaborative efforts to educate Idaho providers about their system and to train them in SSI/SSDI Outreach, Access and Recovery (SOAR). SOAR is a program designed to increase access to SSI/SSDI for eligible adults who are experiencing or at risk of homelessness ad have a mental illness, medical impairment, and/or a co-occurring substance use disorder. This training helps providers to facilitate more effective completion of eligible client SSI/SSDI benefit applications. The Division of Behavioral Health includes two staff trained in the SOAR benefits skills. The Division of Behavioral Health is in the process of improving the structure of the SOAR training in the hopes more people will be able to access the training. The training is a 12 week program utilizing web video and conference calling. The training is provided free of charge and is eligible for continuing education credits from the NASW.

How Systems Address Needs of Diverse Racial, Ethnic and Sexual Gender Minorities as well as American Indian/Alaska Native Populations in the State.

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The 2016 Census Bureau estimates 91.7% of Idaho citizens self-identify as white; 83.1% as White/not Hispanic; .6% Black, 1.3% American Indian/Alaska Native; 1.3% Asian; .1% native Hawaiian/Pacific Islander and 11.8% Hispanic/Latino origin. Regions 3 and 4 contain the largest concentrations of individuals with Hispanic heritage, with up to 15% of the population.
Cultural issues are addressed through learning applications available to all staff on the Department of Health and Welfare's Learning Hub website, but this does not address specifics related to Native American Tribes. A curriculum specific to Gay, Lesbian, Transgender, Bisexual or Questioning (GLTBQ) populations was developed and included in SFY 2012. The Idaho Minor in Prevention Curriculum includes attention to culture, age and gender. Literacy is addressed during service delivery, and materials may be read to the individual if they are unable to read. Regional service information and treatment materials are available in English and Spanish in Behavioral Health offices, and other languages can be addressed through translator resources. The annual Idaho Conference on Alcohol Drug Dependency (ICADD) offers a session on elements of culture.

With respect to LGBTQ populations, Annual Gay Pride week celebrations are held in the Treasure Valley (Region 4) and the Magic Valley (Region 5). The Boise Gay and Lesbian Community organizations in Idaho host educational and supportive websites at http://tccidaho.org (Boise) and http://sites.google.com/site/gayidahofalls/ (southeastern Idaho and Idaho Falls). Other websites are available to identify counseling resources that specialize in LGBTQ issues and services.

Idaho's six federally recognized tribes are the Shoshone Bannock, the Northwest Band of the Shoshone, the Nez Perce, the Coeur d'Alene, the Kootenai and the Duck Valley (Shoshone Paiute) Tribes. The Division of Behavioral Health's Substance Use Disorder provider network includes the tribally owned Benewah Medical and Wellness Center in northern Idaho (Plummer). Interaction with the Division on SUD treatment services is limited to the facility renewal process. The Division continues to contract with Benchmark Research Safety to provide funds to tribal organizations, school districts on tribal lands or other entities serving tribal populations. Historically three Idaho Tribes (i.e., Shoshone Bannock, Nez Perce and Kootenai) have applied for substance abuse prevention programs. In SFY 2014, prevention responsibilities and funds were allocated to the Office of Drug Policy (ODP) in the Governor's office. The ODP is responsible to contract for substance abuse prevention programs.

The Idaho Tobacco Project which is dedicated to preventing minors' access to tobacco has met with the Shoshone Bannock and the Nez Perce Tribes to provide retailer education resources.
The Division of Behavioral Health efforts are ongoing in engaging Tribal leaders. The regional behavioral health center staff actively engage in coordination with tribal representatives. Regions 3 and 4 regularly communicate and coordinate services with the Duck Valley Reservation and are planning on providing an 8 hour CIT training as requested by the Tribe. This training will include collaboration with the BH Tribal Coordinator, law enforcement and paramedics. The Department of Health and Welfare has a designated Tribal liaison. The Division of Medicaid has quarterly meetings with Tribal representatives. The Division of Behavioral Health has also attended these meetings on an as needed basis. The Division values the development of opportunities to collaborate with Tribal leaders formally identified a representative to serve as an active liaison to leaders of Idaho tribes. This liaison will work with the Department of Health and Welfare's Tribal

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Relations Manager to build relationships with Tribal leaders from each Tribe, and to invite ongoing input into behavioral health planning and service.

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Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state?s unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[1] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

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Primary Prevention Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.
(this step should also address how the state plans to meet the unmet service needs and gaps)

The Office of Drug Policy (ODP) completed a Substance Abuse Prevention Needs Assessment for Idaho in 2016 (https://prevention.odp.idaho.gov/wp-content/uploads/sites/33/2017/02/2016-Needs-Assessment-2.pdf). The report was a collaborative effort of Idaho's State Epidemiological Outcomes Workgroup (SEOW) and ODP. In addition to the SEOW, other vital state partners that contributed to the report were the Drug Enforcement Administration, the Idaho Department of Transportation, and the Idaho Liquor Division. ODP focused on substance use and related consequences as the first step in developing an outcomes-based approach to prevention. Through data obtained in this process, ODP was able to identify needs and critical gaps within the current primary prevention service system. These unmet service needs and critical gaps include the following:

- A lack of surveillance infrastructure regarding sexual orientation data regarding individuals who identify as lesbian, gay, bisexual, transgendered, queer, intersex, or asexual (LGBTQIA) remains. There is not enough known about these subpopulations in Idaho. It has been documented in the literature that LGBT populations may disproportionately suffer from alcohol- and drug-related consequences when compared to non-LGBT populations; however, it is not clear if this is the case with the quantitative data sources available in Idaho. In 2015, the Behavioral Risk Factor Surveillance System (BRFSS) included two modified, more targeted questions regarding not only gender identity, but also sexual preference, allowing for a more detailed analysis in the future. To remedy surveillance issues regarding Idaho's subpopulations, ODP will work to identify organizations that may represent these Idahoans to ensure their needs are better met in the future by the State's prevention efforts.
- Two additional populations for which there is limited information are returning Veterans and school age students who do not attend school. ODP has reached out to the local Idaho Division of Veteran's Services as well as the Idaho National Guard to solicit their active participation in work groups and planning committees. ODP continues to explore avenues to connect with out of school adolescents and young adults.
- Inconsistent and incomplete data collection from sub-recipients hindered ODP's ability to obtain solid outcome data related to program delivery. In July 2016, ODP implemented its own data collection system which replaced the previous online data management system. The new system is used to collect basic demographic and process information as well as outcome information recommended in CSAP's core measures. All sub-recipients that receive prevention grants from ODP, which are funded with SABG funds, are required to use the system. The long-range goal is for ODP to collect data that informs both its decisions with regard to evidence-based programming and its SABG Application process. Provider compliance with data reporting using the new system has significantly improved.
- A critical challenge for the community coalitions, as well as prevention providers in general, has been the lack of available community level data at very specific and detailed geographic units of analysis to provide a current and updated picture of the substance abuse problems at local levels. Idaho's primary *Student Use and School Climate Survey* was last funded in 2008. It included a comprehensive listing of substance abuse-related components and indicators. Since then, there have been several attempts to obtain community-level survey data from multiple governmental agencies. ODP solicited feedback from groups including coalitions, providers, Idaho Department of Juvenile Corrections, the Out of School Network, and others, to formulate a behavioral health survey that would better meet our needs. The survey will be used as a guide to establish

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prevention priorities for the state, counties, and municipalities and guide prevention planning efforts. The "*Idaho Healthy Youth Survey*" (IHYS) will be administered in the fall of 2017.

- Prior to 2016, the Idaho Board of Alcohol/Drug Counselor's Certification (IBADCC) identified a total of three credentialed Certified Prevention Specialists in the state. In response, ODP, in partnership with Community Anti-Drug Coalitions of America (CADCA), developed a series of both in-person and webinar trainings on the Prevention Specialist domains. The goal of the program is to increase prevention knowledge and best practices in the field, as well as to increase the number of prevention professionals in Idaho. Technical assistance for participants to assist in navigating the credentialing process, exam preparation to achieve certification, and compliance with continuing education requirements is also included. As of July 1, 2017 Idaho now has a total of 14 Certified Prevention Specialist registered with IBADDC.
- In 2016, ODP mapped the spatial distribution of consumption and consequence data as well as existing prevention services across all regions providing ODP a very visual and dramatic representation of areas of need and corresponding existing prevention services. ODP has made this information available to community partners and agencies and continues to use this information to guide its planning of services in identified underserved areas.

For the 2018-2020 planning cycle, ODP will continue to assist providers and coalitions with planning data to identify and deliver a greater number of EBP education programs and encourage the implementation of environmental approaches to prevention at local levels. ODP continues to work to establish subcommittees to specifically address each of the above identified unmet service needs. These committees will not only serve to build relationships and provide anecdotal data and information, but it is hoped they will lead to better surveillance infrastructure in Idaho. Ongoing training and technical assistance that ODP provides to high-need communities with specific priority populations will better enable Idaho to support a more strategic, comprehensive array of services and programs and begin to close critical gaps.

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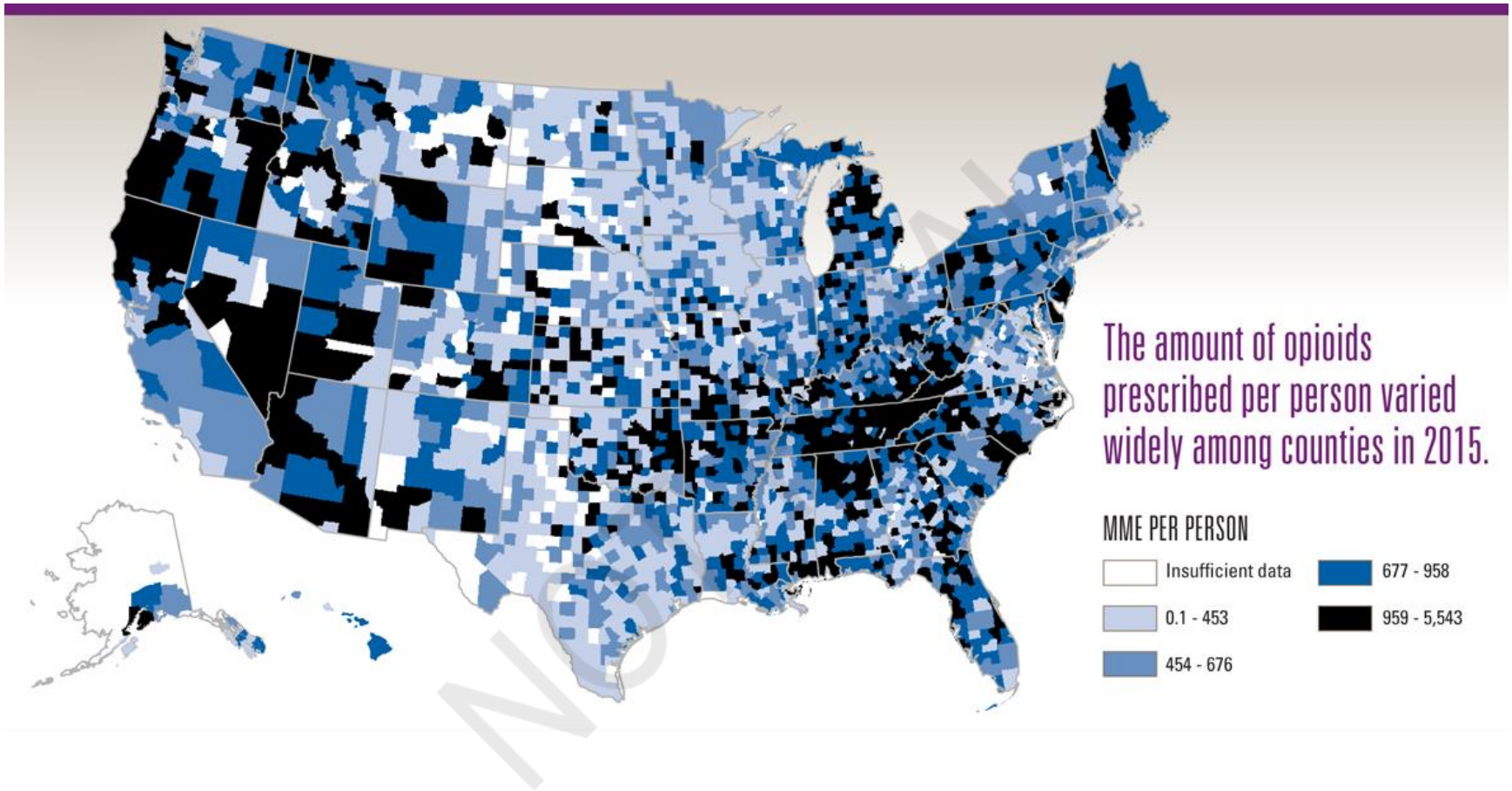
Opioid Prescribing

Where you live matters



Source: https://www.cdc.gov/vitalsigns/opioids/infographic.html#graphic-b

Regional Behavioral Health Board

Gaps and Needs Analysis

2016

Identified Regional Service Needs and Gaps *Relating to Prevention, Treatment and Rehabilitation Services*	**Short Falls, Challenges and Problems**	**Project Proposals and Progress** *Including those related to Family Support Services and Recovery Support Services*	***Improvement and Strategy Measures Accomplishments***	***Region***
	Many questions asked; answers slow to come to the new process. Details investigated, discussed and voted prior to application. Uncharted process developed.	Approval as Stand-Alone Behavioral Health Board by BHPC Partnered with Panhandle Health District. Admin Assistant employee part-time in partnership with PHD.	Approved as standalone Behavioral Health Board by BH Planning Council, Sept 2015. Exploring options/ opportunities for additional funding (grants, gifts, partnerships).	**1**
	Slow process for facility approval, remodeling. Developing operations process and data system.	Crisis Center for North Idaho in CDA Crisis Center funded in 2015.	Crisis Center opened Dec. 9, 2015. Working on process, final improvements to facility, building community partnerships, robust data system.	**1**
	Providing additional training, train-the-trainer opportunities to expand the number of TIC trained providers. Expand Endangered Children's trainings.	Education on Trauma Informed Care (TIC): Children's Mental Health. Drug Endangered Children's Protocol TIC provided as continuing accredited education to school. private individuals,	Formation of community based partnerships with agencies across multiple disciplines. Partial funding for presentation that reached 700 providers	**1**

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		hospital staff. April 2015	provided by Children's Committee (gift from Kootenai Children's Alliance).	
	Many officers, first responders not yet trained. Difficult to free up offices for entire training time. Some areas have few trained persons.	Crisis Intervention Training (CIT) provided to Law Enforcement Personnel. Many officers and first responders trained in BH and SUD issues.	CIT Training funded in part by BHB in April 2015. Bonner and Boundary Counties have many trained officers with assistance of NAMI and BHB.	**1**
Increased availability of and access to mental health services for children, youth, & adults	-Nature of frontier & rural areas -Need for crisis services & support - Child, youth, adult - Hospital based ER Psych. Crisis Team - Respite providers - Telehealth structure inadequate - No child psychiatrist in Region - No local In-patient services for children & youth	-Continued telehealth in outlying areas -Children's MH Planning Council Subcommittee -Increased number of psychiatric nurse practitioners -Needs assessment on inpatient services for children and youth in Region 2 – LCSC Social Work Program.	- Advocate for St. Joe's telehealth - Acquire data on use of ER for SUD and psychiatric services - Grass roots effort to obtain Crisis Center in Lewiston	**2**
Increased availability of and access to SUD Services	-Nature of frontier & rural areas -Limited services -Detox facility -Stigmatizing attitudes -Funding Silos -Treatment resources for youth not in Juvenile Justice System	- Latah Country Recovery Center opened - Increased prescription drop off boxes - Drug courts - Community Meeting – Recovery Center 11/13/15	- Latah Country Recovery Center opened - Increased prescription drop off boxes - Drug courts - Community Meeting – Recovery Center 11/13/15	**2**
Funding for services for individuals with dual diagnosis	- Existing funding priorities not meet needs - Lack of data on population - Lack of long term treatment options	- Continue to survey stakeholders to prioritize needs - All area SUD providers certified on dual diagnosis (MH/SUD)	- Continue data collection - Latah County NAMI assisting WSU with data collection	**2**
Housing	- Lack of Crisis Beds - Lack of transitional & supportive housing - Limited safe & sober housing - Limited housing for	-Iris Apartments – 1 crisis bed -*Rising Sun Homes* -Opened 3/2015 in Lewiston - Exploring additional	- Explore grant options - Housing Committee created to pursue funding - Partnership with WSU	**2**

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	women - Lack of Therapeutic Foster Homes-Path Has no homes in Region	home in Lewiston -*Abbadaddy House*-Cottonwood - Housing Committee conducting needs assessment	for research & grant resources	
Transportation	- Limits access to treatment & support services - Shackling policy remains degrading - Lack of transportation options for children & youth to facilities - Taxi services unaware of funding - Limited driving privileges for SUD and mental health population	- Access to telehealth reduces need for transportation - CIT training for first responders -Shackling legislation passed in 2014	-Explore Virtual Care Works -Shackling policy – Additional reform	**2**
-Explore Virtual Care Works -Shackling policy – Additional reform	- Stigmatizing attitudes - Improve media relations - Lack of resources for public education - Inadequate knowledge of need for parent/caregiver respite - Support for Lewiston NAMI - Few outcomes measures available on program & educational effectiveness	- Training for medical staff, schools & law enforcement - Respite Training developed - AMH Designated Examiner training - Mental Health First Aid - Parenting with Love and Logic/Limits - Children's MH subcommittee - Youth Mental Health First Aid - Purchase & show "Paper Tigers in 5 counties during 2016	Develop outcome measures to determine effectiveness of training and educational programs	**2**
Children and youth Mental Health Court	- Lack of funding, staff, program design & providers	- Currently understudy by Corrections & Mental Health - Utilize Region 1 model	- Continue discussion with state - Gain support from District Judges and Magistrates	**2**
Ongoing funding needed for Federally qualified healthcare	- Lack of health insurance - Idaho did not take Medicaid expansion funds - Snake River Clinic has limited funding & resources	- CHAS Clinic established for indigent clients - State Healthcare Innovation Plan funded by Feds and awarded to DHW	-Continue to advocate at State level to access available federal Medicaid Funds	**2**

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		www.yourhealth.Idaho.gov - Increased access to health insurance through Affordable Care Act - Reduction in funds spent from county catastrophic budget	- Healthy Idaho	
Physicians Workforce Development - identify independently licensed clinicians nationwide	-Psychiatrist salaries below national standards	-2014 Legislature approved loan repayment for physicians for Psychiatrists at State Hospitals - School loan repayment for physicians relocating to Idaho		**2**
Prevention – Substance Abuse, Mental Health and Suicide	-Inadequate funding for prevention services -Increased suicide prevention training	- LCSC Counseling Center secured grant focusing on prevention on college campus - LCSC Counseling Center applied for second preventative grant - Mental Health First Aid classes available in Nez Perce & Latah Counties -Suicide prevention – Support use of gun locks through distribution of locks and education - Suicide memory walks – 3 – with educational materials and counselors		**2**
1. Services for non-criminal justice at-risk youth and adults	Funding, a successful model (school disciplinary hearings), parental/caregiver involvement	**Proposal:** Research funding sources such as the Juvenile Justice Commission, develop a model for schools/communities to refer at-risk youth Engage parents/caregivers in family supports (family therapy/groups), Work with DHW for crisis services (law enforcement, schools,	Decrease in referrals to juvenile probation outcomes/data from successful model implementation and crisis calls deferred increase in parental /caregiver involvement in family supports.	**3**

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		parents, caregivers). Engage in community trainings such as trauma informed care suicide prevention at-risk youth behavior education **Progress/Accomplishments:** Region 3 was a pilot for Vallivue and Nampa School Districts that utilized funding to deter youth from the criminal justice system. Potential to follow that pilot model/outcomes. CIT Trainings within the schools, youth mentoring program		
Crisis Assistance	Crisis Assistance	**Youth:** Shelter Care, a form of short-term intervention, residential respite care. Implement more prevention programs within schools. **Adults:** Community Recovery Centers to assist those in recovery Crisis Center to assist in stabilization and referrals/connections to community resources **Progress/Youth:** Working with Juvenile Probation to develop Shelter Care model	**Youth:** Data/outcomes from Shelter Care Prevention data/outcomes from schools Decrease in youth hospitalizations and referrals to juvenile probation. **Adults**- Decrease in: Probation and Parole Incarceration Hospitalization Client holds Increase in case management and adult clients receiving treatment services.	**3**

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		Increase transportation services to needed behavioral health services Increase individual/family group therapy Add full ACT option with Optum **Progress/Adult:** Increase transportation services to needed behavioral health services Increase individual/family group therapy Increase youth mentoring programs		
1. Prev ention, Enrichment, and Resiliency	Funding and connecting of current available resources.	More afterschool programs with the assistance of applications for the State Dept. of Education 21st Century Grant Increase school participation in Prevention Block Grant funding Engage Mayor's Youth Advisory Councils to promote healthy youth involvement Engage BHB to assist in the writing of grant funding opportunities. **Progress:** CIT Trainings Youth mentoring programs	Overall reduction of Recidivism, Incarceration, and hospitalization by changing environmental strategies.	**3**
Youth Mental Health Court	Funding, lack of grant writing experience (opportunities exist),	Engage BHB to assist in the writing of grant funding	Data/outcomes of referrals through	**3**

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	engaging judicial involvement.	opportunities Engage judicial system and juvenile probation. Review model in District 6 with data review. **Progress:** CIT trainings Youth mentoring programs	judicial system juvenile probation hospitalization.	
Transportation	Funding, rural areas access, 3rd party transportation provider not coordinated through client and insurance (for example: AMR). Adolescents and families have little to no access to transportation to treatment and/or recovery support services.	Possibility of utilizing existing transportation services such as those delivered in rural communities at senior centers Bringing services to the school districts where youth/adult/parent/caregivers already frequent Connection to Community Recovery Centers and Peer/Recovery supports	Decrease in No-Show appointments Increase in available client service attendance	**3**
Housing	Rural housing availability associated with employment opportunities, available units/vouchers, funding	Engage more housing providers in case management of existing/potential residents Connection to Community Recovery Centers and Peer/Recovery supports Develop a form of transportation that focuses specifically on meeting the needs of adolescents and their family members in treatment services.	Decrease in homelessness or those at risk of homelessness. Increase in attendance and participation for adolescents and their family members in treatment services. Reduction of family violence and unhealthy family dynamics that contribute to substance abuse and mental health problems.	**3**

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		Progress: BH meeting with housing authorities to provide on-site BH referrals.		
Employment	Connecting existing resources to those in need, transportation, stigma Lack of access to effective funding and preparation for GED testing.	Engage clients through case management with employment opportunities Educate communities/clients on employment opportunities even for those with disabilities Connection to Community Recovery Centers and Peer/Recovery supports Provide services to aid in preparation and assistance with GED testing.	Increase in employment Decrease in unemployment Promotes resiliency and recovery. Increase in individuals who obtain their GED and are thus more prepared for the work force.	**3**
Optum Idaho SUD Referrals	Lack of SUD diagnosis and internal referral process	Engage Optum to provide data reports, monitoring/enforcing that providers are operating within their scope of practice, using evidenced based practices, appropriate referral of co-occurring clients. **Progress:** Have requested data and measures to ensure SUD referrals.	Increase diagnosis and treatment of SUD and co-occurring.	**3**
Spanish Speaking Providers	Lack of training and availability	Work towards providing more training for the Spanish speaking work force.	Increase in the number of Spanish speaking providers.	**3**
1. SUD Treatment in rural	Lack of treatment options and resources in rural areas (Homedale, Council,	Work towards developing treatment options for clients who live in rural	Increase in individuals who are able to access treatment	**3**

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areas	Wilder, etc)	areas.	Decrease in expanding substance abuse problems in rural areas.	
Increased collaboration with Medical Providers	Lack of awareness in regards to the options available for BH services and providers. Lack of communication with mutual clients.	Work to develop opportunities, mechanisms, and systems that would allow for more seamless communication between BH and medical providers.	Overall improvement in the comprehensive quality of care delivered to clients throughout the region. Could be a model for other regions to follow towards the same goals. Improvement of the general understanding of what other providers are doing to treat clients (Behavioral Health with medical providers and vice versa).	**3**
HOUSING -Some housing options exist in Ada County, but there are no options in Valley, Elmore or Boise counties.	-Affordable and accessible housing including for offenders, and releases from hospitals	-Address housing policies that support eviction due to lack of compliance; support alternative policies that do not threaten housing but support accountability.	-Decrease risk for homelessness in our vulnerable populations.	**4**
	-Supported housing for chro mentally ill -Supported housing for you to return home after state o other residential) -Additionally: lack of housin treatment options for youth to remain at home -Lack of mid level care for youth/adults	-Establish a supported hou entity that supports indepe living through medication management and life skills internal access to MH servi community planned suppo groups. -Increase in SUDS daily rate housing to allow agencies t ability to open additional h -Establish an Emancipation type program.	-Support funding for provision of Medicaid mid level services (IOP/ Partial Care)	**4**

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		-Develop temporary residential housing and treatment for youth with mental illness who are unable to remain in homes. -Invest in home based therapies and family support services		
Sober/Transitional Housing	-Process to get into sober/transitional housing takes 1-4 weeks	-More housing options available -2 week grace period for GAINS assessment (if engaged in Recovery Support Services) -Provide more support while accessing programs and services		**4**
Mother/child Housing for individuals with Behavioral Health challenges	-There are no supported family housing options available. -There are no detox/in-patient facilities for pregnant women	-Develop family/parenting programs with supported housing -Expand existing detox and treatment to include pregnant women		**4**
		-Transitional housing for individuals moving between levels of care.		**4**
TRANSPORTATION	-Bus system supports minimal needs of the region as a whole.	-Bus system expansion. -Lines and available hours -Explore and develop transportation regarding treatment appointments for children and adults. -More direct ride options for SUD/MH clients	-Improve access to care/services/supports and decrease no show rates.	**4**
	- Bus pass availability for MH/SUD treatment needs	-Establish a state supported bus pass program for MH/SUD individuals to attend treatment, medical, probation and other related appointments in areas with transportation.		**4**

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	-Lack of transportation options in rural areas for adults and youth	-Develop transportation options in rural areas and/or increase tele-medicine.		**4**
		-Utilize Trained Peer Transport services from rural areas for access to treatment. Utilize and fund peer transport options to reduce law enforcement transports when unnecessary		**4**
		-Expand Village Van and Access transit services		**4**
SERVICES FOR NON-CRIMINAL JUSTICE AT-RISK YOUTH	-Schools in more rural areas do not have the resources to provide services needed for children/families with mental illness.	-Research funding sources such as the Juvenile Justice Commission, develop a model for schools/communities to refer at-risk youth, engage parents/caregivers in family supports (family therapy/groups), work with DHW for crisis services (law enforcement, schools, parents, caregivers). Engage in community trainings such as trauma informed care, suicide prevention, at-risk youth behavior education. -Evaluate/develop supportive youth groups, peer services for youth	-Decrease in referrals to juvenile probation, outcomes/data from successful model implementation and crisis calls deferred, and increase in parental /caregiver involvement in family supports.	**4**
	-Lack of training and resources to hire within. These services are currently contracted out which limits response and resources for the school.	-Provide for funding streams to allow for training school staff on mental illness and behavioral health. Funding stream to hire these positions in-house. -Develop Peer Support		**4**

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		programs for public high schools		
	-Minimal trauma informed care and strengthening families training opportunities	-Establish and/or continue to support training opportunities.		**4**
	-Support for children of incarcerated parents	-Establish a state-wide system, at the court level, to identify children of parents being incarcerated; provide professionals to engage them in prevention interventions immediately. -Develop and facilitate peer support groups for children and families of incarcerated individuals.		**4**
RESILIENCY, RECOVERY AND WELLNESS SUPPORT	-Support for community mental health crisis centers in all regions	-Further support for community Recovery Centers, Peer Wellness Centers, and Crisis Centers -Expand Recovery Wellness programs for SUD/MH clients (Mindfulness, Meditation, etc...)		**4**
	-Additional resources for community supervision	-Provide for additional probation officers based on per capita population. -Support- IDOC in Mentoring Program		**4**
	-Lack of available respite care workforce for families with kids diagnosed as mentally ill	-Maintain respite care programs. -Establish subsidized respite care programs.	-Continue education/funding for respite program to increase training and workforce.	**4**
	-Lack of support/education/training for Crisis Intervention Teams (CIT) to respond to families	-Provide training for first responders on mentally ill children and their families.		**4**

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		-Add Peer Supports to (PET) Psychiatric Evaluation Team and emergency rooms		
-Stigma which creates barriers to accessing resources, treatment, and appropriate utilization of available services		-Provide trainings and empowerment workshops to raise awareness and recovery support from the community		**4**
SYSTEM ISSUES -Lack of clarity around desired outcomes from authorities	- Policy and legislation requirements are often redundant and in conflict with current licensing standards	-Establish and communicate measureable goals for state mental health/SUD system, in a fashion that incorporates input from all levels. -Break down barriers regarding state licensing conflict with crisis shelters and respite care and increase training, including access to supervision for Recovery Coaches, Peer Support, and Family Support Services.	-Follow and gain feedback from DHW regarding outcomes project for SUD services for 2016	**4**
-Lack of coordination of care between behavioral health care and primary health care providers	Need for better communication and consistency across division lines	-Establish working relationship with licensing boards so that policy and legislation is written with current licensing standards in mind.		
	-Health data exchange does not accept records from BH providers because of real and perceived barriers relate to privacy (ie 42 CFR & protections for psychotherapy notes) -People with serious mental illness die on average between ages 53-56. 2/3 of premature	-Remove payment barriers to BH providers by reinstating collateral contact and telephonic case management codes under fee for service.		**4**

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	deaths are due to preventable/treatable medical conditions. 70% of individuals with significant MH/SUD have a least 1 chronic health condition, 30% have 3 or more.			
	-Need for better communication with contract managers	-Create and fund treatment teams (Med-Psycho-Social) and a program that facilitates collaboration and communication between providers. -Continue to invest in integrated health care such as medical homes, SHIP and Community Health Centers. Idaho needs to continue to seek ways to "close the gap" in health insurance.		**4**
	-Need to create funding stream for gaps in care -Offender re-entry -Patients released from IDOC/SHS -Medicaid expansion population	-Division lines (Behavioral Health and Medicaid) collaborate, measure goals/outcomes of both populations concurrently, drill down with contract managers and into provider network.	Encourage the State to apply for available CCBHC funding to create MH FQHC's in state.	**4**
		Increase coordination across agencies (schools, Juvenile Corrections, Correction, Courts, Medicaid and Regional mental health services).	Encourage partners to collaborate with BHB's, providing information regarding funds that may be available for both offender re-entry and State hospital clients for housing and treatment	**4**
	Establish a culture of collaboration with	Reestablish town hall		**4**

NOT FINAL

	Medicaid provider and contractor. Increase oversight of Medicaid contractor, increase communication across lines.	meetings with Optum-Medicaid.		
	Legislative support of program needs	-Support of legislation related to proposed mental and behavioral health services and programs. -Support the belief that the lack of health care coverage is a significant problem for people receiving MH services and ask that the legislature seriously consider health care provision options.		**4**
TREATMENT SERVICES AND INTERVENTION				**4**
Reduction in Community Based Rehabilitation Services (CBRS)	-Limited other treatment and/or support options -Lack of mid level services (IOP/Partial Care) -Lack of Family engagement for preventative services	-Continued supportive provider trainings. -Creation of additional services to support the void of CBRS -Trainings needed for providers to engage families	-Coordinate with stakeholders to support addition of Medicaid funding for mid-level services) -Continue to look at trainings state wide.	**4**
Optum Idaho SUD Referrals	Lack of SUD diagnosis and internal referral process	Engage Optum to provide data reports, monitoring/enforcing that providers are operating within their scope of practice, using evidence based practices, appropriate referral of co-occurring clients. Progress: Have requested data and measures to ensure SUD referrals.	Increase diagnosis and treatment of SUD and co-occurring.	**4**

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Lack of integration and collaboration between mental health, SUD's, and health treatment	Policy barriers to quality care and accessibility.	-Improve communication between Medicaid/Behavioral Health division lines -Support policy changes that allow for assessments to be conducted based on licenses not facility approval, -Improve oversight by Medicaid contractor to identify clients with SUD needs and conversely push toward Drug Dependent Epidemiology (DDE) programs for all SUD providers -Incorporate American Society of Addiction Medicine (ASAM) in Medicaid paperwork, allowances In Idaho Behavioral Health plan the billing matrix to bill for communication.	Improved service provision and patient outcomes. Maintain capacity (provider networks).	**4**
Insufficient access to SUD services	-Lack of SUD residential treatment options longer than 30 days. Lack of services for non-intravenous drug users (non-IVDU), Pregnant Women and Women with Children (PWWC), non-felony individuals with addictions	-Provide support for treatment of adults with addictions (non-criminal justice). -Address budget constraints with regard to residential services		**4**
ACCESS TO SERVICES -Half of all mental illness emerges by age 14 and three quarters by age 24. In the US, there is an average lag of 8	Mental health services for families in rural areas -knowledge of resources, awareness in urban and rural areas	Increase Tele-health utilization; provide state-subsidies for professionals willing to work in outlying areas. Load re-payment options. -Support Aim Early Idaho	-Provide education to follow Rule on Tele-health services.	**4**

NOT FINAL

to 10 years between onset of mental health conditions and the start of treatment. While nearly 1 and 5 American youth live with a mental health conditions, less than half receive any services.	-2/55 agencies in Region IV have appropriate Infant mental health (0-3) service availability -Idaho lacks any significant early intervention programs, treatment and support programs for its youth.	program and state endorsement training -Open tele-health with Medicaid up to mid level clinicians. -support education/marketing on the Idaho Care Line (211)		
	-Inability to access reimbursement for prevention or treatment Lack of supportive funding to assist with medications (adult and children)	-Support Medicaid expansion or Healthy Plan Idaho.		**4**
	-SOAR needs faster accessibility to Medicaid approval. -Lack of urban and rural transitional services and support (youth and adult)	-Increase SOAR trained professionals in the area. -Diversify potential workforce to community health or Peer Support staff .		**4**
	-Address culture and flow of services within schools to avoid needing to press legal charges prior to achieving needed services -4th District Court has no current Juvenile drug court	Decrease time frame for those in need to access services. -Increase groups and other supports for transitional aged youth. -Support continued awareness/ education of available programs within schools		**4**
-Lacking ability for case managers under Optum Idaho to effectively coordinate care due to face to face limitations of service	-Lack of clarity regarding CM eligibility guidelines, contradictions between Optum definition, IDAPA, and case managers.	-Seek clarification and transparency of service delivery that compensates providers for expected service function and outcomes		**4**

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ACCESS TO SERVICES WITHOUT CRIMINAL JUSTICE INVOLVEMENT	Increased need for diversion programs	Establish diversion programs in lieu of incarceration. -Allow-access to services to individuals w/out CJ involvement.		**4**
	Legislation to de-criminalize substance use disorders	Work toward addressing recommendation outlined in Justice Reinvestment Initiative (JRI).		**4**
	-Limit incarceration terms, reassess risk levels	Establish diversion programs that include treatment and community supervision in lieu of incarceration for low risk offenders. -Gather data from IDOC regarding response Matrix, geared toward reducing re-incarceration for those on probation or parole.		**4**
			PROGRESS AND ACCOMPLISMENTS: 1) Systems expanding/ attending to Infant Mental Health Issues. Coordination with Progress Stakeholders occurring 2) Adolescent track added to state-wide ICADD conference 3) Increased funding for Access to Respite care and programs developed 4) Optum reports 100% access to MH services in what was a once struggling area (Idaho City) Included coordination with police, schools and	**4**

NOT FINAL

			providers 5) Nearly 50% of Boise Police Officers are now trained in CIT to support appropriate diversion and non-criminalization of MH issues. 6) MH coordinator position added in BPD to support community efforts. 7) Telehealth now approved under SUD funding. 8) Grant Application submitted for a Community Safety Center (Safety/justice Grant) by law enforcement stakeholders in Ada County. 9) Peer Wellness Center opened in Boise.	
Transitional and permanent housing for men and women.	Lack of funding sources and actual support housing place. Lack of resource to pay first/last month rent and deposit.	Research County-owned houses in Bingham and the possibility of implement a similar process in Bannock. Channeling PATH funding through RBHB for regional input and decision making related to housing dollars. Utilizing PATH dollars to help with deposits and first/last month rent. Research and present feasibility of Oxford house model. (Arthur St.) Develop gran to fund the	Educated legislators and other government officials via an annual legislative dinner. Use of PATH Peer Specialist to help coordinate housing upon discharge from State Hospitals. Process by which regional PATH specialist presents cases to the Regional Behavioral Health office; intent is to review applications and develop additional resources for the	**6**

NOT FINAL

		same if supported by RBHB. Resource sharing with regions currently have functioning Oxford houses. Spirit of Hope house provides housing and has an individual at the house to maintain and collect the rent, etc. No counseling services are available or other programs to aid in job searches or other community resources.	client.	
Supported Employment	Challenges with skills identification and acquisition as well as transportation to employment/training site.	Community Partners (Working Solutions, Voc. Rehab, DOL) present/ educate RBHB about services available to consumers. RBHB partnering with Working Solutions, Voc. Rehab, and Department of Labor in an effort to educate consumers about employment assistance during a regional resource fair.		
	Difficulty obtaining employment with criminal record		Changes to Administrative Rule related to background checks for Peers and Recovery Coaches.	**6**
	Difficultly obtaining employment with felony record.	Partner with community businesses to be more "felon" friendly. Promote "Ban the Box" initiative.		**6**
Transportation	Limits access to treatment if client does not have Medicaid.	Bus or other transportation vouchers are needed.	Regional Behavioral Health Center provides bus and gas vouchers for consumers to access treatment.	**6**

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			Find Support for providing bus passes	
	Transportation to SE Crisis Center.	Coordinate with Voc Rehab in an effort to enhance transportation options.	Voc Rehab currently provides transportation vouchers to assist with transportation to and from place of employment.	**6**
	Development of low/no cost transportation.	Gas and bus vouchers for transportation to SECC.	Bus vouchers purchased by RBHB to assist with access to SECC.	**6**
		Research a bikes loan and possible community partnerships.	Increase availability of loaner or low cost bikes.	**6**
Case Management	Uninsured consumers in need of BH services are unable to access case mgt.	Workgroup to develop Recovery Center as a clearing house for resources and connections	Trained workforce of Recovery Coaches and Peer Specialists who can connect Consumers to services at places like a Recovery Center.	**6**
Collaboration between school districts, juvenile justice, DHW, and providers resources available for children.	No Common Database/Website	RBHB CMH subcommittee visited schools in the region with DBH-CMH,J.J., and community providers	CMH committee provides newsletters to school district	**6**
		Educate teachers and parents about funds available for BH treatment for uninsured. Include resources in RBHB hosted resource fair.		**6**
Parent education/support-to include respite, telephonic and tele-medical	Parents are unaware of available services.	Use websites and newsletters to disseminate information.	Educating through newsletters issued to school districts and counties.	**6**
		Educate teachers		**6**

NOT FINAL

		and parents about funds available for BH treatment for uninsured. Include resources in RBHB hosted resource fair.		
Timely access to preventative and needed ongoing health care (BH and physical health) services for both adults and children.	Limited access to care for uninsured. Limited ongoing access to medical care. No available drop in centers. Not enough therapeutic foster homes.	Health care for uninsured is expensive. Research and present drop in center models for adolescents to RBHB. Recovery Support is working on securing funding for a Recovery Center for adults. Increase incentives for Therapeutic foster home	Encourage and advocate for Medicaid expansion or similar alternative.	**6**
	No detox facilities in the southern end of the state.	Provide training for local doctors re detox protocol.		**6**
Family-run programs available as an option, along with the traditional approach.		Training by Federation for family support partners.	Optum is preparing to begin paying for H0046 Family Support by a qualified Family Support Partner.	**6**
Doctors and hospitals, especially in rural areas, need training when working with juveniles who are contemplating suicide.	Accessing medical personnel.	Contact all medical facilities in Region 6 and offer training related to risk assessment.	Dr. Rudd training on Risk assessment. 33 tele-health providers in the Optum network.	**6**
More information about suicide prevention and risk assessment for all ages.	Parents and school personnel do not have a protocol when students reveal thoughts of suicide.	Allow time at the annual Children's Mental Health training conference in Region VI.	Children's Mental Health annual Conference in Region 6 focus on risk and suicide assessment.	**6**
		Utilize websites and new letters to educate parents, consumers, and community members about risk and suicide assessment and resources for the same.	Funding approved by JFAC for Office of Suicide Prevention.	**6**

NOT FINAL

	Large rural area to cover with education	**Awareness: Blue Cross Grant for Children's Mental Health Awareness Obtained grant of $15,000. Developing roadshow training through Region 7 (will be held in six counties).**	**Grant for Children's Mental Health Awareness**	**7**
		Transformation of R7BHB Signed contract and MOU with Eastern Idaho Public Health. Submitted Readiness Application, which was approved.	**Successfully transformed structure and support of R7BHB.**	**7**
	Challenges getting word out about the program.	**STAR Program (First Episode Psychosis) IDHW is facilitating this effort (in its first year)**	**Program started: R7BHB supports project and want to become more involved as appropriate.**	**7**
	Lots of unanswered questions at this point in time.	**Respite Care Beginning discussion and evaluation of R7BHB's desire/ability to take on at the local level.**	**R7BHB voted to explore.**	**7**
	Lack of data identifying prevalence; systemic issues, law enforcement and mental health treatment capacity.	**Stepping Up (Reducing people with mental illness incarcerated in county jail) R7BHB established a subcommittee to implement the initiative in the Region.**	**R7BHB identified subcommittee participants and are planning ongoing coordination meeting. Working with the national Stepping Up initiative.**	**7**
	Sustainability; identifying recovery coaches and peer support.	**Recovery Center – Center for Hope Received $150,000 Millennium Fund grant.**	**Center of Hope obtained 501(c)3 status; established board of directors, found physical space; involved with the R7BHB.**	**7**
	Sustainability of future training; reaching throughout the 10 county region to provide training	**Training Crisis Intervention Training; Mental Health First Aid**	**Just completed CIT training in Rexburg.**	**7**
	Sustainability; meeting needs across the region.	**Behavioral Health Crisis Center Opened in December 2014; community**	**Opened in December 2014; community awareness is growing; meeting targets.**	**7**

NOT FINAL

		awareness is growing; meeting targets.		
	Time needed to review and update the plan; integrating substance abuse and mental health needs for all ages.	**Strategic Planning**	**Initial plan created for R7BHB; Gaps & Needs Analysis conducted in March 2014.**	**7**
	Non available in the area.	**Detox Centers** **Under investigation by R7BHB.**		**7**

NOT FINAL

Idaho's Response to the Opioid Crisis (IROC)

Abstract
Idaho's Response to the Opioid Crisis (IROC) will address the opioid epidemic which Idaho is currently facing using a multifaceted approach that seeks to expand access to Medication Assisted Treatment (MAT), reduce access to opioids through prevention efforts, enhance the recovery oriented system of care, and reduce opioid-related deaths.
Through IROC, Idaho will focus on serving 840 people in year one and 1,025 people in year two who have an Opioid Use Disorder (OUD) diagnosis, are uninsured, are within the 18-36 year old age group and who are re-entering communities from the Criminal Justice System. IROC will:
Approach 1) Introduce publicly-funded MAT to Idaho by adding Methadone and Suboxone to the array of treatment and recovery support services (RSS) that are currently available. Individuals with OUD who are eligible for substance use disorder (SUD)-related services will be able to access these medications at various locations throughout the state. This will be accomplished by increasing the number of Suboxone and Methadone providers in Idaho, training traditional treatment providers in evidence-based treatment models focused on OUD, and by creating a system in which traditional treatment providers can refer individuals to MAT services. Through the MAT program, IROC will seek to provide services to no less than 250 Idahoans per year who are in need of medication.
Approach 2) Reduce access to opioids and prevent overdose deaths by: Using prescriber report cards to create social norms of decreased opioid prescribing; reducing diversion of opioids by establishing drop-box programs in pharmacies statewide; and educating prescribers on use of the Prescription Drug Monitoring Program (PDMP) and the Center for Disease Control and Prevention's (CDC's) prescribing guidelines, which will result in fewer prescriptions for opioids being written and filled. Among other objectives, these steps seek to reduce the number of prescriptions per capita by 5%, decrease the percentage of clients on high dose opioid therapy by 5%, and increase the rate of PDMP use by 10% within a one-year period.
Approach 3) Broaden the boundaries of Idaho's recovery-oriented system of care to engage persons in a recovery process from the point of initial contact. Among other objectives, this system of care seeks to reduce overdose events and fatalities, reduce "no shows" through immediate contact with a peer, and to help support services and sober recreational activities to the OUD population.
Approach 4) Increase the use of Naloxone to reverse opiate overdoses through training and provision of Naloxone to first responders and others (including Federally Qualified Health Centers) and other community members who may come in contact with individuals, at risk of opiate overdose. This will be accomplished by identifying a minimum number of first responder agencies that will begin carrying Naloxone, performing community and provider trainings, and by providing Naloxone kits to identified and trained entities.

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Project Narrative

Section A: Population of Focus and Statement of Need

A-1 Communities of focus

Through the preliminary efforts of the needs assessment and strategic plan for the Idaho's Response to the Opioid Crisis (IROC) project, the communities of focus at highest risk have been identified as:

- **Uninsured**: those who are uninsured and of low socioeconomic status who also meet diagnostic criteria for Opioid Use Disorder (OUD). Idaho does not have expanded Medicaid and has identified a gap population of 78,000 uninsured adults.
- **18-36-year-old age group:** "Idaho ranks fourth nationally for nonmedical use of prescription pain relievers by persons 12 years and older" (Olson, 2016). Within that community, a special emphasis will be placed on individuals between the ages of 18 and 36 years of age because of their higher prevalence of OUD compared to that of other age groups.
- **Criminal Justice Reentry:** People who are criminal justice-involved and are reentering society either from jail or prison will be another emphasis within the communities of focus because of the potential for accidental overdose from returning to use following a period of abstinence.

The comprehensive demographic profile of this population in the local area is obtained from relevant Treatment Episode Data Set (TEDS) information during the Federal Fiscal Year (FFY) 2016, in addition to empirical data from reputable research and statistical entities that are cited throughout the Project Narrative.

A-1 Race

Idaho's communities of focus are represented by the following racial demographics:

Race	Percent of the communities of focus
Alaska Native	1.02%
American Indian	1.52%
Asian	0.15%
Black/African American	0.44%
Native Hawaiian	0.15%
Other	5.22%
Pacific Islander	0.07%
White/Caucasian	87.01%
More than one race	4.28%
Unknown/Refused	0.15%

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A-1 Ethnicity

Idaho's communities of focus are represented by the following ethnic demographics:

Ethnicity	Percent of the communities of focus
Chicano/Other Hispanic	0.07%
Cuban	0.00%
Hispanic or Latino - specific origin not specified	3.92%
Mexican	1.45%
Not of Hispanic or Latino Origin	93.47%
Other Specific Hispanic or Latino	0.22%
Puerto Rican	0.07%
Unknown/Refused	0.07%

A-1 Federally Recognized Tribes

In Idaho, there are the following federally recognized tribes:

- Coeur d'Alene Tribe
- Kootenai Tribe of Idaho
- Nez Perce Tribe
- Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho

As indicated above, the American Indian demographic represents 1.52% of the communities of focus. However, there are additional individuals who have received services through Indian Health Services (IHS) that are not represented in the data. The Tribal Council has been contacted and there are efforts in place to ensure that all of the federally recognized tribes in Idaho will have access to services through IROC funds. Idaho will continue to evaluate the needs of the Tribes through the development of an updated strategic plan and needs assessment.

A-1 Language

Although Idaho is predominantly homogenously Caucasian, there is a strong presence of diversity in certain regions of the state. Idaho has a vibrant Hispanic community in addition to several refugee communities in the southwest part of the state. The OUD epidemic has impacted people in Idaho from all walks of life where different languages are spoken. Through the use of technology and a wide array of professionals, they can all receive access to treatment services in their own language.

A-1 Sex

Idaho's communities of focus are represented by the following sex demographics:

Gender	Percent of the communities of focus
Female	43.76%

NOT FINAL

Male	56.24%

A-1 Gender Identity
Based on the demographic data available from the Williams Institute through UCLA, as of June 2016, Idaho's transgender population is 0.41% of the population (A.R. Flores, June 2016). Additionally, the Center for American Progress reports that people who identify as transgendered have a two to three times higher prevalence of substance use disorder than those who do not identify as transgendered (Hunt, March 9, 2012). Although this represents a small segment of the communities of focus, the professional and culturally competent treatment of people who identify as transgendered is a priority.

A-1 Sexual Orientation
Based on the data available from the most recent Gallup poll, Idaho's LGBT population is 2.7% of the population (G.J. Gates, 2013). The Centers for Disease Control and Prevention (CDC) reports that people who identify as LGBT have a higher prevalence of substance use disorder than those who do not identify as LGBT (Centers for Disease Control and Prevention, 2016). Although this represents a small segment of the communities of focus, the professional and culturally competent treatment of people who identify as LGBT is a priority.

A-1 Age
Idaho's communities of focus are represented by the following age demographics:

Age Demographic	Prevalence of OUD
14-17	23.53%
18-24	32.92%
25-36	30.62%
37 and older	14.71%

A-1 Rural/Urban Population
Idaho's population is comprised of urban, rural, and frontier regions. According to the National Center for Frontier Communities, of Idaho's 44 counties, nine are urban, nine are rural, and the remaining 26 are considered to be frontier (National Center for Frontier Communities, 2012). The nine urban counties have the highest representation in the communities of focus, although the rural counties have also been severely impacted by the opioid epidemic and interventions will be designed to serve those populations. As would be expected, the frontier counties have the lowest prevalence of OUD, yet efforts will be made to provide service to people living in these areas.

A-1 Socioeconomic Status
Idaho's communities of focus are represented by the following socioeconomic demographics:

Federal Poverty Level	Percent of the communities of focus
Below 100%	87.52%

NOT FINAL

105%	0.65%
110%	0.22%
115%	0.29%
120%	0.22%
125%	0.22%
126 - 200%	0.07%
Unknown	10.81%

Those individuals who are represented in "Unknown" are under 200% of the poverty level. However, based on the data reporting limitations, we are unable to identify which exact income category they fall under.

A-1 Insurance

Idaho's communities of focus are represented by the following insurance demographics:

Insurance Type	Percent of the communities of focus
Blue Cross/Blue Shield	1.60%
Health Maintenance Organization (HMO)	0.07%
Medicaid	3.70%
Medicare	1.23%
None	89.26%
Other (e.g., TRICARE)	3.63%
Private Insurance (other than BCBS or HMO)	0.51%

Those individuals indicating an insurance coverage other than "None" qualified for a financial hardship due to not being able to afford their deductible/co-pay or not having a provider who accepts their coverage within 30 miles of their residence.

A-2 Differences of focus population in comparison with the general population

The communities of focus were selected specifically to address the lack of access, service use, and outcomes in comparison to the general population. According to Census data, Idaho has a higher percentage of individuals (15.1%) that are classified as living in poverty than the national average (13.5%) (US Census Bureau, 2016). Idaho also has a higher percentage of individuals (12.9%) that are uninsured than the national average (10.5%) (US Census Bureau, 2016). While Idaho provides clinical treatment for individuals with substance use disorders, we do not currently dedicate Substance Abuse Prevention and Treatment Block Grant or state dollars specifically targeted for an OUD program or Medication Assisted Treatment (MAT).

A-2 Access

NOT FINAL

In a non-Medicaid expansion state like Idaho, those of low socioeconomic status and the uninsured have the greatest need for services and lack access to those services. Idaho does not currently use block grant or state funding to provide any medication assisted therapies. This has created a lack of access for many individuals in the communities of focus.
In Idaho, there are only three Opioid Treatment Providers (OTPs) that provide Methadone as a MAT. These OTPs do not currently receive any state or federal funding. Individuals receiving services through these agencies must be able to pay out of pocket for medications and counseling or have insurance that will cover them. Additionally, three Federally Qualified Health Centers (FQHCs) in Idaho are also providing Suboxone under limited grant funding through the Health Resources and Services Administration (HRSA), but most of this funding has been exhausted.

A-2 Service Use
Currently, because of limited funding available, those within the communities of focus can seldom access services unless they are already under felony supervision, have been identified as homeless and are utilizing specific grant resources, are intravenous drug users, or are pregnant women or women with young children. As illustrated in the chart below, there is a significant gap between those who need treatment and those who receive treatment as compared to the general population. This gap is even greater for those who cannot afford to access care through either private pay or insurance benefits and is especially significant for MAT services in Idaho. Service use is often interrupted for this population due to inability to sustain payments once beginning treatment, which can end in crisis and/or prompt a return to illicit substance use in a person's effort to avoid withdrawal symptoms.
Idaho-specific data from SAMHSA's 2013-14 National Survey on Drug Use and Health (NSDUH), indicates the following measures (Center for Behavioral Health Statistics and Quality, 2014):

Measure	Total:	Age Groups		
		12-17:	18-25:	26 or older:
PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT				
Illicit Drug Dependence	20,000	3,000	7,000	11,000
Illicit Drug Dependence or Abuse	31,000	5,000	10,000	16,000
Alcohol Dependence	41,000	2,000	10,000	30,000
Alcohol Dependence or Abuse	88,000	5,000	22,000	61,000
Alcohol or Illicit Drug Dependence or Abuse	109,000	8,000	25,000	76,000
Needing But Not Receiving Treatment for Illicit Drug Use	28,000	5,000	9,000	14,000
Needing But Not Receiving Treatment for Alcohol Use	83,000	5,000	20,000	59,000

A-2 Outcomes
Preliminary TEDS outcomes for the members of the communities of focus that were able to receive services show a dropout rate exceeding 50% for those who had OUD as their primary diagnosis. Additional outcomes for this population also show an overrepresentation of use within

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past 30 days of discharge from services, minimal engagement in treatment services prior to discharge, minimal engagement in self-help groups within 30 days of discharge, homeless or dependent housing, unemployment, and lack of income. Although there could be several valid explanations for these outcomes, unaddressed withdrawal symptoms have been shown as a contributing factor impacting people with OUDs' ability to engage in treatment services. Idaho-specific data from SAMHSA's 2013-14 National Survey on Drug Use and Health (NSDUH), indicates the following measures (Center for Behavioral Health Statistics and Quality, 2014):

Measure	**Total:**	**Age Groups**		
		12-17:	**18-25:**	**26 or older:**
PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT				
Illicit Drug Dependence	20,000	3,000	7,000	11,000
Illicit Drug Dependence or Abuse	31,000	5,000	10,000	16,000
Alcohol Dependence	41,000	2,000	10,000	30,000
Alcohol Dependence or Abuse	88,000	5,000	22,000	61,000
Alcohol or Illicit Drug Dependence or Abuse	109,000	8,000	25,000	76,000
Needing But Not Receiving Treatment for Illicit Drug Use	28,000	5,000	9,000	14,000
Needing But Not Receiving Treatment for Alcohol Use	83,000	5,000	20,000	59,000

A-2 How the proposed project will improve these disparities

The IROC project seeks to reduce the disparities in access, service use and outcomes through providing access to MAT and Recovery Support Services (RSS), both individual and community-based. These services will assist individuals in stabilizing their withdrawal symptoms and other major life areas, improving employment likelihood, insurance access, and sustainability of progress made while in treatment.

A-2 Improving Access

The IROC project will improve access to services by providing funding for at least 250 individuals per year for MAT, clinical treatment and RSS such as transportation, housing, child care, etc.

This project will also provide community-based recovery supports for an additional 250 persons per year who have no other means of access by:

- assisting individuals who are being seen in Emergency Departments (EDs) related to their OUD, thereby improving access to appropriate treatment services and preventing future ED admissions.
- having peers contact individuals re-entering the community from criminal justice institutions and engage them in recovery services and recovery communities.
- helping individuals access services to prevent relapse to OUD and serving as a connection for those who may still require MAT following re-entry to the community.

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- incorporating services to assist individuals who decide to medically detoxify from opioids rather than participate in MAT and engage them in treatment services following detoxification.
- using peers to work with individuals following engagement in formalized clinical treatment services to engage in long-term recovery community services, providing a support system to prevent relapse following discharge from care.

Additionally, recovery community centers will provide 3,600 support group contacts across the state per year.

A-2 Improving Service Use

The IROC project will help individuals use services consistently and receive therapeutic doses of treatment. This will be accomplished through the utilization of case management services and access to peers. Service use will be tiered and provide the greatest amount of services and support during the first three months of recovery. Upon successful engagement in treatment services, individuals will be assisted in developing transition plans and building capability to be self-sufficient in maintaining access to MAT as long as they and their prescriber determine it to be necessary. They will be encouraged to use the informal recovery supports, recovery community centers, and recovery activities. Clients will be encouraged to establish relationships with others in recovery and develop habits of ongoing utilization of recovery community services.

A-2 Improving Outcomes

The IROC project will measure the number of individuals that receive MAT, clinical treatment, recovery support services and services from the recovery community. For people who receive MAT and/or treatment, TEDS will be collected to demonstrate positive change in SAMHSA's National Outcome Measures (NOMs). Additionally, outcome data will be collected using the Follow-Up Survey developed by the state of Idaho's Division of Behavioral Health, which measures TEDS and additional information at 30 days, six months, and 12 months post discharge on individuals that are willing to participate. Outcomes will be collected on the number of individuals who receive peer services through EDs, re-entry support services, and recovery community activities. The engagement of these individuals is linked to positive outcomes, including reduced OUD-related overdoses and deaths, readmissions, recidivism, and relapse.

A-3 Nature of the OUD problem

The nature of the OUD epidemic is increasing significantly in Idaho. Although Idaho has not reached the level of severity seen in some other states, opiate use is becoming a substantial problem leading to increased crime, overdose deaths, and acuity of symptoms in people seeking treatment. Although Idaho has had major problems with alcohol and methamphetamine use over the past few decades, recently there has been a shift in substance of use towards opiates. Initially the increases were attributed to prescription drug misuse, which continues to be a problem, but in the past two years there have been noteworthy increases in reported heroin use.

A-3 Currently available resources

The resources currently available for recovery from Substance Use Disorders (SUD) in Idaho include the block grant funding for those who are involved in the criminal justice system, three specialized-population HRSA grants through FQHCs, and private insurance/self-pay. The block

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grant funds primarily go toward serving people with intravenous drug use (IVDU) and pregnant women and women with children (PWWC). Funds are made available when possible to expand eligibility to people who have a need for treatment, but do not fall into those priority populations. However, due to limited funding, the need for services far exceeds the amount of services available. Additionally, the available funding currently supports traditional milieus of treatment, not including MAT. Funding for those in the criminal justice system is primarily for those who have felony convictions or are participating in Drug Court. The HRSA grants are available for specific populations including migrant farm workers and homeless, but are currently at capacity and have not fully met the need. Private insurance and self-pay programs are available, and even with the agencies that attempt to provide pro-bono or sliding scale services to the communities of focus, they cannot afford to do so and continue to stay in business. Idaho is a non-Medicaid expansion state and is home to an estimated 78,000 uninsured adults.

A-3 Service gaps

The primary service gaps are for those who are of low socioeconomic status, uninsured, and are between the ages of 18 and 36, as well as those who are re-entering the community following incarceration. The re-entry services are of significant importance for those who have been in county jails on misdemeanor charges because existing re-entry funding is only for those who are under felony supervision through the Idaho Department of Correction. Currently, MAT is the largest service gap due to lack of funding and coordination of prescribers. Additionally, there is a lack of services provided by peers and the recovery community due to insufficient funding. Idaho currently has funding available for residential treatment, so this service will not be paid for through this project to ensure the IROC funds will go to the gaps in the current system.

A-3 Extent of the need

Based on the numbers from the NSDUH finding, 23,000 individuals over the age of 18 need treatment yet are not receiving it for illicit substance use (Center for Behavioral Health Statistics and Quality, 2014). The FFY 16 TEDS numbers indicate that 25.19% of those who received treatment reported an OUD in Idaho. Estimated projections of the need based on those numbers indicate that 5,794 people would be included in the communities of focus and need treatment for OUD, but are not receiving services. These people need access to MAT, formalized clinical treatment, and support provided by peer and recovery communities.

Section B: Proposed Implementation Approach

B-1 Purpose of the Project

The overarching goal of the Idaho's Response to the Opioid Crisis (IROC) project is to decrease the number of opioid-related deaths in Idaho. Idaho welcomes the opportunity to access funding that will move us forward in terms of addressing the opioid crisis by:

- increasing access to treatment and recovery support services,
- reducing unmet treatment needs and
- reducing opioid overdose related deaths

These purposes will be achieved through the provision of targeted prevention interventions, evidence-based treatment and Recovery Support Services (RSS) activities for Opioid Use Disorder (OUD). We are proposing a four-pronged approach that will focus on: implementing public funding for Medication Assisted Treatment (MAT) in Idaho, prevention activities

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centered on strengthening the Idaho Prescription Monitoring Program through Physician Report Cards and medication take-back boxes, increasing the availability of RSS delivered through Recovery Community Centers and Recovery Coaches, and the significant expansion of the use of Naloxone by first responders and others who come in regular contact with individuals at risk of prescription opioid and/or heroin overdose. Training on the administration of Naloxone and prescriber education will also be provided. The chart below describes each of these goals as well as the measurable objectives of these goals.

Operational Goal	Goal Description	Measurable Objectives
1 To expand access to evidence-based MAT to persons with an OUD	Medication Assisted Treatment: To introduce publicly-funded MAT to Idaho by adding Methadone and Suboxone to the array of treatment and recovery support services that are currently available. Individuals with OUD who are eligible for Substance Use Disorder (SUD)-related services will be able to access these medications at various locations throughout the state.	a) Increase the number of Suboxone and Methadone providers in Idaho. b) Train traditional treatment providers in an evidence-based treatment model focused on OUD and including abstinence-based treatment as well as the integration of MAT. c) Create a system in which traditional treatment providers can refer individuals and collaborate with MAT services. d) Provide MAT services to no less than 250 Idahoans per year who are in need of medication.
2 Reduce access to opioids	Prevention: Reduce access to opioids and prevent overdose deaths by: Using prescriber report cards to create social norms of decreased opioid prescribing; reduce diversion of opioids by establishing drug drop off program in pharmacies statewide; and educate prescribers on use of the Prescription Drug Monitoring Program (PDMP) and the Center for Disease Control and Prevention's (CDC's) prescribing guidelines resulting in fewer prescriptions for opioids being written and filled.	a) Decrease the number of opiate prescriptions per capita by 5% as measured by the PDMP database after the implementation of the Provider Report Cards. b) Decrease the rate of multiple provider episodes (five or more prescribers and five or more pharmacies in a six month period) for prescription opioids per 100,000 residents by 5% as measured by the PDMP database after the implementation of the Provider Report Cards. c) Decrease the percentage of clients on high dose (>100 MME) opioid therapy by 5% as measured by the PDMP database after the implementation of the Provider Report Cards. d) Decrease the percentage of prescribed opioid days that overlap with benzodiazepine prescriptions by 5% as measured by the PDMP database after the implementation of the Provider Report Cards. e) Reduce availability of unused prescription medications by increasing the number of pharmacy prescription drug take back bins from five to 30 in pharmacies across the state between July 2017 and June 2018, as measured by the Office of Drug Policy (ODP) and contracted reverse distributors. f) Increase prescriber education sessions by 40% across the state between July 2017 and June 2018 as measured by ODP and the public health districts. g) Prescribers will increase their rate of use of the PDMP by 10% from September 2017 through September 2018 as measured by the Idaho Board of Pharmacy (IBOP).

NOT FINAL

3 Enhance the recovery oriented system of care for persons with Opiate Use Disorders	A recovery oriented system of care broadens the boundaries of a traditional treatment system to emphasize services to engage persons in a recovery process from the point of initial contact, to deliver evidence based treatment matched to individual needs, and to utilize recovery supports, including Recovery Coaching, throughout the entire recovery process.	a) To reduce repeat overdose events and fatalities by linking individuals receiving intervention for an opiate overdose in a health facility through an immediate contact with a peer. b) To reduce the incidence of first appointment "no shows" through an immediate contact with a Peer. c) To reduce overdose fatalities and return to opiate use by individuals released from prison or jail through an immediate contact with a Peer providing ongoing support and a warm handoff to further services. d) To provide specialized community-based recovery support and mutual help support services and sober recreational or leisure activities to the OUD population with emphasis on the young adult (age 18-36) population and persons who have experienced a life threatening opiate overdose.
4 Reduce deaths resulting from overdose of prescription opiates or heroin	To increase the use of Naloxone to reverse opiate overdoses through training and provision of Naloxone to first responders and others - including Federally Qualified Health Centers (FQHCs) - and other community members who may come in contact with individuals at risk of opiate overdose.	a) To reduce the number of opiate-related overdose fatalities by identifying a minimum number of first responder agencies willing to adopt the practice of carrying Naloxone. b) Provide training on the safe administration of Naloxone for a minimum number of entities identified in (4a). c) Provide Naloxone kits to a minimum number of entities who have completed the training identified in (4b). d. Provide community training to a minimum number of persons who may come in contact with individuals at risk of opiate overdose.

B-2 Other Resources

The Goal 1 objectives center on creating a publicly-funded MAT system in Idaho, and include training treatment providers, increasing the number of MAT providers and financially supporting the delivery of traditional and MAT treatment services to qualifying Idahoans. At this time, Idaho does not use Substance Abuse Prevention and Treatment Block Grant or state general funds to support MAT. The Opioid STR funding offers Idaho the opportunity to expand this much needed service to Idahoans experiencing OUD and reducing opioid-related overdose deaths.

Idaho currently provides opioid-related services funded by the Health Resources and Services Administration (HRSA) and the CDC. In 2016, three FQHCs received funding to provide MAT. Those FQHCs, and the amount of funding they received, are: Boundary Regional Community Health Center, Inc. ($325,000); Community Health Clinics, Inc. ($352,083); and Dirne Health Centers ($325,000). With this funding, these three FQHCs agreed to implement Opioid Replacement Treatment Programs (ORTPs) to a total of 90 Idahoans. As of January 2017, the majority of the slots available for MAT through this funding have been filled and the funding has been exhausted. The IROC project will not duplicate these efforts; rather, it will be used to reach still-unserved Idahoans. One of the FQHCs located in rural Idaho noted patient inability to attend appointments as a current access barrier to receiving MAT and treatment services. Individuals with addiction living in rural communities struggle with transportation. This issue is exacerbated during the winter months because of severe weather conditions. Funding for treatment continues

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to be a barrier. Most ORTP patients are unemployed and lack insurance. This makes it difficult for them to finance the appropriate level of treatment they need and their medication. Idaho's MAT system funded through this grant will provide RSS dollars targeted toward transportation and will help to close the gap to treatment and MAT that many of Idaho's currently uninsured face, addressing both of the aforementioned barriers.

Goal 2 of this proposal – to reduce access to opioids – centers on enhancing Idaho's OUD Prevention Services. The Division of Public Health, which is located in the Idaho Department of Health and Welfare (DHW), successfully applied for, and received the "Prescription Drug Overdose: Data-driven Prevention Initiative (DDPI)" grant offered by the CDC. This grant included $575,988 for Year 1; Idaho will seek another two years of funding through this source. The application for this funding was developed in collaboration with ODP, the IBOP, and the Idaho Public Health Districts. Funds are being used for: strategic planning which will be led by ODP; the purchase of Appriss Gateway and NarxCHECK software to enhance utilization of the PDMP; and funding for the local public health districts and Idaho State University's College of Pharmacy to develop and provide training and support for prescribers in utilizing the CDC Opiate Prescribing Guidelines and the Idaho PDMP. In addition, the Division of Public Health is working to improve data collection to characterize and monitor the drug overdose problem in Idaho, by identifying additional data sources from the IBOP, working with the Coroner's Association to improve death reporting in overdose cases, and the state Emergency Medical Services program, also located in the Division of Public Health. Discussions and meetings with the Division of Public Health, the Division of Behavioral Health, ODP, and the IBOP have already occurred, on how to use IROC funding to enhance, rather than duplicate, efforts initiated under the DDPI grant. In particular, strategic planning by the ODP will encompass objectives from both grants; ongoing meetings of the Idaho Prescription Drug Abuse Workgroup, which includes all major stakeholders in these funding opportunities, and other ad hoc meetings will be used to continue to coordinate efforts. Lastly, further enhancements proposed by the IBOP with this new funding (Prescriber Report Cards) will sync with, rather than hinder, the implementation of new software being implemented to the PDMP under the current DDPI proposal.

NOT FINAL

B-3 Project Timeline: January 2017 (1-17) – July 2018 (7-18)

				1-17	2-17	3-17	4-17	5-17	6-17	7-17	8-17	9-17	10-17	11-17	12-17	1-18	2-18	3-18	4-18	5-18	6-18	7-18
Infrastructure	**Project Director**	Job description developed	Ben Skaggs																			
		Job description posted	Lynn Richter																			
		Interviews	Rosie Andueza																			
		Position offered																				
		Weekly targeting	Project Director - TBD																			
	Needs assessment	Gather information	Project Director - TBD																			
		Complete report																				
		Submit report to SAMHSA																				
	Strategic plan	Gather information	Project Director - TBD																			
		Complete report																				
		Submit report to SAMHSA																				
	Increase access to MAT	Recruit physicians authorized to	Ben Skaggs																			

NOT FINAL

		dispense Suboxone																				
		Recruit OTPs providing methadone services in northern and eastern Idaho																				
Treatment and Recovery Support Services	**Individual OUD Services**	Develop OUD Network	BPA Health																			
		Establish referral sources	Ben Skaggs																			
		Complete MOU with referral entities																				
		Develop referral pathways for participants																				
		Referral training	BPA Health																			
		Enroll participants																				
		Sustainability Plan	Project Director - TBD																			
	Recovery Community Organization and Recreational Activities	RFP Developed	Ben Skaggs																			
		RFP application period																				
		RFP application review																				
		Notice of award to																				

NOT FINAL

		RCO				■																
		Quarterly reports	RCO								■	■	■	■	■	■	■	■	■	■	■	■
	Naloxone	Establish relationship with vendor	Office of Drug Policy	■	■																	
		Purchase kits as needed						■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
		Distribute kits as needed						■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
		Quarterly reports									■	■	■	■	■	■	■	■	■	■	■	■
Prevention	**Prescriber Report Cards**	Operationalize report cards	Idaho Board of Pharmacy					■	■	■	■	■	■	■	■							
		Quarterly reports									■	■	■	■	■	■	■	■	■	■	■	■
	Pharmacy Take Back Programs	Mini-grant application materials developed	Office of Drug Policy						■	■	■											
		Mini-grant application period										■	■									
		Mini-grant application review												■								
		Notice of award to pharmacies													■							
		Install permanent take back receptacles														■	■	■	■	■	■	■
		Pharmacy sustainability															■	■	■	■	■	■
	Prescriber Education	Review baseline opioid prescribing	Health Districts		■																	

NOT FINAL

		practices report																				
		Coordinate with Idaho State University																				
		Notice of award to Health Districts	Office of Drug Policy																			
		On-site training to statewide prescribers	Health Districts																			
		Quarterly reports	Office of Drug Policy																			

B-3 Project Timeline: August 2018 (8-18) – July 2019 (7-19)

				8-18	9-18	10-18	11-18	12-18	1-19	2-19	3-19	4-19	5-19	6-19	7-19
Infrastructure	Project Director	Job description developed	Ben Skaggs	Complete											
		Job description posted	Lynn Richter												
		Interviews	Rosie Andueza												
		Position offered													
		Weekly targeting	Project Director - TBD												
	Needs assessment	Gather information	Project Director - TBD	Complete											
		Complete report													
		Submit report													

NOT FINAL

		to SAMHSA		
	Strategic plan	Gather information	Project Director - TBD	Complete
		Complete report		
		Submit report to SAMHSA		
	Increase access to MAT	Recruit physicians authorized to dispense Suboxone	Ben Skaggs	Complete
		Recruit OTPs providing methadone services in northern and eastern Idaho		
Treatment and Recovery Support Services	Individual OUD Services	Develop OUD Network	BPA Health	Complete
		Establish referral sources	Ben Skaggs	
		Complete MOU with referral entities		
		Develop referral pathways for participants		
		Referral training	BPA Health	
		Enroll participants		
		Sustainability Plan	Project Director - TBD	

NOT FINAL

	Recovery Community Organization and Recreational Activities	RFP Developed	Ben Skaggs	Complete
		RFP application period		
		RFP application review		
		Notice of award to RCO		
		Quarterly reports	RCO	
	Naloxone	Establish relationship with vendor	Office of Drug Policy	Complete
		Purchase kits as needed		
		Distribute kits as needed		
		Quarterly reports		
Prevention	Prescriber Report Cards	Operationalize report cards	Idaho Board of Pharmacy	Complete
		Quarterly reports		
	Pharmacy Take Back Programs	Mini-grant application materials developed	Office of Drug Policy	Complete
		Mini-grant application period		
		Mini-grant application review		
		Notice of award to pharmacies		

NOT FINAL

		Install permanent take back receptacles									
		Pharmacy sustainability									
	Prescriber Education	Review baseline opioid prescribing practices report	Health Districts	Complete							
		Coordinate with Idaho State University									
		Notice of award to Health Districts	Office of Drug Policy								
		On-site training to statewide prescribers	Health Districts								
		Quarterly reports	Office of Drug Policy								

NOT FINAL

B-4 Organizational/Management Structure

The Idaho Department of Health and Welfare will manage the overall IROC project with aspects of implementation and continuous system management being contracted out to other entities. The Idaho Single State Agency (SSA) at DHW's Division of Behavioral Health will be the award recipient of the Opioid STR grant. The SSA will be responsible for the following components of project implementation and management:

- hiring and supervision of IROC key staff;
- definition of populations to be served and development of referral pathways;
- establishing referral sources and completing Memoranda of Understanding (MOU) with referral entities;
- establishment, management and monitoring of necessary contracts;
- monitoring and management of the client intake rate;
- oversight of data collection;
- management of the Web Infrastructure for Treatment Services (WITS) Electronic Health Record (EHR) and voucher management system;
- budget development, monitoring, and management through bi-weekly expenditure reports.

The SSA will contract with the Idaho Management Services Contractor (MSC), BPA Health, to manage other components of project implementation and ongoing management including:

- recruitment and management of the OUD provider network;
- increase the number of Suboxone and Methadone providers in Idaho;
- ongoing provider trainings and orientation;
- processing of provider claims, payments, and appeals;
- client intake, eligibility determination, and referrals ensuring client choice of provider;
- creation of treatment vouchers in WITS, Idaho's EHR, and ongoing clinical management of IROC client services;
- the BPA Health SUD provider network will deliver all clinical treatment and will coordinate the delivery of associated MAT.

The SSA will also contract with FEi Systems to manage the IROC module as the EHR for IROC clients and voucher management system. This contract includes the following deliverables:

- hosting and maintenance of the WITS IROC module;
- training for providers, the MSC, and stakeholders;
- enhancements required to implement the chosen IROC populations.

Five percent of the award will be used toward the above-described activities, including the hiring of an IROC Project Director. This individual will monitor all grant-associated contracts to ensure that services are reaching the intended populations, deliverables are progressing along pre-established timelines, and reporting is submitted on time and accurately.

B-5 Prevention Activities

Prescriber Report Cards

One of the most effective tools states have to respond to the opioid epidemic is the PDMP. PDMPs can assist prescribers and dispensers to make the best clinical decisions for their clients, while reducing inappropriate prescribing of controlled substances. Despite the known benefits, PDMPs are sub-optimally used by both prescribers and dispensers. As a result, states have

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experimented with unsolicited reports, which send information to a prescriber or dispenser to inform them about clients who have certain characteristics (e.g., patterns of doctor shopping). Idaho seeks to implement a new unsolicited report system, known as Prescriber Report Cards, that is endorsed by the U.S. Department of Justice as a best practice for enhancing state PDMPs. A pilot program in Arizona reported a 10% decrease in the number of opiate prescriptions after deploying Prescriber Report Cards, with a 4% drop in overdose deaths (Brandeis University, 2016). The IBOP will operationalize the new system through its current PDMP vendor, Appriss, and quarterly report cards will be sent to all prescribers of controlled substances and provide a summary of a healthcare provider's prescribing history, including their ranking compared to the "average" prescriber of the same specialty, and a summary or graphical representation of their prescribing history. This is a promising practice that provides an opportunity for self-examination of a prescriber's practice as it pertains to their prescribing of controlled substances, and allows for the ability to track any changes in these metrics over time. It is believed these reports will positively affect social norms among prescribers and decrease the number of opioids prescribed, thereby decreasing access, abuse and related overdose deaths (Brandeis University, 2016).

Pharmacy Take Back Programs

The United States is amid an opioid overdose epidemic, according to the CDC, and data has led experts to believe that one contributing factor is pervasive availability of prescription pain medication, often obtained from a home medicine cabinet (U.S. Department of Health and Human Services, 2012). In response, the Secure and Responsible Drug Disposal Act of 2010 was enacted to allow ultimate users to transfer prescription medications to retail pharmacies for disposal. However, while retail pharmacies are well suited for collecting unwanted, unused, or expired prescription medications, only five retail pharmacies out of 286 in Idaho have installed prescription drug drop boxes. The Idaho State Pharmacy Association attributes this to significant program startup costs and pharmacies have agreed that the main deterrent from collecting unused, unwanted or expired prescription medications is the initial cost associated with the program.

Studies have shown that prescription drug drop box programs can be an effective strategy in combating prescription drug abuse (Drug Enforcement Agency, 2011). A two-year study of prescription medication drop boxes placed in a rural area concluded that "drug donation boxes can be an effective mechanism to remove controlled substances from community settings" (Gray, 2015). Researchers further assert that pharmacies are an "ideal venue to collect and destroy" unused prescription medications (Garey, 2004). ODP and IBOP believe that increasing the locations of medication disposal throughout the state will decrease the amount of prescription medication available for misuse, abuse and diversion in Idaho.

Therefore, ODP and IBOP will invite pharmacies statewide to apply for mini-grants to implement a prescription drug drop box program. The mini-grants will cover the startup costs including: purchase and installation of the prescription drug drop box bin, liners, graphics for each receptacle, marketing materials, and reverse distribution for one year. Pharmacies will be required to include a sustainability plan in their grant proposals to continue the medication disposal program after the mini-grant has expired. Further, pharmacies will be required to collect data necessary for the purposes of evaluation. ODP and the IBOP will collaborate to determine areas of need, including criteria such as hotspots for dispensing and/or use and current

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medication drop box locations. Priority will be given to pharmacies located in areas with high use and/or dispensing, and low availability of current drop box locations.
This project will include three of the seven strategies for effective community change endorsed by the Community Anti-Drug Coalitions of America including providing information, changing physical design, and reducing barriers (Community Anti-Drug Coalitions of America , 2016). It is believed this strategy will decrease diversion of these dangerous drugs, thereby reducing opioid abuse and related overdose deaths.

Prescriber Education

The Idaho Department of Health and Welfare (DHW) was recently awarded a Prescription Drug Overdose Prevention: Data Driven Prevention Initiative (DDPI) grant through the Centers for Disease Control and Prevention. With this funding, DHW has developed and implemented a statewide public health intervention of prescriber education that seeks to increase use of the IBOP's PDMP and positively impact opioid prescribing behaviors through training on the CDC Guidelines for Prescribing Opioids for Chronic Pain (Dowell, 2016).
Through the DDPI grant, all of Idaho's Public Health Districts have received a baseline opioid prescribing practices report for review, including a comparison of prescribing practices by Public Health District, as well as counties and townships within each Public Health District. By March 1, 2017, Public Health Districts will coordinate with Idaho State University and begin public health campaigns to inform, educate, and encourage the use of the IBOP PDMP and the CDC Guidelines for Prescribing Opioids for Chronic Pain (Dowell, 2016). This education will be delivered to prescribers via on-site trainings and delivery of educational toolkits.
With Opioid STR grant funding, ODP will coordinate with DHW to expand activities planned with the Public Health Districts through the DDPI grant. With the toolkits already developed and staff prepared to deliver trainings, Public Health Districts will receive Opioid STR grant funds through contracts with ODP, allowing them to deliver approximately 40% more on-site trainings to prescribers statewide. These trainings will focus heavily on use of Idaho's PDMP, CDC Guidelines for Prescribing Opioids for Chronic Pain, and co-prescribing Naloxone with opioids. It is believed this strategy will reduce doctor shopping and decrease prescriptions for opioids, thereby reducing access to and diversion of these drugs, opioid abuse and related overdose deaths.

Naloxone

On July 1, 2015, Idaho's law allowing easier access to Naloxone went into effect. Since that time, significant progress has been made in educating prescribers and pharmacists about the new law and their roles in it. Many pharmacies are now stocking Naloxone and prescribers and pharmacists are becoming more knowledgeable and comfortable recommending and dispensing the medication. However, first responder agencies have been slow to embrace the new law. Although a few law enforcement agencies have begun to supply Naloxone kits for their officers, and have saved lives as a result, many agencies are still hesitant, citing training concerns and inability to fund the kits.
Therefore, Idaho is seeking Opioid STR grant funds to provide Naloxone kits for first responders. If equipped with this life-saving drug, first responders will be able to administer Naloxone and keep an overdose patient alive until they can be transported to an emergency department. Idaho is a very rural state with vast stretches between emergency departments. Because of this, ODP will prioritize rural agencies that are at least one hour from an emergency

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department. Priority will also be given to first responder agencies in areas of the state with the highest overdose death rates. In addition to providing Naloxone kits, ODP will provide the agencies with appropriate training in using the kits and consult with them regarding internal policies and procedures for drug administration.

B-6 Treatment/Recovery Support Services

The following treatment and RSS will be implemented as part of Idaho's comprehensive strategic plan to address the opioid crisis utilizing a chronic care model. These services embrace SAMHSA's definition of recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Medication Assisted Treatment (MAT)

A major component of IROC will be the introduction of an MAT service delivery system that will provide an evidence-based treatment model for clinical treatment as well as the use of Methadone and Suboxone when requested by the client. At this time, Idaho does not use block grant or state general funds to support MAT. The Opioid STR grant funding offers us the opportunity to expand this much needed service to Idahoans experiencing OUD and to reduce deaths to overdose. Strategies to accomplish this goal include:

- Strategy 1: The recruitment of additional physicians authorized to dispense Suboxone.
- Strategy 2: The recruitment of OTPs providing Methadone services in northern and eastern Idaho.
- Strategy 3: The development of an OUD specialty treatment provider network. Providers wishing to join this specialized network must apply and demonstrate that they meet certain standards, including a philosophical orientation that accepts and promotes the use of medication in the treatment of the disease of addiction. OUD treatment providers are expected to facilitate the health insurance application and enrollment process for eligible uninsured clients. These providers will be trained in an evidence-based practice (EBP) shown to be effective with this population.
- Strategy 4: Coordination between clinical treatment and MAT. OUD Specialty Network providers will establish relationships/Memoranda of Understanding (MOUs)/contracts with MAT providers, will refer appropriate clients to MAT providers and will be responsible for coordinating all aspects of a client's care. Payment for MAT services will be issued from the state of Idaho to the treatment provider who will then be responsible for payment of associated MAT costs.

Enhanced Recovery Support Services (RSS)

Another primary focus of the IROC project is to provide RSS for Idahoans accessing OUD services. This includes the traditional RSS, including transportation, childcare, safe and sober housing, care coordination, drug testing, etc. However, with IROC funding, Idaho intends to enhance the current recovery oriented system of care by broadening the boundaries of a traditional treatment system to emphasize services to engage persons in a recovery process from point of initial contact, throughout and beyond the treatment episode. We will do this by:

- Strategy 5: Linking individuals receiving intervention for an opiate overdose in a health facility through immediate contact with a Recovery Coach.
- Strategy 6: Reducing the incidence of first appointment "no shows" through an immediate contact with a Recovery Coach.

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- Strategy 7: Reducing overdose fatalities and return to opiate use by people released from prison or jail through an immediate contact with a Recovery Coach providing ongoing support and a warm handoff to further services.
- Strategy 8: Providing specialized community-based recovery support and mutual help support services and sober recreational or leisure activities to the OUD population with emphasis on the young adult (age 18-36) population and persons who have experienced a life threatening opiate overdose.

Naloxone Training and Distribution

A final goal of the treatment/RSS/Prevention portion of the IROC project is to increase the use of Naloxone to reverse opiate overdoses through training and provision of Naloxone to first responders and others (including FQHCs) and other community members who may come in contact with individuals, at risk of opiate overdose. Idaho will accomplish this by:

- Strategy 9: Identifying first responder agencies willing to adopt the practice of carrying Naloxone.
- Strategy 10: Providing training on the safe administration of Naloxone for entities identified in Strategy 9.
- Strategy 11: Providing Naloxone kits to entities that have completed the training identified in Strategy 10.
- Strategy 12: Providing community training to persons who may come in contact with individuals at risk of opiate overdose.

B-7 Identifying, recruiting, and retaining the population of focus

Idaho will implement several mechanisms to effectively identify, recruit, and retain the communities of focus. Those will include utilization of an experienced MSC, working with correctional personnel to identify those getting ready to reenter the community, training on and distribution of Naloxone kits, and utilization of peers involved in recovery communities.

Idaho will work closely with the MSC of the block grant funds in achieving these tasks. The MSC currently performs the screening and intake processes for block grant funds and will be contracted with to serve in the same capacity for the IROC project. The MSC screening and intake staff are professionals with several years of experience in identifying and recruiting individuals for treatment. Additionally, the MSC has care coordination staff that will be engaged with the identified communities of focus to retain them in care.

The MSC has established relationships within county jails and correctional facilities based on Idaho's policy of enabling potential clients to screen for eligibility of services prior to being released from custody. These relationships, in partnership with the peers as described below, will allow for successful identification, recruitment, and retention of the communities of focus.

Through the training and distribution of Naloxone, Idaho will be better able to identify, recruit, and retain the communities of focus. Idaho has passed legislation making Naloxone available through a standing order. There have been efforts geared toward training medical professionals on the use of Naloxone, but these efforts have not been linked to treatment efforts. Professionals, concerned individuals, and the communities of focus will be trained on the administration of Naloxone and provided with kits to be able to have an opportunity to discuss OUD, the risks of overdose, and most importantly provide reversals of overdoses.

The peers involved in the recovery communities will work with the MSC, emergency department personnel, and correctional staff to identify, recruit, and retain the communities of focus. The

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peers will serve as an invaluable resource in assisting the communities of focus by sharing their experiences, listening to the individuals without attempting to be the experts, and using their skills to link them to the services best suited to meet their goals. This will help immensely in identifying, recruiting, and retaining the communities of focus by helping them implement their own recovery plan rather than an authority telling them what they are required to do.

B-7 Consideration of language, beliefs, norms, values, and socioeconomic status

The approach for identifying, recruiting, and retaining the communities of focus will take into consideration the language, beliefs, norms, values, and socioeconomic status of clients primarily through the utilization of peers and meeting the clients where they are.

Peers will be specifically recruited who are in recovery from an OUD and come from diverse backgrounds related to language, beliefs, norms, values, and socioeconomic status. Peers that are in the first few years of recovery are still aware of and can identify with the language, beliefs, norms, values, and socioeconomic status of the communities of focus. From knowledge of things as simple as the subculture nomenclature, to the unwritten codes that exist, as well as being able to identify with the common struggles of those who fall into poverty from substance use and the consequences of use, the peers will be able to connect with and identify, recruit, and retain the communities of focus.

It is well documented that an internal desire to no longer experience pain from consequences motivates people to seek change through self-identification and voluntary recruitment (DiClemente, 1999). Meeting clients where they are, through maintaining points of access within jails and emergency rooms, will help in hearing clients' frustration with living a lifestyle that is conducive to OUD. Peers will be able to address the lifestyle represented by involvement in anti-social language, beliefs, norms, and values leading to medical problems, legal problems, and poverty. Peers can also help clients focus on there being a way out.

It is equally well documented that hopefulness and self-efficacy support ongoing recovery and strengthen retention in services (Bandura, 1977). Having skilled staff through the MSC and peers who can practice motivational interviewing skills will enhance retention. Incorporating clients' language, beliefs, norms, values, and socioeconomic status into goals to achieve recovery from OUD will greatly increase the identification, recruiting, and retention of this community.

The trainings and distribution of Naloxone will incorporate the communities of focus' language, beliefs, norms, values and socioeconomic status through demonstrating concern for the well-being of individuals. Clients' language, beliefs, norms, and values will be described throughout the training to gain trust and to allow the kits to be distributed and achieve overdose reversals. Additionally, the provision of free Naloxone kits addresses the low socioeconomic status and lack of access to insurance or health care within the communities of focus.

B-8 Numbers to be Served/Desired Outcomes

Services	Year 1 Client Target Numbers:	Year 2 Client Target Numbers:	Projected Target Numbers:
Medication Assisted Treatment	250	250	500
Hospital on-call immediate response	90	160	250
Detoxification Companion	15	40	55
Jail/Prison Reentry Response	35	50	85

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Continuing Care Recovery Services	325	400	725
Sober recreational activities	125	125	250
TOTALS	840	1025	1865

These figures were arrived at by closely analyzing the cost of each of the activities and designing their delivery in such a manner that will allow IROC to stay within the $2 million per year budget.

Desired Outcomes

MAT: When prescribed and monitored properly, MATs have proved effective in helping clients recover from OUD. Moreover, they have been shown to be safe and cost-effective and to reduce the risk of overdose. People with OUD will be offered MAT to complement clinical treatment for this disorder; opiate-related deaths and overdoses will decrease.

Hospital on-call immediate response: People experiencing an overdose will have the opportunity to connect with the recovery community and receive referrals and a warm handoff to further appropriate services, resulting in no further overdose admission.

Detoxification Companion: People experiencing a detoxification in a supervised setting will receive a "companion" to assist in meeting immediate physical needs (thus saving some time for health personnel). They will also have the opportunity for connection with a person through the recovery community who has a similar lived experience, resulting in completing supervised detox and a warm handoff to a further level of care and services.

Jail/Prison Reentry Response: People leaving jail or prison will have a connection with a person engaged in the recovery community as a warm handoff to the next service they've been referred to receive at release. They will have the opportunity to participate in planning and receive information on recovery community resources, resulting in their keeping scheduled appointments with probation and further community treatment and RSS.

Continuing Care Recovery Services: People will connect with the local recovery community and receive RSS that they may participate in on a long term basis and will avoid relapse.

Sober Recreational Activities: People in the early stages of recovery from OUD will have the opportunity to partake in sober recreational activities. By leveraging physical activity and social connection, participants will be able to build confidence and find the support they need to live productive and fulfilling lives in recovery.

Section C: Proposed Evidence-Based Service/Practice

C-1 System design and implementation models

Idaho's system design and implementation models to increase the availability of services to prevent and treat Opioid Use Disorder (OUD) will include the creation of a specialty treatment network for those with OUD that will utilize Evidence Based Practices (EBPs) and Medication Assisted Treatment (MAT). The design will also include targeted recovery community activities, utilization of peer services, creating and expanding prescription take back access, training and provision of Naloxone, and enhancing the Prescription Drug Monitoring Program (PDMP) through the use of public prescriber report cards.

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The OUD specialty treatment network will include substance use disorder treatment centers that offer outpatient and intensive outpatient treatment services in compliance with the American Society of Addiction Medicine (ASAM) levels of care. To be a part of this network, a provider will either have to be an approved MAT provider or contract directly with a MAT provider. These services will be integrated and seamless, including providing access to the medications. This network will employ experts in providing EBPs including the Matrix Model and Cognitive Behavioral Therapy (CBT). The network will work closely with recovery communities and peers involved with the communities of focus. Idaho will develop an application for providers to join the OUD treatment network and work with the Management Services Contractor (MSC) to enroll providers, implement the model, and monitor the performance of the providers. Because MAT services are not currently available in Idaho's publicly-funded Substance Use Disorders (SUD) system, the creation of the specialty network will in turn increase the availability of these services. The OUD treatment network is designed to continue beyond the term of the funding provided through this grant, with sustainability plans in place.

Idaho will work directly with grassroots organizations involved in building recovery communities throughout the state. These organizations follow the recovery models that have been documented to increase recovery capital and engagement in recovery. These organizations will have drop-in centers and meeting places for the communities of focus to go to for support. Additionally, they will create opportunities for activities in the community that reinforce lasting recovery. Lastly, these organizations will coordinate opportunities to get out into nature and to be physically active, activities which have been documented to be supportive of recovery. These services are not currently available in this capacity, so the availability of new funding will increase availability of these services. This model will be accomplished through a contract with the organization responsible for these services and activities. The implementation and services will be monitored through contract monitoring and reporting. These services will be an enhancement to existing services, with sustainability plans in place.

Under the contract with a grassroots organization and through the OUD specialty treatment network, peer services will be provided to the communities of focus. These services will follow the established best practices to have the therapeutic benefits of peer involvement. There is already an existing implementation of the utilization of peers within the MSC's provider network; enhanced access to these services will be offered through the implementation of the OUD treatment network and recovery communities. Peers will be available to assist the communities of focus in learning from their experience and accompanying them through the tasks associated with early recovery. These services will be an enhancement to existing services, with sustainability plans in place.

Idaho will utilize prescription take back programs through pharmacy drop boxes to reduce inappropriate access to prescription medications. These programs have been documented to be successful in reducing the availability of substances, the number of young people starting to experiment with opiates, and reducing accidental overdoses. Idaho will work directly with the Office of Drug Policy (ODP) on implementation of this model through the expert prevention specialists they currently have available. These services are not currently available in this capacity in Idaho, so the creation of the drop boxes will increase availability of the take back program. ODP will contract with pharmacies and have a sustainability plan in place as a part of the implementation of this model.

Idaho will partner with ODP to provide training and Naloxone kit distribution to follow the best practices established in preventing overdoses. The communities of focus, concerned individuals,

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and professionals that have interaction with the communities of focus will be recruited and trained on how to communicate effectively about the use of Naloxone. The training will include an emphasis on the importance of connecting those who have an overdose reversal with treatment services as soon as possible following the reversal. Individuals receiving the Naloxone training who identify as being a part of the communities of focus will be provided with referrals for treatment services.

The Division of Behavioral Health will partner with the Idaho Board of Pharmacy (IBOP) on implementing prescriber report cards through contracting to establish existing empirically proven systems that compare the prescribing practice of like prescribers to each other. This enhancement to the PDMP, which is a valuable tool in reducing the over-prescribing of opiates, will increase the availability of data on prescriber patterns to allow providers within specific specialties to compare themselves to similar prescribers to get insight into the appropriateness of their prescribing practices. Additionally, these report cards will be available to regulators and consumers so informed decisions can be made about prescribers and their practices. This will be implemented through contracts between the IBOP and there is a sustainability plan in place.

C-2 Describe the Opioid Use Prevention and Treatment EBP(s) that will be used

The OUD prevention and treatment EBPs that will be used include: Medication Assisted Treatment (National Institute on Drug Abuse, 2012); Matrix Model (National Institute on Drug Abuse, 2012); Cognitive Behavioral Therapy (CBT) (P.K. McHugh, September 2010); Recovery Community Organizations (RCOs) (SAMHSA, 2016); Peer Support (SAMHSA, 2016); Prescription Drop Boxes (Drug Enforcement Agency, 2011); and PDMPs (Prescription Drug Monitoring Program Center of Excellence at Brandeis, 2016).

The EBPs will be implemented with fidelity to the models. The integration of MAT, CBT, and relapse prevention programs like the Matrix Model have demonstrated effectiveness in treating SUD (P.K. McHugh, September 2010). These EBPs are appropriate for the communities of focus and meet SAMHSA's goals for this program. The EBPs were designed and have been documented as being effective interventions and prevention for the communities of focus largely through SAMHSA or other nationally recognized EBP repositories.

MAT, the Matrix Model, and CBT are all designed to work as interconnected components of clinical treatment (P.K. McHugh, September 2010). All three of these interventions are recognized by SAMHSA as best practices and/or evidenced based practices (National Institute on Drug Abuse, 2012) (National Institute on Drug Abuse, 2012) (P.K. McHugh, September 2010). MAT assists in addressing the ASAM Dimension 1 (Withdrawal Potential) problems which impede the communities of focus' ability to participate in treatment. CBT is designed to be integrated with SUD treatment to address ASAM Dimensions 3 (Cognitive, Mental, or Behavioral) and 5 (Relapse Potential) (P.K. McHugh, September 2010). The Matrix Model has been shown to be effective in treating alcohol use disorder, stimulant use disorders, and OUD (National Institute on Drug Abuse, 2012). The Matrix Model addresses all six of the ASAM Dimensions through the manualized workbooks. All of these interventions are linked to improvement in TEDS measurements as established by SAMHSA.

SAMHSA, as well as other reputable sources, has a growing body of literature on the efficacy of Recovery Community Organizations (RCOs) and peers in assisting the facilitation of improved recovery capital which incorporates TEDS measurements (abstinence, connectedness to recovery supports, employment, living, income, etc.) (SAMHSA, 2016). Among other benefits, the use of

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these services has also been shown to improve retention in clinical treatment modalities that address the communities of focus and SAMHSA's goals.

The prevention efforts of prescription take back programs and PDMPs have been documented as best practices in reducing the availability of substances and reducing the ongoing patterns of availability through prescriptions (Prescription Drug Monitoring Program Center of Excellence at Brandeis, 2016). Lack of options for proper disposal of opiate medications can lead to storage of the medications in unsecured locations like bathrooms and bedrooms of adults that had been prescribed more than they needed. These prescriptions frequently end up in the hands of young people who misuse the medications, leading to the potential development of an OUD or accidental overdose. The training and distribution of Naloxone kits will expand access to this life saving medication and prevent overdose deaths. Efforts will be made to get people with the greatest likelihood of overdose death into treatment with access to MAT. This will improve outcomes by reducing the number of overdose deaths and targeting the highest needs within the communities of focus with immediate access to services. The prescription drop boxes will provide an easy alternative to storing the medications at home and lead to their proper disposal and destruction. The report cards enhancing the PDMP will assist providers in becoming more educated about prescribing practices, leading to less opiates being prescribed, which will lead to less diversion of the medications and ultimately to fewer opioid related deaths.

C-3 How EBPs will help address disparities in access, use, and outcomes

All of the chosen EBPs will help address the disparities in access, use, and outcomes for the communities of focus. The EBPs will each address different aspects of access, use, and outcomes, in their respective area (treatment, recovery, prevention).

The implementation of MAT, Matrix Model, and CBT will provide access for the use of comprehensive MAT which, when implemented with fidelity, leads to better retention or use of services as well as improved outcomes. The communities of focus lack access to affordable OUD treatment in Idaho. Without having the availability of MAT, use of treatment services is generally negatively impacted, in turn leading to poor outcomes because a therapeutic dose of services wasn't received. The chosen combination of complementary EBPs will address the withdrawal potential and integration of counseling EBPs identified as being effective for the communities of focus.

The expansion of RCO and peer services will greatly improve access, use, and outcomes for the communities of focus. The outreach activities through the RCOs and peers will improve access to individuals who otherwise would not have had knowledge of eligibility for services. Upon engaging the communities of focus, the RCOs and peers will be readily available to provide services which do not require appointments and will reduce potential delays due to traditional office hours or eligibility determinations. These best practices will provide a sense of belonging and community that is of extreme importance because it replaces the unhealthy sense of identification with active substance users with identification with those who are in recovery. The ability to view one's self congruently with current behaviors allows for a sense of homeostasis and is conducive to maintaining internalized change and positive outcomes (Peil, March 2014). The social model of recovery that is the foundation of RCOs and peers has been well documented as improving access, use of services, and outcomes (CSAT, 1999).

Prescription drop boxes and prescriber report cards will provide invaluable prevention services to reduce the number of people developing OUD and becoming a part of the communities of focus. Additionally, these best practices will reduce the availability of substances to the communities of

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focus, which can assist in fostering abstinence. The use of prevention to reduce the number of those developing OUD can improve access and outcomes by allowing for the funds for treatment to be spent on fewer individuals, thus providing a more robust array of services for those in need. Although it is difficult to measure the impacts of prevention efforts, the reduction in demand for treatment services is invaluable. Additionally, the training and provision of Naloxone kits can reverse overdoses and give an individual within the communities of focus a chance to engage in treatment services to improve access, use of services, and outcomes.

C-4 Modifications to EBPs

Idaho does not plan on modifying any of the EBPs to be used in the IROC program. Idaho plans on integrating EBPs as they are designed to be integrated. Idaho also plans on using specific recovery and prevention EBPs within the intended settings and with the intended populations.

C-5 Monitoring the delivery of the EBPs

Idaho will monitor the delivery of EBP implementation to be in compliance with the guidelines through contract monitoring of the MSC and the use of the MSC's Provider Oversight Committee. The Division of Behavioral Health currently has at least weekly contact with the MSC and formalized quarterly contract monitoring of the Scope of Work within the contract. Included in the Scope of Work are the standards that the MSC is required to hold the provider network to. Currently, there are sections on the use of EBPs as a part of clinical audits, which has the MSC's statewide Regional Coordinators reviewing files, observing sessions, and interviewing staff about their efficacy in delivering the EBPs with fidelity. Division of Behavioral Health staff monitor the MSC's auditing of the providers through reports, site visits, and accompanies the Regional Coordinators on some of the audits of providers. The contract with the MSC will be amended upon award of the Opioid STR grant to include the EBP monitoring of the OUD specialized network.

An additional safeguard is the MSC's Provider Oversight Committee that consists of SUD treatment providers, and staff from the MSC, Division of Behavioral Health, Department of Correction, Department of Juvenile Corrections, and Drug Court staff. The committee meets quarterly to review proposals of EBPs and any potential modifications. If the committee approves a proposal, the subsequent auditing holds the provider to the standards they were approved for through the proposal. If the request is denied, the providers are notified in writing that they cannot use the proposed program or modification. The MSC's contract with providers within the provider network stipulates that if they are found to be providing services that are not using approved EBPs, they can be charged back for all services provided and used through the unapproved practice.

Section D: Staff and Organizational Experience

D-1 Capability and Experience of Applicant Organization

The Division of Behavioral Health has successfully implemented three different Access to Recovery (ATR) grants (1, 3 and 4) as well as the SAMSHA sponsored Idaho Youth Treatment Program (IYTP). Partner organizations under the ATR and IYTP grants included treatment and recovery support service providers that live in the communities that they serve, setting a foundation for continuing future partnerships. Many of these providers share the same cultural and linguistic diversity with their clients. By maintaining a network of providers that reflects the

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community they serve, BPA Health and the Single State Agency (SSA) ensure that the clients get the best, most appropriate services from someone who understands their circumstances.
Idaho's Association of Recovery Centers is comprised of eight recovery community centers, located throughout the state. Each center has its own advisory board, executive director, and volunteer coordinator. Each center relies heavily on the use of volunteers and recovery allies who are directly connected to the grassroots and community-based organizations in their respective communities. Such organizations include 12-step fellowships, faith-based organizations, small businesses, voluntary health clinics, community colleges, and individuals who are positive allies of the recovering community. While relatively new organizations, they are deeply embedded within the network of grassroots and community-based organizations, and as such reflect and connect to the culture and language(s) of the communities of focus. Each of these recovery community centers has implemented the types of group and individual services represented in this IROC project proposal, from young adult recreational groups, other support groups, one-on-one peer mentoring/coaching, life skills education, behavioral health education and prevention activities. They are all significantly involved in the provision of recovery coaching and peer services, similar to those in this proposal. These affiliations place recovery community centers within the culture(s), language and values of the state of Idaho and enables them to meaningfully speak to and represent the recovery movement in the state.

D-2 Capability and Experience of Partnering Organizations
The Idaho Department of Health and Welfare (DHW) intends to partner with five key organizations on the Idaho's Response to the Opioid Crisis (IROC) Project. These partners have linkages rooted in the culture and languages of the OUD population necessary for the successful implementation and operationalization of this project.

BPA Health: BPA Health is the current Management Services Contractor for the Idaho Public Substance Use Disorders (SUD) system and has 18 years of experience providing services to SUD clients. BPA Health delivers many services, including provider network management, customer service call center, client intake, service coordination, care coordination, claims processing, outcomes, and reporting.
BPA Health team members have participated with state agency staff, regional stakeholders, and decision making bodies, lending expertise in the areas of system management and addiction medicine. BPA Health's Medical Director is DATA 2000 certified and currently practicing in Idaho. He is also a founding member of the Idaho Chapter of the American Society of Addiction Medicine (ASAM). BPA Health regional field staff are located throughout the state, and all administrative operations are housed in the Boise office. The subcontractors BPA Health will use are monitored through vigorous means to ensure that services performed on the system's behalf are always high quality.
BPA Health continuously monitors the availability of providers meeting access standards for persons with disabilities, and communication standards based on Culturally and Linguistically Available Services (CLAS), using a provider database. All providers who apply to participate in the network will submit information about their specialties and modalities. BPA Health currently has 84 treatment providers in 145 sites and 28 stand-alone recovery support service providers in 68 sites. BPA Health develops and recruits providers for community based services in each region, and continuously monitors for changes to the geographic locations of those practitioners and uses any available measures to ensure the network meets all client treatment plans.

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BPA Health is currently partnered with Boundary Regional Community Health Center's (dba Kaniksu Health Services) Medication Assisted Treatment (MAT) for opioid users program. Through this partnership, BPA Health offers professional technical assistance to medical and clinical staff, work flow consultation, and training opportunities.

Idaho Office of Drug Policy: In 2007, the Idaho Office of Drug Policy (ODP) was established by Idaho Code 67-821 as the "official in the state designated to oversee and execute the coordination of all drug and substance abuse programs within the state of Idaho." In 2011, the Governor established the Prescription Drug Work Group to address the growing problem of prescription drug abuse and overdose and named the administrator of ODP to chair this group. The work group includes broad representation from local, state, and federal law enforcement, public health, healthcare providers, healthcare associations and licensing boards, behavioral health specialists, advocacy and treatment groups, legislators, and other stakeholders. Since its inception, this group has championed legislative changes to address the opioid crisis such as a Naloxone law, mandated registration for the state's Prescription Drug Monitoring Program (PDMP), and enhancements to the PDMP.

ODP is adept at bringing stakeholders and other private and public partners together to implement change. This is evident by the ongoing work of ODP's Strategic Prevention Framework Advisory Council, as well as its associated work groups, including the state's work groups on marijuana, alcohol health outcomes, and prescription drug abuse. These groups consist of stakeholders from throughout the state collaborating to prevent substance abuse. ODP is also well connected to Idaho's grassroots organizations and community coalitions. These relationships have been built through ODP's grant funding, participation in the ODP's work groups, attendance at trainings offered by ODP, and resources offered such as the use of conference call lines and website support.

Lastly, ODP is well equipped to perform all duties associated with managing the prevention portions of the IROC project. ODP has demonstrated its ability to establish and monitor federal grant funding through administration of the prevention portion of Idaho's Substance Abuse Prevention and Treatment Block Grant as well as Idaho's Strategic Prevention Framework State Incentive Grant from SAMHSA.

A letter of support from the Office of Drug Policy is included as Attachment 4.

Idaho Board of Pharmacy: The Idaho State Board of Pharmacy (IBOP) is a self-governing agency whose mission is to promote, preserve and protect the health, safety, and welfare of the public by and through the effective control and regulation of the practice of pharmacy. The IBOP maintains and operates the state's PDMP, a statewide electronic database which collects designated data on controlled substances dispensed in the state of Idaho. The IBOP has a longstanding track record of streamlining and enhancing the PDMP.

A letter of support from the Idaho Board of Pharmacy is included as Attachment 5.

Recovery Idaho: Recovery Idaho is a statewide Recovery Community Organization. Under its direct fiscal umbrella is the Gem County Recovery Community Center. This center is strongly embedded within both the recovery community in rural Gem County and the human services community there. An Advisory Board made up of community members, both those in recovery from addictions and mental illness and those in leadership capacities in this rural area, represent connections to the community and mirror the culture of small town entrepreneurs and

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agricultural families. As such, the Gem County center is directly connected to and representative of the culture, language, norms, and values of the community. In addition, Recovery Idaho is affiliated with the Idaho Association of Recovery Centers. These additional seven centers, located throughout the state, are each comprised of volunteers, board members, and recovery allies who are directly connected to the grassroots and community-based organizations in their respective communities. Such organizations include 12-step fellowships, faith-based organizations, small businesses, voluntary health clinics, community colleges, and individuals who are positive allies of the recovering community. While relatively new organizations, they are deeply embedded within the network of grassroots and community-based organizations, and as such reflect and connect to the culture and language(s) of the communities of focus. Each of these recovery community centers has implemented the types of group and individual services represented in this project proposal, from young adult recreational groups, other support groups, life skills education and behavioral health education and prevention activities. They are all significantly involved in the provision of recovery coaching and peer volunteer services, similar to those proposed in the project proposal.
Recovery Idaho is a two-year-old (as of July 2017) statewide recovery community organization with experience as the fiscal and administrative service umbrella for the Gem County Recovery Community Center. Recovery Idaho is able to offer similar service, to allocate funds and to collect, manage, and report on key performance indicator data for the services of the recovery centers to be provided under this proposal. Recovery Idaho is also able to provide training for Recovery Coaches, including specialized "endorsement" training for recovery coaches in Opiate Use Disorder (OUD) and Crisis Intervention services. Recovery Idaho is developing the capacity to provide recovery coach supervision where it is needed in small programs unable to provide such supervision through their own staff. Like recovery community centers, Recovery Idaho is governed by a board that includes representatives of the community centers, recovering persons and recovery allies from across the state that represent the diverse citizenship of this state, including rural, small communities and suburban/urban centers. These affiliations place Recovery Idaho within the culture(s), language and values of the state of Idaho and enable Recovery Idaho to meaningfully speak to and represent the recovery movement in the state.

Idaho Primary Care Association: The Idaho Primary Care Association (IPCA) is a not-for-profit 501(c) (3) membership organization with a mission to foster relationships between Idaho health centers, community partners and key stakeholders to enable effective provision of safety net healthcare. Since 1983, the IPCA has been the leading state advocate for community-based health care programs. The association plays a vital role in educating federal, state and local policy makers about issues relating to health care and the role of community health centers. The IPCA also provides training and technical assistance to Idaho's community health centers in the areas of community development, quality improvement, workforce development and health center operations.

D-3 Staff Positions for IROC: Roles, Level of Effort and Qualifications
The following positions will be responsible for the successful implementation and operationalization of the IROC Project. Because no more than 5% of the total grant award may be used for administrative and infrastructure development costs, most of the positions/responsibilities below will be filled by existing staff.

Position:	Project Director

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Name:	To be selected
Level of Effort:	100% (.5 FTE)
Qualifications and Experience:	The person selected will be competent in planning and coordinating program development projects; developing project goals; developing work plans, timelines, implementation strategies and plans; developing/implementing strategies to encourage and obtain stakeholder and/or community support; administering a project budget; and preparing fiscal, narrative and evaluative reports.
Position:	Organization Administrator/Single State Administrator (SSA)
Name:	Rosie Andueza
Level of Effort:	10%
Qualifications and Experience:	Rosie Andueza is the SSA and has experience in overseeing the implementation and management of the Substance Abuse Prevention and Treatment Block Grant, Idaho Access to Recovery (ATR)-4 grant, the Idaho Youth Treatment Program (IYTP) grant and overall administration of Idaho's publicly-funded Substance Use Disorders (SUD) program.
Position:	Treatment and RSS Coordinator (State Opioid Treatment Authority)
Name:	Ben Skaggs
Level of Effort:	25%
Qualifications and Experience:	Ben Skaggs is Idaho's State Opioid Treatment Authority (SOTA) and has experience working with clinical treatment and MAT providers. Ben is a Licensed Clinical Social Worker (LCSW) with hands-on experience providing SUD and mental health treatment. Ben also has experience developing, and evaluating SUD system operating procedures and recommending changes; developing technical written materials such as policies, technical manuals or rules/regulations; providing technical program assistance to SUD providers; and with the development of referral pathways.
Position:	IT Coordinator
Name:	Michelle Buskey
Level of Effort:	25%
Qualifications and Experience:	Michelle Buskey has experience with analyzing system output data and data integrity; budget and voucher management; providing technical assistance to web-based system users; translating technical material into easily understandable oral and written communications; working with an electronic health record; and knowledge of federal regulations relating to SUD system operations.
Position:	Fiscal Coordinator
Name:	Sean Corey
Level of Effort:	5%
Qualifications and Experience:	Sean Corey has experience in developing budgets; preparing complex financial documents; planning and reviewing financial operations; and auditing financial data for completeness and compliance with federal and state laws and regulations.
Position:	Prescriber Report Cards Lead
Name:	Teresa Anderson (Idaho Board of Pharmacy)
Level of Effort:	10%

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Qualifications and Experience:	Teresa Anderson has served as the Idaho State Board of Pharmacy's Prescription Drug Monitoring Program (PDMP) Information Coordinator for the past 20 years. Ms. Anderson had a major role in the development, design and implementation of Idaho's PDMP. She has served on the Executive Board for the National Association of State Controlled Substances Authorities, as Board Member and Treasurer for the Alliance of States with Prescription Drug Monitoring Programs, and as member of the Planning Committee for the Harold Rogers Prescription Drug Monitoring National Meetings. She is currently on the National Association of Boards of Pharmacy InterConnect Steering Committee, the Prescription Behavior Surveillance System Oversight Committee, the Veterans Opioid Safety Coalition, and the National Association of Model State Drug Laws Resource Group. She was recently elected by her peers to serve on the PMIX Working Group Executive Committee and AWARxE Advisory Committee.
Position:	Office of Drug Policy (ODP) oversight of Pharmacy Take Back Mini-Grants, Prescriber Education Contracts, and Naloxone Distribution Grants
Name:	Nicole Fitzgerald, MPA, CHES, CPS (Office of Drug Policy)
Level of Effort:	20%
Qualifications and Experience:	Nicole Fitzgerald has five years of project management experience in implementing public health and health promotion programs and projects. Currently, she oversees the contractual agreements with ODP's grants evaluator, media vendors, and grant application system. Her experience within the field of health promotion ranges from substance abuse prevention to worksite wellness and population health management.

D-4 Key Staff Members: Experience and Qualifications

There will be seven key staff on the IROC Project to include a Project Director, Organization Administrator/SSA, Treatment and Recovery Support Services (RSS) Coordinator, IT Coordinator, and Fiscal Coordinator. The Project Director (.5 FTE) will be at 100% level of effort and their salaries and benefits will be funded by the IROC grant. All of the individuals below (with the exception of the yet-to-be hired Project Director) have years of experience working in Idaho's public system and are familiar with Idaho's culture and language needs. All other key staff will be an in-kind contribution. The table below summarizes the positions, experience, and qualifications.

Position:	Project Director
Name:	To be selected
Qualifications and Experience:	The person selected will be competent in planning and coordinating program development projects; developing project goals; developing work plans, timelines, implementation strategies and plans; developing/implementing strategies to encourage and obtain stakeholder and/or community support; administering a project budget; and preparing fiscal, narrative and evaluative reports.
Position:	Organization Administrator/Single State Administrator (SSA)
Name:	Rosie Andueza
Qualifications and Experience:	Rosie Andueza is the SSA and has four years of experience in overseeing the implementation and management of the Substance Abuse Prevention and Treatment Block Grant, Idaho ATR-4 grant, the IYTP grant and overall administration of Idaho's publicly-funded SUD program. Prior to her work in the SUD system, Rosie successfully managed Idaho's Food Stamp (SNAP) program for several years.

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Position:	Treatment and RSS Coordinator (State Opioid Treatment Authority)
Name:	Ben Skaggs
Qualifications and Experience:	Ben Skaggs is Idaho's State Opioid Treatment Authority (SOTA) and has experience working with clinical treatment and MAT providers. Ben is a Licensed Clinical Social Worker (LCSW) with hands-on experience providing SUD and mental health treatment. Ben also has experience developing and evaluating SUD system operating procedures and recommending changes; developing technical written materials such as policies, technical manuals or rules/regulations; providing technical program assistance to SUD providers; and with the development of referral pathways.
Position:	IT Coordinator
Name:	Michelle Buskey
Qualifications and Experience:	Michelle Buskey has experience with analyzing system output data and data integrity; budget and voucher management; providing technical assistance to web-based system users; translating technical material into easily understandable oral and written communications; working with an electronic health record; and knowledge of federal regulations relating to SUD system operations.
Position:	Fiscal Coordinator
Name:	Sean Corey
Qualifications and Experience:	Sean Corey has experience in developing budgets; preparing complex financial documents; planning and reviewing financial operations; and auditing financial data for completeness and compliance with federal and state laws and regulations.
Position:	Prescriber Report Cards Lead
Name:	Teresa Anderson (Idaho Board of Pharmacy)
Qualifications and Experience:	Teresa Anderson has served as the Idaho State Board of Pharmacy's Prescription Drug Monitoring Program (PDMP) Information Coordinator for the past 20 years. Ms. Anderson had a major role in the development, design and implementation of Idaho's PDMP. She has served on the Executive Board for the National Association of State Controlled Substances Authorities, as Board Member and Treasurer for the Alliance of States with Prescription Drug Monitoring Programs, and as member of the Planning Committee for the Harold Rogers Prescription Drug Monitoring National Meetings. She is currently on the National Association of Boards of Pharmacy InterConnect Steering Committee, the Prescription Behavior Surveillance System Oversight Committee, the Veterans Opioid Safety Coalition, and the National Association of Model State Drug Laws Resource Group. She was recently elected by her peers to serve on the PMIX Working Group Executive Committee and AWARxE Advisory Committee.
Position:	Office of Drug Policy (ODP) oversight of Pharmacy Take Back Mini-Grants, Prescriber Education Contracts, and Naloxone Distribution Grants
Name:	Nicole Fitzgerald, MPA, CHES, CPS (Office of Drug Policy)
Qualifications and Experience:	Nicole Fitzgerald has five years of project management experience in implementing public health and health promotion programs and projects. Currently, she oversees the contractual agreements with ODP's grants evaluator, media vendors, and grant application system. Her experience within the field of health promotion ranges from substance abuse prevention to worksite wellness and population health management.

D-5 Gathering Input

Consumers, clients, and their family members will be involved at the organizational level in the planning, implementation, and evaluation of IROC services in several ways. Program staff will

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collaborate with Idaho's seven Regional Behavioral Health Boards (BHBs). Each BHB's composition statutorily includes consumers and family members. While there are currently no grant-funded individuals on BHBs, a client or family member could access grant-funded services if needed. The needs assessment and strategic plan completed under this grant will include data from and/or on populations that will be served under this grant. Grant-funded services will be largely based upon data collected for the needs assessment. Partner organizations under the grant include treatment and Recovery Support Service (RSS) providers that live in the communities that they serve. Many of these providers share the same cultural and linguistic diversity as their clients. By maintaining a network of providers that reflects the community they serve, BPA Health (Idaho's Substance Use Disorders program Management Services Contractor) and the SSA ensure that the clients get the best, most appropriate services from someone who understands their circumstances. Additionally, BPA Health has regionally-based clinical field staff throughout the state. These individuals are tasked with building relationships in their region and understanding a community's needs. These regional field staff members will function as critical avenues of feedback on program operations for each area of the state, ensuring that client's needs are met and assisting in the recruitment of providers to better meet client's needs.

Section E: Data Collection and Performance Measurement

E-1 Ability to collect and report on the required performance measures

Through the use of Idaho's Substance Use Disorders (SUD) Electronic Health Record, the Web Infrastructure for Treatment Service (WITS), Idaho is able to collect and report on performance measures related to treatment and providers of treatment. Within WITS, the measures from FOA Part I – Section I-2.2, including the Substance Abuse Prevention and Treatment Block Grant data requirements, the number of people who receive OUD treatment, and number of providers implementing MAT, will be collected and reported on.

The number of people who receive OUD recovery supports and the number of OUD prevention and treatment providers trained - to include nurse practitioners, physician assistants, physicians, nurses, counselors, social workers, case managers, etc. - will be measured through data collection tools. These tools will be required as a term of the contract with the providers and further defined in Attachment 1: Data Collection Instruments/Interview Protocols. This data will include the number of Emergency Department and reentry contacts, recovery community contacts, trainings, Naloxone kits distributed, reversals known, medications destroyed, report cards created, and other deliverables.

The numbers and rates of opioid use will be collected and reported through the State Epidemiological Outcomes Workgroup (SEOW) using standardized measurements that have been a part of their methodology for the past several years. Finally, the numbers and rates of opioid overdose related deaths will be measured and reported on through partnership with the Division of Public Health and the Centers for Disease Control and Prevention (CDC).

E-2 Data collection

The data collection plan is the responsibility of the Project Director. The Project Director will coordinate all efforts through WITS and the contracts with recovery and prevention providers to ensure all measurable objectives are collected, analyzed and reported accurately. The original design for WITS was built using a multi-tier architecture that optimizes performance and flexibility by separating data, business logic, and user interfaces. The core of the WITS system

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uses web-based technology to support the management of multi-agency substance use disorders treatment data. Using the best-practice approach of WITS, FEi Systems, in collaboration with other Substance Abuse Prevention and Treatment Block Grant states, developed a voucher module to directly support the data collection, management, analysis, and reporting effort in the areas of Provider Management, Client Management, Billing Management, and Outcome data. WITS provides a substantial tool for system management and monitoring. Additionally, service providers receive training and support from the Idaho WITS Helpdesk on correct use and data collection. The data for the recovery and prevention activities will be reported on quarterly and invoices will not be processed unless accompanied by the required reporting data.

E-2 Data management
Hosted securely in off-site servers, WITS and all Opioid Use Disorder (OUD) collected information is monitored and managed at multiple levels (i.e. management services contractor, provider, etc.) for both quality and accuracy. Periodic quality assurance activities also ensure the capture and dissemination of quality data. The data collected from the recovery and prevention providers will be maintained on the Division of Behavioral Health's secure network with shared access to select personnel. This data will include copies of invoices, reports, and a centralized tracking database that will be monitored and updated regularly by the Project Director.

E-2 Data Analysis
The Single State Agency (SSA) contracts with the Management Services Contractor (MSC) for regularly scheduled and ad-hoc analysis including budget, target population and utilization management. OUD analysis will meet the defined targets of the grant (i.e. federal reporting) and assist stakeholders in understanding program performance and progress toward treatment system goals. This data can be partitioned and reported based on provider, regional and state program needs. The data for the recovery and prevention activities will include quarterly analysis coordinated by the Project Director with the cooperation of the MSC and Division of Behavioral Health data management staff.

E-2 Data Reporting
Reports are furnished at the determined frequency. Additional reports will be developed in partnership with stakeholders to understand the success and opportunities of the Idaho's Response to the Opioid Crisis (IROC) project. WITS data is analyzed using SQL Server Reporting Services (SSRS) and SQL Management Studio driven software allowing for flexible, multi-factor analysis. The data for the recovery and prevention treatment will be compiled into regular reports by the Project Director and provided to Division of Behavioral Health Program Management staff for review on a quarterly basis.

E-3 Data Driven Quality Improvement
The MSC, in partnership with the Division of Behavioral Health Data Team, under the coordination of the Project Director, will provide data on treatment enrollment, completion, length of care for specific racial and ethnic populations, identified priority populations and other sub-populations (e.g. LGBT) within the communities of focus for the grant. This data will also be examined by the Project Director and Quality Assurance/Quality Improvement staff to ensure that current levels of access and outcomes remain consistent and any disparities that are identified are addressed by the stakeholders for the specific communities of focus. The data for

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the recovery and prevention activities will be reviewed in a similar manner and will include the MSC, Division of Behavioral Health data management team and Quality Assurance/Quality Improvement staff reviewing the information with the Project Director and contract holders of the services to assure consistent data driven quality improvement.

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STATE BEHAVIORAL HEALTH PLANNING COUNCIL

FY2016 REPORT TO THE GOVERNOR, STATE LEGISLATURE, AND JUDICIARY

FINAL

SUPPORTING BEHAVIORAL HEALTH SYSTEMS THAT ARE COORDINATED, EFFICIENT, ACCOUNTABLE, AND FOCUSED ON RECOVERY.

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INTRODUCTION

The Council would like to express our gratitude for the supportive actions of the Governor and the Legislature regarding the state's behavioral health system this past year. We appreciate the passage of legislation developing an Office of Suicide Prevention, funds for two (2) additional crisis centers, funding support for establishing four (4) additional community recovery centers, and support for the Jeff D. agreement by funding respite services and the Child and Adolescent Needs and Strengths (CANS) tool.

Actions such as these do not go unnoticed by advocates and we are grateful for your support in the continued improvement of Idaho's behavioral health system.

Idaho Behavioral Health Planning Council

The Idaho Behavioral Health Planning Council (BHPC) was established through the passage of Senate Bill 1224 in 2014. This bill amended Idaho Code 39-3125, see Appendix One (1), and replaced the previous "Idaho State Planning Council on Mental Health" with the "State Behavioral Health Planning Council." It also expanded the focus of the newly established council to include both mental health and substance use disorder issues. The Behavioral Health Planning Council was formally established as a new body on July 1, 2014.

As defined in both state and federal law, the purpose of the Council is to:

- Serve as an advocate for children and adults with behavioral health disorders.
- Advise the state behavioral health authority on issues of concern, on policies and programs, and to provide guidance to the state behavioral health authority in the development and implementation of the state behavioral health systems plan.
- Monitor and evaluate the allocation and adequacy of behavioral health services within the state on an ongoing basis, as well as the effectiveness of state laws that address behavioral health services.
- Ensure that individuals with behavioral health disorders have access to prevention, treatment, and rehabilitation services.
- Serve as a vehicle for policy and program development.
- Present to the Governor, the Judiciary, and the Legislature by June 30 of each year a report on the Council's activities and an evaluation of the current effectiveness of the behavioral health services provided directly or indirectly by the state to adults and children.

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- Establish readiness and performance criteria for the Regional Behavioral Health Boards (BHB) to accept and maintain responsibility for family support and recovery support services.

In early 2014, the Planning Council began reorganizing its membership to cover the full-spectrum of mental health and substance use disorder services. This includes members from state agencies, private service providers and prevention programs, as well as consumers, family members, and others representing the diversity of Idaho citizens. This unique cross-section of individuals makes up the Idaho Behavioral Health Planning Council (BHPC). A complete list of the membership is found in Appendix Two (2).

The diversity of the membership creates a broad knowledge base for the BHPC which allows us to work with and support many aspects of the behavioral health system. The bulk of the work done by the BHPC is completed by its workgroups. The BHPC workgroups include:

- Children's Mental Health,
- Crisis Centers and Recovery Centers,
- Prevention, Education and Legislation, and
- Regional Behavioral Health Board Support.

These workgroups are working on several projects including respite education, Naloxone training, and supporting the regional Behavioral Health Boards (BHBs) during their transition to stand-alone boards.

The BHPC looks forward to continued active participation in the improvement of Idaho's Behavioral Health System. The membership is eager to partner with all of the system's stakeholders by sharing our knowledge, expertise, and lived experience in order to improve the lives of all Idahoans.

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Regional Behavioral Health Boards

The Regional BHBs are a critical component to Idaho's transformed Behavioral Health System. The BHPC continues to support and encourage effective communication between the BHPC and each of the BHBs. Below are brief updates about the activities of each of the BHBs from the past fiscal year.

Region 1 Behavioral Health Board

The Region 1 BHB partnered with the Panhandle Health District and was approved by the BHPC as a stand-alone board in September 2015. During the course of the past year, the Board supported the July 25, 2016 opening of the Crisis Center for North Idaho in Coeur d'Alene, partnered with community organizations to provide Trauma Informed Care trainings to over 700 providers, received a grant for suicide prevention training, and helped fund the regional Crisis Intervention Training for law enforcement personnel. They look forward to continued partnerships within the community as they work with local organizations to support the opening of the Kootenai Recovery Community Center in their region.

Region 2 Behavioral Health Board

In early 2016, the Region 2 BHB partnered with the North Central District Public Health. Highlights of the past year for Region 2 include the opening of the Nez Perce County Recovery Center, successful Crisis Intervention Training for law enforcement personnel from across the region, and Youth Mental Health First Aid trainings conducted in several communities. The board is grateful for community partnerships that continue to support the Latah County Recovery Center. The Region 2 BHB continues to advocate for increased use of telehealth services, a complete coverage solution for those in the "gap population," and improved crisis services for Region 2.

Region 3 Behavioral Health Board

In the past year, the Region 3 BHB partnered with the Southwest District Health. The Board is also actively working with the Southwest District Health Statewide Health Innovation Plan (SHIP) Manager to create Patient Centered Medical Homes. The Board created subcommittees and their members are working with the Region 3 BHB Executive Board to address the needs and gaps in the region and develop a strategic plan.

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One of these is the Crisis Center subcommittee whose members are working collaboratively with community organizations to support placement of the next crisis center in Region 3. The Region 3 BHB sponsored scholarships to the Idaho Conference on Alcohol and Drug Dependency conference, supported Crisis Intervention Team trainings, participated in the Children's Mental Health Awareness Week poster contest, supported a golf program for youth in the juvenile justice system, and participated in the opening of the Canyon County Recovery Center.

Region 4 Behavioral Health Board

The Region 4 BHB partnered with the Central District Health Department to serve the behavioral health needs of Ada, Boise, Elmore and Valley counties. The board made great strides in its organization and houses three (3) active committees including a Wellness and Recovery Committee, Youth Behavioral Health Committee, and Provider Committee. With representation by a diverse group of skilled individuals, the board plans to implement a comprehensive data collection process that will determine ways in which the region's needs and gaps can be addressed. This is a motivated board that plans to actively seek grants and affect positive change for Region 4 consumers of behavioral health services.

Region 5 Behavioral Health Board

Over the past year, the Region 5 BHB filled all of its board positions and completed a board orientation process. They also supported mental health awareness activities in the Twin Falls, Wood River Valley, and Mini Cassia areas. A strong working relationship has been established with South Central Public Health. The Region 5 BHB has invested significant time and energy into supporting the new crisis center in Twin Falls and looks forward to the positive impact that center will have on the region.

Region 6 Behavioral Health Board

The Region 6 BHB continues to move toward supporting recovery in their region by educating the public about mental health issues and encouraging communication between service and support providers within their region. Their children's mental health (CMH) subcommittee is reaching out to local school districts through a newsletter and a resource guide. Behavioral Health Board members seek to educate legislators and other government officials on behavioral health issues within the state and the region. The

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Region 6 BHB seeks greater connections between all providers of behavioral health services and a reduction of silos in order to increase support for those in recovery.

Region 7 Behavioral Health Board

In September 2015, the Region 7 BHB, through a contract from Idaho Department of Health and Welfare's (IDHW), Division of Behavioral Health (DBH), partnered with Eastern Idaho Public Health (EIPH) for the provision of administrative and support services to the board. This partnership is working well. In December 2015, a grant of nearly $15,000 from the Blue Cross Foundation for Health was awarded to the Region 7 BHB/EIPH for a regional community engagement project focusing on children's mental health issues, allowing the board to facilitate education to individuals throughout the region and connect them with resources to assist children with mental health needs. This outreach occurred in Clark, Bonneville, and Teton Counties, with events scheduled in Lemhi, Bingham, and Butte Counties in the coming months. Their children's mental health subcommittee has been actively engaging and educating the community regarding several respite projects in the region. The Region 7 BHB is also excited about the funding awarded to support the recovery center (Center for HOPE) in Eastern Idaho and continues to work to support its efforts to serve as a resource to individuals with mental health or substance use issues in Eastern Idaho.

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SUCCESSES DURING 2015-2016

Crisis Centers

In 2014, the Idaho Legislature awarded funding for one crisis center to be located in Idaho Falls. The following year, additional funding was awarded and a crisis center opened in Coeur d'Alene. During the 2016 session, the legislature awarded funding for two additional centers, one in Twin Falls and the other in Boise. The Twin Falls Center opened its doors in November; a Request for Proposal will be issued for the Boise center in early 2017. These centers provided crisis services for more than a thousand Idahoans, helping them avoid incarceration or a visit to the emergency department. These diversions have helped individuals through moments of crisis, preserving their dignity, and have saved Idahoans significant tax dollars in circumvented legal and medical costs.

The chart below represents the number of people served in the crisis centers. These figures represent an unduplicated count.

Behavioral Health Community Crisis Centers

			SFY2015	SFY 2016
Behavioral Health Crisis Center of Eastern Idaho	Crisis Center Visits		735	1950
	Clients Served (unduplicated)		377	689
	Average Length of Stay (In Hours)		11.51	16.66
	Diagnosis Type	Substance Use Only	82	157
		No Significant Mental Health or Substance Use Diagnosis	22	37
		Mental Health Only	264	876
		Mental Health & Substance Use Diagnosis	298	835
		Inadequate Information	34	19
Northern Idaho Crisis Center	Crisis Center Visits		-	615
	Clients Served (unduplicated)		-	414
	Average Length of Stay (In Hours)		-	7.05
	Diagnosis Type	Substance Use Only	-	25
		No Significant Mental Health or Substance Use Diagnosis	-	29
		Mental Health Only	-	214
		Mental Health & Substance Use Diagnosis	-	146
		Inadequate Information	-	72

NOTE: The Behavioral Health Crisis Center of Eastern Idaho, located in Idaho Falls, opened in December 2014. The Northern Idaho Crisis Center, located in Coeur d'Alene, opened in December 2015.

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Recovery Centers

Since 2015, Idaho has opened eight (8) recovery centers. These centers are located in Moscow, Emmett, Caldwell, Boise, Coeur d'Alene, Lewiston, Pocatello and Idaho Falls. Recovery Centers serve individuals seeking recovery, providing a venue for sober activities and much needed peer support. Thousands of individuals in Idaho have received services from these centers and have maintained lives of sobriety. Millennium Funding provided resources for start-up costs as well as some funding for second year operations for these centers. Each of the centers is struggling to secure sustainable funding in order to keep the doors open.

Respite Funding

The 2016 Legislature demonstrated its support of the Jeff D. settlement agreement by increasing the respite budget for CMH to almost $1 million. Respite is defined in Idaho Administrative Procedures Act (IDAPA) 16.07.37 Children's Mental Health Services as "time-limited care provided to children" during "circumstances which require short term, temporary care of a child by a caregiver different from his usual caregiver. The duration of an episode of respite care ranges from one (1) partial day up to fourteen (14) consecutive days."

During the process of writing the Jeff D. agreement and implementation plan it was noted that current respite services are not adequate for families of children with serious emotional disturbance (SED). This additional funding provides opportunities for changes to be made to the current respite model that will allow respite services to be accessible and effective for all families of children with SED in Idaho.

Office of Suicide Prevention

Thanks to the 2015 and 2016 Legislatures and the Governor, suicide prevention in Idaho received a boost in funding and awareness. The 2015 Legislature tasked the Health Quality Planning Commission (HQPC), headed by Dr. Robert Polk, with finding a way to reduce suicide. After inviting commentary from various prevention groups and reviewing efforts nationwide, the HQPC asked for, and received, an appropriation of nearly $1 million to fund 60% of the Idaho Suicide Prevention Hotline (ISPH), to create the Office of Suicide Prevention to be housed in IDHW, Division of Public Health, to provide suicide prevention training for middle and high schools, and to produce suicide prevention awareness campaigns.

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Naloxone Education

During the 2015 legislative session, a law passed that increases the accessibility of opioid antagonist medications that literally reverses overdoses caused by opiates. It is not often we can point to a policy and say with certainty that it will save lives, but that is exactly what this new law will do. This year, the Office of Drug Policy (ODP) and Idaho's Prescription Drug Workgroup worked diligently to educate prescribers, pharmacists, and the public about the new law through trainings, newsletters, on-line videos, print materials and the media. Discussions were also held with law enforcement agencies and schools regarding Naloxone programs and how they may be incorporated into and benefit these types of organizations. These education and awareness efforts will continue throughout the next year.

Children's Mental Health Reform Project (CMHR)

On May 17, 2016, the Jeff D. Implementation Plan was approved by the United States District Court of Idaho. The approval of the Implementation Plan was the first step in the Jeff D. Settlement Agreement that was approved by the court in June 2015. The plan, which is the foundation for Idaho's CMHR Project, outlines the steps that will be taken to improve access to mental health services for approximately 9,000 children with SED in Idaho. Some of the highlights of the plan include:

- a Child and Family Team approach to treatment planning (a process which increases parent and child voice,
- improving communication between all professionals involved in the child's treatment),
- new services designed to provide a complete spectrum of community-based treatment for children and families,
- increased parent and youth involvement in system design and improvement, and
- new strengths-based assessment process.

At the system-level, the plan creates cross-system partnerships that will develop a new infrastructure for communication and collaboration on children's mental health cases. This will allow all of the systems which touch a child to operate in-sync in order to facilitate and coordinate ongoing services and supports for as long as the child and family need them. The results will be a system that more efficiently uses state dollars while more effectively serving children and families.

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CHILDREN'S MENTAL HEALTH

Prevention

Training and Education

Many of the Regional BHBs across Idaho supported educational and training opportunities on various children's mental health topics during the past fiscal year. Some of these trainings included Youth Mental Health First Aid, Trauma-Informed Care, and educational programs using a unique format to bring regional experts on a variety of CMH topics into rural communities. The Idaho Federation of Families (IFOF) for CMH continues to host monthly webinars on topics related to CMH that are available for parents and professionals to view from their home or office.

Respite Funding

The additional funding for respite that was approved during the 2016 Legislative Session will allow regions to provide more comprehensive and family-driven respite services. Previously respite services were only available to families whose child had an open case with CMH. Recent changes made to the respite process, as well as the additional funding provided by the legislature, will allow any child with a SED to access funding for respite services. Removing this barrier and increasing access to these services is a huge support for Idaho families.

Idaho Lives

The Idaho Lives Project (ILP) is a program of the Idaho State Department of Education and Suicide Prevention Action Network of Idaho (commonly known as SPAN Idaho), funded from a three-year Substance Abuse and Mental Health Services Administration (SAMHSA) Garrett Lee Smith (GLS) grant. Over three years the project trained 38 secondary schools with Sources of Strength, the only peer-based best-practice program proven to reduce all types of risky behaviors over the lifespan, including suicidal behavior. Sources are listed on SAMHSA's National Registry of Evidence-based Programs and Practices. Another portion of the program addressed clinical training in Assessing and Managing Suicide Risk as most university programs and licensing boards do not require mental or medical professionals to have any suicide-specific training. The trainer, Dr. David Rudd, well known for his work nationally with the military, provided training to over 1,600 Idaho providers. In addition to these two (2) programs, the ILP trained juvenile justice centers in awareness and intervening with suicidal juveniles. This project

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will continue for the next few years in a reduced capacity to train secondary schools with Sources of Strength.

Idaho Youth M.O.V.E. (Motivating Others through Voices of Experience)

Idaho Youth M.O.V.E. is a state-wide group of diverse, motivated youth who wish to make a positive change in their communities. They advocate for youth rights and are the voice for mental health and the need for services in the systems where they serve. They work towards empowering youth to be equal partners to enact change. Idaho Youth M.O.V.E. has grown and now has chapters in Boise, Pocatello, Gooding, and Nampa as of 2016, with plans to establish groups in Northern Idaho in the upcoming summer. The groups help develop leadership, advocacy, pro-social behavior, and community.

Intervention

Child and Adolescent Needs and Strengths (CANS)

As part of the Jeff D. Implementation plan, Idaho will utilize a new tool in the assessment for children with a SED. The CANS is a communication tool that is used by various child-serving systems in all 50 states. It is designed to support decision-making in the child's treatment plan, as well as assist in quality improvement measures for the system. Idaho will implement an electronic version of the CANS that can be utilized across child-serving systems. While full implementation of the CANS tool will not occur until 2018, training of clinicians and creation of the digital platform are already beginning.

Trauma-Informed Efforts in Foster Care

Over the past several years, the Department has been focused on enhancing their practice in assessing and treating trauma. Through the Title IV-E Child Welfare Waiver Demonstration project they have implemented research-based programs and strategies to serve children, youth, and families involved in the child welfare system. These efforts will assist the program in improving overall well-being, reduce length of time in care, increase placement stability, achieve more timely permanency, and reduce congregate care for children and families served. These researched-based programs include the implementation of the Nurturing Parent Program and the CANS tool, and the expansion of Family Group Decision Making that includes fidelity measures.

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Idaho Department of Juvenile Corrections

In the past twenty years, there have been significant steps to strengthen collaboration and coordination in Idaho's juvenile justice system under Idaho's Juvenile Corrections Act. The success of this collaboration is most apparent in the numbers we have seen. As the 10 to 17-year-old population increases, there has been a decline in arrests, bookings, and commitments to state custody. This is tangible evidence of the ongoing efforts to take a strong developmental approach to juvenile justice through increased understanding of adolescent development and building services in communities.

Treatment

Idaho Caregivers Alliance

The largest workforce caring for people with mental illness, particularly children with emotional disturbance, is family members. These caregivers are often unrecognized and invisible, in spite of saving the state millions of dollars each year. The unseen cost of this caregiving is the toll it can take on family members. While they generally welcome their responsibilities, sometimes the demands are so overwhelming that the related stress causes problems with health, employment and family dynamics, and other relationships. Access to critical information or an occasional break from caregiving means the difference between providing a stable and nurturing environment or one that can break a family apart. The strength of these family caregivers is impressive but it is also has limits.

There are various resources that can inform and sustain family caregivers:

- information about available services for their child or family member, provided in easy to understand terminology,
- assistance from a person knowledgeable about the service system that can help guide families through the first steps or when a crisis occurs,
- training for the caregivers themselves on strategies they can use to take care of themselves,
- occasional time away from 24/7 caregiving to refuel and recharge their batteries, as well as
- flexibility at work that can accommodate caregiver demands, particularly those that are unexpected.

Pockets of support are available in some Idaho communities but these are isolated, fragmented, and may have narrow eligibility requirements. A framework that adequately

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supports family members to meet their caregiving responsibilities is needed. The BHPC works in partnership with the Idaho Caregiver Alliance, the SHIP and others to develop plans and seek funding and resources to build that framework.

Family Support Services

As of May 2016, Family Support Services is a Medicaid billable service that will benefit families of children with a mental health disorder. The IFOF conducted three (3) 40-hour trainings across Idaho in which 71 parents/care takers with "lived experience" were trained and recommended to IDHW, DBH for certification as Certified Family Support Partner (CFSP). These individuals will be employed in the community by mental health provider agencies. The role of a CFSP is to support, educate and mentor parents that are navigating various systems as they seek appropriate care for their children.

Jeff D. Implementation Plan

The approval of the Jeff D. Implementation Plan in May 2016 was a huge step forward for Idaho's Children's Mental Health system. This plan outlines the services that will comprise a complete spectrum of care for children with a SED, with a focus on community-based services. While the State will be using a phased-in approach to rolling out the new and enhanced services across the state, these services can be expected as early as 2017, beginning with enhanced respite care and a newly developed partial hospitalization service.

Next Steps for Children's Mental Health

- There are limited services and supports in Idaho for **transitional age youth**…those between the ages of 16 and 24 who will lose (or have already lost) their services through CMH. This transitional age is challenging for any young adult, and those struggling with emotional and behavioral challenges are at risk for more serious mental health and substance use issues without appropriate support and treatment.

- The approval of the Implementation Plan for the Children's Mental Health Reform Project (Jeff D.) was undoubtedly an exciting step forward for Idaho's children and families. This new system relies heavily on the involvement of parents, professionals, and other stakeholders. Because of this, **education about and engagement in the CMH Reform Project** is a critical next step in order to ensure the success of the project in the coming years.

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- Idaho continues to experience a shortage of child and adolescent psychiatrists. And while this shortage is found nationwide, in Idaho we continue to see families driving up to four hours from their home to access needed psychiatric services. By continuing to create a solid foundation for consistent and responsive **psychiatric telehealth services** we can increase the accessibility of this service.

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ADULT MENTAL HEALTH

Prevention

Training and Education

Many of the Regional BHBs across Idaho supported educational and training opportunities on various adult mental health topics during the past fiscal year. Some of these trainings included Crisis Intervention Training for local law enforcement officers, Mental Health First Aid training, and a variety of suicide prevention trainings.

Idaho Suicide Prevention Hotline (ISPH)

In 2015, the ISPH answered 4,866 calls from Idahoans; of these callers, 1,015 were from young people, age 10-24. Because of the high number of youth callers, a limited pilot project was added that allows for text and chat; funding provided from the Legislature will allow text and chat to be available throughout Idaho this fall. Approximately 617 of the hotline calls 2015 were from Idaho military members or their families. In addition to taking calls from people in crisis or needing help for someone who is in crisis, the ISPH began work with St. Alphonsus to make follow up calls to suicidal patients after their release from the emergency room or the hospital. Research has proven that follow up after a hospital visit can save suicidal patients' lives. The ISPH also offers free posters and cards that show the call number and the warning signs for suicide.

Recovery Centers

The Community Recovery Centers that have been supported through Millennium Funds provide opportunities for those in recovery from a mental health crisis to find services that will continue to help support them in their recovery journey. These services include National Alliance on Mental Illness support groups, sober entertainment (movies, game nights, bowling, etc.), phone banks, veteran support groups, smoking cessation, crisis support for families, grief support, art therapy, free counseling, and peer mentorship. They also offer referrals to and assistance in accessing housing, medical assistance, transportation, and employment.

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Intervention

Crisis Centers

Crisis centers are currently open in Idaho Falls, Coeur d'Alene, and Twin Falls, with additional centers in Boise planning on opening in the coming months. These centers provided crisis services for more than a thousand Idahoans over the past two years. They have helped individuals avoid incarceration or a visit to the emergency department, and these diversions not only save Idahoans significant tax dollars, but also preserve the dignity of the individual experiencing the crisis.

Treatment

Peer Support Specialists

Peer Support Specialists are individuals who use their own lived experience with mental illness to provide empowerment and encouragement to support the recovery of others experiencing mental health disorders. Peer support is based on the belief that recovery is possible for everyone. It is a strengths-focused, peer-driven, highly effective non-clinical service provided to individuals in recovery from mental illness. Peer Specialists have the unique opportunity to share their own recovery story in their professional setting, which contributes to a strong and trusting relationship with those they serve. There are currently 170 trained and certified peer support specialists in Idaho and 75 peers are trained each year. Peer support is an evidence based practice that helps prevent individuals from returning to jail and/or state hospitals, and the behavioral health system could greatly benefit from increased training availability.

SHIP

The DBH staff conducted onsite surveys on behalf of the SHIP Behavioral Health Integration Workgroup between October 14 and December 14, 2015. Forty-seven patient-centered medical homes (PCMH) enrolled in the Idaho Medicaid Health Home Program participated. A majority of these primary care clinics offered co-located or semi-integrated behavioral health services. The survey highlighted a solid foundation for behavioral health integration throughout the state, as well as opportunities to further extend integration as clinics transition to PCMH practices in the months and years to come.

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Next Steps for Adult Mental Health

- Idaho's rural and frontier areas continue to struggle with a lack of access to psychiatric care. Creating stable **psychiatric telehealth programs** should be a priority for supporting Idaho's behavioral health system.

- There has been much discussion about the "coverage gap" - the 78,000 Idahoans who lack any form of health insurance coverage. They don't qualify for traditional Medicaid and earn too little to qualify for assistance on Idaho's insurance exchange. Many in this "coverage gap" struggle with treatable behavioral health issues, but due to their lack of insurance are not able to access treatment that supports their recovery. This lack of consistent mental health treatment leads to crisis situations that not only cost significant tax payer money but also create trauma for the individual and make recovery difficult. Finding **a complete, Idaho-based solution for the "coverage gap"** will improve access to care for many adults with mental illness.

- Every region of the state expressed the need to resolve Idaho's limited access to **affordable, suitable, and sustainable housing**. They have identified problem areas that are especially critical in rural communities such as the lack of crisis beds, transitional, supportive and traditional housing. Housing is necessary to help assure success for those individuals who are or have been in treatment for behavioral health issues. Limited housing affects many aspects of the population including woman, children and individuals who are being released from the State Hospitals. Shelter is a basic essential need that can assist individuals in their journey towards recovery, acceptance and success.

- Idahoans who are **lesbian, gay, bisexual, and transgender** are not a protected population and face the risk of being denied services, employment, and housing based on their gender identity or sexual orientation. Without these protections, Idahoans who are gay and transgender are more susceptible to behavioral health issues but can be denied services when seeking help; this creates an accessibility concern. All Idaho families need to be able to earn a living and provide for their families, have access to services and housing without fear of being turned away.

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SUBSTANCE USE DISORDERS

Prevention

Office of Drug Policy

Substance abuse prevention in Idaho has seen continued growth and success during the past year. Seventeen (17) Idaho communities are now receiving funds through the Office of Drug Policy's Strategic Prevention Framework (SPF) Grants program to implement population level prevention strategies. The SPF program also provides funds for six (6) law enforcement agencies to conduct operations to enforce underage drinking laws and curb prescription drug misuse. In addition, 46 prevention providers statewide were awarded funding from the Substance Abuse Prevention and Treatment block grant to deliver evidence-based prevention programs in their communities.

Recovery Centers

The Community Recovery Centers that have been supported through Millennium Funds provide opportunities for those in recovery from a substance use disorder to find services that will continue to help support them in their recovery journey. These services include life skills training, smoking cessation, drug testing, recovery coaching, case management, child care, help accessing safe and sober housing, and support in finding Substance Use Disorders (SUD) treatment options.

Youth Drug and Alcohol Prevention Coalitions in Idaho

There were 14 Idaho prevention coalitions that attended the Community Anti-Drug Coalitions of America Coalition Academy and graduated in Washington, D.C. this year. This is an extensive three-week training that was held over the course of a year, in Boise. Eleven (11) additional coalitions just completed the course and will graduate in February, 2017. There are currently 29 active prevention coalitions that are working with the Community Coalitions of Idaho (CCI), a statewide coalition of coalitions, and the Idaho Office of Drug Policy, to address youth substance abuse.

The CCI members are working to address the growing problem of prescription drug misuse, alcohol use and marijuana use among youth. Several coalitions will be addressing the prescription drug misuse problem by providing prescription drug collection programs and educating physicians of the importance of using the Prescription Monitoring System. They will also use media, billboards, and social media to raise awareness

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of this increasing issue and implementing a variety of activities in communities across the state. Our coalitions have been effectively implementing strategies to decrease underage drinking, marijuana use, vaping, and many other drug related trends.

Intervention

Naloxone

The education and awareness efforts surrounding the use of Naloxone to treat opioid overdose continues to positively impact the potential of this policy to save lives. The Office of Drug Policy (ODP) and Idaho's Prescription Drug Workgroup continues to educate prescribers, pharmacists, and the public about the new law various methods. These efforts to educate all of the individuals and organizations that could potentially benefit from the understanding of Naloxone will continue throughout the next year.

Treatment

In FY 16, DHW's Division of Behavioral Health managed nearly $7 million in combined federal block grant and state dollars for treatment and recovery support services. This money served different populations, including Intravenous Drug Users, Pregnant Women and Women with Children, Adolescents, State Hospital patients returning to the community, Supervised Misdemeanants, parents involved with child protection, mental health clients, and certain problem-solving courts ("drug courts"). This year, the DHW was able to provide services to a new category: Idahoans who fall under 100% of federal poverty guidelines. These services helped bridge the Idaho's Medicaid expansion gap. However, demand outweighed supply and services for this population were terminated before year's end.

Other highlights include:

- Telehealth SUD services in the publicly-funded network were made available this year.
- There has been an increase in the numbers of individuals accessing treatment who claim heroine/opioids as their primary drug of choice, indicating a rise in use of these drugs in our state.
- Recovery Coaching is now a reimbursable service in this system.

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Idaho Department of Corrections (IDOC)

The IDOC budget for direct SUD services in FY16 is $7,062,100. These funds provide community-based drug and alcohol treatment services for adult felons through a statewide private provider network. At the start of FY16, available treatment services included assessment, outpatient/intensive outpatient care and recovery support services (case management, drug testing, safe/sober housing, life skills and transportation). To improve offender outcomes, in January 2016, the IDOC added a 28-day residential treatment option to the service matrix. As the end of FY16 approaches, it is estimated that the private provider network will serve approximately 4,300 IDOC offenders.

Recovery Coaches

Efforts to increase the number of Idaho Recovery Coaches continue. To date, more than 400 coaches have been trained. Recovery Centers and treatment providers are beginning to employ coaches as they see the value of providing peer-to-peer services. Many, but not all, pubic funders of treatment are supporting the service. The Idaho Board of Alcohol/Drug Counselor's Certification now offers a certification for Recovery Coaching.

Next Steps for Substance Use Disorder Treatment

Medication Assisted Treatment (MAT)

In terms of DHW and next steps for MAT, the DHW is currently exploring options for funding this service using block grant and state dollars. Without additional funding, the introduction of MAT into our cadre of services will result in others not receiving treatment due to lack of funds. The Obama administration is promoting significant funding for states to combat the opioid crisis. Idaho continues to watch that proposal closely. Idaho currently has some MAT providers across the state and while some are receiving federal grant monies (from grants they have independently applied for), none are receiving state funding at this time.

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IDENTIFIED BARRIERS

Each year the Regional BHBs submit a report to the BHPC detailing their successes, as well and the needs and gaps within their regions. Upon reviewing the reports, the BHPC recognized many statewide trends regarding barriers to both accessing services and maintaining recovery.

Barriers to Accessing Services

- Lack of consistent, reliable **telehealth** services.
- Lack of **providers** (psychiatrists, as well as other behavioral health providers), especially in rural areas.
- Lack of access to services for **non-criminal justice, at-risk youth and adults**
- Lack of **collaboration among providers** about mental health and physical health needs (often due to system limitations, not the choice of the professional).
- Lack of access to insurance coverage for the **"gap" population.**

Barriers to Maintaining Recovery

- Lack of **housing**, including traditional housing (especially for women and families) and models with more supervision for high risk patients with complex medical and co-occurring conditions transitioning out of hospital settings.
- Lack of consistent, reliable **transportation.**
- Lack of **supported employment** for those with the most serious mental health challenges.
- **Stigma** often limits access to opportunities that are currently available.
- Lack of **family engagement** for youth during treatment (due to a variety of issues including not being able to take off time from work, lack of transportation for parents, lack of understanding about the treatment process, etc.).

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CONCLUSION

In closing, the Council would like to, once again, thank the Governor and the Legislature for their supportive actions with regards to the behavioral health system this past year. Your support allows for the continued improvement of Idaho's behavioral health system.

As we look forward to the next fiscal year and beyond:

- The BHPC supports increased numbers of problem-solving courts which provide alternatives and treatment for those facing criminal charges complicated by their mental health diagnosis or substance use disorder.

- The BHPC supports collaboration with the Courts, Juvenile and Adult Corrections, and County probation to better meet the needs of those with a mental health diagnosis or substance use disorder in the criminal justice system.

- The BHPC supports the work of the regional BHBs and their collaboration with their local community networks to provide the mental health and SUD supports for adults, children, and families.

- The BHPC supports the investment in prevention programs and activities to reduce substance abuse and protect the health, safety and quality of life for all, especially Idaho's youth.

- The BHPC supports the work of crisis and recovery centers that provide resources to those seeking treatment and supports to aid their recovery.

- The BHPC supports the new system of care within CMH which will more efficiently and effectively meet the mental health needs of Idaho's children diagnosed with a serious emotional disturbance.

- The BHPC supports efforts to decrease the "silos" within the behavioral health system and increase opportunities for shared communication, treatment, and recovery support for both children and adults.

- The BHPC supports increased used of peer support services within all aspects of Idaho's Behavioral Health system, including recovery support coaches, peer support specialists, and family support partners.

- The BHPC supports the continued development of consistent, sustainable telehealth services within behavioral health.

There is much work left to do, but the Council remains hopeful that by working together we can continue to transform Idaho's behavioral health system into one that is responsive and effective.

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Appendices

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Appendix 1: Statute – IC 39-3125

TITLE 39
HEALTH AND SAFETY
CHAPTER 31
REGIONAL BEHAVIORAL HEALTH SERVICES

39-3125. STATE BEHAVIORAL HEALTH PLANNING COUNCIL. (1) A state behavioral health planning council, hereinafter referred to as the planning council, shall be established to serve as an advocate for children and adults with behavioral health disorders; to advise the state behavioral health authority on issues of concern, on policies and on programs and to provide guidance to the state behavioral health authority in the development and implementation of the state behavioral health systems plan; to monitor and evaluate the allocation and adequacy of behavioral health services within the state on an ongoing basis; to monitor and evaluate the effectiveness of state laws that address behavioral health services; to ensure that individuals with behavioral health disorders have access to prevention, treatment and rehabilitation services; to serve as a vehicle for policy and program development; and to present to the governor, the judiciary and the legislature by June 30 of each year a report on the council's activities and an evaluation of the current effectiveness of the behavioral health services provided directly or indirectly by the state to adults and children. The planning council shall establish readiness and performance criteria for the regional boards to accept and maintain responsibility for family support and recovery support services. The planning council shall evaluate regional board adherence to the readiness criteria and make a determination if the regional board has demonstrated readiness to accept responsibility over the family support and recovery support services for the region. The planning council shall report to the behavioral health authority if it determines a regional board is not fulfilling its responsibility to administer the family support and recovery support services for the region and recommend the regional behavioral health centers assume responsibility over the services until the board demonstrates it is prepared to regain the responsibility.

(2) The planning council shall be appointed by the governor and be comprised of no more than fifty percent (50%) state employees or providers of behavioral health services. Membership shall also reflect to the extent possible the collective demographic characteristics of Idaho's citizens. The planning council membership shall include representation from consumers, families of adults with serious mental illness or substance use disorders; behavioral health advocates; principal state agencies and the judicial branch with respect to behavioral health, education, vocational rehabilitation, adult correction, juvenile justice and law enforcement, title XIX of the social security act and other entitlement programs; public and private entities concerned with the need, planning, operation, funding and use of mental health services or substance use disorders, and related support services; and the regional behavioral health board in each department of health and welfare region as provided for in section 39-3134, Idaho Code. The planning council may include members of the legislature.

(3) The planning council members will serve a term of two (2) years or at the pleasure of the governor, provided however, that of the members first appointed, one-half (1/2) of the appointments shall be for a term of one (1) year and one-half (1/2) of the appointments shall be for a term of two (2) years. The governor will appoint a chair and a vice-chair whose terms will be two (2) years.

(4) The council may establish subcommittees at its discretion.

History:

[39-3125, added 2006, ch. 277, sec. 3, p. 849; am. 2014, ch. 43, sec. 7, p. 109.]

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Appendix 2: BHPC Membership by Region

Name	Position	Region	Email
Sandra McMichael	Consumer/SUD	1	smcmichael@bmc.portland.ihs.gov
Angela Palmer	Treatment Provider/SUD	1	angela.palmer@sequelyouthservices.com
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Abraham Broncheau	Tribal	2	abebwolfis@gmail.com
Jennifer Griffis	Parent of Child/Adolescent	2	jengriffis@gmail.com
Elda Catalano	Hispanic	3	ecatalano@canyonco.org
Judy Gabert	SPAN Idaho	3	jgabert@spanidaho.org
Rosie Andueza	DHW-Behavioral Health	4	Rosie.Andueza@dhw.idaho.gov
Evangeline (Van) Beechler	LGBTQ	4	ebeechler@gmail.com
Carol Dixon	Certified Family Specialist	4	cdixon@idahofederation.org
Jane Donnellan	Vocational Rehab	4	jane.donnellan@vr.idaho.gov
Jen Haddad	Family & Child Services	4	HaddadJ@dhw.idaho.gov
Magni Hamso	Physician	4	mhamso@trhs.org
Marianne King	Office of Drug Policy	4	marianne.king@odp.idaho.gov
Tiffany Kinzler	Medicaid	4	KinzlerT@dhw.idaho.gov
Greg Lewis	Corrections/Adult	4	glewis@idoc.idaho.gov
James Meers	Veteran	4	jmeers99@gmail.com
Julie Mitchell	Housing	4	juliew@ihfa.org
Jason Stone	Corrections/Youth	4	Jason.Stone@idjc.idaho.gov
Hilary Trappett	Suicide Survivor	4	htrappett@gmail.com
Rick Huber	Consumer/MH	5	rick2727272000@yahoo.com
Angenie McCleary	Counties	5	AMcCleary@co.blaine.id.us
Susan Hepworth	Consumer/Senior Adult	6	skhepworth53@gmail.com
Holly Molino	Treatment Provider/MH	7	holly@accesspointkids.com
Jon Shindurling	Judiciary	7	jshindurling@co.bonneville.id.us

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Appendix 3: Acronyms

Acronym	Meaning
BHB	Behavioral Health Board
BHPC	Behavioral Health Planning Council
CANS	Child and Adolescent Needs and Strengths Assessment
CCI	Community Coalitions of Idaho
CFSP	Certified Family Support Partner
CHMR	Children's Mental Health Reform Project
CMH	Children's Mental Health
DBH	Division of Behavioral Health
DHW	Department of Health and Welfare
EIPH	Eastern Idaho Public Health
GLS	Garrett-Lee Smith grant
HQPC	Health Quality Planning Commission
IDAPA	Idaho Administrative Procedures Act
IDHW	Idaho Department of Health and Welfare
IDOC	Idaho Department of Corrections
IFOF	Idaho Federation of Families
ILP	Idaho Lives Project
ISPH	Idaho Suicide Prevention Hotline
MAT	Medication Assisted Treatment
ODP	Office of Drug Policy
PCMH	Patient-Centered Medical Homes
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SHIP	Southwest District Health Statewide Health Innovation Plan
SPF	Strategic Prevention Framework

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Youth Empowerment Services (YES) System Capacity Analysis Report

January 30, 2017

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Youth Empowerment Services (YES)
System Capacity Analysis Report

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1) Projected Number of Class Members Page 13

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Youth Empowerment Services (YES)
System Capacity Analysis Report
Jan 30, 2017

Executive Summary

Opportunities to improve outcomes for children, youth, and families in Idaho through the Youth Empowerment Services (YES) Project include providing timely access to a full array of mental health services in the scope, intensity and duration that meets the needs of the target population. A comprehensive analysis of the capacity of Idaho's mental health treatment system to deliver the continuum of mental health services is needed periodically to effectively guide the state's transformation efforts in workforce development to successfully meet this goal.

This initial YES System Capacity Analysis Report is based on the requirements in the Jeff D Agreement and Idaho Implementation Plan. The YES Quality Management Improvement and Accountably (QMIA) Data and Reports Committee completed the initial system capacity assessment. The QMIA Data and Reports Committee is a workgroup, involving representatives from the Idaho Department of Health and Welfare (DHW) Divisions of Behavioral Health (DBH), Medicaid, and Family and Community Services (FACS), along with the Idaho Department of Juvenile Corrections (IDJC) and the State Department of Education (SDE), was formed to develop YES reports that are across the child serving systems.

This capacity analysis has revealed some of the gaps in the current data capture infrastructure that must be addressed to move toward a system in which all the partners are capturing similar data, using the same naming conventions, have the same definitions for variables and then are able to engage in meaningful data sharing. Despite the noted data limitations, the following conclusions were derived from this analysis:

- The proportion of children served in Region 7, exceeds the proportion served in the highest populated region, Region 4 for both DBH and Medicaid.
- The percent of medication management services for Medicaid appears to be higher than the national average despite the affirmed shortage in child and adolescent psychiatrists in Idaho.
- Psychotherapy appears to be accessed significantly less in Idaho than it is accessed nationally.

Over the next one to two (1-2) years more extensive analyses on the system capacity needs for Jeff D Class Members will be conducted and reported. The intent of further study into system capacity will be to uncover more in-depth information about child, youth and family needs, and how the system is able to meet those needs.

Information gleaned from this report will be utilized for system planning, specifically for workforce development. Based on the result of this initial capacity analysis the recommendations for planning for workforce development in order to maintain and enhance system capacity are:

- Continue analyze and assess current capacity and needed capacity on an on-going basis based on an in-depth need-based planning study
- Implement Child and Adolescent Needs and Strengths (CANS) and the Transformational Collaborative Outcomes Management (TCOM) system which will provide useful data about child, youth and family outcomes
- Evaluate the cause of apparent capacity issues by region
- Consider setting recruitment goals by region and by type of service needed
- Provide training on practices that are effective (evidence based, evidence informed and proven practices) but are currently not utilized extensively
- Consider establishing staffing models by program type
- Work with local universities to ensure education is focused on areas of need throughout the state.
- Support primary integration by developing new models of integration and pilot them

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Youth Empowerment Services (YES)
System Capacity Analysis Report
Jan 30, 2017

Introduction

The Idaho Department of Health and Welfare (DHW) Divisions of Behavioral Health (DBH), Medicaid, and Family and Community Services (FACS), along with the Idaho Department of Juvenile Corrections (IDJC) and the State Department of Education (SDE) have initiated the Youth Empowerment Services (YES) project. The aim of the YES project is to transform statewide public mental health systems over the next four (4) to seven (7) years to improve outcomes for Idaho's children, youth and families. The goals for this transformation are based on the Jeff D. Settlement Agreement which resulted from the most recent mediation to resolve the lawsuit filed originally in 1980. The steps toward transformation are outlined in Idaho's Youth Empowerment Services (YES) Implementation Plan. (See the YES website at www.youthempowermentservices.idaho.org for copies of the Jeff D. Settlement Agreement and Implementation Plan).

Opportunities to improve outcomes for children, youth, and families in Idaho through YES include providing timely access to a full array of mental health services in the scope, intensity and duration that meets the needs of the target population. A comprehensive analysis of the capacity of Idaho's mental health treatment system to deliver the continuum of mental health services is needed periodically to effectively guide the state's transformation efforts in workforce development to successfully meet this goal.

The YES Quality Management Improvement and Accountably (QMIA) Data and Reports Committee completed an initial system capacity assessment to begin the practice of using cross-system data to assess capacity. The QMIA Data and Reports Committee is a workgroup, involving all five child serving systems noted above, and was formed to develop YES reports that are across the child serving systems. This initial YES System Capacity Analysis Report is based on the requirements in the Jeff D Agreement and Idaho Implementation Plan.

The initial YES System Capacity Analysis is based on the following requirements in the Jeff D Agreement and in the YES Implementation Plans:

Jeff D. Settlement Agreement:

> Section 82. Throughout the sustained performance period, Defendants shall maintain the critical system infrastructure developed during the implementation period and continue to provide the full array of services and supports to Class Members statewide. In order to sustain the children's mental health system of care Defendants shall:
>
> a. Annually update the range of expected Class Member service utilization;
> b. Maintain statewide capacity to timely provide Services and Supports in the appropriate scope, intensity and duration to Class Members for whom it is medically necessary;
> c. Provide the full array of Services and Supports statewide to Class Members for whom it is medically necessary;
> d. Timely provide Class Members with Services and Supports that are appropriate in scope, intensity and duration to meet to his or her individual strengths and need;

YES Implementation Plan:

> Section H. Assess system capacity by January 30, 2017.

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1. Develop methodology to assess the current statewide system capacity and estimate the statewide system capacity necessary to provide all of the service and supports statewide to Class Members under the Agreement.

2. Identify metrics to be used to measure current statewide and regional capacity, taking into account historical utilization data.

3. Utilize metrics to measure current statewide and regional capacity for the timely delivery of services and supports.

4. Formulate initial recommendations to inform Workforce and Community Stakeholder Development, to establish and maintain system capacity.

Report Limitations

While not comprehensive this initial analysis will provide baseline information that can be used for decision-making that will support improving system capacity. Due to the complexity of the child mental health serving system and data limitations this initial analysis only addresses outpatient services and does not address timeliness, intensity, or duration. It is notable that there were other limitations that also impacted initial capacity analysis:

- There are variations in reliability of the data which may impact accuracy.
- There were limited resources available to complete the analysis.
- The data needed must be gleaned from several complex systems that operate independently therefore duplication could not be minimized.
- Indicators of system capacity are not currently collected by any of the partner agencies; therefore, the analysis is limited to extrapolation of utilization data from Division of Medicaid and Division of Behavioral Health.

Profile of Children, Youth and Families

The YES Capacity Analysis begins with a broad examination of all children and youth under the age of 18 in Idaho (Section 1) by payer type, and the estimated number of Class Members (Section 2). The capacity analysis then focuses on how current service utilization is distributed across service types, and how patterns of use differ between DBH and Medicaid and across Idaho's seven (7) regions (Sections 3 and 4). This information will assist in understanding the variation between the two systems. This portion of the analysis is based on the most recent data about utilization of outpatient services by the child and youth population that is presumed to meet the criteria to be a Class Member of the Jeff D. lawsuit. The capacity analysis then shifts to focus on assessing capacity needs for the system transformation (Section 5).

1) Total number of Idaho Children and Youth (under the age 18):

Table 1: Idaho's Child and Youth Population by Payer

Column	Year	Population	Medicaid	Privately Insured	Uninsured
1	2014	430,918	188,290	215,407	27,221
2	2015	432,837	201,925	206,211	24,701
3	2016	434,465	208,687	207,794	17,984

Data Source: Medicaid

- Columns 1 and 2: Years 2014 and 2015: Idaho population under age 18, U.S. Census Bureau Annual Population Estimates
- Column 3: 2016: Medicaid estimated Idaho population under age 18

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Discussion: It is notable that for the past two (2) years there appears to be trend for an increase in the number of children and youth under the age of 18 who are Medicaid members (+11%) and trend for a decrease in the number of children and youth under the age of 18 who are uninsured (-34%). It is unknown if this trend will impact the system capacity needed to meet the requirements of the Settlement Agreement.

2) Projected number of Jeff D Class Members

Idaho continues to work on finalizing its projection of the numbers of Jeff D. Class Members. There have been three (3) in-depth studies completed, two (2) by Boise State University (BSU) and one (1) by a collaborative group including Medicaid, Optum, and DBH staff. The projection has varied somewhat in each group's analysis as the proxy indicators or "caseness" has varied. The actual number of Class Members will remain an estimate until Idaho has implemented the standardized assessment instrument designated in the Agreement (the Child and Adolescent Strengths and Needs or CANS).

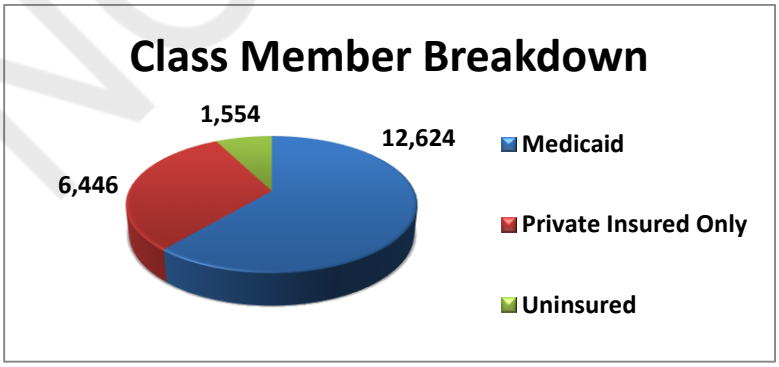
BSU Projection:

The estimate of Idaho's youth populations ages five (5) to 17 who experience SED and have an impairment in functioning severe enough to qualify them for Jeff D services was suggested to be between 17,734 to 23,318 children or youth. The estimate was based on the BSU study "Prevalence of Serious Emotional Disturbance (SED) and Mental Health (MH) Service Utilization in Idaho," conducted on behalf of the YES project. This estimate was based on a meta-analysis of the epidemiological literature on children's mental health in the US published from 1993 to 2015. This is based on a prevalence rate of 6.47% with a confidence interval of 5.59% to 7.35%.

The estimate by the Center for Substance Abuse Treatment (CSAT) committee of 21,000 was within the ranges noted in the BSU estimate and was in fact very close to the number predicted through BSU's meta-analysis (317,248 youth ages 5-17 X 6.47% = 20,526). (Note there was a difference in age groups used (5-17 for BSU), (0-17 for IDHW)

CSAT Projected Total Class Members: 21,000 (Rounded)

Diagram #1:



Data Source: Medicaid

Discussion: DBH is working with BSU and Medicaid to finalize the projected number of Class Members but for purposes of this capacity analysis projection of 21,000 will be utilized. It is notable however that this projection includes 6446 children and youth who are privately insured and that is unknown how many children or youth who are privately insured will choose to utilize the public mental health system for services.

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*3) Number of Presumed Class Members** currently served by DBH and Medicaid by Region:*

DBH and Medicaid utilize data in their current systems to try to identify how many children and youth currently being served would potentially be deemed as Class Members. These two systems utilized different proxy indicators as the data collected by each system varies.

DBH used the scores on the Child and Adolescent Functional Assessment Scale (CAFAS) to predict Class Membership. The CAFAS score of 80 matches the definition currently in IDAPA Administrative Code for SED (IDAPA 16.07.37) Additionally a CAFAS score of 80 matches to the expected CANS scores that will be used to determine class membership once the CANS has been implemented.

Medicaid used state fiscal year (SFY) 2016 Idaho Behavioral Health Plan (IBHP) enrollment and claims data and diagnostic information. Medicaid also used the number of services that were delivered within this timeframe. Children that met the criteria for diagnosis and also received 10 or more SED claims were presumed to meet the criteria for Jeff D. Class Membership.

Table 1: Estimated number of children and youth currently served who are Presumed to be Class Members

	DBH			**Medicaid**	
Region	Current Presumed Class Members**	% of Total		Current Presumed Class Members**	% of Total
1	127	10.5%		1,617	11.3%
2	60	4.9%		487	3.4%
3	151	12.4%		3,080	21.5%
4	236	19.4%		3,322	23.1%
5	201	16.6%		1,569	10.9%
6	114	9.4%		1,088	7.6%
7	307	25.3%		3,150	21.9%
Other/Unknown	18	1.5%		41	0.3%
# of Presumed Class Members receiving services**	1,214			14,354**	

**In this report current Presumed Class Members are or may be duplicated within or across regions, and within or across DBH and Medicaid systems. Due to the possible duplication the total number of Presumed Class Members served in this table is not equal the projection of estimated number of Class Members.

Discussion: This analysis demonstrates significant variability across the regions and between DBH and Medicaid. The proportion of children served in Region 7, exceeds the proportion served in the highest populated region, Region 4.

4) Assessing current system capacity:

Several methodologies were used to assess current system capacity to provide services in the scope that meets the needs of children, youth and families.

The first method was focus on what is known about Idaho's capacity to provide mental health services.

Health Provider Shortage Area (HPSA):
There are known shortages in Idaho's capacity to provide mental health services as demonstrated by the states' Health Provider Shortage Area (HPSA) designation. A HPSA is an area designated by the Health Resources &

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Services Administration (HRSA) as having a shortage of primary care, dental care or mental health providers. Based on the criteria for mental health providers established by HRSA a score is given to each area based on the population and the number of providers in the region. Although some counties in Idaho are not defined as having shortages in mental service providers (such as Ada County) there are many others that are designated. Based on the number of counties that are designated HRSA considers the state of Idaho overall to be designated as a HPSA state for mental health.

The State Behavioral Health Planning Council noted the following in their 2016 Report to the Governor: "Idaho continues to experience a shortage of child and adolescent psychiatrists. And while this shortage is found nationwide, in Idaho we continue to see families driving up to four hours from their home to access needed psychiatric services."

Substance Abuse Mental Health Services Administration (SAMHSA):
While the comment from the Planning Council is anecdotal there is national data published by SAMHSA which verifies the comment. The SAMHSA data (see Table 2 on page 7) shows that the ratio of child and adolescent psychiatrists to the state's population indicates that there is still a shortage of children's psychiatrists although the number of psychiatrists has increased since 1990.

Discussion: As of 2009 Idaho's rate was 5.0 children's psychiatrists per 100,000 youth. There are only 3 states with rates that re worse than Idaho's rate. It is notable that while the SAMHSA data about Idaho regarding the total number of psychiatrists is useful it is not known if the numbers reflect the number of psychiatrists working in the public mental health system or currently practicing.

Table 2: Idaho's Child and Adolescent Psychiatrists

	Number of Child and Adolescent Psychiatrists			Child and Adolescent Psychiatrists per 100,000 youth		
Year	1990	2000	2009	1990	2000	2009
Number/rate per 100,000	9	17	21	3.0	4.6	5.0

Idaho's Service Utilization Data:
Using current utilization data (SFY 2016) the QMIA Data and Reports Committee evaluated the most commonly used outpatient treatment services by type and geographic distribution of services delivered by DBH (Table 3) and Medicaid (Table 4). A direct comparison between the two systems is not feasible for the following reasons:

1. Services provided by DBH are intended for a target population that is substantially different from the Medicaid population. DBH serves children who are primarily court ordered into services while Medicaid serves primarily those who are voluntary.
2. The top most commonly used services vary by DBH and Medicaid system based on the difference between the populations served.
3. Data contains duplication because of the lack of a common identifier of clients among the partner agencies in the analysis.
4. Terms and definitions across child serving systems differ and therefore data often cannot be compared directly

The metrics used for the assessment of current system capacity were:

- Provider location based on provider address from provider claims
- Scope (types) of outpatient services delivered from provider claims
- Presumed Class Members currently served based on Medicaid proxy criteria
- Services stratified by Region as defined by DBH

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Table 3: Count of DBH Services Utilized Most Frequently by Current Presumed Class Members**

Region	Division of Behavioral Health (DBH) Regional Clinics Type of Service							
	CMH Case Mgmt.	Medication Management Services			Parenting With Love and Limits	Wraparound	Total Types of Services	% of Total Services
		Psychiatric Diagnostic Evaluation	Nursing Services	15 Minute Outpatient (99213)				
1	114	37	0	0	23	14	188	10.2%
2	49	8	20	0	20	2	99	5.4%
3	125	53	23	20	35	0	256	13,9%
4	199	101	1	44	29	0	374	18.7%
5	194	5	0	0	22	0	221	11.9%
6	93	52	0	18	31	0	194	10.5%
7	235	210	0	0	36	14	495	26.8%
Other	11	2	1	1	2	0	17	0.9%
Total	1,020	468	45	83	197	30	1844	
Percent	55.3%	25.4%	2.4%	4.5%	10.7%	1.6%		

Data Source: DBH

** Current Presumed Class Members are or may be duplicated across regions, and across multiple services. Due to the possible duplication the total number of Presumed Class Members served in this table is not equal the projection of estimated number of Class Members.

Discussion: There are several observations that can be made based on the estimated number of clients served by DBH and the services they received:

- The proportion of children served in Region 7 exceeds the proportion served in the highest populated region, Region 4.
- Greater than 50% of services provided was Children's Mental Health CMH Case Management which reflects the referral source of the population served (court ordered services under the Idaho Statue 20-511A).
- The total of the three (3) types of medication management services is 596 or 32%.

Table 4: Count of Medicaid Behavioral Health Services Utilized Most Frequently by Presumed Class Members

Regions	Division of Medicaid Behavioral Health Type of Service						
	Individual Therapy by Non-Prescriber	Family Therapy	Medication Management		Mental Health Assessment/ Treatment Plans	Case Mgmt.	Total
			Psychiatric Diagnostic Evaluation	Prescriber Visits			
1	1,273	1,131	1,065	197	679	414	4,759
2	439	335	284	58	217	107	1,440
3	2,732	2,143	2,267	1,067	958	597	9,764
4	2,903	2,304	2,381	987	871	588	10,034
5	1,334	1,158	966	348	327	161	4,294
6	993	799	748	277	430	267	3,514
7	2,932	2,378	2,180	765	1,512	1,351	11,118
Other	35	25	11	6	3	8	88
Total	12,641	10,273	9,902	3705	4,997	3,493	45,011
Percent	28.1%	22.8%	22.0%	8.2%	11.1%	7.8%	

Data Source: Medicaid/Optum

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Discussion: There are several observations that can be made based on the estimated number of clients served by DBH and the services they received:

- The proportion of children served in Region 7 exceeds the proportion served in the highest populated region, Region 4.
- Approximately 50% of services are either individual or family therapy.
- Approximately 30% of services are Medication Management services.

5) Estimating System Capacity Needed:

Estimating how many Class Members are not currently receiving services (unmet need):

To estimate the number of Class Members who are not currently accessing services the number of projected Class Members currently receiving services was multiplied by the prevalence rate and compared to the number of presumed Class Members currently being served.

Metrics:

- Estimated number of uninsured and Medicaid members under the age of 18 as of 2016
- Prevalence rate of 6.47% (as noted in the BSU Class Member analysis)
- Number of presumed Class members currently served

The results (See Table 5 on page 9) indicate that it is likely that most of the Class Members may be accessing some type of mental health services. However, this result should not be interpreted as an indication that Class Member needs are being met. The only thing we know is the number of children and youth that currently have some contact with the outpatient mental services is close to the projected numbers who need those services. There needs to be more study of the use of services to assess the amount of service being delivered to individuals. This will include intensity and duration of services. Also as noted previously it is unknown how many of those who are privately insured will access the public mental health system.

Table 5: Population and Expected Need Based on Prevalence and Number Presumed Class Members Currently Served

	DBH (Uninsured)	Medicaid
Total Population	17,984	208,687
# of Projected Class Members	1,164	13,502
# of Presumed Class Members currently served	1150	13,300
Variance	+14	+202

Data Source: DBH, Medicaid/Optum

Type of Services Needed:
Additional analysis regarding the projected need for service was gained by comparing service utilization in Idaho to service utilization nationally. The national statistics for percentage of services in Table 6 were reported in "Examining Children's Behavioral Health Service Utilization and Expenditures" (Faces of Medicaid, Center for Health Care Strategies, Inc., Dec 2013, page 33).

The data analyzed was focused solely on Medicaid as the national data is for Medicaid services. The Medicaid service of "Psychiatric Evaluation" and "Prescriber Visits" were combined to equal the national "Medication Management" category.

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The metrics used to estimate system capacity needed were:

- Current utilization of types of services from provider claims
- Percentage of number of Presumed Class Members

Table 6: Comparison of % of Service Utilized Nationally to % of Presumed Class Members Currently Served

	Division of Medicaid Behavioral Health Type of Service					
	Individual Therapy by Non-Prescriber	Family Therapy	Medication Management		MH Assessment/ Tx. Plans	Case Mgmt.
			Psychiatric Diagnostic Evaluation	Prescriber Visits		
National %	53.1%	19.4%	22.3%		8.8%	8.7%
Idaho Medicaid %	28.1%	22.8%	30.2%		11.1%	7.8%
Variance	-25.0%	3.4%	7.9%		2.3%	-0.9%
Potential for Unmet Need	Yes	No	No		No	No

Data Source: Medicaid/Optum

Discussion: There are several observations that can be made based on the estimated number of clients served in Idaho by Medicaid and the services they received:

- The percent of medication management services appears to be higher than the national average despite the affirmed shortage in child and adolescent psychiatrists in Idaho. This suggests that physician extenders are filling the psychiatrist gap for the provision of prescriber services (or medication management).
- Psychotherapy appears to be accessed significantly less in Idaho than it is accessed nationally; therefore, additional analysis is needed to determine if the low use of the service is due to lack of providers, lack of geographical access to the providers that exist, lack of awareness of the service, lack of interest in the service or other determinants.

Conclusions

This analysis has revealed some of the gaps in the current infrastructure that must be addressed to move to a system in which all the partners are capturing similar data, using the same naming conventions, have the same definitions for variables and then are able to engage in meaningful data sharing.

Despite the data limitations the following conclusions are derived from this analysis:

- The proportion of children served in Region 7, exceeds the proportion served in the highest populated region, Region 4 for both DBH and Medicaid.
- The percentage of medication management services for Medicaid appears to be higher than the national average despite the affirmed shortage in child and adolescent psychiatrists in Idaho.
- Psychotherapy appears to be accessed significantly less in Idaho than it is accessed nationally.

The initial capacity analysis has revealed several areas that the Data and Reports Committee recommends should be addressed. Over the next one to two (1-2) years more extensive analyses on the system capacity needs for Jeff D Class Members will be conducted and reported. The intent of further study into system capacity will be to uncover information about child, youth and family needs.

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1. Additional analysis needed for comprehensive assessment of current capacity and estimated need to timely provide services and supports in appropriate scope, intensity and duration to Class Members

    - Estimate of need for Child and Family Team (CFT) and Intensive Care Coordination (ICC) services
    - Rates of access by demographics including age, race/ethnicity, diagnosis
    - Gap Analysis by region
    - % spent compared to total healthcare expenditures
    - % spent by level of care
    - Mean $'s spent per person
    - % of change in access to services
    - Analysis of use of other levels of care including but not limited to: peer and family supports, home and community based services, partial hospitalization respite, crisis services hospitalization and residential
    - Analysis of use of psychotropic meds with and without accompanying mental health services
    - Use of services by the foster care and adoptive populations

2. Future analysis may also include solicitation of precise information directly from providers as well. This will provide useful detail regarding provider competencies, interests, scope of practice, specialties, training needs, opportunities for system expansion and other information vital to building a comprehensive network that will meet the needs of the Class Members as described.

3. To further inform system planning the capacity will be further analyzed in terms of how and why various services are being used and which ones were the most effective. To achieve this work Idaho will conduct an in depth need-based planning study of Idaho's current child serving system to identify;

    - How Idaho identifies and serves children and youth with the highest needs and risk behaviors, and how these individuals are linked to outpatient settings.
    - What services are in place now that successfully prevent inpatient hospitalizations.
    - Why children, youth and families do not go to, or stop going to outpatient clinics.
    - Trends in the use of prescribing of psychotropic medications.

Recommendations for Workforce Development:

Based on the result of this initial capacity analysis the initial recommendations for Workforce Development to establish and maintain system capacity are
:

- Continue to analyze and assess current capacity and needed capacity on an ongoing basis based on an in-depth need-based planning study;
- Implement CANS and the TCOM system, which will provide useful data about child, youth and family outcomes;
- Evaluate the cause of apparent capacity issues by region
- Consider setting recruitment goals by region and by type of service needed
- Provide training on practices that are effective (evidence based, evidence informed and proven practices) but not utilized extensively
- Consider establishing staffing models by program type
- Work with local universities to ensure education is focused on areas of need throughout the state and

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- Support primary integration by developing new models of integration and pilot them

Glossary:

Caseness: The degree to which the accepted standardized diagnostic criteria for a given condition are applicable to a given patient

Duration: The length of time a person receives services

Intensity: Level of care, amount of intervention, amount of support provided

Outpatient: Psychotherapy and/or skills building offered in an office, school, or other community setting

Prevalence: The expected rate of occurrence of a mental health disorder or behavior

Proxy Indicators: Indirect measure that approximates or represents a phenomenon in the absence of a direct measure

Scope: The focus of a disorder, the treatment plan work, and services to be provided for a child and family team

Timely: An expected duration between receipt of referral and initiation of services that would not cause undo harm or distress to the individual receiving services

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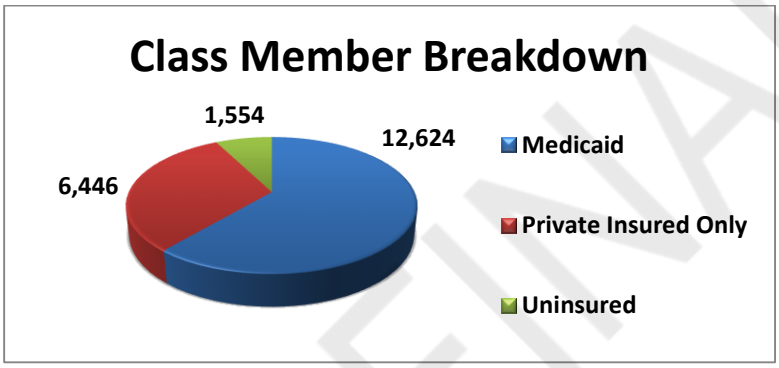
Attachment 1

Jeff D. Projected Class Size

Class Member Defined As:

Children in Idaho, who are under 18 years of age, have a serious emotional disturbance (SED) and a functional impairment.

Projected Total Class Members: ***21,000 (Rounded)***



Methodology:

Using U.S. Census population estimates and Current Population Survey data along with Medicaid historical claim data (children age 0-17, who had at least a frequency of 10 mental health claims/visits within a year and that had an ICD-9 diagnosis that have generally been considered as diagnoses associated with SED), an estimate of the total number of children (0-17) with Serious Emotional Disturbance (SED) that affected their social functionality (estimated by the frequency of mental health claims/visits) was made based on the population distribution of Idaho children (0-17) of those who had Medicaid insurance, private insurance only, and those who were uninsured. In this statewide estimation it was assumed that children who were uninsured had the same SED + affected functionality prevalence rate as those children that had Medicaid insurance and it was assumed that the children who had private insurance only had half of the SED + affected functionality prevalence rate than that of those who were on Medicaid or uninsured.

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YES QUALITY MANAGEMENT IMPROVEMENT AND ACCOUNTABILITY QUARTERLY REPORT

3rd Quarter SFY 2017

June 30, 2017

NOT FINAL

Youth Empowerment Services
Quality Management Improvement and Accountability

Data and Reports Committee
Candace.Fasletti@dhw.idaho.gov

YOUTH EMPOWERMENT SERVICES (YES)

Quality Management Improvement and Accountability (QMIA)Quarterly Report

June 30, 2017

INTRODUCTION

The Youth Empowerment Services (YES)[1] Data and Reports committee is pleased to present the Quality Management Improvement and Accountability Quarterly Report (QMIA-Q). The report is a requirement of the Jeff D Agreement[2] and is a critical aspect of the YES project. The QMIA-Q report was assembled with information about children, youth, and families in Idaho and from data collected by the Department of Health and Welfare's Divisions of Behavioral Health (DBH), Medicaid, and Family and Community Services (FACS), as well as the Idaho Department of Juvenile Corrections (IDJC), and the Idaho State Department of Education (SDE).

The goal of the YES project is to develop, implement, and sustain a family-driven, coordinated, and comprehensive children's mental health delivery system. This enhanced system will lead to improved outcomes for children, youth, and families such as:

- Children and youth being safe, in their own homes, and in school.
- Minimization of hospitalizations and out of home placements.
- Reduction in potential risks to families.
- Avoidance of delinquency and commitment to the juvenile justice system and to receive mental health services.
- Correction or improvement of mental illness, reduction in mental disability and restoration of functioning.

A critical aspect of YES is the development of methods to evaluate how effective Idaho is at achieving the goals of the Jeff D Agreement and to assure accountability by establishing regular stakeholder reporting. The QMIA-Q report will be delivered to YES workgroups to support decision making related to plans for system improvement by building collaborative systems, developing new services, and creating workforce training plans.

The initial QMIA-Q reports will focus on statewide and regional level data to provide stakeholder groups baseline information about the child-serving system in Idaho, including:

- Profiles of Idaho's youth
- Access and barriers to care such as gaps in services

[1] For more information regarding the YES project you may refer to the following website: yes.idaho.gov.

[2] A copy of the Jeff D Agreement you can be located at: http://youthempowermentservices.idaho.gov.

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- Development of youth and family voice and engagement
- Appropriate use of services including utilization of restrictive levels of care
- Effectiveness of services, based on child, youth, and family outcomes
- Cross system linkages based on needs and strengths

The QMIA-Q report will be structured to concentrate on the delivery of care based on five key decision points. These decision points allow us to understand major activities of the system and represent areas of high potential impact in improving children and youth's experience as well as outcomes of care. This methodology for evaluation has been demonstrated to be an effective method to assess complex systems and is the foundation of the Transformation Collaborative Outcomes Management (TCOM) system created by Dr. John Lyons and Dr. Nathaniel Israel and adopted by Idaho.

Five Key Decision Points:

Diagram by provided by Dr. Nathaniel Israel, Chapin Hall, TCOM PowerPoint

Access: This decision point represents a youth and family's experience when entering the system of care. This is where the determination regarding the child/ youth's fit for system services is made. The goal is that youth and families experience timely access to system services.

Engagement: The engagement decision point refers to the assessment of strengths and needs and determining how services might fit these by utilizing maximum youth and family participation throughout the process. The goal here is for youth and families to experience system services as useful and empowering.

Appropriateness: This decision point is present throughout the treatment planning process, where the goal is that routing to services should be focused on individualization regarding both type and intensity. Ongoing youth and family engagement and empowerment is key at this decision point; because service plans will be made based on youth and family needs and strengths.

Effectiveness: The effectiveness decision point refers to ongoing monitoring of services and supports. Continuous evaluation of the effectiveness of services is necessary to make changes based on how

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particular programs are helping. The goal is to ensure increasingly effective services that are efficient at supporting youth and families in meeting their goals.

Linkages: Connections should be made to other services and supports that are needed both during care as well as during transitions. The linkages goal is to ensure that gains experienced during care are meaningful, durable, and sustainable.

Throughout the implementation of YES, there will be ongoing improvements in the QMIA-Q reports. The report will become increasingly collaborative, focused, and informative. Input on the report is welcomed. Please contact YES@dhw.idaho.gov with your questions or concerns.

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YES QMIA QUARTERLY REPORT

This is the third of the YES Quality Management Improvement and Accountability Quarterly (QMIA-Q) reports to be published. This quarter, the QMIA report includes data about Idaho youth and youth risk behaviors, potential gaps in mental health services that may be a barrier to care, family engagement information based on Division of Behavioral Health (DBH) satisfaction surveys, utilization of services and possible unmet needs, use of restrictive levels of care such as hospital and residential services, and client outcomes and linkages.

Profiles of Idaho Youth

One general measure that can be used to assess the current condition of a state is the percentage of students who graduate high school. Per the 2017 County Health Rankings and Roadmaps (CHRR), a report published by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, the percent of Idaho 9th graders on average who graduate in four years is lower than the U.S. average.

Table 1: Rate of Graduation

High school graduation: percent of 9th-graders who graduate in four years			
US. Median	Idaho	Idaho Counties Range	Best County
88%	79%	60%-94%	Valley- 94%

Another measure is youth risk behavior. The Idaho State Department of Education published a report on youth risk behavior as part of the national Youth Risk Behavior Surveillance System (YRBS). The following data on risk behaviors (Figures 1, 2 and 3) are based on responses from 1,760 students in 48 public high schools in 2015.

Figure 1: Mental Health Related Measures

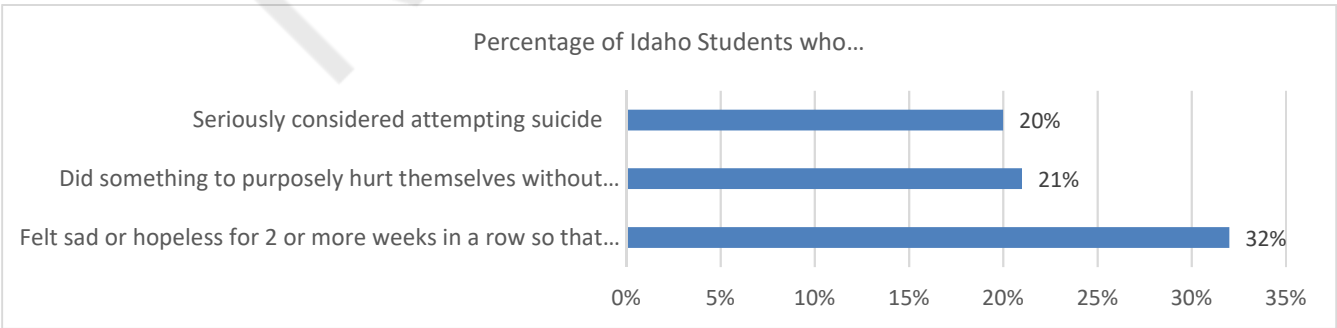

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Figure 2: Percentage of Students Who Seriously Considered Attempting Suicide during Past 12 Months.

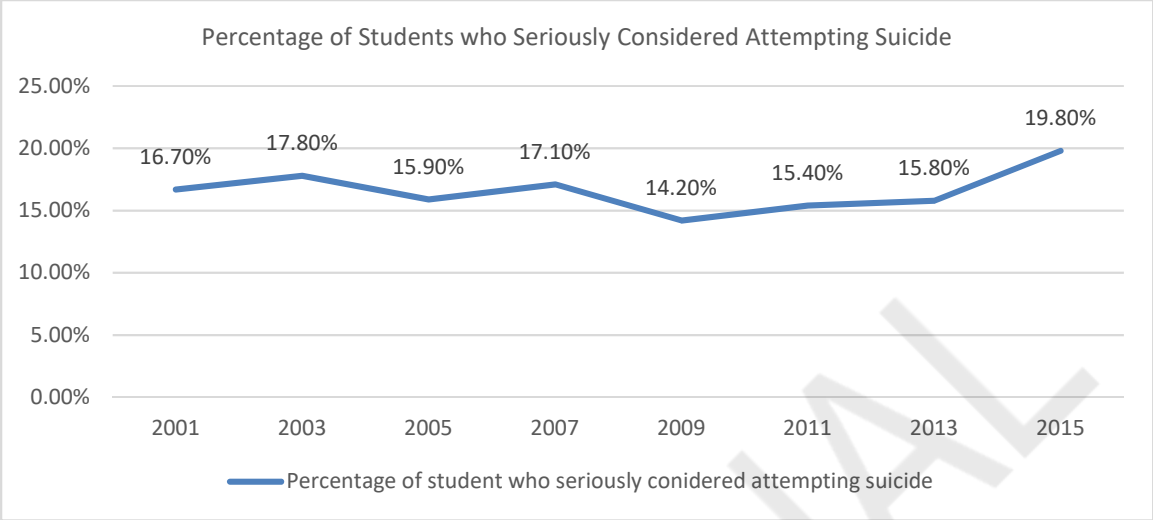
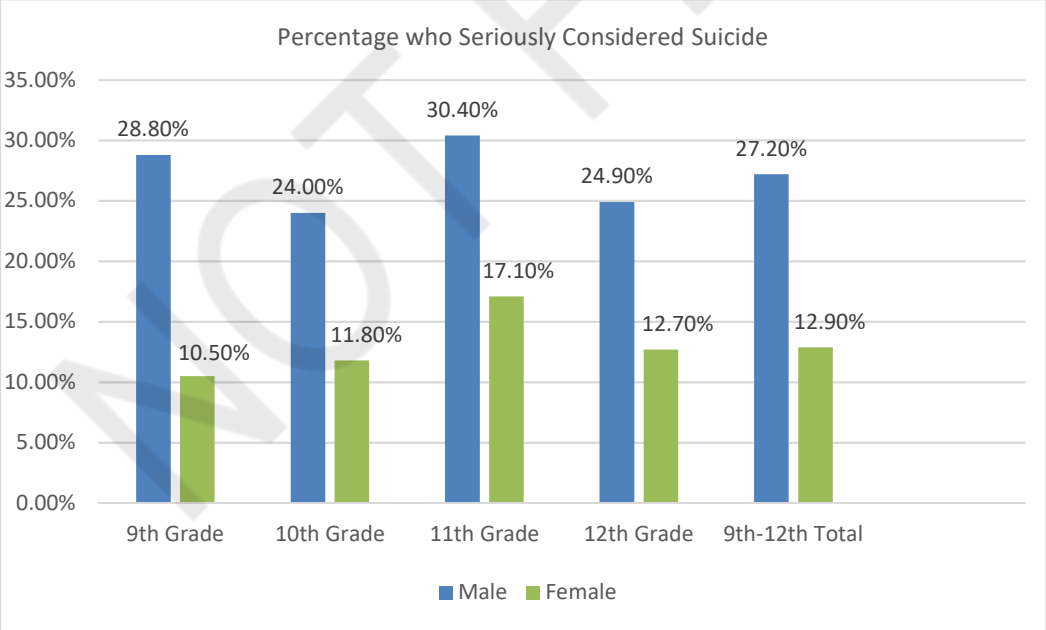


Figure 3: Percentage of Idaho students who Seriously Considered Attempting Suicide During the Past 12 Months by Grade.



While adolescents are generally healthy, this data about risk behaviors for Idaho youth highlights the need for ongoing collaborative work to improve the child-serving system. More information about the YRBS can be attained by contacting the State Department of Education at 208-332-6947.

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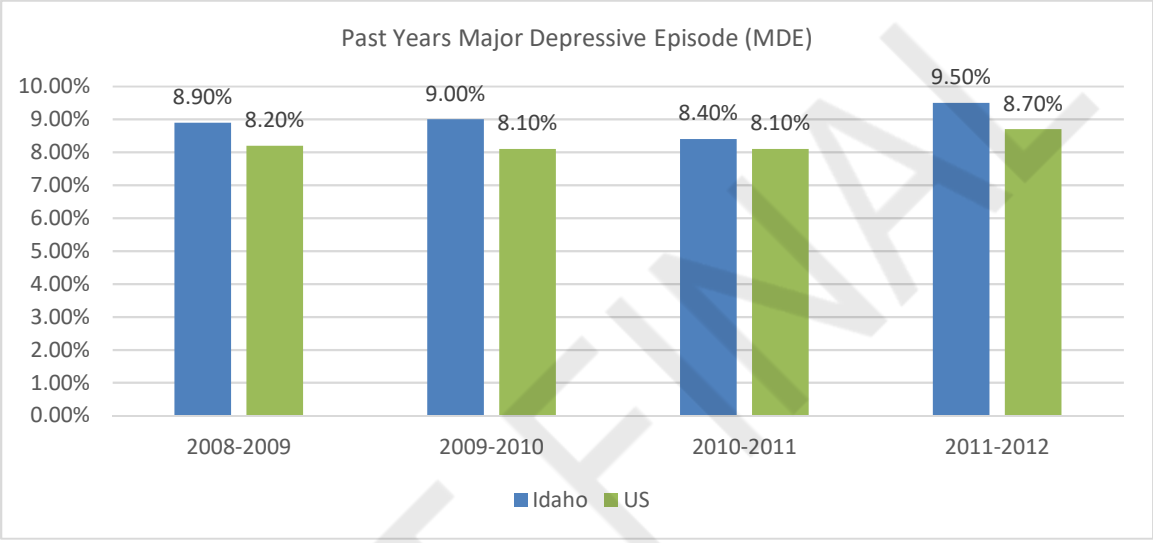
Potential Gaps in Mental Healthcare Services (Access)

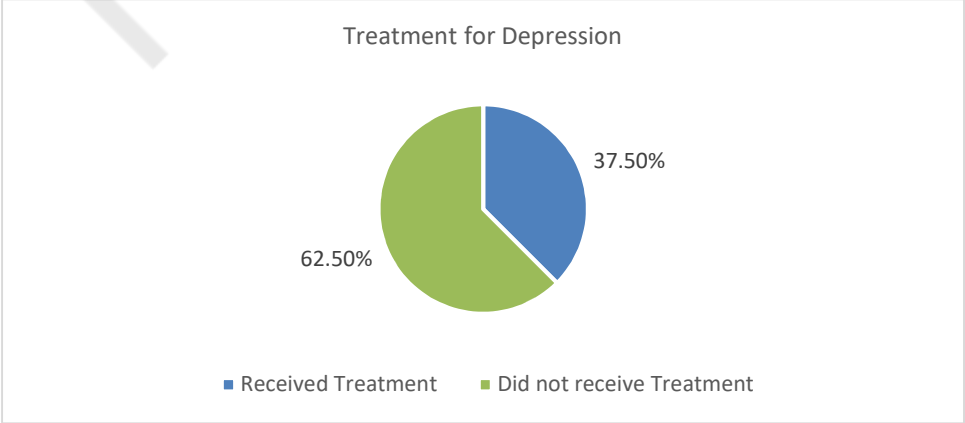
The Behavioral Health Barometer, 2013, a report about all 50 states provided by Substance Abuse and Mental Health Services Administration (SAMHSA), indicates the percentage of people aged 12-17 who have had a Major Depressive Episode (MDE) in the past year. Utilizing this data from SAMHSA, states can compare themselves to the average for the U.S.

Figure 4: Past year Major Depressive Episodes



The SAMHSA report also included information by state about the rate that that youth with a MDE received treatment. In Idaho, only about 37.5% received treatment. It was noted in the report that Idaho's rate of youth with MDE and rate of treatment for MDE are similar to the national rates. In each of the years included in the SAMHSA report, the percentage of youth with MDE in Idaho is slightly higher than the US average.

Figure 5: Treatment for Depression



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The following data about possible gaps in services was previously reported in the last QMIA - Q report (QMIA-Q 3/31/2017) and is being repeated intentionally to ensure that the YES workgroups have a chance to review the data so other stakeholders, who may not have read past QMIA-Q reports, can find the information easily.

Table 2 is a comparison of presumed class members (PCM) who received mental health services and the distribution of Medicaid members across the state (penetration rate). This data can inform those who are developing plans for system improvement of possible geographical areas throughout Idaho that need to focus on reducing barriers and improving access to care.

Table 2: Distribution of Presumed Class Members (PCM) by region

DBH Regions	# PCM	% of PCM	# Medicaid Members	% of Medicaid	Penetration rate
Region 1	1,592	12.0%	29,290	12.5%	5.4%
Region 2	437	3.3%	9,997	4.3%	4.4%
Region 3	2,866	21.6%	52,048	22.2%	5.5%
Region 4	3,189	24.0%	48,662	20.8%	6.6%
Region 5	1,365	10.3%	33,345	14.2%	4.1%
Region 6	1,050	7.9%	19,178	8.2%	5.5%
Region 7	2,793	21.0%	41,979	17.9%	6.7%
Statewide Total	13,292	100.0%	234,499	100.0%	5.7%

In comparing the distribution of Medicaid members to the statewide average of penetration (5.7%), it is possible* that Class Members may be underserved in Regions 1 (5.4%), 2 (4.4%), 3 (5.5%), 5 (4.1%) and 6 (5.5%). These results indicate a need to monitor regional penetration rates to be able to make meaningful service determinations moving forward.

*Please note, this data is not accompanied by a confidence interval (CI) rating, therefore any interpretation should be considered a hypothesis at this time.

Table 3 is a comparison of presumed class members (PCM) served by age and by YES partner agency. This data can inform those who are developing plans for system improvement of possible age groups of children and youth throughout Idaho needing improved access to care.

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Table 3: Distribution of Presumed Class Members by Age

Age	Medicaid	Medicaid	DBH	DBH	FACS	FACS	IDJC	IDJC	SDE*	SDE*
	#	%	#	%	#	%	#	%	#	%
0-4	477	3.6%	6	0.3%	83	16.6%	0	0%	NA	NA
5-9	4,363	32.8%	89	5.3%	119	23.8%	0	0%	203	15.1%
10-13	4,221	31.8%	277	16.6%	104	20.1%	22	10.4%	529	39.4%
14-17	4,231	31.8%	1301	77.8%	194	38.8%	189	89.6%	611	45.%

Percentages shown indicate % of presumed Class Member population each age group represents for each State agency.

Children ages 5-9:

- May be underserved in DBH. It is notable that this discrepancy may be due to the target population for DBH services being those in crisis or court-ordered.
- May be under-identified in FACS and in schools.

Children/youth ages 10-13:

- May be underserved in DBH. As noted previously, this may be due to the target population being those in crisis or court ordered.
- May be under-identified in FACS.

Youth ages 14-17:

- Expected prevalence is 21.4% to 22.2% for a mental illness.
- May be underserved in less restrictive levels of care as they make up the largest number of children and youth in any age group in DBH, FACS, and SDE.

**Please note SDE data has been updated to reflect Idaho State Department of Education 618 Part B Child Count Report 2015-2016. Previous QMIA report data was sourced from 2014-2015 report.*

Youth and Family Engagement

Youth and family engagement is one of the foundations of the transformation planned in the YES project. One way to assess the progress in this area is to review client feedback on core engagement practices. This feedback can lead to identification of and need for training on engagement practices.

DBH administers an annual satisfaction survey to families of children and youth receiving its services. The survey instrument is the Youth Satisfaction Survey for Families (YSS-F). In the most recent survey, the results on several items related to family engagement are noted in Table 4.

*Although the response rate for this survey is quite low (n=41), it is consistent with the National average survey response rate. Generally, this response pool would be considered of low reliability and statistical significance, therefore we are not considering this sample an accurate representation of our

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state. It is important to note, however, that these results are meaningful and were therefore included here because time was taken by families to complete this survey and share their experiences, which all have value. The below data allows us limited insight into youth and family perception of our current service delivery system. As we move forward in this system transition, we will see a myriad of comprehensive, significant and reliable data become available.

Table 4: Youth Satisfaction Survey – Family version Outcomes, SFY 2016.

YSS-F Items	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable
I helped to choose my child's treatment goals.	21 (51.22%)	10 (24.39%)	1 (2.44%)	4 (9.76%)	3 (7.32%)	2 (4.88%)
I was given the opportunity to participate in my child's treatment.	22 (53.66%)	13 (31.71%)	2 (4.88%)	2 (4.88%)	1 (2.44%)	1 (2.44%)
Staff members were willing to see my child as often as I felt was necessary.	19 (46.34%)	13 (31.71%)	4 (9.76%)	3 (7.32%)	2 (4.88%)	0 (0%)

Appropriateness

An appropriate use of services is demonstrated by a match between needs and strengths to services that are sufficient to effectively address client intensity and types of needs. The data regarding current services delivery and utilization can be used to assess system gaps for additional and/or alternative types of services that may be needed.

One method to measure the appropriate use of services is a comparison of services used in Idaho to the national average.

Table 5: Comparison of State and National Medicaid Behavioral Health Utilization of Specific Services

	Members Currently Served by Division of Medicaid and Behavioral Health Type of Service					
	Individual Therapy by Non-Prescriber	Family Therapy	Medication Management		MH Assessment/ Tx. Plans	Case Mgmt.
			Psychiatric Diagnostic Evaluation	Prescriber Visits		
National %	53.1%	19.4%	22.3%		8.8%	8.7%
Idaho Medicaid %	28.1%	22.8%	30.2%		11.1%	7.8%
Variance	-25.0%	3.4%	7.9%		2.3%	-0.9%

- The percentage of medication management services for Medicaid appears to be higher than the national average despite the affirmed shortage in child and adolescent psychiatrists in Idaho.
- Psychotherapy appears to be accessed significantly less in Idaho than it is accessed nationally.

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Another measure of appropriateness of care available in Idaho is the rate of evidence-based practices (EBPs) used in Idaho by DBH compared to national rates. Per the Mental Health and Substance Use Report on Expenditures and Services (MHEASURES) report, there is a comparison of two EBPs used in Idaho to national stats:

- Multi-systemic Therapy (MST): 4.6% nationally, 3.6% Idaho
- Functional family therapy (FFT): 4.8% nationally, 5.6% Idaho

Another EBP used in Idaho by DBH is Parenting with Love and Limits (PLL).

Table 6: Count of Families by Region served by Parenting with Love and Limits (PLL) fiscal year to date March 2017:

	PLL (SED)							Statewide total
Regions	1	2	3	4	5	6	7	
# families enrolled	13	14	9	23	27	17	31	134

As of March 2017, DBH has served 13 families in Region 1, 14 from Region 2, 9 families in Region 3, 23 from Region 4, 27 from region 5, 17 from region 6 and 31 families from region 7 (fiscal year to date.)

Effectiveness

Service effectiveness means that services are effective and efficient at supporting clients in meeting their goals. The more that children, youth, and families must depend on access to more restrictive levels of care, the more likely it is that the system may not be effectively or efficiently providing less restrictive levels of care. An example of this would be a child or youth who has been placed in a residential facility, but based on their needs, could be living at home if they had appropriate and effective community supports. For this reason, measures of effectiveness include assessing the use of restrictive levels of care. The following is current utilization information regarding children and youth who are involved in the DBH system.

Estimates show that approximately 50 to 75 percent of the 2 million youth (nationally)encountering the juvenile justice system meet criteria for a mental health disorder. Approximately 40 to 80 percent of incarcerated juveniles have at least one diagnosable mental health disorder (International Journal of Environmental Research and Public Health; Mental Illness and Juvenile Offenders, 2016).

Table 7 provides data about the use of Idaho Statute 20-511A which is a rule whereby a judge can order DHW to submit to the court a mental health assessment and a plan of treatment for a youth. Data is for fiscal year to date (YTD) through March 2017.

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Table 7: Utilization of Rule 20-511A

	20-511A							Statewide total
Regions	1	2	3	4	5	6	7	
20-511A utilization	30	26	39	93	53	30	92	363

System of Care (SoC) outcomes analysis has shown that youth and family engagement within an SoC model results in children and youth who are less likely to receive psychiatric inpatient services and are less likely to visit an ER for behavioral and/or emotional issues (National Technical Assistance Center for Children's Mental Health; Return on Investment in Systems of Care for Children with Behavioral Health Challenges, 2014). As our system transforms, a goal is to see a downshift in service-utilization to less restrictive, community-based program environments.

Tables 8 and 9 provide information about the use of hospitalization in State Hospital South and the use of Residential Services (out of home Placements). This data will be tracked and trended over time to assess changes in the utilization of these intensive services. Data is YTD.

Table 8: Utilization of State Hospital South (SHS):

	State Hospital South Usage							Statewide total
Regions	1	2	3	4	5	6	7	
# of utilizers	8	2	19	32	11	3	9	84

The above table shows the number of children/youth utilizing State Hospital South categorized by region.

Table 9: Utilization of Residential placements:

	Residential Placements							Statewide total
Regions	1	2	3	4	5	6	7	
# of placements	3	4	7	18	3	4	1	40

The above table shows the number of children/youth in residential placements categorized by region.

Linkages

The final category of data for this QMIA-Q is associated with cross-system linkage. This initial data is limited to data from the DBH client satisfaction survey. The items from the survey below indicate how the family felt about the effectiveness of the support they received that allowed them to experience gains that are meaningful in their communities.

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DBH administers an annual satisfaction survey to families of children and youth receiving services from DBH. The survey instrument is the Youth Satisfaction Survey for Families (YSS-F). In the most recent survey, the results on several items related to linkages are noted in Table 10.

*Although the response rate for this survey is quite low (n=41), it is consistent with the National average survey response rate. Generally, this response pool would be considered of low reliability and statistical significance, therefore we are not considering this sample an accurate representation of our state. It is important to note, however that these results are meaningful and were therefore included here because time was taken by these families to complete this survey and share their experiences, which all have value. The below data allows us limited insight into youth and family perception of our current service delivery system. As we move forward in this system transition, we will see a myriad of comprehensive, significant and reliable data become available.

Table 10: Youth Satisfaction Survey – Family version Outcomes, SFY 2016.

YSS-F Items	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable
My child is better at handling daily life	10 (24.39%)	18 (43.9%)	4 (9.76%)	5 (12.2%)	2 (4.88%)	2 (4.88%)
My child gets along better with family members	10 (24.39%)	16 (39.02%)	7 (17.07%)	2 (4.88%)	4 (9.76%)	2 (4.88%)
My child is better able to do things he or she wants to do	5 (12.2%)	19 (46.34%)	7 (17.07%)	4 (9.76%)	4 (9.76%)	2 (4.88%)

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Glossary

- **Child and Adolescent Needs and Strengths (CANS):** A tool used in the assessment process that provides a measure of a child's or youth's needs and strengths.

- **Class Member**: Idaho residents with a serious emotional disturbance (SED) who are under the age of 18, have a diagnosable mental health condition, and have a substantial functional impairment.

- **ED:** ED is an acronym for an emotional disturbance used by schools. An IDEA disability category in which a student has a condition exhibiting one or more of five behavioral or emotional characteristics over a long period of time, and to a marked degree, that adversely affects educational performance. The term *does not* include students who are socially maladjusted unless it is determined they have an emotional disturbance. The term emotional disturbance *does* include students who are diagnosed with schizophrenia.

- **IEP:** The Individualized Education Plan (IEP) is a written document that spells out a child or youth learning needs, the services the school will provide and how progress will be measured.

- **Jeff D. Class Action Lawsuit:** The Settlement Agreement that ultimately will lead to a public children's mental health system of care (SoC) that is community-based, easily accessed and family-driven and operates other features consistent with the System of Care Values and Principles.

- **Parties:** The litigants in the Jeff D Lawsuit.

- **Presumed Class Member (PCM):** A presumed Class Member is a child, or youth who is currently receiving publicly funded mental health services and who may meet the criteria to be a Jeff D class member based on proxy indicators.

- **QMIA:** A quality management, improvement, and accountability program.

- **Penetration Rate:** The degree to which a defined population is served, calculated by dividing those served by the total population which matches the defined population.

- **Plaintiffs**: Representatives of those children, youth, and families who brought the Jeff D. legal action and their counsel.

- **Serious Emotional Disturbance (SED)**: The mental, behavioral, or emotional disorder that causes functional impairment and limits the child's functioning in family, school, or community activities. This impairment interferes with how the youth or child needs to grow and change on the path to adulthood, including the ability to achieve or maintain age-appropriate social, behavioral, cognitive, or communication skills.

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- **Settlement Agreement (Jeff D. Settlement Agreement):** The contractual agreement agreed to between the parties to the Jeff D. class action lawsuit for a resolution to the underlying dispute.

- **SFY**: The acronym for State Fiscal Year which is July 1 to June 30 of each year. The noted year indicates the year at the end of June.

- **System of Care:** An organizational philosophy and framework that involves collaboration across agencies, families, and youth for improving services and access, and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children.

- **TCOM**: The Transformational Collaborative Outcomes Management (TCOM) approach is grounded in the concept that the different agencies that serve children all have their own perspectives and these different perspectives create conflicts. The tensions that result from these conflicts are best managed by keeping a focus on common objectives — a shared vision. In human service enterprises, the shared vision is the person (or people served). In health care, the shared vision is the patient; in the child serving system, it is the child and family, and so forth. By creating systems that all return to this shared vision, it is easier to create and manage effective and equitable systems.

- **Youth Empowerment Services (YES)**: The name chosen by youth groups in Idaho for the new System of Care that will result from the Children's Mental Health Reform Project.

- Other definitions can be found at http://youthempowermentservices.idaho.gov/Portals/105/Documents/YESWebglossary.pdf

Of special note:
Comparison for SED and ED
These two terms are similar but are not synonymous.

- SED is an acronym for a serious emotional disturbance used by the child-serving mental health system. SED refers to a level of emotional disturbance that causes functional impairment and limits the child's functioning in family, school, or community activities. This impairment interferes with how the youth the child needs to grow and change on the path to adulthood, including the ability to achieve or maintain age-appropriate social, behavioral, cognitive, or communication skills. SED in Idaho is defined in state rule 16.03.09.852.01.A.
- ED is an acronym for an emotional disturbance used by schools. An IDEA disability category in which a student has a condition exhibiting one or more of five behavioral or emotional characteristics over a long period of time, and to a marked degree, that adversely affects educational performance. The term *does not* include students who are socially maladjusted unless it is determined they have an emotional disturbance. The term emotional disturbance *does* include students who are diagnosed with schizophrenia.

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Step 2 Unmet Service Needs and Current Gaps - Instructions

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

Identification of Data Sources Used to Identify Needs and Gaps

The U.S. Census Bureau (2016) estimates that Idaho's population is 1,683,140, with a 2015 estimate of 91.7% white persons; 0.6% black; 1.3% American Indian/Alaska Native; 0.1% Native Hawaiian or Pacific Islander; 2.6% reporting two or more races; 11.8% Hispanic and 83.1% white, not Hispanic. The United States Census Bureau estimated that Idaho has 20 residents per square mile, compared to a national average of 87.4 per square mile. Idaho has twenty-two rural counties (less than 100 persons per square mile), nineteen frontier counties (i.e., less than seven per square mile) and three urban counties (More than 100 persons per square mile). Idaho ranks 11th in area size of the fifty states, with 82,643 square miles and diverse areas that include wilderness, mountains, deserts, farmland and canyons. The Idaho Department of Labor's jobless report indicated a 3.2 unemployment rate in May 2017, with an estimated 2016 average unemployment rate of 3.8 percent.

Multiple sources of data, and input from the State Behavioral Health Planning Council, help provide information on Idaho's behavioral health unmet service needs and critical gaps. Data is also included from the state's Youth Empowerment Services project to reform Idaho's Children's Mental Health service delivery system. Additionally, information is included on the $2 million Idaho's Response to the Opioid Crisis grant program that will help address needs in Idaho for individuals with an opioid use disorder. Information on unmet service needs and critical gaps in Idaho's substance use disorder prevention system is included in a separate response.

The WITS system was implemented October 1, 2009 for collection of Adult Mental Health (AMH) data for public services provided through regional mental health center (RMHC) sites and October 1, 2013, for all SUD Network providers. Implemented in SFY 2009, the VistA data infrastructure system is used by State Hospital South (SHS) and State Hospital North (SHN). The Division has an Interagency Agreement with the Idaho Division of Vocational Rehabilitation (IDVR), and IDVR provides monthly reports on employment services provided to shared clients. Employment data is extracted from WITS for federal reporting on the National Outcome Measures (NOMS). The Office of Consumer and Family Affairs (OCAFA) provides monthly reports of services for consumer and family advocacy/education, peer specialist certification and Programs for Assistance in Transition from Homelessness (PATH) outreach, engagement and case management activities provided by PATH peer specialists. Children's mental health data is collected and extracted from WITS. Consumer survey information is based on annual and end of service MHSIP and YSS-F survey requests. Regional computer kiosks provided easier access for service recipients to complete these surveys. Medicaid data must be

requested. Medicaid's contract with the data management vendor, Molina, began in May 2010. This system handles Medicaid service and billing data.

The Substance Use Disorders treatment (SUD) program also gathers and reports data from several sources. The National Survey on Drug Use and Health (NSDUH) provides Idaho specific data to evaluate incidence and prevalence of substance abuse and to estimate populations in need of substance use disorders treatment services. The Division of Health implements the Youth Behavioral Risk Survey (YRBS) and the Behavior Risk Factor Surveillance System (BRFSS), and this data is useful for substance use disorder treatment needs assessments and planning. Substance use disorder service provider treatment data is collected in the WITS data system.

The SUD treatment data is used to create a number of standard reports that are utilized for State planning and assessment. Standard reports include State Utilization Management and Grant Data; Level of Care Capacity and Census Management; Budget Tracker; Treatment Completion Data; Length of Stay Report; County/Regional Utilization Report; Pregnant Women with Children (PWWC) Chart Audit Results and Client, Provider & Stakeholder Satisfaction reports. Each of the seven regions in Idaho has a Regional Behavioral Health Board that provides an annual report and updated information to help determine regional and local treatment needs, emerging trends, gaps in service and the need for programs and services in regions throughout the State. During SFY 2018-2019, the Department plans to continue use of the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), YRBS, BRFSS, substance use disorder treatment data and information from regional behavioral health boards to assess SUD treatment needs in Idaho.

Idaho implemented the full WITS system for the SUD Treatment Services Delivery System in October 2013. This allows contracted network treatment providers to use WITS to assess clients, manage treatment, bill for services and collect outcome measurement data in real-time. All contracted network providers are required to utilize WITS as their electronic health record and to track and submit claims for payment of state funded community substance abuse services. The managed care service contractor maintains the adjudication process in WITS and providers are paid based upon the submitted and accepted claims in WITS. Additionally, the Department's contract with Chestnut Health Systems allows for the Global Appraisal of Individual Needs (GAIN) SS to be used for all client screenings and the GAIN-I for all clinical assessments. The Idaho State Epidemiological Outcomes Workgroup (SEOW) is composed of state agency staff and community stakeholders (Idaho Prevention Fellow, researchers) with an interest in the substance abuse prevention system. In regards to prevention, the SEOW operates as an ad hoc research resource for policy decision makers. Additionally, the group maintains a web dissemination resource for more general data related questions.

In SFY 2018-2019, the Office of Drug Policy is responsible to contract for SUD prevention programs.

The Division has fully implemented WITS and developed standardized Dashboard reports which include 28 data analyses and reports utilized by DBH administration and regional program managers to monitor and inform services in the community regional behavioral health programs.

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Data is collected regarding priority populations including, access to care, enrollment, and discharges. Data is utilized to inform and support legislative proposals, grant reporting, budget allocations, supervision, and quality assurance. Efforts are underway to create a data sharing mechanism between WITS and the IDJC database to exchange necessary client data for common clients. WITS completed the conversion for DSM-5 to ICD-10 in 2015.

Unmet Service Needs and Critical Gaps

According to the U.S. Census Bureau data for 2015, Idaho's total population estimate was 1,616,547, with an estimate of 1,186,901 aged 18 or older and an estimate of 429,646 under age 18. The SAMHSA/CMHS estimation methodology establishing prevalence indicates percentages for adults at 5.4% for Serious Mental Illness (SMI) and 2.6% for Serious and Persistent Mental Illness (SPMI). Five percent of the estimated SMI population is estimated to be homeless. Five percent of children/adolescents are estimated to have serious emotional disorder (SED) diagnoses. Based on these percentage estimates, it may be concluded that there are 64,093 adults in the state of Idaho with serious mental illness, 30,859 adults in the state of Idaho with serious and persistent mental illness, 3,205 adults with SMI who are also homeless and 21,482 children with serious emotional disorder diagnoses. Idaho's TEDS data for 2015-2016 indicates a treatment admission rate of 7,443 aged 12 and older; an estimated 540 admitted per 100,000 population aged 12 and older; 2,518 primary alcohol admissions and 1,355 primary marijuana admissions.

The information below represents the best estimates of the Idaho Department of Health and Welfare's Division of Behavioral Health (Division), based on available data and reflects the limitations of our reporting and information systems.

Calculated Estimates	**Total Population**	**% Estimate**	**Estimated Value**
Number of adults with SMI	1,186,901	5.67%	67,298
Number of adults with SPMI	1,186,901	2.60%	30,859
Number of adults with SMI who are homeless	67,298	5.00%	3,365
Number of children with SED	429,646	3.28%	14,082
Number of adults residing in rural/frontier counties*	626,388	---	626,388
Number of adults with SMI residing in rural/frontier counties*	67,298	52.78%	35,520
Number of children residing in rural/frontier counties*	228,691	---	228,691
Number of children with SED living in rural /frontier counties*	14,082	53.23%	7,496
Number of older adults with SMI (age 65 and older)	67,298	18.77%	12,632
Number of older adults residing in rural/frontier counties*	125,040	---	125,040

**52.78%=Number of adults residing in rural/frontier counties divided by the number of adults
**53.23%=Number of children residing in rural/frontier counties divided by the number of children
**18.77%=Number of older adults (age 65 and older) divided by the number of adults

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The State Behavioral Health Planning Council, with input from seven statewide Regional Behavioral Health Boards, is tasked with monitoring and evaluating the gaps and needs of the behavioral health service delivery system in Idaho. The Planning Council, in partnership with the Regional Behavioral Health Boards, completed a gaps and needs analysis for 2016 which was submitted to the Governor, Legislature and Judiciary in the Planning Council's SFY2016 annual report. The annual report is included as an attachment (State Behavioral Health Planning Council Annual Report 2016). The planning council changed its reporting period during this time to better align with the convening of Idaho's Legislature each January, so the analysis does not encompass the entirety of SFY 2017.

The Planning Council, upon reviewing the reports of the Regional Behavioral Health Boards, detailed the following statewide trends regarding barriers to both accessing services and maintaining recovery in Idaho:

Barriers to Accessing Services

- Lack of consistent, reliable telehealth services.
- Lack of providers (psychiatrists, as well as other behavioral health providers), especially in rural areas.
- Lack of access to services for non-criminal justice, at-risk youth and adults
- Lack of collaboration among providers about mental health and physical health needs (often due to system limitations, not the choice of the professional).
- Lack of access to insurance coverage for the "gap" population.

Barriers to Maintaining Recovery

- Lack of housing, including traditional housing (especially for women and families) and models with more supervision for high risk patients with complex medical and co-occurring conditions transitioning out of hospital settings.
- Lack of consistent, reliable transportation.
- Lack of supported employment for those with the most serious mental health challenges.
- Stigma often limits access to opportunities that are currently available.
- Lack of family engagement for youth during treatment (due to a variety of issues including not being able to take off time from work, lack of transportation for parents, lack of understanding about the treatment process, etc.).

Sample of Regional Gaps and Needs Analysis (Complete document attached as G&N 2016 Report)

Regional Behavioral Health Board Gaps and Needs Analysis 2016

<u>Population Specific Concerns</u>

Mental Health Services

- Limited access in frontier and rural areas
- Limited Spanish-speaking treatment providers
- Lack of treatment long-term treatment options for individuals with a dual mental health and substance use disorder diagnosis

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- Need for Behavioral Health Crisis Centers in all regions

Substance Use Disorder Services

- Limited access in rural and frontier areas
- Siloed funding structure
- Lack of treatment resources for youth not involved with juvenile justice system
- Need for long-term treatment options for individuals with a dual mental health and substance use disorder diagnoses
- Need for more detox facilities
- Need for SUD residential treatment options for longer than 30 days

Children's Behavioral Health Services

- Limited access in rural and frontier areas
- Children and youth specialty courts (mental health court or drug court)
- Lack of services for non-criminally involved at-risk youth
- Need for more child psychiatrists
- Need for therapeutic foster homes
- Reduction in Community Based Rehabilitation Services (CBRS)
- Need for school-based MH/SUD services including prevention and early intervention
- Need for parent education and training

System Concerns

- Need better integration and collaboration between MH and SUD services within the Medicaid/Optum system, as well as treatment and services for those with dual diagnosis (SUD and MH)
- Improved process needed for behavioral health crisis center approval and development
- Additional training needed to increase number of trauma-informed care providers
- Few outcome measures available on program and educational effectiveness
- Inadequate prevention funding and services
- Need for increased suicide prevention training
- Lack of clarity around desired outcomes from behavioral health authority
- Need for increased education of first responders on working with mentally ill children and their families
- Need for an integrated and collaborative behavioral health and physical health model
- Need for urban and rural transitional services for youth and adults

Gaps in Support Services

- Limited housing options, including housing for women, rural housing, and transitional and supportive housing
- Limited transportation availability limits access to treatment and support services
- Need for connection to employment resources for mental health and substance use clients
- Support needed for children of incarcerated parents
- Need for case management for uninsured clients
- Sustainability of Recovery Community Centers

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Gaps in Clinical Services

- Need for increased respite care (children and adult)
- Need for additional crisis services (children and adult)
- Need for increased inpatient services for youth

Other Needs

- Psychiatrist salaries below national standards
- Additional resources needed for community supervision of those on probation or parole
- Resources to address stigma
- Increased need for criminal justice diversion programs for low-risk offenders with mental health and substance use issues
- Need for collaboration between school districts, juvenile justice, the behavioral health authority and providers on resources available to children

Statewide Assessment of Idaho's Publicly Funded Adult Mental Health System

Idaho will be working with the Western Interstate Commission for Higher Education (WICHE) to commission an updated assessment of Idaho's publicly-funded adult mental health system. The goals of the report are to:

- Update the WICHE evaluation completed in 2008, titled "Idaho Behavioral Health System Redesign: Findings and Recommendations for the Idaho State Legislature."
- Assess the adult mental health system of care Idaho currently has in place, initiatives that are currently under development, and the state's overall needs.
- Conduct strategic planning to determine the steps needed to accomplish the state's overall needs for its adult mental health system.
- Evaluate the work done by the Idaho Department of Health and Welfare's Division of Behavioral Health for its effectiveness and efficiencies, and determine critical areas of focus.

Idaho's Response to the Opioid Crisis (IROC)

In the Centers for Disease Control and Prevention's (CDC's) VitalSigns Fact Sheet "Opioid Prescribing: Where You Live Matters" (July 2017), a map displayed the amount of opioids prescribed per person in counties across Idaho and the United States. The map is attached as CDC Opioid Prescribing Map, and is also available online: https://www.cdc.gov/vitalsigns/opioids/infographic.html#graphic-b .

As the CDC notes with the graphic: "Higher opioid prescribing puts patients at risk for addiction and overdose. The wide variation among counties suggests a lack of consistency among providers when prescribing opioids." The map indicates counties with the highest prescribing rates in Idaho were in the following parts of the state: south-central and south-east Idaho, portions of central Idaho, and counties in Idaho's northern panhandle.

In 2017, Idaho applied for and was awarded a $2 million SAMHSA State Targeted Response to the Opioid Crisis grant, to implement a program named Idaho's Response to the Opioid Crisis (IROC). Through the preliminary efforts of the needs assessment and strategic plan for the IROC project, the communities of focus at highest risk were identified as:

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- Uninsured: those who are uninsured and of low socioeconomic status who also meet diagnostic criteria for Opioid Use Disorder (OUD). Idaho does not have expanded Medicaid and has identified a gap population of 78,000 uninsured adults.
- 18-36-year-old age group: "Idaho ranks fourth nationally for nonmedical use of prescription pain relievers by persons 12 years and older" (Olson, 2016). Within that community, a special emphasis will be placed on individuals between the ages of 18 and 36 years of age because of their higher prevalence of OUD compared to that of other age groups.
- Criminal Justice Reentry: People who are criminal justice-involved and are reentering society either from jail or prison will be another emphasis within the communities of focus because of the potential for accidental overdose from returning to use following a period of abstinence.

The comprehensive demographic profile of this population in the local area was obtained from relevant Treatment Episode Data Set (TEDS) information during the Federal Fiscal Year (FFY) 2016, in addition to empirical data from reputable research and statistical entities, which are cited in the IROC Project Narrative File, which is included as an attachment.

Idaho's communities of focus for the IROC project are represented by the following age demographics:

Age Demographic	**Prevalence of Opioid Use Disorder**
14-17	23.53%
18-24	32.92%
25-36	30.62%
37 and older	14.71%

Idaho's communities of focus for the IROC project are represented by the following insurance demographics:

Insurance Type	**Percent of the communities of focus**
Blue Cross/Blue Shield	1.60%
Health Maintenance Organization (HMO)	0.07%
Medicaid	3.70%
Medicare	1.23%
None	89.26%
Other (e.g., TRICARE)	3.63%
Private Insurance (other than BCBS or HMO)	0.51%

Note: Those individuals indicating an insurance coverage other than "None" qualified for a financial hardship due to not being able to afford their deductible/co-pay or not having a provider who accepts their coverage within 30 miles of their residence.

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Idaho-specific data from SAMHSA's 2013-14 National Survey on Drug Use and Health (NSDUH), indicates the following measures (Center for Behavioral Health Statistics and Quality, 2014):

Measure	Total:	Age Groups		
		12-17:	18-25:	26 or older:
PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT				
Illicit Drug Dependence	20,000	3,000	7,000	11,000
Illicit Drug Dependence or Abuse	31,000	5,000	10,000	16,000
Alcohol Dependence	41,000	2,000	10,000	30,000
Alcohol Dependence or Abuse	88,000	5,000	22,000	61,000
Alcohol or Illicit Drug Dependence or Abuse	109,000	8,000	25,000	76,000
Needing But Not Receiving Treatment for Illicit Drug Use	28,000	5,000	9,000	14,000
Needing But Not Receiving Treatment for Alcohol Use	83,000	5,000	20,000	59,000

Youth Empowerment Services: Implementing a new system of care for Idaho children and youth

In 2015, as a result of mediation and a settlement agreement in the Jeff D. Class Action lawsuit, Idaho began work on a collaborative effort with state partners to implement a new system of care for Idaho's children and youth with Serious Emotional Disturbance (SED). The project, called Youth Empowerment Services, will become a sustainable system of care providing public sector children's mental health services by 2020. Full implementation will be followed by three years for proving sustainability.

The new system of care will embody the following principles of care:

- Family-centered by emphasizing family strengths and maximizing family resources
- Family & youth voice and choice are intentionally utilized throughout the process
- Strengths-based services and supports
- Individualized care that emphasizes the unique strengths and needs of the child and the child's family Team-based with the parents included as active participants on the team
- Array of community-based services available to meet the unique needs of child & family
- Collaboration across all child-serving systems from treatment planning to policy establishment and monitoring of these policies
- Early identification and interventions made available in a variety of settings
- Outcome-based to measure success of treatment plans and services
- Unconditional commitment from providers to achieve goals of the treatment plan
- Culturally competent services that respect individual's culture and preferences

Noticeable changes to services include:

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1. The assessment process will include a new tool (CANS—Child and Adolescent Needs and Strengths) for measuring the child's needs and strengths, as well as the family's. The process will help determine the mental health diagnosis as well as the level of functional impairment.
2. The treatment planning process will utilize a Child & Family Team (CFT) approach that allows the family to drive the creation of the plan.
3. Choices in available services which are being implemented in a phased-in approach from January, 2018 until May, 2020.
4. The review process will include the CFT for noting the changes that have occurred in the child's behavior and developing plans to address such changes.

The YES project is a collaboration between the Department of Health and Welfare's Divisions of Behavioral Health (DBH), Medicaid, Welfare and Family and Community Services (FACS); the Idaho Department of Juvenile Corrections; the Idaho State Department of Education; Jeff D. plaintiffs and attorneys; and a network of parent representatives with lived experience navigating Idaho children's mental health system. The YES project currently has ten workgroups, as well as a number of sub-workgroups, with representation from the partnering entities. It also has an Interagency Governance Team and a Quality Management Improvement and Accountability (QMIA) Council, with additional sub-committees.

The YES QMIA Data and Reports Committee completed a system capacity analysis report in January 2017 that projected an estimated 21,000 class members who could qualify for services under the YES program. The report (attached as YES Capacity Report January 2017) also indicated that "It is notable however that this projection includes 6446 children and youth who are privately insured and that is unknown how many children or youth who are privately insured will choose to utilize the public mental health system for services."

Class Members are defined as Idaho residents with a serious emotional disturbance (SED) who are under the age of eighteen (18), have a diagnosable mental health disorder based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) and have a substantial functional impairment.

The capacity report's executive summary provides some information about the analyses of gaps and needs that have been done and will continue to be conducted during the implementation of the YES program.

From YES Capacity Report January 2017 Executive Summary

This capacity analysis has revealed some of the gaps in the current data capture infrastructure that must be addressed to move toward a system in which all the partners are capturing similar data, using the same naming conventions, have the same definitions for variables and then are able to engage in meaningful data sharing. Despite the noted data limitations, the following conclusions were derived from this analysis:

- The proportion of children served in Region 7, exceeds the proportion served in the highest populated region, Region 4 for both DBH and Medicaid.

- The percent of medication management services for Medicaid appears to be higher than the national average despite the affirmed shortage in child and adolescent psychiatrists in Idaho.
- Psychotherapy appears to be accessed significantly less in Idaho than it is accessed nationally.

Over the next one to two (1-2) years more extensive analyses on the system capacity needs for Jeff D Class Members will be conducted and reported. The intent of further study into system capacity will be to uncover more in-depth information about child, youth and family needs, and how the system is able to meet those needs.

Information gleaned from this report will be utilized for system planning, specifically for workforce development. Based on the result of this initial capacity analysis, the recommendations for planning for workforce development in order to maintain and enhance system capacity are:

- Continue analyze and assess current capacity and needed capacity on an on-going basis based on an in-depth need-based planning study
- Implement Child and Adolescent Needs and Strengths (CANS) and the Transformational Collaborative Outcomes Management (TCOM) system which will provide useful data about child, youth and family outcomes
- Evaluate the cause of apparent capacity issues by region
- Consider setting recruitment goals by region and by type of service needed
- Provide training on practices that are effective (evidence based, evidence informed and proven practices) but are currently not utilized extensively
- Consider establishing staffing models by program type
- Work with local universities to ensure education is focused on areas of need throughout the state.
- Support primary integration by developing new models of integration and pilot them

The YES QMIA Data and Reports Committee also completed a YES QMIA Quarterly Report in June 2017 (attached as YES QMIA Quarterly Report June 2017). The report detailed:

- Profiles of Idaho's youth
- Access and barriers to care such as gaps in services
- Development of youth and family voice and engagement
- Appropriate use of services including utilization of restrictive levels of care
- Effectiveness of services, based on child, youth, and family outcomes
- Cross system linkages based on needs and strengths

From YES QMIA Quarterly Report June 2017:

Potential Gaps in Mental Healthcare Services (Access)

The Behavioral Health Barometer, 2013, a report about all 50 states provided by Substance Abuse and Mental Health Services Administration (SAMHSA), indicates the percentage of

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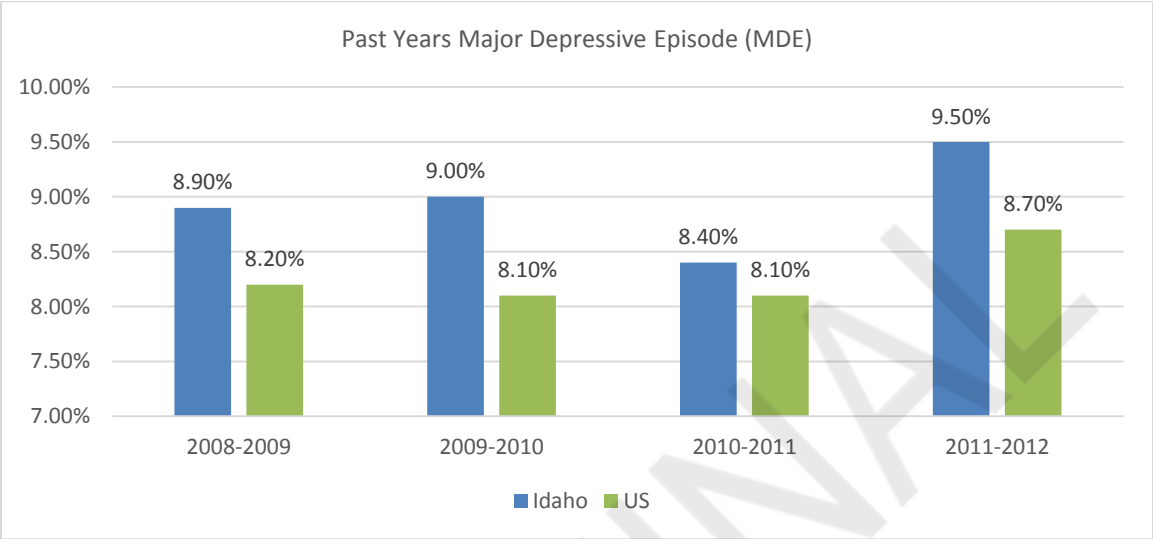
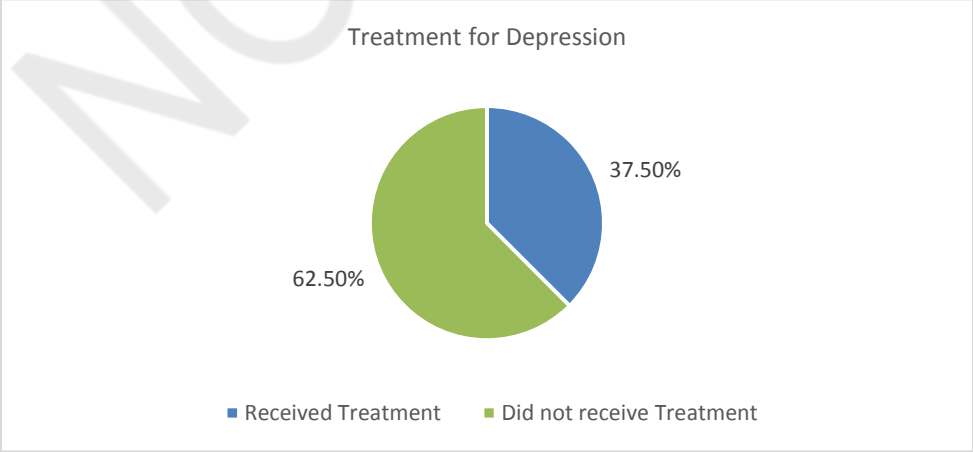
people aged 12-17 who have had a Major Depressive Episode (MDE) in the past year. Utilizing this data from SAMHSA, states can compare themselves to the average for the U.S.

Figure 4: Past year Major Depressive Episodes



The SAMHSA report also included information by state about the rate that that youth with a MDE received treatment. In Idaho, only about 37.5% received treatment. It was noted in the report that Idaho's rate of youth with MDE and rate of treatment for MDE are similar to the national rates. In each of the years included in the SAMHSA report, the percentage of youth with MDE in Idaho is slightly higher than the US average.

Figure 5: Treatment for Depression



The following data about possible gaps in services was previously reported in the last QMIA - Q report (QMIA-Q 3/31/2017) and is being repeated intentionally to ensure that the YES

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workgroups have a chance to review the data so other stakeholders, who may not have read past QMIA-Q reports, can find the information easily.

Table 2 is a comparison of presumed class members (PCM) who received mental health services and the distribution of Medicaid members across the state (penetration rate). This data can inform those who are developing plans for system improvement of possible geographical areas throughout Idaho that need to focus on reducing barriers and improving access to care.

Table 2: Distribution of Presumed Class Members (PCM) by region

DBH Regions	Number of PCM	% of PCM	% of Medicaid	# Medicaid Members	Penetration rate
Region 1	1,592	12.0%	12.5%	29,290	5.4%
Region 2	437	3.3%	4.3%	9,997	4.4%
Region 3	2,866	21.6%	22.2%	52,048	5.5%
Region 4	3,189	24.0%	20.8%	48,662	6.6%
Region 5	1,365	10.3%	14.2%	33,345	4.1%
Region 6	1,050	7.9%	8.2%	19,178	5.5%
Region 7	2,793	21.0%	17.9%	41,979	6.7%
Statewide Total	13,292	100.0%	100.0%	234,499	5.7%

In comparing the distribution of Medicaid members to the statewide average of penetration (5.7%), it is possible* that Class Members may be underserved in Regions 1 (5.4%), 2 (4.4%), 3 (5.5%), 5 (4.1%) and 6 (5.5%). These results indicate a need to monitor regional penetration rates to be able to make meaningful service determinations moving forward.

*Please note, this data is not accompanied by a confidence interval (CI) rating, therefore any interpretation should be considered a hypothesis at this time.

Table 3 is a comparison of presumed class members (PCM) served by age and by YES partner agency. This data can inform those who are developing plans for system improvement of possible age groups of children and youth throughout Idaho needing improved access to care.

Table 3: Distribution of Presumed Class Members by Age

	Medicaid	Medicaid	DBH	DBH	FACS	FACS	IDJC*	IDJC*	SDE	SDE
	#	%	#	%	#	%	#	%	#	%
0-4	477	3.6%	6	0.3%	83	16.6%	0	0%	NA	NA
5-9	4,363	32.8%	89	5.3%	119	23.8%	0	0%	173	13.5%
10-13	4,221	31.8%	277	16.6%	104	20.1%	22	10.4%	517	40.3%

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14-17	4,231	31.8%	1301	77.8%	194	38.8%	189	89.6%	590	46.1%

Children ages 5-9:

- May be underserved in DBH. It is notable that this discrepancy may be due to the target population for DBH services being those in crisis or court-ordered.
- May be under-identified in FACS and in schools.

Children/youth ages 10-13:

- May be underserved in DBH. As noted previously, this may be due to the target population being those in crisis or court ordered.
- May be under-identified in FACS.

Youth ages 14-17:

- Expected prevalence is 21.4% to 22.2% for a mental illness.
- May be underserved in less restrictive levels of care as they make up the largest number of children and youth in any age group in DBH, FACS, and SDE.

**Please note SDE data has been updated to reflect Idaho State Department of Education 618 Part B Child Count Report 2015-2016. Previous QMIA report data was sourced from 2014-2015 report.*

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Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

NOT FINAL

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

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Planning Steps
Quality and Data Collection Readiness

1. **Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).**

The State is currently using a data collection and reporting system that was developed in house using Microsoft Excel. The data reporting spreadsheet is sent quarterly, and client-, program-, and provider-level data are all collected.

***Client-level data** includes the following: 1) aggregated demographic data (i.e., race, ethnicity, gender, and age); 2) attendance/participation data; and, 3) risk factors, if applicable, for individuals served through SABG funding by cohort for each program or activity.*

***Program-level data** includes the following: 1) duration of program/activity; 2) program/activity session date(s); 3) number of program(s)/activity (ies) delivered; 4) program/activity type (i.e., individual or environmental); 5) program/ activity name; 6) IOM category; 7) CSAP strategy; and, 8) sub-strategy.*

***Provider-level data** includes organization name, address, city, state, zip code, and contact name.*

ODP does not collect or maintain any personal identifying information on individuals served with block grant funding.

Beginning in FY16, the Office of Drug Policy (ODP) began to transition from KIT Prevention Services (KPS) to our own in house system in response to ongoing performance concerns with the KPS system. Providers identified multiple barriers to data collection and reporting with the KPS system, and it became clear adjustments to state level data collection efforts were necessary. ODP's goal was to develop a user-friendly, efficient and robust program of data collection that could be used to evaluate the impact of the block grant funded primary prevention programs and activities. Webinars and in-person technical assistance and training sessions were scheduled to successfully complete the transition to the new system. As a result, ODP has seen a significant increase in timely and accurate direct reporting from our providers since the revised data collection system has been implemented.

The ODP data collection forms can be accessed using an internet connection and web browser. ODP staff, as the identified program administrators, has access to all of the data entered into the system; Primary prevention providers have access to their individual Provider data only. All data is filtered by region and fiscal year.

There are approximately forty eight (48) primary prevention providers using the ODP data management system to track SABG funded community substance abuse prevention services. The data collection forms and protocol can be viewed at: https://prevention.odp.idaho.gov/provider-information/.

2. **Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).**

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The state's current primary prevention data collection and reporting system is specific to substance abuse prevention program data and is not part of a larger data system. The ODP system captures primary prevention program data only.

3. **Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?**

Yes, participant level data can be collected in the ODP system but is not required for primary prevention programs. This data includes basic demographic information (age, gender, race and ethnicity) of each individual participant, but does not include any client-identifying information. Most Providers collect this demographic information as group summary-level information.

4. **If not, what changes will the state need to make to be able to collect and report on these measures?**

N/A

Please indicate areas of technical assistance needed related to this section.

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Quality & Data Collection Readiness (2018)

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
    - Data for state-funded non-Medicaid mental health and substance abuse treatment is collected through the use of a centralized electronic health record (EHR), Web Infrastructure for Treatment Services (WITS). Treatment data is entered into WITS by the service provider. Data is reported from the collected date through the user of Sequel Server Reporting Services (SSRS) and the use of the Idaho Department of Health and Welfare's data warehouse. The treatment data can be reported at the client, program, provider, and state level.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
    - The state electronic health record (EHR) is used for all non-Medicaid state-funded substance use disorder treatment as well as mental health treatment provided by the Idaho Department of Health and Welfare. The data is securely sent to the Idaho Department of Health and Welfare, Division of Behavioral Health, which then loads it into the department's data warehouse.

1. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
    - Yes, Idaho is able to collect and report data at the individual client level. The electronic health record is currently being updated, which includes structural changes to the database which will require modification of reports, including those used for client level reporting.

1. If not, what changes will the state need to make to be able to collect and report on these measures?
    - Not applicable

Please indicate areas of technical assistance needed related to this section.

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Primary Prevnetion Workforce Development

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Increase the number of Certified Prevention Specialists in Idaho.

Objective:

Idaho will increase the number of Certified Prevention Specialist to 24 as measured by the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC) data base by June 30, 2019

Strategies to attain the objective:

Provide ongoing training and technical assistance to local prevention providers to enhance quality prevention programming and equip them with the knowledge necessary to take the CPS exam.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Certified Prevention Specialists registered in Idaho with the IBADCC

Baseline Measurement: Number of active Idaho Certified Prevention Specialists registeded with the IBDADCC as of June 1, 2017, is 16.

First-year target/outcome measurement: Number of active Idaho Certified Prevention Specialists registeded with the IBDADCC as of June 1, 2018, will be 19.

Second-year target/outcome measurement: Number of active Idaho Certified Prevention Specialists registeded with the IBDADCC as of June 1, 2019, will be 24 .

Data Source:

Idaho Board of Alcohol Drug Counselor Certification Database

Description of Data:

CPS Registration Certifications

Data issues/caveats that affect outcome measures::

No data issues forseen

Priority #: 2

Priority Area: Primary Preventio Outcomes Measurement

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Strengthen Idaho's data collection and evaluation capacity to accurately measure prevention program outcomes.

Objective:

NOT FINAL

Idaho will increase the number of SABG funded prevention providers in compliance with data collection and reporting requirements from 59% to 65% by June 30, 2019, as measured by provider reports entered in to the ODP data tracking system

Strategies to attain the objective:

Provide ongoing training and technical assistance to local prevention providers to enhance evaluation capacity to accurately evaluate their programs/activities.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of primary prevention providers in compliance with established quarterly data report deliverables as entered into the ODP data management system.
Baseline Measurement:	Number of current SABG funded primary prevention providers incompliance with reporting data as of June 30, 2017, is 59% as meausred by ODP data management system.
First-year target/outcome measurement:	Number of current SABG funded primary prevention providers incompliance with reporting data as of June 30, 2018, is 59 62% as meausred by ODP data management system.
Second-year target/outcome measurement:	Number of current SABG funded primary prevention providers incompliance with reporting data as of June 30, 2019, is 65% as meausred by ODP data management system.

Data Source:

Office of Drug Policy data management system

Description of Data:

ODP Qualitative and quantitative data tracking reports

Data issues/caveats that affect outcome measures::

No data issues foreseen.

Priority #:	3
Priority Area:	Primary Prevention Evidence-based Programming
Priority Type:	SAP
Population(s):	Other (Primary Prevention Providers, Coalitio Members)

Goal of the priority area:

Increase the number of prevention providers implementing programs/activities as defined under CSAP strategy "Community-based Processes."

Objective:

Idaho will increase the number of SABG funded providers implementing prevention services by implementing programs/activities defined under CSAP strategy of Community-based Process from 1 provider to 5 providers by June 30. 2019 as measured by provider reports entered into the ODP data management system

Strategies to attain the objective:

Identify approved community-based process strategies and disseminate recommendations for programs/activities to specific, selected providers.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of primary prevention providers reporting programs/activities defined under the community-based strategy as meausred by ODP data management system.
Baseline Measurement:	Number of primary prevention providers reporting programs/activities defined under the community-based strategy as of June 30, 2017 is 1 as meausred by ODP data management system.
First-year target/outcome measurement:	Number of primary prevention providers reporting programs/activities defined under the

NOT FINAL

community-based strategy as of June 30, 2018 will be 3 as meausred by ODP data management system.

Second-year target/outcome measurement: Number of primary prevention providers reporting programs/activities defined under the community-based strategy as of June 30, 2019 will be 5 as meausred by ODP data management system.

Data Source:

Office of Drug Policy data tracking system.

Description of Data:

Evaluation data entered by providers.

Data issues/caveats that affect outcome measures::

Providers may need further training regarding correct identification of community-based process activities.

Priority #: 4

Priority Area: Intravenous Drug Users

Priority Type: SAT

Population(s):

Goal of the priority area:

Continue to ensure that Idaho does not have a waiting list for services for this population given the opioid epidemic.

Objective:

Ensure timely access to treatment for this population.

Strategies to attain the objective:

Monitor time frames experienced by this population in accessing care, assess network capacity on a regular basis; recruit new providers as needed; analyze current process and make changes where needed in order to expedite services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Status of waiting list.

Baseline Measurement: No wait for access to service currently.

First-year target/outcome measurement: No wait list.

Second-year target/outcome measurement: No wait list.

Data Source:

WITS; DBH Dashboard

Description of Data:

Screening, referral and intake data available through WITS. If Idaho ever needs to create a waiting list, that too will be a WITS product. The DBH Dashboard providers information regarding days between intake and service delivery.

Data issues/caveats that affect outcome measures::

None at this time.

Priority #: 5

Priority Area: Pregnant Women and Women with Dependent Children

NOT FINAL

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Expand number of providers in the PWWDC specialty network.

Objective:

To make PWWDC services available throughout Idaho.

Strategies to attain the objective:

Work with Managed Care Services Contractor to recruit and train additional providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of providers.

Baseline Measurement: There are currently 7 providers in this specialty network.

First-year target/outcome measurement: Increase number of specialty providers to 8.

Second-year target/outcome measurement: Increase number of specialty providers to 10.

Data Source:

MSC contractor.

Description of Data:

Provider Enrollment Report.

Data issues/caveats that affect outcome measures::

We may have a new MSC contractor for FFY 19.

Priority #: 6

Priority Area: Tuberculosis

Priority Type: SAT

Population(s): TB

Goal of the priority area:

All SUD clients are screened for TB and referred for medical services as appropriate.

Objective:

Ensure that any individual in need of TB treatment is referred for medical care.

Strategies to attain the objective:

Screen all SUD applicants for TB and make medical referrals as appropriate.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of client screened for TB

Baseline Measurement: Number of clients screened for TB in 2016.

First-year target/outcome measurement: 85% of SUD clients are screened for TB

Second-year target/outcome measurement: 90% of SUD clients are screened for TB

NOT FINAL

Data Source:

WITS

Description of Data:

Number of clients responses to TB questions entered into WITS system.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 7

Priority Area: Adult Mental Health- System Concerns, Barriers to Accessing Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Assess the adult mental health system of care Idaho currently has in place, initiatives that are currently under development, and the state's overall needs.

Objective:

Conduct a statewide assessment of Idaho's publicly funded Adult Mental Health system.

Strategies to attain the objective:

Contract with the Western Interstate Commission for Higher Education (WICHE) to commission an updated assessment of Idaho's publicly-funded adult mental health system.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Conduct a statewide assessment of Idaho's publicly funded Adult Mental Health system.

Baseline Measurement: Last assessment conducted in 2008.

First-year target/outcome measurement: Contract in place for the assessment of the current adult mental health system of care, current initiatives, and the state's overall needs.

Second-year target/outcome measurement: Assessment reviewed and strategic planning conducted to determine the steps needed to meet the state's overall needs for its adult mental health system.

Data Source:

WICHE assessment report, Division Administration, contract monitoring

Description of Data:

Assessment findings and final report, contract monitoring reports.

Data issues/caveats that affect outcome measures::

Possible issues may be encountered during the contracting process as the state will need to develop a contract and enter into a contract to conduct the assessment.

Priority #: 8

Priority Area: Barriers to Maintaining Recovery

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

NOT FINAL

Implement Homes with Adult Residential Treatment (HART) services in Idaho.

Objective:

Contract for HART services in each of the three designated Hub service areas of the state.

Strategies to attain the objective:

Idaho has identified a gap in community placement options for individuals with mental illness who have complicated personal care and behavioral challenges. The appropriate model for providing the level of support necessary to safely manage and effectively treat individuals with mental illness of a certain severity does not exist in Idaho. To address this service gap, a workgroup of providers, advocates, stakeholders and Department of Health and Welfare (DHW) representatives was established to develop a specialized category of residential care for individuals with a SPMI. This new residential level of care is called Homes with Adult Residential Treatment and will consist of coordinated residential care and clinical behavioral health services in a homelike setting. Funding has been allocated to conduct a demonstration of the HART model.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Enter into contracts for HART services in each of the three service hub areas of the state.
Baseline Measurement:	There are currenlty no HART serivces available in the state.
First-year target/outcome measurement:	Identify HART demonstration project providers and enter into contracts.
Second-year target/outcome measurement:	Conduct assessment to determine feasibility of expanding HART services statewide.

Data Source:

Contraxx contract monitoring, Optum Idaho, Division Administration

Description of Data:

Numbers of contracted services providers and numbers of services provided.

Data issues/caveats that affect outcome measures::

Implementation and expansion of HART services will be dependent on Legislative approval of funding and availability of providers.

Priority #: 9

Priority Area: Barriers to Accessing Services

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Implement and expand access to First Episode Psychosis (FEP) services in Idaho.

Objective:

Fully implement the Idaho Strength Through Active Recovery (STAR) FEP program in three regions.

Strategies to attain the objective:

Idaho is in the process of implementing the STAR program in three regions, providing state-delivered services to provide FEP treatment based on the On-Track Coordinated Specialty Care (CSC) treatment model. Ongoing implementation strategies include identifying staffing resources, addressing training needs, developing standard procedures and developing data and outcome tracking.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of fully implemented FEP teams.
Baseline Measurement:	Idaho currenly has one active FEP team and two teams still in development.

NOT FINAL

First-year target/outcome measurement: Two teams in the implementation stage.

Second-year target/outcome measurement: Three teams in the implementation stage.

Data Source:

WITS, Division Administration

Description of Data:

Numbers of clients receiving FEP services, numbers and types of services provided, outcome data

Data issues/caveats that affect outcome measures::

The implementation of FEP services is currently being funded from the designated block grant allotment. Challenges to implementing the regional FEP programs include outreach to increase referrals on clients that have a short duration of untreated psychosis prior to being hospitalized, rural access, and staffing issues. We serve numerous counties in rural areas, which makes accessing services and travel difficult for clients and team members. One of our greatest challenges is staffing, as the Department does not have the authority to hire additional permanent positions outside of the current approved limit established by the Idaho Legislature. This makes building a team, maintaining and adding additional staff as needed a challenge. Additionally, limited availability of psychiatric providers impacts available prescriber time to dedicate to the FEP programs. The Region 6 program has faced significant challenges due to turnover in staffing and a change in administration and is in the process of reconfiguring the FEP service team.

Priority #: 10

Priority Area: Barriers to Maintaining Recovery

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Provide Family Engagement services.

Objective:

Enter into a contract for the provision of Family Engagement services.

Strategies to attain the objective:

As Idaho moves forward with the development of a new system of care for children with SED a primary need identified by parent and stakeholders is the availability of family engagement services. The Division will need to identify the categories of needed services and supports, develop an Request For Proposal (RFP) and select a contractor for the provision of needed services and supports.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Contract initiated for the provision of Family Engagement supports and services.

Baseline Measurement:

First-year target/outcome measurement: Specific services and supports identified, defined and a RFP posted.

Second-year target/outcome measurement: Contract for Family Engagement services implemented.

Data Source:

Contraxx contract monitoring, YES, Division Administration

Description of Data:

Contract monitoring reports and numbers and types of services delivered.

Data issues/caveats that affect outcome measures::

Funding availability, identification of a qualified contractor, development of needed service types.

NOT FINAL

Priority #: 11

Priority Area: Barriers to Maintaining Recovery

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Increase access to Peer Support and Family Support services.

Objective:

Implement contract for standardized certification criteria for Certified Peers Support Specialists and Family Support Partners.

Strategies to attain the objective:

The Division will develop and publish a RFP for certification process, select a contractor and enter into a contract.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Contract for peer support specialist and family support partner certification implemented.

Baseline Measurement: No contract

First-year target/outcome measurement: Contract for certification initiated.

Second-year target/outcome measurement: Reporting in place for tracking numbers of Peer Support Specialsits and Family Support Partners certified.

Data Source:

Contraxx, contract monitor

Description of Data:

Contract monitoring reports

Data issues/caveats that affect outcome measures::

Contracting will be dependent on the receipt of a qualified bidder and the ongoing availability of funds to maintain the contract.

Priority #: 12

Priority Area: Increased Access to Services

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase access to Wraparound services for children and youth with SED.

Objective:

Implement Wraparound services in the seven DBH children's mental health programs.

Strategies to attain the objective:

Enter into an agreement with Portland State University to provide training and coaching to children's mental health staff. Develop phase in plan for implementing the service across the state. Track progress of service implementation.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Wraparound services are available and provided in each of the seven regional CMH programs.

NOT FINAL

Baseline Measurement: Service is not provided on a statewide basis.

First-year target/outcome measurement: CMH staff trained on the Wraparound model.

Second-year target/outcome measurement: Wraparound services implemented in each of the seven CMH programs.

Data Source:

WITS, Youth Empowerment Services (YES), Division Administration

Description of Data:

Number of staff trained, number of clients receiving services

Data issues/caveats that affect outcome measures::

Funding availability, continued approval of the YES Implementation Plan.

Priority #: 13

Priority Area: Increased Access to Services

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Implement Child and Adolescent Needs and Strengths (CANS) statewide.

Objective:

Develop and use the CANS tool statewide to screen unmet mental health needs, assess individual and family strengths and needs, support clinical decision-making and practice, including formulating treatment plans, measure and communicate client outcomes, and improve service coordination and quality.

Strategies to attain the objective:

Develop plan for deployment of CANS, including a training plan for creating and maintaining statewide capacity for use of the tool, automation of the tool and descriptions of agencies' and providers' roles and responsibilities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Statewide implementation of the CANS assessment tool.

Baseline Measurement: The current assessment tool for childen's mental health is the CAFAS.

First-year target/outcome measurement: Development of automated CANS system.

Second-year target/outcome measurement: Implement statewide CANS deployment plan.

Data Source:

DBH, Interagency Governance Team (IGT), WITS

Description of Data:

Trainings conducted, status of automation of the tool, locations implementing the CANS, number of assessment completed.

Data issues/caveats that affect outcome measures::

Funding availability, approval of the Idaho customized tool, approval of the Implementation Plan. Constraints around the identification and development of electronic requirements for implementation of the CANS (timeframes, funding, system requirements).

Priority #: 14

Priority Area: Barriers to Accessing Services, System Concerns

NOT FINAL

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Establish a due process procedural system and tracking for compliance and continuous quality improvement..

Objective:

Develop and operate a constitutionally and federally-compliant fair hearing system, and create and operate a centralized complaint routing and tracking system.

Strategies to attain the objective:

Establish requirements in IDAPA rule, develop procedures, develop materials, provide training

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Implement standardized due process requirements.

Baseline Measurement: Standardized system not in place.

First-year target/outcome measurement: Develop a standardized complaint and administrative hearing system.

Second-year target/outcome measurement: Create process for centralized complaint routing and tracking system.

Data Source:

IGT, DBH

Description of Data:

Implementation report, YES updates

Data issues/caveats that affect outcome measures::

Continued approval of the Implementation plan. System capacity to meet planned timelines due to staffing or other limited resources.

Priority #: 15

Priority Area: Barriers to Maintaining Recovery

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Provide consumer and family advocacy, empowerment and education.

Objective:

Provide education to consumers of mental health services regarding their rights and responsibilities in accessing behavioral health services.

Strategies to attain the objective:

DBH will contract with a consumer advocacy organization to provide information and education to adults with SMI and their families. The contractor will provide and maintain an updated website. The contactor will participate in stakeholder groups and meetings and provide educational activities to individuals and providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Provide training and educational activities for adult consumers and providers of mental health services.

NOT FINAL

Baseline Measurement:	Training activities have not been regularly reported or tracked.
First-year target/outcome measurement:	Provide three Parity Awareness training events.
Second-year target/outcome measurement:	Provide four educational or awareness events to consumers and providers.

Data Source:

Contraxx, DBH contract monitor

Description of Data:

Contract monitoring reports are utilized to ensure compliance with contract scope of work requirements. Updates will be provided to DBH leadership.

Data issues/caveats that affect outcome measures::

Successful completion of signed contract and compliance with contract terms.

Footnotes:

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$6,621,128		$0	$6,655,710	$6,250,400	$0	$0
a. Pregnant Women and Women with Dependent Children**	$650,000		$0	$0	$0	$0	$0
b. All Other	$5,971,128		$0	$6,655,710	$6,250,400	$0	$0
2. Primary Prevention	$1,813,000		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$1,813,000		$0	$0	$0	$0	$0
b. Mental Health Primary							
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
4. Tuberculosis Services	$1,000		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$84,433		$0	$0	$53,326	$0	$0
10. SubTotal (1,2,3,4,9)	$6,706,561	$0	$0	$6,655,710	$6,303,726	$0	$0
11. SubTotal (5,6,7,8)	$0	$0	$0	$0	$0	$0	$0
12. Total	$8,519,561	$0	$0	$6,655,710	$6,303,726	$0	$0

NOT FINAL

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Idaho is not an HIV/AIDS designated state.

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention		$0	$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary*			$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$190,808	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$6,572,500	$0	$28,639,100	$0	$0
7. Other 24 Hour Care		$0	$0	$0	$5,361,100	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$1,621,865	$1,611,200	$3,958,913	$38,474,900	$0	$0
9. Administration (Excluding Program and Provider Level)		$95,404	$0	$0	$0	$0	$0
10. SubTotal (1,2,3,4,9)	$0	$95,404	$0	$0	$0	$0	$0
11. SubTotal (5,6,7,8)	$0	$1,812,673	$8,183,700	$3,958,913	$72,475,100	$0	$0
12. Total	$0	$1,908,077	$8,183,700	$3,958,913	$72,475,100	$0	$0

NOT FINAL

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

The above figures represent the best efforts to project planned expenditures covering two state fiscal years. These should be considered estimates only as the state budgets are appropriated annually by the Idaho State Legislature. Totals were estimated based on the current state FY18 allocated budget.

NOT FINAL

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	1202	32
Women with Dependent Children	11973	638
Individuals with a co-occurring M/SUD	41058	1604
Persons who inject drugs	9453	460
Persons experiencing homelessness	780	135

Please provide an explanation for any data cells for which the stats does not have a data source.

Please see document titled "Table 3 Data Sources" for an explanation of the data sources and limitations.

Footnotes:

NOT FINAL

Table 3 Data Source Explanation

Aggregate Number Estimated in Need Data Sources:

Limitation: The NSDUH survey does not include data on the Homeless population reported at the state level. The process Idaho used to calculate this data is detailed in Need Data footnote 5.

1. **Pregnant Women**
    a. *Data sources:*
        i. National Survey on Drug Use and Health, 2015 (NSDUH)[1, 2]
            1. National rates of pregnant females aged 12-44 who needed treatment for illegal drug or alcohol use in the past year
            2. Idaho state-level population estimates
2. **Women with Dependent Children**
    a. *Data Sources:*
        i. National Survey on Drug Use and Health, 2015 (NSDUH)[1, 2]
            1. National rates of females with children <18 in their household who needed treatment for illegal drug or alcohol use in the past year
            2. Idaho state-level population estimates
        ii. US Census Data for the State of Idaho[3]
            1. Idaho Demographics-Idaho Gender Breakdown
3. **Individuals with a Co-occurring M/SUD**
    a. *Data Sources:*
        i. National Survey on Drug Use and Health, 2015 (NSDUH)[1, 2]
            1. National rates of those with any mental illness (based on revised predicted SMI probability) who needed treatment for illegal drug or alcohol use in the past year
            2. Idaho state-level population estimates
4. **Persons who Inject Drugs**
    a. *Data Sources:*
        i. National Survey on Drug Use and Health, 2015 (NSDUH)[1, 2]
            1. National rates of those who have used a needle to inject drugs who needed treatment for illegal drug or alcohol use in the past year
            2. Idaho state-level population estimates
5. **Persons Experiencing Homelessness**
    a. *General Comments:*
        i. The NSDUH survey excludes people with no fixed address (e.g., homeless people not in shelters), so an alternative source of data was required to estimate need for this population
        ii. Estimates calculated assuming Idaho follows the national trends seen in the SAMHSA Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States
    b. *Data Sources:*
        i. SAMHSA Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States[4]
            1. National rates of those who are homeless and who experience a substance use issue
        ii. 2016 Annual Homeless Assessment Report (AHAR) to Congress (US Department of Housing and Urban Development)[5]
            1. Estimate of the Homeless Population in Idaho

NOT FINAL

Aggregate Number in Treatment:

Limitation: Data for this section only reports individuals who received treatment funded by the SSA. In Idaho, the in addition to the Department of Health and Welfare, Division of Behavioral Health the Departments of Corrections and Juvenile Corrections, as well as the Idaho Supreme Court received funding to deliver substance use disorders services to the populations they serve. If a pregnant women commits a crime, she will be treated in the Court or Corrections system; likewise for individuals who are injecting drugs, co-occurring, homeless or women with dependent children. Also, individuals with private insurance or who self-pay for treatment services are not required to provide data to the SSA. Thus, the only data reported under the "Received Treatment" section are those who received SSA-funded treatment. This number under-represents the actual number of individuals who received treatment in Idaho.

1. **Source for all Data:**
    a. WITS data obtained from/using SSRS by Robert
2. **Pregnant Women:**
    a. Count of pregnant women at time of intake
3. **Women with Dependent Children**
    a. Calculated by subtracting the number of pregnant women at intake from the number served under PWWC funding
4. **Individuals with a Co-Occurring MH/SUD**
    a. Count of clients who had a mental health problem indicated on the admission
5. **Persons who Inject Drugs**
    a. Count of clients served under IVDU funding
6. **Persons Experiencing Homelessness**
    a. Count of clients who listed a living situation of "Homeless" on the admission
7. **General Comments:**
    a. Client counts based on clients who had a claim in SFY2016 associated to IDHW funding
    b. A client may have been served under more than one identified population
    c. Information reflects data entered into the provider record

NOT FINAL

References:

1. *Substance Abuse and Mental Health Services Administration (SAMHSA)'s public online data analysis system (PDAS). Retrieved July 13, 2017, from National Survey on Drug Use and Health, 2015 website: //pdas.samhsa.gov/#/survey/NSDUH-2015-DS0001/crosstab/?weight=ANALWT_C&results_received=true*

2. *2014-2015 National Survey on Drug Use and Health: Guide to State Tables and Summary of Small Area Estimation Methodology*. Retrieved July 13, 2017, from SAMHSA website: https://www.samhsa.gov/data/sites/default/files/NSDUHsaeMethodology2015/NSDUHsaeMethodology2015.pdf

3. *American Fact Finder.* Retrieved July 13, 2017, from United States Census Bureau website: https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

4. *Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States*. Retrieved July 13, 2017, from SAMHSA website: https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf

5. *The 2016 Annual Homeless Assessment Report (AHAR) to Congress*. Retrieved July 13, 2017, from The U.S. Department of Housing and Urban Development website: https://www.va.gov/homeless/docs/2016-AHAR-Part-1.pdf

NOT FINAL

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$6,621,128
2 . Primary Substance Abuse Prevention	$1,813,000
3 . Early Intervention Services for HIV*	
4 . Tuberculosis Services	$1,000
5 . Administration (SSA Level Only)	$84,433
6. Total	$8,519,561

NOT FINAL

* For the purpose of determining the states and jurisdictions that are considered “designated states” as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to

do so.

Footnotes:

Please note, Idaho is not a designated state.

NOT FINAL

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	$277,000
	Selective	$23,000
	Indicated	
	Unspecified	
	Total	$300,000
Education	Universal	$635,000
	Selective	$240,000
	Indicated	
	Unspecified	
	Total	$875,000
Alternatives	Universal	$45,271
	Selective	$74,729
	Indicated	
	Unspecified	
	Total	$120,000
Problem Identification and Referral	Universal	
	Selective	$15,000
	Indicated	$75,000
	Unspecified	
	Total	$90,000

NOT FINAL

Community-Based Process	Universal	$63,000
	Selective	
	Indicated	
	Unspecified	
	Total	$63,000
Environmental	Universal	$54,788
	Selective	$5,212
	Indicated	
	Unspecified	
	Total	$60,000
Section 1926 Tobacco	Universal	$15,000
	Selective	
	Indicated	
	Unspecified	
	Total	$15,000
Other	Universal	
	Selective	
	Indicated	
	Unspecified	$305,000
	Total	$305,000
Total Prevention Expenditures		$1,828,000
Total SABG Award*		$8,519,561
Planned Primary Prevention Percentage		21.46 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

NOT FINAL

NOT FINAL

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	
Universal Indirect	
Selective	
Indicated	
Column Total	$0
Total SABG Award*	$8,519,561
Planned Primary Prevention Percentage	0.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:
Idaho choose to complete Table 5a, since it allows for the reporting of Synar Compliance expenditures as well as IOM levels of prevention care.

NOT FINAL

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	c
Heroin	c
Inhalants	c
Methamphetamine	c
Synthetic Drugs (i.e. Bath salts, Spice, K2)	c
Targeted Populations	
Students in College	c
Military Families	c
LGBT	c
American Indians/Alaska Natives	b
African American	c
Hispanic	b
Homeless	c
Native Hawaiian/Other Pacific Islanders	c
Asian	c
Rural	b
Underserved Racial and Ethnic Minorities	b

NOT FINAL

Footnotes:

NOT FINAL

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	$41,826	$249,200	$32,729	
2. Infrastructure Support	$109,806	$685,000		
3. Partnerships, community outreach, and needs assessment	$322,000	$210,000	$60,469	
4. Planning Council Activities (MHBG required, SABG optional)	$40,000			
5. Quality Assurance and Improvement	$600,000	$82,000	$54,215	
6. Research and Evaluation		$80,000	$31,729	
7. Training and Education			$21,988	
8. Total	$1,113,632	$1,306,200	$201,130	$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

MHBG-
Infrastructure Support $54,903 per year Administration
Partnerships Etc.- $161,000 per year OCAFA

NOT FINAL

Planning council- $20, 00 per year
Quality Assurance- $300, 000 per year Certification Contract
WITS- $20,913 per year from RMTS

NOT FINAL

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

NOT FINAL

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[30] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

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NOT FINAL

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[44] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

   In December 2014, Idaho received a state innovation model grant from the Center for Medicare and Medicaid Innovation for $39,683,813. The grant is funding a four-year implementation of a Patient Centered Medical Home (PCMH) initiative with the goal of redesigning Idaho's healthcare system from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes. Goal's for the State Healthcare Innovation Plan (SHIP) include:

   Goal 1: Transform primary care practices across the state into patient-centered medical homes (PCMHs).
   Idaho will test the effective integration of PCMHs into the larger healthcare delivery system by establishing them as the vehicle for delivery of primary care services and the foundation of the state's healthcare system. The PCMH will focus on preventive care, keeping patients healthy and stabilizing patients with chronic conditions. Grant funding will be used to provide training, technical assistance and coaching to assist practices in this transformation.

   Goal 2: Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood.
   Idaho's proposal includes significant investment in connecting PCMHs to the Idaho Health Data Exchange (IHDE) and enhancing care coordination through improved sharing of patient information between providers.

   Goal 3: Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical neighborhood.
   At the local level, Idaho's seven public health districts will convene Regional Collaboratives that will support provider practices as they transform to PCMHs.

   Goal 4: Improve rural patient access to PCMHs by developing virtual PCMHs.

NOT FINAL

This goal includes training community health workers and integrating telehealth services into rural and frontier practices. The virtual PCMH model is a unique approach to developing PCMHs in rural, medically underserved communities.

Goal 5: Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level and statewide.
Grant funds will support development of a state-wide data analytics system to track, analyze and report feedback to providers and regional collaborative(s). At the state level, data analysis will inform policy development and program monitoring for the entire healthcare system transformation.

Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.
Idaho's three largest commercial insurers, Blue Cross of Idaho, Regence and PacificSource, along with Medicaid will participate in the model test. Payers have agreed to evolve their payment model from paying for volume of services to paying for improved health outcomes.

Goal 7: Reduce overall healthcare costs.
Financial analysis conducted by outside actuaries indicates that Idaho's healthcare system costs will be reduced by $89M over three years through new public and private payment methodologies that incentivize providers to focus on appropriateness of services, improved quality of care and outcomes rather than volume of service. Idaho projects a return on investment for all populations of 197% over five years.

The PCMH model centers around building a system where patients are surrounded by a care team that encompasses all areas of their physical and mental health, including both primary health care and behavioral health care services. Idaho currently has 110 PCMHs in the SHIP project, and is aiming to establish 165 by the project's end. Depending on the clinic, behavioral health services may be available through an embedded on-site treatment team, or through an established referral method. Idaho is also piloting a system for reverse integration, where behavioral health service providers can work to integrate primary care into their services. Idaho has also formed a Behavioral Health Integration Workgroup to advise and address the behavioral health needs of the SHIP project. The group has been meeting since early 2015 and includes representation from the SSA/SMHA, community primary health care and behavioral health care service providers and contractors, medical associations, and more. A list of Behavioral Health Integration Workgroup members is attached as BHI Workgroup Members. A copy of the Behavioral Health Integration Workgroup charter is also attached as BHI Workgroup Charter.

More information about the SHIP can be found at http://ship.idaho.gov/SHIPHome/tabid/2978/Default.aspx.

Additionally, five of Idaho's seven regions participate in the Health Resources & Services Administration (HRSA) Loan Repayment program. The five regions have established Memorandums of Agreements with community providers of substance use disorder and primary care services for coordination of care.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Idaho's Statewide Healthcare Innovation Plan (SHIP) seeks to establish medical homes with the capacity to address all of a patient's needs. Thus, SHIP has developed systems and provides technical assistance to support the development of patient-centered medical homes (PCMH). The technical assistance offered to medical centers provides training in the PCMH model; assistance integrating behavioral health services including co-occurring services; access to other community resources such as dentists, food assistance, etc.; access to the SHIP Transformation Portal for education sessions and the Idaho Health Data Exchange; the annual Learning Collaboratives; coaching from professionals; and mentoring for current PCMHs. Assistance is also available to negotiate with insurance companies.

Idaho provides reimbursement to cover the costs of training and certification.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ☐ Yes ☐ No

and Medicaid? ☐ Yes ☐ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The Idaho Department of Insurance is responsible for monitoring access to M/SUD services offered by QHPs.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ☐ Yes ☐ No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education ☐ Yes ☐ No

b) Health risks such as

i) heart disease ☐ Yes ☐ No

NOT FINAL

ii) hypertension ☐ Yes ☐ No

viii) high cholesterol ☐ Yes ☐ No

ix) diabetes ☐ Yes ☐ No

c) Recovery supports ☐ Yes ☐ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ☐ Yes ☐ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ☐ Yes ☐ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Idaho's healthcare delivery and support systems are preparing for significant changes in the coming year. As we develop a value-based healthcare delivery system and redesign services for children with serious emotional disturbances, and individuals with intellectual and developmental disabilities, we face significant challenges in ensuring that our policies and practices meet federal compliance requirements and recommendations. Idaho Medicaid's current policy unit has several new staff, who are still learning the complexities of Medicaid policy and compliance with federal regulations. There are several competing projects/issues that would potentially impact the parity analysis and implementation. For one, the state is in the middle of a settlement agreement for services for children with SED. There is a need for strong but appropriate utilization management with this process. The settlement agreement requires compliance by May/June 2020. The state is also undergoing a large amendment to the Behavioral Health contract. Idaho is trying to implement a 1915(i) wavier to meet the settlement agreement. The state is also renewing its 1915 (b) waiver. There are also several initiatives that will be dependent upon legislation which will significantly impact available staff resources.

10. Does the state have any activities related to this section that you would like to highlight?

Idaho is a participant in the Medicaid and CHIP Parity Policy Academy. The Division of Medicaid is partnering the Division of Behavioral Health to prepare Idaho for Medicaid and CHIP parity compliance and to ensure quality and cost effective services for participants. Idaho has completed the initial assessment and conducted gap analysis of the parity requirements. It is anticipated Idaho Medicaid will be on track to meet the timeline requirements for implementing parity and has determined the following plans are impacted by the Medicaid Parity rule:

• 3 ABP's
• State Plan
• Medi/Medi MCO contract
• PAHP-OP Behavioral Health
• CHIP expansion and State CHIP

In November of 2016, a new contract with the Office of Consumer and Family Affairs (OCAFA) was established requiring specific activities around parity education. In the previous contract, the OCAFA was required to post information about parity on their website. They have enhanced their website with additional information about parity that further explains the definition of parity and what it means for consumers of mental health services and consumers of substance use disorder services. Information about parity can be found on a few different webpages within their site located at http://www.consumerandfamilyaffairs.org/. The current contract also tasks OCAFA with holding three parity trainings throughout the state, one in each of the state's regional based hubs. These have not yet taken place, but are in the process of being developed. The OCAFA spent some time researching parity in Idaho and learned from the Department of Insurance (DOI) that Idaho does not have laws concerning mental health parity and yet insurance companies are bound by federal parity law, which the DOI enforces. The OCAFA has worked with the DOI to suggest that they update the information on the DOI's website regarding parity.

Please indicate areas of technical assistance needed related to this section

Footnotes:

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PROJECT CHARTER

Behavioral Health Integration Workgroup

Version 3.0 – August 2015

Workgroup Summary

Chair/Co-Chair	Ross Edmunds, Dr. Charles Novak
Mercer Lead	Katie Falls, Maija Welton
SHIP Staff	Casey Moyer
IHC Charge	▪ Lead the development of an integrated and coordinated behavioral healthcare (BH) patient-centered medical home system. The workgroup aims to support the Regional Collaboratives in helping patient-centered medical homes (PCMHs) move toward or enhance BH integration and to evaluate the current system regarding level of BH integration.
SHIP Goals	▪ Goal 1: Transform primary care practices across the state into patient-centered medical homes. ▪ Goal 2: Improve care coordination through the use of electronic health records and health data connections among PCMHs and across the medical neighborhood. ▪ Goal 4: Improve rural patient access to PCMHs by developing virtual PCMHs. ▪ Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value. ▪ Goal 7: Reduce overall healthcare costs.

Business Alignment

Business Need	▪ Integration of BH and primary health is important to provide coordinated care in the PCMH model and establish appropriate linkages with the medical neighborhood.

Success Measures	SHIP Desired Outcomes	Measurement	Workgroup's Role
	• Improved patient access to PCMH-based care in geographically remote areas of Idaho.	• Cumulative # (%) of Virtual PCMHs established in rural communities following assessment of need. Model Test Target – 50.	• Collaborate with other workgroups to incorporate BH services in PCMH practices.
	• Increase overall integration of the behavioral health care system through improved telehealth usage.	• Cumulative # (%) of designated or recognized Virtual PCMH practices that routinely use Telehealth tools to provide specialty and behavioral health services to rural patients. Model Test Target – 50.	• Support the Telehealth Council in expanding telehealth technology to enhance access to behavioral health and other specialty services.

NOT FINAL

Success Measures	SHIP Desired Outcomes	Measurement	Workgroup's Role
	• Increase connectivity of PCMH electronic health records systems with the statewide exchange.	• Cumulative # (%) of designated PCMHs with an active connection to the Idaho Health Data Exchange (IHDE) and utilizing the clinical portal to obtain patient summaries, etc.	• Collaborate and advise PCMH contractor to ensure practices are utilizing EHR systems fully to document data elements used for analytics reporting.

Planned Scope

Deliverable 1	**Result, Product or Service** • Evaluation of current levels of BH integration in Idaho within PCMH.	**Description** • Conduct survey to gain an understanding of the current levels of BH/PH integration in the healthcare system.
Est. Timeframe	**Start**: 07/01/2015	**End**: 02/28/2015
Milestones	**Event** • Administer provider surveys. • Review collaboration/integration models in Idaho and nationally. • Choose or develop a BH Integration/Collaboration evaluation survey.	**Target Date** • November 2015 • February 2016
Deliverable 2	**Result, Product or Service** • Methodology for baseline and ongoing tracking of levels of BH integration.	**Description** • Updated annual survey of current levels of BH integration, developing actionable recommendations from the data gleaned from surveys.
Est. Timeframe	**Start**: 12/30/2015	**End**: 04/30/2016
Milestones	**Event** • Develop a methodology for administering and analyzing the evaluation tool.	**Target Date** March 2016
Deliverable 3	**Result, Product or Service** • Evidence-based BH screening tools.	**Description** • Identify screening tools that could be adopted in PCMHs.
Est. Timeframe	**Start**: 12/30/2015	**End**: 05/31/2016

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Milestones	**Event** • Identify evidence-based screening tools. • Work with the SHIP Identified Partner to incorporate screening tools in PCMH.	**Target Date** • March 2016 • April/May 2016
Deliverable 4	**Result, Product or Service** • Framework of options available for PCMH to integrate in the practice.	**Description** • Recommendations of BH/PH models of integration for adoption in Idaho.
Est. Timeframe	**Start**: 03/01/2016	**End**: 04/01/2016
Milestones	**Event** • Identify and reach out to current PCMH to discuss Idaho models of BH integration. • Develop framework of integration options.	**Target Date** • February 2016 • March/April 2016
Deliverable 5	**Result, Product or Service** • Recommendations regarding BH incentives.	**Description** • Recommend incentives that would be effective in promoting BH/PH integration in Idaho.
Est. Timeframe	**Start**: 07/01/2015	**End**: 04/01/2016
Milestones	**Event** • [TBD] • [TBD]	**Target Date** • [TBD] • [TBD]
Deliverable 6	**Result, Product or Service** • Communications materials and presentations.	**Description** • Provide outreach, education, and technical assistance regarding BH/PH to practices looking to become PCHMs.
Est. Timeframe	**Start**: 12/30/2015	**End**: 04/01/2016
Milestones	**Event** • [TBD] • [TBD]	**Target Date** • [TBD] • [TBD]

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Project Risks, Assumptions, and Dependencies

Risk Identification	Event	H – M – L	Potential Mitigation	Potential Contingency
	• Inadequate services in the community to meet BH needs identified in the primary care setting.	H	Increase access to BH services through telehealth.	Availability of telehealth services.
Assumptions	• [TBD]			
Dependencies and Constraints	• [TBD]			

Project Reporting and Scope Changes

Changes to scope must be approved by the IHC after review by SHIP team.

Version Information

Author	Katie Falls (Mercer)	**Date**	07/09/2015
Reviewer	Gina Westcott (Behavioral Health)	**Date**	08/26/2015

Charter Approval Signatures

Approval by the Workgroup on: September 8, 2015.

Final Acceptance

Name / Signature	Title	Date	Approved via Email
Dr. Charles Novak	Chair	09/08/2015	☒
Ross Edmunds	Co-Chair	09/08/2015	☒
Cynthia York	SHIP Administrator	09/08/2015	☒
Katie Falls	Mercer Lead	09/09/2015	☒

NOT FINAL

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NOT FINAL

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities[45], Healthy People, 2020[46], National Stakeholder Strategy for Achieving Health Equity[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[45] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
[46] http://www.healthypeople.gov/2020/default.aspx
[47] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf
[48] http://www.thinkculturalhealth.hhs.gov
[49] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
[50] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208
[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

NOT FINAL

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

   a) Race — Yes No

   b) Ethnicity — Yes No

   c) Gender — Yes No

   d) Sexual orientation — Yes No

   e) Gender identity — Yes No

   f) Age — Yes No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? — Yes No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? — Yes No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? — Yes No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? — Yes No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? — Yes No

7. Does the state have any activities related to this section that you would like to highlight?

   Idaho is currently engaged in an ongoing collaborative effort to implement a new system of care for Idaho's children and youth with Serious Emotional Disturbance (SED). The Youth Empowerment Services (YES) project has been authorized by the Department of Health & Welfare and established as a part of Children's Mental Health Reform Project to operationalize the Idaho Implementation Plan in response to the settlement agreement for the Jeff D lawsuit. By focusing on the development of a new system of care for children and youth with SED the state expects primarily to build a transformational process across specific child-serving entities that will eventually result in better outcomes for the families that access it. Though the Yes Project the State plans to develop and implement a sustainable, accessible, comprehensive, and coordinated behavioral health service delivery system with functional interfaces across multiple child-serving agencies for publicly-funded community-based mental health services to children and youth with serious emotional disturbance. The Implementation Plan includes an objective on sustainable workforce and community stakeholder development including the establishment of the Workforce Development Workgroup and the development of the Workforce Development Plan.

   Please indicate areas of technical assistance needed related to this section

   None

Footnotes:

The Idaho WITS data system has the capability to report sexual orientation and preferred language however these are not required data fields and are not mandatorily reported by providers using the WITS system.

NOT FINAL

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS)[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

NOT FINAL

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[52] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[53] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[54] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] http://psychiatryonline.org/

[57] http://store.samhsa.gov

[58] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

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Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☐ Yes ☐ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

   a) ☐ Leadership support, including investment of human and financial resources.

   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   c) ☐ Use of financial and non-financial incentives for providers or consumers.

   d) ☐ Provider involvement in planning value-based purchasing.

   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

   f) ☐ Quality measures focus on consumer outcomes rather than care processes.

   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

   Does the state have any activities related to this section that you would like to highlight?

   None at this time.

   Please indicate areas of technical assistance needed related to this section.

   None

Footnotes:

NOT FINAL

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? Yes No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? Yes No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   Idaho is implementing the STAR (Strength Through Active Recovery) program in three regions providing state-delivered services to provide FEP treatment based on the On-Track CSC treatment model. FEP treatment services are available or being developed in Idaho's Behavioral Health Regions 3, 6 and 7, located in the southwestern and eastern parts of the state. Each of the three teams are in various stages of implementation.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

   We are part of the MHBG 10% Early Intervention Study that will provide feedback as to our fidelity to the Coordinated Specialty Care model as well as client outcomes. We are using and plan to use any feedback to help promote our fidelity to the coordinated specialty care model as well as any other evidenced based practices that we can use in our FEP programs. We also participate in the NTTAC Early Psychosis Learning Collaborative in an effort to assist us with identifying and implementing strategies to improve our FEP programs. All the three state FEP programs participate in a conference call once a month basis to share ideas, successes, failures and also to further develop program implementation. A primary focus of the conference calls is to ensure consistency in the development on delivery of FEP services across the three programs. Additionally, the programs work closely with EASA from Oregon and have participated in several trainings and site visits with the EASA programs.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? Yes No

5. Does the state collect data specifically related to ESMI? Yes No

NOT FINAL

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☐ Yes ☐ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Idaho is implementing the STAR (Strength Through Active Recovery) program based on the On Track New York coordinated specialty care model. The program consists of a regionally based interdisciplinary team assigned to work with eligible clients. Members of the team include a psychiatrist, team lead, registered nurse, primary clinician, recovery coach, individual placement specialist, peer specialist and an outreach specialist. On some teams these roles may be fill by the same staff person depending on the size of the caseload and available staffing. Shared decision making and critical time interventions are core components of the treatment program. Risk assessment and safety planning is conducted with each client. The STAR program in Region 7 has recently developed a multi-family group and connects clients with a WRAP group. Family support, education, and supported employment are also core components of the program. Each team has an assigned psychiatrist providing medication management and education on medications and side effects. Each of the three programs are in various stages of implementation with the most advanced program being the program in Region 7. The Region 3 program is in the beginning stages of implementation and the program in Region 6 in nearing the final stages of program development.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

1. Provide an annual statewide training for FEP staff. This training may focus on differential diagnosis, critical time intervention, shared decision making, Coordinated Specialty Care model or other related topics.
2. Create statewide policy for FEP teams.
3. Develop and implement a dedicated FEP website.
4. Develop standardized FEP data and outcome measure.
5. Develop and implement process for collecting and analyzing statewide FEP data.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Data is collected at the time of admission in to the program and then every 6 months Data is collected using the following tools: Minimum data set, Modified Colorado Symptom Index, Global Functioning Social and Role Scale and the Lehman Quality of Life Question. We are also looking at using the PANSS (Positive and Negative Sydrome Scale) in the future.

10. Please list the diagnostic categories identified for your state's ESMI programs.

- Schizophrenia
- Schizoaffective Disorder
- Schizophreniform
- Bipolar I
- Delusional Disorder
- Psychosis NOS

Does the state have any activities related to this section that you would like to highlight?

The state sponsored a differential diagnosis training to help with referrals and to increase awareness of our FEP programs. The training was opened to all the of the seven regional behavioral health centers as well as private community behavioral health providers at no cost to the attendees.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

NOT FINAL

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? ☐ Yes ☒ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

   The state does have policies about person centered planning in our Family and Community Service Developmental Disability Division but does not have policy currently in our Division of Behavioral Health. The Division of Behavioral Health does have a Standard of care for Person Centered Planning that establishes a goal for behavioral health services statewide.
   The state is in a developmental phase of creating policies for person centered planning for children, youth and families who are accessing Medicaid and designated mental health services through a 1915i waiver. It is expected that the policies will be operational by January of 2018 if the 1915i waiver has been completed.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   The state engages consumers and their care givers in the assessment and treatment planning process through policies that indicate treatment plans shall be based on principles of care that are client-centered, strength based, recovery oriented.

4. Describe the person-centered planning process in your state.

   As noted the state in in process of developing policy related to person centered planning. The state DBH is working collaboratively with the state Medicaid Division to establish a person centered planning process that will be made available to all children, youth and families receiving services under the 1915i waiver. The person centered plan will be based on a standardized assessment of functionality (the CANS) and will be develop through a philosophical foundation of a child, family, team. The state is working with several subject matter experts as well family and youth representatives to develop the shared vision of a person centered plan and the policies that will be associated with it.

   Does the state have any activities related to this section that you would like to highlight?

   Not at this time.

   Please indicate areas of technical assistance needed related to this section.

   The state would be interested in technical assistance to develop training for youth and family members on person centered planning.

Footnotes:

NOT FINAL

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ☐ Yes ☐ No

2. Are there any concretely planned initiatives in our state specific to self-direction? ☐ Yes ☐ No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:

   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

   Does the state have any activities related to this section that you would like to highlight?

   No

   Please indicate areas of technical assistance needed to this section.

Footnotes:

NOT FINAL

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☐ Yes ☐ No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ☐ Yes ☐ No

   Does the state have any activites related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section

Footnotes:

NOT FINAL

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   Four. Meetings are conducted quarterly.

2. What specific concerns were raised during the consultation session(s) noted above?

   Some concerns were expressed regarding the common assessment tool, the Global Appraisal of Individual Needs (GAIN), being culturally insensitive.

   Does the state have any activites related to this section that you would like to highlight?

   Idaho is actively pursuing a new common assessment tool and the tribes are involved this process.

   Please indicate areas of technical assistance needed to this section

Footnotes:

NOT FINAL

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ☐ Yes ☐ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ☐ Yes ☐ No

   - ☐ Data on consequences of substance using behaviors
   - ☐ Substance-using behaviors
   - ☐ Intervening variables (including risk and protective factors)
   - ☐ Others (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

   - ☐ Children (under age 12)
   - ☐ Youth (ages 12-17)
   - ☐ Young adults/college age (ages 18-26)
   - ☐ Adults (ages 27-54)
   - ☐ Older adults (age 55 and above)
   - ☐ Cultural/ethnic minorities
   - ☐ Sexual/gender minorities
   - ☐ Rural communities
   - ☐ Others (please list)

NOT FINAL

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- Archival indicators (Please list)

Gallons of liquor sold per capita; Treatment Episode Data Set; National Incident-Based Reporting System; Automation of Reports and Consolidated Orders System

- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? ☐ Yes ☐ No

If yes, (please explain)

The State of Idaho Substance Abuse Prevention Needs Assessment is used to guide SABG funding decisions by identifying specific priority populations on which the state is focused. In Idaho, the priority populations identified are: Rural/Frontier; Native American; Hispanic; and, Underserved Racial and Ethnic Minority populations. In the needs assessment, Native Americans were identified as a population that suffers disproportionately from alcohol-related harms. From this data, ODP sponsored a retreat for Native American youth and began funding Project Venture, an evidence-based experiential program designed specifically for this population.

Additionally, multi-stakeholder workgroups have been formed to address data collection challenges and interpret data in support of planning, implementation and evaluation of primary prevention programs.
ODP is committed to expanding our capacity building efforts to facilitate an increased sharing of information and delivery of best practice programs and have found the workgroups to be highly successful in this effort

Finally, ODP has translated our Parenting Program Surveys into Spanish to better address priority populations. By tailoring prevention programs and data collection practices to meet the needs of Idaho's priority populations, the State can make better informed decisions about the allocation of SABG primary prevention funds.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

NOT FINAL

Narratve Question

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Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? ☐ Yes ☐ No

   If yes, please describe

   The Office of Drug Policy (ODP), in partnership with both the International Certification and Reciprocity Consortium (IC&RC) and the Idaho Board of Alcohol/Drug Counselor Certification, INC. (IBADCC) is currently implementing a statewide Certified Prevention Specialist (CPS) credentialing program for the substance misuse prevention workforce. In FY16, ODP established the following expectation for all primary prevention grant applicants: “To increase qualified providers of substance abuse prevention services, beginning in SFY2019, at least one staff member in each agency or organization receiving Block Grant funds to deliver substance abuse prevention programs/services from ODP must hold a Certified Prevention Specialist (CPS) certification.” Graduated efforts to move the workforce towards compliance with this expectation have been underway over the last three years.

   ODP enlisted the Community Anti-Drug Coalitions of America (CADCA) in the development and instruction of two cohorts of an 18 -hour training series to equip prevention providers with the knowledge necessary to take the CPS exam. Cohorts were delivered both in-person and online to reach workforce members in rural and frontier communities as well as our urban areas. Information in each of the following domains was provided: Planning and Evaluation; Prevention Education and Service Delivery; Communication; Community Organization; Public Policy and Environmental Change; and, Professional Growth and Responsibility.

   Additional information in the required Ethics and the Planning and Evaluation domains was acquired through on-site training at annual conferences held within the state, as well as monthly webinars coordinated by ODP.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? ☐ Yes ☐ No

   If yes, please describe mechanism used

   The development of the mechanism to provide training and technical assistance to the substance misuse prevention workforce utilized information obtained in a statewide Workforce Development Survey conducted by ODP in February 2016, and includes the following components: 1) web-based training and education sessions; 2) in-person training and education opportunities; and, 3) on-going telephone and on-site technical assistance provided by ODP staff.

   In addition to the two cohorts of CPS training mentioned above, ODP hosts annual grantee web-based trainings designed to educate new grantees and update returning grantees regarding SABG guidelines, requirements and performance expectations. Monthly provider education sessions reinforce training in the identified domains and allow for two-way interaction with facilitators that enhance specific skills.RMC Research Corporation, the State evaluators, delivers semi-annual presentations to

NOT FINAL

address compliance, fidelity and data collection as related to the statewide evaluation plan. Continuing education opportunities are made available through scholarships to the Idaho Conference on Alcohol and Drug Dependency, the Northwest Alcohol Conference, the Idaho Prevention Conference, and the CADCA Academy and Mid-Year Conference. Finally, on-going technical assistance and support is provided by ODP staff directly to the prevention workforce members via phone and scheduled site visits. Training resources are also available through the CAPT and through the online CADCA workstation.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ☐ Yes ☐ No

If yes, please describe mechanism used

Idaho does have a formal mechanism to assess community readiness to implement prevention strategies. Readiness and capacity to implement prevention strategies is currently determined through the competitive grant application process. Applicants are required to provide a community assessment, information about their organization's capacity, and detailed plans for implementation and evaluation. The Regional Review Committees then determine the applicant's readiness to implement the proposed strategies based on their submitted application materials.

All funded community coalitions administer the Kaizen survey to determine capacity within their coalitions. Coalitions are required to report community memberships and partnerships so that ODP can ensure they have proper sector representation. RMC Research Corporation, the State evaluator, administered a community readiness survey to all grant funded coalitions in May 2017 and is currently in the process of analyzing outcomes.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

NOT FINAL

Narratve Question

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Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ☐ Yes ☐ No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

   Idaho Prevention Strategic Plan is located in the attachment section

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ☐ Yes ☐ No ☐ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

   a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   b) ☐ Timelines
   c) ☐ Roles and responsibilities
   d) ☐ Process indicators
   e) ☐ Outcome indicators
   f) ☐ Cultural competence component
   g) ☐ Sustainability component
   h) ☐ Other (please list):
   i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ☐ Yes ☐ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ☐ Yes ☐ No

   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

   Idaho has an active Evidence-Based Practices Workgroup. Programs that are listed on the Idaho Evidence-Based Program List are considered evidence-based and, therefore, may be used by prevention providers across the state. Programs that are listed as effective on national registries including the National Registry for Evidence-Based Programs and Practices (NREPP), Blueprints, and

NOT FINAL

Office of Juvenile Justice and Delinquency Prevention are also deemed evidence-based. However, if the program is not listed on a national registry, the program must be reviewed by the Idaho Evidence-Based Practices Workgroup to identify if there is evidence of effectiveness.

The EBP Workgroup is composed of research professionals from several state agencies. For a program to be reviewed by the EBP Workgroup, an application and three research articles must be submitted. The Evidence-Based Practices Workgroup members score the materials and either disapprove or approve of the program provisionally. If the program has been approved provisionally, the program provider must supply the EBP Workgroup with outcome data. Once the outcome data has been reviewed, the program will be either disapproved or added to the Idaho Evidence-Based Program List.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

NOT FINAL

Narratve Question

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Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) ☒ SSA staff directly implements primary prevention programs and strategies.

   b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

   c) ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

   d) ☐ The SSA funds regional entities that provide training and technical assistance.

   e) ☐ The SSA funds regional entities to provide prevention services.

   f) ☒ The SSA funds county, city, or tribal governments to provide prevention services.

   g) ☒ The SSA funds community coalitions to provide prevention services.

   h) ☒ The SSA funds individual programs that are not part of a larger community effort.

   i) ☐ The SSA directly funds other state agency prevention programs.

   j) ☒ Other (please describe)

   The Idaho Department of Health and Welfare (SSA) transfers primary prevention funds to the Idaho Office of Drug Policy. The Idaho Office of Drug Policy administers all primary prevention efforts as described above.

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) Information Dissemination:

   Regional Alcohol and Drug Awareness Resource Center
   Lock Your Meds statewide Prescription Drug Media Campaign
   Be The Parents statewide Underage Drinking Media Campaign
   Coalition Town Hall Events
   Idaho Drug Free Youth Leadership Conference

   b) Education:

   Project Alert; Nurturing Parenting Program; Second Step; Project Towards No Drug Abuse; Project Towards No Tobacco Use; Positive Action; Al's Pal's; Strengthening Families; Life Skills Training; Guiding Good Choices; Project Venture; Active Parenting; Too Good For Drugs; Refuse, Remove, Reason; and, Boomerang Project/Link Crew

NOT FINAL

c) Alternatives:

Cross Age Mentoring Program (CAMPS); Positive Action/Prime Time for Kids After School Activities; Drop-in Recreational Activities; and, Community Service Activities.

d) Problem Identification and Referral:

Project Towards No Drug Abuse+
Active Parenting/Families In Action
Strengthening Families Programs

e) Community-Based Processes:

Community and Volunteer Training
Planning and Coalition Development
Kaizen assessment tool
School Survey Design and Implementation

f) Environmental:

"Escape the Vape" Vaping Policy change
Sticker Shock Campaigns
Prescription Medication Take-back Programs
Social Host Ordinances

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? ☒ Yes ☐ No

If yes, please describe

To avoid duplication of prevention efforts, Idaho has moved oversight of all Federal substance abuse prevention dollars to the Office of Drug Policy (ODP). This ensures that all SAP efforts are coordinated through one state office and reduces the possibility of duplication of efforts. However, there are some state agencies that occasionally fund what can be considered substance abuse prevention programs. Because of the strong relationships we have built with these agencies, we work together to stay informed of these programs and ensure that we are not duplicating efforts.

Because ODP awards SABG funds to sub recipients through a competitive application process with the assistance of Regional Review Committees, the members of these committees are very familiar with prevention efforts occurring in their communities and help ensure no duplication of services is occurring.

In addition, individual grantees are required to sign an Assurance of Compliance with Federal Law Regarding Supplanting of Funds when applying for SABG funds and again upon acceptance of grant funds stating, "I have read the definition below and understand Federal Block grant funds, if awarded, will not be used to supplant expenditures from other Federal, State, or local sources. Grant funds cannot be used to supplant current funding of existing activities."

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

NOT FINAL

Narratve Question

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Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ☐ Yes ☐ No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

   Evaluation plan is located in Attachment Section.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

   a) ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   b) ☐ Includes evaluation information from sub-recipients
   c) ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
   d) ☐ Establishes a process for providing timely evaluation information to stakeholders
   e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   f) ☐ Other (please list:)
   g) ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

   a) ☐ Numbers served
   b) ☐ Implementation fidelity
   c) ☐ Participant satisfaction
   d) ☐ Number of evidence based programs/practices/policies implemented
   e) ☐ Attendance
   f) ☐ Demographic information
   g) ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

   a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc

NOT FINAL

b) ☐ Heavy use

☐ Binge use

☐ Perception of harm

c) ☐ Disapproval of use

d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

NOT FINAL

Footnotes:

NOT FINAL

Idaho Office of Drug Policy

SABG Prevention Program Strategic Plan

SFY2016 - 2017

Vision

The Idaho Office of Drug Policy envisions an Idaho free from the devastating social, health, and economic consequences of substance abuse.

Mission

Lead Idaho's substance abuse policy and prevention efforts by developing and implementing strategic action plans and collaborative partnerships to reduce drug use and related crime, thereby improving the health and safety of all Idahoans.

Goals

Goal 1: **Create and sustain a statewide prevention program to promote behavioral health and wellness and reduce substance use.**

Goal 2: **Improve prevention efforts through evidence-based programs/environmental strategies as determined by community needs.**

Goal 3: **Expand capacity of the prevention workforce.**

Goal 4: **Effectively measure prevention program outcomes of evidence-based programs/environmental strategies.**

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Goal 1: Create and sustain a statewide prevention program to promote behavioral health and wellness and reduce substance use.	
Objective: Develop, implement and sustain primary prevention programs/services.	
	Strategy 1: Identify essential prevention services
	Activities: a. Utilize recommendations from the Strategic State Prevention Planning Committee and results from the State Behavioral Health Planning Council to identify a list of essential prevention services b. Assist communities in prioritizing essential services based on regional needs assessments **c.** Survey communities and current prevention providers to determine available services, gaps and limitations
	Strategy 2: Identify population(s) to be served
	Activities: **a.** Review available data to identify underserved populations and areas of need **b.** Conduct inventory of current prevention providers and determine gaps in services **c.** Match prevention services to identified population(s) d. Actively recruit prevention providers to build capacity **e.** Provide training and technical assistance to prevention providers in implementing identified programming
Goal 2: Improve prevention efforts through evidence-based programs/environmental strategies as determined by community needs.	
Objective: Increase the number of prevention providers employing evidence-based primary Prevention programs/environmental strategies to fit individual community needs.	
	Strategy 1: Identify and implement evidence-based primary prevention programs/environmental strategies
	Activities: a. Review utilization of both direct service programs and environmental strategies in use by providers across the state b. Disseminate inventory of effective programs as established by Evidence-Based Practices Workgroup c. Provide training on evidence-based programs, curricula, and strategies that support primary prevention services d. Provide ongoing technical assistance to providers to support local evidence-based programs

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Goal 3: Expand capacity of the prevention workforce.	
Objective: Increase the number of Certified Prevention Specialists (CPS) in Idaho from 3 to 12 as measured by the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC) data base by June 30, 2017.	
	Strategy 1: Coordinate recommended standards for prevention services
	Activities: a. Survey current prevention providers to determine baseline b. Develop recommended standards for prevention providers across the state c. Educate prevention providers regarding state plan d. Determine workforce development priorities e. Provide training and technical assistance f. Work to identify integrated funding stream for certification/credentialing g. Identify a training portal (IT product) to enhance training options and streamline CEU tracking
Goal 4: Effectively measure prevention program outcomes of evidence-based programs/environmental strategies.	
Objective: Strengthen data collection and evaluation capacity to accurately measure prevention program outcomes.	
	Strategy: Develop capacity of the prevention workforce to evaluate programs and improve outcomes
	Activities: a. Provide training and technical assistance to enhance evaluation capacity for local prevention providers b. Develop evaluation tools and resources to support local providers to evaluate their programs **c.** Disseminate evaluation tools to local prevention providers
	Strategy : Implement coordinated data collection and reporting processes across prevention programs and providers
	Activities: a. Review provider data collection and management process to determine current capacity and identify needed enhancements b. Provide training and technical assistance on the collection and reporting of required data c. Collect data, analyze and report outcomes at state and regional levels

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Idaho SPF SABG Grant Program Statewide Evaluation Plan

NOT FINAL

November 2016

Prepared for

Idaho Office of Drug Policy
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Idaho Strategic Prevention Framework and Substance Abuse Block Grant Evaluation

Statewide Evaluation Plan

NOT FINAL

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Executive Summary

In August 2016, Idaho's Office of Drug Policy (ODP) contracted with RMC Research to serve as the external evaluator for 2 federal substance abuse prevention grants: the State Prevention Framework State Incentive Grant (SPF SIG) and the Substance Abuse Block Grant (SABG). Both grants are funded by the Substance Abuse and Mental Health Service Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP).[1] This document provides a plan for all evaluation activities related to Idaho's SPF SIG and SABG programs, in addition to selected state-level activities. This plan covers SPF SIG and SABG evaluation activities for the 2017 and 2018 fiscal years.

Background

Idaho's SPF SIG award funds community coalitions that are required to implement evidence-based environmental strategies designed to prevent prescription drug abuse, although grantees can also address underage drinking and marijuana use with the funds. SPF SIG grantees are required to use the SPF 5-step planning process to guide the selection, implementation, and evaluation of prevention activities and to promote sustainability. To date, 16 community coalitions have been funded through SPF SIG.

Idaho's SABG primarily funds providers implementing evidence-based direct service programs for youth, families, and other individuals at risk for substance abuse, although some grantees use the funds to implement environmental strategies. Idaho currently has 46 SABG-funded entities delivering programs and strategies focused on primary prevention of substance use. As of November 2016, 8 SPF coalitions have received SABG funding and may be implementing direct service programs with this funding.

Idaho is implementing state-level activities that are also a focus of this evaluation. The BeTheParents.org media campaign targets parents of underage youth and educates them about strategies to encourage their children to abstain from alcohol. In addition, six law enforcement agencies statewide are funding environmental strategies using SPF SIG funds.

Evaluation Overview

The evaluation questions address infrastructure and capacity, intervention implementation, and substance use outcomes for SPF and SABG grantees. The evaluation questions will be answered through collecting new and existing data, including surveys of key informants and coalition members, interviews with law enforcement grantees, implementation and outcome data from local communities, and an analysis of state-level data sources. Results from all of the components will be included in the **Annual Aggregate SPF/SABG Statewide Evaluation Report**, which will summarize all evaluation results for SABG and SPF SIG.

SPF SIG Evaluation

Evaluation of communities' implementation of SPF will be structured around common evaluation questions describing community-level infrastructure, resources and capacity, coalition activities, program implementation, program outcomes, and local facilitators and barriers to program

[1] SABG is additionally funded by the Center for Substance Abuse (CSAT) to support substance abuse treatment, but these activities are not the focus of this evaluation.

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implementation. The major goal of the evaluation will be to provide information on implementation of SPF SIG across all 16 SPF-funded communities. Evaluation activities will include an analysis of process data collected by ODP, surveys of coalition members and project directors, and the collection of primary data on local community outcomes. In addition to answering the evaluation questions in this document in the annual aggregate report, the SPF SIG evaluation consists of the following deliverables:

- **Annual Coalition Evaluation Reports.** These reports will provide SPF coalitions with a summary of their evaluation data collected by ODP and RMC Research throughout the year.
- **Cross-Site Evaluation Report.** This report will present information for all coalitions within one document for easy comparison. The report will compare coalition activities, populations served, capacity, readiness and infrastructure, and outcomes.
- **SPF PFS Data Collection Plan.** In Year 1, RMC Research will review the requirements of the Partnerships for Success (PFS) cross-site evaluation and provide recommendations for changes to ODP's data collection processes to align with PFS evaluation requirements. In Year 2, RMC Research will assist with the data collection plan for the PFS application.

RMC will also conduct **Biannual Coalition Training Sessions** to inform SPF grantees of evaluation activities and data collection requirements and to provide technical assistance on topics of interest to grantees. SABG grantees and SPF law enforcement grantees will be invited to the training sessions, although they are not required to attend.

SABG Evaluation

The SABG evaluation will summarize implementation and outcome data for SABG programs, including the number and characteristics of individuals served, implementation successes and challenges, and pre- and post-program outcomes for participants. ODP will supply outcome and process data, and RMC Research will administer to SABG providers a survey to ask about their implementation of the SABG. As part of the evaluation, RMC Research will provide the **Comprehensive Report of Current SABG Processes**, which will include recommendations regarding the SABG participant surveys and ODP's current processes for data collection, analyses, and reporting of SABG outcomes.

State-Level Evaluation

The state-level evaluation will examine the influence of SPF SIG and SABG on trends over time in selected state-level outcomes related to prescription drug use, underage alcohol use, and marijuana use. The evaluation also includes selected state-level activities such as the BeTheParents.org underage drinking campaign and the SPF law enforcement grants. The SPF law enforcement evaluation will document implementation activities and successes and challenges, and will involve interviews with grantees and a review of progress reports. The goals of the BeTheParents.org evaluation are to examine the statewide reach of the campaign and to determine the effects of the campaign on parental attitudes and behaviors that prevent underage drinking. Data collection for BeTheParents.org will include a social media survey of parents, website analytics for the BeTheParents.org website, and measures of advertisement penetration.

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Introduction

Idaho's Office of Drug Policy (ODP) is an office within the Executive Office of the Governor that is responsible for the statewide coordination of policy and prevention programming related to substance abuse. As part of these efforts, ODP administers 2 federal substance abuse prevention grants, the State Prevention Framework State Incentive Grant (SPF SIG) and the Substance Abuse Prevention and Treatment Block Grant (SABG). Both grants are funded by the Substance Abuse and Mental Health Service Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP).

The SPF SIG is a SAMHSA infrastructure grant program that supports an array of activities to help states, tribes, and jurisdictions build a solid foundation for delivering and sustaining effective substance abuse prevention services. The SPF SIG is implemented by CSAP and is designed to *(a)* prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; *(b)* reduce substance abuse-related problems in communities; and *(c)* build prevention capacity and infrastructure. CSAP provides funding to states, tribes, and jurisdictions, who can in turn fund local community grantees. State-level SPF SIG recipients and their community grantees are required to implement the 5 steps of the SPF:

- Profile population needs, resources, and readiness to address the problems and gaps in service delivery;
- Mobilize and/or build capacity to address needs;
- Develop a comprehensive strategic plan;
- Implement evidence-based prevention programs, policies, practices, and infrastructure development activities; and
- Monitor process, evaluate effectiveness, sustain effective programs and activities, and improve or replace activities that fail.

Idaho was awarded SPF SIG funding in August 2013 and to date has awarded funds to 16 community coalitions. Coalitions are required to implement evidence-based environmental strategies designed to prevent prescription drug abuse, although coalitions can also address underage drinking and marijuana use with the funds.

Idaho's ODP has administered the prevention portion of the SABG since July 2013. The SABG provides funds to state, tribes, and jurisdictions to prevention and treat substance abuse. To receive funds, applicants must meet the following requirements:

- Have a designated unit of its executive branch that is responsible for administering the SABG (e.g., Idaho's ODP);
- Apply annually for SABG funds;
- Have the flexibility to distribute SABG funds to local government entities (e.g., cities, counties); and
- Fund local community organizations to deliver substance abuse prevention activities or substance use disorder treatment and recovery support services.

At least 20% of SABG funds must be allocated to substance abuse primary prevention activities. Idaho's SABG prevention grants primarily fund providers implementing evidence-based direct service programs for youth, families, and individuals at risk for substance abuse, although some grantees use the funds to implement coalition activities, such as environmental strategies. Idaho currently has 46 SABG-funded entities delivering programs and strategies focused on primary prevention of substance use. As of

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November 2016, 8 SPF coalitions had received SABG funding and could currently be in the process of implementing direct service programs with this funding.

Idaho is implementing state-level activities that are also a focus of this evaluation. The BeTheParents.org media campaign targets parents of underage youth and educates them about strategies to encourage their children to abstain from alcohol. The campaign focuses on educating parents about ways to help their children find their passion and become engaged in activities to prevent alcohol use. In addition, six law enforcement agencies statewide are funding environmental strategies using SPF SIG funds.

In August 2016, ODP contracted with RMC Research to serve as the external evaluator for the project. This document provides a plan for all evaluation activities related to Idaho's SPF SIG and SABG grants and selected state-level activities.

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SPF SIG Evaluation Activities

Overview

The evaluation of the 16 SPF SIG-funded community coalitions' implementation of SPF will be structured around common questions regarding community-level infrastructure, resources and capacity, coalition activities, program implementation, program outcomes, and local facilitators and barriers to program implementation. The goal of the evaluation will be to provide information on implementation of the SPF SIG grant across all 16 SPF-funded communities and the grant's effects on Idaho's priority areas (i.e., prescription drug use, alcohol health outcomes, and marijuana use).

The evaluation questions described in this section will be answered in aggregate across all communities in the **Annual Aggregate SPF/SABG Statewide Evaluation Report**, which will provide an overview of the progress of the SPF program in Idaho. Evaluation activities undertaken through SPF will also inform the **SPF Partnerships for Success (PFS) Data Collection Plan** that RMC Research will assist ODP in developing as part of the SPF PFS application. RMC Research will use many of the data sources described in this section to provide an **Annual Coalition Evaluation Report** for each of the 16 community coalitions funded through SPF. The information in these 16 reports will be summarized and coalitions will be compared in the **SPF Cross-Site Report**.

Evaluation Questions

Exhibit 1 outlines the proposed evaluation questions and the data sources that will be used to address each question. Evaluation questions relate to the effects of SPF SIG in 3 areas: *(a)* Infrastructure, capacity, and readiness; *(b)* Strategy implementation; and *(c)* Substance use outcomes. RMC Research's review of the SPF strategic plans and KIT Solutions database from FY2015-2016 suggested that SPF-funded grantees are exclusively focused on youth substance use, so evaluation questions related to outcomes are focused on youth outcomes.

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Exhibit 1. SPF Cross-Site Evaluation Questions

SPF SIG Evaluation Questions	Data Sources
Infrastructure, Capacity, and Readiness	
1. Did SPF communities show change over time in capacity and infrastructure?	▸ Kaizen Coalition Surveys ▸ SPF Community Infrastructure Assessment ▸ SPF Provider Spreadsheet
2. Did SPF communities show change over time in readiness?	▸ SPF Community Readiness Survey
Intervention Implementation	
3. Which types of substance abuse prevention programs and strategies did SPF coalitions implement?	▸ SPF Provider Spreadsheet
4. Who was served or reached by SPF strategies and what were their characteristics?	▸ SPF Provider Spreadsheet
5. What implementation successes and challenges did coalitions experience?	▸ SPF Provider Spreadsheet ▸ SPF Community Infrastructure Assessment
Community-Level Outcomes and Outputs	
6. Did implementation of the SPF SIG lead to community-level improvement in prescription drug use outcomes among youth?	▸ SPF Local Community Outcomes
7. Did coalitions that targeted marijuana or alcohol use see community-level improvement in these outcomes among youth?	▸ SPF Local Community Outcomes
8. Which factors accounted for variation in outcomes across funded subrecipient communities?	▸ SPF Local Community Outcomes ▸ SPF Community Readiness Survey ▸ Kaizen Coalition Surveys ▸ SPF Provider Spreadsheet
9. What were the outputs of SPF strategies?	▸ SPF Provider Spreadsheet
10. For SPF coalitions implementing direct service programs, what were the effects on participants?	▸ SABG Program Participant Surveys ▸ SABG Attendance/Demographics Spreadsheet

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Data Collection

To address the evaluation questions above, RMC Research will utilize data that ODP is currently collecting and will conduct primary data collection to supplement existing data sources, which include the cumulative **SPF Provider Spreadsheet** that ODP will provide quarterly to RMC Research. RMC Research will use the quarterly reports to conduct preliminary analyses and develop templates for reporting,[2] but final reports will use data from the 4th quarter cumulative spreadsheet that represents data for the entire fiscal year. We will use data from this spreadsheet, along with **U.S. census or district data**, to calculate the penetration rate of strategies. RMC Research will also utilize data from the **Kaizen Coalition Surveys** collected during the second quarter of each fiscal year; the data will be in Excel

[2]For the Annual Coalition Reports, the SPF Cross-Site Report, and the Annual Aggregate SPF/SABG Statewide Evaluation Report

spreadsheets provided by ODP. Because some SPF coalitions are also receiving SABG funds, we will include their SABG data in SPF reporting. ODP will annually provide the data from the **SABG Program Participant Surveys** and the **SABG Attendance/Demographics Spreadsheet** to RMC Research.

RMC Research will collect additional data directly from SPF coalitions. RMC Research will develop 2 Excel spreadsheets, one for survey data and one for administrative data, to collect **SPF local community outcomes** from local evaluators. The spreadsheets will be modeled on the spreadsheets RMC Research developed for the national cross-site evaluation of SPF SIG. This process will allow local evaluators to enter summary data for survey and administrative outcomes they have collected since receiving the SPF grant. On March 9, 2017, RMC Research will conduct a training session to demonstrate how to enter data into the spreadsheets, establish a timeline for data collection, and discuss procedures for collecting the data from local evaluators. We will develop a guidance manual that will provide information on the purpose of the spreadsheets and instruction on how to complete the spreadsheets. RMC Research will also provide technical assistance to local evaluators as needed. Grantees will be asked to submit their completed spreadsheets by June 1 of each year.

In May of each year, RMC Research will administer the **SPF Community Infrastructure Assessment (SPF CIA)** to coalition directors and the **SPF Community Readiness Survey** to coalition members. These surveys will be administered online using SurveyMonkey.

Measures

This section describes the content and development of the proposed surveys and the template to collect community outcomes from local evaluators. It also describes the content of existing data sources collected by ODP, including the **SPF Provider Spreadsheet** and the **Kaizen Coalition Surveys**. The content of the **SABG Attendance/Demographics Spreadsheet** and the **SABG Program Participant Surveys** will be described in the next section, which focuses on SABG evaluation activities.

SPF Provider Spreadsheet

All SPF coalitions will submit data to ODP every quarter using the SPF Provider Spreadsheet, an Excel file developed by ODP that collects data on the following indicators:

- Coalition members
- Coalition partners
- Meetings held
- Measurement tools utilized
- Training sessions conducted
- Technical assistance provided
- Problem statements
- Goals and objectives
- Strategies employed
- Service activities, including duration and location
- Demographics of service activity participants
- Progress reports, including barriers, successes, and future plans

Collectively, these indicators will be used to answer multiple SPF implementation and outcomes-related evaluation questions.

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Kaizen Coalition Surveys

The Kaizen assessment, offered by the National Guard, is a survey of coalition members designed to measure the coalition's ability to successfully implement the 5 steps of the SPF, as shown in Exhibit 2. In addition to assessing completion of the step, the survey measures member consensus, participation, and perceptions of utility at each step. The term *Kaizen* is taken from the Japanese management approach to continuous process improvement, and ideally coalitions will use the results of the Kaizen survey to improve their work and track their progress.

After survey administration, the National Guard provides feedback to coalitions through a coaching report. Although the coaching report includes actionable recommendations, it does not track grantees' progress over time, nor does it compare grantees' progress to a benchmark. In the annual coalition evaluation reports, RMC Research will provide grantees with visuals that allow them to view their progress. We will also show them how their score compares to the average coalition score for each of the SPF steps.

Exhibit 2. The 5 SPF Steps

SPF Steps[a]	Primary Goals
1. Assessment	▸ Identify problems and related behaviors ▸ Assess risk and protective factors ▸ Assess resources and readiness
2. Build Capacity	▸ Raise stakeholder awareness ▸ Engage diverse stakeholders ▸ Strengthen collaborative efforts ▸ Develop the workforce t
3. Planning	▸ Prioritize risk and protective factors ▸ Select effective interventions ▸ Build a logic model
4. Implementation	▸ Develop a clear action plan ▸ Balance fidelity and adaptation ▸ Establish implementation supports
5. Evaluation	▸ Evaluate process and outcomes ▸ Communicate evaluation results

Note. [a]From http://www.samhsa.gov/capt/applying-strategic-prevention-framework

SPF Community Infrastructure Assessment

One of the primary goals of the SPF SIG is to help communities strengthen local prevention infrastructure and capacity. The SPF Community Infrastructure Assessment (CIA) will be a more comprehensive measure of local infrastructure and capacity to address substance use issues than the Kaizen coalition surveys, which will assess some aspects of capacity (e.g., coalition functioning). The SPF CIA will only be administered to the SPF project director at the grantee community, whereas the Kaizen coalitions surveys are administered to coalition members.

The SPF CIA will be developed by RMC Research, based partly on the infrastructure assessments used in the national cross-site evaluations of the SPF SIG and PFS and other state infrastructure surveys.

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Exhibit 3 shows the proposed content of the SPF CIA, which will explore several facets of local infrastructure for substance use prevention, including organizational structure; strategic planning; data and data systems; workforce development; evidence-based programs, policies, and procedures (EBPPPs); cultural competency; evaluation and monitoring; and sustainability.

Exhibit 3. Proposed Content of the SPF CIA

Infrastructure Domains	Constructs Measured
Organizational Structure	▸ Decision-making authority ▸ Written guidelines for decision making ▸ Incorporation of input from community and state stakeholders
Strategic Planning	▸ Mission and vision ▸ Input from stakeholders on mission and vision ▸ Perceived level of support for the strategic plan ▸ Staff time allocated to planning ▸ Availability of planning-related technical assistance ▸ Mechanisms for linking state and local planning efforts ▸ Use of strategic plan
Data and Data Systems	▸ Capacity to collect data and maintain data systems ▸ Resources to develop data capacity ▸ Extent to which epidemiological data is shared ▸ Availability of technical assistance or local expertise in understanding and using data
Workforce Development	▸ Written professional development plans or policies ▸ Workforce development opportunities ▸ Accessibility of workforce development opportunities ▸ Areas of need
Evidence-Based Programs, Policies, and Procedures	▸ Consistency across state and local entities in defining EBPPPs ▸ Availability of resources and technical assistance to assist in selection, implementation, and adaptation of EBPPPs
Cultural Competency	▸ Policies and practices related to cultural competency ▸ Capacity to identify health disparities
Evaluation and Monitoring	▸ Availability of evaluator expertise ▸ Utilization of evaluation data ▸ Streamlining of reporting requirements
Sustainability	▸ Diversification of funding ▸ Plans to address sustainability ▸ Integration of strategies into organizational practices, policies, or partnership structures

SPF Community Readiness Survey

RMC Research will administer the SPF Community Readiness Survey to coalition members in the summers of 2017 and 2018. RMC Research will develop items based on the Community Readiness

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Model developed by researchers at the Tri-Ethnic Center for Prevention Research (Oetting et al., 1995). Community readiness is defined as the degree to which a community is ready to take action on an issue. Communities might be more ready to address one issue (e.g., underage drinking) than another (e.g., prescription drug use). Groups within the community (e.g., law enforcement, schools) could be at varying levels of readiness. Coalition members, as representatives of different community sectors, will provide estimates of readiness within their sectors.

The Community Readiness Model includes the 5 dimensions of readiness shown in Exhibit 4. For each dimension, survey questions will assess communities' current stage of readiness for the goal in question (e.g., prevention of underage drinking). The model defines 9 stages of community readiness from *no awareness* of the problem to *professionalization* that is characterized by supportive leaders; high community involvement; sophisticated knowledge of the problem and its causes in the community; highly trained staff members running programs and activities; and robust evaluation of community programs, policies, and activities (see the Appendix for detailed descriptions of the 9 stages of readiness).

Survey questions will ask the coalition members to respond based on the community members' perspectives for each of the grantee's substance use priorities (obtained from SPF provider spreadsheets). For each community, coalition members' responses will be aggregated to calculate a score on each dimension for each priority. Although all 16 SPF-funded communities have already begun mobilizing for substance use prevention, this survey will quantify their level of readiness for each issue they are addressing, providing ODP and the coalitions with snapshots of their ongoing progress. The annual coalition evaluation reports will describe the survey results, along with recommendations for actions to increase the community's level of readiness.

Exhibit 4. Dimensions of Community Readiness

Dimensions	Lowest Level of Readiness	Highest Level of Readiness
Community Knowledge of Efforts	Community members have no knowledge about local efforts addressing the issue.	Most community members have extensive knowledge about local efforts: they know the purpose, who the efforts are for, and how the efforts work. Many community members know the effectiveness of local efforts.
Leadership	Leaders believe that the issue is not a concern.	At least some of the leaders are continually reviewing evaluation results of the efforts and are modifying financial support accordingly.
Community Climate	Community members believe that the issue is not a concern.	The majority of the community members are highly supportive of efforts to address the issue. Community members demand accountability.
Community Knowledge of Issue	Community members have no knowledge about the issue.	Most community members have detailed knowledge about the issue: they know detailed information about causes, consequences, signs, and symptoms.
Resources Related to the Issue	There are no resources available for (further) efforts.	Diversified resources and funds are secured, and efforts are expected to be ongoing. There is additional support for new efforts.

SPF Local Community Outcomes

RMC Research will adapt spreadsheets developed for the SPF SIG cross-site evaluation to collect SPF local community outcomes survey and event data from Idaho SPF coalitions. In the survey data

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spreadsheet, SPF coalitions will be asked to enter information about the survey administration (e.g., data collection date) and measures descriptions (e.g., measure source item and response option wording). Outcomes information for survey data will include the calculated value, value type (e.g., percentage), standard error, standard deviation, and sample size. In the administrative data spreadsheet, SPF coalitions will be asked to enter information to describe the data, such as administrative data type (e.g., fatality analysis reporting system, uniform crime reporting system, state/grantee agency reporting system, local/community agency reporting system), data source timeframe, event definition, and measure calculation. Outcome information for administrative data will include the number of events, denominator definition and value, calculated value, and value type.

Analysis Plan

The following sections outline the proposed analyses for each of the SPF SIG evaluation questions. The inferential analyses described in this section will be presented in the **Annual Aggregate SPF/SABG Statewide Evaluation Report,** which aggregates data across all communities. However, much of the data discussed will also be presented at the community level in the **Cross-Site Report** and the **Annual Coalition Evaluation Report.** For details about the differences in the content and approach of the reports, see the Deliverables section.

Infrastructure, Capacity, and Readiness

The following section describes the analyses for the 2 evaluation questions pertaining to community-level infrastructure and capacity to support prevention activities and community readiness to implement substance use prevention strategies.

Did SPF communities show change over time in capacity and infrastructure?

The first administration of the SPF CIA will serve as the baseline assessment of SPF communities' infrastructure and capacity. RMC Research will descriptively analyze the baseline survey results (e.g., mean, standard deviations, range). In the second year of the contract, RMC Research will explore the psychometric properties of the SPF CIA scales. We will conduct factor analyses to examine the multidimensionality of the scale items. We will assess the *internal consistency reliability* of the survey by grouping similar items that are intended to measure the same construct (e.g., organizational structure, sustainability) and calculating Cronbach's coefficient alpha for these items. Only scale items that contribute to reliability will be maintained in the final scale score.

After the second administration of the SPF CIA in the second year of the contract, RMC will examine change from baseline for each of the scale scores using repeated measures analysis of variance (ANOVA) using the *GLM* command in SPSS.

Did SPF communities show change over time in readiness?

Similar to the SPF CIA, the first administration of the SPF Community Readiness Survey will serve as the baseline assessment. RMC Research will calculate the mean of coalition members' responses for each item on the survey. A score will be calculated for each dimension of readiness (e.g., community knowledge of efforts, leadership) by summing the coalition members' mean score on items representing that construct. The internal consistency reliability of the scales representing dimensions will be assessed, and items not contributing to scale reliability will not be included in the calculation of the score for that dimension. Linear mixed models (LMMs) will be used to examine change over time in readiness. LMMs are excellent for handling nested observations; in this case, coalition members nested within a community. The LMM approach allows the development of

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regression equations at each level of nesting (i.e., individual, community) to account for variation at different levels of the model. This approach has multiple advantages over traditional GLMs, including more tolerance for missing values, the ability to include covariates while adjusting for random effects associated with each community, and greater flexibility regarding covariance structures (West, Welch, & Galecki, 2014). LMMs will be conducted with the *MIXED* command in SPSS.

Intervention Implementation

This section describes the analyses for the 4 evaluation questions pertaining to community-level intervention implementation of environmental and direct service strategies (the latter only in the case of SPF communities receiving SABG funds).

Which types of substance abuse prevention programs and strategies did SPF coalitions implement?

Using the SPF Provider Spreadsheet, RMC Research will descriptively summarize the goals, priorities, and strategies implemented by SPF grantees. Strategies will be reported by substance targeted, strategy type, Institute of Medicine (IOM) category, and Community Anti-Drug Coalitions of American (CADCA) category. These data will provide information on the most common strategies implemented in the SPF-funded communities.

Who was served or reached by SPF strategies and what were their characteristics?

RMC Research will descriptively summarize the populations served (age, race, sex) for each type of strategy communities implement as well as aggregated across all types of strategies. For SABG-funded programs, we will also summarize the attendance and program event data (e.g., average number of participants per session, length of session).

What implementation successes and challenges did coalitions experience?

Implementation successes and challenges are reported in the SPF Provider Spreadsheet. RMC Research will qualitatively analyze the successes and challenges fields to identify common themes. We will examine consistencies in reported successes and challenges across coalitions and provide suggestions for facilitating successes and avoiding challenges in the future.

Community-Level Outcomes and Outputs

This section describes the 5 evaluation questions pertaining to community-level outcomes of environmental and direct service strategies (the latter only in the case of SPF communities receiving SABG funds).

Did implementation of the SPF SIG lead to community-level improvement in prescription drug use outcomes among youth?

Because the second administration of the Idaho Youth Prevention Survey will not occur until the fall of 2018, data on community-level consumption and intervening variable outcomes will likely be limited during this evaluation contract. As discussed previously, RMC Research will work with ODP local evaluators to obtain locally collected data on survey and administrative outcomes. We anticipate that the number and types of outcomes available will differ between communities, presenting particular challenges for inferential analyses that require identical outcome measures.

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Meta-analysis is a method for maximizing sample sizes when measures differ across communities. If several communities have more than one time point available for an outcome, meta-analyses can be used to quantify the magnitude of change in the outcome across all communities from the beginning of SPF SIG funding to the present. Meta-analyses can be conducted when outcome measures differ (e.g., different response options to a prescription drug use question) because they focus on standardized effect sizes rather than raw data. RMC Research will conduct a random-effects meta-analysis[3] on the effect sizes and calculate a summary effect. The summary effect will provide an estimate of the success of SPF SIG in reducing alcohol, marijuana, and prescription drug use across all SPF-funded communities with available outcome data for baseline and follow-up.

For meta-analyses, it is necessary to calculate an effect size, which is an estimate of the magnitude of the change over time. One method of calculating an effect size is to calculate odds to reflect the occurrence of a "successful event." For instance, if 25% of underage youth used alcohol in the past 30 days, then the percentage that did not use alcohol is 75%. Thus, the odds of a successful event (i.e., no alcohol use in the past 30 days) are calculated as 3.0 (3 successes to every 1 failure). From these odds, an odds ratio can be computed to reflect the amount of change in outcomes over time by dividing the odds of a successful event at follow-up by the odds of a successful event at baseline. Odds ratios are centered at 1.0; odds ratios greater than 1.0 indicate greater odds of success at follow-up compared with baseline (i.e., improvement), whereas odds ratios less than 1.0 indicate greater odds of success at baseline (i.e., worsening).

Did coalitions that targeted marijuana or alcohol use see community-level improvement in these outcomes among youth?

The approach to the analyses for marijuana and alcohol use outcomes will be identical to that for prescription drug use outcomes, except that these analyses will only be conducted for coalitions that targeted those outcomes. It is unlikely that coalitions would have available data for an outcome they did not target, but even if data were available we could not attribute change over time within a community to SPF SIG if the outcome was not targeted by the SPF-funded coalition.

Which community-level factors accounted for variation in outcomes across SPF-funded grantee communities?

Community-level factors that could influence outcomes in grantee communities are the mix of interventions implemented (e.g., environmental or direct service); community infrastructure, capacity, and readiness; and coalition functioning. Sample sizes are likely to be too low for regression analyses or ANOVA because there are only 16 grantees and limited outcomes due to the data availability challenges described previously. However, we can potentially conduct descriptive analyses. For instance, we might be able provide data on differences in outcomes for communities with higher than average infrastructure to those with lower than average infrastructure. Or we might compare outcomes for communities that implemented only environmental interventions

[3] A random effects meta-analysis assumes that the true effect could differ between communities and that this effect size is distributed around a mean. RMC Research decided to conduct a random-effects meta-analysis because communities differ on multiple factors that could influence alcohol- and drug-related outcomes, including population demographics, political environment, laws relating to alcohol and drug use, policing methods, and economic trends. These differences are likely to result in different true effect sizes for the outcomes in question for each community.

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versus those that implemented both environmental and direct service interventions. In this way, we will be able to identify characteristics associated with more and less successful coalition outcomes.

What were the outputs of SPF strategies?

RMC Research will use the data reported in the SPF Provider Spreadsheet to summarize the strategy outputs. Outputs will differ by type of strategy; for instance, examples of information dissemination strategy outputs are the number of printed materials disseminated, the number of public service announcements aired, and the number of events planned. For environmental strategies, examples of outputs are the number of compliance checks conducted and the number of local ordinances passed.

For SPF coalitions implementing direct service programs, what were the effects on participants?

Only a small subset of SPF coalitions are implementing direct service programs; thus, sample sizes limit the types of inferential analyses that can be conducted. For instance, low Level 2 (i.e., community) sample sizes mean that LMMs are not possible. Yet, it is important to document the outcomes of direct service programs for SPF coalitions because these programs could influence community outcomes. Because pre- and posttest data are unmatched, RMC Research will conduct independent *t*-tests to compare changes in survey outcomes from pretest to posttest. We will conduct analyses separately for each program and separately for youth, older youth, and adults.

RMC Research will conduct a more comprehensive analysis of direct service programs for the SABG evaluation; data for direct service programs implemented by SPF grantees will be included in those outcomes if the direct service programs were funded through a SABG. These analyses are described in the SABG Evaluation Activities section. That section also describes psychometric analyses RMC Research will conduct on the participant surveys.

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SABG Evaluation Activities

Overview

Idaho currently has 46 SABG-funded entities in 7 regions, primarily delivering evidence-based direct service programs focused on primary prevention of substance use, although some are also implementing coalition activities with the funds. To date, a few SABG-funded entities have also received SPF funding. SABG-funded entities must implement interventions from a list of evidence-based programs and environmental strategies provided by ODP.

Evaluation of SABG efforts will involve ensuring that appropriate data collection procedures for collecting implementation and outcome data have been established, which will include a review of SABG youth surveys and a parenting survey. As part of this process, RMC Research will provide an annual **Comprehensive Report of Current SABG Process** for analyzing and reporting SABG outcomes. The **Annual Aggregate SPF/SABG Statewide Evaluation Report**, which will serve as the summary of all evaluation results for SABG and SPF SIG, will include SABG process and outcomes results.

Evaluation Questions

Exhibit 5 outlines the evaluation questions for SABG evaluation activities and accompanying data sources.

Exhibit 5. SABG Evaluation Questions

SABG Evaluation Questions	Data Source
1. What program-level challenges and success in implementing SABG-funded programs did community-level stakeholders experience?	▸ SABG Community-Level Key Informant Survey
2. How many individuals were served by direct service programs funded by SABG? What were their characteristics?	▸ SABG Attendance/Demographics Spreadsheet
3. What were the effects of SABG direct service programs on participants? Which programs had the strongest positive outcomes?	▸ SABG Program Participant Surveys

Data Collection

ODP will provide the **SABG Attendance/Demographics Spreadsheet** quarterly and **SABG Program Participant Survey** data annually to RMC Research. The SABG Attendance/Demographics Spreadsheet Summary will list the number and characteristics of individuals served by SABG-funded programs, and the program participant survey data will help RMC Research examine the SABG programs with the strongest positive effects.

To gather relevant information about subrecipient and program-level challenges and successes in implementing SABG-funded programs, RMC Research will develop and administer the annual **SABG Community-Level Key Informant Survey** with community-level SABG project directors. RMC Research will administer the key informant survey in May of each project year by sending a survey link to key informants via email.

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Measures

This section describes the content and development of the **SABG Community-Level Key Informant Survey**, which will be administered in May of each funding year, and the content of the **SABG Attendance/Demographic Spreadsheet Summary** and the **SABG Program Participant Surveys**, which were developed by ODP.

SABG Community-Level Key Informant Survey

The Community-Level Key Informant Survey will include questions about technical assistance needs and resources, successes and barriers that SABG-funded communities experienced when implementing interventions, the impact of SABG on their community prevention infrastructure, and any other questions of interest to ODP. Questions about technical assistance needs and resources could address different intervention types (i.e., direct service or environmental interventions), support in selecting and adapting appropriate interventions, and other areas of need for additional guidance from the state..

SABG Attendance/Demographic Spreadsheet Summary

The SABG Attendance/Demographic Spreadsheet developed by ODP collects direct service attendance information and direct service participants' demographic information. The attendance information includes the cohort name, program name, number of participants per session, and length of sessions. The demographic information collected includes race, ethnicity, gender, and age.

SABG Program Participant Surveys

ODP, in collaboration with the previous contractor, has developed 3 program participant surveys for SABG-funded communities: an older youth survey, a younger youth survey, and a parenting survey. Students in Grades 6 through 12 complete the older youth survey, and students in Grades 4 and 5 complete the younger youth survey. Both surveys include questions related to perception of risk of using marijuana, prescription drugs, alcohol, and cigarettes; perception of wrongdoing of using marijuana, prescription drugs, alcohol, and cigarettes; frequency of interpersonal behaviors (e.g., How often do you resolve conflicts with someone without yelling? How often do you talk behind someone's back? How often do you feel safe at school?); and peer influence on alcohol. The older youth survey includes additional items, such as 30-day use of alcohol, prescription drugs, marijuana, and tobacco and peer influence on prescription drug, marijuana, and tobacco use.

The parenting survey was adapted by ODP from developed scales (Spoth, Redmond, & Shin, 1998), which have been assessed for construct validity (Redmond, Spoth, Shin, & Lepper, 1999) and predictive validity (Spoth, Neppl, Goldberg-Lillehoy, Jung, & Ramisetty-Mikler, 2006). The parenting survey items include questions related to general child management (e.g., In the course of a day, how often do you know where your child is?); discipline strategies (e.g., How often do you discipline your child for something at one time, and then at other times not discipline him or her for the same thing?); involvement of children in family activities and decision making (e.g., I find ways to keep my child involved with fun activities in our family. How often do you ask your child what he or she thinks before making decisions that affect him or her?); substance use rules and communication (e.g., I have explained the consequences of not following my rules concerning alcohol, tobacco, or other drugs to my child); parent-child affective quality (e.g., During the past month, how often did you get angry with him/her? During the past month, how often did you act loving and affectionate toward him/her?); and attitudes toward children's substance use (e.g., If my child began smoking it would have a very serious negative effect on his or her health).

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Analysis Plan

Below we describe our approach to analysis organized by SABG evaluation question for the SABG data, the community-level key informant survey, SABG attendance/demographic spreadsheet, and SABG project participant surveys.

What program-level challenges and successes in implementing SABG-funded programs did community-level stakeholders experience?

RMC Research will conduct descriptive analysis of data collected via the SABG Community-Level Key Informant Survey to assess the impact of SABG on the prevention community infrastructure and the key challenges and successes SABG-funded programs experienced in implementing interventions and accessing technical assistance to build program staff capacity. If appropriate, we will conduct organization-type subgroup analysis to examine any difference in challenges and successes between organization types (e.g., health department, coalition). RMC Research will consult with ODP regarding subgroup analyses that might be of interest.

How many individuals were served by direct service programs funded by SABG? What were their characteristics?

RMC Research will conduct descriptive analysis of the demographic information (i.e., race, ethnicity, gender, age) collected by the SABG attendance/demographic spreadsheet to assess the individuals who were served by direct service programs funded by SABG statewide. We will summarize the attendance and program event data (e.g., number of participants per session, length of session) to fully describe the SABG-funded programs. In addition to reporting these numbers statewide, we will also report them by program.

What were the effects of SABG direct service programs on participants? Which programs had the strongest positive outcomes?

RMC Research will obtain the pre- and posttest survey data for parents and youth for each program from ODP. RMC Research will explore the psychometric properties of the program participation surveys, which will include an assessment of the internal consistency reliability of the survey. Reliability analyses will group similar items that are intended to measure the same construct and calculate Cronbach's coefficient alpha for these items. This statistic indicates how well the grouped items complement each other in their measurement of different aspects of the same construct they are intended to measure. When possible, RMC Research will develop scales from the survey items to increase reliability of measurement.

One of the primary goals of the program-level outcome analysis will be to discover the highest performing programs for youth and adults. A powerful inferential technique RMC Research will use to discover which programs had the strongest effects is LMMs. SPF SIG program-level data represent data in which observations are nested—for instance, prevention program youth participants nested within programs which are nested within providers. The LMM approach develops regression equations at each level of nesting to account for variation at different levels of the model. Participant, program, and provider characteristics (if sample sizes allow for a 3-level model) can be entered into the model to predict participant-level outcomes.

One major limitation of the SABG data is that the pre-tests and post-tests are unmatched at the participant level (i.e., a participant's pre-test cannot be matched to his or her post-test). Unfortunately, unmatched data significantly limits the analyses that can be conducted and inferences that can be made

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about program effects. If matched data were available, it would be possible to investigate whether the type of program received influenced the observed *change* in participants' outcomes from pre-test to post-test. Without matched data, the analyses will limited to investigating the programs' influence on post-test survey outcomes instead of *change over time*. Since the goals of SABG programs are to change participants' attitudes and use, this is a major limitation of the analyses. To address this limitation, we will use the participant-level pre-test scores to construct a covariate that can be entered into the analysis to control for pre-test differences. If possible, the average pre-test score for each cohort (e.g., Second Step conducted in Mrs. Johnson's 7th hour classroom) will be entered as a covariate to help account for differences in pre-test scores between cohorts. If cohort-level pre-test data is not available, we will instead use the pre-test average for that program for that provider. Compared to analyses using matched surveys, these analyses will be conservative tests of program effects, likely underestimating the true effects due to reductions in statistical power. As a result, inferences regarding the most effective programs will be more tentative than if the data were matched.

One LMM will be conducted for each type of outcome (e.g., substance use, interpersonal behaviors). RMC Research will aggregate and report on survey outcomes separately for adults, younger youth, and older youth. In addition to identifying the programs with the strongest outcomes using the above LMM, RMC Research will report outcomes for each program separately across all communities. These analyses will allow us to identify which programs might be considered model programs for each population served by SABG grants.

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State-Level Evaluation Activities

Overview

The Annual Aggregate SPF/SABG Statewide Evaluation Report will report on the implementation of various state-level interventions and state-level outcomes. State-level interventions include the BeTheParents.org underage drinking campaign and the SPF law enforcement grants. The focus will be on documenting the reach of the programs (numbers served), implementation activities, and outcomes over time for each of these activities. Collectively, these evaluations will incorporate a wide range of data sources, including surveys of parents and youth, web analytics, measures of advertisement reach and penetration, interviews of key stakeholders, and administrative data.

Evaluation Questions

Exhibit 6 outlines the evaluation questions for the state-level evaluation activities and the proposed data sources.

Exhibit 6. State-Level Evaluation Questions

State-Level Evaluation Questions	Data Source
State-Level Intervention Implementation	
1. **To what extent did the BeTheparents.org campaign reach the target audience of parents of children aged 8–20? Did reach vary by geographical area?**	▸ Social media parent survey ▸ Social media page data ▸ Website analytics (visitors to website, click-through rates, etc.) ▸ TV and radio ad reach and penetration
2. What activities did law enforcement SPF grantees complete?	▸ Law enforcement key informant interviews ▸ Law enforcement quarterly progress report
3. What implementation challenges and successes did law enforcement SPF grantees experience and what infrastructure was developed?	▸ Law enforcement key informant interviews
State-Level Outcomes	
4. Did the implementation of the SPF SIG and SABG lead to state-level improvement on targeted outcomes?	▸ Youth Risk Behavior Surveillance System ▸ Behavioral Risk Factor Surveillance System ▸ National Survey on Drug Use and Health
5. To what extent did the BeTheParents.org campaign educate parents about how to reduce underage drinking among their children and help them “find their passion”?	▸ Social media parent survey

Data Collection

To address the evaluation questions shown in Exhibit 6, RMC Research will conduct multiple data collection activities including parent surveys and law enforcement key informant interviews. We will analyze extant data sources such as the Youth Risk Behavior Surveillance System and the Behavioral Risk Factor Surveillance System will also be analyzed. In addition, RMC Research will obtain data from ODP’s

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marketing contractor, Neighborhood All-Stars. The following sections describe proposed data collection activities as they pertain to each of the 3 components of the state-level evaluation: the BeTheParents.org campaign, law enforcement grants, and state-level outcomes.

BeTheParents.org Underage Drinking Campaign

Idaho's BeTheParents.org underage drinking campaign is designed to equip parents with strategies and resources to help prevent their children from drinking alcohol. Through the website, parents have access to educational materials regarding the effects of alcohol on the developing brain, information about how to talk to their children about underage drinking, information about how to help children "find their passion," and links to local resources and professional help. To engage parents, the campaign maintains several social media accounts, including a Facebook page, a Twitter account, and a YouTube channel. The evaluation of the BeTheParents.org campaign will assess the reach and influence of the campaign via the data sources described below.

Using 2 methods, RMC Research will measure the extent to which the BeTheParents.org campaign reaches the target audience of parents of children aged 8–20. First, RMC Research will develop a **social media parent survey** that asks parents about their exposure to, their recall of, and their impressions of the advertising campaign. Data from a recent Pew research study indicate that Facebook is an excellent venue for surveying adults: an estimated 71% of adult internet users reported that they use Facebook (Duggan, Ellison, Lampe, Lenhard, & Madden, 2015). In addition, 84% of American adults use the internet (Perrin & Duggan, 2015). Using Facebook advertisements that link to the social media parent survey, RMC Research will target adults in Idaho with children between the ages of 8 and 20 using age and zip code as sampling criteria. Second, RMC Research will summarize the analyses of **media data** conducted by ODP's media contractor.

The parent survey will serve the dual purpose of measuring reach and the extent to which the BeTheParents.org campaign educates parents about the risks and signs of alcohol use and how to prevent their children from drinking alcohol. Survey respondents will be asked a series of questions designed to measure changes in parents' knowledge of the risks and signs of alcohol use and the utility of the campaign (if they have seen it) in helping them talk to their children about alcohol and find their passion.

The survey will be administered in March 2017 and March 2018 to serve as annual measures. The target sample size for the social media parent survey is 599 per survey administration. This sample size provides a 95% confidence interval of plus or minus 4 percentage points for representativeness at the state level. It might be possible to obtain a larger sample size and smaller confidence interval, depending on the number of clicks the survey receives on Facebook, the resulting cost per click, and the available budget.

Law Enforcement SPF Grantees

Eight law enforcement agencies were funded as SPF subrecipients. Law enforcement agencies have discretion regarding the types of activities and interventions they implement through their grant. Data collection efforts will focus on understanding the activities and interventions that law enforcement agencies implemented.

RMC Research will conduct **law enforcement key informant interviews** with leaders of the law enforcement agencies' SPF grants to learn about the activities they conducted as part of their grants, the implementation challenges and successes they experienced, the partnerships they formed with other agencies, and the steps they took toward achieving sustainability. RMC Research staff members will

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conduct interviews via telephone annually in May. RMC Research will also review the **quarterly progress reports** each law enforcement agency grantee submits to ODP.

State-Level Outcomes

RMC Research will utilize 2 extant data sources to answer the state-level outcome evaluation question: the **Youth Risk Behavior Surveillance System** (YRBSS) and the **National Survey on Drug Use and Health** (NSDUH). The YRBSS is a national survey administered by the Centers for Disease Control and Prevention (CDC) in schools to representative samples of students in Grades 9–12. It collects data on a variety of health-related measures including alcohol and drug use. The NSDUH is administered by RTI International through a contract with the Substance Abuse and Mental Health Services Administration (SAMHSA). It is administered to 70,000 randomly selected individuals aged 12 and older in their homes. The NSDUH focuses solely on mental health issues and the use of tobacco products, alcohol, and illicit drugs. RMC Research will download respondent-level YRBSS data from the CDC's website and download aggregate state-level NSDUH data from RTI International's website.

Measures

This section describes the content and development of the **social media parent survey** and the **law enforcement key informant interviews,** and the content of the **media data**, the **YRBSS**, and the **NSDUH**.

Social Media Parent Survey

RMC Research will develop the **social media parent survey** collaboratively with ODP. The survey will answer the implementation and the outcome evaluation questions regarding the BeTheParents.org media campaign. The survey will measure parents' exposure to and recall of the media campaign, parents' awareness of its messages, parents' knowledge of the concept of helping their children find their passion, and parents' reported behaviors related to speaking with their children about alcohol and helping their children find their passion. RMC Research will review validated surveys and utilize questions from such surveys when possible. Surveys with potentially useful survey items include the National Survey of Parents and Youth, Partnership Attitude Tracking Survey, Legacy Media Tracking Survey, and Florida Anti-Tobacco Media Evaluation survey.

RMC Research will employ several methods to ensure the validity of the parent survey. First, we will establish face validity by mapping the evaluation questions to the survey items to ensure that the survey measures all of the desired constructs of the evaluation. Second, we will assess readability using the Flesch-Kincaid Grade Level Test and the survey will be modified until it is at a Grade 8 reading level to ensure that the target audience will understand the survey questions. Next, RMC Research will conduct a brief pilot test of the survey to confirm that the time to complete the survey is as intended. Using the information obtained through reliability and validity testing, RMC Research will recommend modifications to the survey questions and discuss modifications with ODP staff.

Media Data

The media contractor will conduct BeTheParents.org website analytics, which will generate data on the number of visitors to the website, bounce rates, and average session and page view duration. The media contractor will provide analytics about BeTheParents.org social media efforts including its Facebook page, Twitter account, and YouTube channel. Such data will include the number of impressions of each of these social media platforms. The third type of media data analytics that will be obtained from the media contractor encompass the reach (e.g., number of people who saw the advertisements) and frequency (e.g., number of times each person saw the advertisements) of the BeTheParents.org TV and

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radio advertising campaign. All of these measures will also be used to determine whether the BeTheParents.org campaign reached the intended audience and, if possible with available data, whether reach varied by geographical area.

Law Enforcement Key Informant Interviews

RMC Research will develop the **law enforcement key informant interview** protocol in collaboration with ODP. Interview questions will address the following indicators related to the implementation of the law enforcement SPF SIG grants: number and characteristics of activities and strategies implemented, implementation challenges and successes experienced throughout the funding period, partnerships formed with other agencies, and steps taken toward attaining sustainability after funding ends.

Law Enforcement Quarterly Progress Report

The **law enforcement quarterly progress reports** contain progress made on each law enforcement agency grantee's goals and objectives in addition to qualitative descriptions of the activities they conducted as part of their grant.

YRBSS and NSDUH

Exhibit 7 shows the relevant survey items from each of the extant survey data sources that RMC Research will utilize to assess statewide improvement in Idaho's targeted outcomes of prescription drug, alcohol, and marijuana use.

Exhibit 7. Extant Survey Items

Survey	Population	Survey Items
YRBSS	Adolescents	▸ Age of first alcoholic beverage use ▸ Age of first marijuana use ▸ Past 30-day use of alcoholic beverages ▸ Past 30-day use of marijuana ▸ Past 30-day consumption of 5 or more drinks in a row ▸ Where obtained alcoholic beverages ▸ Past 30-day use of nonprescribed prescription drugs ▸ Lifetime use of nonprescribed prescription drugs ▸ Past 30-days times been in a car driven by someone who had been drinking alcohol or using drugs ▸ Past 30-days times driven a car after drinking alcohol or using drugs
NSDUH	Adults	▸ Past month nonmedical use of pain relievers ▸ Past month nonmedical use of psychotherapeutic drugs ▸ Past month nonmedical use of tranquilizers

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Analysis Plan

This section describes the analysis plan for each of the state-level implementation and outcome related evaluation questions.

To what extent did the BeTheParents.org campaign reach the target audience of parents of children aged 8–20? Did reach vary by geographical area?

ODP's media contractor will provide descriptive **media data** for the reach and penetration of the various components of the BeTheParents.org campaign, including the website, social media pages, and TV and radio advertisements. The **social media parent survey** will be used to analyze awareness of the campaign. RMC Research will conduct analyses of both data sources to assess whether reach varied by geographical area.

To what extent did the BeTheParents.org campaign educate parents about how to help their children "find their passion" and to what extent did parents follow through with doing so?

RMC Research will conduct descriptive analyses of the **social media parent survey** data to determine the recall, impressions, and actions taken by the BeTheParents.org campaign's target audience, parents of children 8 to 20 years old. RMC Research will analyze data to check for geographic variability and conduct analyses to identify potential variations in demographic subgroups grouped by race/ethnicity, education level of parents, and household income.

What activities did law enforcement SPF grantees complete? What implementation challenges and successes did law enforcement SPF grantees experience and what infrastructure was developed?

RMC Research staff members will transcribe **law enforcement key informant interviews** and conduct thematic qualitative analysis. We will review **law enforcement quarterly progress reports** and extract relevant information. Using both of these data sources, RMC Research will provide detailed descriptions of the activities implemented, the challenges and successes, the partnerships formed, and the steps taken toward sustainability reported by law enforcement agencies.

Did the implementation of the SPF SIG and SABG lead to state-level improvement on targeted outcomes?

RMC Research will conduct descriptive analyses showing trends over time of the **YRBSS** and **NSDUH** survey items. When possible, simple chi-square tests will be conducted to detect changes in survey items from year to year.

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Deliverables

This section describes the deliverables to be completed as part of this evaluation, including the content of the reports and grantee training sessions.

SPF PFS Data Collection Plan

RMC Research will collaborate with ODP to develop an **SPF PFS data collection plan** to be used in ODP's PFS application. This plan will meet the state's evaluation and monitoring needs while addressing process and outcome data requirements for PFS. We will compare the required data collection components for PFS to ODP's current process, work with ODP to develop or revise data collection instruments, and then recommend processes for collecting the required data. Whenever possible, such processes will align with those that ODP has already established for its SPF SIG grant.

Comprehensive Report of Current SABG Processes

RMC Research will provide the **Comprehensive Report of Current SABG Process** for analyzing and reporting SABG outcomes. RMC Research will review the SABG program processes and materials (e.g., SABG program participant surveys developed by ODP) and provide feedback. Below are the questions that will guide RMC Research's development of the report, organized by project stage.

Data Collection

1. Are the data collection protocols and procedures clear and understandable? What, if anything, could be improved?
2. Is the data collection form easy to navigate and understand?
3. Is the data collection form likely to provide reliable and valid data? What, if anything, could be improved?

Measures

4. Do the SABG surveys chosen match the SABG goals?
   a. Are the surveys capable of capturing change?
   b. If so, are they capturing the type of change we would expect to see based on SABG activities?
5. Are the chosen survey instruments reliable and valid?
   a. Are the instruments existing instruments or were they developed by ODP?
   b. If they are developed instruments, has reliability and/or validity testing been done?
   c. If they are existing instruments, what does the research reveal about their validity/reliability?
   d. Are the instruments appropriate for the population?

Analysis and Reporting

6. Are there any additional reporting approaches that might maximize understanding and utility of results?
7. What additional analyses could be useful with these data?

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Annual Coalition Evaluation Reports

The annual coalition evaluation reports will be user-friendly reports that summarize coalition progress using the evaluation data collected throughout the fiscal year. These reports will provide easily comprehensible information that will make a valuable contribution to the coalition's continuous quality improvement efforts. When possible, the reports will graphically display coalition data in comparison with the previous year's data and the most recent year's data in comparison with the average score across all coalitions. These graphics will visually summarize progress, both over time and compared to a benchmark (i.e., the statewide average). Each report will be organized into the following sections:

- **Accomplishments and Activities.** Coalition accomplishments during the fiscal year will be summarized, including success and challenges, number of meetings held, training and technical assistance completed, and changes in partnerships or members. The report will summarize activities implemented (environmental strategies and evidence-based programs, if applicable).
- **Populations served.** For each strategy or program implemented, the report will list the number of participants, including a summary of the participants by race, ethnicity, gender, and age group. Total numbers served and the estimated penetration rates of interventions will also be included.
- **Capacity, infrastructure, and readiness**. Kaizen survey results quantifying coalition progress on each of the 5 SPF steps and describing how coalitions work together (participation, consensus, and utility) will be reported. The results from the SPF CIA will show each coalition's scores on various domains of grantee infrastructure (e.g., organizational structure, strategic planning, sustainability). Scores on all 5 dimensions of community readiness will be displayed in the report.
- **Outcomes.** If available, local community survey and administrative outcome data will be reported and compared to baseline values. Outputs from environmental interventions (e.g., number of compliance checks conducted) will be reported. If the SPF coalition is also a SABG provider, pre-post outcome data will be reported for programs implemented.

The primary data sources for the annual coalition evaluation reports will be the SPF provider spreadsheets, community-level surveys, and the SPF local community outcomes.

Cross-Site Evaluation Report

The annual coalition evaluation reports each describe one coalition's activities and are designed for grantees, whereas the **Cross-site Evaluation Report** will present information for all coalitions within one document so that ODP can make easy comparisons. The function of the report will be to compare coalition activities, populations served, capacity, readiness and infrastructure, and outcomes. The report will contain all of the data presented in the coalition reports, but it will display results for all communities in easily comprehensible tables and graphics so that grantee progress is easy to track. When possible, the report will present grantee results relative to the grantee average and summarize progress over time with comparisons among grantees.

Annual Aggregate SPF/SABG Statewide Evaluation Report

The **Annual Aggregate SPF/SABG Statewide Evaluation Report** will summarize the evaluation results for the SABG and SPF SIG. In addition, it will serve as the main report of the state-level evaluations of the BeTheParents.org campaign and the SPF law enforcement grants. Collectively, these evaluations will incorporate a wide range of data sources, including surveys of parents and youth, website analytics, measures of advertisement reach and penetration, interviews of key stakeholders, and administrative

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data. The report will focus on providing a big picture overview of SPF and SABG progress throughout Idaho. Therefore, unlike the **Annual Coalition Evaluation Report** and the **Cross-Site Evaluation Report**, data will not be displayed for individual communities and the focus will not be on comparing and contrasting communities. Rather, the focus will be on answering the evaluation questions, in aggregate, across all Idaho grantees.

Grantee Training Sessions

RMC Research will conduct **grantee training sessions** twice per funding year. The content of the grantee training sessions will be based on grantee need. The dates and content of the grantee training sessions for the current funding year have been determined and are described below. The first grantee training session in the second year of funding could include training on assessing fidelity to environment interventions. SPF providers are required to attend the grantee training sessions conducted by RMC Research; the sessions are optional for SABG-funded providers and SPF law enforcement grantees.

Funding Year 1: Training 1

- **Date and Time:** December 1, 2016 at 3:00pm–4:00pm Mountain Time
- **Title:** Meet Your State Evaluator
- **Description:** The December Evaluation Training will be the first in a series of training sessions offered by RMC Research, which has been contracted by Idaho's ODP to evaluate the implementation and outcomes of the SPF SIG and SABG-funded initiatives. During the training, RMC Research staff members will introduce themselves and their related organizational work, explain the importance and purpose of evaluation for federal grants, and outline the expected evaluation activities, including how RMC Research will assist grantees in completing evaluation-related tasks. We encourage you to reflect on your funded activities and bring your evaluation-related questions to the group so that we can all learn from each other!

Funding Year 1: Training 2

- **Date and Time:** March 9, 2017 at 11:00am–12:30pm Mountain Time
- **Title:** Submitting Community-Level Outcome Data
- **Description:** As part of the state evaluation activities, Idaho SPF coalitions are being asked to collect and submit available community-level outcomes data. During this training, RMC Research staff will discuss the importance of collecting and reporting community-level outcomes data and explain the data entry and submission process. RMC Research has adapted spreadsheets developed for the SPF SIG cross-site evaluation to collect SPF local community outcomes survey and event/administrative data (e.g., hospitalization, arrests data) from Idaho SPF coalitions. These spreadsheets will be described in detail and the training will conclude with a step-by-step data entry demonstration.

NOT FINAL

Timeline

Exhibit 8. Timeline for RMC Activities and Deliverables

RMC Deliverables | Data Collection Activities | Training Sessions

Year 1 Task	Due Date	August 18, 2016–August 17, 2017												
		2016					2017							
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
1. Comprehensive Report of Current SABG Processes	12/21/16													
2. Grantee Training Sessions	Biannually													
3. SPF PFS Data Collection Plan	2/18/17													
4. Administer Social Media Parent Survey	Annually													
5. Administer SABG Community-Level Key Informant Surveys	Annually													
6. Conduct Law Enforcement Agency Key Informant Interviews	Annually													
7. Administer SPF Community Infrastructure Assessment	Annually													
8. Administer Community Coalition Member Readiness Survey	Annually													
9. SPF Local Community Outcomes	Annually													
10. Annual Coalition Evaluation Reports	9/29/17													
11. Annual Aggregate SPF/SABG Statewide Evaluation Report	9/29/17													
12. Cross-Site Evaluation Report	9/29/17													

Exhibit continues

NOT FINAL

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Exhibit 8. Timeline for RMC Activities and Deliverables (continued)

RMC Deliverables | Data Collection Activities | Training Sessions

Year 2 Task	Due Date	August 18, 2017–August 17, 2018												
		2017					2018							
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
1. Comprehensive Report of Current SABG Processes	11/18/2017													
2. Grantee Training Sessions	Biannually													
3. Administer Social Media Parent Survey	Annually													
4. Updated Transition Plan	5/17/18													
5. Administer SABG Community-Level Key Informant Survey	Annually													
6. Conduct Law Enforcement Agency Key Informant Interviews	Annually													
7. Administer SPF Community Infrastructure, Capacity and Readiness Survey	Annually													
8. Administer Community Coalition Member Survey	Annually													
9. Collect SPF Local Community Outcomes	Annually													
10. Annual Coalition Evaluation Reports	8/17/18													
11. Annual Aggregate SPF/SABG State of Idaho Report	8/17/18													
12. Cross-Site Evaluation Report	8/17/18													

NOT FINAL

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Exhibit 9. Timeline for ODP and Marketing Contractor Activities and Deliverables

ODP Deliverables Contractor Deliverables

Year 1 Task	Due Date	August 18, 2016–August 17, 2017												
		2016					2017							
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
1. ODP provides Kaizen data to RMC Research	6/15/17													
2. ODP provides SPF provider data to RMC Research	Quarterly & 7/22/2017													
3. ODP provides younger youth survey, older youth survey, and parenting survey data to RMC Research	7/31/17													
4. ODP provides attendance/demographics spreadsheet summary to RMC Research	7/15/17													
5. ODP's marketing contractor provides descriptive BeTheParents.org campaign data to RMC Research	7/15/17													

Year 2 Task	Due Date	August 18, 2017–August 17, 2018												
		2017					2018							
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
1. ODP provides Kaizen data to RMC Research	6/15/18													
2. ODP provides SPF provider data to RMC Research	Quarterly & 7/10/2018													
3. ODP provides younger youth survey, older youth survey, and parenting survey data to RMC Research	7/15/18													
4. ODP provides attendance/demographics spreadsheet summary to RMC Research	7/15/18													
5. ODP's marketing contractor provides descriptive BeTheParents.org campaign data to RMC Research	7/15/18													

NOT FINAL

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NOT FINAL

Appendix—Stages of Community Readiness

Below are the 9 stages of community readiness and the definitions of those stages developed by the Tri-Ethnic center for Prevention Research (Edwards et al., 2000):

1. **No Awareness.** The community or the leaders do not generally recognize the issue as a problem: "It's just the way things are." Community climate might be an unrecognized factor in encouraging the behavior; community members might believe that one group (i.e., in terms of gender, race, social class, age, etc.) engages in the behavior and not another.

2. **Denial.** There is little or no recognition that this might be a local problem, but usually some community members recognize that the behavior is or can be a problem. If community members perceive that it is a local problem, they feel that nothing needs to be done about it locally. "It's not our problem." "It's just those people who do that." "We can't do anything about it." Community climate tends to be passive or guarded.

3. **Vague awareness.** There is a general feeling among some community members that there is a local problem and that something ought to be done about it, but there is no immediate motivation to do anything. There might be stories or anecdotes about the problem, but ideas about why the problem occurs and who has the problem tend to be stereotyped and/or vague. No identifiable leadership exists or leaders lack energy or motivation for dealing with this problem. Community climate does not serve to motivate leaders.

4. **Preplanning.** Some community members clearly recognize that there is a local problem and that something should be done about it. There are identifiable leaders, and there could be a committee, but efforts are not focused or detailed. There is discussion but no real planning of actions to address the problem. Community climate is characterized by community members beginning to acknowledge the necessity of dealing with the problem.

5. **Preparation.** Planning is occurring and focuses on practical details. There is general information about local problems and about the pros and cons of prevention activities, actions, or policies, but information might not be based on formally collected data. Leaders are active and energetic. Decisions are being made about what will be done and who will do it. Resources (people, money, time, space, etc.) are being actively sought or have been committed. Community climate is characterized by at least modest support of efforts.

6. **Initiation.** Sufficient information is available to justify efforts (activities, actions, or policies). An activity or action has been started and is underway, but it is still viewed as a new effort. Staff is in training or has just finished training. There could be great enthusiasm among the leaders because limitations and problems have not yet been experienced. Community climate can vary, but there is usually no active resistance, (except, possibly, from a small group of extremists), and there is often modest involvement of community members in the efforts.

NOT FINAL

7. **Stabilization.** One or 2 programs or activities are running, supported by administrators or community decision makers. Programs, activities, or policies are viewed as stable. Staff members are usually trained and experienced. There is little perceived need for change or expansion. Limitations might be known, but there is no in-depth evaluation of effectiveness nor is there a sense that any recognized limitations suggest an immediate need for change. There may or may not be some form of routine tracking of prevalence. Community climate is generally characterized as supportive of the activities that are occurring.

8. **Confirmation/expansion.** There are standard efforts (activities and policies) in place and authorities or community decision makers support expanding or improving efforts. Community members appear comfortable in utilizing efforts. Original efforts have been evaluated and modified and new efforts are being planned or tried in order to reach more people, individuals who are more at risk, or different demographic groups. Resources for new efforts are being sought or committed. Data are regularly obtained on the extent of local problems and efforts are made to assess risk factors and causes of the problem. Increased knowledge and desire for improved programs could lead to a community climate in which challenges to specific efforts arise, but the climate is fundamentally supportive.

9. **Professionalization.** Detailed and sophisticated knowledge of the prevalence, risk factors, and causes of the problem exists. Some efforts might be aimed at general populations, whereas others are targeted at specific risk factors and/or high-risk groups. Highly trained staff members are running programs or activities, leaders are supportive, and community involvement is high. Effective evaluation is used to test and modify programs, policies, and activities. Although the community climate is fundamentally supportive, community members will ideally continue to hold programs accountable.

NOT FINAL

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

   Please see attached document titled 10. Statutory Criterion- Criterion 1 for narrative.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

   a) Physical Health — Yes No

   b) Mental Health — Yes No

   c) Rehabilitation services — Yes No

   d) Employment services — Yes No

   e) Housing services — Yes No

   f) Educational Services — Yes No

   g) Substance misuse prevention and SUD treatment services — Yes No

   h) Medical and dental services — Yes No

   i) Support services — Yes No

   j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) — Yes No

   k) Services for persons with co-occuring M/SUDs — Yes No

   Please describe as needed (for example, best practices, service needs, concerns, etc)

   Please see attached document titled 10. Statutory Criterion- Criterion 1 for narrative.

3. Describe your state's case management services

   Case management services are a core service within the AMH service array. A primary case manager is assigned in the electronic health record. The assigned clinical staff is tasked with the overall management of the case while open for services and will also assist with other case management needs such as; finding SUD treatment, housing, applying for the prescription assistance program, food programs, and applying for other state benefits. The case manager prepares the treatment plan, contacts the client before each scheduled prescriber appointment to get an update on their progress, and periodically meets with their client after the prescriber appointment to address any problems and link the client with needed resources. The ACT Teams integrates case management services in their contact with clients ensuring the individualized treatment plan is being implemented and the client can access need resource in their community.

   Medicaid reimbursable case management services are available under the Idaho Behavioral Health Plan, managed by Optum Idaho. Optum Idaho provides mental health and substance use disorder services for members eligible for Medicaid and enrolled in the Idaho Behavioral Health Plan who live in Idaho. Early Periodic Screening, Diagnosis and Treatment (EPSDT) services are provided and monitored through proactive care management of children and adolescents up until twenty-one (21) years of age. If a medically necessary outpatient service is required and is not available through a network providers, Optum Idaho will negotiate a single-case agreement with a qualified non-network provider to deliver the service.

NOT FINAL

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Division of Behavioral Health has implemented two planning initiatives to facilitate community integration and decreasing institutionalization. These initiatives will focus on developing community based housing services which are not currently available and developing standardized protocols for continuity of care for clients discharged from a state hospital.

The first initiative is the development and funding of Homes with Adult Residential Treatment (HART) services. Idaho has limited supported housing resources available for individuals being discharge from a state hospital and as a result inpatient discharges can be delayed due to lack of available housing. The Division has requested and received from the Idaho Legislature funding to develop a new level of care in Idaho specifically intended to meet the housing and clinical treatment needs in a coordinated setting for individuals with a serious and persistent mental illness who would otherwise be at risk of being homeless, incarcerated or hospitalized. The Division has developed a model framework identifying the core components of the HART residential services and has collaborated with the Division of Medicaid and the Idaho Behavioral Health Plan contractor, Optum Idaho has developed a Medicaid reimbursable package of clinical services which will be available for each legible client. This clinical service model package will included authorization for assessment, treatment planning, counseling/psychotherapy, medication management, community based rehabilitation services, community supports services, group therapy, and case management. It is envisioned that the HART setting will be a homelike community housing setting which includes the provision of clinical services to be delivered based on an individualized assessment and treatment plan. It is the hoped that this new service will allow individuals with SPMI to remain in their communities, decrease inpatient hospitalizations and re-hospitalizations and allow for greater community integration for those receiving the services. The Division will begin the initial implementation of the program through a demonstration project in which 3 to 4 providers are selected in various locations across the state. Services will be funded via contract with the Division of Behavioral Health and through the Idaho Behavioral Health Plan. Additionally, Enhanced Safe and Sober Housing will be available for clients discharging from one of the two State Hospitals who are going into SUD treatment. This housing will provide more support and assistance than is afforded in traditional safe and sober living environments, including Recovery Coaching and services to support dual diagnosis treatment. It is anticipated this service will be ready to launch in August 2017.

The second initiative is the establishment of the State Hospital Discharge Workgroup. This workgroup is tasked with updating the current State Hospital Discharge Policies for the Division and establishing standardized protocols for discharge follow-up and aftercare services. The workgroup consists of representatives from all seven regional behavioral health centers, administrators from both state hospitals, and the Division of Medicaid.

The Division of Behavioral Health has established policies regarding state hospital discharges. The policies identify discharge protocols for adults and adolescents from the state hospitals and delineates responsibilities for the hospital staff and regional staff to ensure a coordinated discharge. Each region has a designated hospital discharge coordinator tasked with coordination and monitoring all clients discharged from the state hospitals.

The regional staff are responsible for arranging follow-up care and clinical services necessary for transitioning the discharged patient to community care. Three days following the Seven (7) Day Notice, the Region shall communicate back to the hospital the arranged community living placement with address, psychiatric service appointments dates/times (including psychotherapy and CBRS if needed), community pharmacy with phone number and any needed medical follow-up appointments.

The patient will be discharged to regional care or outpatient services for 30 days oversight. The region shall document all contacts and interventions provided in the patient's EHR during these 30 days following discharge from the hospital at a high acuity contact standards.

In the event a patient will be discharging from the state hospital to a region other than the original committing region, the committing region will communicate at their earliest convenience with the receiving region regarding the reason for a change in region placement. The two regions will then negotiate the areas of care that each region will be responsible for and coordinate with the state hospital, facilitation of the patient's discharge to the new region.

The state hospital and the regions coordinate a plan to transport the patient back to their community, unless they are returning to jail or discharging out of state. The patient shall be transported from the state hospital directly to the regional office where the patient shall meet with their regional behavioral health case manager at that time. For adolescents, the state hospital, the regional behavioral health case manager and the patient's parent(s) and/or legal guardian shall coordinate a plan to transport the patient back to their community, unless they are returning to detention Any variation of this practice shall be documented in both hospital and community mental health EHR systems.

NOT FINAL

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	67,298	31,967
2.Children with SED	14,082	6,689

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The information below represents the best estimates of the Idaho Department of Health and Welfare's Division of Behavioral Health (Division), based on available data and reflects the limitations of our reporting and information systems. Adults with SMI calculated from 2015 URS table with a 2.3% increase for statewide population growth. Children with SED calculated from YES project Class Size Estimation Team, averaging the estimated upper and lower bounds. Incidence is defined as the number of individuals with SMI/SED who may receive mental health services in the state, though not necessarily solely through the Division of Behavioral Health. The estimated incidence is based off of figures found in the SAMHSA 2015 Idaho Behavioral Health Barometer's assessment the 47.5% of adults with any mental illness will receive treatment or counseling.

Prevalence and incidence estimates are utilized for planning purposes are used consistently in identify system gaps and needs and planning for the behavioral health service system array for both AMH and CMH. The Behavioral Health Administration and Program Managers review quarterly and annualized utilization data. The data includes regional admission and discharge rates and regional hospital bed utilization patterns. Regional rates of discharged clients successfully keeping their first CMHC appointment and the 30-day readmission rates are also regularly shared and reviewed. In addition, problem cases identified as having barriers to prompt and/or successful community placement are reviewed at these meetings. Over the next one to two (1-2) years more extensive analyses on the system capacity needs for Jeff D Class Members will be conducted and reported. The intent of further study into system capacity will be to uncover more in-depth information about child, youth and family needs, and how the system can meet those needs. Information will be utilized for system planning, specifically for workforce development. Based on the result of this initial capacity analysis the recommendations for planning for workforce development to maintain and enhance system capacity are:

• Continue analyze and assess current capacity and needed capacity on an on-going basis based on an in-depth need-based planning study
• Implement Child and Adolescent Needs and Strengths (CANS) and the Transformational Collaborative Outcomes Management (TCOM) system which will provide useful data about child, youth and family outcomes
• Evaluate the cause of apparent capacity issues by region
• Consider setting recruitment goals by region and by type of service needed
• Provide training on practices that are effective (evidence based, evidence informed and proven practices) but are currently not utilized extensively
• Consider establishing staffing models by program type
• Work with local universities to ensure education is focused on areas of need throughout the state.
• Support primary integration by developing new models of integration and pilot them

These estimates represent publicly provided and/or funded mental health services rendered by the public sector as well as Medicaid reimbursed services provided by the private sector.. Some individuals may receive services from both public mental health system and private sector providers. As of July 1, 2011, numbers served for adult mental health and children's mental health were captured in the Division's Web Infrastructure for Treatment Services (WITS) system. All SUD network providers were required to input data into WITS as of October 1, 2013. Idaho's Behavioral Health Crisis Centers began using WITS as of December 1, 2014.

The State of Idaho uses the estimation methodology for adults and children required by the Substance Abuse Service Administration's Center for Mental Health Services (CMHS) and the National Prevalence figures prepared for MHSIP by the National Research Institute and distributed by CHHS to determine prevalence of Serious Mental Illness (SMI), Serious and Persistent Mental

NOT FINAL

Illness (SPMI), homeless with SMI and children with Serious Emotional Disorders (SED). Background details on the definition for SMI were published previously in the Federal Register on May 20, 1993. Estimation methodologies were published in the Federal Register on June 24, 1999.

NOT FINAL

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	Yes No
b)	Educational services, including services provided under IDE	Yes No
c)	Juvenile justice services	Yes No
d)	Substance misuse preventiion and SUD treatment services	Yes No
e)	Health and mental health services	Yes No
f)	Establishes defined geographic area for the provision of services of such system	Yes No

NOT FINAL

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

Please see attachment titled 10. Statutory Criterion for MHBG- Criterion 4 for narrative.

NOT FINAL

Narratve Question

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Please see attachment titled. 10. Statutory Criterion for MHBG - Criterion 5 for narrative.

NOT FINAL

Footnotes:

NOT FINAL

10. Statutory Criterion for MHBG- Criterion 4

Outreach to Homeless

The homeless population served through the mental health system in Idaho includes those individuals who are homeless or at risk of homelessness. The need for assistance with accessing and maintaining housing is a required component of the comprehensive assessment. Housing may be identified as a primary focus area which may be addressed if a functional limitation is identified in the assessment process. Needed services would then be identified on the individualized treatment plan in order to assist a consumer access and maintain housing in their community.

Outreach and services for homeless individuals with serious mental illness are provided in Idaho under the auspices of the Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program of the Center for Mental Health Services. PATH grant funds include the allocation of a small amount for each regional RBHC to help with housing costs (i.e., one time rental assistance or security deposits); with the majority of funds allocated to a contract with the Office of Consumer and Family Affairs (OCAFA). The OCAFA contract allows for two part time PATH Certified Peer Specialists to be assigned to each of the seven regional DBH service sites. The PATH Certified Peer Specialists strive to conduct up to 75% of their time in face to face outreach to those in their region who have a mental health diagnosis and who are literally homeless. PATH Certified Peer Specialist have received training in evidence based practices related to Supported Housing, Supported Employment and SSI/SSDI Outreach and Recovery (SOAR), and Mental Health First Aid. PATH peer specialists also assist in Point in Time (PIT) homelessness activities in all regions.

Other funds available to those who are homeless or at risk of homelessness are provided through funding from the Department of Housing and Urban Development (HUD). Idaho Housing and Finance Association (IHFA) and Boise City Ada County Housing Authority (BC/ACHA) apply for and administer grant funding received from HUD. Although the State of Idaho is not directly involved in the HUD Continuum of Care, the Division of Behavioral Health (DBH) does collaborate with both agencies to coordinate and support homeless initiatives in Idaho. Additional resources to the homeless include the Charitable Assistance to Community's Homeless (CATCH) program. This program mobilizes community resources for those who are homeless in Regions 3 and 4. The Idaho Housing and Finance Association (IHFA) manages Shelter Plus Care vouchers in all but Regions 3 and 4, where housing services are handled through the Boise City/Ada County Housing Association (BCACHA). The process for accessing Shelter Plus Care beds was standardized in SFY 2009, leading to an increased level of regional involvement with this program. Growth, however, exceeded the supply with IHFA accepting limited referrals.

Julie Williams, Executive Director of Idaho Housing and Finance Authority (IHFA), is the housing representative on the State Planning Council for Mental Health. IHFA is integrally involved in housing issues in Idaho, and is primarily responsible to oversee HUD Special Needs grants, including Housing for Persons with AIDS/HIV (HOPWA), Emergency Shelter Grants-Stewart B. McKinney (ESG), Supportive Housing Program Stewart B. McKinney (SHP), Shelter Plus Care Program (S+C) and Homeless Assistance.

NOT FINAL

Idaho Housing and Finance Authority searches out and acts on other grant opportunities that best serve the housing needs of limited income Idahoans. They have received funding to provide technical assistance to nonprofit housing sponsors and allocations of Section 8 funding designated for special need populations. They have also assisted community efforts to obtain private foundation grant funds to help serve homeless individuals. Idaho Housing and Finance Authority recently secured federal and other funding for housing for persons diagnosed with AIDS. Efforts are underway to obtain equipment and software to help build the technological capabilities of nonprofit housing organizations.

Shelter Plus Care housing is available in all regions of the State of Idaho. This program assists in providing housing to those who are diagnosed with a mental illness and who are also homeless. The Adult Mental Health program provides documentation of the mental health services match required for the Shelter Plus Care federal grant.

Through the Bureau of Facility Standards, the Department of Health and Welfare licenses or certifies a variety of supportive/assistive residential facilities and homes that are available to persons with a serious mental illness in Idaho. These supportive housing options include licensed Residential and Assisted Living Facilities and Certified Family Homes throughout the state.

Community -Based Services to Individuals in Rural Areas

For the purposes of this document, we will conform to the classification system that is followed by the Federal Census Bureau. Under their classification, an urban county is defined as a county having a population center of greater than 20,000. A rural county is defined as a county having no population center of 20,000 or more, yet an average of six or more persons per square mile. A frontier county is defined as a county that averages less than six persons per square mile. Idaho is a predominantly rural state consisting of 22 rural counties, 19 frontier counties and 3 urban counties. Per the U.S. Census Bureau, the total state population estimate for 2015 is 1,616,547. Of the fifty states, Idaho ranks 13th in area size with 82,747.21 square miles.

Idaho has a diverse geology and biology, containing large areas of alpine mountainous regions, vast desert plains, farmland valleys, and deep canyons and gorges. Many areas of the state have few roads. Some areas are vast wildernesses with no roads. Only five out of a total of 44 counties meet the criteria of a Metropolitan Statistical Area (MSA) as defined by the Federal Office of Management and Budget. The remaining 39 counties are classified as rural (at least 6 people per mile) or frontier (less than 6 people per square mile). These frontier areas comprise 59% of Idaho's total land area. Two thirds of Idaho's landmass consist of state and federal public lands. In accordance with the 2015 estimates, there were an average of 19.6 persons per square mile in the state compared to the national average of 87.4 persons. Idaho counties with the largest populations include Ada, Canyon, Kootenai, Bonneville, Bannock and Twin Falls. There are 19 counties with a population under 10,000.

A rural service system must maintain resource flexibility and creativity while being as responsive as possible to individual, family and community needs. A review of the literature relating to human services delivery in rural areas in the United States identifies a range of social, psychological and economic factors that must be considered in delivering services in rural areas. These factors include:

NOT FINAL

(1) Low population densities make it difficult to provide some services (for example, inpatient treatment) which require a “critical mass” of consumers to be economically and programmatically viable. (2) There can be difficulties associated with the availability of professionally trained staff in rural areas. In addition, it is often difficult to attract and retain qualified staff to move to rural areas to work. (3) The incidence of poverty is likely to be higher in rural areas. (4) In rural areas, long distances and lack of transportation options can be barriers to service access. (5) Social and geographical isolation can produce significant psychological difficulties for the individual and the family.

There are known shortages in Idaho’s capacity to provide mental health services as demonstrated by the states’ Health Provider Shortage Area (HPSA) designation. A HPSA is an area designated by the Health Resources & Services Administration (HRSA) as having a shortage of primary care, dental care or mental health providers. Based on the criteria for mental health providers established by HRSA a score is given to each area based on the population and the number of providers in the region. Although some counties in Idaho are not defined as having shortages in mental service providers (such as Ada County) there are many others that are designated. Based on the number of counties that are designated HRSA considers the state of Idaho overall to be designated as a HPSA state for mental health.

As indicated in the statistics stated above, Idaho is predominantly a rural state. Staff in the state-operated community mental health system have developed extensive skills and knowledge about how to effectively and efficiently deliver services to isolated rural communities and individuals.

Below are listed some of the ways in which the public mental health system in Idaho has attempted to address and reduce some of the inherent problems of rural service delivery.

1) The state has made and continues to make significant investments in technology, including personal computers and computer networks, laptop computers, cellular phones, electronic mail and fax machines. Telephone conference calls, with the ability to bring together multiple individuals at a time from all over the state, are used extensively. In the area of electronic mail, we have a daily system of notification regarding admissions, discharges and problem cases at the state hospitals. Video conferencing equipment has been installed at eleven locations (i.e., central office, SHS, SHN, Idaho State School and Hospital and seven regional main offices). Use of this system allows expansion of the service array to rural and frontier areas and to those areas that need additional psychiatric services to meet the needs of clients; reduction of transportation costs; service delivery in the client’s community setting; provision of educational opportunities; reduction in costs while maintaining high quality service options. Idaho Medicaid allows for reimbursement of tele-health services related to pharmacological management and psychotherapy. Telehealth psychiatric monitoring services are provided through the high definition videoconferencing system to clients in residing in rural counties. A clinician is present in the rural office with the client while the prescriber remains at the primary office location. This allows for increased access to limited prescriber time and decreases expenses related not having the prescriber drive to the rural lotion. Additionally, text messaging reminders for appointments have been implemented for clients who agree to participate in the program.

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3) The state's support for consumer empowerment and self-help also extends the limited resources of our rural state to better serve adults diagnosed with a serious mental illness by developing a natural support system. This is further enhanced through the use of certified Peer Support Specialist and Family Support Partners. Certified peer support specialists provide supplemental adult mental health services through the ACT teams at regional centers and at the state hospitals. PATH peer support specialists often provide outreach services to homeless individuals with SMI.

4) As described previously, adult mental health services are delivered through the seven regional community mental health centers. In addition to the location of each CMHC in the seven major population centers, each region operates field offices for a total of 19 locations. Considerable staffing resource are dedicated to providing access to clinic and ACT services for those living in the more remote areas of the state.

Services to Older Adults

The State of Idaho is committed to serving the mental health needs of its adult citizens, including those of older adults. Older adults who are eligible for regional mental health services through the Division of Behavioral Health are offered the full array of Behavioral Health Services that are available to all eligible adults.

The Office on Aging is responsible to provide Adult Protective Services to older adults in Idaho. This agency also coordinates homemaker services. Regional Behavioral Health Center programs provide support, education, consultation and backup to the Office on Aging when mental health issues are identified. Occasionally, the Regional programs provide after-hours crisis services for those older adults who are in crisis. The Idaho Commission on Aging is another resource. Their mission is "To improve quality of life for all older Idahoans, vulnerable adults, and their families through education, advocacy, accountability and service; to provide opportunity for all to live independent, meaningful and dignified lives within communities of their choice.

According to Medicaid regulations, the State Mental Health Authority is responsible to provide Qualified Mental Health Professionals (QMHP) to assess individuals referred to nursing home settings with the Patient Admission Screening and Annual Resident Review (PASARR) evaluation tool. Years ago, some mental health clients were admitted to nursing homes without physical disability diagnoses. This practice was revised such that a physician must make all referrals. Those indicating symptoms of mental health concerns (e.g., depression, anxiety, etc.) are evaluated accordingly. The Regional Medicaid Unit assesses physical reasons for nursing home admissions. Individuals with both physical reasons and mental health issues may be accepted into nursing home facilities. In these instances, the psychiatrist will review psychiatric medications and adjust as needed. The QMHP can order the nursing home facility to arrange for counseling or other mental health services, if such services are determined to be in the best interest of the client.

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10. Statutory Criterion for MHBG- Criterion 5

Financial Resources

The funding allocation for the Division of Behavioral Health is determined as part of the larger Idaho Department of Health and Welfare's budget. The State of Idaho uses a historical budget methodology based on the prior year's budget for the overall budget appropriation for the program. This includes the use of a historical budget based on the prior year's expenditures for allocating appropriated funds.

Each year the Division program budget is submitted to the State Legislature for the exact amount as in the prior year. Inflation factors are then added for personnel and for individual operating and trustee and benefit payment categories. The inflation amounts for the submission are set by the state's Division of Financial Management.

The prior year's approved budget plus the inflationary increases constitute the new fiscal year's base amount. To the base are added any program enhancements that are requested by the agency. This would include increased program funding requests, requests for additional personnel, etc. The final total is the program's annual budget submission.

After the budget is set by the legislature, the approved amount is allocated to the different program areas based on the prior year's expenditure level. This is not universal in the program in that personnel is set according to expected need based on the number of employees, salary and benefit rates.

The major categories of revenue available for Idaho's state community mental health program include state general funds, federal funds, and program receipts and are allocated for State FY2018 as follows:

MH Financial resources:			
State General Funds		$	40,227,000
Federal Funds			
MEDICAID	10975A	$	188,325
MEDICAID CMHR PROJECT @ 50%	10990A	$	1,193,400
SSBG-CHILD CLINICAL SERVICES- JEFF D	12005B	$	1,865,562
COMM. MENTAL HEALTH BLOCK	12540C	$	2,956,485
EMERGENCY PREPAREDNESS	35910C	$	32,500
PATH	61000C	$	299,625
IYTP	61600C	$	369,600
Other federal sources		$	1,264,268
Total MH Financial Resources		$	48,396,764

Staffing

The Department of Health and Welfare's Division of Behavioral Health Program is currently allocated a statewide total of 210.56 established full time equivalent (FTE) staff in the Adult Mental Health Program

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and 97.67 FTE staff in the Children's Mental Health Program. The overall totals reported above include FTE assigned to the Division office. The tables below identify the breakdown of regional staff by adult and children's mental health programs.

STATEWIDE DISTRIBUTION OF CMHC STAFF as of 7/1/2017

CHILDREN'S MENTAL HEALTH						
New Allocation of Budget By			New Allocation of Staff By Region			
*SFY18 Budget		$4,726,500	SFY18 Staff Allocation	Current Established FTE	SFY18 FTE Distribution	Position Change
Region 1	12.0%	$ 569,108	12.0%	10.00	8	-1.93
Region 2	10.3%	$ 486,020	10.3%	6.50	7	0.39
Region 3	16.2%	$ 767,936	16.2%	9.67	11	1.22
Region 4	21.8%	$1,030,516	21.8%	16.00	15	-1.39
Region 5	12.7%	$ 601,591	12.7%	7.50	9	1.03
Region 6	8.5%	$ 400,873	8.5%	5.15	6	0.53
Region 7	18.4%	$ 870,616	18.4%	12.00	12	0.34

ADULT MENTAL HEALTH						
New Allocation of Budget By			New Allocation of Staff By Region			
SFY18 Budget		$ 13,680,000	SFY18 Staff Allocation %	Current Established FTE	SFY18 FTE Distribution	Position Change
Region 1	12.3%	$ 1,681,653	12.3%	23.17	24	0.37
Region 2	10.5%	$ 1,440,076	10.5%	19.30	20	0.86
Region 3	17.4%	$ 2,376,687	17.4%	32.67	33	0.60
Region 4	21.9%	$ 2,992,217	21.9%	39.00	42	2.88
Region 5	11.3%	$ 1,550,772	11.3%	24.67	22	-2.96
Region 6	8.6%	$ 1,177,764	8.6%	18.67	16	-2.18
Region 7	18.0%	$ 2,461,290	18.0%	34.00	34	0.45

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Training for Mental Health Service Providers

The Division of Behavioral Health will continue in SFY 2018 to assume leadership in identifying the statewide training needs of the public mental health service delivery system. The Division has prioritized the need for improved statewide consistency and the development and implementation of program standards, policies and competencies. The training priorities for SFY 2018 include the following:

- Child and Adolescent Needs & Strengths (CANS). The state will be implementing use of the tool for the purpose of assisting in assessment, treatment planning, and outcome measurement

processes. CANS will help to identify those children and families who are risk of using emergency health services. All Medicaid providers will be trained on the CANS.

- Intensive Care Coordination (ICC). The State plans to train all providers in utilizing an ICC model that brings together children and their families to help develop and implement a care plan that will assist them in realizing their treatment goals including reduction of emergency services.
- Wraparound Services. The State plans to train CMH clinicians in delivering wraparound services to children and youth who qualify for ICC. Wraparound will target those children, youth, and their families who often use emergency health services
- FEP Program – The Division of Behavioral Health funded a statewide Differential Diagnosis Training held in Twin Falls – 180 state and private agency providers were invited with over 120 in attendance. Ongoing training will continue in FY2018 to address critical time intervention, shared decision making, Coordinated Specialty Care model or other relevant FEP topics.

The Regional Behavioral Health Programs continues to provide funding for identified training opportunities and needs for the regional AMH and CMH staff. Each regional program dedicates program funds to facilitate staff training. The regional program will often provide or sponsor trainings to private providers, Regional Behavioral Health Boards, community partners, and contractors, and others as needs are identified. Each year the top training priorities are identified by the program managers and training is planned based those priorities. Regional trainings for state staff have been offered to include: Trauma Informed Care, Motivational Interviewing, Ethics, Evidence Based Practices, Designated Exam practice/process, Chemical Dependency, Suicide Risk Assessment, Assessing Dementia and Homeless Outreach. Additionally, regional staff have provided trainings to several assisted living facilities and housing providers to include general mental health information, working with clients with a personality disorder, and risk/safety assessment.

The Division contracts with a family-run organization to provide support, education, and advocacy for families in Idaho. The contract requires the contractor to provide monthly training to parents and families of children with SED on advocacy, the children's' mental health service delivery system, available resources and other child serving programs, and being a consumer of services.

Several training modules area available for online use through the Department of Health and Welfare's Learning Hub. The Learning Hub provides a variety of training modules for both online learning and for scheduled ground classes. Continuing Education Units (CEUs) are available for many of these courses, and this feature is helpful to Idaho clinical and social work staff who have requirements for at least 20 CEUs per year. Training modules that are especially pertinent to Idaho Behavioral Health staff include treatment of integrated co-occurring disorders competency; cultural competency modules and ethics. The Learning Hub tracks courses and whether participants complete and pass each course taken. Regional supervisors are responsible to ensure that their staff complete and pass required modules to provide services.

Training for Emergency Health Services

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The following is a description of Idaho's coordinated efforts and training infrastructure for emergency responders and law enforcement. Across the state of Idaho, many entities are working to ensure Idaho emergency responders and law enforcement officers receive the highest quality training possible. Crisis Intervention Teams (CIT) are increasingly prevalent across the United States. Idaho Department of Health and Welfare (IDHW), Division of Behavioral Health (DBH) has identified CIT International as an industry leader and is a leader in the task of organizing the training of CIT's Memphis model CIT Core Elements. This activity is happening in all seven regions of Idaho, with varying levels of participation by local law enforcement groups. Region 4 and the Boise Police Department (BPD), for instance have been working on CIT programming since 2006. They completed their first CIT 40-hour training academy in 2009. Members of their collaborative have presented at 3 CIT International conferences and have graduated over 130 BPD officers from their CIT40 course. Around the state, the structure of these types of collaborations vary, with some police departments leading their own training efforts while other departments look to IDHW DBH regional offices for guidance. In all regions, CIT training programs rely on subject matter expert guest speakers to deliver specific information. IDHW DBH regional offices work to coordinate these presenters for each of their regions. Idaho is also considering adding an 8 hour CIT training element to its POST academy in 2018.

In Region 4, a Crisis Intervention Team Coalition has been formed between the Boise Police Department, Ada County Sheriff's office, Meridian Police Department, Garden City Police Department, IDHW DBH Region 4 office, IDHW Adult Protection, IDHW Developmental Disabilities, Ada County Paramedics, local hospitals and local behavioral health providers. This group meets monthly and has the following items listed as their current mission:

- Emphasize treatment rather than incarceration of people with behavioral health concerns.
- Decrease the proportion of people with behavioral health concerns in the Ada County jail.
- Prevent the inappropriate incarceration and/or criminalization of people with behavioral health illness.
- Decrease inappropriate behavioral health calls for law enforcement officers.
- Decrease officer injury rates.
- Decrease injury rates to persons experiencing a behavioral health crisis requiring law enforcement involvement.
- Increase law enforcement officers' knowledge about behavioral health concerns, and increase skills in their interactions with people experiencing behavioral health concerns.
- Provide training law enforcement officers.
- Improve the relationships between law enforcement departments and Behavioral Health providers.

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Their work includes meeting to discuss any recent relevant incidents, including individuals placed in temporary custody (called mental health holds) and mental health crisis responses in the field. They discuss follow up need based on acuity of entrance into the system (symptoms and behaviors that trigger a hold), mental health history, interactions (chronic or acute) with LE and treatment, etc. They then assign different cases to the most appropriate treatment provider in the Collaborative—IDHW DBH Mobile Crisis Unit, Adult Protection Services, Developmental Disabilities, Veterans Affairs, Children's Mental Health team, the Suicide Hotline, etc., and work with the client to find the most effective treatment pathway in order to prevent future or ongoing crisis.

Two significant efforts from this group have been identified as exemplary practices in Idaho: The Psychiatric Emergency Team (PET) and the accommodation registry.

This group developed Idaho's first Multi-Agency Accommodation Registry. This registry is designed to help law enforcement officers helping professionals best work with community members who may be experiencing a crisis. The registry is voluntary; nobody's information is shared without their consent. Individuals can enroll through IDHW DBH Region 4 Mobile Crisis Unit (MCU). They can provide information that may be useful for professionals to read prior to interacting with them. Examples of questions from the enrollment form include:

- What I can do to help myself (Crisis Plan attached in possible)
- What it looks like when I need help
- What others can do for me
- What I do not want other to do

Providing this information, along with a brief substance abuse and psychiatric history, helps first responders learn about an individual prior to meeting them. If an individual is actively engaged with a behavioral health service provider, listing their contact information can help first responders coordinate interventions. In some instances, (e.g. person is suicidal, homicidal or gravely disabled due to mental illness) that intervention includes placing someone in temporary custody (Mental Health Hold). This process can be initiated in Idaho by Law Enforcement officers or a Physician connected to a hospital. This can be a time-consuming process that relies on many resources to work properly. Region 4's Psychiatric Emergency Team is an example of service improvement and increase efficiency that can occur when multiple agencies partner together. This PET is a partnership between the Boise Police Department, Ada County Sheriff's office, Ada County Paramedics and IDHW DBH Region 4 MCU. In this model, members of the team evaluate a patient in the field – potentially skipping the time-consuming and expensive step of transporting a patient to a local emergency department for medical clearance prior to admission into a psychiatric hospital. The presence of an MCU member also allows for greater potential for holds to be diverted and safety plans to be created or enacted. Patients can receive referrals to community resources and experience improved outcomes as compared to a hold in which they only interface with law enforcement.

In Northern Idaho, CIT efforts are also gaining momentum. Bonner County Sheriff's Department has partnered with IDHW DBH Region 1 to hold 9 CIT academies and has now trained 90% of their

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department. Other entities have been less enthusiastic historically, but progress is being made. Kootenai County Sheriff's Office, for instance had been resistant to CIT training until this past year. Over the past three years, IDHW DBH Region 1 staff conducted several 4 hour courses to various counties/departments in Region 1 to provide training in De-escalation and Crisis Intervention techniques. This activity was intended to market a CIT40 academy and explain the importance of being certified as a CIT officer. As a result, in November 2016, IDHW DBH completed the first Kootenai County Academy. 30 officers attended and it was received an overall 90% approval rating.

IDHW DBH Region 1 plans to conduct two full time academies annually in Region 1 for Bonner and Kootenai. IDHW DBH Region 1 staff also conducted a seminar at CIT International April 2016 in Chicago. The focus was on how to market CIT to rural or resistant organizations/counties. They utilized their knowledge and experience from other parts of the state to explain how CIT was implemented and explained their current strategy of expanding CIT in Region 1.

Additionally, Regional staff regularly meet or consult with local hospital Emergency Room staff, psychiatric staff, and adult protection to provide education and address concerns regarding management of individuals hospitalized for mental health concerns. This is done on a regional basis to better meet the needs of the local community service providers.

The Division hired a Behavioral Health Disaster Preparedness Program Specialist over a year and a half ago. During this time, efforts have been underway to establish relationships between DBH and the Public Health Districts, community Health Care Coalitions, and numerous other partners and stakeholders statewide. These efforts have enhanced the behavioral health presence in preparedness initiatives statewide, including disaster exercises, regional coalition meetings, and trainings.

How the State Intends to Expend the MHBG Grant

The State intends to expend the MHGB block grant for FY 2018-19 as follows:

	Block Grant Funds
Adult Mental Health Services	$652,246
Planning Council	$20,000
Consumer and Family Empowerment Contract (AMH)	$161,000
Suicide Prevention Council	$10,000
Suicide Hotline	$50,000
Certification Contract (AMH and CMH)	$300,000
Parenting with Love and Limits (CMH)	$270,000
Family Run Organization Contract (CMH)	$199,120
10% FEP Set Aside	$190,808
Administration 5%	$54,903
FY 2018 Proposed Budget Total	$1,908,077

It is understood, as required by Public Law 102-321, that no Federal CMHBG funds are to be used to pay for inpatient services.

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The following projects will be funded using federal Mental Health Block Grant (MHBG) funds in FY2018-19:

$161,000 will be used to fund the contract with the Office of Consumer Affairs (through Janus, Inc) for the provision of advocacy and education to consumers and family members throughout Idaho.

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

$60,000 will be used to contribute toward the funding of Suicide Prevention and the Suicide Hotline.

$300,000 will be dedicated toward funding a new credentialing contract for Peer Support Specialists and Family Support Partners.

$199,120 will be used to fund the contract with a Family Run Organization for family education and support services, a respite services including information and referral, training and reimbursements.

$270,000 will be used to provide the evidence based program Parenting with Love and Limits in the CMH program statewide.

$190,808 will be dedicated to the three regional programs in Regions 3, 6 and 7 for continued development and implementation of the STAR FEP program which is based on the CSP On Track program.

$652,246 will be placed in the Department of Health and Welfare's Mental Health Cost Pool and allocated to the seven-regional adult mental health budgets to fund various community mental health program categories using the Random Moment Time Study.

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10. Statutory Criterion for MHBG- Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The State of Idaho provides state funded and operated community based mental health care services through Regional Behavioral Health Centers (RBHC) located in each of the seven geographical regions of the state. Each RBHC provides mental health services through a system of care that is both community-based and consumer-guided. The mission of the Division of Behavioral Health is to provide services of the highest quality by working together to inspire hope, recovery and resiliency in the lives of Idahoans living with behavioral health disorders and their families. The Division of Behavioral Health helps children, adults and families address and manage personal challenges resulting from mental illnesses and/or substance use disorders. The division recognizes that many people suffer from both a mental illness and substance use disorder and is integrating services for these co-occurring disorders to improve outcomes. The division is comprised of the Children and Adult Mental Health programs, as well as the Substance Use Disorders Program. The division also administers the state's two psychiatric hospitals, State Hospital North and State Hospital South, for people who have been court-ordered into the state's custody.

The needs of Idaho adults who have a mental health diagnosis are diverse and complex. The division works to ensure that programs and services ranging from community-based outpatient services to inpatient hospitalization services are available to eligible Idaho residents. Eligibility includes service to those who are:

1. Experiencing psychiatric crisis;
2. Receiving treatment by court order;
3. Diagnosed with a serious mental illness or a serious and persistent mental illness with no other resources available to meet their needs.

The provision of state-funded mental health treatment to Idaho residents is distributed between seven community-based regional behavioral health centers serving all 44 counties in the state. Each regional behavioral health center is staffed with a variety of licensed treatment professionals (psychiatrists, nurse practitioners, social workers, clinicians, and other mental health workers). Each regional behavioral health center offers crisis services and ongoing mental health services. While those individuals with private insurance or Medicaid may choose from a variety of private mental health service providers, the Idaho Department of Health and Welfare's (DHW) Division of Behavioral Health (DBH) has historically been responsible to provide services to adults who do not have Medicaid or other forms of insurance or payment, and to those who may have Medicaid but whose needs are too complicated for private providers to manage effectively.

Emergency services are provided statewide through the Adult Mental Health crisis units. Crisis units provide phone and consultation services 24/7. Crisis units also screen all adults who are being petitioned for court-ordered commitment. The court-ordered commitment process is followed when the court determines that someone is likely to injure themselves or others. People

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who are placed under commitment may be treated in a community or state hospital, or they may receive intensive community-based care for acute needs. During SFY2016, 76 percent of the participants receiving services from the division received crisis services. The remaining 24 percent received ongoing mental health treatment. The primary goal of ongoing mental health services is to promote recovery and improve the quality of life for Idaho adults with mental health diagnoses.

The adult mental health service array includes clinic services, medication management, Assertive Community Treatment (ACT), case management services, co-occurring integrated disorders treatment, crisis response, collaboration with vocational rehabilitation and strong collaboration with mental health courts. The division's regional behavioral health centers provide court-ordered evaluation, treatment recommendations and other necessary treatment provisions for individuals being sentenced under Idaho Code 19-2524, 18-211/212, 66-329, and/or Mental Health Court. Adults referred through Mental Health Court receive Assertive Community Treatment (ACT) services, with ACT staff integrally involved in collaborative mental health court meetings. Eligible individuals can also receive case management services through regional behavioral health centers. Case managers use person-centered planning to identify mental health needs. Once treatment needs are identified, case managers link the participant to available community resources, coordinate referrals, advocate for the participant, and monitor service effectiveness and participant satisfaction. Short- and long-term, non-intensive services are available on a limited basis. Community support services are available on a limited basis. These services include outreach, medication monitoring, benefits assistance, community-based rehabilitation services, employability, and housing support. The following reflects the types and numbers of services provided by the Adult Mental Health program in SFY2017.

Service Type	SMHA System
Clients served through Clinic Services	683
Clients served through Med-Only Clinic Services	1930
Clients served through CBRS Services	141
Clients Served through ACT Services	277
Clients Served through Mental Health Court Services	354
Holds and Petitions (I.C. 66-326)	5871
Civil Commitments (I.C. 66-329)	1142
% Holds Diverted from State Hospitalization	88.72%
Clients Receiving PAP Med Scholarships	1222
19-2524 Evaluations	4555
I.C. 18-211	257
I.C. 18-212	160

	Reg 1	Reg 2	Reg 3	Reg 4	Reg 5	Reg 6	Reg 7	Total
Total Served	1628	945	2908	4543	1480	1126	2183	14,813

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ACT services provide a full array of community-based services as an alternative to hospitalization for adults with serious and persistent mental illnesses who have the most intense service needs. ACT services are provided by a team of professional staff and certified peer support specialists. Services include individualized treatment planning, crisis intervention, peer support services, community-based rehabilitation services, medication management, case management, individual and group therapy, cooccurring treatment and coordination of other community support.

According to the National Survey on Drug Use and Health, in 2014, an estimated 39.1 percent of adults with a substance use disorder within the past year also had a co-occurring mental illness. The division's regional behavioral health centers provide integrated treatment for those diagnosed with co-occurring mental health and substance use disorders. If regional behavioral health centers are unable to provide a full range of co-occurring treatment for participants, they may refer or collaborate with a private agency to provide additional services.

The Division also includes the management and oversite of the two state funded psychiatric hospitals, State Hospital South and State Hospital North. State Hospital South (SHS) celebrated its 130th year of service on July 13, 2016. Included in this celebration was the final placing of more than 1,000 headstones in the hospital's cemetery. Since the hospital was established in 1886 in Blackfoot, it has provided care to over 29,000 patients. The cemetery grounds are a point of pride because they honor pioneers of mental health who lived the life and left their legacy. The hospital is licensed by the state to serve 90 adult patients, 16 adolescent patients, and 29 residents in the Syringa Chalet skilled nursing home. The hospital is accredited by the Joint Commission, which is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting established performance standards. Patients are referred to the hospital by regional behavioral health centers after civil or competency restoration commitment in their local courts. Civilly committed patients have been found to be a danger to themselves, a danger to others, or gravely disabled. Competency restoration patients (13% of the adult population in SFY2016) have been found unfit to proceed in the criminal justice system because of mental illness. SHS admitted 102 competency restoration patients in SFY2016. That represented a 59.36% increase over the previous fiscal year.

Patient-centered treatment for all the hospital residents is provided by an interdisciplinary team of benefits specialists, dental professionals, dieticians, nursing staff, psychiatric and general practice physicians, physician assistants, physical therapists, psychologists and counselors, recreational therapists, social workers, treatment coordinators, and other support staff.
Each adult unit also has a peer specialist who promotes recovery by offering hope and encouragement to patients as well as modeling personal success in managing a mental health disorder. During treatment, patients are assisted by a multidisciplinary team in developing a personalized Wellness Recovery Action Plan for when they return to community living.

State Hospital North (SHN) in Orofino is a 60-bed psychiatric hospital that provides treatment for adults in psychiatric crisis. The hospital collaborates with patients, their families, and the referring regional behavioral health center to develop goals for hospitalization and to arrange follow-up care after an inpatient stay. Hospitalization at State Hospital North is intended to be of short to intermediate duration with the objective of stabilizing presenting symptoms and

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returning the patient to community living in the shortest reasonable period of time. Length of stay is variable based on patient needs and prevailing best practices within the mental health field. The median length of stay is about 55 days. Admissions to State Hospital North are referred through the Regional Behavioral Health Centers. Treatment is individualized and is delivered by interdisciplinary treatment teams consisting of psychiatrists, a nurse practitioner, a medical doctor, licensed nurses, psychiatric technicians, master's level clinicians, psychosocial rehabilitation specialists, therapeutic recreation specialists, a dietitian, and support personnel. Staff deliver a number of specialized services that include assessments and evaluations, medication management, a variety of therapies, opportunities for community integration, involvement in recreational and educational activities, and discharge planning. The facility uses the Recovery Approach in treatment and promotes alignment with the patient in developing a self-directed care plan to assist them as they work toward their recovery goals

Idaho Code 19-2524 includes a section to the Judgment Chapter of the Criminal Procedure Title of the Idaho Code that deals with substance abuse and mental health treatment and allows judges some broadened sentencing options. The legislation allows a judge to order a substance abuse assessment and/or a mental health examination for certain convicted felons and felony parole violators that appear before the court. Based on the results of an assessment or examination, and if the court places the defendant on probation, a judge may order, as a condition of probation, that the defendant undergo treatment consistent with a treatment plan contained in the assessment or examination report. A treatment plan would be subject to modification by the court.

Regional AMH programs continue collaboration efforts in response to increased requests for best practice services to mental health court referrals. The model used to support mental health court referrals as an alternative to jail is provision of intensive ACT services and collaboration with court representatives to develop an individualized treatment plan that allows participants to stabilize and learn additional life management skills such as taking necessary medications, avoiding drug and alcohol use and avoiding criminal activities that brought them into the legal system. Region 7 is a designated national training site for these services. In addition to collaborating with the courts and corrections to establish referral, assessment, monitoring and treatment procedures, regional AMH programs also review and revise treatment services as needed in an effort to provide best practice, efficient and effective services.

Regional Behavioral Health programs offer crisis services to adults who are at risk of harming themselves or others, or who are determined to be gravely disabled. Crisis services include designated examinations and short term stabilization. Regional mental health programs conduct assessments, develop treatment plans, and provide ongoing mental health services. Individuals transitioned to a private behavioral health service provider continue to receive regional mental health service delivery until a suitable treatment plan and community supports are in place. The treatment plan focuses on services and supports to maintain the individual in their community and to reduce the likelihood of re-hospitalization. The treatment plan also addresses transitional needs (public to private) to assure continuity of care. In most cases, regional mental health programs provide services to the individual for not less than 30 days.

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In an effort to best meet the psychiatric needs of individuals who are diagnosed with a serious mental illness and who also have criminal charges, the State of Idaho is pursuing alternatives to jailing these individuals. Mental Health Courts work with regional ACT teams to provide least restrictive treatment service options to eligible referred clients. State Hospitals serve forensics clients in the general hospital population with a treatment focus on restoring them to fitness to proceed. When there is a need for hospitalization to avert danger to self or others and a bed is not available at one of the two state hospitals, a client may be hospitalized temporarily at a community hospital. Bed days at community hospitals are funded by dollars that are legislatively allocated each year.

Medicaid Covered Behavioral Health Services

On September 1, 2013, Idaho Medicaid implemented the Idaho Behavioral Health Plan (IBHP). United Behavioral Health (dba Optum Idaho) was selected to administer the plan using a managed care approach. This approach allows Idaho to develop an accountable care system to improve health outcomes. The IBHP represents a huge step forward in the transformation of the behavioral health care system in Idaho by:

- Requiring the use of evidence-based practices in the delivery of services
- Integrating the services of mental health clinic, community based rehabilitation (CBRS) agencies, services coordination agencies and substance used disorder agencies into one, "behavioral health" service system
- Replacing artificial service limits with a care management process that relies on individualized clinical reviews of a member's medical necessity for services

The IBHP provides services for children with serious emotional disturbance and adults with serious mental illness or serious and persistent mental illness as well as any adults or children who manifest symptoms indicative of behavioral health issues. Members are able to choose their provider within the Optum network.

Optum's care managers are actively engaged with providers, members and other stakeholders throughout Idaho to ensure that patients receive the right care at the right time. Medicaid reimbursable outpatient behavioral health services including case management services for mental health and substance use needs are covered by Optum Idaho through the Idaho Behavioral Health Plan. The amount and length of services provided is based on individual needs and medical necessity. There are no service limitations for covered services however some services require prior authorization. Covered outpatient behavioral health and substance use disorder services include: comprehensive diagnostic assessment, individual psychotherapy, family psychotherapy, community crisis interventions, group psychotherapy, pharmacologic management, individualized treatment plan, psychological testing, case management, nursing assessment, community based rehabilitation services, drug/alcohol testing, skills training and development, community transition support, peer support specialist, family support specialist, and intensive outpatient program. For more information on the Idaho Behavioral Health plan please visit the Optum Idaho Website at www.Optumidaho.com.

Behavioral health and primary health integration

In December 2015, the Idaho Health Care Coalition established a Behavioral Health Integration sub-committee headed by the division. This committee supports the work of the Statewide

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Healthcare Innovation Plan (SHIP) by leading the transformation and development of an integrated and coordinated behavioral health care system. Integrated Primary Care combines medical and behavioral health services to address the full spectrum of health concerns for each patient. Idaho recognizes the critical importance of integrating behavioral health into the Patient Centered Medical Home (PCMH) to increase quality of life and life expectancy for people with behavioral health conditions. It is important to note that integration is not a replacement for specialty behavioral health care. Close collaboration between specialty behavioral health and primary care is critical to ensure that people receive clinically appropriate services. Integration and collaboration are the means to increased community-based services. The primary goal of the subcommittee is to support the public health district SHIP managers and the Regional Collaborative as they integrate behavioral health into the PCMH.

Behavioral health program approval

Behavioral health transformation focuses on a combined system of care for mental health and substance use disorders. The department recognizes the benefit and necessity of integrated monitoring and credentialing of community mental health and substance use disorders treatment programs and has established a behavioral health program approval rule chapter (IDAPA 16.07.15) that allows community mental health agencies and those that treat substance use disorders to obtain state approval as a behavioral health program. This change is the result of a statewide negotiated rulemaking process that included partnering agencies, contractors, providers, and other system stakeholders. This change will advance efforts to integrate Idaho's mental health and substance use disorders systems by establishing uniform requirements for health, safety, environment of care, and program administration.

Homes with Adult Residential Treatment (HART)

A survey conducted in 2016 by the Idaho Small Provider Association estimates there are 500-600 Idahoans diagnosed with a Serious Mental Illness (SMI) who live in Residential Assisted Living Facilities (RALFs). While these facilities provide a place to stay for people unable to live on their own, the facilities are not designed to provide the care this group needs, including constant supervision to ensure that residents take medication, eat, and manage their other health-related needs. In late 2015, a workgroup was formed to design a new model to provide long-term support to help these Idahoans remain stable and out of expensive hospitals. The workgroup includes providers, advocates, stakeholders, and DHW staff from the divisions of Medicaid and Behavioral Health. The 2016 Idaho Legislature appropriated $1 million in bridge funding to the division to help RALFs deliver services for this population by providing supplemental payments while the HART model is developed. Additional funding was allocated in 2017 to continue the bridge funding and to implement a demonstration project of the model.

Peer Support Specialists, Family Support Partners and Recovery Coaches

For the past several years, the division has worked with families, clients, advocates, community partners, and other stakeholders to establish certification and training standards to support the development and implementation of peer services in Idaho. In SFY2016, the division focused efforts on workforce development for peer support specialists, family support partners, and recovery coaches. These efforts included development of training curricula; sponsoring training for peer support specialist and family support partners; conducting ongoing training for recovery

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coaches; and providing agency readiness trainings to employers. In September 2015, the division began to implement certification
requirements for peer specialists. Implementation of certification requirements for family support partners began in February 2016.

Suicide Prevention Program: In SFY2016, the Joint Finance and Appropriations Committee appropriated approximately $970,000 in ongoing general funds and four full-time positions to the Division of Public Health to establish the Suicide Prevention Program. This program will begin a comprehensive approach to suicide prevention by undertaking implementation strategies developed in support of the Idaho Suicide Prevention Plan. This approach begins with a public awareness campaign, supporting the Idaho Suicide Prevention Hotline and supporting youth training in resilience and well-being.

Behavioral Health Community Crisis Centers
The Idaho Legislature has approved funding for four behavioral health crisis centers around the state, including one in Boise that's expected to open in the next few months. The others are in Idaho Falls, Twin Falls and Coeur d'Alene. The crisis centers provide a humane and affordable alternative to jails or hospital emergency departments for people who are in crisis from a mental illness or substance use disorder. The centers are open 24/7. People in crisis are stabilized and then connected to community resources that can help them effectively deal with their situations and avoid further crises, frequently avoiding incarceration or a trip to the emergency department.

Secure mental health facilities
Idaho has seen an increase in the number of mental holds from law enforcement and physicians over the past several years. Although this has not resulted in an increase in the number of civil commitments, there has been an increase in the number of commitments under I.C. 18-212 for restoration to competency. In addition, staff members have observed that civilly committed patients have become more dangerous. These patients are difficult to discharge because it is difficult to find appropriate housing and treatment to meet their diverse and challenging needs. When patients are not discharged in a timely fashion, it creates a bottleneck at the state hospitals and requires patients to be held longer in community psychiatric hospitals. When community psychiatric hospitals are holding the division's patients waiting to be admitted to our state hospitals, it causes the community psychiatric hospitals to fill up. Patients are being cared for in emergency departments and in critical access hospitals that are unable to adequately and appropriately meet their needs. The division is researching the feasibility of establishing secure mental health facilities to provide a safe setting for dangerous patients to receive treatment in an appropriate environment to deal with the violence.

Behavioral health needs of felony probation offenders
In 2015, DHW and the Department of Correction collaborated to contract with the Western Intermountain Commission on Higher Education (WICHE) to evaluate the behavioral health needs of Idaho's felony probation offenders. This gap analysis is required annually by the Idaho Legislature as a result of the Justice Reinvestment Initiative. DHW provides mental health treatment for felony probation and parole offenders, while the Department of Correction is responsible for treatment of substance use disorders for that population. The Justice Reinvestment Initiative recommends that resources be focused on those offenders with the

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highest risk of recidivism and who are the highest risk to the community. The WICHE evaluation identified 7,388 offenders with moderate to high risk and high mental health needs and provided estimates for the delivery of mental health and substance use disorder treatment services.

Idaho IDHW Central and Regional offices, Idaho Department of Corrections, community mental health providers, and Federally Qualified Health Centers (FQHC) will be involved in the project. Idaho IDHW will be responsible for creating, monitoring, and managing contracts for mental health services. Idaho Department of Corrections will be the entity that will provide referrals of clients to the new project. Community mental health providers and FQHCs will be providing the mental health services to the clients.

The new Felony Probation and Parole project will address the need for mental health services for the Felony Probation and Parole population. The project will provide an avenue for referred Felony Probation and Parole clients to access mental health services to help in the efforts of establishing and maintaining mental health stability and ultimately reducing recidivism. The clients will have an opportunity to be provided with a diagnostic evaluation, treatment planning, medication and/or medication management services, individual counseling, and group counseling. The projected numbers to be served is between 4000-4500 clients on an ongoing basis. Data to be collected during the project timeframe will be the number of clients referred, level of participation, number of probation/parole violations, number of discharges, hospital visits, and Pre and Post LSI-R scores. The project has a timeframe of one year.

Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)

The Idaho State Department of Education (SDE) is the government agency tasked with supporting schools and students. The agency is responsible for implementing policies including compliance with the Individuals with Disabilities Education Act (IDEA), distributing funds, administering statewide assessments, licensing educators, and providing accountability data. The agency provides leadership, expertise, research, and technical assistance to school districts and schools to promote the academic success of students. To enable all students to achieve high academic standards and quality of life, the Special Education department works collaboratively with districts, agencies, and parents to ensure students receive quality, meaningful, and needed services. The SDE offers facilitation and mediation of special education meetings, as well as overseeing the state administrative complaints and due process hearings systems as required by the Individuals with Disabilities Education Act (IDEA). Per the SDE website, the Idaho Public school system encompasses 115 district, 48 charters, 728 schools and serves over 291,000 students.

Employment Services

In addition to services provided statewide by the Division of Vocational Rehabilitation (VR) located in local communities, Idaho has developed a unique program of assigning vocational rehabilitation counselors to several regional CMHC assertive community treatment teams (ACT). Vocational Rehabilitation counselors provide vocational services to ACT consumers as well as other consumers participating in the regional mental health programs. Services include work skills assessments, career counseling, rehabilitation plan development, and referrals to

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vocational and educational services such as job coaching, transportation, job shadowing, adult education and literacy services (GED and college level courses), and transitional/sheltered work experiences. The Division of BH maintains a contract with the Idaho Division of Vocational Rehabilitation to work with all ACT team patients on employment and vocational opportunities. This has been a very successful partnership and will continue. Idaho does not have a supportive employment program established under the Behavioral Health Authority.

Housing Services

Through the Bureau of Facility Standards, the DHW licenses or certifies a variety of supportive/assistive residential facilities and homes that are available to persons with a serious mental illness in Idaho. These supportive housing options include licensed Residential and Assisted Living Facilities and Certified Family Homes throughout the state.

Idaho also has a Shelter Plus Care Program, administered through Idaho Housing and Finance Association (IHFA). Shelter Plus Care is a rental assistance program for persons diagnosed with a serious and persistent mentally illness and who are also homeless. The program operates in each of the seven regions of the state, with funding support from the HUD Continuum of Care Awards. Each region has funding for rental assistance for 9 to 11 dwelling units. In addition to Shelter Plus Care, IHFA also manages the Section 8 Rental Assistance voucher program in Idaho. Julie Williams is the housing representative for the State Planning Council on Mental Health in Idaho.

Educational Services

Idaho also has three state universities, four state colleges, two private universities and two private colleges. Through the Vocational Rehabilitation program, consumers with an approved Vocational Rehabilitation plan may attend classes at these institutions as part of their own recovery. The need for referral to educational services is identified during the comprehensive assessment process and included in the individualized treatment plan.

Medical and Dental services

Medical and Dental Services Medical and dental needs for consumers in the public mental health system are identified during the assessment process. The assessment is used to address the individual's medical history and current health problems and identify needs. Case management services provide assistance with coordination of and referrals to community medical and dental providers.

Access to medical and dental services for those without private insurance or Medicaid benefits is limited across the state. Available community providers, such as the Terry Reilly Health Clinics, provide medical and dental services on a sliding fee scale in limited areas. There is also a limited county indigent program that varies by county with respect to covered services and that is usually limited to one-time expenses. The Idaho Medicaid program encourages recipients to sign up for its managed care program, Healthy Connections. This program provides a medical home for Medicaid clients by having one doctor responsible for the client's entire health care, referring a client to a specialist when necessary.

NOT FINAL

The Division of Medicaid administers comprehensive healthcare coverage for eligible Idahoans in accordance with Titles XIX and XXI of the Social Security Act and state statute. The division contracts with individual healthcare providers, agencies, institutions, and managed care entities to provide healthcare services for low-income families including children, pregnant women, the elderly, and people with disabilities. Medicaid participants have access to covered benefits through three benefit plans that align with health needs:

1. The **Basic Plan** is primarily designed to meet the health needs of those in generally good health and those without disabilities.
2. For individuals with more complex needs and medical conditions, the **Enhanced Plan** adds developmental disability, children's service coordination, and long- term care services and supports.
3. Individuals who are dually enrolled in both Medicare and Medicaid have access to the **Coordinated Plan**. This plan affords them the same services as the Enhanced Plan and allows them to enroll in managed care designed to streamline the Medicare and Medicaid benefits. There are many advantages to enrolling in managed care, but one of the most popular value-add services is access to a care coordinator who assists people with complex medical conditions as they navigate the system.

Medicaid currently has managed care programs for dental services, non-emergent medical transportation, outpatient behavioral health, and comprehensive managed care for those who are eligible for both Medicare and Medicaid. Medicaid also provides a Patient-Centered Medical Home care management program through its Healthy Connections primary care benefits. In 2017, Medicaid will add a shared savings option to its Patient-Centered Medical Home program. When primary care practices maintain quality and reduce costs, they can earn a share of savings. This program will be voluntary for primary care providers and will not affect the Medicaid payment arrangements that providers currently receive for providing care to Medicaid participants. The strategy is anticipated to improve care, improve health, and lower healthcare costs.

NOT FINAL

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i) Screening ☐ Yes ☐ No

ii) Education ☐ Yes ☐ No

iii) Brief Intervention ☐ Yes ☐ No

iv) Assessment ☐ Yes ☐ No

v) Detox (inpatient/social) ☐ Yes ☐ No

vi) Outpatient ☐ Yes ☐ No

vii) Intensive Outpatient ☐ Yes ☐ No

viii) Inpatient/Residential ☐ Yes ☐ No

ix) Aftercare; Recovery support ☐ Yes ☐ No

b) Are you considering any of the following:

Targeted services for veterans ☐ Yes ☐ No

Expansion of services for:

(1) Adolescents ☐ Yes ☐ No

(2) Other Adults ☐ Yes ☐ No

(3) Medication-Assisted Treatment (MAT) ☐ Yes ☐ No

NOT FINAL

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2

NOT FINAL

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ☐ Yes ☐ No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services? ☐ Yes ☐ No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ☐ Yes ☐ No

4. Does your state have an arrangement for ensuring the provision of required supportive services? ☐ Yes ☐ No

5 Are you considering any of the following:

a) Open assessment and intake scheduling ☐ Yes ☐ No

b) Establishment of an electronic system to identify available treatment slots ☐ Yes ☐ No

c) Expanded community network for supportive services and healthcare ☐ Yes ☐ No

d) Inclusion of recovery support services ☐ Yes ☐ No

e) Health navigators to assist clients with community linkages ☐ Yes ☐ No

f) Expanded capability for family services, relationship restoration, custody issue ☐ Yes ☐ No

g) Providing employment assistance ☐ Yes ☐ No

h) Providing transportation to and from services ☐ Yes ☐ No

i) Educational assistance ☐ Yes ☐ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

IDBH uses a Managed Services Contractor, BPAH, for the provision of PWWDC services. BPAH has developed a specialty network to serve this population and ensure that they have access to all of the required services. In addition to formal quarterly contract monitoring of this BPAH contract, IDBH meets with this contractor on a weekly basis. Utilization and budget reviews are performed regularly to ensure that PWWDC services are being accessed. BPAH conducts regular auditing of all PWWDC providers, including on-site visits as necessary. If BPAH or any of the PWWDC providers fail to meet contract requirements, a corrective action plan is generated and monitored until an acceptable level of performance is reached. If a specialty provider is unable to meet expectations, they will be terminated from the specialty network

NOT FINAL

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

   a) 90 percent capacity reporting requirement — Yes No

   b) 14-120 day performance requirement with provision of interim services — Yes No

   c) Outreach activities — Yes No

   d) Syringe services programs — Yes No

   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation — Yes No

2. Are you considering any of the following:

   a) Electronic system with alert when 90 percent capacity is reached — Yes No

   b) Automatic reminder system associated with 14-120 day performance requirement — Yes No

   c) Use of peer recovery supports to maintain contact and support — Yes No

   d) Service expansion to specific populations (military families, veterans, adolescents, older adults) — Yes No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The Idaho Department of health and Welfare, Division of Behavioral Health (Division), contracts with BPS Health to manage the delivery of substance use disorder services funded by the SAPT block grant. The Division's contract with BPA Health includes all SAPT block grant requirements including those for persons who inject drugs. BPA Health is responsible for ensuring all providers serving this population comply with SAPT block grant requirements. This is monitored regularly during contract monitoring meetings with BPA Health. In addition, BPA Health is required to submit regularly scheduled reports to the Division evaluating compliance with these requirements. BPA Health supplies weekly budget reports to the state to monitor budget compliance and allow for program capacity management. As a result, we have not needed to employ wait lists in at least the last 5 years. BPA Health monitors client intakes with internal reports to ensure that clients meet program criteria. BPA Health requires periodic clinical reviews while clients are in treatment to ensure that clients continue to meet program criteria.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — Yes No

2. Are you considering any of the following:

   a) Business agreement/MOU with primary healthcare providers — Yes No

   b) Cooperative agreement/MOU with public health entity for testing and treatment — Yes No

   c) Established co-located SUD professionals within FQHCs — Yes No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The Idaho Department of health and Welfare, Division of Behavioral Health (Division), contracts with BPS Health to manage the delivery of substance use disorder services funded by the SAPT block grant. The primary tasks of the contract are care management and provider system maintenance. BPA-Health is solely responsible for screening all applicants for SUD services for clinical and financial need. All screenings are conducted vial the telephone and include a required set of questions. Included in the required questions are inquiries regarding testing and risk for tuberculosis (TB). Applicants who have not been tested recently are informed of the importance of testing and are given referrals to obtain tests at low cost when indicated. For individuals admitted to treatment, the second level screening for TB occurs at the provider level. Idaho requires all SAPT block grant funders use the Global Appraisal of Individual Needs (GAIN) for client assessment. This tool includes a section on health risks as well. All individuals indicating they are positive for or at risk of TB are referred to the Idaho Health Districts for appropriate services. BPA

NOT FINAL

Health does clinical chart audits of provider records which are audited for compliance related to Tuberculosis services. Providers are required to have documentation indicating that the client was given referrals for Tuberculosis testing.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? ☐ Yes ☐ No

2. Are you considering any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas ☐ Yes ☐ No

   b) Establishment or expansion of tele-health and social media support services ☐ Yes ☐ No

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ☐ Yes ☐ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ☐ Yes ☐ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ☐ Yes ☐ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ☐ Yes ☐ No

   If yes, plese provide a brief description of the elements and the arrangement

NOT FINAL

Criterion 8,9&10

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — Yes No

2. Are you considering any of the following:

   a) Workforce development efforts to expand service access — Yes No

   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — Yes No

   c) Establish a peer recovery support network to assist in filling the gaps — Yes No

   d) Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — Yes No

   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — Yes No

   f) Explore expansion of service for:

      i) MAT — Yes No

      ii) Tele-Health — Yes No

      iii) Social Media Outreach — Yes No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — Yes No

2. Are you considering any of the following:

   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — Yes No

   b) Establish a program to provide trauma-informed care — Yes No

   c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — Yes No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) — Yes No

2. Are you considering any of the following:

   a) Notice to Program Beneficiaries — Yes No

   b) Develop an organized referral system to identify alternative providers — Yes No

   a) Develop a system to maintain a list of referrals made by religious organizations — Yes No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — Yes No

2. Are you considering any of the following:

   a) Review and update of screening and assessment instruments — Yes No

   b) Review of current levels of care to determine changes or additions — Yes No

NOT FINAL

c) Identify workforce needs to expand service capabilities ☐ Yes ☐ No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background ☐ Yes ☐ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? ☐ Yes ☐ No

2. Are you considering any of the following:

   a) Training staff and community partners on confidentiality requirements ☐ Yes ☐ No

   b) Training on responding to requests asking for acknowledgement of the presence of clients ☐ Yes ☐ No

   c) Updating written procedures which regulate and control access to records ☐ Yes ☐ No

   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure ☐ Yes ☐ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ☐ Yes ☐ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   4 providers

3. Are you considering any of the following:

   a) Development of a quality improvement plan ☐ Yes ☐ No

   b) Establishment of policies and procedures related to independent peer review ☐ Yes ☐ No

   c) Develop long-term planning for service revision and expansion to meet the needs of specific populations ☐ Yes ☐ No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? ☐ Yes ☐ No

   If YES, please identify the accreditation organization(s)

   i) ☐ Commission on the Accreditation of Rehabilitation Facilities

   ii) ☐ The Joint Commission

   iii) ☐ Other (please specify)

NOT FINAL

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ☐ Yes ☐ No

2. Are you considering any of the following:

   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ☐ Yes ☐ No

   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ☐ Yes ☐ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

   a) Recent trends in substance use disorders in the state ☐ Yes ☐ No

   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ☐ Yes ☐ No

   c) Preformance-based accountability ☐ Yes ☐ No

   d) Data collection and reporting requirements ☐ Yes ☐ No

2. Are you considering any of the following:

   a) A comprehensive review of the current training schedule and identification of additional training needs ☐ Yes ☐ No

   b) Addition of training sessions designed to increase employee understanding of recovery support services ☐ Yes ☐ No

   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ☐ Yes ☐ No

   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ☐ Yes ☐ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

   a) Allocations regarding women ☐ Yes ☐ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

   a) Tuberculosis ☐ Yes ☐ No

   b) Early Intervention Services Regarding HIV ☐ Yes ☐ No

3. Additional Agreements

   a) Improvement of Process for Appropriate Referrals for Treatment ☐ Yes ☐ No

   b) Professional Development ☐ Yes ☐ No

   c) Coordination of Various Activities and Services ☐ Yes ☐ No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Behavioral Health
Behavioral Health Sliding Fee Schedules: https://adminrules.idaho.gov/rules/current/16/0701.pdf

NOT FINAL

Behavioral Health Program Approval: https://adminrules.idaho.gov/rules/current/16/0715.pdf
Behavioral Health Community Crisis Centers: https://adminrules.idaho.gov/rules/current/16/0730.pdf
Behavioral Health Certification of Peer Support Specialists and Family Support Partners: https://adminrules.idaho.gov/rules/current/16/0719.pdf
Minimum Standards for Nonhospital, Medically-Monitored Detoxification/Mental Health Diversion Units: https://adminrules.idaho.gov/rules/current/16/0750.pdf

Mental Health
Adult Mental Health Services: https://adminrules.idaho.gov/rules/current/16/0733.pdf
Children's Mental Health Services: https://adminrules.idaho.gov/rules/current/16/0737.pdf
Appointment of Designated Examiners and Designated Dispositioners: https://adminrules.idaho.gov/rules/current/16/0739.pdf

Substance Use Disorders
Substance Use Disorders Services: https://adminrules.idaho.gov/rules/current/16/0717.pdf

NOT FINAL

Footnotes:

Idaho is not an HIV/AIDS designated state.

NOT FINAL

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? ☐ Yes ☐ No

   Does the state have any activities related to this section that you would like to highlight?

   See Idaho's QA Plan attached to this section.

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

NOT FINAL

Quality Assurance Program

Division of Behavioral Health

Submitted by Candace Falsetti- CO 3rd, 7-14-2017, #3

NOT FINAL

2017

Idaho Department of Health and Welfare

Quality Assurance Program

NOT FINAL

Quality Assurance Program

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Appendices:

Appendix A- Outcome Measures

NOT FINAL

Quality Assurance Program

NOT FINAL

Quality Assurance Program

Revisions:

Type of revision	Date	Revision #	Notes
Quality Assurance Program	**March 16, 2015**		
Major revision	**March 27, 2015**	**1**	**Added definitions Clarified role of QA Checked BPA QA description Checked IYTP description**
Minor revision	**April 24th, 2015**	**2**	**Clarified role of QA compared to Contract Monitors**
Major revision	**July 14th, 2017**	**3**	

Definitions:

Key indicators: Designated measures that are used to evaluate success often associated with quality improvement processes- Key indicators may include structure, process and outcome measures. For example: number of staff trained in trauma informed care, or reduction in cost of inpatient stays

Outcome measures: A measure of the quality of health care, the standard against which the end result is assessed- For example: a reduction in symptoms of depression.

Performance Improvement Project (PIP) or Quality Improvement Project (QIP): A project developed to address identified areas for improvement targeted includes a proposed intervention or improvement plan, a method for analyzing the impact of the intervention, and a Quality Assurance (QA) plan for ensuring on-going improvement.

Quality Assurance (QA): The systematic monitoring and evaluation of the various aspects of a project, service, facility or system to ensure that standards of quality are being met.

Quality Improvement (QI): Consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted groups.

Quality Assurance Program (QAP): Systematic quality assurance activities that are organized and implemented by an organization to monitor, assess, and improve the quality of health care. Activities are cyclical so that an organization continues to seek higher levels of performance to optimize its care.

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Quality Assurance Program

Quality Assurance Program Overview

The Idaho Department of Health and Welfare (IDHW) is committed to reducing the impact of substance abuse and mental illness on Idahoans and Idaho's communities. To support this goal the Division of Behavioral Health (DBH) has developed a Quality Assurance Program (QAP). The goal of the QAP is to support improvement in behavioral health services and outcomes for Idahoans by monitoring system performance, evaluating quality of care provided, and reporting outcomes.

Quality improvement principles and activities are imbedded throughout the Division of Behavioral Health (DBH). Each operational unit in DBH is actively involved in identifying and implementing improvement. The Quality Assurance Unit is responsible for the specific activities noted here as the Quality Assurance Program.

Quality Assurance Program Objectives

The foundation of the Quality Assurance Program (QAP) is the implementation of a multidimensional and multi-disciplinary QA Team that effectively and systematically monitors and evaluates the quality of behavioral health services. The QA Team may identify and initiate corrective action as necessary to drive improvement in behavioral health care delivery and will promote the most effective use of resources while maintaining high standards.

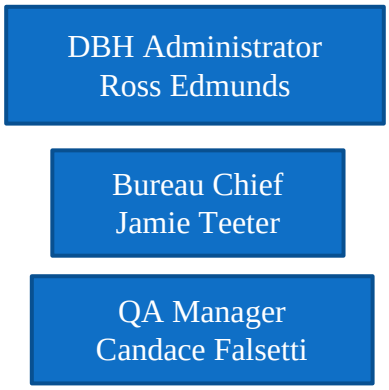
A list of key indicators of performance and outcome measures is included in Appendix A. A portion of the key measures identified are available currently through various sources of data and reports while others are aspirational and if identified as desirable would potentially require collaboration and partnership with other systems, levels of government, and private organizations.

The measures were identified based on the following philosophy:

- QA will utilize standardized outcome tools to track key indicators of performance and outcomes measures whenever possible, and will encourage and support the implementation of such tools.
- The key indicators of performance and outcome measures to be utilized or QA will encompass all the elements needed to evaluate quality, including measures of structure, process, and outcomes.
    - Structural measures assess the availability, accessibility, and quality of resources.
    - Process measures evaluate the delivery of behavioral health care services.
    - Outcome measures demonstrate the final result of behavioral health care.

Key indicators of performance and outcome measures will be reported and will be utilized to evaluate the impact of the QAP.

DBH QA Management Structure



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Quality Assurance Program

Quality Assurance Methodology

The Quality Assurance (QA) methodologies that will be employed will include review of State operated and contractor records, reports, policy and procedures, site visits, direct interviews, and surveys. QA findings will be assessed and addressed as quality improvement (QI) through various quality techniques such as Plan-Do-Study-Act, Six Sigma, Lean, and Root-Cause Analysis.

QAP Functional Areas

QAP identifies the areas of responsibility specifically assigned to the Quality Assurance Unit. These functional areas are listed below.

19-2524 Utilization Management

Preadmission Screening and Resident Review (PASRR)

Continuous Quality Improvement (CQI)

Behavioral Health Program Approval

Critical Incident Review

Jeff D Quality Management Improvement Activities (QMIA) Plan Development

Peer and Family Support Partners

Idaho Behavioral Health Plan (Optum)

Managed Services Contractor (BPA)

Quality Improvement Work Plan (QIWP)

Performance Improvement Projects (PIPs)/Quality Improvement Projects (QIP)

A high level description of each functional area follows.

19-2524 Utilization Management

In accordance with Idaho Statute 19-2524 all individuals in the state of Idaho who are found guilty of a felony have a right to a screening for their potential need of substance use or mental health services. The goal of the Statute is to ensure that consideration is given to the behavioral health needs as part of presentencing determination.

The process begins with a pre-sentencing screening conducted by the Idaho Department of Correction (IDOC). The screening instrument used by the IDOC is the GAIN. This instrument has been validated as a behavioral health assessment tool (not just a screening tool). The results of the GAIN Assessments are reviewed by DBH QA staff who are licensed and qualified to review the mental health sections of the GAIN. If the GAIN results (as reported in the GRRS) have adequate and substantive information which allows the DBH clinician to a make a treatment recommendation to the court an “Examination Report” is completed with recommendations for treatment. If the information is not adequate to develop a treatment recommendation the DBH clinician requests a full Mental Health Evaluation (MHE) to be completed in

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person by DBH Regional Clinicians. Information regarding treatment recommendations are communicated to the Pre-sentencing Investigator (PSI) and are notated in the PSI's report to the court.

In addition to the review processes noted the 19-2524 staff work with IDOC and the Idaho Supreme Court to collaborate on on-going improvements to the process.

Preadmission Screening and Resident Review (PASRR)

The goal of the PASRR program is to help ensure that individuals who need mental health services receive them, that they are not inappropriately placed in nursing homes for long term care, and that "psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care (Medicaid.gov)." Licensed clinical staff in the QA unit are assigned to review PASRR forms sent by nurse reviewers from hospitals (and on occasion from other environments) to develop recommendations, which may include a comprehensive MH evaluation. The designated lead PASRR staff also works with CMS as needed, participates in the national workgroup (PTAC), collaborates with Medicaid long term care staff, establishes and implements standards, and develops and provides training to clinicians, facilities and other providers.

Continuous Quality Improvement (CQI)

DBH Central Office (CO) QA Unit conducts site and medical record reviews for all outpatient state operated mental health clinics. The process is directed by CQI Policy and is based on rule, policy and standards. Through the review processes the QA Unit identifies items that do not meet requirements and works with programs to develop plans of correction to make improvements.

Behavioral Health Program Approval (BHPA)

In accordance with Idaho Statute and IDAPA all Substance Use Disorder (SUD) providers must have facility approval by the state authority. DBH QA staff completes all initial site certifications for SUDs programs and monitors the work of the Managed Services Contractor (MSC), BPAH, who is responsible for the follow up monitoring.

Mental Health programs that are part of the publicly funded services in Idaho are not required to have BHPA but may request approval voluntarily. DBH QA staff completes all initial and on-going site certifications for MH programs.

Critical Incidents

State operated Regional Mental Health Programs report all Critical Incidents to central office administrators and QA. Critical incidents are also reported by the Medicaid managed care contractor (Optum) and the MSC. The QA unit tracks and trends all reported critical incidents. QA may identify certain incidents for Root Cause Analysis (RCA). The results of trends in incidents or findings in RCA are utilized to address systemic issues and as appropriate may become part of DBH PIPs/QIPs.

Quality Management Improvement Accountability (QMIA) Plan for Jeff D Lawsuit

DBH QA worked with the Jeff D implementation team to develop a Quality Management Improvement Accountability (QMIA) plan that defines the QA processes to be implemented in regards to the Jeff D Lawsuit Class Members. The plan was created by a workgroup that included representatives from all the

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parties in the lawsuit. The plan includes an enhanced QA infrastructure, improved access to data that is used for planning and decision making, increased emphasis on voice from family and youth, data indicators that will reflect the way the system is working, and reporting that will be periodically published to inform stakeholders as to the progress that is being made in transforming the child mental health serving system.

As part of the developemtn of the QMIA the QA Unit is also involved in the development of an enhanced system for Due process and building a centralized complaint handling and tracking process.

Peer and Family Support Partner Certification

The DBH QA Unit has been responsible to review training records and references related to certifying peer and family support partners.

Idaho Behavioral Health Plan (IBHP):

DBH has a role in conducting QA for the Idaho Behavioral Health Plan (IBHP), currently Optum Idaho. The IBHP has contract requirements that support development toward the transformation of the behavioral health care system in Idaho including:

- Replacing service limits with a care management process that relies on individualized clinical reviews of a member's medical necessity for services
- Ensuring the use of appropriate evidence-based practices in the delivery of services
- Working towards developing integration of the services of mental health clinic, psychosocial rehabilitation (PSR- now called Community Based Rehabilitation Services or CBRS) agencies, service coordination agencies and substance use disorder agencies into one, "behavioral health" service system

Managed Services Contractor (MSC)

In addition to, and in support of, contract monitoring QA unit staff conduct quality assurance (QA) of the MSC.

The objectives for QA are to:

i. Evaluate targeted MSC processes to ensure they are within an acceptable range to meet state laws, requirements and standards.

MSC responsibilities that QA will evaluate include, but are not limited to:

a. Efforts to support Behavioral Health Transformation goals
b. Care Management processes including but not limited to:
    i. Review of Eligibility
    ii. Service Authorization and Denials
c. Administration of a SUDS Provider Network:
    i. Provider credentialing
    ii. Provider audit findings, action plans
    iii. Provider training plans
d. Quality Assurance
    i. Client rights
    ii. Grievances

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ii. Assess the impact of MSC processes on SUDS clients based on the aims set by the Institutes of Medicine (IOM) for quality assurance, including that MSC is assuring that services are:

a. Safe
b. Effective
c. Efficient
d. Equitable
e. Client Centered
f. Timely

QA is conducted at least quarterly, and as needed. Quarterly QA is planned collaboratively with DBH Partners. In addition, the DBH Partner Agencies meet quarterly with MSC staff to evaluate quality of care, network adequacy, and implementation of evidence based practices throughout the system. QA is conducted via site review, record review, and review of policies. Results of QA are analyzed and plans of correction are requested when warranted.

Quality Improvement (QI) Work Plan

On behalf of DBH, QA oversees the DBH Quality Improvement Work Plan (QIWP). The QIWP is based on goals from the DBH strategic plan. The QIWP quantifies the goals and targets of measurable outcomes to assess the impact of the DBH Strategic Plan and QAP. The QIWP includes outcomes measures such as:

- Hospitalization and readmission rates
- Client satisfaction surveys
- Wait times
- Access to care based on race/ethnicity.

Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs)

Systemic issues that are appropriate may be addressed through a PIP or QIP. A PIP/QIP is a project that is based upon a targeted problem and a plan to implement a specific intervention that is expected to result in a positive outcome.

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<u>Role of QA Unit in Contract Monitoring</u>

Contract Monitoring and QA are systematic methods used by IDHW to monitor and assess contractor performance.

Contract monitoring is performed by the designated IDHW contract monitor according to DHW/DBH procedures and processes established within the contract. The focus of Contract Monitoring involves activities to evaluate and enforce performance of contract services and contract required performance measures. Contract Monitoring focuses *on the steps taken or procedures used* to provide the required service. Best practices noted in the Office of Federal Procurement “Guide to Best Practices for Contract Administration”--Acquisition Central identify the following activities as aspects of contract monitoring:

- Did the contractor perform the services defined in the contract?
- Did the contractor perform the services on time?
- Were deliverables delivered or achieved in required form and on time?
- Did the services meet the Department's expected (and defined) standard?
- Were services itemized in the billing actually delivered?

QA is a component of monitoring which may inform DBH contract monitors but which focuses on the *quality of the product delivered* rather than the steps taken or procedures used or specific contract performance measures. DBH QA Unit utilizes the types of issues seen in the diagram below to assess quality:

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QA done by the QA Unit will conform to healthcare quality assurance concepts and models and therefore focuses on specific aspects of the services provided, not on the contract requirements per se. The QA Unit will focus on quality aspects of care as noted by the Institute of medicine: safety, effectiveness, efficiency, equitable, client centered, and timely. QA Unit will also assess compliance with Federal and or State rules, and may be a subject matter expert in the area reviewed. The QA Unit may evaluate quality based on State standards, accepted community guidelines, and other recognized guidelines which may exceed the contract requirements.

The level of the involvement that the QA Unit has in monitoring contracts is determined by the amount of risk associated with the contract, including the following elements:

- Contract is critical to achieving IDHWs mission

- IDAPA requirements associated with contractors responsibilities
- Likelihood that nonperformance or underperformance could jeopardize health or safety
- Dollar value of contract
- Age of contract
- Length of time agency has been doing business with IDHW
- Audit findings
- Availability of alternatives
- Potential impact on public confidence

The methodology used in reviews for both contract monitoring and the QA Unit and may include desk review of reports and data, pre-planned inspections, validation of complaints and random unscheduled inspection. To minimize contradictions, duplication and confusion the QA Unit will work together with contract monitors to clarify roles as needed.

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Appendix A

Proposed Key Indicators of Performance and Outcome Measures

Domain	Measure	Question	Data Elements	Data Source(s)
Access	Eligible participants have been appropriately identified	What proportion of the population has been identified as eligible participants?	Total number of population Total number of eligible participants	Census data Encounter data
	Eligible participants have access to services	What proportion of eligible participants receives services?	Total Number receiving services Total Number Not Receiving Services Penetration Rate	Encounter data
		Are service denials appropriate?	IBHP, MSC denials Notices of Action	QA review of denials
		What types of services have they received?	Number receiving: Engagement, Assessment, and Treatment Planning Service Coordination, Case Management, and Care Coordination Clinical Treatment Services Support Services (??) Crisis Services	Encounter data
	Barriers to access are identified and plans for remediation exist	Of those eligible participants who did not receive services, what barriers did they encounter?	Analysis to identify gaps between the needs of the eligible and services provided. Identify incidences when more restrictive levels of care are provided due to gaps in services	
		Are plans and strategies in place to resolve or eliminate barriers that may arise and impede access to services?	Gap analysis and plans to mitigate No show rates?	
	Eligible participants have timely access to care	How much time has passed between needs assessment and delivered service?	Number of days between initial assessment and delivered service(s) (or initial contact and completion of Treatment Plan) Outpatient services are provided within 7 days of inpatient discharge	Encounter data

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Quality Assurance Program

Domain	Measure	Question	Data Elements	Data Source(s)
Client/Family Centered (Engagement)	Parent/Family voice, choice, and preference are assured throughout the process	What proportion of cases involves caregivers and children in case planning and service delivery?	Number of cases in which client or family were involved in service planning Number of cases in which age-appropriate children were involved in case planning	Client satisfaction surveys Direct client survey (phone calls?)
		How do clients/family perceive the quality of the collaboration?	Client and family perception of collaborative service delivery	
	Collaborative Assessment of Environmental Factors	Are client and family strengths and needs integrated into treatment?		
	Services are maintained	Are clients and families engaged in services long enough to achieve good outcomes?	Retention rates Number of face-to-face contacts in first 30 days of service Number of days since last face-to-face	
	Barriers to engagement are identified and plans for remediation exist	Are plans and strategies in place to resolve or eliminate barriers that may arise and impede engagement with services?		
Services are appropriate to need	Services are needs based rather than service based	What proportion of eligible participants were screened, assessed, or otherwise their needs were determined?	Number of eligible participants screened and assessed	
		Are client and family strengths and needs integrated into treatment?		Medical record review
		Are providers utilizing Evidence Base Practices (EBPs) based on client and family needs?		
		Is the treatment consistent with the treatment plan?		Medical record review
		Are the services identified in the treatment adequate?	Measure for the quantity, duration, and frequency of service Measure treatment intensity	Medical record review

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Domain	Measure	Question	Data Elements	Data Source(s)
		Have there been changes in the needs or status of the client and if so, has the plan of care been adjusted as necessary?		Medical record review
	Medications, including psychotropic medications are appropriate to the client's need	Is the prescription and use of medication consistent with the client's diagnosis?	Verification of diagnosis with prescription	Pharmacy data Medical record review
Services are culturally appropriate	Services are culturally competent and respectful of the culture of clients and their families	Does the screening and assessment account for the client and family culture?		Medical record review
	Services and supports are provided in the client and family's community	Have reasonable efforts been made to provide services within reasonable proximity to the client and families homes?		
		Have existing connections with families, schools, friends, and other informal supports been maintained?		
Effectiveness	Children and adults are protected from abuse and neglect, and maintained in their homes	Do children and adults have freedom from abuse and neglect?	Number of children without a substantiated report of maltreatment while receiving services, in-or-out-of home The proportion of children that did not have another substantiated report of maltreatment following the initial report.	
		Are children safely maintained in their homes when possible?	Number of children who remain in their families of origin	
	Children have stability and permanency in their living situation	What effect does the treatment have on the child's permanency goals?	Length of stay in foster care Number placement moves, account for positive vs. negative moves Re-entry Of those children who are removed from their homes, the number of days between removal and reunification	

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Quality Assurance Program

Domain	Measure	Question	Data Elements	Data Source(s)
	Adults have stability and permanency in their living situation	What effect does treatment have on housing?		
	Clients are receiving the least restrictive level of care appropriate for their needs	Are clients and families receiving appropriate services?	Hospitalization and readmissions, + length of stay Residential care and length of stay	
	Clients are attending school or obtaining work	What effect does the treatment have on school attendance? Employment	Days attended school Job acquisition and retention	
	Clients have reduced symptomology and increased functioning	What effect has the service had on reducing symptoms and improving functioning?	Proportion of eligible participants exhibiting clinically significant improvement Proportion of eligible participants moving to lower levels of care Reduced self-harm, suicide attempts Reduced arrests and/or involvement with Juvenile Justice Abstinence or Reduced substance use % of clients with movement to lower levels of care within 60 days of episode closure	
	Clients have increased natural supports and social integration Clients have improved family mental health/substance abuse and relationship status	To what extent are family strengths and needs assessed and integrated into treatment?	Items from the *CANS*, CALOCUS, CAFAS/PECFAS , GAIN, LOCUS Measure for Social connectivity? Wellness Assessment (Optum's WA)	Results of outcomes tools
	High utilizers	Are clients and families receiving appropriate services?		Encounter data
Linkages	Evidence of Care coordination with other mental health providers	To what extent is the treatment plan coordinated with other agencies?	Treatment plan indicates coordination with other agencies as needed Client perceptions of service availability, access post-	

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Domain	Measure	Question	Data Elements	Data Source(s)
			discharge	
	Evidence of Care Coordination with Primary Care	To what extent is treatment integrated?	Treatment plan indicates coordination with other primary care	
	Evidence that physical health issues are assessed	To what extent are physical health issues assessed?		
Safety	Risks are identified and clients are provided with appropriate care	Are risk assessments conducted?	Risk assessments	
System Development	Development of Quality of Care Standards	Are standards implemented changes made to care standards as needed?	Standards of care	
Workforce Development	Providers receive needed training	Are providers provided training?	Training	Sign-in sheets
	Providers utilize EBPS	Are providers utilizing EBPs?		

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13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ☐ Yes ☐ No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ☐ Yes ☐ No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ☐ Yes ☐ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ☐ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight.

   Trauma Informed Training was conducted at State Hospital South (SHS) in January 2017. Approximately 187 SHS staff and 2 nursing students attended the training. This was the highest attendance ever for a non-mandatory training. Preparation for the training was initiated in August 2016 to develop the customized training specific to the needs identified by SHS. The same trainer also provided Trauma Informed training in March of 2015, with 113 SHS staff attending.

   As a direct result of the trainings the following changes have been implemented at the state hospital:
   • Renaming the units;
   • Painting the doors to the units-Cascade Falls being the first;
   • Introduced aroma therapy on the units;
   • The adolescent unit has stopped using the level system and introduced a Safety System, which they report is working great for

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staff and patients;
• More units are holding the Therapeutic Community Groups consistently on the units;
• Wording in our patient treatment plans and documentation has changed;
• Changed the décor of the Yoga/Wellness room;
• Initiated increased Rec Therapy activities onto the units for those who cannot leave the units;
• Adapted policies;
• Placed rocking chairs on the units;
• Introduced more weighted blankets;
• Working on adding rice packs with aroma therapy to more units;
• Asked the units to remove the struggle between staff and patients around food and snacks;
• Made dietary adjustments;
• Lavender lotion has been delivered to the units for staff and patients to use for calming;
• Some of the safe rooms have been updated since the 2015 visit;
• When painting, color choices have been considered;
• After the 2015 visit, the adolescent unit began visual, calming and welcoming changes to the unit;
• Worked on the admission process and taking of patient pictures to be less institutional;
• Added the visual accents (frosted window film) on the dining room windows to provide more dinning privacy;
• Made several changes to the way we ask questions on the nursing assessment;
• Added stuffed animals to the units;

On the SHS internal website, a dedicated Trauma Informed Care page has been developed. Additionally, Trauma Informed Care trainings have been conducted in several Regional Behavioral Health Centers, at State Hospital North and the Division office.

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

NOT FINAL

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

[63] http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ☐ Yes ☐ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ☐ Yes ☐ No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ☐ Yes ☐ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ☐ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight?

   N/A

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

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15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ☐ Yes ☐ No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? ☐ Yes ☐ No
3. Does the state purchase any of the following medication with block grant funds? ☐ Yes ☐ No
   a) ☐ Methadone
   b) ☐ Buprenophine, Buprenorphine/naloxone
   c) ☐ Disulfiram
   d) ☐ Acamprosate
   e) ☐ Naltexone (oral, IM)
   f) ☐ Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? ☐ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight?

   At the time of this writing, Idaho is in the process of implementing a Medication-Assisted Treatment system using State Targeted Response to the Opioid Crisis (Opioid STR) grant funds. A part of this project includes implementation of quality assurance activities.

   Please indicate areas of technical assistance needed to this section.

   **Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

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16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[65],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   - a) ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) ☐ Psychiatric Advance Directives
   - c) ☐ Family Engagement
   - d) ☐ Safety Planning
   - e) ☐ Peer-Operated Warm Lines
   - f) ☐ Peer-Run Crisis Respite Programs
   - g) ☐ Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) ☐ Assessment/Triage (Living Room Model)
   - b) ☐ Open Dialogue
   - c) ☐ Crisis Residential/Respite
   - d) ☐ Crisis Intervention Team/Law Enforcement
   - e) ☐ Mobile Crisis Outreach
   - f) ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) ☐ WRAP Post-Crisis
   - b) ☐ Peer Support/Peer Bridges

NOT FINAL

c) ☐ Follow-up Outreach and Support

d) ☐ Family to Family Engagement

e) ☐ Connection to care coordination and follow-up clinical care for individuals in crisis

f) ☐ Follow-up crisis engagement with families and involved community members

g) ☐ Recovery community coaches/peer recovery coaches

h) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

In Region 4, a Crisis Intervention Team Coalition has been formed between the Boise Police Department, Ada County Sheriff's office, Meridian Police Department, Garden City Police Department, IDHW DBH Region 4 office, IDHW Adult Protection, IDHW Developmental Disabilities, Ada County Paramedics, local hospitals and local behavioral health providers. This group meets monthly and has the following items listed as their current mission:
• Emphasize treatment rather than incarceration of people with behavioral health concerns.
• Decrease the proportion of people with behavioral health concerns in the Ada County jail.
• Prevent the inappropriate incarceration and/or criminalization of people with behavioral health illness.
• Decrease inappropriate behavioral health calls for law enforcement officers.
• Decrease officer injury rates.
• Decrease injury rates to persons experiencing a behavioral health crisis requiring law enforcement involvement.
• Increase law enforcement officers' knowledge about behavioral health concerns, and increase skills in their interactions with people experiencing behavioral health concerns.
• Provide training law enforcement officers.
• Improve the relationships between law enforcement departments and Behavioral Health providers.
Their work includes meeting to discuss any recent relevant incidents, including individuals placed in temporary custody (called mental health holds) and mental health crisis responses in the field. They discuss follow up need based on acuity of entrance into the system (symptoms and behaviors that trigger a hold), mental health history, interactions (chronic or acute) with LE and treatment, etc. They then assign different cases to the most appropriate treatment provider in the Collaborative—IDHW DBH Mobile Crisis Unit, Adult Protection Services, Developmental Disabilities, Veterans Affairs, Children's Mental Health team, the Suicide Hotline, etc., and work with the client to find the most effective treatment pathway in order to prevent future or ongoing crisis.
Two significant efforts from this group have been identified as exemplary practices in Idaho: The Psychiatric Emergency Team (PET) and the accommodation registry.
This group developed Idaho's first Multi-Agency Accommodation Registry. This registry is designed to help law enforcement officers helping professionals best work with community members who may be experiencing a crisis. The registry is voluntary; nobody's information is shared without their consent. Individuals can enroll through IDHW DBH Region 4 Mobile Crisis Unit (MCU). They can provide information that may be useful for professionals to read prior to interacting with them. Examples of questions from the enrollment form include:
• What I can do to help myself (Crisis Plan attached in possible)
• What it looks like when I need help
• What others can do for me
• What I do not want other to do
Providing this information, along with a brief substance abuse and psychiatric history, helps first responders learn about an individual prior to meeting them. If an individual is actively engaged with a behavioral health service provider, listing their contact information can help first responders coordinate interventions. In some instances, (e.g. person is suicidal, homicidal or gravely disabled due to mental illness) that intervention includes placing someone in temporary custody (Mental Health Hold). This process can be initiated in Idaho by Law Enforcement officers or a Physician connected to a hospital. This can be a time-consuming process that relies on many resources to work properly. Region 4's Psychiatric Emergency Team is an example of service improvement and increase efficiency that can occur when multiple agencies partner together. This PET is a partnership between the Boise Police Department, Ada County Sheriff's office, Ada County Paramedics and IDHW DBH Region 4 MCU. In this model, members of the team evaluate a patient in the field – potentially skipping the time-consuming and expensive step of transporting a patient to a local emergency department for medical clearance prior to admission into a psychiatric hospital. The presence of an MCU member also allows for greater potential for holds to be diverted and safety plans to be created or enacted. Patients can receive referrals to community resources and experience improved outcomes as compared to a hold in which they only interface with law enforcement.

Please indicate areas of technical assistance needed to this section.

None at this time.

Footnotes:

NOT FINAL

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

NOT FINAL

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ☐ Yes ☐ No

   b) Required peer accreditation or certification? ☐ Yes ☐ No

   c) Block grant funding of recovery support services. ☐ Yes ☐ No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

   Persons in recovery, family members and peers are involved in all levels of planning and delivery of behavioral health services. Partnership begins at the highest level with these populations' membership in the State Behavioral Planning Council and Regional Behavioral Health Boards. The use of peers in service planning and delivery is expanding throughout Idaho as the state moves from an SSA-issued certification to processes managed by independent certifying bodies. For substance use disorder peers, certification is now managed by the Idaho Board of Alcohol/Drug Counselor Certification which is ICRC affiliated. For the mental health peers the process is moving to a certification issued by the College of Western Idaho, a public technical school within the state. Establishing the certification systems has supported recognition of the value of peers in the recovery system and established a recognized scope of practice within the mental health and substance use disorder provider networks.

   Expanding the importance of peers in the Idaho Behavioral Health system has been the development of crisis and recovery support centers. The crisis centers are community-based organizations established as an alternative to hospitalizing or incarcerating individuals experiencing a mental or substance used disorder crisis. These centers operate 24/7/365 offering a broad of array of medical and behavioral health services based on individual needs. Professionals and peers work together to provide stabilization services.

   Supporting this effort is the development of recovery resource centers. Once an individual has been stabilized, recovery resource centers staffed primarily by peers, provide support services to help prevent relapse and sustain long-term recovery by building recovery capital, providing peer support, offering assistance with accessing education and employment, demonstrating hope, inviting all to participate, promoting volunteerism, and creating public awareness.

2. Does the state measure the impact of your consumer and recovery community outreach activity? ☐ Yes ☐ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   Idaho has a statewide certification program for peer specialists, family support partners and recovery coaches. Currently, peer support is a Medicaid reimbursed service through the Idaho Behavioral Health Plan. The Division of Behavioral Health employs at least one peer specialist on each of the regional ACT teams as well as one part time peer specialist at each state hospital. It is Idaho's goal to continue the strong momentum it currently has with regard to peer support and recovery coaching over the coming years.

   For the past several years, the division has worked with families, clients, advocates, community partners, and other stakeholders to establish certification and training standards to support the development and implementation of peer services in Idaho. In SFY2016, the division focused efforts on workforce development for peer support specialists, family support partners, and recovery coaches. These efforts included development of a certified family support partner training curricula; sponsoring trainings for certified peer support specialist and family support partners; conducting ongoing training for recovery coaches; and providing agency readiness trainings to employers. In September 2015, the division began to implement certification requirements for peer specialists. Implementation of certification requirements for family support partners began in February 2016. As of July 11, 2017, the division certified a total of 439 peer support specialists and 94 family support partners.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

   Idaho funds recovery support services to help people enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice. To this end, Idaho has two levels of recovery coaching services for individuals with substance use disorders (SUD)

NOT FINAL

The first level is a formal level where services will be delivered by certified recovery coaches as part of a comprehensive treatment team. Over the last few years, Idaho has focused on adding Recovery Coaching to the array of treatment services and embedding it in our recovery oriented system of care. The individuals delivering these services have successfully completed 40 hours of recovery coach-specific training as well eight hours of ethics. (Idaho is moving to require recovery coaches be certified by the Idaho Board of Alcohol Drug Counselor Certification (ICRC affiliate) in order to be eligible for reimbursement.) Services offered by these individuals vary based on client need. The funded array of support services includes: case management, drug/alcohol testing, safe and sober housing, transportation, child care, life skills, and interpreter services.

The second level of recovery coaching services are provided by volunteers in recovery community centers. Recovery Community Centers are peer-operated centers that serve as resources of community-based recovery support. People do not live at these centers, but rather these centers can help individuals build recovery capital at the community level by providing advocacy training, recovery information and resource mobilization, mutual-help or peer-support organization meetings, social activities, and other community-based services. They may also help facilitate supportive relationships among individuals in recovery, as well as community and family members.

Idaho is currently home to eight Recovery Community Centers located in: Coeur d'Alene, Moscow, Lewiston, Emmett, Caldwell, Boise, Pocatello and Idaho Falls, with the first center opening in 2014. Since that time, these centers have served provided thousands of hours of services (all volunteer) and helped hundreds of Idahoans find recovery in their lives.

5. Does the state have any activities that it would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

NOT FINAL

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

   housing services provided. ☐ Yes ☐ No

   home and community based services. ☐ Yes ☐ No

   peer support services. ☐ Yes ☐ No

   employment services. ☐ Yes ☐ No

2. Does the state have a plan to transition individuals from hospital to community settings? ☐ Yes ☐ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   The State of Idaho does not currently have an actively managed Olmstead plan. Based on an Idaho Attorney General opinion, Idaho declared that the state was in full compliance with Olmstead, and that no plan was necessary, nor has the state been involved in any litigation or a settlement agreement with the DOJ regarding community integration. However, noting that there was widespread disagreement with this position, the Governor created a “Community Integration Committee” (CIC) to explore barriers to integrated services for people with disabilities, and to make non-binding recommendations to the state. The Committee consulted reports, evaluations, people with disabilities, and advocates. The Committee’s last report was submitted in 2004. While the Community Integration Plan has not been monitored in several years, the emphasis on community integration and community living is still strongly implemented by individuals and systemically remains a core foundation in the delivery of behavioral health services. The Division of Behavioral Health has for years utilized state funding to assist patients access appropriate community housing. This includes individual projects for brick and mortar, rental assistance programs, and contracts with providers of community living and supportive housing.

   Ongoing efforts to address community integration are largely focused on individualized community based client services. Idaho has an average length of stay at its state institutions far below the national average. Additionally, Idaho boasts a 30 and 180 day readmission rate below the national average. As systemic barriers to community living and reintegration are identified, they are addressed to assure the rights of Idahoans are upheld. The Division of Behavioral Health has developed a policy regarding state hospital discharges which identifies the minimum expectations for discharge protocols for adults and adolescents from the state hospitals and delineates responsibilities for the hospital staff and regional staff to ensure a coordinated discharge as the client is reintegrated back into their community. Each regional behavioral health center has a designated discharge coordinator assigned to follow-up and provide after care services for a minimum of 30 days for every client being discharge from one of the two state hospitals. The Department utilizes a managed care organization to administer its Medicaid outpatient services. The array of services include standard outpatient services, but introduced a new service to Idaho called community reintegration. This service

NOT FINAL

pulls together case management, peer support, and medication management into a short term intervention to successfully reintroduce patients into their communities safely and effectively. Additionally, the Division of Behavioral Health maintains Assertive Community Treatment (ACT) teams in every region of the state to assist eligible patients transitioning home from hospitalization.

Does the state have any activities related to this section that you would like to highlight?

The Division of Behavioral Health has implemented two planning initiatives to facilitate community integration and decreasing institutionalization. These initiatives will focus on developing community based housing services which are not currently available and developing standardized protocols for continuity of care for clients discharged from a state hospital. The first of these initiates is the establishment of the State Hospital Discharge Workgroup. This workgroup is tasked with updating the State Hospital Discharge Policies for the Division and establishing standardized protocols for discharge follow-up and aftercare services. The workgroup consists of representatives from all seven regional behavioral health centers, administrators from both state hospitals, and the Division of Medicaid.
The second initiative is the development and funding of Homes with Adult Residential Treatment (HART) services. Idaho has limited supported housing resources available for individuals being discharge from a state hospital and as a result inpatient discharges can be delayed due to lack of available housing. The Division has requested and received from the Idaho Legislature funding to develop a new level of care in Idaho specifically intended to meet the housing and clinical treatment needs in a coordinated setting for individuals with a serious and persistent mental illness who would otherwise be at risk of being homeless, incarcerated or hospitalized. The Division has developed a model framework identifying the core components of the HART residential services and has collaborated with the Division of Medicaid and the Idaho Behavioral Health Plan contractor, Optum Idaho in developing a Medicaid reimbursable package of clinical services. It is envisioned that the HART setting will be a homelike community housing setting which includes the provision of clinical services to be delivered based on an individualized assessment and treatment plan. It is the hoped that this new service will allow individuals with SPMI to remain in their communities, decrease inpatient hospitalizations and re-hospitalizations and allow for greater community integration for those receiving the services. The Division will begin the initial implementation of the program through a demonstration project in which 3 to 4 providers are selected in various locations across the state. Services will be funded via contract with the Division of Behavioral Health and through the Idaho Behavioral Health Plan. Additionally, Enhanced Safe and Sober Housing will be available for clients discharging from one of the two State Hospitals who are going into SUD treatment. This housing will provide more support and assistance than is afforded in traditional safe and sober living environments, including Recovery Coaching and services to support dual diagnosis treatment. It is anticipated this service will be ready to launch in August 2017.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

NOT FINAL

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

NOT FINAL

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010

[71] http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

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Please respond to the following items:

1. Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED? ☐ Yes ☐ No

   b) The recovery and resilience of children and youth with SUD? ☐ Yes ☐ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

   a) Child welfare? ☐ Yes ☐ No

   b) Juvenile justice? ☐ Yes ☐ No

   c) Education? ☐ Yes ☐ No

3. Does the state monitor its progress and effectiveness, around:

   a) Service utilization? ☐ Yes ☐ No

   b) Costs? ☐ Yes ☐ No

   c) Outcomes for children and youth services? ☐ Yes ☐ No

4. Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☐ Yes ☐ No

   b) Mental health treatment and recovery services for children/adolescents and their families? ☐ Yes ☐ No

5. Does the state have plans for transitioning children and youth receiving services:

   a) to the adult behavioral health system? ☐ Yes ☐ No

   b) for youth in foster care? ☐ Yes ☐ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   The state of Idaho remains committed to establishing and monitoring a system of care approach to support the recovery and resilience of children and youth with mental health and substance use disorder diagnoses in several ways. The Division of Behavioral Health's Policy Unit is tasked with developing policy and clinical practice standards. The Division's Quality Assurance (QA) Unit provides quality assurance oversight on provider implementation of clinical practice standards. The Medicaid contracted Idaho Behavioral Health Plan provider, Optum Idaho is a key partner in the planning process, and with respect to collecting and evaluating system data to help guide system activities. The Division contracts with the Idaho Federation of Families for Children's Mental Health to provide supportive services for children and their families. The Substance Use Disorder Treatment (SUD) Management Services contractor, Business Psychology Associates, (BPA) oversees the delivery of treatment and recovery support services to youth addicted to alcohol or other drugs. The intake process, using the GAIN assessment, provides the care manager with the information needed to make a diagnosis as well as identify other service needs. The SUD Treatment provider assigned to treat the youth will be responsible for delivery of treatment services. The SUD Treatment provider may also provide case management or the service may be provided by a different organization. In any case, the case manager is responsible to ensure youth receive all services they and their family need to support and sustain a full recovery.

NOT FINAL

The Children's Mental Health Program (CMH) within the Division of Behavioral Health is a partner in the development of a community-based System of Care for children with SED and their families. The program provides services and supports that increase the capacity for children with an SED and their families to live, work, learn, and participate fully in their community. Most Medicaid behavioral health plan treatment services are delivered by private sector providers in the community through referrals by the CMH program. Providers must be members in the Idaho Behavioral Health Plan network as managed by Optum Idaho. Idaho's system of care is made up of individuals representing public and private organizations, such as behavioral health, Medicaid, education, juvenile justice, parent advocacy groups, and community and business organizations. Parents and family members play an essential role in developing the system of care. They are involved in all levels of development, including policies, laws, and their own service plans. Without parental involvement and the support to sustain their involvement, the system of care would not be able to achieve positive outcomes for the children and their families.

The Children's Mental Health program provides assessment, case management services and continues with the implementation of the EBP Parenting with Love and Limits (PLL) statewide. The Child and Adolescent Functional Assessment Scale (CAFAS) is used as an eligibility and outcome measure for children and youth qualifying for and receiving services from the Children's Mental Health program. This behaviorally based instrument is backed by extensive research supporting its validity and sensitivity to measure change. PLL is an effective evidenced based program in treating youth with disruptive behaviors and emotional disorders. The annual evaluation continues to demonstrate positive outcomes that are consistent with national PLL programs. Idaho's program showed improvement in functioning and reduced the amount of time a youth and his or her family receives services from the Children's Mental Health program. Forty percent of families have their cases closed within three months of completing PLL services, compared to an average length of service of 12 months for non-PLL families. Youth receiving Parenting with Love and Limits showed significant reductions in negative behaviors as measured by the Child Behavior Checklist instrument. A multi-year evaluation indicates negative behaviors declined in the areas of aggressive behaviors, rule breaking, conduct disorder, oppositional defiant behaviors, externalizing behaviors, and internalizing behaviors. The rate of graduation from PLL in SFY16 was 85 percent, which continues to exceed the 70 percent goal. Since its start in 2008, PLL has served over 1,354 families statewide.

In January 2016, the Children's Mental Health program made modifications to the authorization process for respite services to allow families receiving services from private providers to have access to respite care. The modifications allow the Children's Mental Health program to receive referrals from community providers and authorize respite services for families with children with serious emotional disturbance who are not otherwise receiving services through the division's CMH program.

Youth transition to adult services at age 18. Independent living and transition planning begins any time between age 14 and 16. Youth served in the state's behavioral health system begin actual transition to the adult system 6 months before their 18th birthday. These transition activities include planning/staffing for the provision of adult services, connecting to community resources, and introducing adult service providers to the youth.

DHW continues to work with county juvenile justice, magistrate courts, the Idaho Department of Juvenile Corrections, and parents in situations involving youth with mental health issues and the courts. Idaho Code Section 20-511A of the Juvenile Corrections Act allows the court to order mental health assessments and plans of treatment if a youth under court jurisdiction is believed to have a serious emotional disturbance.

In January 2016, the Children's Mental Health program made modifications to the authorization process for respite services to allow families receiving services from private providers to have access to respite care. The modifications allow the Children's Mental Health program to receive referrals from community providers and authorize respite services for families with children with serious emotional disturbance who are not otherwise receiving services through the program.

Total Children Served by Service Type SFY2017
Clinic Services 1016
Out of Home Placement 158
PLL Services 188
Case Management 1360
I.C. 20-519B 5
Rule 19/20-523 175
I.C. 16-2414 5
I.C. 20-511a 509

The state has established "Principles of Care" in response to the settlement of the Jeff D class action lawsuit Settlement Agreement. The settlement aims to address the gaps in Idaho's mental health system, making it more effective and efficient in meeting the needs of children with serious emotional disturbances and their families. The settlement commits the state to taking a number of concrete steps to develop and implement a sustainable, coordinated, and comprehensive mental health system, including:

- Creating a statewide process, across all child-serving systems, to identify and screen youths for unmet mental health needs
- Providing a comprehensive array of community-based services and supports to children when medically necessary
- Delivering services using a consistent approach that engages families, youths, and their support systems
- Monitoring and reporting on service quality and outcomes for youths

The settlement is the result of more than a year of negotiations. Participants include key community stakeholders representing

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parents, advocates and private providers, along with representatives from DHW including Medicaid, Family and Community Services, the Idaho Department of Juvenile Corrections (IDJC), and the Idaho State Department of Education (SDE).

The Interagency Governance Team (IGT) provides the state level vehicle for collaborative efforts with the accessing educational services under IDEA. At the individual child level, CMH staff will use a child and family team approach as described in the Practice Manual to coordinate services which is to include other child serving agencies. Additionally, children with intensive needs will be provided with a facilitated wrap around approach to treatment planning which will include collaboration with child serving agencies. Within the statewide substance use disorders treatment system, responsibility for partnering with schools on is the responsibility of the community-based provider network. This method reduces bureaucracy and increases the capacity of treatment providers and case manager to use local resource to develop community-based solutions to address the needs of each child and adolescent.

Children and adolescent substance use disorder services are delivered to individuals under the age of 18. Services are accessed through the DBH contractor Business Psychology Associates (BPA) and delivered by community providers. Idaho Substance Use Disorders Response:

Currently, Idaho has three distinct systems for the delivery of substance use disorders services to children and adolescents. Children qualifying for Medicaid are served under the Department of Health and Welfare, Division of Medicaid contract with OPTUM. This is a managed care contract that makes OPTUM responsible for the delivery of all aspects of substance use disorders, co-occurring and mental health services for children and adolescents. The Idaho Legislature also provides funds to the Department of Juvenile Corrections for the delivery of substance use disorders services to children and adolescents involved in the county or state criminal justice systems. Both of these systems are established outside the scope and authority of the SSA.

The Department of Health and Welfare's Division of Behavioral Health (DBH) contracts with Business Psychology Associates (BPA) to manage the delivery of care for children and adolescents diagnosed with a substance use disorder, who are not served under either of the systems outlined above. With a statewide network of private providers, BPA has developed a substance use disorders treatment system that is accessible, acceptable and effective. Four major components within this system ensure that children and adolescents receive all the services and supports they need to build a sustainable recovery.

The first component is the qualifying clinical and financial screening. Per state-established procedures, all children, adolescents and adults seeking state-supported substance use disorders treatment services are screened clinical and financial need to determine eligibility for DBH-funded services. The requirement for financial need is waived if the child or adolescent needs treatment and the parents refuse to provide financial information or pay their co-pay. Once a child/adolescent is determined to be eligible, BPA makes available information the network treatment providers in their community who treat children and adolescents. Based on this information the child and their family/guardian select a provider.

The second component of the DBH-required system is a comprehensive assessment and client-driven treatment plan. All providers within the BPA network are required to employ the "Global Appraisal of Individual Needs" (GAIN) assessment to evaluate client need in the dimensions of the "Diagnostic and Statistical Manual." This enables the substance use disorders treatment provider to assess the "whole" child and identify the full scope of their needs. Based on the findings of the GAIN assessment, the treatment provider works with the child/adolescent, and if appropriate, the parent/guardian, to develop a treatment plan the is client driven.

The third component of the DBH-required system is delivery of treatment services partnered with ongoing review and updating of the treatment plan. Once again, in partnership with the child/adolescent, and their parent/guardian as appropriate, treatment and support services are delivered to address the client's needs and goals. Based on the assessment and the child/adolescent's decisions, treatment services may include the whole family. Case management services are also initiated in the delivery of treatment services. The case manager provides the essential element of the partnership, pulling together treatment services with community-based resources to enable the child/adolescent to initiate the foundation for a sustained recovery. The case manager bears the primary responsibility for working with other agencies such as education, juvenile corrections and child protection.

The fourth component of the DBH-required system is discharge planning. Discharge planning is initiated with the child/adolescent, and if appropriate, the parent/guardian, as soon as the treatment plan is completed. Discharge planning not only focuses the treatment episode on recovery and resilience, it also builds a foundation for a successful, sustained recovery. The Division of Behavioral Health does offer a grace period for a minor who entered an adolescent treatment program at age 17 and turned 18 before the treatment episode was completed. In this case, the individual may remain in the adolescent treatment program until it is clinically determined they may be discharged. Should the individual relapse after completion of the treatment episode, they would be referred to a facility treating adults.

The Idaho Department of Juvenile Corrections, along with the Idaho Department of Corrections and the Idaho Judiciary, is a partner in the contract the Division of Behavioral Health holds with Business Psychology Associates. They access the treatment provider network and cover the cost of services via the contract. Per the first paragraph of this response, the Department of Juvenile Corrections has its own county-based system serving children and adolescents involved in the criminal justice system. The Department of Education, does not fund or manage the delivery of substance use disorders services. The Department of Education works with the Department of Juvenile Corrections and the Division of Behavioral Health to ensure children and adolescents

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within their systems are able to access education services, and, when appropriate have access to the resources and support.

The Department of Health and Welfare's Division of Family and Community Services is the state agency responsible for child welfare. The Division of Behavioral Health partners with the Division of Family and Community Services on the delivery of substance use disorders services for adults and children/adolescents involved in the child protection system. This partnership ensures parents and children get all services needed to facilitate re-unification and reduce recurrence of problem behaviors. Children involved in the child protection (CP) system, have an assigned CP case manager who continues to supervise their case while they are receiving treatment services. As a part of discharge planning, the treatment provider and CP case manager meet to identify the resources the child/adolescent will need to sustain recovery, including housing.

7. Does the state have any activities related to this section that you would like to highlight?

Thousands of Idaho children with serious emotional disturbance (SED) could have better access to community-based mental health services as a result of the June 2015 settlement agreement reached in the Jeff D. federal class action lawsuit. The Youth Empowerment Services initiative has been established to carry out the work identified in the Idaho Implementation Plan which was developed as the state's response to the settlement agreement. The agreement was approved by the district court in May 2016. The Implementation Plan is the first step to completing the requirements outlined in the settlement agreement. The plan describes the work of developing and implementing a transformational process that will result in a new system of care for children with serious emotional disturbance by 2020. That will be followed by a three-year sustainability period in which the state will continue to be monitored to ensure the system of care works as intended. The work is being led by the division and includes the following state agency partners: Division of Medicaid, Division of Family and Community Services, Division of Welfare, Idaho Department of Juvenile Corrections, and the State Department of Education. The Idaho Implementation Plan lists seven objectives, or areas of work, that describe strategies for meeting the requirements listed in the settlement agreement. The work of each of the objectives is inter-related and should be read in the context of the entire implementation plan. While acknowledging the complexities of developing the infrastructure and new systems, the plan is concrete and feasible in its steps toward accomplishing the outcomes required by the agreement.
The following work, and more, is addressed in the implementation plan:
• The plan provides for a continuum of care with enhanced services and supports to facilitate a home and community-based approach to service delivery. Medicaid benefits are intended to be the primary funding source for the continuum of care.
• A new ideology will be adopted that articulates the "System of Care Values and Principles" promoted by Substance Abuse and Mental Health Services Administration (SAMHSA). Involvement of class members and their families in the development, operation, and improvement of the system of care is key in this process.
• Providing sufficient access to the enhanced continuum of care is vital and will be accomplished with effective tools and processes such as the Child and Adolescent Needs and Strengths (CANS) tool and a wraparound planning and treatment process. Multiple pathways will help families gain access to assessment and services.
• The state is developing a workforce development plan. The scope of the plan will address the current and future demands for a sufficient and competent mental health workforce and education, training, and ongoing coaching of stakeholders. A practice manual will be developed to provide information about new requirements and guidance to promote stakeholders' understanding of the features of the system of care.
• The state will work across systems to build a centralized complaint routing and tracking system. The state will build procedural due process safeguards that afford proper notice to class members and their families and fair hearings upon request.
• A governance structure that operates through collaboration will be put in place to ensure successful implementation and oversight of the plan. The structure will include representation by class members, class members' families, family advocacy, and other stakeholders.
• The measurement and reporting of treatment outcomes and the performance of the system of care will be accomplished through the development of a Quality Management, Improvement and
Accountability (QMIA) process.
More detailed information is available on the website devoted to this work at: www.youthempowermentservices.idaho.gov or www.yes.idaho.gov.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

NOT FINAL

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ☐ Yes ☐ No

2. Describe activities intended to reduce incidents of suicide in your state.

   Idaho has established a broad range of programs to prevent, intervene and support loss. Following is a list of programs currently supported by the state.
   - Established a state suicide prevention program
   - Suicide prevention hotline services
   - Sources of Strength training for schools statewide
   - Comprehensive, statewide public awareness campaign
   - Gatekeeper trainings for professionals and the public
   - Loss survivor and attempt survivor support groups
   - Suicide assessment and treatment training for behavioral health providers
   - Established a Lethal Means Task Force educating on access to lethal means
   - Zero Suicide education to health system partners
   - Education for media on safe reporting
   - Improving coroner reporting of suicide
   - School post-vention services
   - Prevention efforts in Boise parking garages
   - Suicide prevention conferences

3. Have you incorporated any strategies supportive of Zero Suicide? ☐ Yes ☐ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ☐ Yes ☐ No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? ☐ Yes ☐ No

   If so, please describe the population targeted.

   Idaho is in the process of establishing its first statewide program for suicide prevention. The purpose of the program is to build on current local activities and initiatives to create a comprehensive statewide suicide prevention system. The target population for this initiative is all residents of the State of Idaho.

   Does the state have any activities related to this section that you would like to highlight?

   Idaho has initiated a first of its kind statewide public awareness campaign that is comprehensive. With partners, Idaho convened the third annual Western States Suicide Conference this year.

   Please indicate areas of technical assistance needed related to this section.

   N/A

Footnotes:

Please Note: In response to question #1, Idaho has not updated the plan as of this submission date, but Idaho will formally begin the process of writing a new plan in September, 2017.

In response to question #3, Idaho is currently applying for grants to enable the state to provide strategies supportive of Zero Suicide.

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21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ☐ Yes ☐ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ☐ Yes ☐ No

   If yes, with whom?

   A stakeholder governance body, the Interagency Governance Team (IGT) will assist in identifying children' s mental health system barriers, assist in resolving those barriers, and provide oversight and accountability for the implementation of the Agreement. Members of the IGT include parents, youth, advocates, Departments of Health and Welfare and Juvenile Corrections, State Department of Education, and a private mental health provider. Please see attachment titled 21. Support of State Partners for additional information.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

   Idaho has established collaboration with other child and youth serving agencies to address behavioral health needs in several ways. The governor appointed Behavioral Health Integration Committee is developing a memorandum of understanding for collaboration between key child and youth serving agencies. The Juvenile Justice Children's Mental Health (JJCMH) workgroup includes representation from regional mental health programs, the Idaho Division of Juvenile Corrections, county probation and the Federation of Families. The JJCMH meets regularly to address system issues and to identify shared policy goals between agencies.

   The Idaho State Department of Education (SDE) is the government agency tasked with supporting schools and students. The agency is responsible for implementing policies including compliance with the Individuals with Disabilities Education Act (IDEA),

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distributing funds, administering statewide assessments, licensing educators, and providing accountability data. The agency provides leadership, expertise, research, and technical assistance to school districts and schools to promote the academic success of students. To enable all students to achieve high academic standards and quality of life, the Special Education department works collaboratively with districts, agencies, and parents to ensure students receive quality, meaningful, and needed services. The SDE offers facilitation and mediation of special education meetings, as well as overseeing the state administrative complaints and due process hearings systems as required by the Individuals with Disabilities Education Act (IDEA). Per the SDE website, the Idaho Public school system encompasses 115 district, 48 charters, 728 schools and serves over 291,000 students. The IGT referenced in #1 provides the state level vehicle for collaborative efforts between the DBH and SDE. The IGT includes the SMHA Commissioner and a state level educational representative. Individual clinicians working with a child and family coordinate with the schools at the individual child level.

The Division is responsible for only a segment of the Behavioral Health System, and therefore plans to collaborate with other partners to identify methods to provide training in evidence based mental health and recovery services. The Division is currently in the process of finalizing a Memorandum of Agreement with the designated behavioral Health provider in in Eastern Oregon that closest boarder Idaho. This agreement will attempt to formalize protocols and enhance cooperation when conducting emergency assessments on Oregon residents who present for emergency psychiatric intervention at local Idaho hospitals. It is hoped with a more proactive intervention and earlier involvement of the Oregon behavioral health provider inpatient admissions and 24-hour mental holds for Oregon residents can be decreased . The Division of Behavioral Health has implemented a Behavioral Health Program approval under IDAPA 16.07.15. This new rule replaces the existing substance use disorder facility approval rule, IDAPA 16.07.20, which will be repealed as of July 1, 2016. This creates one program facility approval for both SUD and mental health providers and furthers efforts to integrate Idaho's mental health and substance use disorders systems by establishing uniform requirements for health, safety, environment of care, and program administration. SUD treatment facilities are required to obtain the facility approval in order to participate in the public provider network. Mental Heath providers are not required at this time to seek facility program approval but my voluntarily apply for program approval.

The substance abuse prevention services have been collaborative with a broad range of community providers, sharing CSAP and other organization developed evidence or research-based webinars, providing written materials and videos through the Idaho RADAR Center and participating in cross-training activities with Juvenile Corrections and Education. The SSA will continue to support two prevention tracks in the annual Idaho Conference on Alcohol and Drug Dependency. One track focuses on prevention professional development and has had speakers on adolescent development, identifying drug-endangered children, providing youth with emotional support, and risk and protective factors. The second track focuses on coalition development and includes current research on youth engagement, preventing underage drinking and community planning for healthy youth. In addition, the annual conference provides cutting edge research on topics of multi-disciplinary interest include ethics, culturally appropriate care, adolescent brain development, child trauma and healthy child development. A variety of training tools are used to disseminate current research and information on evidence-based programming for SUD Treatment and Recovery support services.

The Division of Behavioral Health is dedicated to the pursuit of a behavioral health service system that is focused on a philosophy of recovery and resilience. As of February 2013, Certified Peer Specialists were working on teams providing mental health services related to Assertive Community Treatment (ACT), and Projects for Assistance in Transition from Homelessness (PATH). The Division of Behavioral Health directly hires peers for ACT teams in each of seven regions. Each of the State hospitals also have half-time peers on staff. The Division is also in the process of developing a Peer Support Specialist and Family Support partner Credentialing, developed Peer Support Specialist standards and a state job classification description. The Division has also implemented a website dedicated to providing peer specialist training, certification and endorsement information.

Parenting with Love and Limits (PLL) is an evidence based treatment model implemented in the DBH children's mental health program for adolescents, aged 10-17, with emotional and behavioral problems. The PLL model combines parenting management group therapy, family therapy, and wound work into one system of care to quickly engage parent and the children. The PLL model is grounded in structural and strategic family therapy. It is a brief therapy model, which much emphasis being placed on engaging families quickly and giving them concrete tools and skills to create a new structure a within the family system to help create lasting change. Approximately 1,300 families have been served statewide through the PLL program since 2008. Families are referred through a variety avenues including through the CMH program, youth involved in the juvenile justice system, by juvenile probation officers or through a court ordered 20-511A treatment plan.

The Idaho Youth Treatment Program (IYTP) provides treatment to transitional aged youth, ages 18-25, using the Adolescent Community Reinforcement Approach (A-CRA) evidence based practice. Services were provided in Regions 2 and 4 during the first year of the grant and were expanded in 2015 to include Region 3. Two more regions will be added each year in 2016 and 2017. A-CRA is Idaho's first evidence based behavioral health service specifically targeted to the transitional aged youth.

The Division has an Interagency Agreement with the Idaho Division of Vocational Rehabilitation. This Agreement supports the placement of a vocational rehabilitation (VR) counselor at each of the regional CMHC sites. The VR counselor is responsible to attend at least one weekly ACT team meeting. Often, the VR counselor attends more than one weekly ACT meeting and may also attend weekly mental health court meetings that relate to shared clients. The contract was amended to change the definition of eligible participant to individuals with SMI as the contract previously limited eligible participants to individuals with SPMI. This change allows for greater access to IDVR services.

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The Division participated in community networking meetings sponsored by the courts for the purpose of creating a veteran's court. These meetings included representation from the courts, behavioral health treatment providers, the veteran's administration, law enforcement and other stakeholders. There are veteran's courts operating in Ada, Canyon and Bannock and New Perce counties.

The Veteran's networking committee meets at least quarterly to identify treatment needs and resources for military populations. Representation includes the Idaho National Guard, the Division of Behavioral Health, the Veteran's Administration, the courts, behavioral health providers that contract with the Idaho National Guard and other stakeholders.

The Division meets regularly with the Department of Juvenile Corrections sponsored Enforcing Underage Drinking Laws workgroup to facilitate coordination of substance abuse prevention activities. Representation on this workgroup includes Departments of Education and Transportation, the Liquor Division, the Idaho State Police, the Idaho College/Universities Coalition and Idaho Prosecuting Attorneys Association. This workgroup addresses issues identified by member agencies and seeks to use research based strategies to address youth access, desire and opportunities to drink alcohol. Workgroup efforts have been instrumental in targeting parents to work with their children and adolescents to reduce underage drinking. A primary prevention services funded by the SSA are delivered by community-based organizations or community coalitions. These groups receive small amounts of funding from the SSA which enables them to deliver substance abuse prevention services as a part of other activities provided. This integration of services makes prevention resources available to a broad range of populations within Idaho.

Does the state have any activities related to this section that you would like to highlight?

Please see attachment titled 21. Support of State Partners

Please indicate areas of technical assistance needed related to this section.

Footnotes:

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Idaho Caregivers Alliance (ICA)
A consortium of state, regional and local governmental, private and non-profit organizations and individuals that work together to improve community-based supports for family caregivers who care for people of all ages. DBH has a member representative.

IGT

Overview

The Idaho Department of Health and Welfare, the State Department of Education and the Idaho Department of Juvenile Corrections, as Defendants in the Jeff D. class action lawsuit, must use a collaborative interagency governance structure to coordinate and oversee implementation of the Jeff D. Settlement Agreement as described in the Idaho Implementation Plan. The interagency governance structure is intended to improve the coordination of and access to intensive mental health services for Jeff D. Class Members and thereby improve both effectiveness of services and outcomes for youth and their families. Governance informs decision-making at a policy level that has legitimacy, authority and accountability. The governance structure for the implementation of the Agreement is authorized under the Idaho Behavioral Health Cooperative as defined in I.C. Chapter 31, Title 39.

IGT Purpose

The purpose of the Interagency Governmental Team (IGT) is to collaboratively coordinate and oversee the implementation of the court approved Settlement Agreement in the Jeff D. class action lawsuit. The Idaho Implementation Plan is the basis for the Children's Mental Health Reform (CMHR) Project Plan. The IGT shall advise the parties to the Settlement Agreement on implementation of the system of care described in the Agreement and serve as a vehicle for communication among parties, to identify and remove barriers to implementation, and monitor implementation of the Agreement through the CMHR Project Plan.

The overarching responsibility of the Interagency Governance Team is to provide for:

- Adherence to the Settlement Agreement and Implementation Plan among constituencies;
- Steady progress in implementing agreed-upon commitments, practice improvements and quality management, improvement and accountability;
- Meaningful partnership with families, youth, and other community stakeholders;
- Effective use of data to inform progress in achieving cross-system outcomes;
- Appropriate interface with key advocates, State Legislature and the Judiciary;
- Sustainability of a shared investment including vision, empowered leadership and system improvements.

Membership

The Idaho Behavioral Health Cooperative will appoint membership to the IGT. The Administrator of the Department of Health and Welfare (DHW), Division of Behavioral Health, will lead the Governance partnership that will include partners from the Idaho Department of Juvenile Corrections (DJC), the Idaho State Department of Education (SDE), Children's Mental Health Representative (DHW), Medicaid Representative (DHW), Division of Family and Community Services (FACS) Representative (DHW), Parent

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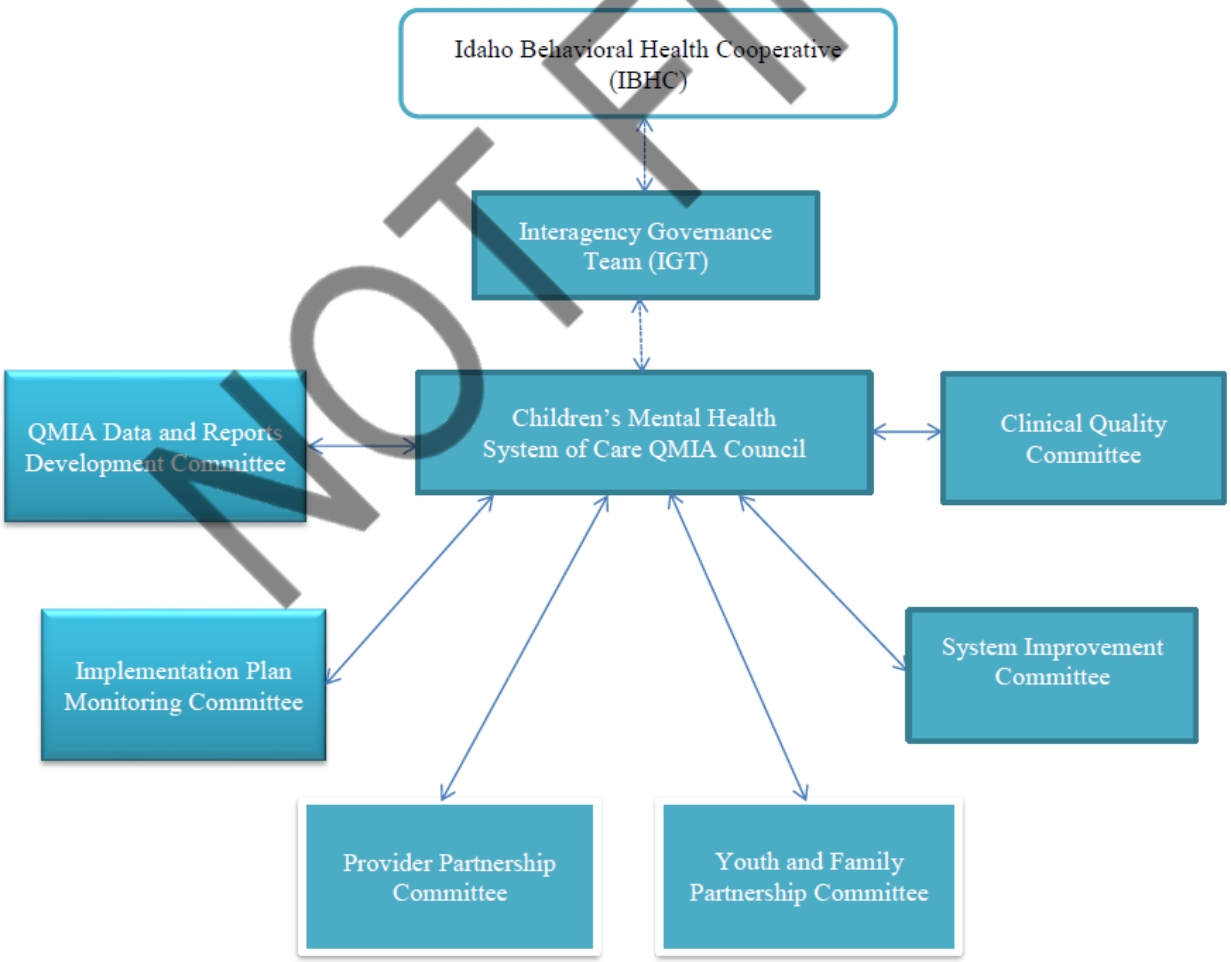
of a Class Member or former Class Member currently below the age of 23, Class Member or former Class Member under the age of 23, Family Advocacy Organization Representative, County Juvenile Justice Administrator, and Private Provider Representative. The length and scope of membership will be determined by the initial IGT membership.

QMIA Council

The QMIA Council is a collaborative made up of executive level staff and children's mental health stakeholders with chartered responsibilities specific to meeting the terms of the Jeff D Settlement Agreement. The QMIA Council provided reports and recommendations to the Interagency Governance Team (IGT). The Council meets regularly to review reports, set goals for improvement, monitor progress, and communicate outcomes. The QMIA Council is supported by the development of specialized QA subcommittees to address various aspects of care. QA subcommittees identify gaps, characterize areas of improvement, set targets for improvement, develop and refine cross-system indicators, and recommend practice and policy changes. All of the QA Committees work collaboratively with the YES Project Team and any implementation workgroups.



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Idaho Association of Counties Juvenile Justice Administrators (IACJJA)

Association comprosied of administrators of county juvenile justice programs in the State of Idaho. Objectives are to promote "best practices" for the juvenile justice system in the State of Idaho through:

- continued collaboration with the Department of Juvenile Corrections, the Courts, Department of Health and Welfare and other departments and agencies,

• information sharing and cooperation among the counties of the State of Idaho regarding issues relevant to juvenile justice,

• the promotion of effective programs including, but not limited to, substance abuse treatment and mental health treatment throughout the state,

• the promotion of professionalism through training.

DBH participates in quarterly meetings but is not a member

Idaho Behavioral Health Cooperative

Established in Regional Behavioral Health Services Act (Idaho Code 39-3124):

"The behavioral health authority shall establish the Idaho behavioral health cooperative to advise it on issues related to the coordinated delivery of community-based behavioral health services. The membership shall include representatives from the Idaho state judiciary, the Idaho department of correction, the Idaho department of juvenile corrections, the office of drug policy, the Idaho association of counties, the state behavioral health planning council, an adult consumer of services, a family member of a youth consumer of services, the state department of education and the Idaho department of health and welfare, at a minimum, but may also include other members as deemed necessary by the behavioral health authority. The Idaho behavioral health cooperative shall meet quarterly, with additional meetings called at the request of the state behavioral health authority."

Idaho Advisory Council on HIV/AIDS (IACHA)

Share pertinent program and outreach updates, and identify opportunities for increased collaboration and support among members and partners. Addresses HIV/AIDs prevention and education in MH/SUD programs. DBH participates in quarterly meetings but is not a member.

Idaho Crossover Youth Capstone Project

Idaho's Capstone Project is the initial piece of Idaho's Crossover Youth Project. It is an in-depth case file review of 10 or fewer crossover youth as well as an assessment and analysis of the information currently available in the IDHW, IDJC, and court case management systems. The results of Idaho's Capstone Project will inform the direction of, and next steps for, the Idaho Crossover Youth Project.

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The goal of Idaho's Capstone Project is to develop a heightened understanding of the processes and practices/policies that contribute to youth involvement in multiple systems. In order to make data informed decisions regarding optimizing system integration and thereby improving outcomes for crossover youth, Idaho seeks to:

a) Identify and better understand the pathways of Idaho's dually involved youth.[1]
b) Highlight key decision points on those pathways.
c) Recognize opportunities to enhance system integration.
d) Recruit key stakeholders necessary to plan and implement interventions that will result in improved outcomes for dually involved youth

The project is currently in the evaluation phase and Idaho is working with Georgetown University to establish next steps in the Idaho Crossover Youth Project initiative

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[1] For purposes of this project, the team has adopted the following definition of dually involved youth: A person who has at any time during his or her minority had an open child protection case and an open juvenile justice case. The cases need not be open simultaneously.

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[72] http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   Under Idaho code, the Planning Council is "to serve as an advocate for children and adults with behavioral health disorders; to advise the state behavioral health authority on issues of concern, on policies and on programs and to provide guidance to the state behavioral health authority in the development and implementation of the state behavioral health systems plan; to monitor and evaluate the allocation and adequacy of behavioral health services within the state on an ongoing basis; to monitor and evaluate the effectiveness of state laws that address behavioral health services; to ensure that individuals with behavioral health disorders have access to prevention, treatment and rehabilitation services; to serve as a vehicle for policy and program development; and to present to the governor, the judiciary and the legislature each year a report on the council's activities and an evaluation of the current effectiveness of the behavioral health services provided directly or indirectly by the state to adults and children."

   The Division of Behavioral Health and the Office of Drug Policy each have a representative sitting on the Planning Council. Other staff attend the Planning Council meetings to seek input on services, target populations, draft legislation and federal applications and reports. Staff also provide updates on services, new initiatives, expanding services, block changes etc. Because the Planning Council now covers substance abuse prevention and substance use disorders treatment as well as adult and children's mental health services, they have the capacity to provide input on a broad range of issues.

   This legislation also established seven Regional Behavioral Health Boards, which are composed of multiple adjoining counties. The Regional Boards are responsible to "advise the state behavioral health authority and the state planning council on local behavioral health needs of adults and children within the region." These boards provide the foundation for the Division's annual assessment of need.

   Annually the Planning Council requires each Regional Board to submit a report of gaps and needs within the region. These reports form the foundation of the Planning Council's annual report to the governor and legislature. The reports provide an "on-the-ground" assessment of need for the Division of Behavioral Health. The information covers service gaps, un/under served populations and emerging behavioral health issues in each of the seven regions. This information is combined with client, criminal justice and public health data to identify new or emerging concerns, areas of greatest need and populations at risk and develop state service plans. The Regional Behavioral Health Board and Planning Council reports are attached to this response.

   The draft block grant documents are made available to the Planning Council members and the public by being posted on

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the Substance Use Disorders, Mental Health and Planning Council webpages. The Planning Council receives notice when new block grant documents have been posted on their website. This includes the draft Behavioral Health Block Grant applications and updates as well as SAPT and CMHS block grant reports prior to submission to SAMHSA. Likewise, Regional Behavioral Health Boards are also notified about draft block grant documents and locations where the document can be accessed. The notices are also sent to Regional Behavioral Health Board members, Regional DBH staff, Office of Drug Policy and the State Epidemiological Outcomes Workgroup. Using these methods, the Division ensures that representatives from the primary prevention, early intervention and the mental health and substance use disorders treatment and recovery communities have the opportunity to review and comment on the block grant documents.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i — ☐ Yes ☐ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? — ☐ Yes ☐ No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The duties of the Planning Council are established in Idaho code. Per the statute, the planning council is to advocate for children and adults with behavioral health disorders; to advise the state behavioral health authority on issues of concern, on policies and on programs and to provide guidance to the state behavioral health authority in the development and implementation of the state behavioral health systems plan; to monitor and evaluate the allocation and adequacy of behavioral health services within the state on an ongoing basis; to monitor and evaluate the effectiveness of state laws that address behavioral health services; to ensure that individuals with behavioral health disorders have access to prevention, treatment and rehabilitation services; to serve as a vehicle for policy and program development; and to submit the aforementioned annual report.

The Planning Council completes these tasks in a variety of ways. The fist method used is the membership itself. The individuals recommended to the governor for membership in the Planning Council encompass a broad range of disciplines and personal experiences. Under code required membership includes consumers, families of adults with serious mental illness or substance use disorders; families of children with mental health disorders; behavioral health advocates; health and welfare, education, vocational rehabilitation, adult correction, juvenile justice and law enforcement, entitlement programs; public and private entities concerned with the need, planning, operation, funding and use of mental health services or substance use disorders, and related support services; and a member of the regional behavioral health board in each health and welfare region.

This range of members ensures the Planning Council is receiving input from all the entities/populations involved in the behavioral health prevention and treatment system as well as ensuring all areas in the state are considered.

The Planning Council focuses its advocacy efforts at the state level, while the Regional Boards focus is on the local and regional levels. The Planning Council supported a number of the Division's initiatives during the Idaho 2017 legislative session. These individuals have the capacity, as members of the Planning Council to advocate for behavioral health issues. They provide education to local, regional and state level groups, work to build broad support for behavioral health initiatives and provide technical assistance in developing behavioral health services, programs and resources as well as legislation. They also attend legislative committee hearings and advocate for behavioral health-related legislation.

With the Planning Council's advocacy, the Division was able to get approval for the infrastructure needed to certify Family Support Partners as well as Certified Peer Specialists who are peers trained to work with individuals recovering from SMI and families who have a child diagnosed with SED.

Idaho is in the process of re-building the state's children's mental health program now known as the Youth Empowerment Services Project (YES). With the support of the Planning Council and the families of children diagnosed with SED, the Division received new funding for the implementation of the YES project, including 18 new positions, funding for con-tracts with universities to assist in components of YES, and the establishment of a new income eligibility category in Medicaid for children with SED. The Planning Council's advocacy also successfully supported continuation of funding for Residential Assisted Living Facilities caring for patients with serious and persistent mental illness as well as a pilot project to test a new intensive residential living program called Homes with Adult Residential Treatment (HART). Finally, with the Planning Council's support at Legislature also approved funding necessary to fully fund the crisis centers in Twin Falls and Boise. The Planning Council and Regional Behavioral Health Board member advocacy provided education to legislators within the community as well as during the session, which resulted in the passage of significant behavioral health legislation during the 2017 session.

Does the state have any activities related to this section that you would like to highlight?

The Idaho Behavioral Health Planning Council has successfully integrated mental health and substance use disorders as well as primary substance abuse prevention into their scope. Representatives from substance use disorders and substance abuse professionals as well as recovering individuals are included into the Planning Council under state statute Title 39, Chapter 31 Regional Behavioral Health Services §39-3125.

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

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[73]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

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Behavioral Health Advisory Council Members

Start Year: 2017 End Year: 2018

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Rosie Andueza	State Employees	Division of Behavioral Health	450 W State St Boise ID, 83702 PH: 208-334-5934	anduezar@dhw.idaho.gov
Evangeline Beecher	Others (Not State employees or providers)		3314 N 32nd St Boise ID, 83703 PH: 208-353-7896	ebeechler@gmail.com
Ellis Brady	Providers		POB 7899 Boise ID, 83707 PH: 208-334-4839	bradye@ihfa.org
Abraham Broncheau	Federally Recognized Tribe Representatives		803 Hill Street Kamiah ID, 83536 PH: 208-935-8028	abebwolfis@gmail.com
Elda Catalano	Others (Not State employees or providers)		Canyon County Caldwell ID, 83605 PH: 208-454-7300	ecatalano@canyonco.org
Denise Chapin	Providers		650 W. Addison Avenue West Twin Falls ID, 83301 PH: 208-736-2156	Denise.chapin@vr.idaho.gov
Judy Gabert	Family Members of Individuals in Recovery (to include family members of adults with SMI)		SPAN Idaho Nampa ID, 83687 PH: 208-866-1703	jgabert@spanidaho.org
Jennifer Griffis	Parents of children with SED		155 Cheyenne Drive Grangeville ID, 83815 PH: 208-983-0513	jengriffis@gmail.com
Jennifer Haddad	State Employees	Division of Family and Community Services	POB 83720/5th Boise ID, 83720 PH: 208-334-6953	haddadj@dhw.idaho.gov
Magni Hamso	Family Members of Individuals in Recovery (to include family members of adults with SMI)		300 E. Highland View Drive Boise ID, 83701 PH: 208-391-3245	jagni.hamso@gmail.com
Susan Hepworth	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		823 Northgate Drive Pocatello ID, 83201	skhepworth53@gmail.com
Rick Huber	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		309 Pashermakay Court #7 Rupert ID, 83350 PH: 208-436-1841	rick2727272000@yahoo.com
Marrianne C. King	State Employees	Office of Drug Policy	Bosie ID, 83702 PH: 208-854-3043	marianne.king@odp.idaho.gov
			Medicaid	

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Tiffany Kinzler	State Employees	Medicaid	Boise ID, 83705 PH: 208-346-1813	KinzlerT@dhw.idaho.gov
Leanna Landis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Gregory Lewis	State Employees	Idaho Department of Correction	2400 N 36th St Boise ID, 83703 PH: 208-658-2034	glewis@idoc.idaho.gov
Angenie McCleary	Providers		206 First Avenue South Hailey ID, 83333 PH: 208-788-5500	AMcCleary@co.blaine.id.us
Sandra McMichael	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 388 Plummer ID, 83851 PH: 208-686-1449	
James Meers	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4325 E. Stonebridge Dr Meridian ID, 83642 PH: 208-602-3184	jmeers99@gmail.com
Angela Marie Reynolds	Providers		1200 Ironwood Drive Coeur d'Alene ID, 83814 PH: 208-659-2700	Angelam.renolds@sequelyouthservices.com
Tammy Rubino	Family Members of Individuals in Recovery (to include family members of adults with SMI)		10617 N Lakeview Dr Hayden ID, 83835 PH: 208-651-6335	communitycoalitionsofidaho@gmail.com
Judge Jon Schinderling	State Employees		PH: 208-589-2604	jshindurling@co.bonneville.id.us
Jason Stone	State Employees		POB 83720/DJC Boise ID, 83720 PH: 208-334-5100	jason.stone@idjc.idaho.gov

Footnotes:

Idaho is currently in the process of appointing new/re-appointing current members per Idaho code. At this time, four positions for consumer/family representatives as well as two positions for agency/provider of service are to be filled.

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Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2017 End Year: 2018

Type of Membership	Number	Percentage
Total Membership	29	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	4	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	15	
State Employees	7	
Providers	4	
Federally Recognized Tribe Representatives	1	
Vacancies	2	
Total State Employees & Providers	14	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Persons in recovery from or providing treatment for or advocating for substance abuse services	4	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?
The Planning Council annually collects and reports data needs, gaps, successes and policy recommendations to the Governor, Legislature and Judiciary. The Division of Behavioral Health uses this report for planning. The Planning Council also provides input of new initiatives, serve on program workgroups and reviews all Division block grant documents. After a block grant application or report is completed, it is posted on the Planning Council's website (http://healthandwelfare.idaho.gov/Medical/MentalHealth/BehavioralHealthPlanningCouncil/tabid/320/Default.aspx) as well as the Divisions Mental Health and Substance Use Disorders webpages. Email notices are sent to Planning Council members, Regional Behavioral Health Boards, Partnering state and local agencies and an article is included in the Division's newsletter. The notice provides information on the document, how to access the document, where to send comments/concerns and who to call with questions. Upon the request of the Planning Council, the Division will also host a conference call.

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Footnotes:

Idaho is currently in the process of appointing new/re-appointing current members per Idaho code. At this time, four positions for consumer/family representatives as well as two positions for agency/provider of service are to be filled.

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23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings? ☐ Yes ☐ No

   b) Posting of the plan on the web for public comment? ☐ Yes ☐ No

   c) Other (e.g. public service announcements, print media) ☐ Yes ☐ No

   If yes, provide URL:

   Behavioral Health Planning Council, Regional Behavioral Health Boards receive an email notifying them the application/plan is posted and available for comment. Division of Behavioral Health regional staff; other state agency staff; and the public are notified via the Division of Behavioral Health newsletter. In both cases information is provided on the location of the document and persons to contact if they questions about the document, difficulty accessing it or want to submit a comment.

Footnotes:

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