Idaho

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

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

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 10/01/2019 1.25.25 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

State Information

State Information

Plan Year

Start Year	2020
End Year	2021

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	208-334-5934
Fax	208-332-7305
Email Address	rosie.andueza@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
City	Boise
Zip Code	83720-0036
Telephone	208-334-5726
Fax	208-332-7305
Email Address	ross.edmunds@dhw.idaho.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

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

From	
To	

V. Date Submitted

Submission Date	8/29/2019 1:28:08 PM
Revision Date	10/1/2019 1:24:01 PM

VI. Contact Person Responsible for Application Submission

First Name	Jonathan
Last Name	Meyer
Telephone	(208) 334-6682
Fax	208-332-7305
Email Address	Jonathan.Meyer@dhw.idaho.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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

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Section	**Title**	**Chapter**
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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 Coastal 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 Clean 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Dave Jeppesen

Signature of CEO or Designee[1]: _____

Title: Director, Idaho Department of Health and Welfare

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The signed certifications pages are attached as SABG Certifications.pdf.
A cover letter is attached as 2020.2021 Block Grant Cover Letter Idaho.pdf

BRAD LITTLE
GOVERNOR

June 6, 2019

Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Rm. 17E20
Rockville, MD 20857

Dear Grants Management Officer:

As the Governor of the State of Idaho, for the duration of my tenure, I delegate signatory authority to the current Director of the Idaho Department of Health and Welfare or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG), Community Mental Health Services Block Grant (MHBG), and Projects for Assistance in Transition from Homelessness (PATH) Grant.

This delegation is effective immediately.

If you have any questions, please contact Jonathan Meyer at 208-334-6682 or via e-mail at Jonathan.Meyer@dhw.idaho.gov.

Sincerely,

Brad Little
Governor of Idaho

c: Dave Jeppesen

STATE CAPITOL • BOISE, IDAHO 83720 • gov.idaho.gov • (208) 334-2100 • FAX (208) 334-3454

State Information

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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.
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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.
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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.
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LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: Idaho

Name of Chief Executive Officer (CEO) or Designee: Dave Jeppesen

Signature of CEO or Designee[1]:

Title: Director, Idaho Department of Health and Welfare

Date Signed: 8/06/2019

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

OFFICE OF THE DIRECTOR
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5500
FAX 208-334-6558

August 28, 2019

Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm. 17E20
Rockville, MD 20857
(240) 276-1400

Dear Grants Management Officer:

The state of Idaho's Department of Health and Welfare has completed Idaho's Fiscal Year 2020-2021 Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Plan and Report. The application has been submitted through the WebBGAS system at bgas.samhsa.gov.

Enclosed are:

- The signed Chief Executive Officer's Funding Agreements/Certifications FY 2020--SA, Assurances Non-Construction Programs, and Certifications
- The signed Chief Executive Officer's Funding Agreements/Certifications FY 2020--MH, Assurances Non-Construction Programs, and Certifications
- The signed Disclosure of Lobbying Activities
- The Chief Executive Officer's signatory authority designation letter

The Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grants enable Idaho to implement community-based prevention activities, substance use disorder treatment and mental health services. If you have any questions about this document, please contact Jon Meyer at (208) 334-6682 or Jonathan.Meyer@dhw.idaho.gov.

Sincerely,

DAVE JEPPESEN
Director

DJ/jrm

State Information

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

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services 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 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		
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

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.
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b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
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3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Dave Jeppesen

Signature of CEO or Designee[1]: _____

Title: Director, Idaho Department of Health and Welfare

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The signed certifications pages are attached as MHBG Certifications.pdf

BRAD LITTLE
GOVERNOR

June 6, 2019

Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Rm. 17E20
Rockville, MD 20857

Dear Grants Management Officer:

As the Governor of the State of Idaho, for the duration of my tenure, I delegate signatory authority to the current Director of the Idaho Department of Health and Welfare or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG), Community Mental Health Services Block Grant (MHBG), and Projects for Assistance in Transition from Homelessness (PATH) Grant.

This delegation is effective immediately.

If you have any questions, please contact Jonathan Meyer at 208-334-6682 or via e-mail at Jonathan.Meyer@dhw.idaho.gov.

Sincerely,

Brad Little
Governor of Idaho

c: Dave Jeppesen

STATE CAPITOL • BOISE, IDAHO 83720 • gov.idaho.gov • (208) 334-2100 • FAX (208) 334-3454

State Information

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

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services 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 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		
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

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 Coastal 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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By signing the certification, the undersigned 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.

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The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Dave Jeppesen

Signature of CEO or Designee[1]: _____

Title: Director, Idaho Department of Health and Welfare

Date Signed: 8-16-2019

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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

Dave Jeppesen

Title

Director

Organization

Idaho Department of Health and Welfare

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The signed Disclosure of Lobbying Activities is attached as "Disclosure of Lobbying Activities.pdf.

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

Dave Jeppesen

Title

Director

Organization

Idaho Department of Health and Welfare

Signature:

Date: 7-30-2019

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD 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 and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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Footnotes:

The Primary Prevention response is attached as Primary Prevention Step 1 Strengths and Organizational Capacity.docx.

The CMHS and SAPT response is attached as Step 1 MH and SAPT Response.

Planning Step #1

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

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD 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 and gender minorities, as well as American Indian/Alaskan Native populations in the states.

Overview of the State's Prevention Support System
how the public M/SUD system is currently organized at the state and local levels

The Idaho Department of Health and Welfare (IDHW) serves as the Single State Authority (SSA) for the Substance Abuse Prevention and Treatment Block Grant (SABG) administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), and Center for Substance Abuse Prevention (CSAP).

Since SFY14, IDHW has assigned the oversight of the primary prevention SABG set-aside funds to Idaho's 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 is an identified member of the State Behavioral Health Planning Council, the Idaho Criminal Justice Commission, the Idaho Conference on Alcohol and Drug Dependency Planning Board, and the Idaho Behavioral Health Board Leadership Committee. ODP's administrator has recently been appointed to serve as chairperson for the Governor's newly formed state opioid advisory group. The office also facilitates the Prescription Drug 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. 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. Now in its third year, Idaho's Opioid Misuse and Overdose Workgroup, whose mission is to implement a comprehensive strategic plan to combat the emerging opioid epidemic in Idaho, is seeing notable outcomes. Ranked #5 in the nation for past year prescription pain reliever misuse in 2015-16, Idaho has moved to #25 as reported in the National Survey on Drug Use and Health (NSDUH) in 2016-17. 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 both direct service and community-based environmental strategies that offer a variety of evidence-based programs for children, adolescents, parents/guardians, and families to reduce substance abuse related problems in the communities they serve. Grant applications are reviewed, and sub-recipient awards made with input from Regional Review Committees comprised of substance abuse experts in each of Idaho's seven public health regions. In FY19, 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.

SABG funds are awarded through a competitive bidding process for community-based providers, thus ensuring that the prevention portion of the grant is distributed across the state to provider agencies with the capacity to deliver evidence-based prevention services within their communities. In SFY19, ODP awarded SABG prevention grants to 54 prevention providers. ODP strongly encourages providers to engage in practices that have been demonstrated through prior research as being effective in preventing or reducing substance abuse. Although prevention services can cover the lifespan, prevention services that are delivered through SABG are often aimed at adolescents and young adults. Common substances of concern include cigarettes, e-cigarettes and other vaping devices, alcohol (e.g., underage drinking, binge drinking, and impaired driving), marijuana, prescription drugs (when used in ways not prescribed by a doctor), and other illicit drugs.

In SFY18, Idaho was awarded a Partnership for Success (PFS) grant from SAMHSA with the primary goal of reducing underage drinking across the state and secondary goals of reducing marijuana use and methamphetamine use in certain regions. ODP is distributing the PFS funds to all seven regions of the state through the state's regional public health departments (in collaboration with Regional Behavioral Health Boards [RBHBs]) and local law enforcement agencies. In addition, ODP is providing training to the public health departments and law enforcement agencies related to the Strategic Prevention Framework.

The public health departments employ regional PFS Project Coordinators (PCs) and are responsible for strategic planning, training at least two facilitators on the Strengthening Families program, implementing the Be the Parents campaign, and delivering Drug Impairment Training for Education Professionals (DITEP). Public health agencies may also implement other strategies that fall within CSAP's 6 Strategies, including Life Skills Training and Responsible Beverage Server Training.

The populations served with Idaho's primary prevention funds are defined as "*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:

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.

SABG providers must engage in prevention strategies approved by the Center for Substance Abuse Prevention (CSAP). The following strategies are currently supported by SABG funds through ODP:

Information Dissemination - Idaho's Regional Alcohol and Drug Awareness (RADAR) Center provides free information about alcohol, tobacco and other drugs to Idaho residents. It includes a Video Lending Library of over 900 titles and functions as a statewide information clearinghouse and resource referral center. 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, "Speak Out, Opt Out, Throw Out" (https://form.jotform.com/spustejovsky/speak-out-opt-out-throw-out-order/), is an awareness campaign designed to encourage residents to "speak out" about addiction, "opt out" of opioids whenever possible, and "throw out" any extra painkillers quickly. Both campaigns include materials to address the needs of Idaho's Hispanic, Native American, and young adult 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 receiving 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-based Processes and Environmental Strategies – are most often employed by community coalitions and support community organizing, planning and collaboration of efforts around specific prevention events and actitities.

All recurring services are evaluated using pre and post surveys. 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. Providers are required to report their activities, attendance and demographics, and financial information on a quarterly basis.

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 **2018** United States Census Bureau, Idaho's largest metropolitan area, the Treasure Valley which includes both Ada and Canyon Counties, contains over 39.5% 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, regulations and executive orders regarding 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 **2018,** Idaho was 93 % white, with little variation across counties. Statewide, 12.7% of Idahoans were Hispanic or Latino, 1.6% Asian, 1.7% were American Indian or Alaska Native, 0.9% were Black or African-American, and 2.5% described themselves as being two or more races. The percent of foreign-born persons, 2013– 2017, was estimated at 5.9%, 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. 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. In FY19, SABG funds were used to provide training and technical assistance on two evidence-based programs specifically for American Indian youth and families. The implementation of these programs, Project Venture and White Bison Wellbriety by Idaho's Shoshone-Paiute and Nez Perce tribes has been embraced in each community and experienced significant growth in participation and attendance.

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 and is an active member of ODP's workgroups. The Commission has also aided the Office on several occasions to ensure prevention materials are accurately translated and culturally correct, and to help identify needs and gaps in prevention services for Idaho's Hispanic families. Idaho's underserved Hispanic and rural populations are prioritized during the competitive annual grant review process. For the first time in years, SABG funded Active Parenting programs will be made available in Spanish in Eastern Idaho during FY20.

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 a program developer to develop webinar prevention trainings into on-line courses via a Learning Management System (LMS). These courses will map directly to the required Certified Prevention Specialist domains (Planning and Evaluation; Prevention Education and Service Delivery; Communication; Community Organization; Public Policy and Environmental Change, and Professional Growth) and help ODP to continue to recruit, develop and retain a qualified prevention workforce.

Division of Behavioral Health
Idaho Department of Health and Welfare

DBH Medicaid Expansion Project Plan

Dated 4/22/19, v2.2

1. Background and Purpose

Idaho voters authorized Medicaid Expansion with an initiative in November 2018. The expansion is expected to provide access to preventive health care services to an additional 91,000 low-income Idaho residents. Approximately 8,000 of these residents are being served by the Division of Behavioral Health (DBH), approx. 95% of the 8,000 are expected to qualify for Medicaid under the Expansion rules.

In January 2019 the Medicaid Expansion Enterprise project was launched for purposes of partner collaboration, communication and alignment. Partners include: IDHW Enterprise Project Unit, Division of Medicaid, Division of Self Reliance and Department of Corrections.

Idaho Department of Health and Welfare identified 12.8 million in DBH funds previously approved by the legislature for delivering DBH services to this population for transfer to Medicaid, IDOC and Idaho Courts.

The purpose of this document is to clearly outline the DBH Medicaid Expansion project, so that all partners and team resources have the same vision, goals and understanding of the project work. This document includes the project scope, goals, anticipated requirements, strategy for accomplishing the work and timeline for completing the work.

2. Scope and Strategy

The scope of the Medicaid Expansion project within the Division of Behavioral Health (DBH) is to transition identified Adult Mental Health (AMH) and Substance Use Disorder (SUD) clients, services, and funding to Medicaid beginning 1/1/2020. At the same time increasing our DBH crisis and BH authority roles and responsibilities across the state of Idaho. Scope includes:

1. Collaboration with Enterprise Medicaid Expansion Project Team.
2. Transfer $12.8 Million from DBH to other client serving agencies
    a. $5.4M from Probation & Parole to Medicaid.
    b. $2.4M from SUD to Medicaid (780k has been transferred to the Courts).
    c. $2M from Crisis Centers to Medicaid.
    d. $2M from Community Hospitalization to Medicaid.
    e. $1M from Adult MH Prescriber Services to Medicaid.
3. Redefine DBH role and responsibilities within the State of Idaho by priority population; central office and regions.
4. Termination, revisions to related vendor & provider contracts, rules, policy and procedures as applicable.
5. Transformation of DBH Adult SUD system of care.
6. Transition of DBH AMH and SUD clients currently serving who can qualify for Medicaid to Medicaid.
7. Transition DBH adult probation and parole (P&P) clients currently serving to Medicaid; DBH role.
8. Transition of DBH AMH / SUD clients to the Medicaid funded provider network.

9. DBH clients transitioning are well informed of Self Reliance process, communications, transition to Medicaid.
10. Define and fulfill DBH roles and responsibilities as the Idaho Behavioral Health Authority. Including system oversight, statute changes, policy development, standards, and quality monitoring.
11. Expand DBH roles and responsibilities to effectively meet the needs of Idahoans experiencing behavioral health crises.
12. Updates to current DBH operations, operational components within Central Office, Regional Offices; including processes, tools, communications, documentation, vendor contracts, agency and community partners relations to realize new roles and responsibilities.
13. Identify and implement system modifications/enhancements to support Medicaid expansion in DBH, including establishing and improving connectivity as necessary.
14. Identify and modify reports to support DBH Medicaid Expansion.
15. Project and transition communications; content and materials in collaboration with Enterprise Medicaid Expansion project.

3. Governance

The Medicaid Expansion project includes IDHW enterprise and Division level sponsorship.

IDHW Enterprise Project Management (IEPM) team will provide enterprise project coordination between agency partners, communication and document sharing, IEPM has no decision-making authority.

- Executive sponsors will provide enterprise level project oversight, agency alignment and decision making. Executive sponsors will meet as needed to ensure project timelines are met.
    - DBH project sponsors will provide Division level project oversight and decision making for the Division of Behavioral Health in alignment with the enterprise project. DBH Sponsors will meet weekly (day to be determined).
    - DBH Steering committee members will provide regional and central office leadership, contribute to decision making related to impacted areas throughout the state of Idaho.

Medicaid Expansion Executive Sponsors

Name	Representation	Role
Lisa Hettinger, Deputy Director	IDHW areas of DBH and Medicaid	IDHW decision maker in areas of DBH and Medicaid
Ross Edmunds, Division Administrator	Division of Behavioral Health (DBH)	Represent DBH, contribute to decision making for DBH statewide
Matt Wimmer, Division Administrator	Division of Medicaid	Represent Medicaid, contribute to decision making for Medicaid statewide
Lori Wolff, Deputy Director	IDHW areas of FACS and Welfare	IDHW decision maker in areas of FACS and Welfare

Name	Representation	Role
Julie Hammon, Division Administrator	Division of Self Reliance (SR)	Represent SR, contribute to decision making for SR statewide
Greg Kunz, Project Manager	IDHW Enterprise Project Management	Project Management, coordination, facilitation overall ME project

DBH Project Sponsors

Name	Representation	Role
Ross Edmunds, Division Administrator	Division of Behavioral Health (DBH)	Represent whole DBH, decision maker for DBH statewide
Jamie Teeter, Bureau Chief	DBH Central Office Operations, SUD contract and services	Represent DBH Central Office Operations; contribute to decision making
Todd Hurt, Hub Administrator, regions 1 & 2	Regional Hub Operations, region 1 & 2	Represent Regions 1 & 2 Operations; provide resources, contribute to decision making
Gina Westcott, Hub Administrator regions 3, 4 & 5	Regional Hub Operations, region 3, 4 & 5	Represent Regions 3, 4 & 5 Operations; provide resources, contribute to decision making
Jim Price, Hub Administrator regions 6 & 7	Regional Hub Operations, region 6 & 7	Represent Regions 6 & 7 Operations; provide resources, contribute to decision making

DBH Steering Committee

Name	Representation	Role
Holly Bonwell, Field Program Manager region 1	Region 1 Adult Behavioral Health services and operations	Lead project work in Region 1; provide resources, contribute to decision making
Teresa Shackelford, Field Program Manager region 2	Region 2 Adult Behavioral Health services and operations	Lead project work in Region 2; provide resources, contribute to decision making
Heather Taylor, Field Program Manager region 3	Region 3 Adult Behavioral Health services and operations	Lead project work in Region 3; provide resources, contribute to decision making
Jennifer Burlage, Field Program Manager region 4	Region 4 Adult Behavioral Health services and operations	Lead project work in Region 4; provide resources, contribute to decision making
Scott Rasmussen, Field Program Manager region 5	Region 5 Adult Behavioral Health services and operations	Lead project work in Region 5; provide resources, contribute to decision making
Brad Baker, Field Program Manager region 6	Region 6 Adult Behavioral Health services and operations	Lead project work in Region 6; provide resources, contribute to decision making

Name	Representation	Role
Randy Rodriguez, Field Program Manager region 7	Region 7 Adult Behavioral Health services and operations	Lead project work in Region 7; provide resources, contribute to decision making
Cindy Day, Project Manager	DBH Project Management	Lead project management for DBH; provide resources, project documentation, facilitate decision making, issue and risk management
Treena Clark, CO Program Manager	DBH Policy, Planning	Represent DBH Policy, Planning and Communication operations; provide resources, contribute to decision making
Candace Falsetti, CO Program Manager	DBH Quality Monitoring and Reporting	Represent DBH Quality Monitoring and Reporting operations; provide resources, contribute to decision making
Seth Schreiber, CO Program Manager	DBH Automation and WIT System	Represent DBH Automation, WIT System operations; provide resources, contribute to decision making
Rosie Andueza, CO Program Manager	DBH SUD and Parole & Probation	Represent Regional Operations in area of Single State Agency(SSA) de resources, contribute to decision making

4. Requirements

Initial requirements have been identified in the table below. As the project planning continues, requirements will be confirmed, additional requirements may be determined. Requirements will be tracked in the working project document.

DBH Medicaid Expansion Requirements

#	Business Need	Requirement (*thing we want*)	How to meet requirement
1	Reduce DBH budget by $5.4M from P&P	Remove $5.4 Million from DBH Trustee & Benefits (T&B) budget and give it to Medicaid	JFAC removes from DBH T&B, operating budget; ½ FY2020 and ½ FY2021
2	P&P clients being served by DBH need to receive MH P&P services through Medicaid	Ensure people on probation/parole have access to MH services funded by Medicaid *note: current referral pathway is designed in which parole officer refers client to FQHC, FQHC bills CHCNI for services rendered, CHCNI bills DBH*	CO work with Medicaid, IDOC to determine plan for transition of clients, meeting population needs, billing Medicaid. Ensure clinical record transfer. Develop FQHC communications, contract termination for current FQHC P&P service providers, private providers (2-3)

#	Business Need	Requirement (*thing we want*)	How to meet requirement
			Work with clinics to ensure no gap in services DBH invoices paid for Dates of Service (DOS) through 12/31/19. FQHC's invoice Medicaid for services delivered from 1/1/2020 Complete closing invoices and close out contract
3	Reduce DBH budget by $1.62M from SUD	Remove $1.62 Million from DBH Admin budget and give it to Medicaid	JFAC removes $1.62M from DBH Admin budget; ½ FY2020 and ½ FY2021 (additional $780K to courts for 2.4M total)
4	DBH SUD clients currently being served by DBH need to receive treatment services through Medicaid	Ensure people receiving DBH funded SUD treatment services can receive treatment services funded by Medicaid	CO work with Medicaid, to determine plan for transition of clients, meeting population needs, billing Medicaid/Optum
5	Continue to meet population served requirements of the SUD block grant	Contract in place with BPA Health or other vendor that meets the identified needs of our adult MH/SUD population (not reimbursed by Medicaid)	CO understand impacts to SUD block grant requirements, funds and plan for how will spend remaining federal dollars not transferred to Medicaid Work with BPA Health and partners to evaluate current SUD array of services to determine what is and will be Medicaid reimbursable; gap analysis Communications, contract revisions for current BPA Health vendor RFP if needed Develop and implement new contract
6	# of DBH vendor contracts serving adult MH, SUD clients will be impacted by changes to budget, services providing or facilitating in the regions. Need to determine contracts for updates	DBH vendor contracts serving adult MH, SUD clients accurately reflect how serving population serve and funds available	Regional offices develop Transition plan that include contract impacts. Regional staff work with and central office to identify impacts, make updates to contracts as identified, term contracts if applicable Analysis of related workflows and processes to determine updates needed

#	Business Need	Requirement (*thing we want*)	How to meet requirement
7	DBH MH Court clients currently being served by DBH transition to receive MH Court services through Medicaid	Ensure Mental Health Court clients continue to receive MH Court services; delivered by Medicaid providers to the greatest extent possible	Regional offices develop Transition plan including MH Court clients. CO work with Medicaid to ensure all services necessary to meet the needs of the MH court population are reimbursable and accessible Work with court system for understanding, buy-in of transition plan Providers trained and available
8	Reduce DBH budget by $2M from Crisis Centers	Remove $2 Million from DBH T&B budget and transfer to Medicaid	JFAC removes $2M from DBH T&B budget. ½ FY2020 and ½ FY2021
9	Crisis Centers currently funded by DBH need to develop strategies for sustainability including billing Medicaid due to the loss of $2M from DBH	Ensure Medicaid reimbursement for Crisis Center services. Facilitating process by which Crisis Centers can be reimbursed by Medicaid	CO work with Medicaid, to develop plan, funding methodology for reimbursing services from Crisis Center providers; billing Medicaid CO work with regions on contract changes Work with Crisis Centers on funding changes, plan in place going forward
10	Reduce DBH budget by $2M from Community Hospitalization	Remove $2 Million from DBH T&B budget and give it to Medicaid	JFAC removes $2M from DBH T&B budget. ½ FY2020 and ½ FY2021
11	Majority of payments for committed patients at IMD's will no longer be paid for by DBH because of the transfer of $2M Need to develop strategies for Medicaid reimbursement of patients committed and being served in free standing psych hospitals (IMD's)	Strategies in place for Medicaid reimbursement of patients committed and being served in free standing psych hospitals (IMD's)	Work with Medicaid, to develop plan, funding methodology for delivering services through Community Hospitals; billing Medicaid/Optum Work with Community Hospitals on funding changes, plan in place going forward
12	Reduce DBH budget by $1M from Adult MH Prescriber Services	Remove $1 Million from DBH budget and give it to Medicaid	JFAC removes $1M from DBH budget. ½ FY2020 and ½ FY2021
13	DBH clients currently receiving clinic services (medications and med	Ensure people receiving medications, med management	Regional offices develop Transition plan that includes clinic services.

#	Business Need	Requirement (*thing we want*)	How to meet requirement
	management) to be served by Medicaid	services through DBH can receive services funded by Medicaid	CO work with Medicaid, to determine plan for transition of clients, meeting population needs, billing Medicaid/Optum
14	Need modifications to vendor operational materials and documentation due to transition of DBH services, roles and responsibilities	DBH workflows, process, operational materials & documentation accurately reflect work we do, with who and how	Regional offices develop Transition plan that includes operational impacts, updates to operational materials, documentation. Analysis of DBH regional & CO workflows, processes, operational materials & documentation; what needs removed, updated, or created CO staff to identify impacts, make updates to operational processes, materials, documentation, statewide policy and procedures
15	MH and SUD Grants requirements are met with our current operational model, when model changes will change how we meet the requirements	Meet MH and SUD Grant financial maintenance of effort (MOE) requirements during and after the transition of clients and services	CO works with Federal project officers on compliance with MOE requirements under Medicaid Expansion CO identifies impacts to MH and SUD Grants. Determine tasks and timelines for maintaining alignment with transition
16	DBH clients served and community stakeholders need to be/stay well informed regarding changes coming, impacts and transition of DBH services. Intentional plan to minimize confusion, fear and impact to services	Ability to deliver timely and accurate communications to DBH clients and stakeholders	Regional and CO staff develop initial communication plan for awareness of DBH Medicaid Expansion project Complete updated version of the communication plan to meet needs of identified stakeholders. Develop content, materials, contribute to Medicaid Expansion website and SharePoint project site
17	Need to understand and meet data needs for collaborating with the Enterprise project	Ability to meet Enterprise and DBH project data requirements	Data needs identified, delivered in format, time requested
18	Systems created or updated to achieve Medicaid expansion	Identify and implement system modifications/enhancements to support Medicaid expansion in DBH, including establishing and	CO confirm proposed changes that will impact automated systems used by DBH and other partners/divisions.

#	Business Need	Requirement (*thing we want*)	How to meet requirement
		improving connectivity as necessary	Construct organizational goals, benchmark the current state of automated systems (e.g. WITS), to include system connectivity. Define the desired end state of Automated system use, including system connectivity and integration, required to support Expansion. Analyze impact of proposed changes to existing system(s), including impacts to any AHD-related contracts. Complete a gap analysis. Analyze gap data, prioritize the findings from the Gap Analysis into a series of gap closure strategies Discover the optimum sequence of actions (recognizing predecessor – successor relationships) required to implement gap closure strategies Compile a gap report (e.g. Road Map) that identifies areas of improvement and outlines an action plan to achieve the closure of gaps. Implement Road Map. Key components to the road map are likely to include: • Modification of current systems • Amendment to existing contracts • New system development and/or procurement • System changes (architecture, functionality, access) to facilitate interoperability and data sharing.
19	Define Statewide Crisis System Project	Crisis System Development plan and project	Define what we want Idaho's BH Crisis system to be and DBH Role is in the system

#	Business Need	Requirement (*thing we want*)	How to meet requirement
			Launch Crisis System Development project
20	Need to redefine regional roles & responsibilities because of Medicaid Expansion	Defined DBH role and responsibilities within the State of Idaho by priority population.	Determine what services, role DBH will serve during and after the transition
21	Need to determine scope of Behavioral Health Authority	Fulfil role and responsibilities as the BH Authority in Idaho	Define what we want Idaho's BH Authority scope to be Launch Behavioral Health Authority project Develop statute changes
22	DBH reports will need to be updated based on transition	Have reporting that supports Medicaid Expansion; DBH reporting needs	Identify reports, impacts to reports Develop plan for modifying reports Modify reports
23	Have a transition plan for transitioning ACT services to Medicaid/Optum network providers	Gain understanding of what it will take to transition ACT services to Medicaid/Optum	CO will work with regions and Medicaid/Optum to identify how to transition ACT clients in the future Develop Transition plan for ACT in all regions.

5. Out of Scope

- Children's Mental Health.
- State Hospitals; North and South.

6. Assumptions

1. Probation and Parole service providers (FQHC's) are already part of the Optum Network.
2. If a client is eligible for Medicaid, DBH will not provide services that are reimbursable by Medicaid.
3. DBH will continue to deliver Assertive Community Treatment (ACT) services.
4. No anticipated reductions to DBH central or regional office staffing, however the contract monitor for Probation & Parole program will be reassigned.
5. No change to DBH adult priority populations served; change of services as identified in AS IS/TO BE table.

AS IS	TO BE
DBH currently provides or facilitates services to 6 Priority populations.	DBH continues with following services to 6 Priority populations.
1. People who are in Crisis; Designated Examiners (66.326), crisis after hrs. line, limited crisis response outside of DE varies by region.	1. People who are in *Crisis will continue to be service and DBH will continue to improve crisis services available
2. People who are committed to us; manage disposition of community and state hospitals (I.C. 66.329), outpatient commitment - oversee outpatient services, manage disposition of state hospital, court reporting, prison beds (I.C.18.212).	2. People who are committed to us (I.C. 18.212, I.C. 66.329); no change.
3. People who are court ordered; central office review, regional assessment & report to court, probation & parole with CHCNI contract (I.C.19.2524).	3. People who are court ordered (I.C. 19.2524); transition to Medicaid
4. Mental Health Court; 4 phases including coordination with court, go to court, staffing, provide outpatient services, court reports.	4. Mental Health Court; transition to Medicaid. Optum network providers deliver 4 phases of court services for Medicaid reimbursement.
5. SUD block grant priority populations a. Pregnant women and women with children (20% requirement)	5. SUD block grant priority populations; no change.
6. IV Drug Users Voluntary request for services; Assertive Community Treatment (ACT), MH Clinic, MH Clinic Med Only, State qualified HRSA site.	6. Voluntary; transition to Medicaid with exception of ACT which will retain temporarily. No longer eligible for HRSA

*Any crisis that is behavioral or emotional in nature.

7. Deliverables

High level deliverables identified for DBH Medicaid project include:

#	Deliverable	Deliverable Description	Date
1	Scope and Strategy Document	Approved project scope and strategy	April 2019
2	Tasks & Timelines (WBS)	Identified tasks and timeline to complete the work with assigned resources	April 2019
3	Data Plan	Data elements, needs identified. Plan for meeting data requirements for Enterprise	May 2019

#	Deliverable	Deliverable Description	Date
		Medicaid Expansion project as well as DBH Medicaid Expansion needs	
4	Gap Analysis – BPA Contract	BPA Health Contract gap analysis	May 2019
5	Regional and CO Transition Plans	DBH Regions 1 – 7 and central office develop Transition plans for transitioning work and clients as identified in scope by 1/1/2020.	April 2019
6	Systems Gap Analysis	DBH systems gap analysis	May 2019
7	Communication Plan, v1	Version 1 communication plan for project and transition awareness.	April 2019
8	IDOC Transition Plan	Transition plan for ensuring P&P clients served by DBH today have provider and services lined up by 1/1/2020	June 2019
9	Medicaid / Optum Transition Plan	Transition plan for ensuring adult MH and SUD clients served by DBH today have provider and services lined up by 1/1/2020. Processes in place to meet high needs, timely access of clients	June 2019
10	Communication Plan, v2	Version 2 comprehensive communication plan to meet needs of internal and external stakeholders impacted by Medicaid Expansion, transition from DBH. Will include outreach to referral sources.	June 2019
11	Crisis System Development Plan	DBH role, plan for increasing crisis services in regions throughout Idaho	July 2019
12	Behavioral Health Authority Plan	DBH plan and role in increased elements in being the Mental Health Authority in the state of Idaho.	July 2019
13	SUD Block Grant application	New application due this year includes maintenance of effort under Medicaid Expansion	August 2019
14	BPA Health Contract	Updated BPA Health Contract with 1/1/20 effective date	Nov 2019
15	SUD Grant RFP	Develop & release RFP for SUD grant	June 2019

#	Deliverable	Deliverable Description	Date
		Award RFP for SUD Grant	January 2020

8. Dependencies

For DBH to successfully transition to Medicaid Expansion, the following must be agreed upon and completed by stakeholders identified:

1. Court and IDOC resources must be willing, available, able to work together to meet timelines as outlined.
2. Medicaid, Optum and BPA Health resources must be willing, available and able to work together to meet timelines as outlined.
3. Medicaid/Optum transition plan for priority populations identified for DBH transition.
4. Optum Network readiness assessment demonstrating providers available and ready to deliver services to DBH transitioned clients.
5. Medicaid/Optum must reimburse for crisis center services.
6. Medicaid must pay for the majority of community hospitalization for committed patients before moving to the State Hospital.
7. Optum Network must be able to provide necessary medication management.
8. Optum Network must be able to make outpatient behavioral health services available timely and at an intensity that will meet the need of current DBH clients.
9. The scope and strategy for DBH Medicaid Expansion as written in this document must be approved so we are all working towards the same vision, plan.
10. The timeline for the project as shown in this document must be accepted.
11. The resources for the project must be assigned and supported by IDHW leadership and must be available.
12. DBH has resources necessary to accomplish the existing work and identified goals for Medicaid Expansion.

9. Risks

Initial risks identified, all risks will be tracked and addressed using a project risk, issue and decision log. Strategies for addressing risks will be included in the risk log.

1. Ability to meet MH and SUD block grant financial maintenance of effort.
2. Medicaid provider capacity to meet the needs of additional expansion population especially high needs of MH/SUD clients.
3. Potential for impact to clients served. DBH transition period may need to be longer to ensure clients do not go without services, medications, understand DBH no longer able to meet needs.

4. The transition MH Court services to Medicaid providers is not successful.
5. Medicaid/Optum provider workforce does not have the capacity to meet the needs of the Medicaid population
6. Medicaid provider network not able to meet the needs of DBH clients and DBH will be forced to continue meeting their needs without the necessary budget.
7. System stakeholders continue to have the same expectations of DBH after Medicaid expansion and transition.
8. Medicaid won't pay for community hospitalization because a) Medicaid does not submit an IMD waiver b) Medicaid does not get an IMD waiver, c) Medicaid denies payment for committed patients.

10. Acceptance criteria

DBH Medicaid Expansion will only be considered complete after:

1. All requirements met.
2. DBH Central Office and Staff effectively transition all identified clients.
3. Medicaid / Optum reporting validates client services being rendered.
4. IDOC reporting validates client services being rendered.
5. Court reporting validates client services being rendered.
6. BPA Health contract reflects new DBH priorities.

11. Project Phases

After the scope and strategy document is approved, project work will be divided into three phases and will take place over a 12 month period beginning 2/15/2019 and ending 2/29/2020. As transition off responsibilities will increase what we do in terms of crisis, mental health authority.

The table below provides details of key activities and resource needs during the # phases of the project

Phase	Key Activities	Resources
Planning **Feb - May 2019**	Approved Scope and Strategy Internal Manager's Meeting Assigned Resources Project Kickoff Meeting Agreed upon Tasks & Timelines Identification of Key Stakeholders Communication Plan v1.0	• Ross, Jamie, Treena, Rosie, Candace, Cindy, Seth, Regional Program Managers, Hub Administrators • Resources to be assigned • Ross, Jamie • Resources to be assigned • Cindy Day with CO & Regional Staff

Phase	Key Activities	Resources
	Regional Transition plans; regions 1-7 Central office Transition plans	• Regional Program Managers with staff • Rosie Andueza, Holly Walund and Sherry Johnson, other as assigned
Service Model Transition **April – Dec 2019**	Work with sponsors and steering committee to redefine DBH roles during and after the transition to Medicaid Expansion Work with SR for alignment of DBH role in enrollment Work with IDOC, develop plan, communications for transitioning clients, ensuring benefit coverage Work with Medicaid/Optum develop plan, communications for transitioning clients, ensuring service coverage Develop, deliver communications to clients, community partners Work with contracted vendors, identify contract modification/termination Work with contracted providers, identify contract modification/termination Outreach to community partners, ensure understanding of plan, transition, change in referral process	• CO & regional staff • CO & regional staff • Ross, CO staff • CO & regional staff • Regional staff, resources to be assigned • Regional staff, resources to be assigned • CO & regional staff • CO & regional staff
Transition **June 2019 to Feb 2020**	Continued outreach to community partners, ensure understanding of plan, transition, change in referral process Transition clients to Medicaid Secure MOE approval of MH and SUD Block Grants Updates to vendor and provider contracts Develop Crisis Plan Develop plan for DBH as BH Authority	• CO & regional staff • Regional staff, resources to be assigned • CO staff, resources to be assigned • CO & regional staff • Candace Falsetti lead, CO and regional staff

Phase	Key Activities	Resources
		• Treena Clark, CO and regional staff

12. Project Communications

The project manager will help facilitate communications and information sharing between the sub-project team, Medicaid sponsors and the IDHW enterprise project management team. The below communication matrix lists the established internal meeting schedule and assigned communication responsibilities. A communication plan will be developed in collaboration with expansion partners to reflect responsibilities and ensure alignment.

Communication Matrix

Stakeholder	Purpose	Freq.	Format	Participants/ Distribution	Deliverable	Owner
IDHW Executive Sponsor Mtg	Meeting to review enterprise project status and next steps, cross-divisional coordination, review new and existing issues/risks, etc.	Weekly	In-Person	IDHW Executive Sponsors	Meeting Agenda and Meeting Minutes	Greg Kunz
Enterprise Project Manager Mtg	Enterprise level mtg to coordinate sub-projects with PM's and IDHW Administrators	Monthly	In-Person	IDHW Executive Sponsors and Division PM's	Meeting Agenda and Meeting Minutes	Greg Kunz
ME Project Management Mtg	Meeting to review project needs, barriers, decisions	Initially will be weekly	In-Person	Ross Edmunds Jamie Teeter Cindy Day	Updated Decision log, Risk /Issue log as applicable	Cindy Day
DBH Executive Sponsor Mtg	Meeting to review project status, regional	Monthly	In-Person meeting with conf.	DBH Executive Sponsors, all	Meeting Agenda and Minutes	Cindy Day

Stakeholder	Purpose	Freq.	Format	Participants/ Distribution	Deliverable	Owner
	coordination, new & existing issues, risks, decisions, etc.		call available	team members	Updated Decision, Risk /Issue log as applicable	
DBH Steering Committee Mtg	Meeting to review project status, project coordination and next steps, new and existing issues/risks, decisions needed	2x monthly	In-Person meeting with conf. call available	DBH Steering Committee, all team members	Meeting Agenda and Minutes Updated Decision, Risk /Issue log as applicable	Cindy Day
CO DBH Project Management Mtg	Meeting to review project status, project coordination, resource management, new and existing issue/risks	Weekly	In-Person meeting with conf call available	Meeting invited participants, Cindy Day, others as determined	Meeting Agenda and Minutes Identified decisions needed, risks, issues	Megan Schuelke
Project Team Mtg	Meeting with team members working on area of project	2x Monthly	In-Person meeting	Meeting invited participants, Cindy Day, others as determined	Meeting Agenda and Minutes Identified decisions needed, risks, issues	Project Leads
Daily Scrum Mtg	Meeting to review sprint tasks	Daily	In-Person meeting	CO Project leads, all CO team members can view JIRA	Updates to JIRA	Rohit Sharma
Project Status Report	Report on project status including key accomplishme					Cindy Day

Stakeholder	Purpose	Freq.	Format	Participants/ Distribution	Deliverable	Owner
	nts, next steps, schedule and escalated issues/risks, highlights from Enterprise project meetings. Includes link to WBS					
Project Schedule (WBS)	Weekly project schedule	Updated weekly	Link in project status report, managed in Smart Sheets	All DBH team members, Enterprise project team members	Updated Project Schedule	Cindy Day
Decision Log	List & description of project decisions made, awaiting decision	As Needed	Excel	All DBH project team members	Updated Decision Log	Cindy Day
Risk/Issue Log	List & description of project risks & issues, management plan	As Needed	Excel	All DBH project team members	Updated Risk/Issue Log	Cindy Day
Key Stakeholder Registry	List of all Stakeholders and responsibilities	As Needed	Excel	All DBH project team members	Updated Stakeholder Registry	Cindy Day
Meeting Agenda	Agenda to be covered in the	1 bus. day prior to mtg	Email	Meeting invited participants	Meeting Agenda	Admin Staff

Stakeholder	Purpose	Freq.	Format	Participants/ Distribution	Deliverable	Owner
	mtg with list of invitees					
Meeting Minutes	Discussions covered in the meeting, list of attendees and action items	3 bus. days prior to mtg	Email	Meeting invited participants, others as determined	Meeting Minutes	Admin Staff
Ad Hoc Meetings	Other DBH meetings not covered above	As needed	Email	Meeting invited participants, others as determined	Meeting Minutes	Various
ME Enterprise Project SharePoint site	Shared enterprise project documents and collaboration, includes decision log	As needed	Direct access internal link	IDHW Executive Sponsors, Project Managers	Updated SharePoint Site	Greg Kunz, Robbie Jackson
DBH ME Project SharePoint site	Shared documentatio n and collaboration	As needed	Direct access internal DBH link	All DBH project team members	Current project documentatio n, timeline, decisions, etc.	Cindy Day
ME website	Website setup for all things Medicaid Expansion	As needed	Direct access public internet	Public	Updated ME	Greg Kunz, Robbie Jackson

13. Risk and Issue Management

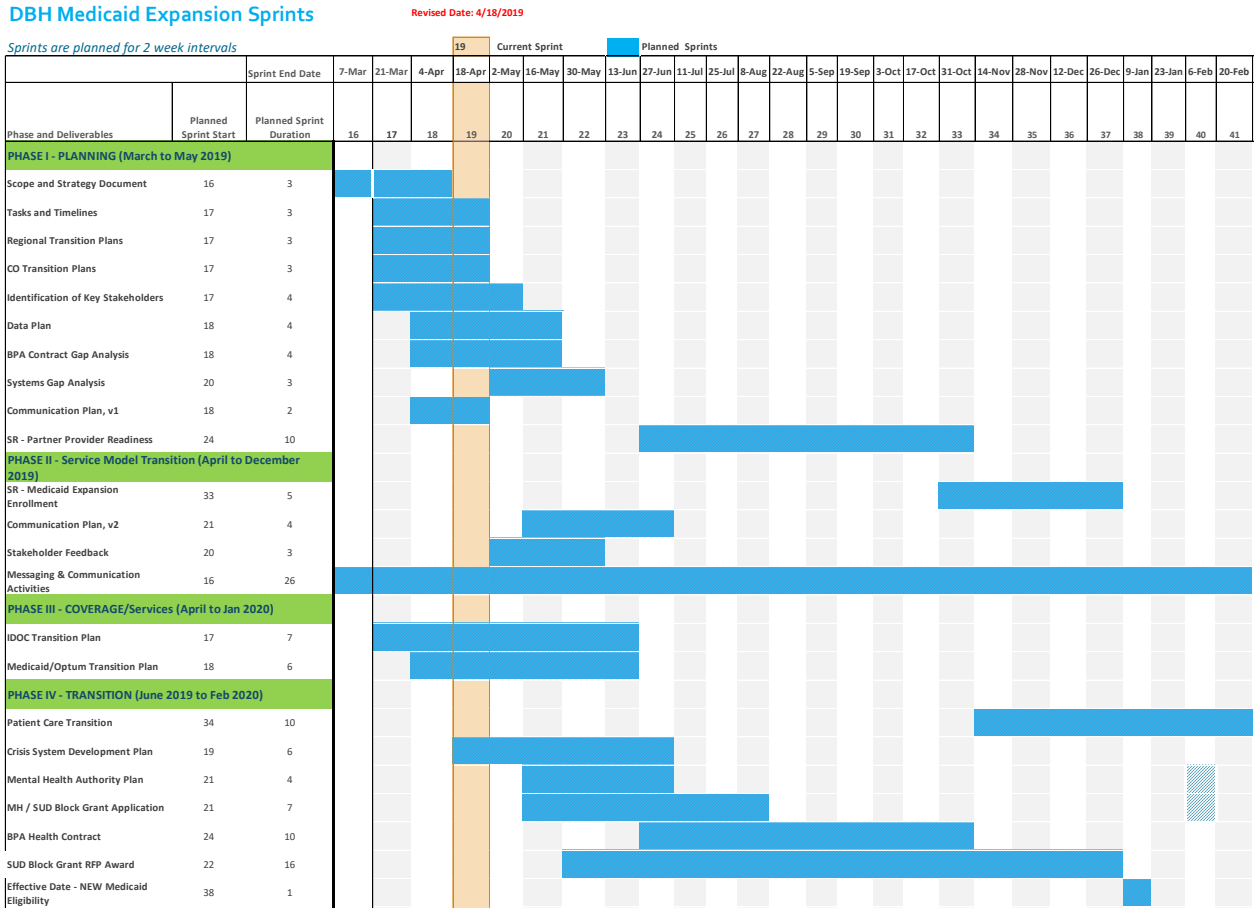
All team members have a responsibility to identify risks and issues that may impact the project. Risks are prioritized using the below probability matrix. The project manager will capture risks and issues for addressing with sponsors at regularly scheduled meetings. The Risk and Issue log will be maintained on the DBH ME Project SharePoint site.

Probability Matrix

Ranking	Probability	Impact Severity
High	Risk event is very likely to occur Risk event has high probability of occurrence	If risk event occurs, a significant impact to cost, schedule, quality, or customer satisfaction will occur
Medium	Risk event is likely to occur Risk event has medium probability of occurrence	If risk event occurs, a moderate impact to cost, schedule, quality, or customer satisfaction will occur
Low	Risk event is unlikely to occur Risk event has low probability of occurrence	If risk event occurs, a small impact to cost, schedule, quality, or customer satisfaction will occur

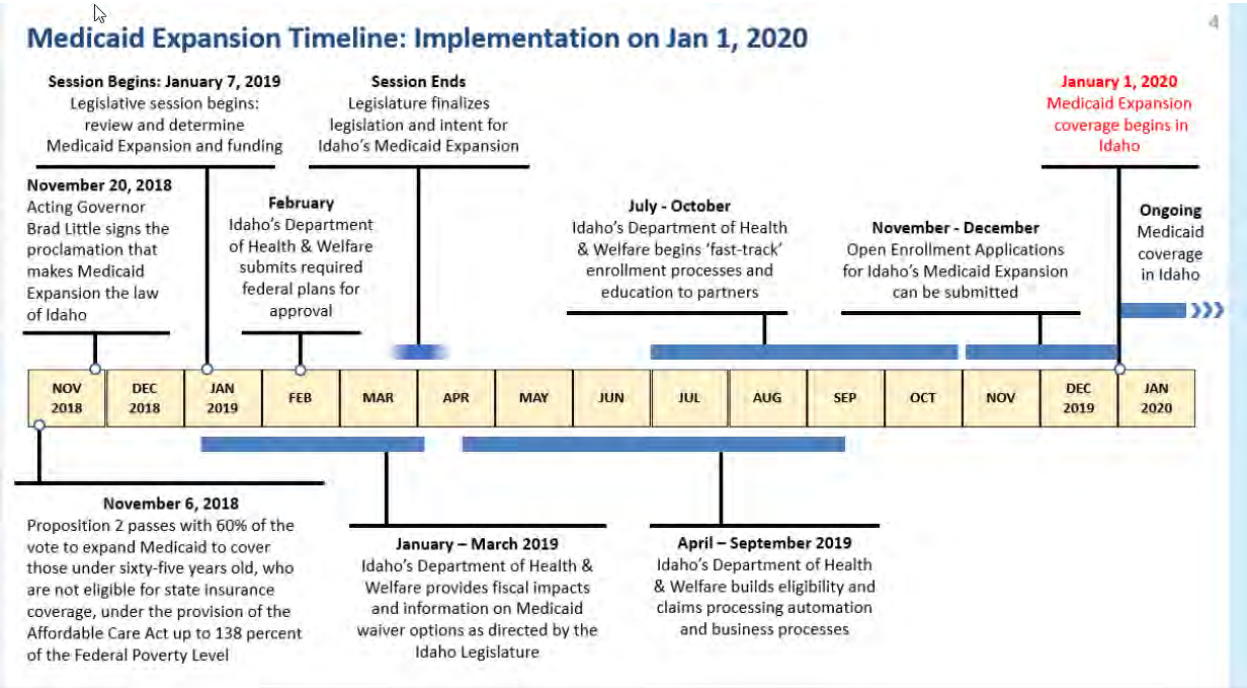
14. Timeline

A high-level timeline for the DBH Medicaid Expansion Project is pictured below. The current timeline contains 27 two-week sprints. Sprint tasks may be rearranged based on resource availability. Additional sprints may be added as additional tasks are identified and agency collaboration takes place.



15. Medicaid Expansion Enterprise Timeline

The Medicaid Expansion Enterprise team in collaboration with all partners has identified the following high-level timeline for Division specific partners alignment.



16. Version History

Version	Date	Name	Comments
1.0	2/26/19	Cindy Day	Initial draft
1.1	3/1/19	Cindy Day	Incorporate initial feedback from Ross and Jamie
1.2	3/4/19	Cindy Day	Incorporate final feedback from Ross, Jamie and Seth
1.3	3/5/19	Cindy Day	Incorporate initial team feedback in 3/5/19 Central Office (CO) Mgrs. Meeting
1.4	3/6/19	Cindy Day	Ross & Jamie review of initial team feedback; updates made
1.5	3/13/19	Cindy Day	Walk through with DBH Steering Committee; feedback incorporated
1.6	3/20/19	Cindy Day	Incorporate regional program manager & central office manager feedback with track changes; ready for final review
1.7	3/27/19	Cindy Day	Added timeline graphic
1.8	3/28/19	Cindy Day	Walk through all feedback with Jamie & Ross; incorporate revisions.
2.0	3/29/19	Cindy Day	Final for distribution to team including Enterprise project leadership
2.1	4/15/19	Cindy Day	Updates made to incorporate Lisa Hettinger feedback, identified questions for Ross, team members

2.2	4/22/19	Cindy Day	Updated to incorporate resolution of Lisa's feedback, updated ME Enterprise timeline graphic

Facts, Figures and Trends 2018-2019

IDAHO DEPARTMENT OF HEALTH & WELFARE

A Message from Director Dave Jeppesen

Welcome to an annual snapshot of the work the Idaho Department of Health and Welfare did in SFY 2018 to promote and protect the health and safety of all Idahoans.

This report illustrates the work this agency does in all eight of its divisions as well as the tremendous impact we have on the lives of all Idahoans. We work with struggling families to make sure they have a safe place to raise their children. We assist people in crisis – whether that's a mental or physical health crisis, or the need for public assistance.

The Behavioral Health community crisis centers continue to assist thousands of Idahoans who suffer from a behavioral health crisis. Idaho had four operating crisis centers in SFY 2018, in Idaho Falls, Coeur d'Alene, Twin Falls, and Boise. Additional crisis centers are being implemented in regions 3 and 6 and at hospitals throughout region 2 as part of an innovative collaboration to meet rural needs. Learn more on page 19.

The Youth Empowerment Services (YES) project has made significant progress in 2018, moving from a lawsuit (Jeff D. v Otter) toward a new system of care for children with Serious Emotional Disturbance (SED). A phased rollout began in January 2018, with full implementation of the transformed children's mental health system of care targeted for mid-2019. Once the new system is fully operational, it will be monitored for three more years to ensure sustainability. Learn more on page 26.

Child and Family Services (CFS) finalized planning for a Three-Year Transformation Project that launched in July 2018. This project's goal is to modernize business practices to allow CFS staff to focus on protecting children and supporting families, rather than unnecessary work and documentation. Learn more on page 40.

The Healthy Connections Value Care Program in Medicaid supports the department's strategic objective to transform Idaho's healthcare delivery system to promote healthier Idahoans while increasing healthcare quality and reducing costs. Starting in 2019, Medicaid will offer financial incentives to providers who control their health care costs and achieve benchmarks related to patient care. Learn more on page 90.

The Division of Public Health was awarded 5-year accreditation status on June 6, 2017, through the national Public Health Accreditation Board (PHAB). IDHW is one of 31 state public health departments to be accredited and has been featured on PHAB's "Accreditation Works" news report. Learn more on page 105.

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Introduction

We have organized the information and data in this handbook to give you an overview of services we provide, numbers of people we serve, and how appropriations are spent. This guide is not intended to be a comprehensive report about the Idaho Department of Health and Welfare, but it should answer many frequently asked questions.

The first few pages of this report provide the big picture, describing the agency's overall budget and major spending categories. Following this overview, we give a brief description of each division and statistical information for many of our programs and services. When possible, we provide historical perspective. The handbook is color-coded by division for easy reference.

To provide the health and human services described throughout this handbook, we diligently follow a Strategic Plan, which details strategic initiatives designed to address gaps in delivering on our key goals:

Goal 1: Improve the health status of Idahoans.

Goal 2: Increase the safety and self-sufficiency of individuals and families.

Goal 3: Enhance the delivery of health and human services.

The department is designed to help families in crisis and to give a hand to vulnerable children and adults who cannot solve their problems alone. Our programs are integrated to provide the basics of food, healthcare, job training, and cash assistance to get families back on their feet so they can become self-reliant members of Idaho communities. Staff in all our divisions depend on each other to do their jobs as they help families solve their problems so we can promote and build a healthier Idaho.

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Our Organization

The Department of Health and Welfare (DHW) serves under the leadership of Idaho Gov. Brad Little. Our director oversees all department operations and is advised by an 11-member State Board of Health and Welfare appointed by the governor.

DHW deals with complex social, economic, and health issues. To do that effectively, our agency is organized into eight divisions: Medicaid, Family and Community Services, Behavioral Health, Welfare (Self-Reliance), Public Health, Licensing and Certification, Operational Services, and Information and Technology. Each division provides services or partners with other agencies and groups to help people in our communities. For example, the Division of Family and Community Services will provide direct services for child protection, but it may partner with community providers or agencies to help people with developmental disabilities.

Each of our public service divisions run multiple individual programs. The Division of Public Health, for instance, includes such diverse programs as Immunizations, Epidemiology, Food Protection, Laboratory Services, Vital Records, Health Statistics, and oversight of Emergency Medical Services and Preparedness.

Many people turn to DHW for help with a crisis in their lives, such as a job loss or a mental health crisis. Along with meeting these needs, DHW programs also focus on protecting the health and safety of Idaho residents. The Division of Licensing and Certification licenses assisted living facilities and skilled nursing facilities, among others. The EMS and Preparedness bureau certifies emergency response personnel such as EMTs and paramedics. The Criminal History Unit provides background checks for people working with vulnerable children and adults, such as in daycares or nursing homes.

One of the guiding principles of all DHW programs is to collect and use performance data so we can ensure we maximize state funding and provide the best services possible. Many of these performance measures are available in this publication. By constantly measuring and collecting performance data, DHW programs are held accountable for continued improvement.

Funding for DHW programs is often a combination of state and federal funds. For example, the federal government pays about 70 percent of each medical claim for service provided to Idaho residents in the Medicaid program. In SFY 2019, the federal government will contribute about 62.5 percent of DHW's total appropriation.

On the following pages you will find more information about our diverse organization and the amazing work our dedicated employees perform to protect the health and safety of Idaho citizens.

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Strategic Plan

Strategic Plan Overview 2019-2023

Governor's Priorities:
Enhancing Economic Opportunity • Empowering Idahoans • Promoting Responsible Government

OUR MISSION
Promote and protect the health and safety of Idahoans.

OUR VISION
Provide leadership for a sustainable, integrated health and human services system.

OUR VALUES
Integrity, high quality customer service, and compassion are the foundation for all Department activities. A focus on these values will lead to success.

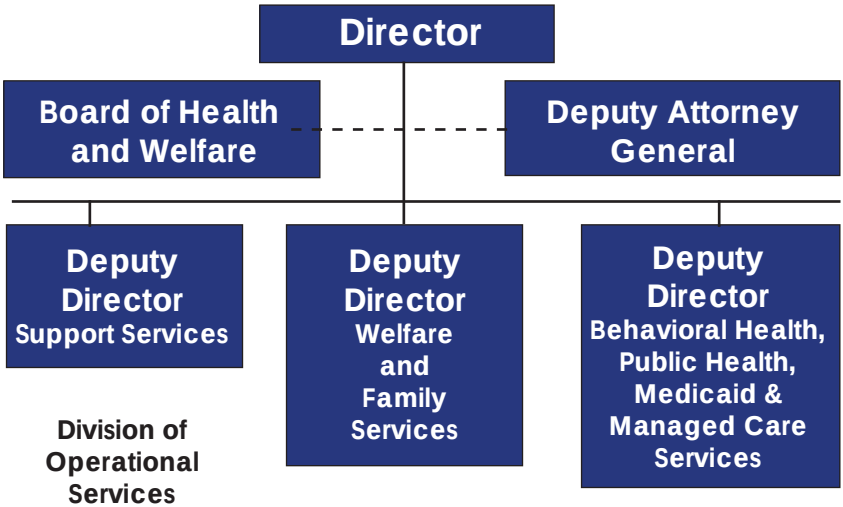
OUR STRATEGIC GOAL
Ensure the delivery of services that promote healthier, safer, self-sufficient Idahoans.

STRATEGIC OBJECTIVES	STRATEGIC INITIATIVES
Objective 1: **Transform Idaho's healthcare delivery system to promote healthier Idahoans while increasing healthcare quality and reducing costs**	• Advance Idaho's healthcare delivery system to enable Idahoans to live healthier lives, to improve healthcare services, and to reduce the cost of healthcare • Control Medicaid costs by financially rewarding providers and organizations that deliver measurably better care to our participants • Improve the children's mental health system in Idaho for children with serious emotional and behavioral disorders
Objective 2: **Protect children and vulnerable adults**	• Ensure children who have experienced abuse or neglect have safe, permanent homes • Develop and implement effective residential care for adult Idahoans with severe, chronic mental illness
Objective 3: **Promote stable and healthy Idahoans through medical coverage, program access, support services, and policy**	• Reduce suicide attempts and deaths in Idaho by collaborating with multi-sector stakeholders • Improve access to residential care settings for residents with Alzheimer's or dementia • Reduce opioid addiction and overdose deaths in Idaho • Provide job training and education to low-income adults receiving state assistance, to help them gain stable, full time employment and eventually move to self-sufficiency
Support System Strategic Initiatives	• Empower Idahoans to make informed decisions to improve their lives by connecting them to community services through the "Live Better Idaho" website • Deliver services to our customers in a safe environment by providing employees with tools and resources for preventing or responding to potentially violent situations • Protect our network and sensitive data by enhancing cybersecurity; and improve the efficiency of department operations by integrating information systems

IDAHO DEPARTMENT OF HEALTH & WELFARE

Read the entire strategic plan at https://healthandwelfare.idaho.gov/AboutUs/StrategicPlan/tabid/134/Default.aspx

Organizational Chart



Division of Operational Services

Division of Information and Technology

Division of Licensing and Certification

Financial Services

Audits & Investigations

Public Information and Communications

Division of Welfare

Division of Family and Community Services

- Southwest Idaho Treatment Center

Division of Medicaid

Division of Behavioral Health

- State Hospital South
- State Hospital North

Division of Public Health

Office of Healthcare Policy

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Office of the Director

Dave Jeppesen, Director, (208) 334-5500

The Office of the Director oversees and sets the vision for the entire department, working with the Governor's office and the Idaho Legislature to provide policy direction for services and programs that are effective and economically sound.

The Director's Office sets a high standard for customer service and ensures implementation of DHW's Strategic Plan.

The office relies on the Executive Leadership Team to help formulate policy. The executive team is comprised of members of the Director's Office, division administrators, regional directors, and administrators of State Hospital South, State Hospital North, and Southwest Idaho Treatment Center. The Director's Office includes:

- The director.
- A deputy director responsible for Behavioral Health, Medicaid and Managed Care Services, Public Health, and Office of Healthcare Policy Initiatives. (Lisa Hettinger, (208) 334-5500)
- A deputy director responsible for Family and Community Services, Welfare, and the regional directors. (Lori Wolff, (208) 334-5500)
- A deputy director responsible for Support Services, Information and Technology, and Licensing and Certification. (David Taylor, (208) 334-5500)

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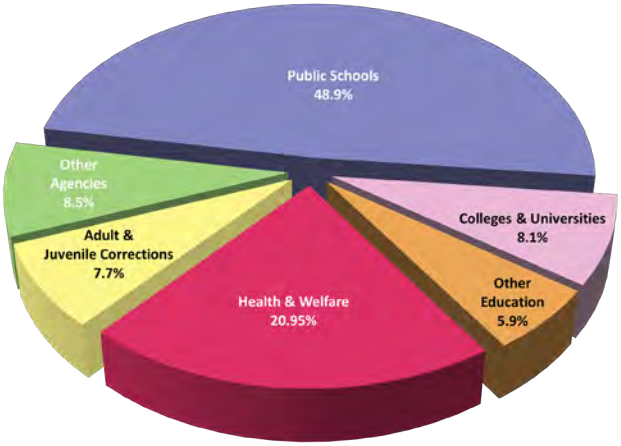
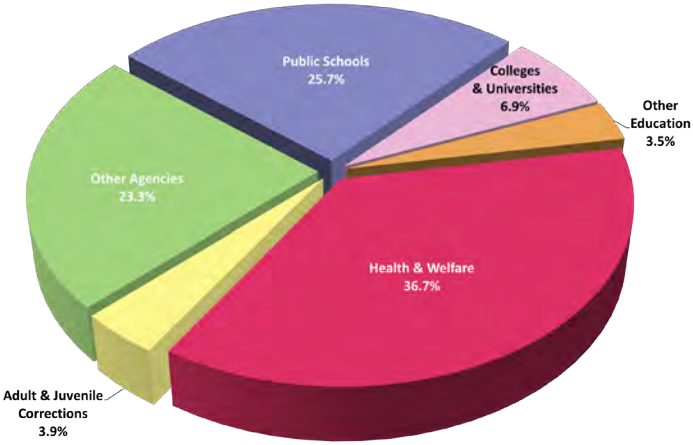
Total State SFY 2019 Appropriations

State General Fund Appropriations for all State Agencies



Total Appropriations for all State Agencies



SFY 2019 Financial Data Summary

In Millions

Functional Area	General	%Total	Total	%Total
Public Schools	$1,785.27	48.9%	$2,140.62	25.7%
Colleges, Universities	295.76	8.1%	576.79	6.9%
Other Education	214.31	5.9%	290.00	3.5%
Health & Welfare	765.24	20.9%	3,053.28	36.7%
Adult & Juvenile Corrections	282.51	7.7%	327.76	3.9%
All Other Agencies	309.64	8.5%	1,936.07	23.3%
Total	**$3,652.72**	**100.0%**	**$8,324.51**	**100.0%**

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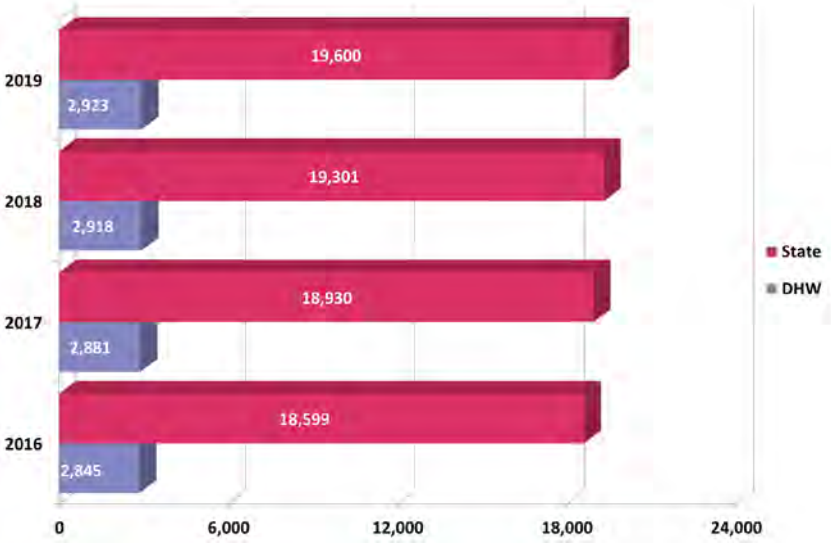
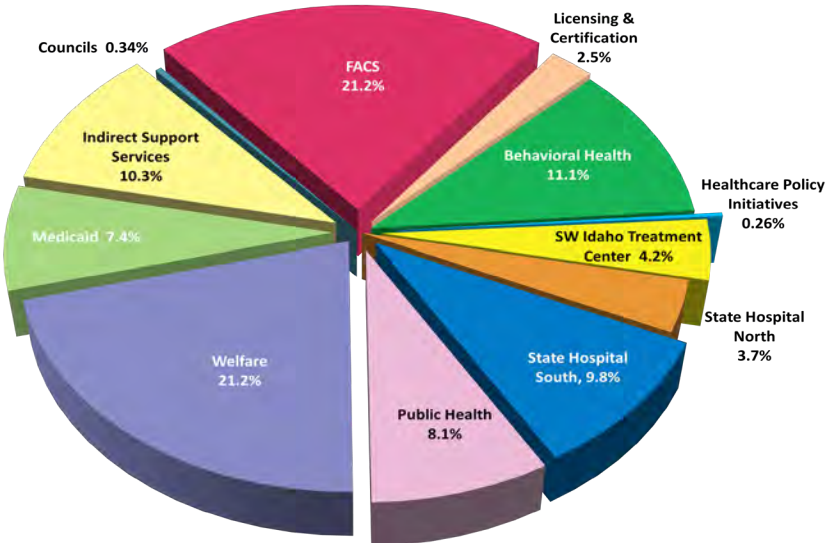
Appropriated Full-Time Positions

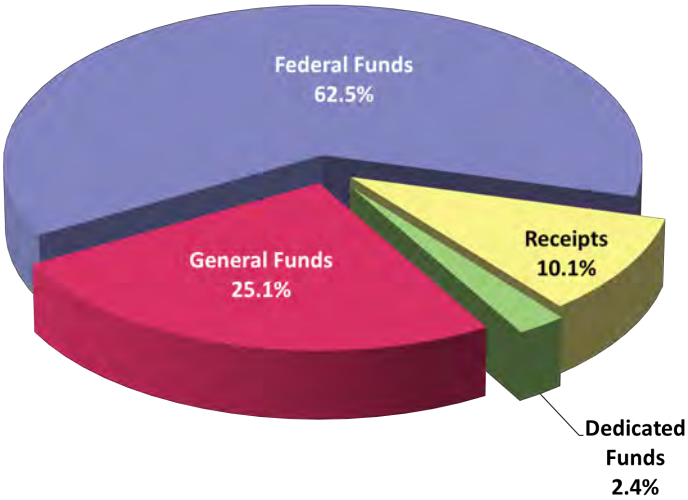
The use of Full-Time Positions (FTP) is a method of counting state agency positions when different amounts of time or hours of work are involved. The department's workforce has remained steady over the last four years, with the state's overall workforce increasing 10.9 percent.



SFY 2019 FTP Distribution - Department of Health & Welfare



SFY 2019 DHW Appropriation Fund Source



Financial Data Summary

Fund Source		Amount
General Funds		$ 765.2 Million
Federal Funds		1,907.1 Million
Receipts		307.9 Million
Dedicated Funds		
Access to Health Insurance	$ 0	
Domestic Violence	520,800	
Cancer Control	344,200	
Central Tumor Registry	120,000	
Liquor Control	650,000	
State Hospital South Endowment	5,061,800	
State Hospital North Endowment	1,549,500	
Prevention of Minors' Access to Tobacco	43,800	
Millennium Fund	2,866,700	
EMS	2,894,200	
EMS Grants	1,400,000	
Hospital, Nursing Home, ICF/ID Assessment Funds	30,000,000	
Immunization Assessment Fund	18,970,000	
Time Sensitive Emergency Fund	426,000	
Technology Infrastructure Fund	8,222,200	
Total Dedicated Funds		$73.1 Million
Total		**$3,053.3 Million**

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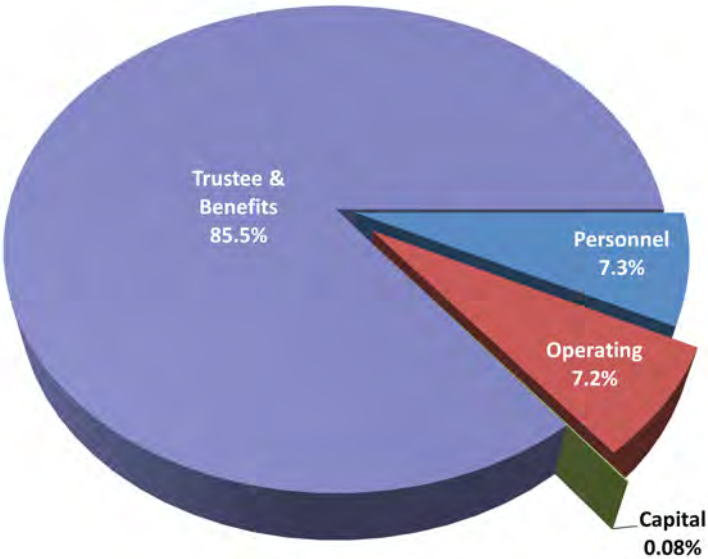
SFY 2019 DHW Appropriation by Expenditure Category

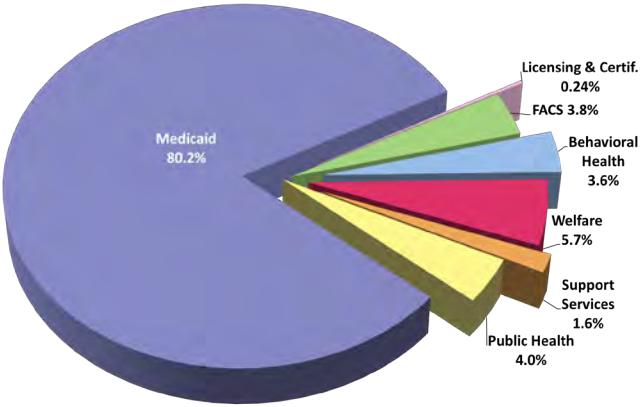


Financial Data Summary

By Object	Amount
Trustee and Benefits	$2,609.2 Million
Personnel Costs	223.0 Million
Operating Expenditures	218.7 Million
Capital	2.4 Million
Total	$3,053.3 Million

- The appropriation for benefits to Idaho citizens increased $163.4 million from SFY 2018 appropriation levels, while personnel costs, operating and capital expenses increased by $29.1 million.
- Payments for services to Idaho citizens make up 85.5 percent of DHW's budget. These are cash payments to participants, vendors providing services, government agencies, nonprofits, hospitals, etc.
- The department purchases services or products from 11,538 companies, agencies or contractors, and more than 41,482 active Medicaid service providers.

Original SFY 2019 DHW Appropriation



By Division	FTP	General	Total
Welfare/ Self-Reliance	**619.50**	**$ 43,445,400**	**$ 175,037,800**
Medicaid			
Low-income children/			
working age adults		182,089,800	731,165,100
Individuals w/Disabilities		217,736,500	1,051,186,300
Dual Eligible		170,904,400	588,094,800
Administration	216.00	14,490,700	79,004,300
Total Medicaid	**216.00**	**$ 585,221,400**	**$ 2,449,450,500**
Licensing & Certification	**71.90**	**$ 1,964,000**	**$ 7,321,500**
Family and Community Services			
Child Welfare	404.80	12,121,900	46,834,000
Foster/Assistance Payments		11,338,200	30,091,500
Service Integration	35.00	736,500	6,067,500
Developmental Disabilities	180.96	11,013,500	21,852,200
SW Idaho Treatment Center	123.75	2,603,200	10,930,900
Total FACS	**744.51**	**$ 37,813,300**	**$ 115,776,100**
Behavioral Health			
Adult Mental Health	210.56	33,771,600	38,350,600
Children's Mental Health	97.67	8,300,600	14,786,700
Substance Abuse	16.00	2,733,200	17,206,300
Community Hospitalization		3,069,000	3,069,000
State Hospital South	285.25	12,193,700	26,181,200
State Hospital North	107.10	7,857,400	9,565,400
Total Behavioral Health	**716.58**	**$ 67,925,500**	**$ 109,159,200**
Public Health			
Physical Health	151.18	5,142,100	102,570,100
EMS & Preparedness	42.84	277,400	11,997,500
Suicide Prevention	4.00	1,233,200	1,323,200
Laboratory Services	39.00	2,259,900	4,896,500
Total Health	**237.02**	**$ 8,912,600**	**$ 120,787,300**
Support Services	**299.60**	**$ 19,508,700**	**$ 48,720,200**
Healthcare Policy	**7.60**	**$ 251,500**	**$ 17,945,400**
Councils	**10.00**	**$ 195,700**	**$ 9,082,000**
Department Totals	**2,922.71**	**$ 765,238,100**	**$ 3,053,280,000**

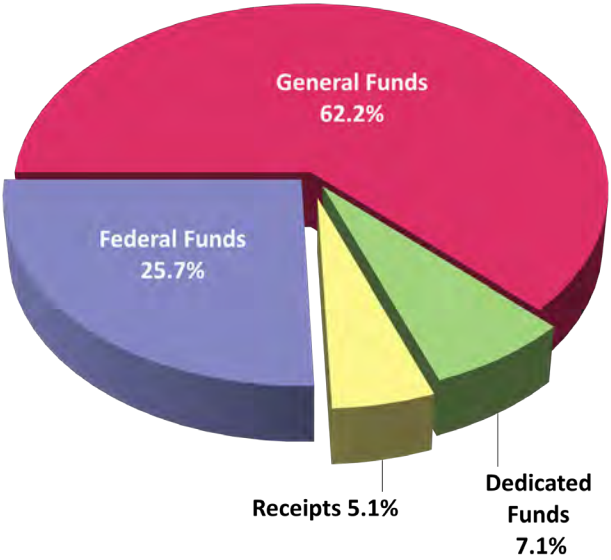
Division of Behavioral Health

Ross Edmunds, Administrator, (208) 334-6997

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.

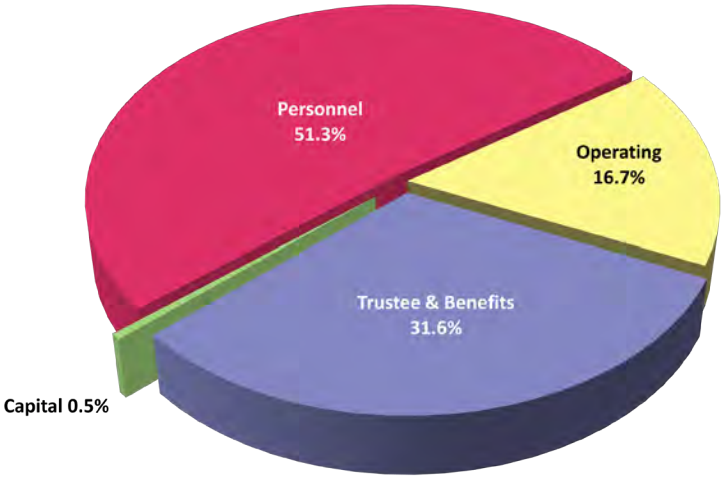
The division includes Children's Mental Health Services, Adult Mental Health Services, Substance Use Disorders Program, and the Idaho Tobacco Project. The division also administers the state's two psychiatric hospitals, State Hospital North and State Hospital South, for people who have been court-ordered into the state's custody.

Behavioral Health SFY 2019 Funding Sources

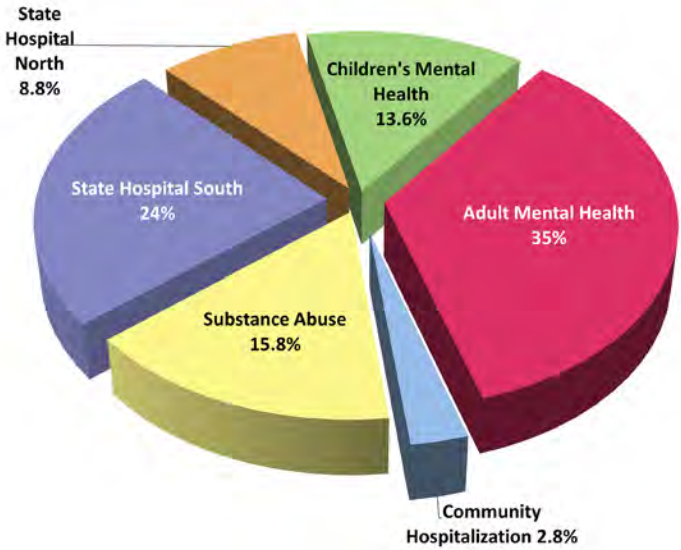


Authorized FTP: 716.58; Original Appropriation for SFY 2019: General Funds $67.9 million, Total Funds $109.2 million; 3.6% of Health and Welfare funding.

Behavioral Health SFY 2019 Expenditure Categories



Behavioral Health SFY 2019 Appropriation by Program



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SFY 2018 Program Highlights

Recovery Community Centers
The division has entered into a contract with Recovery Idaho that provides social support services for individuals with Opioid Use Disorder through Idaho's nine Recovery Community Centers located throughout the state. Services provided under this contract include support groups, recreational activities, and recovery coaching. The recovery centers are also tasked with meeting individuals in hospital emergency departments who have overdosed on opioids to help them access treatment and recovery support services that will help them achieve a life of sobriety. The final component of this contract is for the centers to make this similar type of connection with individuals who have been discharged from a local jail. In the first year of this contract, the Recovery Community Centers provided more than 5,000 recovery support opportunities for individuals seeking assistance from them.

Partnerships with Public Health Districts
The Division of Behavioral Health continues to contract with each of the seven public health districts for administrative assistance and support for the regionally-based Behavioral Health Boards (BHBs). These partnerships have created a venue in which local boards identify community strengths and needs and work collaboratively to capitalize on the strengths while addressing the needs of the local communities. This collaborative approach has resulted in the funding and support of a variety of activities, including community events that promote behavioral health awareness, scholarships for conferences and training, transitional housing needs for individuals with co-occurring disorders, as well as providing recovery coaching services. In addition to working collaboratively with the BHBs, the division and the Division of Public Health have partnered in the area of "prescriber education" in light of the opioid epidemic. Through a contract with DHW, the health districts are educating prescribers on best and safest practices for opioid prescriptions. Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose.

Felony probation and parole population
The division entered into a contract with the Community Health Center Network of Idaho (CHCNI), the umbrella organization for the Federally Qualified Health Care (FQHC) clinic network. The purpose of this contract is to provide mental health services for Idaho's felony parole and probation population. All regions have at least one FQHC providing these services. We continue to work with CHCNI to increase the number of FQHCs participating in the contract to improve access to services.

The following mental health services are provided under this contract:

psychiatric diagnostic evaluation, mental health treatment planning, pharmacological evaluation, pharmacological management, individual counseling, group counseling, family counseling, and care coordination.

By providing these services, we anticipate probation and parole clients will be more successful in their reintegration into the community and less likely to re-offend and face subsequent reincarceration. Data collected from CHCNI will be cross-referenced with Idaho Department of Correction data to determine impacts to the recidivism rates for this population because of these services.

Homes with Adult Residential Treatment (HART)

The Division of Behavioral Health budgeted $2 million to continue the safe and stable housing supplemental payments to assisted living facilities that provide care for adults with serious and persistent mental illnesses as well as to pilot the Homes with Adult Residential Treatment (HART) model.

Supplemental Safe and Stable payments were continued to support approximately 35 assisted living facilities with the provision of critical residential services. The HART demonstration project was initiated to pilot an intensive, treatment-oriented, residential living program for individuals with a serious and persistent mental illness. Contracts have been implemented with four HART facilities across the state.

The HART provides a safe and therapeutic homelike environment that includes meals, living space, assistance with daily living, and clinical treatment services. Each HART provider is required to be an Optum-approved Idaho Behavioral Health Plan provider and able to deliver an array of treatment services including assessment, treatment planning, psychotherapy, community/peer supports, Community Based Rehabilitation Services (CBRS), group therapy, case management, and medication services. It is hoped the HART model will allow for the provision of clinical treatment interventions to better address behavioral health-related issues that have not been able to be addressed without evicting the resident or escalating the resident to a crisis or emergency facility. The division will gather outcome data to determine whether the HART model is a more effective approach to the care of Idahoans with serious and persistent mental illness.

Psychiatric Hospitalization/High Risk Adult Unit

The Department of Health and Welfare was appropriated funding to construct a new adolescent state psychiatric hospital in the Treasure Valley. The adolescent hospital is expected to be complete in July 2020. There are a couple primary reasons for this project: 1) Over 70% of the adolescents who go to the state hospital are from the Treasure Valley; and 2) The state needs to free up space at State Hospital South in Blackfoot for a high-risk unit. In addition to the funding for the construction of the adolescent hospital, the Legislature appropriated funding to remodel and retrofit the current adolescent hospital at State Hospital South so it can be used

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to care for a higher-risk, more violent adult population.

Overall, this will not increase the number of adolescent beds in the state, but it will add adult psychiatric beds to the state system. These beds are highly needed and will match the needs of the more acute, dangerous, and violent population DHW is trying to serve today.

Adult Mental Health Transformation

The adult mental health system in Idaho has improved significantly in the past five years. There are far more services, programs, and resources than in the past. However, these enhancements to the current system of care continue to struggle with meeting the needs of a growing population with increases in the diagnosis of mental illness in Idaho.

The department contracted with the Western Interstate Commission for Higher Education (WICHE) to update and make recommendations to a decade-old gap and resource analysis that WICHE completed under commission from the Legislature. The updated report explains the progress made since the original report in 2008. However, there is still a need for more effective use of the current resources provided for mental health care in Idaho as well as for additional resources. It is clear there needs to be a strategic path forward in Idaho, with broad stakeholder input. The department is leading the collaborative WICHE Steering Committee to ensure the entire system has input on the strategic path forward.

Behavioral Health Crisis Centers

The Behavioral Health community crisis centers continue to meet the needs of thousands of Idahoans who suffer from a behavioral health crisis. Idaho currently has four crisis centers, operating in Idaho Falls, Coeur d'Alene, Twin Falls, and Boise. Additional crisis centers are being implemented in regions 3 and 6, and at hospitals throughout region 2 as part of an innovative collaboration to meet rural needs.

The crisis centers continue to see a wide variety of patients with very challenging needs. They have been highly effective in reducing unnecessary hospitalization and incarceration. As each of the centers have opened their doors, they have quickly become a significant and important part of each communities' continuum of care and services for people suffering from a behavioral health crisis.

The primary challenge with the crisis center model for each community is the requirement for each center to submit a plan to become 50 percent self-sustaining. The plan is due to the state by the end of the center's second year of operation. As of this writing, the centers in Idaho Falls and Coeur d'Alene have reached the full two years and submitted their plans. The plan for Twin Falls will be presented to the 2019 Idaho Legislature as intent language indicates.

The Behavioral Health Crisis Center of Eastern Idaho in Idaho Falls opened in December 2014. The Northern Idaho Crisis Center in Coeur d'Alene opened in December 2015. The Crisis Center of South Central Idaho in Twin Falls opened in October 2016. The Pathways Community Crisis Center in Boise opened in December 2017. The crisis centers in Regions 2, 3, and 6 are expected to open in early 2019.

Behavioral Health Crisis Center of Eastern Idaho				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Crisis center visits	735	1,950	2,481	2,439
Clients served (unduplicated)	377	689	707	824
Average length of stay (hours)	11.51	16.66	19.28	21.67
Diagnosis type				
• **Substance use only**	82	157	362	275
• **No significant mental health or substance use**	22	37	63	49
• **Mental health only**	264	876	814	764
• **Mental health and substance use**	298	835	1,224	1,289
• **Inadequate information**	34	19	10	29

Northern Idaho Crisis Center				
		SFY 2016	SFY 2017	SFY 2018
Crisis center visits		615	1,118	1,621
Clients served (unduplicated)		414	699	999
Average length of stay (hours)		7.05	7.56	8.46
Diagnosis type				
• **Substance use only**		25	54	87
• **No significant mental health or substance use**		29	17	77
• **Mental health only**		214	543	760
• **Mental health and substance use**		146	288	533
• **Inadequate information**		72	45	63

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Behavioral Health Crisis Center of South Central Idaho			
		SFY 2017	FY 2018
Crisis center visits		1,031	2,104
Clients served (unduplicated)		297	527
Average length of stay (hours)		19.60	19.88
Diagnosis type			
• Substance use only		126	175
• No significant mental health or substance use		18	7
• Mental health only		240	429
• Mental health and substance use		528	1460
• Inadequate information		32	14

Pathways Behavioral Health Community Crisis Center			
			FY 2018
Crisis center visits			742
Clients served (unduplicated)			469
Average length of stay (hours)			11.89
Diagnosis type			
• Substance use only			50
• No significant mental health or substance use			16
• Mental health only			302
• Mental health and substance use			235
• Inadequate information			87

NOTE: Pathways Behavioral Health Community Crisis Center opened in December 2017 in Boise, resulting in only a partial year of data.

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Children's Mental Health Services

The Children's Mental Health program is a partner in the development of a community-based system of care for children with a serious emotional disturbance (SED) and their families. The program provides crisis intervention, case management, and other supports that increase the capacity for children with SED and their families to live, work, learn, and participate fully in their communities. Most treatment services are delivered by private sector providers in the community through referrals from regional behavioral health centers operated by the Division of Behavioral Health.

Parents and family members play an essential role in developing a system of care. They are involved at all levels of development, including the making of policies, administrative rules, and laws, as well as their own service plans. Without family member involvement and the support to sustain their involvement, the system of care would be unable to achieve positive outcomes for children and their families.

Functional Assessment Tool

The Child and Adolescent Needs and Strengths (CANS) is Idaho's new tool for measuring the functional impairment of children and youth seeking to participate in the Youth Empowerment Services (YES) system of care. It replaces the division's Child and Adolescent Functional Assessment Scale (CAFAS) as the eligibility and outcome measure for children and youth. Both the CANS and the CAFAS are backed by extensive research supporting their validity and sensitivity to measure change and progress. The division's regional behavioral health centers used the CAFAS for the first half of SFY 2018 before transitioning to the CANS.

Improved Functioning Measured by CAFAS

NOTE: 72 percent of youth receiving two or more CAFAS scores have demonstrated improved functioning during the past year. Of those, 94 percent demonstrated meaningful and reliable improvement with a score change of 20 points or more. CAFAS use was discontinued on Dec. 31, 2017. SFY 2018 data represents 7/1/2017 – 12/31/2017.

Collecting data on the most common CANS treatment needs and useful strengths can inform the system of the direction that will best support those it is serving. Identifying the most prevalent system-wide needs could indicate the addition of services and supports to address these needs should be explored, or help determine which evidence-based practices may be a valuable investment. Strengths describe the assets of the child or youth and family that can be used in treatment planning to support and advance healthy development. As staff begins to collect more CANS data, they will be able to monitor statewide outcomes progress by analyzing needs and strengths from reassessment and discharge CANS.

The following figures show the most prevalent actionable needs and useful strengths of the 1,084 youth who were administered an initial Children's Mental Health CANS between January and June 2018.

Strengths		
	Number of CANS with strengths identified	Percentage of total
Legal permanency	1027	95%
Relationship permanence	967	89%
Family	873	81%
Cultural identity	860	79%
Talents / interests	777	72%

Needs		
	Number of CANS with needs identified	Percentage of total
Family	701	65%
Emotional/Physical Regulation	699	64%
Anger Control	682	63%
Oppositional Behavior	640	59%
Impulsivity	630	58%

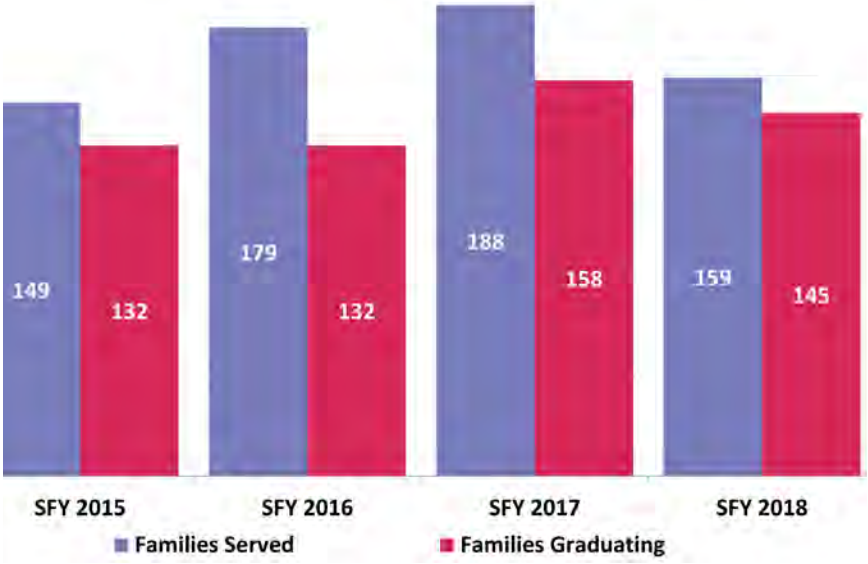
NOTE: Data is system wide and includes CANS assessments completed between Jan. 1, 2018, and June 30, 2018, by the Division of Behavioral Health, community providers, and independent assessor agencies.

Parenting with Love and Limits

The Children's Mental Health program continues to provide Parenting with Love and Limits (PLL) statewide. This evidence-based program is effective 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. Thirty-one 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 families who do not participate in PLL.

Youth receiving Parenting with Love and Limits showed significant reductions in negative behaviors as measured by an instrument called the Child Behavior Checklist. A multi-year evaluation indicates negative behaviors declined in the areas of aggression, rule breaking, conduct disorder, oppositional defiant behaviors, externalizing behaviors, and internalizing behaviors. Of the 159 new families served, 145 families graduated. Since its start in 2008, PLL has served a total of 1,701 families in all seven regions statewide.



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Respite Care

As a result of the Youth Empowerment Services (YES) project, in January 2018 agency respite became a Medicaid 1915(i) service available through the Idaho Behavioral Health Plan (IBHP) to Medicaid-eligible members who meet SED qualifications. In an effort to maintain an effective respite system that meets the needs of all Idaho families that have children with SED, the division has continued to issue vouchers through regional behavioral centers for respite services that are provided by a member of the family's natural support. This allows the family caregiver to hire someone from their natural support system who is familiar with the family and may already be equipped to handle the specific situation. Respite is available to all qualified children and youth who are residents of Idaho, under the age of 18, and are voluntarily seeking this service. Respite services can be furnished in the child or youth's home, another home, a foster family home, or another community-based setting.

Behavioral Health and Juvenile Justice

The division 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 diagnosed with a serious emotional disturbance.

Children Receiving Mental Health Services

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Total Children Served	2,554	2,487	2,320	2,332	2,394
Court-ordered 20-511A	600	583	603	509	466
Parenting with Love and Limits	187	149	179	188	159
Case Management	1,494	1,464	1,411	1,360	1,292
Alternate Care	38	46	65	52	47

Youth Empowerment Services

More detailed information, including a glossary, fact sheets, and work updates, is available on the website devoted to this work: www.yes.idaho.gov.

The Youth Empowerment Services (YES) project has made significant progress in 2018, moving from a lawsuit (Jeff D. v Otter) toward a new system of care for children with Serious Emotional Disturbance (SED). The phased rollout began in January 2018, with full implementation of the transformed children's mental health system targeted for mid-2019. Once the new system is fully operational, it will then be monitored for an additional three years to ensure sustainability.

This project is a collaborative effort among Department of Health and Welfare, Department of Education, Department of Juvenile Corrections, and parents, providers, and other community stakeholders. The framework for the project, as described in the court-approved Idaho Implementation Plan, identifies the strategies and tasks being used in developing the services and supports outlined in the Jeff D. Settlement Agreement.

Of greatest significance is the change in the approach to service delivery for children, youth, and their families. The YES system of care relies on a model of service delivery in which all child-serving systems operate in a coordinated manner to support parents and caretakers as the main drivers of the care and treatment they are seeking. Families will receive information, education, coaching, and other supports so they will be able to effectively navigate the system and participate in the decision points along the way.

This system of care approach has demonstrated across the country that collaborative coordinated care, driven by the youth who use it and their families, results in greater positive outcomes for the youth than those systems that do not operate in a coordinated, family driven manner.

The following are accomplishments related to the Youth Empowerment Services project for SFY 2018:

- An annual progress report detailing each of the implementation plan objectives was completed and submitted to the district court and plaintiff's counsel as per the settlement agreement in May 2018. It is available on the YES website: yes.idaho.gov.
- Children with SED whose families' income amounts up to 300% of the Federal Poverty Level (FPL) are now eligible for Medicaid.
- A contract was developed with Liberty Healthcare to administer independent assessments and determine eligibility for YES services. The Independent Assessment process was initiated on Jan. 1, 2018.
- A person-centered service planning process was designed for Med-

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icaid participants. Division of Behavioral Health staff were trained in person-centered service planning.

- Collaborative workgroups focused on the various objectives outlined in the implementation plan continue to meet on a regular basis to accomplish the work. Stakeholder interest remains high and participation in the workgroups is good. Expert consultants continue to offer technical assistance for the implementation of the improved system of care.
- The Interagency Governance Team (IGT) operates as an advisory body for the implementation efforts. This 17-member team includes representatives from the three agency partners, parents, youth, advocates, and providers. The team is currently chaired by a provider member.
- The cross-system Quality Management, Improvement and Accountability (QMIA) Council published its sixth quarterly QMIA report in July 2018. The QMIA reports are available on the YES website.
- The Idaho CANS web-based tool was implemented across Idaho. All applicable Optum Network providers are anticipated to be delivering services to children once they are certified and trained in the CANS by July 2019.
- CANS training to Optum network providers began in April of 2018. Providers who were certified and met the CANS/ICANS training and setup requirements could begin billing for the CANS effective July 1, 2018.
- Staff from Liberty Healthcare, Optum Healthcare, the Division of Behavioral Health, Division of Family and Community Services, and the Department of Juvenile Corrections have been certified and trained in the CANS.
- The ICANS website (icans.dhw.idaho.gov) was launched in March 2018 to meet the needs of agency staff and providers using the ICANS/CANS. Resources and user guides as well as information on available training are on the ICANS website and are referenced on the YES website.
- The YES website continues to be updated and includes collaborative materials and references for each of the audiences identified: parents, youth, providers, and community. The "YES 101," provides an overview of the YES System of Care and is being used in outreach efforts. An electronic version is available on the YES website. The website serves as a public access site for project implementation, reports, fact sheets, training, and other communications.
- Ongoing training and outreach to families and community stakeholder groups is being conducted.

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Adult Mental Health Services

The needs of Idaho adults who have a mental health diagnosis are diverse and complex. The division works to ensure that programs and services, including community-based supports, outpatient services, and inpatient hospitalization services are available to eligible Idaho residents. The division determines eligibility for adult mental health services through screening and assessment. Adult mental health services may be accessed through the division either through an application for services or through a court order for services.

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, peer support specialists, and other mental health workers). Each center offers crisis services and ongoing mental health services.

Crisis Intervention

Crisis intervention services are provided statewide through the adult mental health crisis units. Crisis intervention services include evaluation, assessment, intervention, stabilization, and follow-up planning. Crisis units provide phone and consultation services 24 hours a day, seven days a week.

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 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 SFY 2018, 74 percent of the participants receiving services from the division received crisis services. The remaining 26 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.

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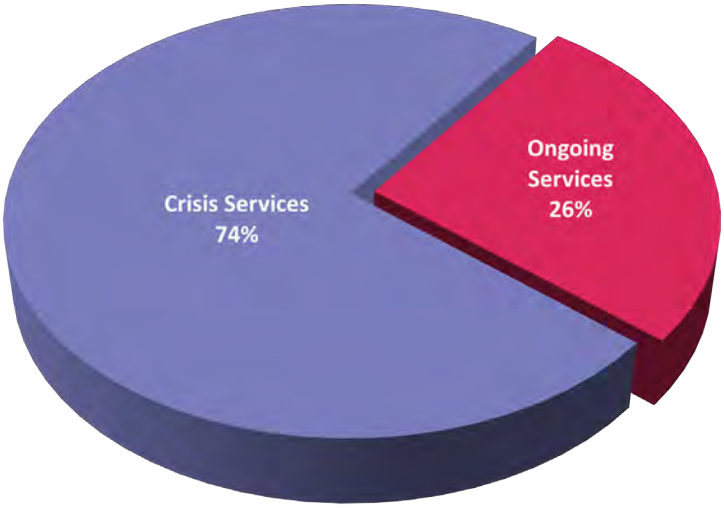
Adults receiving Mental Health Services SFY 2018



Adults Served

The division's regional behavioral health centers provide services to adults determined eligible through a voluntary application process. Eligibility includes service to those who are:

1. Experiencing psychiatric crisis.
2. Receiving treatment by court order.
3. Diagnosed with a serious mental illness (SMI) or a serious and persistent mental illness (SPMI) with no other resources available to meet their needs.

The division's regional behavioral health centers also 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. ACT staff is 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.

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Supportive Services

Community support services are available on a limited basis. These services include outreach, medication monitoring, skill-building services, community-based rehabilitation services, benefits assistance, and housing support.

Assertive Community Treatment (ACT)

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, certified peer support specialists, and recovery coaches.

Services include individualized treatment planning, crisis intervention, peer support services, community-based rehabilitation services, medication management, case management, individual and group therapy, co-occurring treatment, and coordination of other community support services.

Co-occurring Mental Health & Substance Use Disorders Services

According to the National Survey on Drug Use and Health, in 2016 an estimated 43.3 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 to or collaborate with a private agency to provide additional services.

Adult Mental Health Services

	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Adults Served	13,503	13,940	14,358	13,122
Supportive Services (meds, housing and employment)	1,713	2,031	2,107	2,107
Assertive Community Treatment	560	587	573	585
Co-occurring Services	1,777	1,914	2,114	2,097

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State Hospital South

Jim Price, Administrator, (208) 785-8402

State Hospital South (SHS) was established in 1886 in Blackfoot, Idaho. The hospital is currently 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.

Adult patients are referred to the hospital by the regional behavioral health centers after civil or competency restoration commitment from the legal system. Civilly committed patients have been found to be a danger to themselves, a danger to others, or gravely disabled. Competency restoration patients have been found unfit to proceed in the criminal justice system due to mental defect. Restoration patients require the need to modify treatment plans more frequently, and the legal reporting requirements for these patients require considerably more psychologist time for testing and writing reports than for the hospital's patients who are civil commitments.

Patients with increased aggression, substance use disorders, and criminal thinking and behavior require additional staff to maintain safety, and they often require a single room as well as the use of more seclusion and restraints. The requirement for single rooms affects the hospital's occupancy rate and waiting list.

This past year, to manage the risk of elopements from the facility, the hospital extended the height of the fencing that encloses the outside courtyards and added fencing around exterior doors located at the ends of the adult unit hallways. To improve patient safety, alterations were made to patient bathroom doors, and the hospital added padding to seclusion/safe area rooms. Security cameras were also installed in common areas to promote staff and patient safety.

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. The hospital 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.

The Idaho Division of Veterans Services is pursuing plans to develop an Idaho State Veterans Cemetery near the hospital's cemetery. Construc-

tion of the new cemetery could begin in 2019.

During the 2017 legislative session, the Idaho Legislature supported a plan to build a new adolescent hospital in the Treasure Valley. That project is moving forward, with construction expected to be completed in July 2020. The space once used for the adolescent unit at SHS will be converted to adult beds, expanding the facility's capacity with an additional 20 to 25 adult beds.

The 2018 Legislature approved a concurrent resolution permitting the Department of Health and Welfare to enter into an agreement with the Idaho State Building Authority to obtain financing for a new nursing home to be built on the hospital's campus. That project is moving forward quickly. Construction is expected to be completed by July 2020. Syringa Chalet, now 80 years old, will be demolished as part of that project. The new nursing home will expand the number of beds available to elderly residents with mental illnesses who require a skilled nursing level of care.

SHS Adult Inpatient Psychiatric Services				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Adults Patient Days	26,005	28,112	27,734	28,753
Admissions	547	640	582	575
Avg Daily Census	71	76.8	76	78.8
Median Length of Stay (Days)	30	32	34	35
Daily Occupancy Rate	79.2%	85.3%	84.4	87.5%
30-Day Readmission Rate	2.56%	3.75%	1.55%	1.57%
180-Day Readmission Rate	14.26%	15.16%	9.97%	13.04%
Cost/Patient Day	$600	$589	$636	$612

Syringa Skilled Nursing				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Patient Days	8,837	9,355	9,989	10,294
Admissions	14	17	16	8
Occupancy Rate	83.5%	88.1%	94.4%	97.3%
Cost/Patient Day	$621	$604	$623	$604

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Adolescent Unit				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Patient Days	4,562	4,574	3,997	4,088
Admissions	149	131	116	124
Occupancy Rate	78.1%	78.1%	68.4%	70.0%
Median Length of Stay (Days)	29.0	31	29	31
30-Day Readmission Rate	2.7%	0%	0%	0%
180-Day Readmission Rate	8.1%	4.6%	7.8%	5.6%
Cost/Patient Day	$724	$747	$848	$837

State Hospital North

Todd Hurt, Administrative Director, (208) 476-4511

State Hospital North (SHN) in Orofino, Idaho, is a licensed 60-bed psychiatric hospital providing primarily involuntary inpatient treatment for adults in psychiatric crisis who are committed to the Department of Health and Welfare. State Hospital North collaborates with patients, their families, and the referring Regional Behavioral Health Centers to develop targeted goals and objectives for the individual's treatment episode while simultaneously focusing on critical supports and arrangements for follow-up care after discharge.

Hospitalization at State Hospital North is intended to be of a short to intermediate duration with the key objective of stabilizing presenting psychiatric symptoms and assisting patients to return to their communities in the shortest reasonable period of time. The length of stay for inpatient care is variable based on patient needs and prevailing best practices within the mental health field. The median length of stay for the recent year is about 44 days.

Admissions to State Hospital North are initiated by the local community and referred through the Regional Behavioral Health Centers. Treatment is individualized and is delivered by interdisciplinary treatment teams consisting of psychiatrists, nurse practitioners, medical doctors, licensed nurses, psychiatric technicians, master's level clinicians, psychosocial rehabilitation specialists, therapeutic recreation specialists, dietitians, and support personnel.

Employees at the hospital deliver many specialized services that include assessments and evaluations, medication management, individual and

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group therapies, opportunities for community integration, involvement in recreational and educational activities, nutrition, fitness, and discharge planning. The facility uses the Recovery Approach in treatment, retains a trauma-informed culture, and promotes a therapeutic alignment with the person as we develop a self-directed care plan with key recovery goals.

SHN Adult Inpatient Psychiatric Services

	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Adults Patient Days	16,834	18,026	17,644	18,070
Admissions	243	233	206	278
Avg Daily Census	46	49	48	44
Daily Occupancy Rate	77%	82%	81%	74%
Median Length of Stay (Days)	48	55	55	44
30-Day Readmission Rate	2.1%	<1% (.009%)	1.5%	< 1 %
180-Day Readmission Rate	13.6%	7.7%	6.3%	7.2 %
Cost Per Patient Day	$509	$492	$558	$619

Substance Use Disorders Program

The Substance Use Disorders (SUD) Program includes:

- Treatment and recovery support services, including Medication Assisted Treatment (MAT) for opioid use disorder.
- Management of the SUD provider network.
- Training for treatment staff.
- Behavioral health program approval.
- Tobacco inspections.

Services for SUDs are delivered through contracts with private and public agencies with a focus on best practices and evidence-based programs. The goal of treatment is to help participants live their lives in recovery. The division served 3,444 unduplicated Substance Use Disorder clients in SFY 2018.

Idaho currently has a provider network developed and managed by BPA Health. The network contains 78 state-approved treatment providers at 132 locations. Treatment services include, but are not limited to, detoxification, outpatient therapy, residential treatment and Medication Assisted Treatment (MAT).

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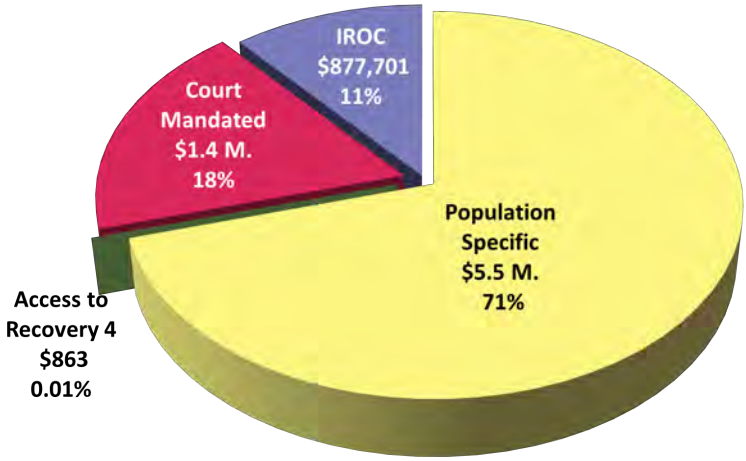
The network also includes 26 stand-alone recovery support service providers at 65 locations. Recovery support services help people enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice. Recovery support services include case management, family life skills, recovery coaching, safe and sober housing for adults, childcare, transportation, and drug testing. Specialized services are available for pregnant women, women with dependent children, and adolescents.

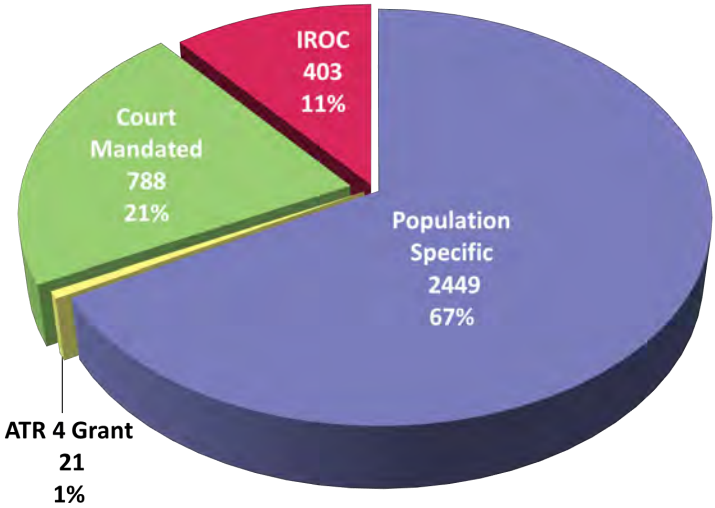
In 2017, Idaho received a $2 million federal grant to help fight the opioid epidemic. With that funding, the division created the IROC (Idaho's Response to the Opioid Crisis) program, serving Idahoans suffering from Opioid Use Disorder (OUD). That funding was renewed for another year in May 2018. From May 2017 to July 2018, the program provided treatment services to 729 individuals with OUD and provided recovery support services on nearly 9,000 occasions.

SFY 2018 Substance Use Disorders Expenditures by Priority Population



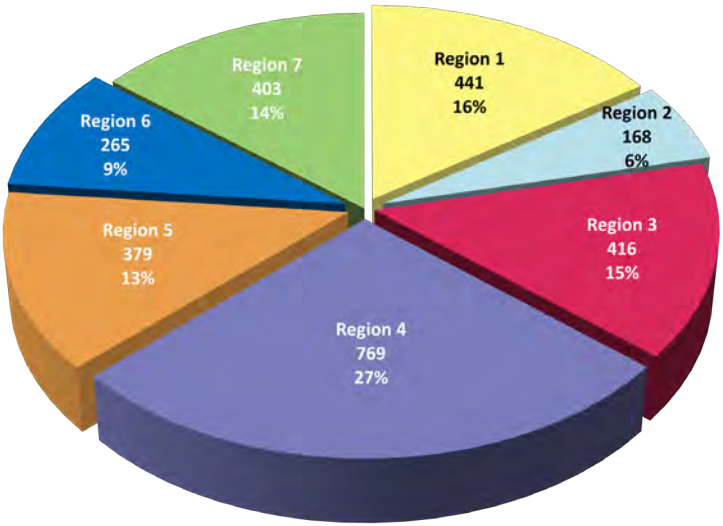
NOTE: Population Specific includes adolescents, adults, IV drug use, women with children, child protection, Idaho Youth Treatment Program clients, and patients at state hospitals.

SFY 2018 Substance Use Disorders Treatment by Priority Population



NOTE: The Idaho Department of Health and Welfare collaboratively funded treatment for some clients in the Population Specific priority populations. Participants may be served in more than one priority population.

SFY 2018 Substance Use Disorders Client Intakes by Region



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The Idaho Tobacco Project

The Idaho Tobacco Project works with retailers to prevent youth access to tobacco products. The Tobacco Project provides retailers with educational materials, no-cost permits, and supports inspections to evaluate compliance with the state statute that prevents minors' access to tobacco. Educational materials include a monthly newsletter, a training CD, point-of-sale resources (posters near cash registers or in staff areas), and online training resources (preventthesale.com/Idaho) to help retailers educate their staff.

To encourage retailers to be vigilant against selling tobacco to minors, youth-purchase inspections are conducted annually at every retailer site where youth can legally enter. In 1998, the first year that statewide youth-purchase tobacco inspections were conducted, the violation rate was 56.2 percent. In 2017, the survey of inspections resulted in a violation rate of 8.54 percent. The chart below summarizes the outcome of the inspections conducted for the past five years.

Inspections					
	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Permittees	1,654	1,663	1,639	1,581	1,398
Inspections	1,976	1,798	1,768	1,755	1,709
Violations	154	135	157	118	146
Non-Compliance Rate	9.1%	7.51%	8.88%	6.72%	8.54%

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Division of Family and Community Services

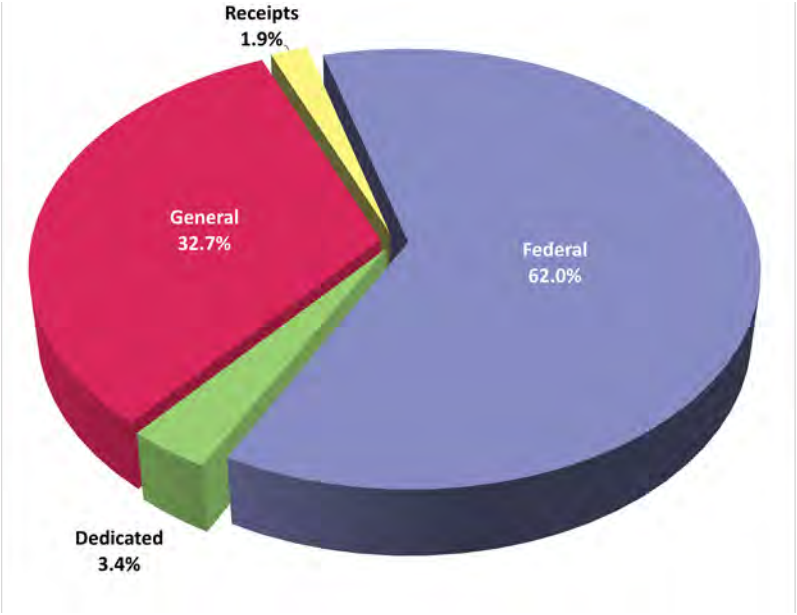
Miren Unsworth, Administrator, (208) 334-0641

The Division of Family and Community Services (FACS) directs many of the department's social and human service programs. These include child protection, adoption, foster care, developmental disabilities, and screening and early intervention for infants and toddlers with developmental delays or disabilities.

FACS also provides navigation services that connect individuals and families in crisis with services that help stabilize their lives. FACS programs work together to focus on the entire family, building on strengths while supporting and empowering them.

The division also administers Southwest Idaho Treatment Center. This facility provides residential care for people with developmental disabilities who face severe behavioral challenges or significant medical complications.

FACS SFY 2019 Funding Sources



Authorized FTP: 744.51; Original Appropriation for SFY 2019: General Funds $37.8 million, Total Funds $115.8 million; 3.8% of Health and Welfare funding.

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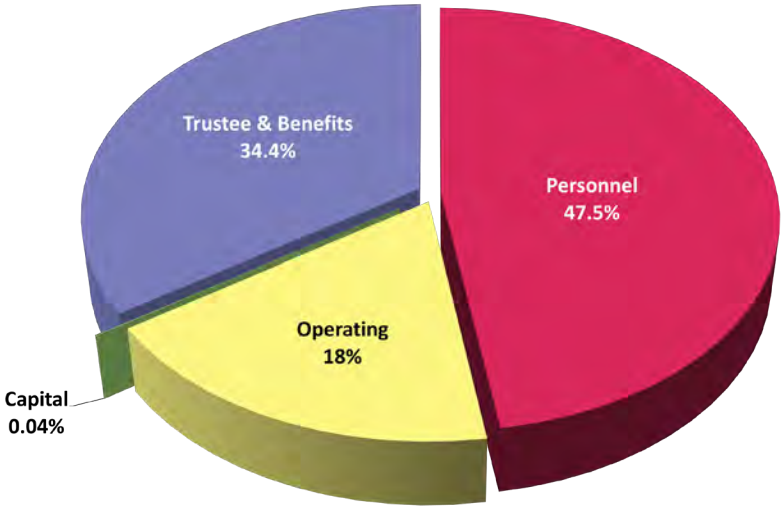
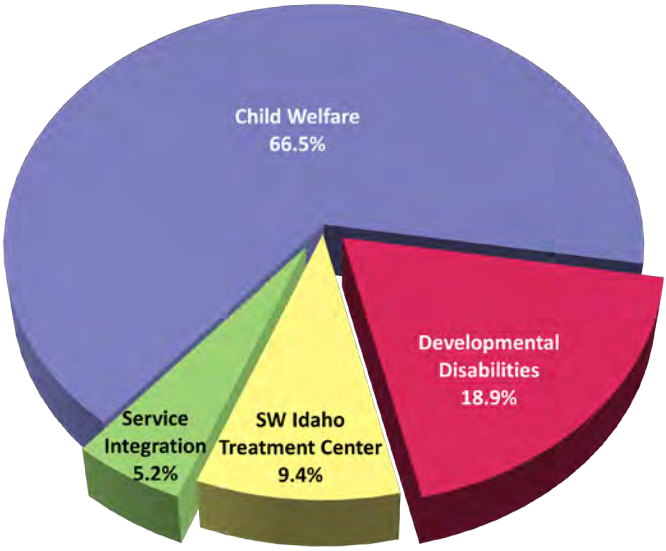
FACS SFY 2019 Expenditure Categories



Note: Personnel costs account for a greater share of expenditures in FACS because of the nature of community-based, client-focused services and 24/7 staffing levels required at Southwest Idaho Treatment Center.

FACS SFY 2019 Spending by Program



Note: Child Welfare includes Child Protection, Foster Care, and Adoption. Almost half of Child Welfare expenses are for Foster Care/Adoptive assistance payments to families and providers.

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SFY 2018 FACS Division Highlights

During SFY 2018, Child and Family Services (CFS) finalized planning efforts for a Three-Year Transformation Project that launched in July 2018. This project is aimed at addressing long-standing pain points within the program. The goal of the project is to ensure Child and Family Services modernizes its business practices, allowing staff to focus on the critical goal of protecting children and supporting families while removing unnecessary work and documentation that currently takes up the majority of their time and effort.

The Three-Year Transformation Project involves:

1. Organizational Restructuring
A new bureau in FACS will focus on business design and process improvement, areas in CFS identified as pain points. These organizational changes are crucial to improving consistency in statewide practice and providing continuity of child protection services for families, children, and foster parents. This bureau will provide process engineering, training, implementation supports, and data gathering and reporting. Redesigning business practices and processes with a focus on decision-making will allow the program to better serve Idaho families, effectively use its resources, and create lasting improvements.

2. A Systemic Focus on Business Priorities
The current child welfare environment is reactive to many inputs and pressures, but often the efforts to change are singular. When reacting to each passing challenge or creating one-time solutions, long-term and sustainable solutions are not implemented. The transformation project is a deliberate staging of priorities over a three-year cycle to ensure improvements in all critical areas we have identified. These include:

- Improving the safety assessment process and timeliness of safety decisions.
- Improving in-home safety plans and prevention activities to keep children from coming into the state's care.
- Improving concurrent planning processes to make permanency placement decisions as quickly as possible.
- Improving the permanency placement process for children under the age of 3 years.
- Creating improved case management and workflow standards across the child welfare workload.
- Redesigning foster care recruitment and licensing processes, as well as training supports.
- Improving performance visibility and data accessibility across all units of work.
- Designing and implementing a new Child Welfare Automated System.

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- Determining strategies and an implementation schedule to ensure compliance with the federal Family First Prevention Services Act.

3. Stabilizing Current Workforce
Turnover within the program continues to be a challenge in getting ahead of workload problems across the state. Although some regions have stability in their workforce, some do not. Trends show that we have better outcomes in areas where positions remain filled and we have longer tenure. Our goal during this project is to improve stability in our statewide workforce by investing in pay increases for social workers, reducing stress and overload in case assignment and workload, providing better tools and training to help staff be successful in their everyday work, and providing data and case management tools to improve decision-making and manage performance.

4. Aligning Business and Technology
FACS will replace its outdated Child Welfare Automated Information System. Idaho's 2018 Legislature approved $ 3.9 million in state general funds for the first year of this three-year plan to begin our efforts to implement a new Comprehensive Child Welfare Information System (CCWIS). CCWIS is a federal classification for a new generation of automated systems with improved case management functionality. FACS will contract with a technical integrator to configure and customize case management software on the Microsoft Dynamics Platform and a business engineering firm to define new business designs and streamline existing processes.

Service Integration

2-1-1 Idaho CareLine

The Idaho CareLine is a statewide, bilingual, toll-free information and referral service linking Idaho's residents to health and human services. 2-1-1 was created through a national initiative for an easy-to remember, three-digit phone number for the sole purpose of providing confidential access for callers to obtain local community health and human services information. In 2002, the Idaho CareLine was designated as the statewide 2-1-1 call center in Idaho.

In SFY 2018, CareLine participated in 54 community outreach events and promoted various IDHW and community campaigns designed to increase the health, stability, and safety of Idahoans.

Idaho CareLine facilitated 98,362 information contacts during SFY 2018; however, staff provided 122,361 individual referrals. The variance between the two figures is a direct result of CareLine's software, which counts individual calls or contacts, rather than the number of referrals provided to

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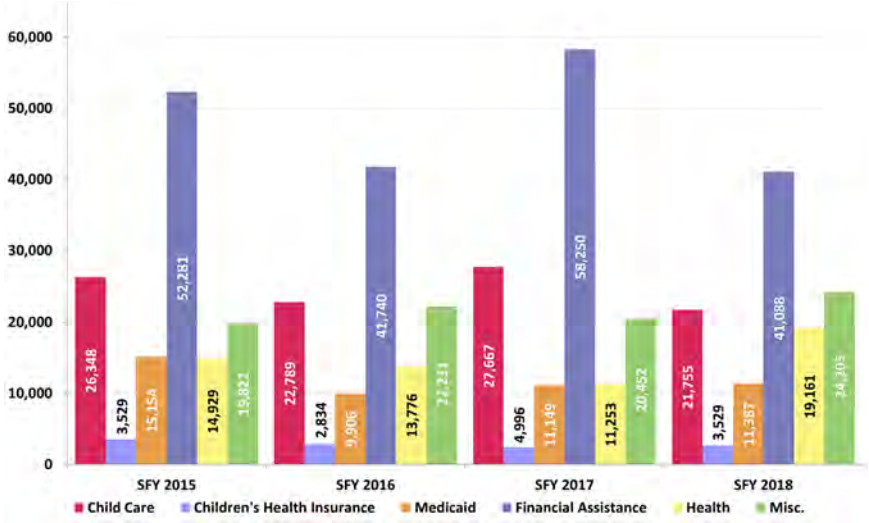
a customer during an individual call or contact. CareLine's referral database currently has 11,382 active services relating to 3,558 programs. This promoted various department and community campaigns designed to increase the health, stability, and safety of Idahoans.

CareLine's resources can be accessed by dialing 2-1-1 or 1-800-926- 2588. Agents assist callers 8 a.m. to 6 p.m. MST Monday through Friday. Resources also can be found by visiting www.211.idaho.gov; or by texting a zip code to CareLine at TXT211. Additional information can be found by visiting 2-1-1 on Facebook and Twitter. Emergency and crisis referral services are available after hours.

Number of Calls Received by Idaho CareLine



Resource and Service Navigation

Resource and Service Navigation identifies and develops resources to support struggling families so they can achieve long-term stability using customized service plans focused on family strengths and community supports. Navigators work with individuals, children, and families for up to 120 days to help them achieve their goals for long-term stability, well-being, and health and safety.

During SFY 2018, Navigation received 8,369 referrals. Navigation provided case management to 3,088 households, made up of 9,037 individuals. Of those, Navigation provided monetary assistance to 1,685 households, made up of 6,189 adults, children, and youth. Navigation provided career enhancement to 75 households, made up of 254 adults, children, and

youth. Navigation services distributed $1.3 million in emergency assistance and career enhancement support, while leveraging community funds on behalf of families in Idaho.

The past three years have shown a significant increase in Navigation's ability to leverage community funds. For every Navigation dollar spent, the community donated funds or provided in goods the amount of 33 cents in SFY 2015; 46 cents in SFY 2016; 38 cents in SFY 2017; and 44 cents in 2018. This demonstrates the program's continued efforts to focus on the health, safety, and stability of Idahoans, while also maintaining close and collaborative community ties.

In addition to Emergency Assistance and Career Enhancement, Navigation also received $60,000 from Casey Family Programs to serve Idaho KinCare families. More than 26,600 children in Idaho are being raised by relatives. Navigators served 98 KinCare households, made up of 321 family members. Navigators continued to work in communities across the state on behalf of about 10,000 kinship families for the Idaho KinCare Project. On July 20, 2018, through a proclamation from Gov. C.L. "Butch" Otter, Idaho celebrated its eighth annual Idaho KinCare Family Day.

Child and Family Services

Child and Family Services (CFS) is responsible for child protection, foster care, adoption, independent living for youth transitioning from foster care to adulthood, and compliance with the Indian Child Welfare Act. The program also licenses families to care for foster children, monitors and assures compliance with the federal title IV-E foster care and adoption funding requirements, and manages the Interstate Compact on the Placement of Children.

Child Protection

Child and Family Services operates a Centralized Intake Unit to process all child protection referrals. The primary responsibility of this unit is to answer calls and document child welfare concerns from the public (called referrals), make priority determinations related to the referral, and assign safety assessments to field social workers based on the priority of the referral. Field social workers conduct safety assessments to determine if the child is safe. Social workers and families work together to ensure the child's safety can be maintained in their homes.

If the child's safety cannot be managed with the child at home, the child may be removed by law enforcement or a court order. When children are removed from their homes, social workers continue to work with the families to return the children to the home as soon as it is safe to do so.

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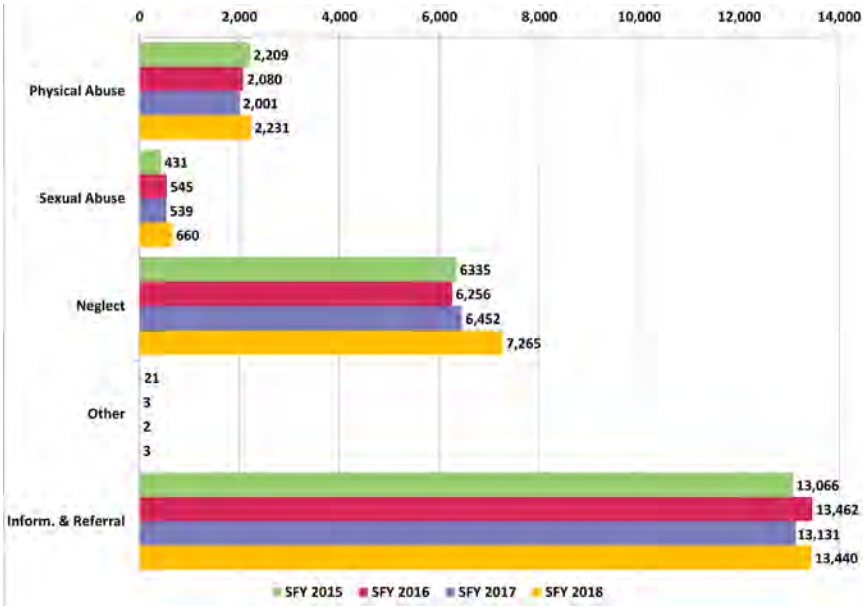
Child Protection and Prevention Referrals



Note: In SFY 2018, there were 23,599 referrals from concerned citizens, slightly up from 22,125 in SFY 2017. Of these referrals, 10,159 were assigned for safety assessment. An additional 13,440 referrals were categorized as Information and Referral. These are circumstances that don't meet criteria for assignment of a safety assessment and are frequently referred to other programs or agencies.

Foster Care

Foster care is a critical component of the state's child welfare services. Resource families (foster, relative, and adoptive) provide care for children who have been abused, neglected, or abandoned, and who cannot be maintained safely in their own homes.

During SFY 2018, 2,936 children were served through the foster care program. In the same year, 1,241 children left foster care. Of these children, 66% were reunified with their parents/caregivers.

Whenever possible, relatives of foster children are considered as a placement resource and may be licensed as resource parents. Relatives can be important supports to the child, the child's parents, and the resource family.

Child and Family Services manages out-of-home placements to:

- Assure the child will be safe.
- Provide services to the family and the child to promote reunification

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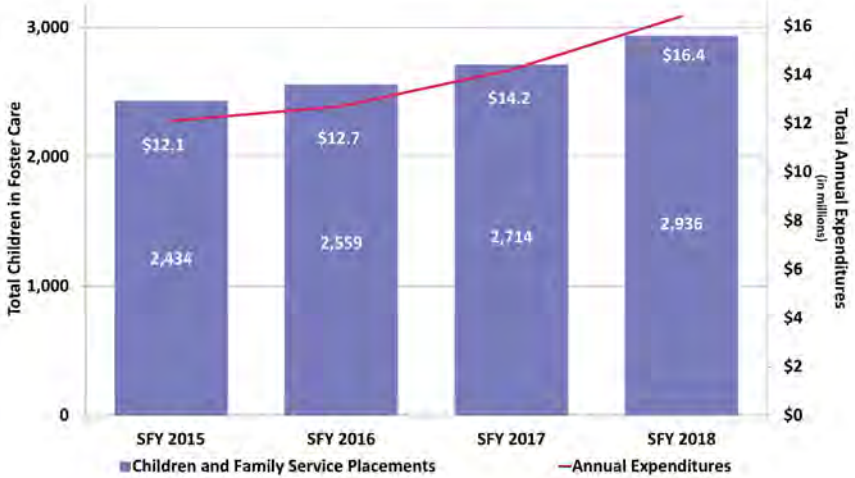
and reduce long-term negative effects of the separation.
- Allow for continued connection between the child, his or her family, and the community.

Knowledgeable and skilled resource families and other care providers are integral to providing quality services to children placed outside their family homes. Licensing processes and requirements are designed to assess the suitability of families to safely care for children.

Resource families work with children and their families with the goal of reunification as soon as the safety issues are resolved that required placement outside the home. When a child's family is unable to make changes that assure a child's safety, the resource family may become a permanent placement for a child.

Children Placed in Foster Care and Annual Expenses



Note: This chart shows total number of children served annually. On June 30, 2018, there were 1,726 children in state care. On June 30, 2017, there were 1,597 children in care.

Treatment foster care is available to children who have complex needs that go beyond what general resource parents are able to provide. Treatment foster parents have additional training and experience that prepares them to care for children with significant specialized needs. Working in collaboration with a treatment team, these foster parents provide interventions specific to each child to develop skills and prepare them to be successful in less restrictive settings.

There is a critical need to recruit and retain resource families for all children in foster care. On June 30, 2018, there were a total of 1,150 licensed resource families. These include resource families in Idaho and resource

families out-of-state where children were placed through the Interstate Compact on the Placement of Children (ICPC). This is an increase of about 50 families since SFY 2017, but there is an ongoing need to recruit families who can provide care to sibling groups, adolescents, and those with emotional, behavioral, and special needs. Resource parents of Hispanic, African American, and Native American heritage also are needed. Foster care recruitment and retention is an area of concentrated focus with the CFS Three-Year Transformation Project.

Licensed Foster Homes

Independent Living

Idaho's Independent Living Program assists foster youth in their transition to adult responsibilities. Supports and services for cultural and personal identity formation, supportive relationships and community connections, physical and mental health, life skills and personal needs, education, employment, housing, transition planning, and establishing permanent connections are funded through this program.

During SFY 2018, the Independent Living Program served 507 youth ages 14 to 21. This includes 62 youth who turned 18, the legal age of adulthood, while they were in foster care.

To help foster youth transition to adulthood and provide educational opportunities, the Education and Training Voucher Program provides up to $5,000 per year. The voucher is available to youth who have been in foster care after the age of 14 and have received a high school diploma or GED. A total of 23 youth participated in the program at colleges,

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universities, technical schools, and other institutions of higher education during SFY 2018.

Older youth often experience barriers to success after leaving foster care. In partnership with the federal Administration for Children and Families, Idaho collects service and outcome information about and from youth for several years after they leave foster care through the National Youth in Transition Database. This helps determine the services that are successful in achieving positive outcomes.

Adoption

Child and Family Services provides adoption services for children in foster care whose parents' rights have been terminated by the court. In most cases, Idaho children adopted from foster care have special needs. These children may have physical, mental, emotional, or medical disabilities, or they may be part of a group of siblings who must stay together. Some children may be older but still need a permanent home through adoption.

The department's goal is to find a family who can best meet a child's needs within 24 months of when the child entered foster care. To help meet this goal, the department looks for relatives who are interested and able to adopt the child. When no relatives are available or if it has been determined that placement with a relative is not in the child's best interest, non-relative foster families often adopt.

Families who adopt children with special needs are eligible to apply for federal or state adoption assistance benefits. These benefits help subsidize the expenses associated with finalizing an adoption and the cost of parenting a child who has special needs.

In SFY 2018, 257 children were adopted from foster care. At the state and local levels, the department and the courts work closely to improve monitoring and processes to reduce delays and help children have safe, caring, stable, and permanent families.

Adoptions Finalized			
SFY 2015	SFY 2016	SFY 2017	SFY 2018
215	195	236	257

Average Monthly Adoption Assistance Payments			
SFY 2015	SFY 2016	SFY 2017	SFY 2018
$359	$359	$363	$369

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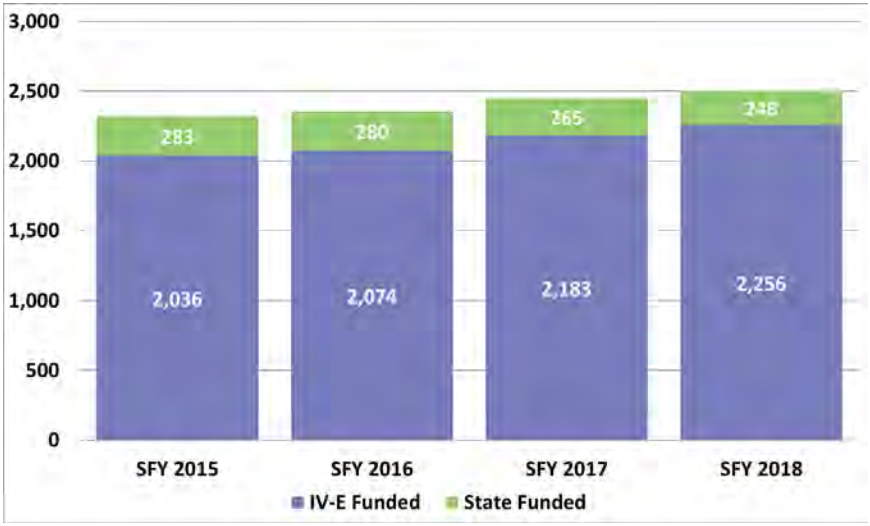
Children Receiving Adoption Subsidies



Developmental Disabilities Services

The Developmental Disabilities Program manages and delivers services for infants, children, and adults who have developmental disabilities. Through partnerships with community members, the program has service choices available for consumers and their families, allowing them to strive for self-direction and full participation in their communities.

Idaho Infant Toddler Program

The Idaho Infant Toddler Program (ITP) coordinates early intervention services for children with developmental delays or disabilities from birth to 3 years of age. The Infant Toddler Program partners with public agencies and private contractors and works closely with parents to enhance each child's developmental potential. Services are provided through a team approach with a primary professional coaching the family.

The four most frequently provided services are:

1. Speech and language therapy
2. Family education (special instruction)
3. Occupational therapy
4. Physical therapy

Services are delivered according to an Individualized Family Service Plan. Teams provide evidence-based services, including teaming, natural environment learning practices, and family coaching across the state. Teams build the capacity of families to promote children's learning. Family feed-

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back about the team approach and coaching continues to be favorable and produce positive outcomes.

The Infant Toddler Program received the full SFY 2018 grant approval. It also received the highest federal rating of "Meets Requirements."

Children served by the program are referred for a variety of reasons, including diagnosable conditions that result in delays or disabilities. Nine percent of children referred for evaluation have been involved in substantiated cases of neglect or abuse. Twenty-six percent of children found eligible for services were born prematurely.

Efforts to identify children who have delays or disabilities through outreach and screening services are a program priority. In SFY 2018, the Infant Toddler Program received 4,210 referrals. Region-specific outreach strategies and online screening by parents has resulted in a steady increase in the number of referrals for five consecutive years. The increase in referrals provides the program with the opportunity to provide services to young children who need them the most. These early intervention services provide a life-long impact for children. During SFY 2018, the program served 4,088 children and their families.

Children Served in the Infant Toddler Program

Children's Developmental Disability Program

The Children's Developmental Disabilities Program oversees services for children with developmental disabilities up to age 18. Services are delivered through two pathways: traditional and family directed services. Traditional services are delivered by community providers using evi-

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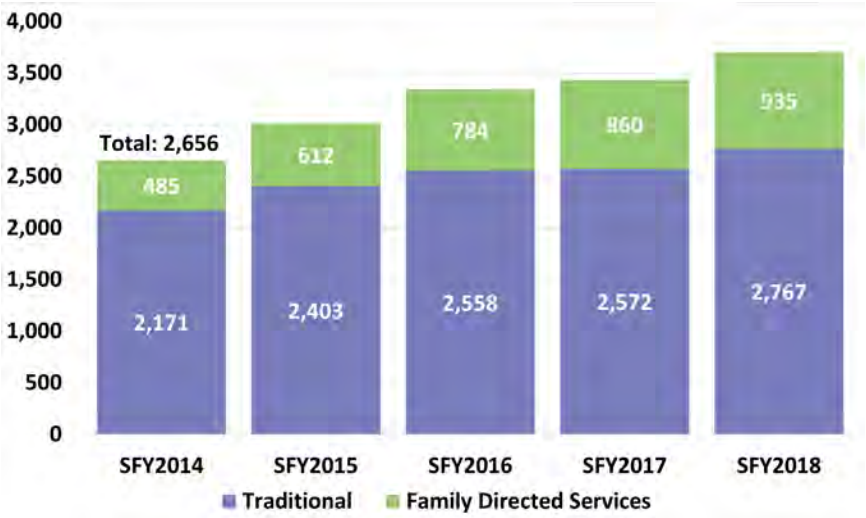
dence-based practices to meet the goals identified on a service plan written as part of the family-centered planning process. The family directed pathway allows parents to have a more hands-on and flexible approach in determining the types of services and supports their children receive. It also allows more control over who provides those services and supports.

The program continues to grow, with enrollment increasing to more than 3,700 children. Over 25% of these children receive services under the family directed program. A parent satisfaction survey in SFY 2018 indicated that 88% of parents and guardians are satisfied with the services their children are receiving.

The program continues to increase the quality of services by focusing on evidence-based practices, family centered planning, and ensuring services are delivered consistent with Home and Community Based Rules.

Traditional and Family Directed Services



Crisis Prevention and Court Services Team

The FACS Crisis Prevention and Court Services Team provides training, technical assistance, and consultation to families and agencies that support individuals with disabilities who are at risk of a community placement disruption because of a behavioral, mental health, or medical crisis. The team's priority is to help the person remain in their community. If that is not possible, the team helps to locate another community placement option that can meet the person's needs. As a last resort, a placement referral may be made to Southwest Idaho Treatment Center.

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Southwest Idaho Treatment Center

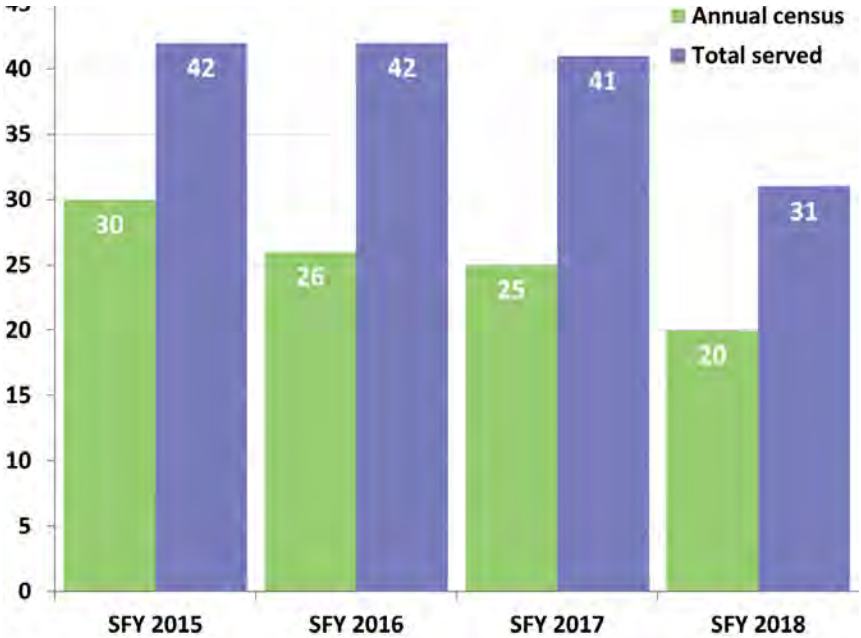
Jamie Newton, Administrator, (208) 475-2434

The mission of SWITC, located in Nampa, is to provide services as a short-term therapeutic stabilization and transition center for clients, focused mostly on those who have been committed to the department because of criminal activity or severe behaviors. SWITC has become a stabilization center for individuals with intricate and challenging needs, with the goal of transitioning them to effective community placements for long-term services as quickly as possible.

The combined efforts of the Crisis Prevention and Court Services Team in maintaining community placements and SWITC in systematically supporting people as they move back into their communities has resulted in a continued decline in the number of clients at the center over the past decade to between 20 and 25.

The 2017 Idaho Legislature passed a bill allowing the creation of a secure treatment facility. Rules governing the Secure Treatment Facility for People with Intellectual Disabilities have been approved by the Board of Health and Welfare. A wing of SWITC is being refurbished to provide for secure services for up to four clients.

SWITC Census



Annual census is a point-in-time count on June 30 each year. Total served is the total number of unique clients served during the year.

Council on Developmental Disabilities

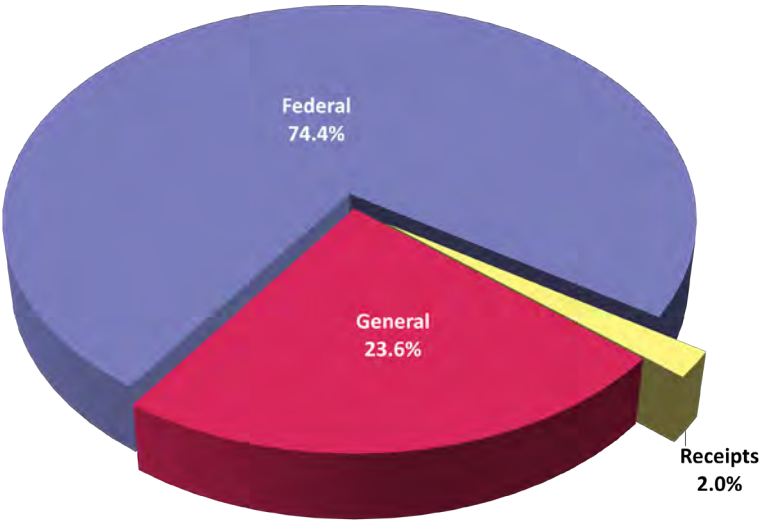
Christine Pisani, Executive Director, (208) 334-2178

The Idaho Council on Developmental Disabilities (ICDD) promotes a participant and family-centered system of comprehensive, coordinated community services by engaging in advocacy, capacity building, and systemic change activities. The council also works to build the capacity of communities to recognize the gifts and talents of all community members so that people with developmental disabilities are living meaningful and included lives. The work of the council is directed by 23 governor-appointed stakeholders, who determine the council's priorities.

Council Vision: All Idahoans participate as equal members of society and are empowered to reach their full potential as responsible and contributing members of their communities.

Council Mission: To promote the capacity of people with developmental disabilities and their families to determine, access, and direct services and support they choose, and to build communities' abilities to support those choices.

SFY 2019 Funding Sources



Funding is channeled through the DHW budget, but councils are independent and not administered by DHW. FTP: 6; General Funds $180,700; Total Funds $765,600.

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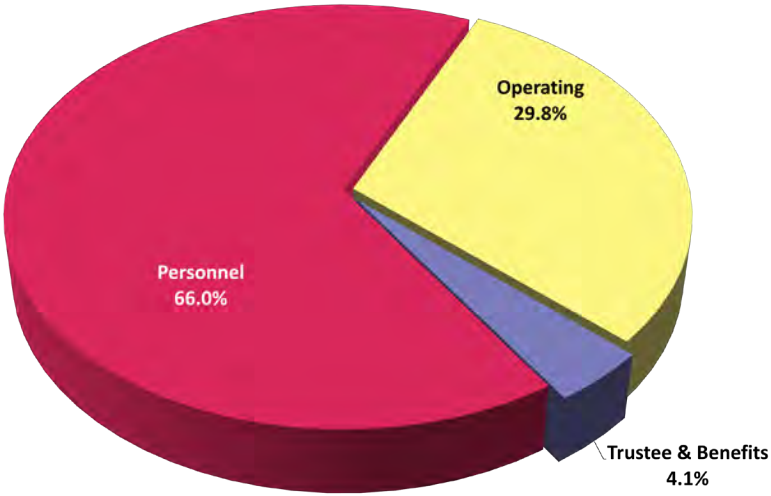
SFY 2019 Expenditure Categories



Council Initiatives

The council has completed the second year of its (2017-2021) five-year plan. Many council projects are multi-year efforts involving systems change initiatives. A snapshot of council initiatives and outcomes for 2018 include:

Adults with intellectual/developmental disabilities experience improved quality in Home and Community Based Services. The Idaho Council on Developmental Disabilities continued to work collaboratively with the Department of Health and Welfare to facilitate Community NOW!, a statewide collaborative workgroup led by adults with intellectual and developmental disabilities (I/DD) and families who participate in Medicaid home and community-based services. The workgroup was created so adults with I/DD and their family members can lead discussions about their experiences with adult developmental disability services provided under Idaho's Medicaid DD Waiver program.

The workgroup was made possible through the shared resources of the department and the Idaho Council on Developmental Disabilities. Community NOW! meetings and discussions took place as part of implementation of the K.W. v. Armstrong settlement agreement. The workgroup brought together more than 60 people, including: adults with I/DD; family members who support and advocate for adults with I/DD; department managers and administrators; advocacy groups such as ICDD, Disability Rights Idaho, Medicaid service providers; and representatives from the

Idaho Attorney General's Office, the American Civil Liberties Union, and Human Services Research Institute.

Intentional work has been done this past year to address Recommendation #1 identified in the 2017 Community NOW! Report: **Establish a quality person-centered planning process based on best practices.**
Outcomes include:

- Stakeholders educated about proposed Idaho person-centered planning model
- An advisory committee of adults with I/DD and families is supported through the council to review and approve all proposals for a person-centered planning approach for the adults in the developmental disability service system.
- Self-advocates and council staff reviewed content and format of the new Department of Health and Welfare's My Choice Matters website and provided suggested language. This new website was created for adults in the DD program and will soon have audio availability in order to have text read to the reader. http://www.mychoicematters.idaho.gov/

People who experience intellectual or developmental disability with a co-occurring mental illness have access to mental health services from skilled service providers.

The council received updated information from the Independent Assessment Provider in March 2018. There are 4,510 adults on the Developmental Disability Waiver and 2,773 of those adults experience a co-occurring mental health diagnosis. The council invested $25,000 and collaborated with the Department of Health and Welfare to host two three-day workshops for mental health clinicians in 2018. Julie Brown, Ph.D., presented in Pocatello at Idaho State University in June and in Coeur d'Alene at North Idaho College in September.

The council supported a parent of an adult with dual diagnosis to speak to the mental health clinicians about the family's experience and lack of mental health services. The current council chair spoke to the clinicians about his experience as a person with a dual diagnosis, the lack of recognition of mental health diagnosis until later in life, and the impact that has had on him personally.

Outcomes Include:

- 81 clinicians received Skills System training to improve their ability to serve adults with a dual diagnosis (I/DD and mental health diagnosis)
- 97% who completed the survey after the training said they were planning to serve more people with a dual diagnosis.

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Build the capacity of individuals and parents to lead, mentor, and advocate for others by increasing their leadership and advocacy skills.

In May 2018, 27 participants graduated from the council's leadership development program, Idaho Partners in Policymaking. The council has been providing this leadership development program since 1997, with over 200 graduates statewide.

Outcomes include:

- 14 adults with intellectual or developmental disabilities, and 13 parents, including five individuals from the Spanish-speaking community, graduated from this intensive eight month leadership program.

Learn more: https://icdd.idaho.gov/

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Council on Domestic Violence and Victim Assistance

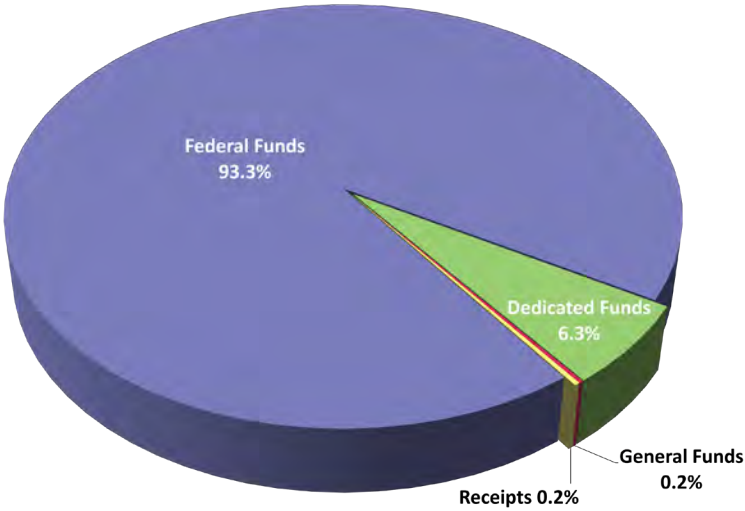
Nicole Fitzgerald, Executive Director, (208) 334-1540

The council was created in 1982 by the Idaho Legislature to promote assistance to victims of crime. The scope of the council includes:

- Administration of federal and state funding provided to programs that serve crime victims.
- Promoting legislation that impacts crime.
- Providing standards for domestic violence, sexual assault, and offender intervention programs.
- Training and public awareness about violence and victim assistance.

In addition, the council serves as a statutory advisory body for programs affecting victims of crime and acts as a coordinating agency for the state on victim assistance issues.

SFY 2019 Funding Sources



Funding is channeled through the DHW budget, but councils are independent and not administered by the department. FTP: 4; General Funds $15,000; Total Funds $8.3 million.

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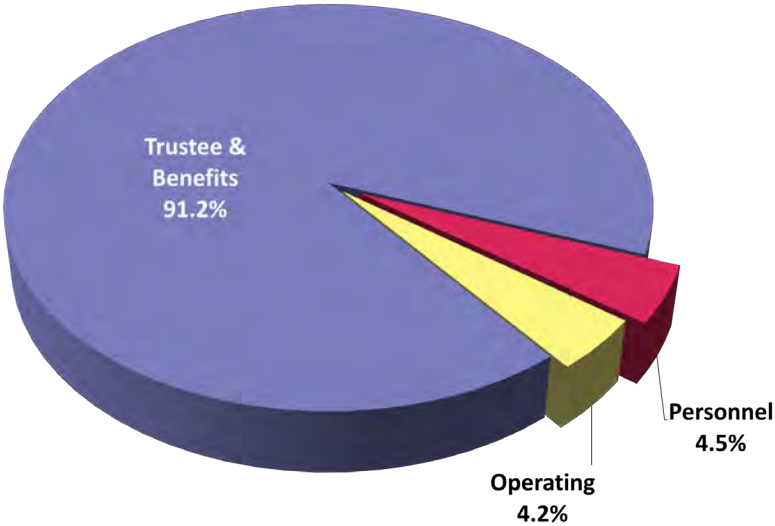
SFY 2019 Expenditure Categories



The council consists of seven members, one from each of the seven judicial districts in Idaho.

As a funding agency, the council administers a combination of federal and state resources. Primary funding sources include: the United States Department of Justice Office for Victims of Crime; the Victims of Crime Act; the Federal Family Violence and Prevention Grant; the Idaho State Domestic Violence Project; and the Idaho Perpetrator Fund.

The council funds 40 programs throughout the state that provide direct victim services, including crisis hotlines, shelters, medical and legal advocacy, juvenile services, counseling, support groups, and victim family assistance.

The council serves as the oversight for all state-approved offender intervention programs throughout the state.

The council also provides statewide training for service providers about crime victim issues, and provides additional resources including publications and educational materials.

For more information, visit https://icdv.idaho.gov/.

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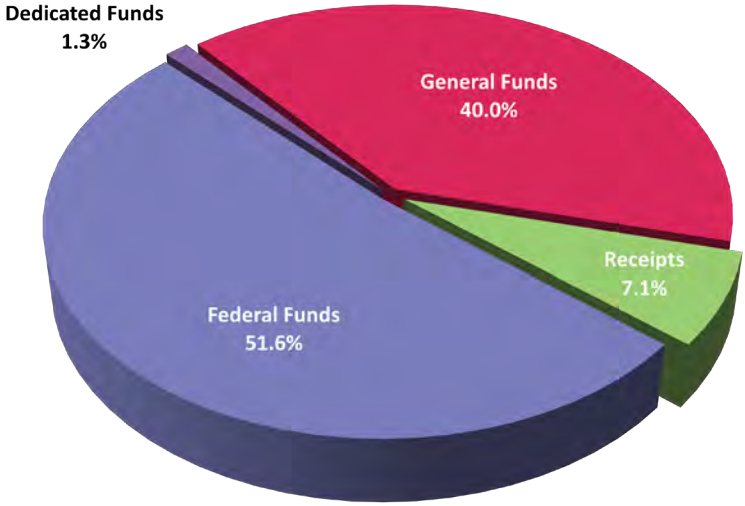
Indirect Support Services

Indirect Support Services provides the vision, management, and technical support for carrying out the department's mission. Indirect Support includes the Office of the Director (details on page 9), Legal Services, Financial Services, Operational Services, Information and Technology, Audits and Investigations, and Public Information and Communications.

The Office of the Director oversees the entire department, working with the Governor's office and the Idaho Legislature to effectively and economically provide policy direction for services and programs.

The staff of Legal Services, through the State Attorney General's office, represents and provides legal advice and litigation services. Financial Services provides administrative and financial support for the department. Information Technology provides automated and computer support for delivery of services, along with hardware, software, and networking support across the state. Audits and Investigations conducts internal audits and external fraud investigations for department benefit programs. Operational Services provides the human resource services to manage the department's workforce of 2,923 employees throughout the state, oversees the department's facilities, and administers the contracting and legislative rule-writing for the agency.

SFY 2019 Funding Sources



Authorized FTP: 299.6; Original SFY 2019 Appropriation: General Funds $19.5 million, Total Funds $48.7 million; 1.6% of Health and Welfare funding.

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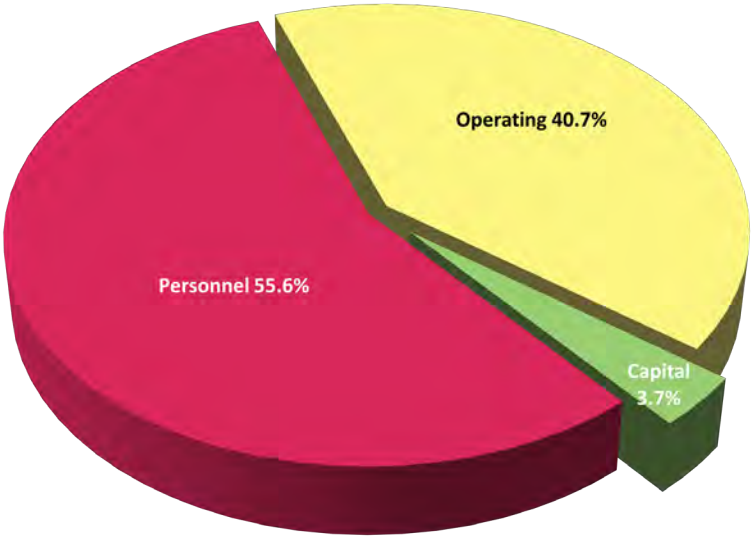
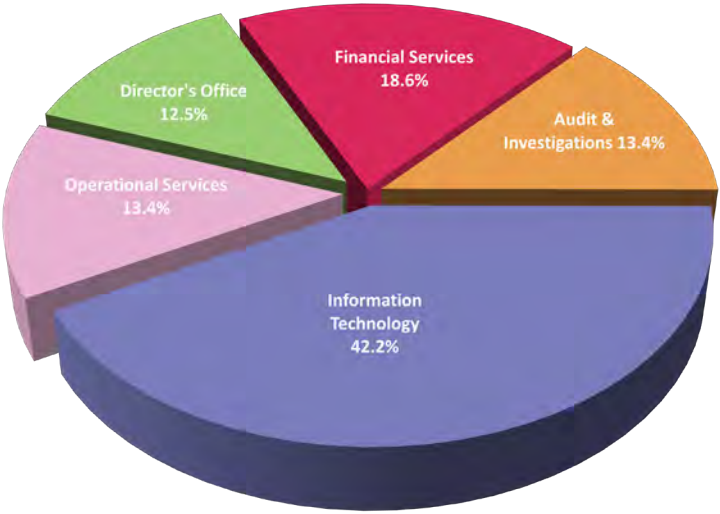
SFY 2019 Expenditure Categories



SFY 2019 Spending by Program



Support Services

David N. Taylor, Deputy Director, (208) 334-5500

Support Services provides administrative services to support the department's programs and goals. It manages the department's budget, cash flow, and physical assets; oversees accounting and financial reporting; provides fraud investigation services; and processes all payroll actions. Through cooperation with other divisions, Support Services provides guidance and support to ensure resources are managed responsibly.

Bureau of Financial Services

Financial Services consists of Financial Management; Financial Policy, Reporting and Reconciliation; Financial Systems Support; Accounts Payable; Revenue Operations; Grant Reporting; Cash Management; Employee Services; and Electronic Benefits.

Financial Management

Financial Management responsibilities include, but are not limited to:

- Operating a federally approved cost allocation plan that facilitates recovery of indirect costs incurred in support of federal programs.
- Managing four Random Moment Time Studies used to charge costs to federal grants that fund Self-Reliance programs, Child Welfare, Children's Mental Health, and Adult Mental Health.
- Preparing and submitting the department's annual budget request to the Division of Financial Management and Legislative Services Office.
- Distributing appropriated funding to more than 2,500 operating budgets within the department.
- Monitoring program expenditure trends to allocated funding.
- Preparing financial analysis and reporting for division and executive management.
- Monitoring established full-time equivalency positions.
- Researching and compiling historical expenditure and revenue information.

Financial Policy, Reporting & Reconciliation

Financial Policy, Reporting and Reconciliation (FPRR) is a critical oversight, monitoring, and control function supporting agency financial operations. FPRR responsibilities include, but are not limited to:

- DHW Comprehensive Annual Financial Report (CAFR)
- Financial reconciliation activities
- Financial policy
- Report development and analysis

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- Training, documentation, and communication strategies for financial operations

Daily, monthly, quarterly, and annual financial reconciliations are performed in this unit. It is also responsible for reports and maintenance of Financial Services' data warehouse, and provides support for interagency systems, such as the P-Card. The priority for this unit is the methodical, continuous evaluation and intervention in financial operations to maintain compliance with GAAP/GASB standards and ensure adherence to applicable rules, laws, regulations and best practices.

Financial Systems Support

This unit supports the automated accounting systems used by DHW. It provides system support including design, testing, troubleshooting, monitoring program systems, interfaces, and help desk support for related accounting functions. The unit supports these systems:

- FISCAL: Primary accounting system including major modules for cost allocation, cash management, budgetary control, and management reporting, as well as coordination and reconciliations with the statewide STARS system.
- BARS: Primary accounts receivable, receipting, and collections system.
- TRUST: Client-level trust management and reporting system to account for funds held as fiduciary trustee.
- Navision: Front-end to DHW's budget, purchasing and vendor payment activities. Navision is also the primary fixed asset inventory and depreciation system of record.
- Contraxx: Electronic contract operation and management system.
- Payables Interfaces: Medicaid, child care, energy assistance, job services payment systems, and vendor management support.

Accounts Payable

This unit supports statewide DHW accounts payable activities, primarily through the Navision accounting system. This unit is responsible for:

- Vendor invoice audit/payments
- Vendor edits
- Warrant issues such as stop payments, forgery, cancellations, and re-issue
- Rotary fund payments
- Interagency payments
- Payables Help Desk phone support
- Navision research assistance
- Electronic Benefit Transfer (EBT) support
- Direct FISCAL entries (Trust payments, adjustments, CRU refunds)

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- P-card filing / maintenance

Revenue Operations

This unit is responsible for department-wide billing, collection, recovery, and receipt posting activities. The Revenue Operations Unit pursues collection of outstanding debts, including DHW fee-for-service, third-party recovery, benefit overpayment, and any other monies receivable as negotiated through repayment agreements. Statewide billing and collection activities include, but are not limited to:

1. DHW's fee-for-service programs, including:

- Designated exams, Department of Correction's evaluations, court testimony billings.
- Medicaid's certified family home licensing fees.
- Criminal History Unit billing (including Adam Walsh background checks).
- Bureau of Laboratories and public health district services.
- Disability determination records requests.

2. Medical billing for services that are reimbursable through third-party insurers and/or Medicaid for:

- Developmental disabilities.
- Infant Toddler Program.
- Adult and children's mental health.

3. Overpayments, civil monetary penalties, and miscellaneous recoveries include:

- Provider and individual fraud (Welfare and Medicaid).
- Foster care overpayments.
- Educational stipend defaults.

4. Interagency billings.

5. Receipting and posting for all centrally processed receipts.

Grant Reporting

This unit ensures compliance with federal funding requirements by:

- Tracking reporting requirements and completing expenditure reports for more than 100 federal grants that fund DHW programs. The largest of these federal grants is Medicaid, for which the SFY 2018 expenditures were $1.46 billion.
- Managing the department's Medicaid School Based Services Program.

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Cash Management

Cash Management ensures adequate cash is available for the department to meet its financial obligations, functioning as the financial liaison to human services programs by:

- Drawing federal funds from the U.S. Treasury to meet immediate cash needs of federally funded programs.
- Requesting state general and dedicated funds through the Office of the State Controller.

Employee Services

This unit handles all employee documents relating to insurance, compensation and payroll deductions, and provides consultation to field offices. It also:

- Operates the Payroll and Employee Information System (EIS) through the Idaho Paperless Online Payroll/Personnel System (IPOPS).
- Provides payroll and benefit support for regional, institutional, Central Office, and field personnel.
- Verifies online time entry for all staff to ensure accurate and timely employee compensation.
- Provides validation and entry of information for new hires, terminations, transfers, and payroll deductions such as health insurance and pension to ensure data integrity.
- Maintains and safeguards employee personnel records.

Electronic Benefit Transfer (EBT)

The Electronic Benefits Transfer unit is responsible for implementation, development, and daily operation of the Electronic Benefits Transfer (EBT), Direct Payment Card (DPC), and Electronic Payment System (EPS) activities. Although overall, electronic payments associated with the Child Support program and cash assistance programs have stayed relatively static with slight increases over the past year, there has been a steady decrease in electronic benefit payments associated with food stamp benefits.

After the recession, SFY 2012 saw the highest peak of disbursed food stamp benefits in the State's history, totaling $366 million. Since then, DHW has seen a steady decline in food stamp benefit payments year-over-year. In SFY 2018 food stamp payments totaled $209 million – down 13% when compared to the previous year, and down 20% compared to SFY 2016.

The EBT Group coordinates information and resources to meet the electronic payment needs of the department. Group members perform related contract monitoring activities; monitor federal, state and department laws, rules, and policies; assess governmental and industry changes for

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impacts to services related to all types of electronic payments; and provide necessary and appropriate information to management regarding electronic payment capabilities and mandated requirements.

DHW contracts with Fidelity Information Services to set up and maintain accounts for food stamp benefits; cash assistance programs for the Temporary Assistance to Needy Families (TANF or TAFI) and Aid to the Aged, Blind, and Disabled (state supplement or AABD).

Participants access their food benefits with an EBT Quest Card. Participants receiving cash benefit payments have the option of accessing their cash on an EBT Quest Card, or receiving the funds by direct deposit into a personal bank account.

DHW has a separate contract with US BANK for Child Support clients who choose to have their payments go to a Direct Payment Card (DPC). Child support payments can be accessed with a US BANK ReliaCard, or they can be deposited directly into a personal bank account.

Electronic Payments Distributed

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Bureau of Audits and Investigations

The Bureau of Audits and Investigations provides support to DHW's public assistance programs through the following units:

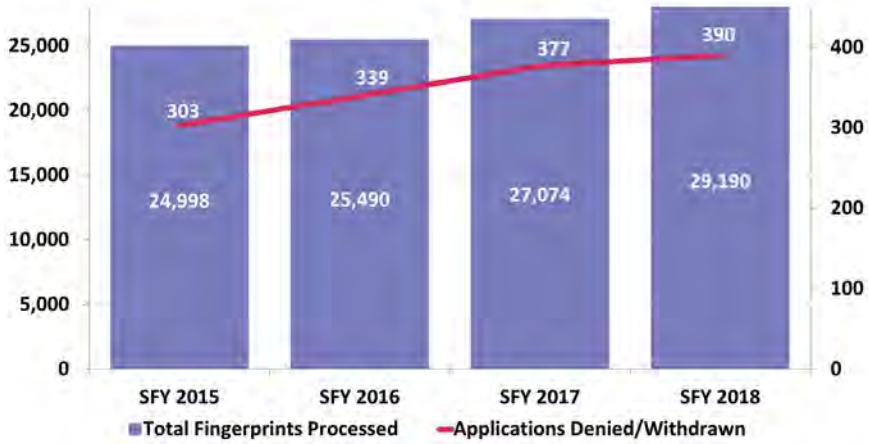
- Criminal History
- Internal Audit
- Fraud Analysis
- Medicaid Program Integrity
- Welfare Fraud Investigations

Criminal History Unit

The Criminal History Unit conducts department-required background checks. The background check is fingerprint-based and includes a search of national and state criminal databases and jurisdictions. It also includes checks of specific registries including National Sex Offender Registry, Medicaid and Medicare Excluded Provider listings; Child and Adult Protection registries; Idaho Nurse Assistant Registry; and Idaho driving records.

The department's background check is completed on people who work in over 40 programs to provide direct care for participants who are children or are disabled or elderly. Learn more at the Criminal History Unit's web site, https://chu.dhw.idaho.gov.

Criminal History Checks by Year



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Fraud Analysis

This unit provides data analysis support for the Bureau of Audits and Investigations. Data mining is used to find hidden patterns of waste, fraud, and abuse in client eligibility data, benefit issuances, and provider billings and claims. Statistical analysis is then used to identify and prioritize cases for investigation.

Internal Audit

This unit provides independent appraisals of the department's various operations and systems of control. It helps the department accomplish its objectives by bringing a systematic, disciplined approach to evaluation, and it improves the effectiveness of risk management, control, and governance processes. Internal auditing assists department staff by furnishing them with analyses, appraisals, recommendations, counsel, information, and by promoting effective control at reasonable costs.

Internal Audit is also responsible for initiating a data governance program that will identify, classify and protect the department's sensitive data.

Internal Audit				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Audits completed	5	3	2	3
Audit recommendations made	11	13	2	16
External reports reviewed	63	60	83	93
Grant risk assessment	NA	NA	209	257

The Medicaid Program Integrity Unit

This unit investigates allegations of Medicaid fraud, waste, and abuse, and conducts federally mandated program reviews and investigations by reviewing provider billing practices and records.

Medicaid investigations are initiated from:

- Data mining and other proactive reviews
- Referrals from other agencies
- Provider self-reporting
- Provider, client, and anonymous complaints

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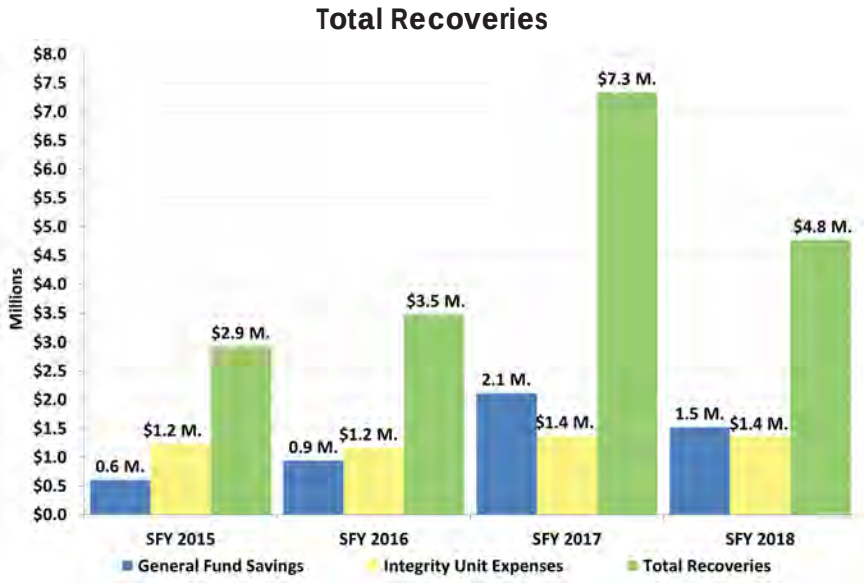
Issues are resolved through:

- Education
- Policy recommendations
- Recoupment of overpayments
- Assessment of civil monetary penalties
- Termination of provider agreements
- Exclusion from the Medicaid program
- Referral for prosecution



The Welfare Fraud Unit

This unit investigates allegations of welfare program waste, abuse, and fraud that include Supplemental Nutrition Assistance program (Food Stamps), cash assistance, Medicaid, child care assistance, and others.

Investigators work with program staff, local law enforcement, Office of the Inspector General, and county prosecutors in every region of the state to investigate allegations. Each year the unit receives about 4,000 complaints from the public and 20,000 leads through data analysis.

Welfare Fraud Cases Investigated

Overpayments and cost savings

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Division of Information and Technology

Michael R. Farley, Administrator, (208) 334-5625

The Information Technology Services Division (ITSD) provides office automation, information processing, and local and wide area networking, including unified communications and internet connectivity, for the department statewide. The division uses best practices and sound business processes to provide information technology solutions to improve the efficiency and effectiveness in providing services to the residents of Idaho. The division also provides leadership and direction in support of DHW's mission to promote and protect the health and safety of Idahoans.

The Information and Technology Services Division:

- Provides direction in policy, planning, budget, and acquisition of information resources related to all Information Technology (IT) projects, and to upgrades to hardware, software, telecommunications systems, and systems security.
- Oversees the review, analysis, evaluation, and documentation of IT systems in accordance with Idaho policies, rules, standards, and associated guidelines.
- Maintains all DHW IT resources, ensuring availability, backup, and disaster recovery for all systems.
- Secures IT resources to meet all state, federal, and local rules and policies to maintain client confidentiality and protect sensitive information.
- Oversees development, maintenance, and enhancement of application systems and programs for all computer services, local area networks, and data communications internally and with external stakeholders.
- Provides enterprise services to strategically align business processes and needs with IT solutions.
- Provides IT-related project management, support, and direction in the planning, development, implementation, and evaluation of large-scale IT Projects.
- Provides direction for development and management of department-wide information architecture standards.
- Participates in the Information Technology Leadership Council (ITLC) to provide guidance and solutions for statewide business decisions.
- Implements the state's Information Technology Authority (ITA) directives, strategic planning, and compliance.
- Collaborates with the Office of Information Technology Services (ITS) in statewide messaging, communications, video conferencing, networking, strategic planning, and ITA initiatives or directives.

The Information Technology Services Division provides reliable, timely, high-quality, innovative, flexible, cost-effective IT solutions, working with our business partners to identify and prioritize products and required ser-

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vices. The division is divided into three distinct areas:

1. Operations.
2. Infrastructure.
3. Application Development and Support.

Bureau of IT Operations

The Bureau of IT Operations provides technical support services and coordinates resources to promote the efficient use of technology throughout the department. The bureau's functions include:

- **Statewide Technical Support:** Provides DHW staff with Level 1, 2, and 3 technical support services for all desktop and mobile computer-related issues, including hardware, software, and network connectivity. State-wide technicians work from a shared queue, which enables faster service to all our customers who can be supported remotely, freeing up local techs' time to support our customers with issues that require hands-on support.
- **Printer support:** The bureau is the primary point of contact for all network and multi-function printing services. Technicians work with Operational Services and local management staff to assure the most cost-efficient and effective selections are made for printing and faxing.
- **Service Management:** Responsible for design and maintenance of service desk support software used by many agency divisions.
- **Endpoint Management:** Responsible for design and maintenance of desktop and laptop images, security patching and software updates. Researches, evaluates, tests, and recommends technology to enhance technical productivity throughout the agency. Provides mobile device security management.
- **Technology training and development:** Introduces new products to DHW staff; offers training classes (both live and online); and maintains SharePoint knowledge sites for IT Technicians and DHW staff.
- **Enterprise Content Management:** works with other divisions to establish document management practices. Maintains software utilized in the process and provides training and support to divisions utilizing the software.

Bureau of IT Infrastructure

The Bureau of IT Infrastructure is responsible for designing, deploying, and maintaining network hardware and software infrastructure, system security procedures and practices, database security, system backup, and disaster recovery. The bureau also provides development and support for all agency business offices and associated partnerships, including the Office of Drug Policy, Community Action Agency, Health Data Exchange, and the Commission for the Deaf, Blind and Hard of Hearing. Finally, the bu-

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reau is responsible for disaster recovery planning, and conducts exercises and testing of recoverability of technology.

The bureau's functions include:

- **Wide Area Network:** Provides wide area, local area, and wireless network design, deployment, and statewide support, as well as data telecommunications infrastructure support.
- **IT Security:** Responsible for user and data security management and standards; database and data warehouse security; enterprise antivirus/HIPS administration; remote access support (Secure Socket Layer Virtual Private Network); and firewall administration and support.
- **UCC:** Designs, deploys and supports unified communications including Voice over IP (VoIP), Fax over IP (FoIP), and video. Also provides support for data center facilities and associated computer systems, including power, cooling, and backup generator for emergencies.
- **Server Support:** Windows and CentOS Linux server build, deployment, and maintenance; server infrastructure and application delivery integration and automation; storage area network support; enterprise electronic messaging support; data backups and restoration; server virtualization; VM provisioning and support; and server security patching.
- **Security and Compliance Audit:** responsible for DHW and ITSD information policies and procedures to maintain compliance with state and federal rules, regulations and guidelines regarding Personally Identifiable Information (PII), Personal Health Information (PHI), the Health Insurance Portability and Accountability Act (HIPAA), the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Office of Inspector General (OIG), FNS Food and Nutrition Services, and CMS Center for Medicaid Services. Also, provides computer forensics support and internal security posture assessments (vulnerability scanning).

Bureau of Application Development and Support

The primary responsibility of the Bureau of Application Development and Support is the design, development, operational maintenance, and support of all business applications, which provide necessary health and human services for the citizens of Idaho. The bureau provides the design and support for the applications necessary to accommodate the entire agency's eight extremely diverse divisions and the programs they administer.

The bureau is also responsible for ongoing enhancements of existing applications; development of new business applications; integration of commercial off-the-shelf products into the agency's application framework; development, maintenance, and support of databases; and creation

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and maintenance of departmental reports for all software (middleware) necessary to support the movement of information between computing platforms.

The bureau's functions include:

- **Web Application Operation & Support group:** Responsible for the operation, maintenance, and support of web-based applications for the entire agency. The team supports over 150 applications, including custom-developed, commercial, and commercial off-the-shelf, as well as commercial off-the-shelf products that have been customized for specific business needs. The team is responsible for the day-to-day operations of each of the applications, in addition to all patching, upgrades, and other routine maintenance. All monitoring of server connections and services are part of the team's duties 24 hours per day, 7 days a week.
- **The Application Development group:** Responsible for gathering requirements, designing (including the architectural flow of the application), and coding the enhancement of existing applications; developing new business applications; and integrating commercial and commercial off-the-shelf applications into DHW's application framework.
    - Provides support for all applications and movement of information between computing platforms.
    - Provides software architectural design and design standards which enable, enhance, and sustain DHW's business objectives.
    - Promotes application delivery, including quality assurance application testing, system production support, time-period emulation qualification, and technical documentation. Previously, the group focused on the design, development, and support of the mainframe application; the group has now broadened their scope of work and skill set to include supporting and developing in Java, Natural, and other programming languages. The team continues to provide the ongoing enhancements and maintenance of the applications remaining on the mainframe system.
    - Provides leadership and guidance of complex integrated systems. Responsible for overseeing the applications that support the Welfare division for all benefits programs, including SNAP, TANF, Child Care, LIHEAP, Supportive Services, and Education & Training programs, and the entire Child Support Enforcement program application.
    - Provides research, design, and capacity planning for setting new systems and/or technology direction, and works with business partners to define system requirements for potential uses of technology and automation of process. The group works with all teams to design the most effective, efficient, and maintainable systems possible and incorporate microservices, reusable APIs, and other relevant technologies for ongoing sustainability.
- **The Business Analyst & Application Support team:** Provides DHW staff

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with support for applications such as WISPr, Vital Statistics, Criminal History, Audits & Investigations, The Knowledge Center, VistA (Veterans Administration) Hospital Management System, and the e-Case file document management system, as well as many other ongoing enhancement and modernization efforts for various business-related applications.

- **The Production Services group:** Supports multi-platforms (Mainframe, Windows, Oracle and Linux) by working with cross functional teams and technology partners both inside and outside of the agency, such as banking partners, the federal government, and other state entities.
    - This group contributes to improving processes, increasing automation, and improving the daily interactions between the many platforms and applications.
    - The group develops scripts to execute automated processes, including defining requirements, testing, and documentation.
    - They work with senior IT resources in supporting testing and implementations of upgrades and new infrastructure technology, the various .NET and JAVA applications, mainframe systems, and data transmissions.
    - The group identifies processing areas needed for optimizations, and works with IT analysts in improving production and non-production processing.
    - They also monitor data transmissions and job processing per predefined requirements and communications.
    - They also support the production environment by applying a disciplined, logical, and comprehensive approach to problem resolution.
    - The group focuses on clear, concise communications for all internal and external interfaces.
- **The Enterprise Data Warehouse group:** Provides a common data repository, data warehouse design, operation, and maintenance for all business-essential and critical information, allowing secure and reliable access to this information for decision-making purposes.
- **The Database Administration (DBA) team:** Responsible for the installation, configuration, upgrade, and migration for all databases utilized by all the applications throughout the agency. The DBA team is responsible for the hardware, operating system, and database software. All upgrades, patching, and changes to the database are managed by this team. The DBA team also creates the structure, views, and, most importantly, the data quality and data integrity of the systems they support.
- **Enterprise architecture:** Designs, develops, and maintains an enterprise model framework, and develops enterprise standards and strategies. Creates and maintains architectural models of business processes, business units, information, technology, and their interrelationships.
- **Licensing and Procurement Management:** Specializes in IT contracts, software, and hardware licensing in partnership with DHW's senior buyers in purchasing, leading the process for the procurement of

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computer software and hardware. Tracks all compliance of licensing and renewal dates for the agency.

- **SharePoint Administration and Support:** Oversees SharePoint upgrades and administration for the enterprise. It also conducts training and aids in SharePoint development for the agency's business units. They design, administer, maintain, and support SharePoint for all department users.
- **DHW External Websites and Social Media team:** In conjunction with the Public Information Office, this group oversees the agency's social media, public service campaign sites, and the external DHW website. The team designs, codes, and maintains all public facing sites, ensuring the content and information presented is relevant and timely.

ITSD Highlights

ITSD has completed multiple ongoing initiatives to support DHW's growing and evolving needs for information technology, while improving efficiency in automation with limited resources.

Technological Improvements

- Idaho Electronic Health Record (EHR) Incentive Management System. This system will provide users with an efficient means of processing and tracking federally-funded incentive payments to Medicaid providers that attest to the adoption of standard-compliant EHR technology.
- The department's Self Reliance team was provided with a feasibility study along with a cost analysis for the EHR Incentive Management System.
- Established Cisco Enterprise License Agreement to enhance the agency's cybersecurity posture for federal and state security controls and compliance.
- Implemented Cisco Identity Service Engine to meet security compliance requirements.
- Continued migration of DHW online Office products including Office 365, Exchange Online, and OneDrive.
- Vital Statistics Event System Re-Write. To modernize, innovate business processes, and increase efficiency, the current mainframe system being used to record vital events was re-written in a modern language that will allow for increased supportability and the elimination of mainframe processing costs.
- Criminal History Unit Application Enhancements for Child Care. We will issue two different types of clearances for applicants, depending on the services they provide to the vulnerable population that we seek to protect. A federal auditor finding questioned whether federal criminal information was accessible to non-DHW users, and is being addressed by enhancing the security mode to limit who can access the information.
- Continued progress in deployment and implementation of network infrastructure at a department co-location site to provide critical

information systems fail-over as part of disaster recovery and business continuity.

- Child Support Modernization. We are working to replace the converted Chilld Support Enforcement System application with a more customer-facing, maintainable, and supportable solution that better serves the citizens of Idaho.
- DHW Mainframe Application Decommissioning Initiative. For approximately 40 years, DHW has been using the State Controller's Office (SCO) mainframe processor for computer processing in support of the DHW business needs. During this year, functional processes were removed and redesigned, except for the department's Financial System, which will be replaced by the SCO's Statewide Financial System Initiative (Luma). Current technology methodologies were utilized during the decommissioning project to eliminate excessive mainframe processing costs.

Accomplishments directly associated with protecting the health and safety of Idahoans:

- Completed Phase VI of the Health Alert Network (HAN), providing an updated user interface for an improved user experience and simpler, more intuitive workflows. Incorporated user-requested features and updated the documentation to reflect the system enhancements
- Year 6 of the Idaho Electronic Health Record Incentive Management System, which provides users with an efficient means of processing and tracking federally-funded incentive payments to Medicaid providers that attest to the adoption of standard-compliant Electronic Health Record Technology.

Initiatives to "Go Green"

- Continued virtualization of our servers to reduce the number of physical devices on the network to reduce power and cooling requirements.
- All newly purchased computers are Energy Star rated and configured with policies that put all computers into sleep mode after a period of inactivity, resulting in less power used within the entire agency and a smaller energy footprint.
- The migration to Office 365 and cloud data on OneDrive, equating to less physical storage hardware. With OneDrive, we will continue to reduce the server footprint and the need for additional expansion of hardware storage space.
- Implementation of collaboration technologies to enhance the remote meetings experience, online participation in training sessions, and remote collaboration for business meetings and project planning sessions. Implementation of these technologies will reduce the need for travel due to options for real-time video conferencing, document sharing, and shared virtual workspaces.
- An enterprise-wide electronic document management solution is in the planning phase. The agency will be able to track, manage,

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and store all types of electronic documents, drastically reducing the agency's paper consumption, printer consumables, and physical document storage space, resulting in a reduced cost to the agency and the environment.

- Completed Projects and Initiatives: Completed Phase VI of the Health Alert Network (HAN) Modernization. This phase included an updated user interface, more intuitive workflows, and user-requested features.
- Criminal History Unit (CHU) enhancements for child care. Security was updated to limit who can view criminal history data; the unit gained the ability to charge various fees; and the rules engine was updated.
- DHW Mainframe Systems Decommissioning Initiative, to remove and replace department applications with modern technology, except for the department's financial system. To include: Child Support, Energy Assistance, Enhanced Work Services, Vital Statistics Events System, etc.
- Replacement of the department's mainframe job scheduling software with a Windows-based software solution.

Current Projects and Initiatives:

ITSD has additional initiatives and projects in progress to support the ever-evolving technology needs of the department:

- Idaho Electronic Health Record (EHR) Incentive Management System: Modifications and enhancements will provide users with an efficient means of processing and tracking federally-funded incentive payments to Medicaid providers that attest to the adoption of standard compliant Electronic Health Record (EHR) technology.
- Core Security (formerly Courion) Access Management: Implementing an automated identification access process to enable more secure, efficient services to DHW staff and improve audit trails while reducing compliance and operational risk.
- Vital Statistics Event System Rewrite: Modernize the current Vital Statistics Event application by rewriting it in a supportable language and removing it from the State Controller's mainframe.
- Assessment and Certification Tool Enhancements: Changes to security will ensure that designated staff have the minimum permissions they need to perform their job functions. Additional changes will be made to support additional participating vendors that offer Medicare/Medicaid supported plans (MMCP).
- Fraud and Investigation Tracking System (FITS) Medicaid Rewrite, which will allow expansion for business process modernization and reporting needs for fraud investigative tracking. The new rewrite will be more maintainable, and easier to upgrade within the agency's infrastructure.
- Women, Infants, and Children (WIC) Mainframe Check printing. Moving this process into a Windows environment using VPSX.
- External Partner Portal project, which is a SharePoint site used in conjunction with DHW's external partners. This project will allow DHW business units to safely and securely share data and collaborate with external partners.

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- Currently evaluating and testing enhanced mobile device management products to address the federal and state required critical cybersecurity controls.
- Implementing AppDynamics application performance manager to monitor and manage application and network performance, and to gain end-to-end visibility across the enterprise.

Major Projects in Progress

Child Welfare Modernization

- Function: Re-platform the iCARE product onto a Microsoft Dynamics 365 /.NET architecture (from Natural for Window). Enhancing the access and usability of the system and reformatting the database for additional data collection, data quality, and reporting functionality.
- Status: The iCARE system is past the end of its serviceable life cycle. iCARE remains functional but is expensive to modify. Many modern tools cannot be effectively incorporated into the product without considerable cost. These conditions result in unsustainable support and maintenance costs, lost opportunities for improvements, and unnecessary delays in responding to the needs of children and staff.
- Replacement strategy: Purchasing the Microsoft Dynamics 365 platform and providing experienced integration teams to move the functionality into the new platform. Additionally, the purchase and integration of LaserFiche, a document management system, will provide storage and retrieval capabilities to enhance the efficiencies of the iCARE system and case management for the Child Welfare division. Moving to the new architecture will facilitate the use of modern development methodologies, as well as the contemporary technologies that aid in effective and efficient work cycles. Funding comes from a mix of SACWIS/CCWIS federal funding and state general funds. The percent cost share will change from a (roughly) 70/30 federal to state allocation, to a 50/50 arrangement in FY 2019. The project will continue through 2021.

Child Support Modernization: Modernization of the Child Support System from the migrated code and data which successfully took place in 2017. Modernization efforts include new user interfaces, streamlined processes and additional information allowing the CS staff to provide information more effectively to the citizens of Idaho.

- Status: After the successful ITSD initiative to migrate the mainframe applications off the State Controller's Office mainframe, Phase II of the project was to modernize the system and enhance many of the capabilities to provide more information and to streamline many of the processes previously utilized in the Child Support program. Modernization continues for the Child Support system, and includes key components such as IBES referral, case open, "Do Not Enforce" task management, employment, paternity, income, and financial views.
- Replacement strategy: Phase II will be to re-write the user interface, and to increase functionality and enhancements to accommodate

process improvements in support of the critical business needs.

Health Alert Network (HAN) Modernization, Phase VII

- Function: The Idaho HAN system is an automated system designed to rapidly deliver time-critical, health-related information to designated health partners. Redesign the HAN system to leverage newer application architectures, allowing for increased supportability of current functionality and ease of implementing future enhancements. Provide an updated user interface for an improved user experience and simpler, more intuitive workflows. Incorporate user requested features and update the documentation to reflect the system enhancements.
- Status: This initiative is continuing to move forward through 2018.
- Replacement strategy: Phase VII will continue through June 2018 and is funded through a federal grant. This project is part of a multi-phased project to modernize the Health Alert Network throughout the state.

Security Implementation

The department has acquired several robust IT security solutions including hardware, software, and maintenance services through an enterprise license agreement with a premiere vendor. This cost-effective solution is to enhance the department's IT security posture and to maintain the DHW network and cybersecurity infrastructure to meet DHW's strict cyber requirements. It also aligns with the Idaho Governor's Cybersecurity Executive Order No. 2017-02 requiring all executive branch agencies to implement the first five Center for Internet Security Critical Security Controls (CIS Controls and CSC Top 5 controls).

DHW is also required to implement the complete Top 20 Critical Security Controls (CSC Top 20) to meet security compliance that is audited annually by the Internal Revenue Service and Centers for Medicare and Medicaid Services, and every three years by the Social Security Administration and other federal agencies. These audits are based on the National Institute of Standards and Technology (NIST) Special Publication 800-53, IRS (IRS Publication 1075 Tax Information Security Guidelines), and CMS MARS-E standards to meet HIPAA privacy and security safeguard.

Assessment and Certification Tool:

The ACT system marries three separate systems – the Children's Personal Care Services Assessment Tool, the Regional Medicaid Services Tool, and the Uniform Assessment Instrument – together into a fully integrated, cohesive environment, which allows the collection and the maintenance of data for assessing a client's actual functioning level, social skills, and physical and cognitive abilities from age one though adulthood. This information is used to help provide Medicaid assistance for clients who need additional resources.

- Status: With two of the systems (Regional Medicaid Services Tool and Uniform Assessment Instrument) incorporated into ACT, work is being done to include the final system (Children's Personal Care Services

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Assessment Tool.

Women, Infants, and Children (WIC) Electronic Benefits System (eWIC): eWIC is a project that will implement the use of Electronic Benefits Transfer (EBT) cards for WIC food benefits. Magnetically encoded payment cards (like credit cards), will be issued to WIC participants. Participants will use the cards to redeem benefits. The cards are replacing WIC checks. This project is federally-mandated to be completed no later than October 2020.

- Status: This project will continue through 2019.
- Replacement strategy: Working with third party vendors (CDP/FIS, CQuest and Maximus) to enhance the WIC food benefit delivery process, and adding the EBTI (eWIC) functionality enhancement. The existing check functionality will continue while rolling out the eWIC cards via a rollout schedule.

Division of Licensing and Certification

Tamara Prisock, Administrator, (208) 364-1959

The Division of Licensing and Certification ensures that Idaho healthcare facilities and agencies are in compliance with applicable federal and state statutes and rules. The division oversees licensing and certification activities for the following types of health care providers:

- Ambulatory surgery centers
- Certified family homes
- Developmental disability agencies
- Home health agencies
- Hospice agencies
- Hospitals
- Portable x-ray providers
- Intermediate care facilities for people with intellectual disabilities
- Nursing homes
- Outpatient physical therapy and speech pathology
- Renal dialysis centers
- Residential care or assisted living facilities
- Residential habilitation agencies
- Rural health clinics

Each unit within the division conducts its responsibilities in ways that promote individuals' rights, well-being, safety, dignity, and the highest level of functional independence.

The division also works closely with health care providers, offering training, technical assistance, and resources aimed at improving the quality of care as well as compliance with licensing or certification requirements. Below are a few examples of the work we are doing with Idaho health care providers:

- We continue to work with nursing facilities and the Department of Labor to address shortages of certified nurse aids (CNAs) and registered nurses (RNs).
- We offer extensive training to facility administrators on how to investigate incidents, accidents, and complaints in facilities.
- We provide regular "Administrator Boot Camps" for new assisted living facility administrators, as well as specialized training for nurses who work in assisted living facilities.
- We continue to work with Idaho's Division of Professional and Technical Education to develop and deliver training in medication assistance to certified family home providers.
- We developed specialized, on-line training for certified family home providers on how to care for individuals with mental illness who present difficult behaviors.
- We present training to nursing facility management on the federal certification survey process.

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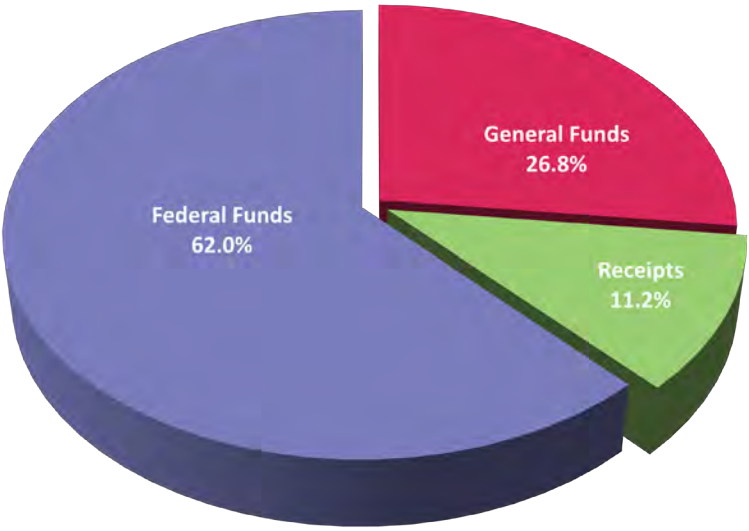
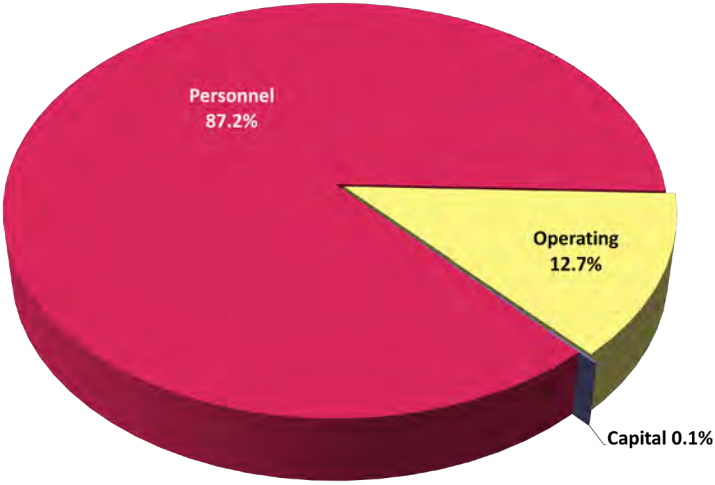
SFY 2019 Funding Sources



Authorized FTP: 71.9; Original appropriation for SFY 2019: General Funds $1.96 million, Total Funds $7.3 million; 0.24% of Health and Welfare funding.

SFY 2019 Expenditure Categories



Bureau of Facility Standards

The Bureau of Facility Standards, in cooperation with the Centers for Medicare and Medicaid Services (CMS), serves and protects Idahoans requiring health-related services, supports, and supervision in care. The bureau licenses and certifies a variety of healthcare providers and suppliers, such as skilled nursing facilities, intermediate care facilities for the intellectually disabled, hospitals, home health agencies, end-stage renal dialysis centers, ambulatory surgical centers, and hospice providers. The bureau also is the single focal point for fire, life safety, and healthcare construction standards in the state.

The Bureau of Facility Standards administers three programs:

1. Long-Term Care
2. Non-Long-Term Care
3. Facility Fire Safety and Construction

The Long-Term Care Program conducts licensing and certification activities to ensure that the state's 81 long-term care facilities, which have 6,233 beds, are in compliance with federal regulations and state rules. These facilities cannot receive Medicare or Medicaid payments if they do not comply with regulations.

The Non-Long-Term Care Team is responsible for surveying, licensing, and certifying approximately 375 healthcare providers in the state, including 51 hospitals; 62 home-health agencies with 24 branch locations; 31 end stage renal dialysis centers; 55 hospice agencies with 33 branch locations; 51 ambulatory surgery centers; 64 intermediate care facilities for the intellectually disabled; 49 rural health clinics; seven occupational therapy/physical therapy clinics with 18 extension units; and six portable X-ray providers. These facilities must comply with federal and state regulations to receive Medicare or Medicaid payments.

The Facility Fire Safety and Construction Program provides oversight and management of the facility fire safety and building construction requirements for all federally-certified healthcare facilities or state-licensed facilities. This team performs facility plan reviews and approvals; on-site plan inspections and finalizations; consultations; and periodic facility fire and safety surveys, which include complaint and fire investigations.

Certified Family Home Program

Certified Family Homes (CFH) provide a safe, family-style living environment for adults who need some assistance with the activities of daily living but do not require a more restrictive institutional setting. There are usually one or two adult residents in a certified family home.

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The CFH Program ensures that services are provided in a safe, home-like environment where residents can receive the appropriate services and supports to promote their health, dignity, personal choice, and community integration. This program provides a safe and stable residence for approximately 3,000 individuals in more than 2,400 homes across the state.

Developmental Disabilities Agency/Residential Habilitation Agency Certification Program

This program ensures developmental disability services and residential habilitation supported living services are provided in accordance with state laws and rules, and that they reflect national best practices.

Developmental disability agencies are privately owned entities certified by the state to provide services to adults and children with intellectual disabilities on an out-patient basis. There are 69 developmental disabilities agencies operating in 159 locations throughout the state.

Residential habilitation agencies are privately owned entities certified by the state to provide services to adults. They consist of an integrated array of individually-tailored services and supports. These services and supports are available to eligible participants and are designed to assist them in living successfully in their own homes, with their families, or in an alternate family home. There are 67 residential habilitation agencies operating 105 businesses throughout the state.

Children's Agency Licensing Program

This program licenses children's residential care facilities, outdoor therapeutic programs, foster care agencies, adoption agencies, and private non-accredited schools operating in Idaho, to ensure services and care is provided to children in accordance with state licensing rule requirements.

Children's agencies are privately-owned and are funded through private pay arrangements and/or state contracts. There are 29 residential care facilities, one outdoor therapeutic program, four foster care agencies, four adoption agencies, and one private non-accredited school operating in Idaho.

Residential Assisted Living Facility Program

This program ensures that businesses that provide residential care or assisted living services to Idaho residents comply with state statute and rules. In Idaho, the residents of residential care or assisted living facilities include 60 percent private-pay residents and 40 percent Medicaid participants. The primary diagnosis of people in these facilities include 45 percent elderly, 34 percent Alzheimer's/dementia, 13 percent mental illness, 3 percent

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developmental disability, 1 percent traumatic brain injury, and 4 percent physical disability or other need for assisted care.

There are 377 facilities in Idaho, operating under 286 licenses, and representing 10,393 beds. Facilities range in size from six to 160 beds. The average building size has been increasing each year, with most of the facilities being constructed with 50 or more beds. Many small facilities, particularly those that serve people with mental illness, have closed.

The program enforces compliance with state rules, and works closely with residents, families, partners in the industry, advocates, other governmental agencies, and stakeholders to ensure safe and effective care to residents. Information on assisted living facilities in Idaho is easily accessible to the public via the FLARES public portal:
https://www.flareslive.com/portal/SearchFacility.aspx

The survey teams provide consultation, technical assistance, and education to improve compliance and promote better health outcomes. Education is accomplished through regular training sessions for the industry, quarterly newsletters, a website with multiple best practice tools and resources, on-line courses, and by coordinating training for the industry by local and national experts.

Workload

The division completed 4,581 surveys (including complaint investigations) in calendar year 2018, which was 401 more surveys than the 4,180 surveys (also including complaint investigations) completed in calendar year 2017. Also, during 2018, 309 new health care entities were licensed/certified to operate in Idaho.

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New Entities Licensed / Certified in 2018		
Facility Type	**Number**	**Number of beds**
Nursing Facilities	4	293
Hospitals	2	95
Assisted Living	6	367
Hospice Agencies	11	N/A*
Home Health Agencies	2	N/A*
Renal Dialysis Centers	2	N/A*
Rural Health Clinics	1	N/A*
Developmental Disabilities Agencies	2	N/A*
Residential Habilitation Agencies	3	N/A*
Children's Agencies	2	N/A*
Certified Family Homes	274	412
Total	**309**	**1,167**

**Note: State surveyors do not count the number of beds in entities that deliver health and medical services and are not residential settings.*

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Division of Medicaid

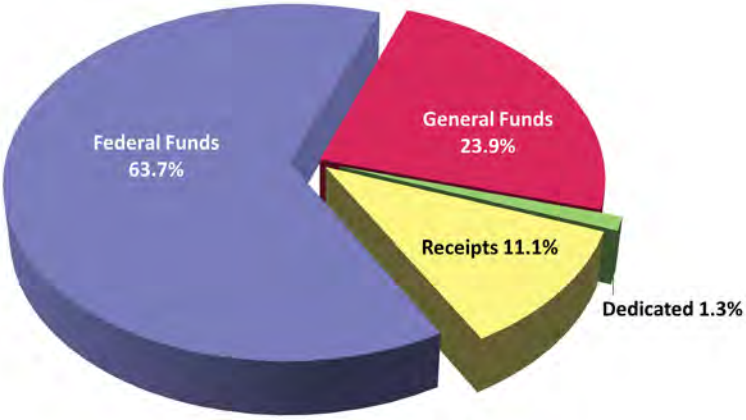
Matt Wimmer, Administrator, (208) 334-5747

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 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 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.

SFY 2019 Funding Sources



Authorized FTP: 216; Original Appropriation for SFY 2019: General Funds $585.2 million, Total Funds $2.5 billion; 80.2% of Health and Welfare funding.

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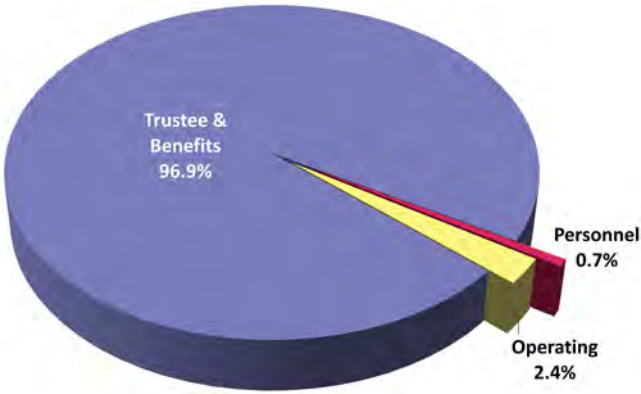
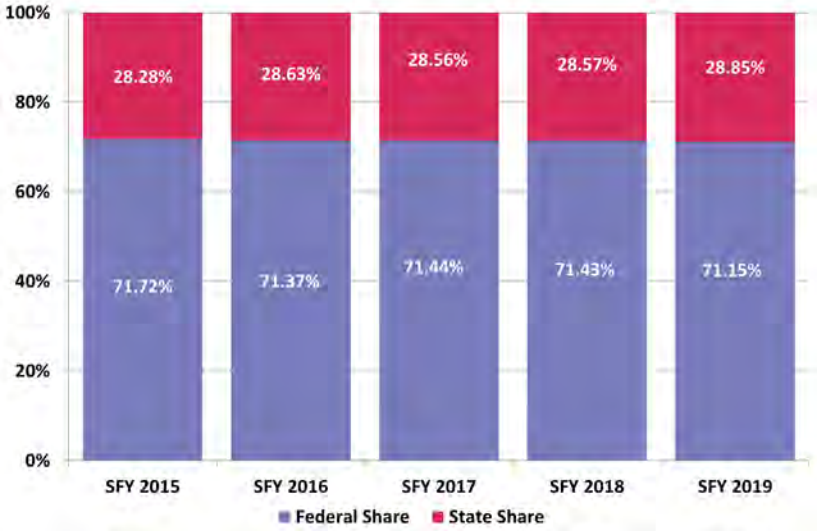
Just over 3 percent of Medicaid's budget is spent on administration, while about 97 percent is paid directly to service providers. This means that each $1 of state general fund spending results in $4.22 that is paid mostly to private healthcare providers who are part of the Idaho healthcare delivery system.

SFY 2019 Expenditure Categories



Funding Medicaid: The Impact of the Federal Medical Assistance Percentage (FMAP) Rate

The FMAP is the percentage the federal government shares of the costs associated with all services provided to Medicaid recipients. The FMAP represents how Idaho's per-capita income compares to the national average.



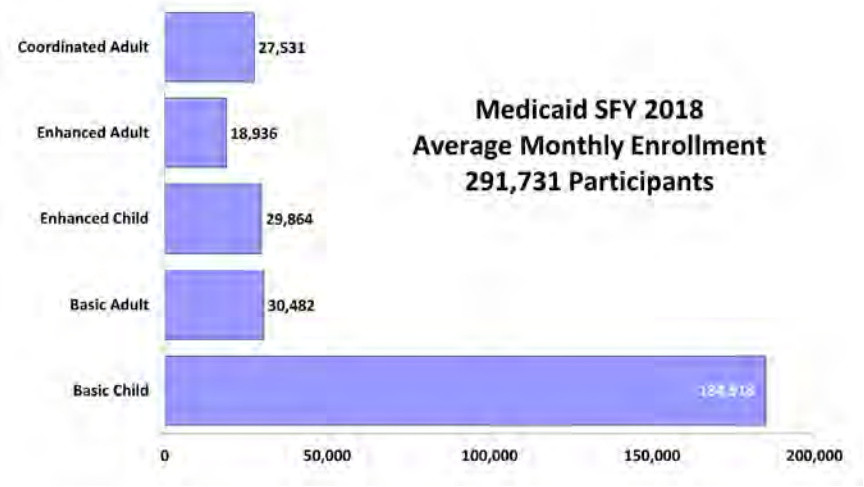
SFY 2018 Budget Analysis

After years of increased Medicaid eligibility, the average number of monthly eligible members dropped in 2018. This was due to a couple of factors. First, Self-Reliance's (SR) federal partners reduced the allowed time for participants to submit their annual re-enrollment information from 30 days to 10 days. Second, SR conducted a statewide re-evaluation process that resulted in an additional decrease of eligible members.

Enrollment and Expenditures Comparison

Medicaid enrollment averaged 291,731 participants per month in SFY 2018, a 3 percent decrease from the SFY 2017 enrollment of 300,838. The projected growth rate is forecast to decline overall in SFY 2019, and then increase slightly for SFY 2020. Medicaid growth should begin to more closely match historical average growth before the recession.

SFY 2018 Enrollees
Average Monthly Participants



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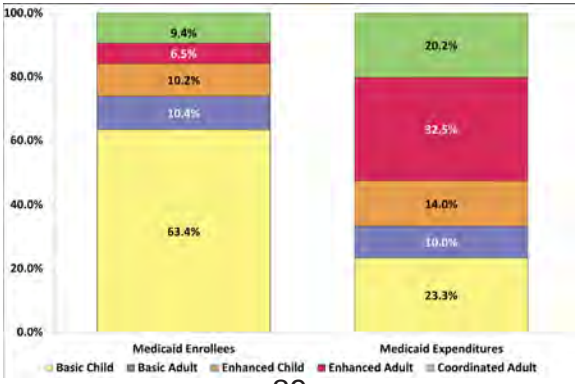
SFY 2018 Expenditures

SFY 2018 Enrollment and Expenditure Comparison

Coverage costs for children enrolled in the Basic Plan average less than $240 a month, while children enrolled in the Enhanced Plan average approximately $880 a month. By comparison, an adult enrolled in the Basic Plan costs $616 a month, while an adult enrolled in the Enhanced Plan averages almost $3,219 a month. Participants enrolled in the Enhanced Plan have more intense healthcare needs that may be so severe that they require an institutional level of care.

Many participants enrolled in the Coordinated Plan are elderly and have greater needs for medical services, including long-term care services such as assisted living facilities or nursing homes. A participant enrolled in the Coordinated Plan costs an average of $1,380 a month because Medicare pays the majority of their medical expenses.



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Medicaid Initiatives

Medicaid Managed Care

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.

Patient-Centered Medical Home (PCMH): Medicaid implemented the Healthy Connections PCMH tier incentive program in 2016 as the initial phase to support primary care providers to transition to the upcoming Medicaid value-based payment reform. Under this model of care, patient treatment is coordinated through the primary care provider to ensure patients receive the necessary care when and where they need it, in a manner they can understand. Over the past two years, 260 of 480 Healthy Connections Primary Care Clinics have advanced PCMH tiers and 53 percent of all Healthy Connections participants are enrolled with an advanced PCMH clinic.

Healthy Connections is expanding and currently collaborating with Healthy Connections providers, network providers, and stakeholders throughout the state in the development of three value-based programs, with roll-out expected in 2019 and 2020. Under the Medicaid payment reform effort, participating providers will have the opportunity to earn a share of the savings by improving quality and reducing costs. These programs will be voluntary and will not affect the current Medicaid payment arrangements.

Healthy Connections Value Care Programs: Medicaid is launching three value-based programs through the Healthy Connections Value Care (HCVC) transformation program.

- Healthy Connections Accountable Care Organizations: Expect to implement at least two accountable care organizations in southwest Idaho in 2019 and roll-out statewide in 2020 and 2021.
- Healthy Connections Accountable Primary Care Program: Expect to implement statewide in 2019.
- Healthy Connections Episodes of Care: Expect to implement in 2020.

The Healthy Connections Value Care Program supports the Department of Health and Welfare's strategic objective to transform Idaho's healthcare delivery system to promote healthier Idahoans while increasing healthcare quality and reducing costs. Medicaid will offer financial incentives to providers who control their health care costs and achieve benchmarks for selected national quality measures related to patient care. Participation is voluntary. Each region of the state will have:

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- Regional Care Collaborative (RCC): The RCC will be established by the department and accountable for identifying healthcare needs across the region and seeking collaborations to improve cost, quality, utilization and data sharing.
- Community Health Outcome Improvement Coalition (CHOICe): The CHOICe will be established by the department and will be accountable for identifying opportunities to improve health and wellness, create health equity, and address the social determinants of health in their communities. CHOICe may be eligible to receive a portion of shared savings, which will be based on regional performance and will be distributed back to the community through a granting process. These shared savings will be used to fund community initiatives that advance population health.

Outpatient Behavioral Health Managed Care: The Idaho Behavioral Health Plan (IBHP) is in its fifth year of operation. The contract with Optum Idaho to administer IBHP services has been extended through June 30, 2019. Primary focus areas continue to be access improvement and supporting the network in providing evidence-based, outcome-driven services.

The divisions of Medicaid and Behavioral Health and Optum Idaho continue working toward the implementation of the Youth Empowerment Services (YES) project for children and youth diagnosed with a severe emotional disturbance. In January 2018 Optum Idaho began the Person-Centered Plan review and approval process for members meeting Medicaid SED eligibility, which requires the development and approval of a Person-Centered Plan. Optum launched the first group of new services on July 1, 2018, and additional services are in development for implementation throughout the following year.

Implementation for the new services requires a tremendous amount of communication, training, and support for the IBHP provider network, which is led by Optum. For more information about YES, please visit www.youthempowermentservices.idaho.gov. For information about Optum, visit www.Optumidaho.com.

Nursing Facility Quality Payment Program: Nursing facilities annually contribute to an assessment fund. These funds are matched with federal monies and distributed to each contributing nursing facility based on Medicaid bed days, which are counted as overnight stays in the facility. Changes made to the "Assessment Fund" statute during the 2018 session of the Idaho Legislature will allow the department to distribute the monies, in part, based on quality performance starting in 2021.

The Nursing Facility Quality Payment Program was developed by a workgroup of nursing facility stakeholders and the department, with the overarching goal of improving the care and lives of nursing facility residents throughout Idaho. Each nursing facility currently reports data on 10 quality

measures. The measures include performance areas such as reports of moderate to severe pain, falls, and urinary tract infections.

Before full implementation of the Nursing Facility Quality Payment Program in 2021, each nursing facility will receive quarterly reports of their quality scores so they can track their progress through the year and potentially improve their performance prior to full implementation. The work group will continue its collaborative efforts to further enhance the program and promote quality care in Idaho's nursing facility community.

Managed Care for Dual Eligibles: The Medicare Medicaid Coordinated Plan (MMCP), which was expanded in 2014, is designed to coordinate all health-related services for participants in both Medicare and Medicaid. Covered benefits include: hospital and medical services, prescription drugs, behavioral health services, Aged and Disabled waiver benefits, community- based rehabilitative services, personal care services, and nursing home care. The purpose of the MMCP is to coordinate benefits to ensure that people who are eligible for both programs receive the most integrated care possible.

Molina Healthcare of Idaho joined Blue Cross of Idaho to administer the MMCP. Dually eligible participants who live in counties where both plans administer the MMCP will be able to select from Blue Cross of Idaho or Molina Healthcare to participate in the program.

Idaho Medicaid is currently in the implementation phase of a new program called Idaho Medicaid Plus, which is designed for dually eligible participants who do not elect to enroll into the MMCP. Idaho Medicaid Plus is offers an improved service delivery system of Medicaid benefits for dually eligible members. This program was piloted in Twin Falls County in the fall of 2018. Enrollment in Idaho Medicaid Plus will be mandatory for dually eligible members who are not enrolled in the MMCP and who also are not tribal members, pregnant women, or participating in the Adult Developmental Disabilities waiver program. Idaho Medicaid Plus will be phased in in additional counties during 2019.

Managed Care for Dental Services: Managed Care of North America (MCNA) Dental continues to administrator the Idaho Smiles Medicaid Dental Program for the department. Since MCNA began managing the Idaho Smiles program, there has been a substantial increase in utilization – 32 percent of the Medicaid population is accessing their dental benefits. Utilization continues to increase with the adult Medicaid population. MCNA continues its outreach efforts to increase the provider network, which has grown to over 550 providers. MCNA has reinstated enhanced dental benefits for all Medicaid eligible adults on the Basic Plan and the Pregnant Women's Program as of July 1, 2018 at the direction of the 2018 Idaho Legislature.

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The department is also working closely with Medicaid stakeholders to propose an increase to the fee schedule reimbursement rates for the Idaho Smiles provider network.

Non-Emergent Medical Transportation: The Non-Emergent Medical Transportation (NEMT) program helps ensure that Idaho Medicaid participants have access to health care services. On March 6, 2018, MTM began providing NEMT services in Idaho. MTM and the department have worked closely to implement a nationally recognized statewide NEMT driver training program to improve safety and services for Medicaid participants. The department continues to work with MTM and other stakeholders to create efficiencies and improvements for the NEMT program. For more information about MTM, visit www.mtm-inc.net/idaho/.

Youth Empowerment Services (YES)

With Legislative approval, Idaho Medicaid implemented a new eligibility group for youth in support of Youth Empowerment Services (YES) on Jan. 1, 2018. This eligibility group is for youth younger than 18 who are over income for traditional Medicaid but have been determined to have a serious emotional disturbance. The income limit for this eligibility group is 300% of the federal poverty guidelines.

Medicaid also implemented an independent assessment process, which is being administered by Liberty Healthcare. This assessment includes the completion of a comprehensive diagnostic assessment and the state-approved functional assessment tool called the Child and Adolescent Needs and Strengths (CANS) to determine whether the youth has a serious emotional disturbance and is eligible to access Idaho Medicaid at the higher income limit.

New and modified services began implementation on January 1, 2018. All services have been designed to meet the terms of the settlement agreement to the extent that Medicaid funds can be used. For more information about YES, please see pages 26-27 or visit www.YES.Idaho.gov.

Idaho Home Choice

The Idaho Home Choice Program, implemented in October 2011, rebalances long-term care spending from institutionalized care to home- and community-based care. The program was originally awarded a five-year grant but is now in its eighth year of operation and has been extended through calendar year 2020. Idaho Home Choice has helped 530 participants transition from institutions into their communities.

At the end of the 10-year grant period, the program expects to have diverted $3,531,977 of Medicaid state general fund spending from institutionalized care to home and community-based care to support the

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transition of 600 individuals into their communities. The Division of Medicaid, Idaho Commission on Aging, State Independent Living Council, and service providers from the Centers for Independent Living and Area Agencies on Aging continue to build the necessary infrastructure to support Idaho Home Choice benefits beyond the end of the grant.

Developmental Disabilities

Children's Developmental Disability Services Enhancement: New federal regulations state that services that prevent, correct, or ameliorate a condition for children with developmental disabilities must be provided in the state plan benefit package. In 2016, the department launched the children's benefit project in collaboration with providers, parents, and other advocates. The new regulations were used as an opportunity to further develop and enhance Idaho's services to ensure children's needs are being addressed through evidence-based and evidence-informed practices. The rules around these service enhancements will be presented to the 2020 legislature.

Community NOW! Service Recommendations: In January 2017, the Department of Health and Welfare, in collaboration with the Idaho Council on Developmental Disabilities (ICDD), launched the Community NOW! collaborative workgroup. It was created in part to help implement the settlement agreement in the KW v. Armstrong lawsuit, but more importantly to hear the voices of adults with intellectual and developmental disabilities. Community NOW! is made up of individuals with intellectual and developmental disabilities, family members representing those who cannot represent themselves, DHW staff, IDCC, service providers, the American Civil Liberties Union, (the attorneys representing people with intellectual and developmental disabilities), Deputy Attorneys General, Disability Rights Idaho, and other advocates. From January to June 2017 Community NOW! conducted 21 meetings in Boise and 14 meetings around the state. Based on the information gathered at these meetings, Community NOW! produced the Service and Support Recommendations report and presented it to DHW leadership. The current focus of Community NOW! is person-centered planning, the group's number one recommendation. DHW has committed to continued collaboration to explore, respond to, and implement the report's recommendations whenever possible. Learn more about Community NOW! at http://mychoicematters.idaho.gov/.

Health Information Technology for Economic and Clinical Health (HITECH)

The Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law in 2009 for the promotion, adaption, and meaningful use of health information technology. Medicaid has initiated two programs under HITECH to reach the goal of statewide care coordination and overall improvement of care in Idaho:

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- Medicaid support for connecting Idaho Medicaid primary care clinics to the Idaho Health Data Exchange (IHDE). This gives Medicaid primary care providers the ability to send and receive information through IHDE to support clinical quality measures and care coordination. Currently, 91 of Idaho's Medicaid primary care clinics can send and receive information through IHDE, and 92 organizations have access to view the IHDE portal. Medicaid will continue to work with IHDE this year to connect additional clinics and hospitals which will help provide greater support and value across the state.

Technology Performance

The Division of Medicaid works closely with contractors for Idaho's Medicaid Management Information System (MMIS) to make system enhancements, improve services to stakeholders, and meet the Centers for Medicare and Medicaid Services (CMS) requirements.

- Molina Medicaid Solutions handles provider enrollment and processing fee-for-service medical claims. The weekly payout from the Molina system averaged $36 million in SFY 2018. This represents payments for fee-for-service claims and managed care fees.
- Magellan Medicaid Administration manages pharmacy benefits. The weekly payout was approximately $4.1 million.
- Truven Health Analytics is a data warehouse and decision support system. The Truven system continues to serve as the Medicaid data warehouse and to support the needs for reporting and information analytics for the Division of Medicaid.
- MMIS contractors saved Idaho Medicaid almost $4.5 million through the Health Insurance Premium Payment Program by helping 406 people acquire and/or retain health insurance that was the primary payer for Medicaid-eligible participants.
- MMIS contractors ensured that Medicare was the primary payer for the 45,652 Medicaid participants who have Medicare through the Medicare Savings Program.

Financial Operations

During SFY 2018, the Bureau of Financial Operations:

- Recovered more than $10 million through the Estate Recovery Program.
- Saved Idaho Medicaid almost $60,000 through the Health Insurance Premium Payment Program by helping 141 people acquire and/or retain health insurance that was the primary payer for Medicaid-eligible participants.
- Ensured that Medicare was the primary payer for the 46,893 Medicaid participants who have Medicare through the Medicare Savings Program.
- Recovered more than $4.8 million from primary insurance, casualty and liability claims, and provider overpayments.

Office of Healthcare Policy Initiatives

Casey Moyer, Administrator, (208) 334-0600

The Office of Healthcare Policy Initiatives (OHPI) was established in 2015 and manages a four-year model test grant the Idaho Department of Health and Welfare (IDHW) received from the Center for Medicare and Medicaid Innovation (CMMI) to implement Idaho's Statewide Healthcare Innovation Plan (SHIP). OHPI is housed within the Director's Office and has oversight responsibility for the day-to-day operations of $39.6 million in grant funds and over 40 vendor contracts.

SHIP was developed to transform Idaho's healthcare system and improve the health of Idahoans. Efforts focused on moving delivery of primary care services to a team-based, care-coordinated patient-centered medical home (PCMH) model, exchanging electronic health data and implementing value-based payment (VBP) models that reward cost-effective quality care.

During 2018-2019, OHPI released and monitored the appropriate use of grant funds, convened stakeholder and staff workgroups, coordinated all activities across SHIP, assessed and mitigated risks, assisted in establishing transformation milestones and monitored progress. This centralized system for supporting, monitoring and tracking progress has been an important component of the model and has remained stable throughout the implementation of the model test.

Activities have focused on seven project goals organized around the triple aim e.g. to improve health outcomes, to improve quality and patient experience of care and to reduce healthcare costs. The model was completely unique to Idaho; it was built on a comprehensive statewide assessment of Idaho's strengths, barriers and gaps, and was designed by Idaho stakeholders to leverage elements of the healthcare system that were working well and to address barriers that were impeding progress.

Goals to Transform Idaho's Healthcare Delivery System

- **Goal 1:** Transform primary care practices across the state into PCMHs.
- **Goal 2:** Improve care coordination through electronic health records (EHRs) and health data connections among PCMHs and across the medical-health neighborhood.
- **Goal 3:** Establish seven regional collaboratives to support the integration of each PCMH with the broader medical-health neighborhood.
- **Goal 4:** Improve patient access to PCMHs in rural areas by developing virtual PCMHs.
- **Goal 5:** Build a statewide data analytics system.

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- **Goal 6:** Align payment mechanisms across payers to transfer payment methodology from volume to value.
- **Goal 7:** Reduce healthcare costs.

Highlights

Work on SHIP began in 2013 when Idaho stakeholders came together to study Idaho's current healthcare system and develop a plan for transformation. The six-month planning process involved hundreds of Idahoans across the state working together to develop a new model of care. In early 2014 Gov. C.L. "Butch" Otter established the Idaho Healthcare Coalition (IHC), which serves as the advisory group for SHIP. The coalition has continued to build on earlier stakeholder work and momentum.

IHC members include private and public payers, legislators, health system leaders, primary care providers, nurses, and representatives of healthcare associations and the community. Experience with the SHIP program has demonstrated the benefit of public/private collaborations to address clinical and economic changes needed to achieve effective healthcare transformation.

OHPI's experience with SHIP demonstrates the value of public/private collaborations, the effectiveness of program design and engaged stakeholders as well as the clinical and economic changes needed for effective transformation. The OHPI operations team works with multiple contractors to support healthcare system transformation and the implementation of SHIP's seven goals.

Technical Assistance Offered to Support Idaho's Healthcare Delivery Transformation

Contractors hired by IDHW to perform technical assistance operations for the model test are:

- Mercer, LLC: provides project management and financial analysis. A detailed Project Implementation Plan is prepared annually, and a financial analysis with actuarial certification is prepared for all four years of the grant. This analysis measures reduction in health care costs (or reduced growth in costs).
- Briljent, LLC: provides subject matter expertise to assist in transformation efforts, quality improvement, and PCMH training for primary care clinics participating in SHIP.
- Idaho Health Data Exchange (IHDE): establishes connections with Electronic Medical Records (EMRs) at clinics to improve care coordination and information sharing among providers.
- HealthTech Solutions, LLC (HTS): SHIP's data analytics contractor, responsible for establishing a connection with IHDE and developing best practices for reporting clinical quality measures. At the state level, data analysis will inform policy development and program monitoring

for the entire healthcare system transformation.

- Subgrants with the seven public health districts were executed to hire SHIP staff to assist in the support of regional collaboratives, medical health neighborhoods, and PCMH transformation. The seven public health districts convened regional collaboratives in 2015 that support provider practices as they transform to PCMHs.
- Statewide project evaluation is being conducted in partnership with University of Idaho and Boise State University. This state-level evaluation is required by Center for Medicare and Medicaid Innovation and utilizes a mixed methodology of data collection including patient interviews, provider surveys, and focus groups to evaluate the success of specific goals.
- Several smaller contracts are in place to assist in the planning, design, and operation of the virtual patient-centered medical home components of community health workers, community health emergency medical services, and telehealth. The virtual PCMH model is a unique approach to developing PCMHs in rural, medically-underserved communities.

Our PCMH transformation model recognizes the challenges that many primary care practices face in converting to a value-based healthcare environment. Support is provided with on-site training and coaching, virtual training and coaching, and a web-based quality improvement portal. All types of primary care practices are represented in the three cohorts of clinics, ranging from rural single-practitioner offices to large practice networks and federally-qualified health centers. A goal has been established by stakeholders, that over the next five years the number of primary care practices who are organized under the PCMH model will double.

During this year, OHPI continued to emphasize and focus on incorporating the full universe of statewide transformational solutions that further advance healthcare delivery reform. Idaho's healthcare stakeholders and residents have received invaluable benefits from the transformation efforts to improve the way Idahoans receive healthcare and build the necessary infrastructure to maintain and advance these changes. OHPI has continually assessed the state's healthcare performance, identified programmatic and policy gaps and developed recommendations for improvement.

Milestones

The following milestones were accomplished during 2018-2019:

- The IHC's seven workgroups and two advisory groups regularly met for discussion and to develop actionable strategies and plans that assist in achieving Idaho's seven goals. The value of stakeholder engagement has been reinforced as the complexities of changing the state's healthcare system were addressed.
- Fifty-three clinics were selected to participate in PCMH Cohort Three.

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The number of clinics participating in SHIP totals 163.

- About 98% of the clinics of the 166 clinics enrolled in SHIP continue to be engaged in PCMH transformation. Adoption of the PCMH model of care requires significant work to build PCMH capacity. Adoption of the PCMH model has been accelerated statewide with provision of PCMH transformation support at the regional level and through national experts.
- Idaho's four largest commercial insurers, Blue Cross of Idaho, Regence Blue Shield, PacificSource, and Select Health, along with Medicare and Medicaid, are participating in the model test. Payers are evolving their payment models from paying for volume of services to paying for improved health outcomes.
- The increase in value-based payment coupled with new care delivery models such as PCMH have bent the cost curve in Idaho. Financial analysis conducted by outside actuaries indicates that Idaho's healthcare system costs were reduced by $213 million over the life of the grant 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.
- Clinics continue to evolve their business models and adapt new strategies to adjust to the changing landscape of payment reform initiatives.
- Innovative workforce development strategies were developed and implemented to address the state's critical health professional workforce shortages, including the training of community health workers, the establishment of community health emergency medical services programs, and the establishment of 13 telehealth grants to expand medical services in rural, under-served communities.
- Idaho's plan included significant investment to connect patient-centered medical homes to the Idaho Health Data Exchange and enhance care coordination. More resources were invested in the health information exchange infrastructure. The health information technology environment in Idaho continues to shift, with increased electronic health records conversions at the practice level that require changes in workflows and policies.
- Project ECHO launched a practice model on opioid addiction and treatment through a multi-point videoconferencing to conduct virtual clinics with community providers, particularly those in geographically isolated areas lacking access to specialists.

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Division of Operational Services

Catherine Libby, Administrator, (208) 334-0632

The Division of Operational Services provides contracting and purchasing services, facility management, business operations support services, human resource management, and coordination of administrative hearings and public records requests.

Contracts and Purchasing

- Purchases services and products in support of department needs, coordinating with the Department of Administration's Division of Purchasing for purchases valued at $5 million and above.
- Provides technical expertise and administrative oversight for DHW competitive bidding, contract and subgrant development and implementation, and product purchases from state wide contracts. There were approximately 1,580 active contracts and subgrants department-wide during SFY 2018, with a total value of approximately $2.3 billion. Additionally, there were approximately 130 contracts for commodities and goods in place and over 1,200 direct purchase orders produced in SFY 2018.
- Develops and maintains DHW's contract and purchasing repositories.
- Develops and maintains contracts and purchasing policy, procedure, and guidance documentation.
- Provides contract management, monitoring, and purchasing training for department staff, and collaborates with the Department of Administration to ensure compliance with purchasing rules and regulations.

Facilities and Business Operations

- Monitors, negotiates, and coordinates leases for 32 buildings totaling more than 640,000 square feet in collaboration with the Department of Administration.
- Manages the operation, care and repair of eight DHW-owned buildings that total about 80,000 square feet.
- Prepares and submits DHW's annual Capital, Alterations, and Repair budget request to the Permanent Building Fund Advisory Council and prepares agency project requests for legislative funding.
- Coordinates and manages statewide remodeling and alteration construction projects funded through the Permanent Building Fund Advisory Council or agency funds.
- Assists and provides consultation to the two state hospitals, Southwest Idaho Treatment Center, and the state laboratory on facility issues.
- Evaluates existing facility use, and prepares space reports and plans for future facility needs.
- Oversees new construction of buildings, land sales, acquisitions, and

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disputes.
- Coordinates and manages interoffice moves and relocations.
- Contracts telephone, power, and data cable installations to ensure uniformity, adherence to DHW standards, and cost controls.
- Manages regional purchases of all paper products, office supplies and postage.
- Administers purchases, statewide allocation, repair, maintenance, and use of motor pool vehicles.
- Contracts with independent contractors and coordinates with the Department of Administration to provide security for various DHW buildings.
- Assists with assessing and managing security threats and safety concerns at department work sites.
- Manages the department's asset inventory and disposal of surplus items.
- Provides facility and operational support for regional staff in all regional offices. These include:
    - **North HUB:** Ponderay, Kellogg, Coeur d'Alene, Moscow, Lewiston and Grangeville
    - **West HUB:** Payette, Caldwell, Nampa, Boise, and Mountain Home
    - **East HUB:** Twin Falls, Burley, Pocatello, Idaho Falls, Preston, Blackfoot, Rexburg and Salmon.

Human Resources

- Develops, implements, oversees, and maintains policies and procedures to protect privacy and confidentiality and limit access to information in DHW records based on business need.
- Ensures DHW personnel actions comply with federal and state laws and that DHW's information privacy practices are closely followed.
- Provides consultation in support of system-wide approaches and recommendations for compensation, position utilization, and classification.
- Supports the department's commitment to advance equal opportunity in employment through education and technical assistance.
- Educates employees on how to maintain a respectful workplace where employees are treated with courtesy, respect, and dignity.
- Consults and manages resolution of civil rights complaints, compliance, employee relations, and agency audits or site reviews.
- Identifies, promotes, coordinates, develops, and provides training to employees on topics including leadership, management, supervision, communication, and program-specific topics.
- Administers DHW's Learning Management System and facilitates development and implementation of online learning opportunities for DHW staff.
- Provides management and consultation on effective recruitment and selection strategies for filling current and future needs.

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Administrative Support

- Coordinates DHW activities related to administrative hearings and public records requests.
- Develops, implements, and maintains policies, procedures, and educational resources related to administrative hearings and public records.

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Division of Public Health

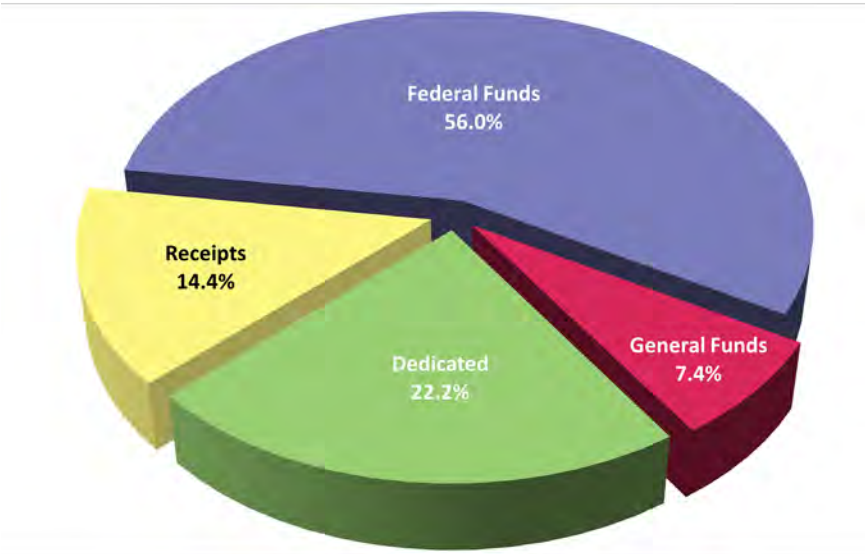
Elke Shaw-Tulloch, Administrator, (208) 334-5950

The Division of Public Health, nationally accredited through the Public Health Accreditation Board, protects the health and safety of Idahoans through a range of services, including immunizations, nutrition services, chronic and communicable diseases surveillance and intervention, food safety regulation, emergency medical personnel licensing, vital records administration, health statistics compilation, rural healthcare provider recruitment, laboratory services and bioterrorism preparedness.

The division's programs and services promote healthy lifestyles and prevention activities while monitoring and intervening in disease transmission and health risks as a safeguard for Idahoans. The division contracts and coordinates with local public health districts and other local providers to deliver many of these services throughout the state.

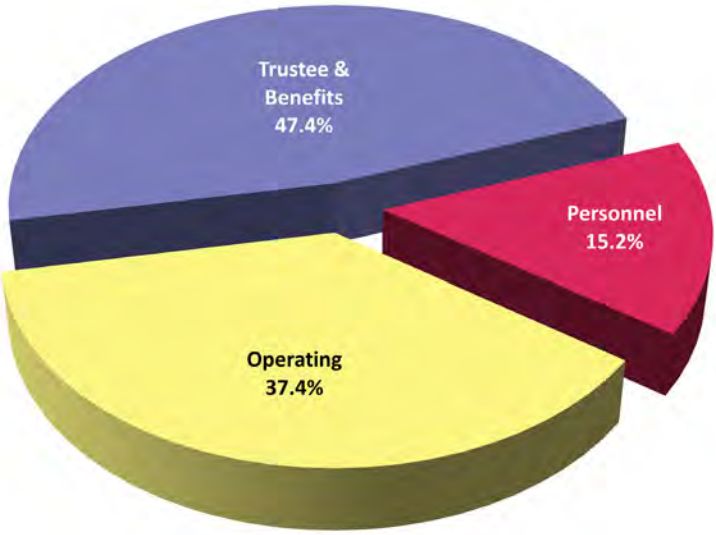
The division includes the bureaus of Clinical and Preventive Services, Community and Environmental Health, Emergency Medical Services and Preparedness, Vital Records and Health Statistics, Laboratories, Rural Health and Primary Care, Communicable Disease Prevention, Public Health Business Operations, and the Suicide Prevention Program.

SFY 2019 Funding Sources

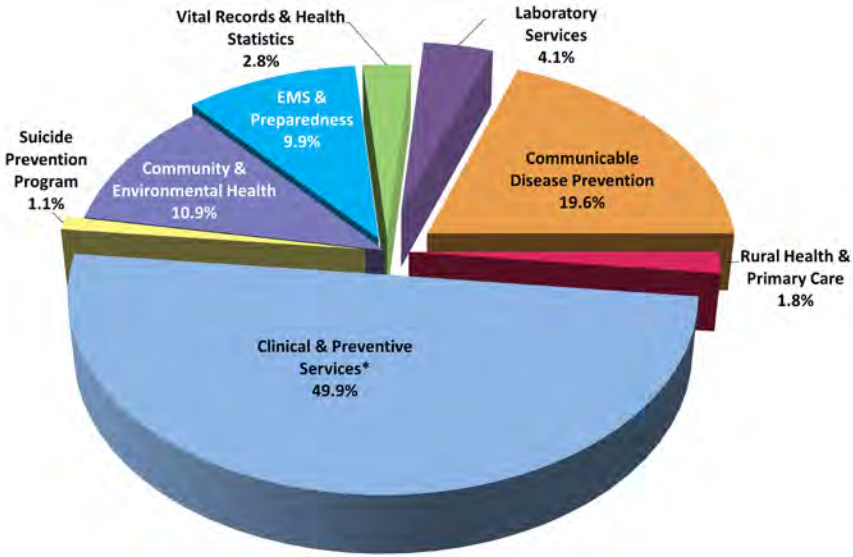


Authorized FTP: 237.02; Original SFY 2019 Appropriation: General Funds $8.9 million, Total funds $120.8 million; 4% of Health and Welfare funding.

SFY 2019 Expenditure Categories



SFY 2019 Spending by Bureau or Program



**The Bureau of Preventive Services include WIC and its associated food costs. WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children.*

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2018: Protecting Public Health in Idaho

Division of Public Health: The Division of Public Health was awarded 5-year accreditation status on June 6, 2017, through the national Public Health Accreditation Board (PHAB). As part of this accreditation status, PHAB requires annual reporting to document continuous quality improvement efforts made on standards identified during the PHAB site visit as opportunities for improvement. The division was required to report on only 9 of the 108 measures assessed. At review of the report, PHAB was satisfied at the division's effort and no long requires reporting on those nine measures. Annual reporting will continue, but the focus will be more about the changing culture of the division, as opposed to conformity to the standards. IDHW is one of 31 state public health departments to be accredited and has been featured on PHAB's "Accreditation Works" news report.

Bureau of Clinical and Preventive Services: During the 2017 legislative session, a law was passed that directed the Idaho Department of Health and Welfare to create a public education program about a common virus called Cytomegalovirus or CMV105. CMV is a virus that rarely causes problems for healthy people. However, when a pregnant woman is infected with CMV, it may cause serious health problems for her unborn baby. The virus is common in settings with young children, such as child care centers, schools, and church nurseries. The Idaho Maternal and Child Health Program worked with partners to create educational products and launch a website with information and resources about CMV: www.CMV.dhw.idaho.gov . Resources have been shared with health care providers who care for pregnant women and children, child care facilities, schools, churches, WIC clinics, and the general public. The Maternal and Child Health Program will continue to work with partners to enhance educational tools and resources to build awareness about reducing CMV transmission among pregnant women or women who may become pregnant.

During the 2018 legislative session, the Idaho Newborn Screening Program was successful in passing rule changes to require screening for Critical Congenital Heart Disease (CCHD). As of July 1st, 2018, all babies born in Idaho must be screened for CCHD. Babies with CCHD can look and act healthy at first but can have serious complications within hours to weeks after birth. If caught early, these heart defects are typically treatable through surgery or some other procedure. In Idaho, it is estimated that approximately 55 babies are born each year with CCHD. The Newborn Screening Program can provide training and technical assistance to facilities and is monitoring screening data collected on the birth certificate to ensure babies receive appropriate follow-up care.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) continues the process of moving from paper to electronic benefits (WIC EBT or eWIC). Work has begun with the Management Infor-

mation System contractor CQuest and the quality assurance contractor MAXIMUS. Idaho WIC joined the Department's (SNAP/TANF/Cash) contract with Fidelity Information Systems (FIS) and Custom Data Processing (CDP) for EBT processing. The program goal is to make the transition by 2019. It is federally required by 2020.

WIC is also in the process of implementing an online nutrition education option for participants called WICSmart. WICSmart is a free smartphone app that allows WIC participants to complete nutrition lessons related to their family's interests and needs. Once a participant completes a lesson, the information may be accessed by their WIC clinic.

The HIV, STD, and Hepatitis Section coordinated with community-based partners in northern and south-central Idaho to initiate HIV mobile testing activities. Mobile testing services will help broaden access to HIV/STD testing in geographic areas experiencing provider gaps and underserved rural populations.

Bureau of Communicable Disease Prevention: The Healthcare-Associated Infection Program partnered with the Bureau of Rural Health and Primary Care, the Idaho Bureau of Laboratories, and Qualis Health to hold Regional Antibiotic Stewardship and Antibiotic Resistance Town Hall meetings across Idaho. Participants identified successes and challenges in promoting appropriate antibiotic use in healthcare settings. The meetings provided stakeholder and community input for future statewide activities and education campaigns that will focus on encouraging appropriate antibiotic use to reduce the development of antibiotic resistance.

The Epidemiology Program has integrated the use of whole genome sequencing (WGS) into disease cluster and outbreak detection in Idaho. Whole genome sequencing is a laboratory method that can identify the "DNA fingerprint" of organisms and allows epidemiologists to identify disease transmission patterns. The program leveraged whole genome sequencing to respond to a cluster of people infected with HIV, to confirm transmission of tuberculosis and intervene. The program also used it to aid in response to a multi-state outbreak of severe E. coli O157:H7 infections that disproportionately impacted Idaho residents.

The Idaho Immunization Program (IIP) enhanced Idaho's immunization registry, the Immunization Reminder Information System (IRIS). The first enhancement makes it easier for Idaho providers enrolled in the Vaccines for Children program to perform annual re-enrollment electronically rather than with paper forms. Enhancements also enabled the system to more efficiently exchange immunization data with provider medical record systems. Users can now query patient immunization records via a secure "real-time" web service to ensure immunization information is current and accurate.

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Idaho Bureau of Laboratories: The Idaho Bureau of Laboratories (IBL) provides testing, inspection, training and outreach laboratory services for stakeholders throughout Idaho. In SFY 2018, IBL worked to enhance biosafety, hazard risk management, and dangerous goods packaging and shipping capability throughout the Idaho Sentinel Laboratory Network (ISLN). The ISLN is a collaboration between IBL and 48 clinical laboratories throughout Idaho with the goal of enabling clinical lab staff to rapidly recognize and refer potential biothreat or high consequence pathogens to IBL for confirmatory testing.

IBL staff developed an eight-hour short course focusing on biosafety, risk management, biothreat agents, and proper shipping requirements and provided this training in seven regional locations from the panhandle to eastern Idaho. ISLN labs that couldn't attend one of the regional workshops received an onsite visit where IBL staff provided safety items and information to help improve lab awareness. Thankfully, high consequence pathogens are rarely encountered, but lab staff always need to be on the lookout for them and must be able to safely handle and ship them to IBL. The 2018 emergence of human plague and tularemia cases in Idaho helped to reinforce this and demonstrate the important role that the Idaho Sentinel Laboratories play in protecting public safety.

Bureau of Community and Environmental Health: The Bureau of Community and Environmental Health (BCEH) staff is passionate about collaborating, connecting, and partnering to address cross-cutting, populations-based health issues. BCEH facilitated the second Collaborating for Health Conference (C4H) that brought statewide partners together to discuss disease prevention and management and to foster community-clinical linkages. National speakers engaged attendees in topics including: health equity and health disparities; adverse childhood experiences (ACEs) influence on health outcomes; the value of prevention and built environments; and transforming interventions to advance public health. Through rich discussions, partnerships and engagement, C4H provides a platform to build on successes, strengthen partnerships, and develop a healthier Idaho.

Bureau of Vital Records and Health Statistics: The National Center for Health Statistics (NCHS) has recognized Idaho for meeting all requirements of the Vital Statistics Cooperative Program. Areas of excellence include the bureau's quick transmission time (measured from the date an event was filed with our office versus when the event is provided to NCHS). The bureau provides all events within one business day. The bureau maintains stringent data standards to ensure quality of data on its records.

Bureau of Rural Health and Primary Care: The bureau is a key partner in the Statewide Healthcare Innovation Plan (SHIP), with a focus on efforts to improve access to health care services in rural and underserved communities. These efforts include establishing Community Health Emergency

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Medical Service programs, community health worker programs, expanding telehealth in patient-centered medical homes and supporting Project ECHO (Extension for Community Health Outcomes). These innovative projects continue to grow. Partnership efforts are focused on transitioning these initiatives after the SHIP grant ends in 2019.

The bureau is successfully expanding medical education loan repayment opportunities for clinicians serving in designated health professional shortage areas (HPSAs). An HPSA designation is required to qualify for loan repayment opportunities. The bureau conducts ongoing analysis of provider shortages in Idaho.

Bureau of Emergency Medical Services and Preparedness: The Business Operations and Support section is working on the updated Prehospital Electronic Record Collection System (PERCS) Elite. The section is concluding the beta testing phase and beginning the rollout for general use. The updated system (NEMSIS 3.4.0) will interface with IGEMS (Idaho Gateway for EMS) and allow for a seamless push of information from an agency's licensure file to PERCS Elite. This capability permits users to use a single set of login credentials for Idaho's Emergency Management Services (EMS) system (PERCS Elite and IGEMS). The new system will include interfaces to improve timeliness, accuracy, and customer satisfaction. The interfaces currently being developed and implemented are for the licensure system and Time Sensitive Emergency (TSE) Data Registry. In addition to the above, the section is working with the EMS Section on quality improvement projects, the bureau's strategic plan, and the Community Health EMS pilot.

The EMS section worked on identifying critical care definitions and standards. These were added to the Emergency Medical Services Physician Commission's Standards Manual. Efforts continue in fostering partnerships with critical access hospitals and EMS agencies throughout the state to provide safe and appropriate patient transfers.

Senate Concurrent Resolution 135 allowed the bureau to conduct town hall meetings as a follow up to the meetings conducted in 2012. All the comments, suggestions and data will be compiled, and a report will be created for presentation to the Legislature. While addressing the barriers with recruitment and retention in our rural volunteer areas, a temporary rule was approved. The Emergency Medical Responder ambulance certification will allow EMR providers to be the attendant in an ambulance with a patient. The temporary rule went into effect on July 1, 2018. Additional education has been finalized and is available to all EMS agencies.

The State Communications Center (StateComm) continues the effort of becoming an Emergency Medical Dispatch Accredited Center of Excellence, with emphasis on training and quality improvement. The National Academies of Emergency Dispatch, through its College of Fellows, has es-

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tablished a high standard of excellence for emergency medical dispatch, providing the tools to achieve it at both the dispatcher level through certification and at the communication center level through the accreditation program. Once successful, StateComm will be the only Emergency Medical Dispatch Accredited Center of Excellence in Idaho. StateComm will join a growing number of accredited centers of excellence across the U.S. and in other countries that provide superior, up-to-date public care and efficient use of resources to achieve maximum results. StateComm also is working in Idaho Public Safety Answering Points to streamline the organ donor notification process and increase the number of prehospital death notifications reported to StateComm.

The Time Sensitive Emergency (TSE) Program has been busy implementing Idaho's TSE System. Each of the six regional TSE committees have been formed and include local critical access hospitals, larger tertiary facilities, and many different EMS agencies. The program began accepting facility applications for designations for trauma, stroke, and cardiac centers in January 2016. As of August 2018, the status of designations is as follows:

- 40 applications have been received for designation.
- 31 have been approved and designated by the TSE Council.
- 7 are in various stages of completion.
- 21 hospitals have one or more TSE designations.

Bureau of Public Health Business Operations: The Public Health Business Operations bureau leads the public health accreditation work for the Division of Public Health. Over the past year the bureau has focused on strengthening data use and access for staff and outside partners. The division's data website: www.gethealthy.dhw.idaho.gov continues to expand with the development of interactive dashboards for population health measures.

The bureau has also spent considerable time in the past year working to dial in subrecipient monitoring for the 400+ subgrants the division has with partners statewide. The bureau is increasing accountability and requiring more transparency in this area.

The bureau also launched a new internal process for identifying quality improvement needs. The Quality Improvement Reporting System, built in SharePoint, allows staff members to log business processes that are not working efficiently or that consistently conflict with policy. Items entered into this system are reviewed regularly and projects are initiated if a trend is identified.

Suicide Prevention Program: The Suicide Prevention Program continued to provide a comprehensive approach to suicide prevention in Idaho through public awareness, education, consultation, training, and support using evidence-based and evidence-informed programs and messaging

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during SFY 2018. Some of the highlights include:

- Implementing a statewide marketing plan based on the idea that everyone has a role in preventing suicide. "Rock Your Role" television spots aired statewide for three months and collateral materials were produced and distributed in every county across Idaho.
- Providing funding and support for the Idaho Suicide Prevention Hotline.
- Providing funding and support for youth suicide prevention through the State Department of Education, including two-day trainings for 10 new schools and booster trainings in 12 schools that had already had initial training in Sources of Strength for youth, and suicide prevention training for all staff at 20 schools. Technical assistance, consultations and/or site visits were provided to over 60 schools.
- Developing and distributing statewide educational brochures and tools on suicide prevention and intervention tailored for specific populations including older people, parents, youth, school personnel, gun owners, and behavioral health providers.
- Providing administrative support to the Idaho Governor's Council on Suicide Prevention and regularly convening a group of suicide prevention stakeholders.
- Submitting a federal grant application to implement the Zero Suicide model, which is an approach used by health systems to close all gaps through which suicidal people may fall when accessing health care.
- Facilitating a task force dedicated to limiting access to lethal means for those who are suicidal, and developing packets of materials for use by gun shops. Packets were distributed in one Idaho region.
- Providing 78 suicide prevention trainings to nearly 4,000 professional groups, including behavioral health providers, medical staff, school personnel, detention officers, law enforcement, call center staff, and many others.

All program activities support the Idaho Suicide Prevention Plan and align with the IDHW strategic plan.

Bureau of Clinical and Preventive Services

Clinical and Preventive Services are delivered primarily through subgrants with local public health districts and contracts with community-based organizations. Bureau sections include HIV, STD and Hepatitis; Special Supplemental Nutrition for Women, Infants and Children (WIC); and Maternal and Child Health.

HIV, STD and Hepatitis Section

The HIV, STD and Hepatitis Section (HSHS) is made up of four separate programs that manage and monitor HIV prevention, HIV care, STD pre-

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vention, and prevention services related to viral hepatitis in Idaho.

HSHS works closely with local public health districts, community health centers, federally qualified health centers, and community-based organizations to ensure prevention and care services are available to target populations.

The primary HIV prevention services include HIV testing, counseling, and referral services for pre-exposure prophylaxis (PrEP) and linkage to HIV medical care; condom distribution; and HIV disease investigation services for newly infected people and their partners. HSHS also manages services for those infected with HIV, including medical case management, the AIDS Drug Assistance Program (ADAP), and support services to enhance access to and retention in HIV medical care and treatment.

STD prevention-related services through HSHS are mainly offered through partnerships with local public health districts. Services include STD testing and treatment; STD education and outreach; and STD disease investigation services for newly infected people and their partners.

HSHS is currently working on the implementation of the Hepatitis Care Cascade Project, which is aimed at increasing screening and detection of Hepatitis C in the baby boomer population and linking newly diagnosed patients to medical care.

HSHS monitors HIV and STD trends throughout the state and deploys resources to partners so targeted interventions can be implemented to combat the spread of disease. Data from 2017 indicates (see chart on next page) that the rate of chlamydia in Idaho continues to increase compared to previous years. The rates of both gonorrhea and syphilis in Idaho also continue to increase at unprecedented rates.

Rate of Sexually Transmitted Diseases			
CY	**Chlamydia**	**Gonorrhea**	**Syphilis**
2017	360.8	56.3	7.8
2016	351.5	37.7	7.5
2015	340.2	28.5	4.9
2014	333.1	27.1	2.8

Note: Rates per 100,000 of population. For HIV/AIDS data, please see Bloodborne Diseases on pages 117-118.

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Women, Infants and Children (WIC) Section

WIC offers nutrition education, nutritional assessment, and vouchers for healthy foods to low-income families to promote optimal growth and development. The program is entirely federally funded. It provides an average of $51 per participant each month in grocery vouchers for prescribed healthy foods based on a nutrition assessment. The section also provides counseling in nutrition and breastfeeding to more than 64,000 participants annually. WIC services are delivered through the seven Idaho public health districts, Marimn Health, and Nimiipuu Health.

Clients Served Monthly and Average Monthly Voucher Value				
Year (SFY)	**2015**	**2016**	**2017**	**2018**
Clients served	40,951	39,473	37,209	34,422
Average voucher	$58	$52	$50	$51

The vouchers WIC provides to parents and caretakers can be used to purchase specific foods based on a child's or pregnant woman's nutritional risks. WIC education focuses on encouraging families to eat meals together, make healthy food choices, eat more fruits and vegetables, limit juice intake, avoid sweetened beverages, increase physical activity and play, and limit sedentary screen time.

Participants typically receive nutrition education four times a year. In addition to clinical assessments related to nutritional status, children are weighed and measured at certain visits to obtain Body Mass Index (BMI).

WIC provides early intervention through nutritional counseling to caretakers of nearly half of all infants (up to 12 months of age) born in Idaho. In 2017, the program served 15,239 children ages 2 to 5 years. Of those children, 674 were identified as overweight based on their BMI and having two valid measures for comparison. Through WIC nutritional counseling, 304 children (45%) improved their weight status by at least 1 percentile on the Centers for Disease Control and Prevention's BMI for Age Chart at their next WIC visit.

During 2015, the Idaho WIC section transitioned from having six-month certification periods for children participating in WIC to 12-month certification periods. Because of that change, the data collection period was extended to a 13-month time frame to allow for making a comparison of two valid BMI measurements. For more information, please visit www.WIC.dhw.idaho.gov.

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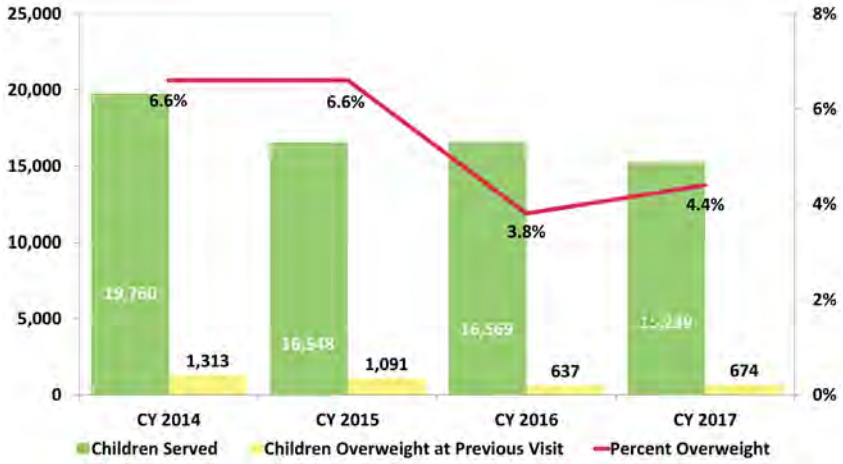
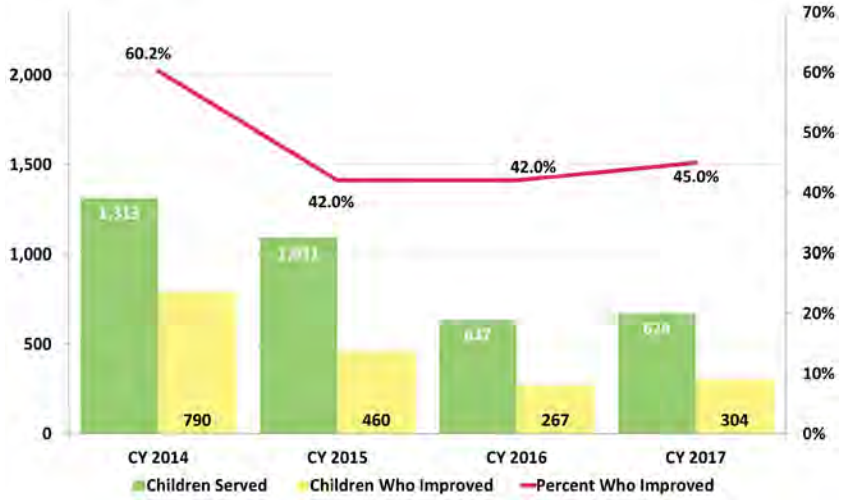
Children Served and Those Overweight, Ages 2-5



Overweight Children (ages 2-5 years) with Improved Status



Maternal and Child Health (MCH) Section

Family Planning, Adolescent Pregnancy Prevention, Newborn Screening, Home Visiting and Children's Special Health Programs are part of the MCH Section.

The Family Planning Program administers funding to four local public health districts and two federally-qualified health centers to provide comprehensive family planning services for Idahoans at 43 clinic sites, including services at one juvenile detention center and one women's correctional facility.

During CY 2017, the Family Planning Program served 9,360 clients in 14,885 visits. Of those clients, 10.5% (988) were 15-17 years old and both male and female. Seventy-eight percent of participants had household incomes at or below 150% of the federal poverty level.

Idaho's teen pregnancy rate is 9.5 pregnancies per 1,000 females ages 15-17, well below the Healthy People 2020 goal of no more than 36 pregnancies per 1,000 females. It is also below the average national rate of 22 for the same group. Idaho's teen pregnancy rate is more than 50% lower than it was 10 years ago, when the rate was 22.9.

Idaho Teen Pregnancy Number and Rate (Ages 15-17 years)		
CY	**Number**	**Rate per 1,000 females**
2017	275	7.4
2016	346	9.5
2015	374	10.6
2014	369	10.7

Note: Idaho teen pregnancy numbers and rates are based on live births, induced abortions, and reportable stillbirths (only those fetal deaths with a gestational period of 20+ weeks or that weigh 350+ grams are required to be reportable by law). The U.S. teen pregnancy rate includes live births, induced abortions, and all fetal deaths. Because fetal deaths are an extremely small proportion of teen pregnancy outcomes for Idaho (less than 1%) and are a sizable proportion of teen pregnancy outcomes for the U.S. (estimated 18 percent), Idaho and U.S. rates are not comparable.

The Newborn Screening Program works with hospitals, birthing centers, and other healthcare providers to ensure that all babies born in Idaho are screened for 48 harmful or potentially fatal conditions, including phenylketonuria (PKU), cystic fibrosis, galactosemia, and congenital hypothyroidism. As of July 2018, all babies also must be screened for critical congenital heart disease (CCHD) using pulse oximetry.

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Newborn screening provides an opportunity for diagnosis and treatment through early detection. Timely treatment allows for normal growth and development and a reduction in infant morbidity and mortality. Most infants with conditions identified through screening show no obvious signs of disease immediately after birth. It is only with time that conditions that could affect an infant's health and development become more obvious.

In Idaho, two newborn screens are conducted, one within 24 to 48 hours of birth and another when the infant is between 10 and 14 days old. For conditions detected using the blood spot, some conditions are detected on the first screen and others on the second screen. For each screen, a small amount of blood is collected from the baby's heel and placed on special filter paper. The filter paper is sent to a regional laboratory for testing. When a screening is positive the Newborn Screening Program coordinates with the laboratory and a baby's healthcare provider to ensure timely diagnosis and treatment. For CCHD screenings, providers ensure babies are linked with appropriate diagnostic services and follow-up care.

The Newborn Screening Program has been screening Idaho babies since 1963. New technology allows screening for many conditions from a small amount of blood. While each of the screened conditions is rare, collectively they affect about 1 in 1,000 infants. On average, there are 20 to 30 diagnosed conditions each year in Idaho. For more information, please visit www.NBS.dhw.idaho.gov.

Number of Diagnosed Conditions by Type and Calendar Year

Condition	2014	2015	2016	2017
Biotinidase Deficiency	0	0	1	1
Congenital Hypothyroidism	6	8	8	5
Cystic Fibrosis	5	8	6	4
Galactosemia	1	0	0	0
Maple Syrup Urine Disease	0	1	0	0
Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCAD)	2	2	4	5
Phenylketonuria	0	1	5	3
Other	5	7	2	4

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Number of Babies Screened, Presumptive Positives, and Diagnosed Conditions by Year			
CY	**Babies Screened**	**Presumptive Positives**	**Diagnosed Conditions**
2017	21,604	1,359	22
2016	21,998	1,141	24
2015	22,276	1,063	27
2014	22,263	989	20
2013	21,769	1,067	19

Data are based on babies receiving first newborn screen.

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program provides funding to the seven public health districts across the state to deliver evidence-based, voluntary home visiting services to expectant parents and families with young children. Participating families gain knowledge and skills to support their children's health and well-being, ensuring a great start to life. Using MIECHV funding, the local public health districts provide home visiting services to 12 Idaho counties using two evidence-based home visiting models: Parents as Teachers and Nurse Family Partnership.

The Parents as Teachers (PAT) home visiting model serves pregnant women and families with children from birth to 5 years old. Families may enroll at any point, from pregnancy until the child is 5. PAT parent educators offer 12 to 24 visits annually, depending on the needs of the family. The PAT curriculum offers services to families for at least two years between pregnancy and kindergarten. Program target outcomes include:

- Increase parent knowledge of early childhood development and improve parenting practices.
- Provide early detection of developmental delays, health issues.
- Prevent child abuse and neglect.
- Increase children's school readiness and school success.

The Nurse Family Partnership (NFP) home visiting model serves first-time, low-income pregnant mothers and their babies. An NFP home visitor must have at least a bachelor's degree in nursing and in most cases maintain registered nursing (RN) credentials. NFP clients receive their first nurse home visit prior to the 29th week of pregnancy, and visits continue happening weekly or bi-weekly until the child is 20 months and then monthly until the child is 2 years old. Program target outcomes include:

- Improve prenatal health and outcomes.
- Improve child health and development.
- Improve families' economic self-sufficiency and maternal life course development.

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Families Served Through Home Visiting Services in Idaho		
FFY	**Number of Families Enrolled**	**Number of Home Visits**
2017	641	6,487
2016*	639	6,504
2015	310	2,433
2014	140	1,507
2013	n/a	n/a

** Received expansion funds*

Bureau of Communicable Disease Prevention

The Bureau of Communicable Disease Prevention encompasses programs that monitor disease trends and epidemics, prevent the spread of communicable diseases, assist newly arrived refugees as they receive health screenings, help safeguard Idaho's food supply, and prevent diseases through immunizations.

Epidemiology

Epidemiology staff track reportable disease trends that impact Idahoans, including whooping cough, salmonellosis, and tuberculosis. They offer consultation and direction to public health districts about the investigation and prevention of communicable and infectious diseases; develop interventions to control outbreaks and prevent future infections; and deliver tuberculosis consultation and treatment services.

Disease surveillance capacity in Idaho is increasing with advances in the use of electronic reporting systems. The use of electronic systems significantly reduces the time it takes to receive and respond to reports of disease and then intervene. Today, more than 97% of reports from laboratories are handled electronically. Idaho's version of the Idaho National Electronic Disease Surveillance System has become fully integrated and is used to monitor data for all reportable diseases. The program now can receive case reports for reportable diseases electronically from clinical electronic health record systems, increasing the ability to rapidly exchange information and respond to reports of disease to prevent further transmission.

Bloodborne Diseases

Bloodborne diseases such as HIV and hepatitis B and C are usually trans-

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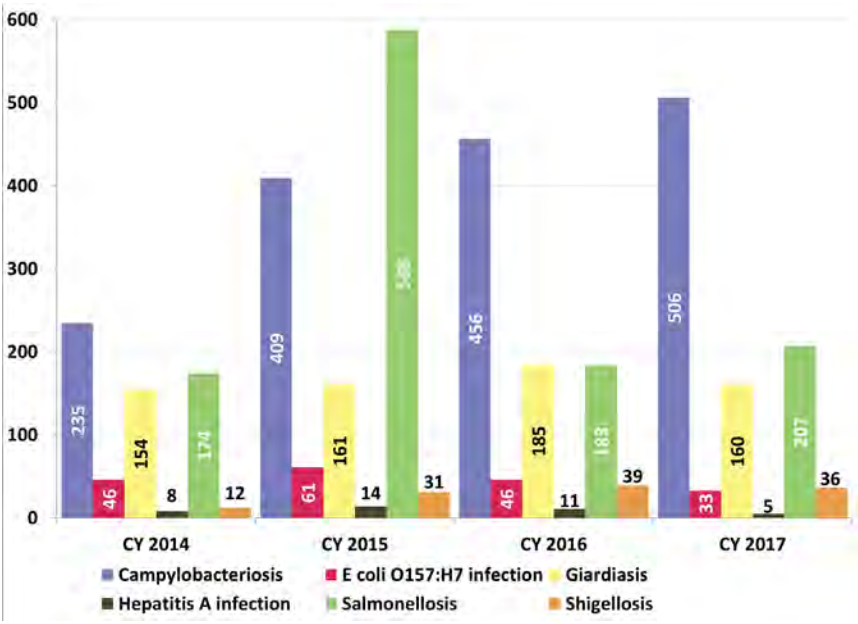
mitted through infected blood when people share contaminated needles, during blood transfusions, or in the exchange of bodily fluids during sexual contact.

Bloodborne Diseases by Calendar Year				
	2014	2015	2016	2017
Bloodborne diseases	43	60	64	71
New HIV/AIDS	21	43	47	53
Idaho residents living with HIV/AIDS	1,544	1,648	1,738	1,842
Acute Hepatitis B	11	12	7	6
Acute Hepatitis C	11	4	10	12

HIV/AIDS presumed living in Idaho is defined as all reports of HIV or AIDS in Idaho, regardless of residence at diagnosis and not reported as deceased.

Enteric Diseases (Diseases of the Intestine)

Enteric diseases affect the gastrointestinal system and are transmitted primarily through contaminated food and water, or hand-to-mouth because of inadequate handwashing after bathroom use.



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Food Protection

The Food Protection Program protects the public from illnesses associated with the consumption of food. The program provides oversight, training, and guidance to environmental health specialists at local public health districts in Idaho. It is also responsible for laws regulating food safety.

Idaho's public health districts issue licenses and perform regulatory inspections of food establishments such as restaurants and delis; investigate complaints from the public; and educate food establishment owners and staff about food safety and how to prevent foodborne outbreaks. The Food Protection Program and environmental health specialists at the public health districts work closely with epidemiologists to investigate foodborne illnesses suspected to be associated with licensed food establishments and other sources, taking steps to reduce disease and prevent outbreaks.

Food Protection				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018*
Foodborne outbreaks	13	16	10	10
Licensed food establishments	5	4	4	2
Other sources/ venues	8	12	6	8
People Ill	348	81	77	29

** Data are provisional. Only confirmed and probable outbreaks and cases are counted.*

Refugee Health Screening Program

The Refugee Health Screening Program's primary responsibility is to ensure that refugees who resettle in Idaho receive a timely health screening and necessary follow-up care. The program works with providers and resettlement agencies in the state to ensure a timely and complete health assessment is performed, referrals are made for follow-up care when health conditions are identified, and education about the Idaho healthcare system is provided.

The program also engages partners such as the Idaho Division of Welfare and the Idaho Office for Refugees to ensure newly arrived refugees are provided the resources and assistance necessary to become integrated and contributing members of Idaho communities.

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Immunization Program

The Idaho Immunization Program (IIP) strives to increase the rate of immunized children in Idaho as well as awareness of vaccine-preventable diseases. IIP provides educational resources to the public and healthcare providers. It also oversees the federally funded Vaccines For Children (VFC) program in Idaho that provides vaccines for children who meet at least one of these criteria: 1) Medicaid eligible; 2) uninsured; 3) underinsured; or 4) American Indian or Alaskan Native.

Using federal and state funds, IIP distributes vaccines to private and public healthcare providers for free for all Idaho children from birth through age 17. Healthcare providers can charge a fee for administering a state-supplied vaccine but they cannot charge for the vaccine itself. This ensures that all Idaho children have access to recommended vaccines, regardless of their ability to pay.

The IIP also conducts quality assurance site visits with providers who are enrolled in the VFC program. Site visits are important opportunities to provide information on vaccine efficacy as well as updates about state and national immunization trends, disease outbreaks, new vaccines, and recommendations by the national Advisory Committee on Immunization Practices (ACIP).

IIP works with schools and licensed childcare providers to increase the number of children who receive all ACIP-recommended immunizations. School and childcare outreach activities include educational opportunities and technical assistance for school nurses and facility staff. IIP staff provide training and assistance to increase the knowledge of school nurses and staff about the immunization schedule, school or childcare immunization rules, and protocols for vaccine-preventable disease outbreaks among children in the facility. For the 2017 to 2018 school year, 86.1 percent of children enrolled as kindergartners in Idaho schools were up to date on all immunizations as required in Idaho Administrative Rules.

Number of Childhood Vaccine Preventable Diseases by Calendar Year

	2014	2015	2016	2017
***Haemophilus influenzae* b (Hib,) invasive**	0	1	0	1
Measles	0	0	0	0
Mumps	26	8	1	5
Pertussis (whooping cough)	367	194	83	89
Rubella	0	0	0	0
Total	393	203	84	95

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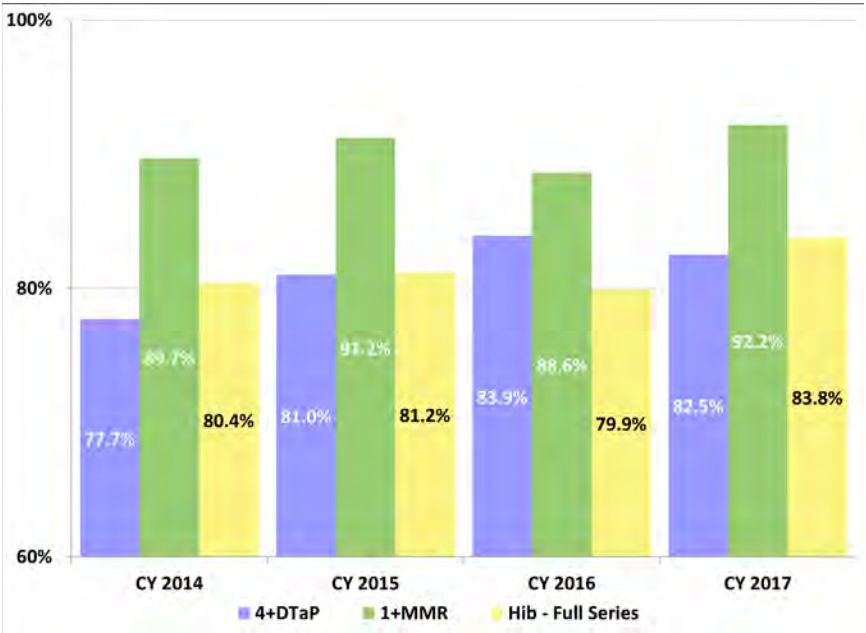
Immunization Rates for Select Childhood Vaccines



Immunization Reminder Information System (IRIS)

IRIS is a web-based immunization information system operating since 1999 that allows healthcare providers, schools, and childcare facilities to access vaccine records for people of all ages who live in Idaho.

IRIS was an "opt-in" registry until 2010, meaning people had to provide consent before their records could be stored in the system. Beginning in July 2010, Idaho's registry became "opt-out." This means the electronic birth certificates for all babies born in Idaho are entered into IRIS. The system remains a voluntary registry because parents and/or legal guardians can have their children's records removed at any time, if desired.

The IRIS database was migrated to a new code platform in 2012 and is now based on the open-source Wisconsin Immunization Registry (WIR). Versions of the nationally recognized WIR system are deployed in more than 20 states.

See chart on next page.

Idahoans Enrolled in Registry				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Ages 0-35 months	79,096	79,599	78,442	74,245
Ages 3-5 years	85,949	84,967	85,872	84,729
Ages 6-18 years	392,079	407,195	420,740	412,239
Ages > 18 years	845,722	940,347	1,044,899	1,081,537
Total	1,402,846	1,512,108	1,629,953	1,652,750

Vaccine Distribution

The IIP provides vaccines for children eligible through the Vaccines for Children (VFC) Program, sponsored by the federal Centers for Disease Control and Prevention (CDC). The IIP also purchases additional vaccines for all other Idaho children. For each of the last three years, the program distributed more than 700,000 vaccine doses statewide to about 340 providers, including local public health districts, hospitals, clinics, and private physicians.

Vaccine Adverse Event Reporting System (VAERS)

In SFY 2018, Idaho submitted 3 reports to the Vaccine Adverse Events Reporting System. Reports contain possible adverse reactions to vaccines, as reported by physicians and public health districts.

This vaccine reporting system evaluates each report to monitor trends in adverse reactions for any given vaccine. Most adverse reactions are mild and vary from pain and swelling around the vaccination site to fever and muscle aches. Serious adverse reactions to vaccines rarely occur.

Number of Adverse Reactions and Rate per 10,000 Vaccinations			
SFY	Adverse Reactions	Vaccines Administered	Rate/10,000
2018	3	873,951	<0.1 (0.03)
2017	11	940,659	0.1
2016	15	1,075,786	0.1
2015	10	897,605	0.1

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Healthcare-Associated Infections Prevention Program

Healthcare-associated infections (HAIs) are infections that develop during or soon after medical treatment for a separate medical condition. HAIs can result from patients' own bacteria; be associated with surgery or invasive medical devices; or be due to exposure to bacteria, viruses, fungi, or spores transmitted from contaminated healthcare workers' hands, environmental surfaces, or medical equipment. Bacteria found in healthcare settings are often resistant to commonly prescribed antibiotics, making HAIs more difficult to treat.

HAIs are the most common complication of hospital care. An estimated 722,000 infections and 75,000 deaths are attributable to HAIs every year in the United States. HAIs result in an estimated $30 billion annually in excess healthcare costs nationally.

Idaho's HAI Prevention Program is actively engaged in reducing HAIs by working with Idaho healthcare facilities to provide infection prevention education and training, performing site visits to hospitals with high infection rates, convening prevention collaboratives, and providing resources to track HAIs and prevent outbreaks.

Idaho Bureau of Laboratories

The role of the Idaho Bureau of Laboratories (IBL) is to provide laboratory services that support DHW programs, the public health districts, other state agencies, and Idaho residents. The bureau offers core services in four areas:

Testing

- Communicable disease agents: enteric, respiratory, vaccine-preventable, zoonotic, sexually transmitted, and emerging infectious diseases.
- Contaminants in drinking and environmental water, food, and soil samples: acute and chronic contaminants regulated by the Safe Drinking and Clean Water Acts.
- Biological and chemical threats: agents of biological or chemical terrorism.

Inspection

- Clinical and drinking water laboratories
- X-ray and mammography units
- Air quality monitoring stations

Training

- On-site, hands-on analytical, biosafety, dangerous-good shipping and compliance training
- Continuing education workshops, webinars and online courses

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- Student internships for college credit

Outreach

- Coordination of the Idaho Sentinel Laboratory Network for the rapid detection and referral of possible biothreat agents
- Clinical laboratory biosafety and security risk assessment
- Participation in public safety drills, exercises, and events with Regional Response HazMat Teams and the 101st Civil Support Team
- Publication of applied public health research

Effective quality management is critical to ensure that the services provided by the laboratory meet regulatory requirements. The bureau is regulated by four different regulatory agencies or programs. As part of an accredited health department, IBL public health and safety surveillance work adheres to the standards of the Public Health Accreditation Board (PHAB).

IBL environmental health testing is regulated by the Environmental Protection Agency (EPA). The lab is an EPA-certified drinking water laboratory and serves as the Principal State Laboratory for the Idaho Department of Environmental Quality and the Alaska Division of Environmental Health (via an interstate partnership agreement). The laboratory bureau chief serves as the drinking water certification authority for Idaho, ensuring that commercial laboratories throughout the United States that test Idaho drinking water comply with both state and federal laboratory certification requirements.

IBL performs limited clinical diagnostic testing for the assessment of patient health and is certified as a high-complexity clinical laboratory by the Centers for Medicare and Medicaid Services (CMS). IBL houses the only full-service tuberculosis laboratory in Idaho, provides analytical support for the Division of Public Health's Refugee Health Screening program, and serves as a reference laboratory for the detection of antibiotic resistant bacteria and other esoteric or emerging pathogens.

IBL is a registered entity through the Centers for Disease Control and Prevention Division of Select Agents and Toxins (DSAT). IBL must comply with all DSAT biosafety, biosecurity, and incident response regulations as the only Laboratory Response Network (LRN) reference laboratory for biological and chemical threat agents in Idaho.

The bureau operates the Idaho Radiation Control Program, which licenses all devices that produce x-rays in Idaho and inspects licensed facilities to ensure they are meeting state radiation safety and training requirements. In SFY 2018, there were 1,430 licensed facilities using x-ray devices across a variety of health care, academic, and industrial settings.

The bureau also registers all clinical laboratories performing patient testing

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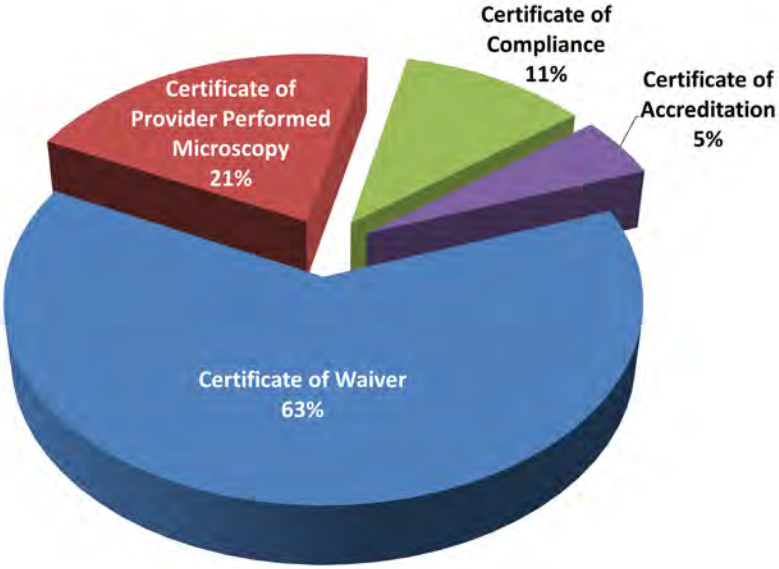
in Idaho. In SFY 2018, there were 1,394 registered clinical laboratories in Idaho. CMS certifies laboratories based on the complexity of testing offered. The certificate designation for each lab indicates the type of the testing they are qualified to do. For example, 62% of Idaho registered labs performed only simple waived testing and hold a Certificate of Waiver (COW). Many physicians' offices perform more complex microscopy testing and have a Provider Performed Microscopy (PPM) certificate. Larger moderate and high complexity laboratories receive either a Certificate of Compliance (COC) if they are inspected by the Idaho Clinical Laboratory Inspector or a Certificate of Accreditation (COA) if their labs are regulated under a CMS approved accreditation agency like the College of American Pathologists or The Joint Commission.

SFY 2018 Registered Clinical Laboratories by Certificate Type



The Clinical Lab Inspector surveys all Certificate of Compliance (COC) laboratories in Idaho every two years on behalf of the Centers for Medicare and Medicaid Services. The COW and PPM labs do not require surveys, and the COA labs are surveyed by the accreditation agency.

For more information about the Idaho Bureau of Laboratories please visit: www.statelab.idaho.gov.

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Bureau of Community and Environmental Health

The Bureau of Community and Environmental Health promotes and protects the health of Idahoans by providing strategies to reduce risk behaviors and prevent injuries; programs to prevent and control chronic diseases; and policies and strategies to prevent and reduce exposure to contaminants.

The bureau is made up of the following programs:

- Tobacco Prevention and Control – Project Filter
- Breast and Cervical Cancer – Women's Health Check
- Comprehensive Cancer Control
- Physical Activity and Nutrition
- Fit and Fall Prevention
- Oral Health
- Diabetes Prevention and Control
- Heart Disease and Stroke Prevention
- Sexual Violence Prevention
- Drug Overdose Prevention
- Environmental Health Education and Assessment
- Toxicology

Tobacco Prevention and Control

The Tobacco Prevention and Control Program, referred to as "Project Filter" works to create a state free from tobacco-related death and disease. Project Filter addresses tobacco use and secondhand smoke exposure by promoting healthy behaviors. The program fosters statewide coordination for successful tobacco control with these program goals:

- Prevent initiation of tobacco use among youth.
- Promote tobacco cessation among users.
- Eliminate exposure to secondhand smoke.
- Identify and eliminate tobacco-related disparities.

Idaho is 11th best in the nation for its low percentage of adults who smoked in 2016, which was 14.5 percent. The national rate of adults who smoked was 17.1 percent.

Despite a continued focus on eliminating tobacco-related health disparities, the prevalence of tobacco use and subsequent health consequences continue to disproportionately impact specific populations. American Indians/Alaskan Natives, Hispanics and Latinos, members of the Lesbian, Gay, Bi-Sexual, Transgender (LGBT) community, those of low socio-economic status (Low SES), those living with mental illness, Medicaid participants, and veterans represent Idaho population groups that experience

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tobacco-related health disparities. In 2016, smoking rates were highest in populations with low SES, at 33.8 percent, followed by those who reported 14 or more mentally unhealthy days at 30.5 percent, American Indian/ Alaskan Natives at 29.4 percent, LGBT at 22.7 percent, and veterans with 18.4 percent.

Project Filter targets programmatic efforts and funds toward the support and promotion of the Idaho QuitLine. The Idaho QuitLine provides barrier-free tobacco cessation benefits to all Idaho residents regardless of income or insurance status. These benefits include free telephonic counseling as well as free nicotine replacement therapy such as patches, gum, and lozenges.

Project Filter conducts state-wide, multi-media efforts to promote Idaho Quitline cessation services. Media efforts include TV and radio ads; digital media including banner ads for news outlets, YouTube, and pre-roll ads on video; Facebook, Twitter and Instagram; and event sponsorship and advertising.

Project Filter also performs outreach on the local level, partnering with each of the seven public health districts in Idaho to support efforts to eliminate tobacco use at the community level. These efforts include technical assistance in the development of tobacco-free policies, free signage to reflect these policies as well as promotion of cessation classes and the Idaho QuitLine at community events.

In an effort to consistently improve and measure its efforts, Project Filter has an evaluator on staff and manages several third-party evaluations and surveys throughout the year. These activities include a third-party evaluation of the services provided by the Idaho QuitLine, an evaluation of the effectiveness of its media efforts, as well as the Adult Tobacco Survey, which measures Idaho residents' attitudes regarding tobacco use and policies.

Physical Activity and Nutrition Program

The Idaho Physical Activity and Nutrition Program (IPAN) promotes a culture of health and vigor by encouraging and enabling all Idahoans to be physically active and make healthy food choices. IPAN promotes these ideals by enhancing education and awareness, supporting successful community programs and practices, and encouraging community designs and public policies that take residents' health into account.

According to The State of Obesity: Better Policies for a Healthier America 2016, Idaho now has the 36th highest obesity rate in the nation, at 27.4 percent. This is up from 18.4 percent in 2000 and 9.3 percent in 1990. Obesity is defined as having a Body Mass Index (BMI) of 30 or higher. In 2017, Idaho high school students had an obesity rate of 11.4 percent, also

ranking Idaho 36th nationally.

In 2016, 82.5% of Idaho adults reported not having consumed the recommended five servings of fruits and vegetables per day. In 2016, 20.2% of Idaho adults reported not participating in any physical activity over the past month. For Idaho youths, only 12.5% of high school students consumed vegetables three or more times during the past week. For activity, only slightly more than half (50.4%) of Idaho's high school students reported being active for at least 60 minutes on five or more days over the past week.

IPAN continues to work on combating the obesity epidemic through initiatives that support and facilitate physical activity and healthy eating. IPAN works in diverse settings across Idaho, such as child care centers, workplaces, farmer's markets, schools, and the design of communities to support Idahoans in making healthy choices in environments that promote good health.

Fit and Fall Proof™

The Idaho Physical Activity and Nutrition Program (IPAN) partners with local public health districts to implement a fall prevention exercise program for older adults called Fit and Fall Proof™(FFP). The program focuses on improving balance, strength, flexibility, and mobility to reduce the risk of falling, as well as increasing participants' emotional and social well-being.

Idaho's fall mortality rate is higher than the national rate. The three-year average fall mortality rate in Idaho for 2014-2016 (the most recent available data) was 12.3 per 100,000 (age adjusted) versus 8.9 per 100,000 for the U.S. during that same time period. Also, 87.4 percent of all unintentional deaths by falls were among people ages 65 and older. During 2016, there were 62 more unintentional fall deaths among Idahoans 65 years of age or older. This represents a 40.5 percent increase in deaths from 2015.

In 2017, Idaho Emergency Medical Services responded to 9,153 fall-related calls for individuals ages 65 and older; nearly 6 percent more calls than were reported in 2015. More than 51 percent of those who fell were ages 85 or older. Eighty percent of those who fell were transported to a hospital. Females in this age group were twice as likely to report a fall injury and have a higher death rate for falls than males. Estimated costs associated with fall-related calls in Idaho are as high as $35 million.

Participation in FFP classes continues to expand, and now more than 129 sites offer the class to Idaho seniors. From July 2017 to June 2018, there were nearly 9,300 visits to FFP classes. The program consistently has a high retention rate, with 81 percent of participants returning for subsequent class sessions. Many FFP participants (35 percent) are from communities with a population of less than 10,000 residents, demonstrating the impor-

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tance of the program in Idaho's rural areas.

Classes are led by trained volunteer peer-leaders and are offered in churches, libraries, senior centers, community rec centers, and other places where seniors gather. Public health districts promote the program by making presentations to community groups and stakeholders to generate interest, recruit new volunteer leaders, and increase the number of participants. Connections with physicians and physical therapists also are being made in hospitals and clinics across the state to increase the number of providers who screen for fall risks, counsel on preventive measures patients can take, and refer to local FFP classes.

Studies have shown that FFP has a positive impact on maintaining balance, preventing falls, increasing energy, and improving social connectedness. Participants comment that "the people, the laughter, and the friendship [they] share" is a great benefit of the program. As Idaho's aging population continues to grow, the need for effective community-based programs that promote "aging in place" also will increase. The FFP program is currently working on gaining evidence-based status to further prove its validity in design and effectiveness in improving the health and longevity of Idaho's senior population.

Age-Specific Injury Death Rates Because of Accidental Falls 2014-2016 (per 100,000 population)			
	<65-84 years	85+	Age-Adjusted Rate
Idaho	36.4	397.8	12.3
United States	30.7	249.8	8.9

Number of Deaths Because of Accidental Falls			
CY	**<65**	**65+**	**Total**
2016	28	215	243
2015	26	153	179
2014	28	201	229
2013	27	167	194

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Idaho Comprehensive Cancer Control Program

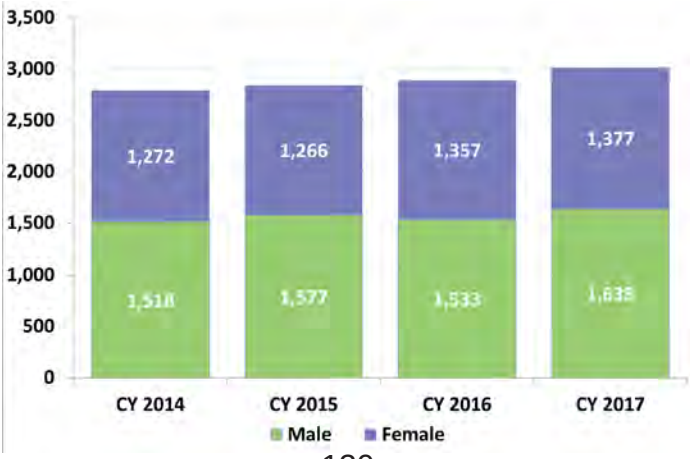
Cancer has been the leading cause of death in Idaho since 2008. An estimated 1 in 2 Idahoans will develop cancer during their lifetimes. Cancers that have good screening methods for early detection and that are highly treatable when detected early include colorectal, breast, and cervical cancers. Some of these can be prevented when abnormal cells are detected and removed before they become cancerous.

Idaho has some of the lowest screening rates in the United States for these cancers, but the Comprehensive Cancer Control Program is working to change that. The goal of the cancer program is to maintain and expand a coordinated, effective, comprehensive cancer control program that:

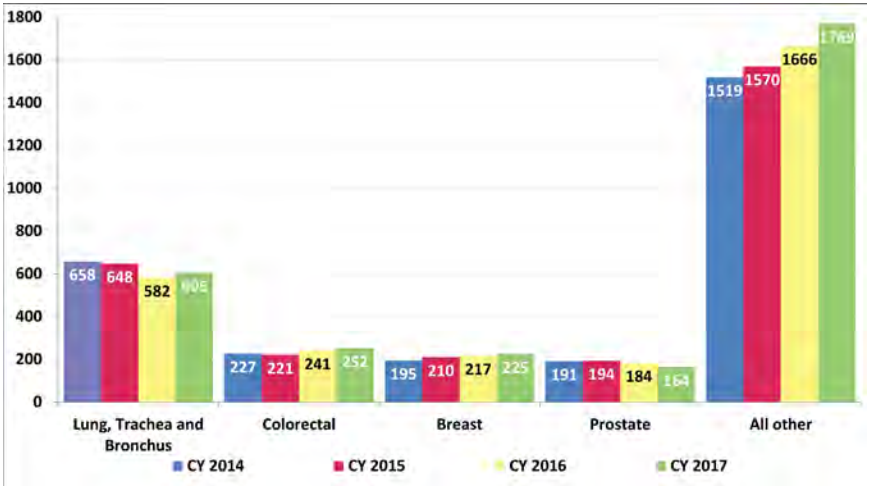
- Defines and raises awareness of the burden of cancer and related issues in Idaho.
- Develops new resources and networks with existing resources statewide.
- Implements evidence-based strategies to reduce the burden of cancer and improve the quality of life for people who have cancer or are in recovery.
- Increases awareness of preventive behaviors to decrease likelihood of Idahoans experiencing a cancer diagnosis according to current science and recommendations.
- Increases awareness of the importance of early detection and diagnosis, which leads to the improvement of cancer screening rates according to current science and recommendations.

In 2017, Idaho reported 3,015 cancer deaths, which was an increase from 2016, when 2,890 cancer deaths were reported. Cancer was the leading cause of death for females and the second leading cause of death for males in Idaho in 2017.

Idaho Cancer Deaths by Sex



Idaho Cancer Deaths by Primary Site of Malignancy



**Note: Colorectal cancer includes deaths caused by cancer of the colon and rectum; it does not include deaths caused by cancer of the anus. The numbers for breast cancer deaths include deaths for both men and women.*

Women's Health Check

Women's Health Check offers free breast and cervical cancer screening for low-income women. Historically, the program served women ages 30-64, but cervical cancer screening services are now available for women as young as 21years old. Qualifying participants must have incomes below 200% of the federal poverty level and must have no insurance coverage for breast and cervical cancer screenings.

The program is funded through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program, established in response to the Breast and Cervical Cancer Mortality Prevention Act of 1990.

In 2001, the Idaho Legislature passed Every Woman Matters law in response to the Breast and Cervical Cancer Prevention and Treatment Act of 2000. This law links women to Medicaid coverage for treatment of breast or cervical cancer if they are diagnosed through Women's Health Check. Women who are not enrolled in Women's Health Check but are diagnosed with breast or cervical cancer do not qualify for coverage under this law.

There are more than 400 individual providers and clinics across the state that provide screenings. After more than 20 years serving the women of Idaho, Women's Health Check has screened more than 35,000 women and funded almost 324,000 Pap tests, and almost 50,000 mammograms.

Diabetes Prevention and Control

The Idaho Diabetes Prevention and Control Program (DPCP), funded by the Centers for Disease Control and Prevention, aims to address the following longterm outcomes:

- Decrease proportion of people with diabetes with an A1C of less than 9.
- Increase number of people with prediabetes enrolled in a CDC-recognized lifestyle change program who have achieved 5-7% weight loss.

A statewide network of contractors, including local public health districts, health systems, evidence-based programs, and other partners works with the DPCP to:

- Increase access and coverage for diabetes self-management education and support programs for people with diabetes that are recognized by the American Diabetes Association and accredited by the American Association of Diabetes Educators.
- Increase use of pharmacist patient care processes that promote medication management for people with diabetes.
- Increase access to and coverage for the National Diabetes Prevention Program (DPP) lifestyle change program for people with prediabetes.
- Increase community clinical links that facilitate referrals and provide support to enroll and retain participants in the National Diabetes Prevention Program lifestyle change program.

The Diabetes Prevention and Control Program provides community-level outreach to link people with several resources, including:

- The National Diabetes Prevention Program, an evidence-based lifestyle change program, can help participants with prediabetes lose 5% to 7% of their body weight and reduce their risk of developing type 2 diabetes by 58%.
- Diabetes self-management education and support programs, which are supported by a large body of evidence, are designed to improve health outcomes, lower medication use, decrease hospitalizations, and decrease other healthcare costs for people with diabetes.
- The Diabetes Alliance of Idaho (DAI) is an independent, volunteer organization made up of individuals and agencies dedicated to the prevention and reduction of the personal and public impact of diabetes in Idaho. The alliance includes representatives from the public, local health districts, universities, insurance, pharmaceutical companies, and a variety of community-based, voluntary, health, and professional organizations. Membership is open to individuals and organizations with an interest in diabetes prevention and management.

The prevalence of diabetes continues to increase nationally and in Idaho.

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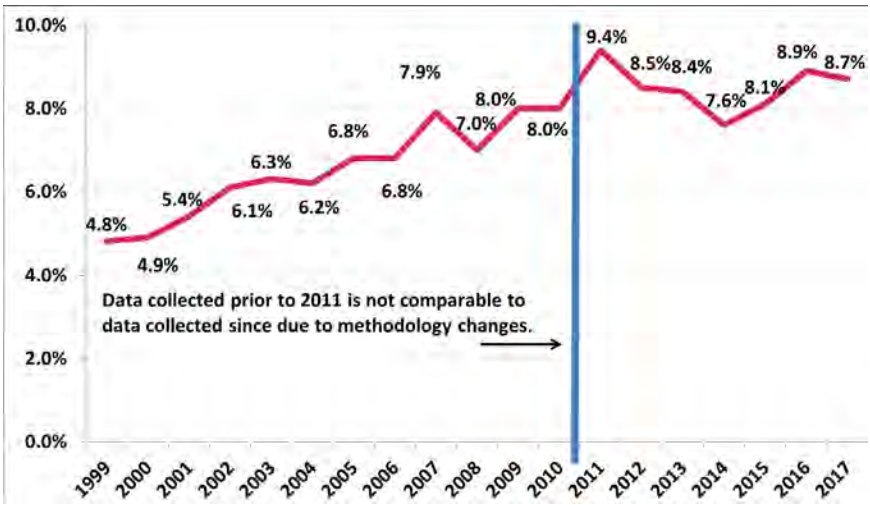
The increase is driven by the rate of people who are overweight and obese, the aging population, and the number of minorities who are at high risk for developing diabetes.

Percent of Idaho Adults Diagnosed with Diabetes



Oral Health

Oral health is a serious public health issue in Idaho. Oral disease contributes to the impact and cost of overall healthcare and can contribute to cardiovascular disease, stroke, pre-term birth, poorly controlled diabetes, and other systemic conditions. The Idaho Oral Health Program (IOHP), funded by the Maternal and Child Health Block Grant, Centers for Disease Control and Prevention, Health Resources & Services Administration, and the DentaQuest Foundation, works with oral health champions and partners across the state to perform the essential public health functions:

- Assess and track dental disease rates.
- Create, support, and evaluate evidence-based initiatives for community disease prevention.
- Develop state and regional oral health action plans to serve as roadmaps for improving oral health in Idaho.
- Facilitate active public/private partnerships to promote and support oral health.
- Reduce barriers to care and assure use of personal and population-based oral health services, especially in counties considered to be a Dental Health Professional Shortage Area.
- Conduct and review research for new insights and innovative solutions to oral health problems.
- Assess public perceptions about oral health issues and educate and empower the public to achieve and maintain optimal oral health.

- Support the statewide Idaho Oral Health Alliance.
- Promote and educate on the benefits of population-based services including school dental sealant clinics, fluoride varnish programs, community water fluoridation, and oral health education for at risk populations.

In addition to performing the essential public health functions, the IOHP provides funding to the local public health districts in the form of sub-grants. Activities conducted by the local public health districts include fluoride varnish clinics at: WIC, Head Start, and Early Head Start programs; and school-based dental sealant clinics in schools with more than 50% participation in the Free and Reduced Lunch Program. All the programs delivered by the public health districts include the provision of oral health screenings and/or assessments, oral health education, and dental home referral when necessary.

Key oral health findings for Idaho include the following:

- More than two-thirds (67.2%) of Idaho third-grade students had dental sealants on at least one tooth recommended for sealants. The Healthy People 2020 goal for children aged 6 to 9 years is a rate of 28.1% or better on one or more of their permanent first molar teeth.
- Nearly two-thirds of Idaho third graders (65.6%) had primary or permanent teeth with decay or filled caries or missing permanent teeth because of tooth decay. The Healthy People 2020 goal for children aged 6 to 9 years is a rate of 49% or less.
- In 2016, 57% of children enrolled in Medicaid had a dental visit.
- Of Idaho adults 18 years and older, 37% did not have a dental visit in 2016.

Heart Disease and Stroke Prevention

The Idaho Heart Disease and Stroke Prevention Program (HDSP), funded by the Centers for Disease Control and Prevention, works to increase control among adults with known high blood pressure and high blood cholesterol.

A statewide network of contractors, including local public health districts, health systems, evidence-based programs, and other partners, including health associations, works with the HDSP to:

- Increase reporting, monitoring, and tracking of clinical data for improved identification, management, and treatment of patients with high blood pressure and high blood cholesterol.
- Increase use of and adherence to evidence-based guidelines and policies related to team-based care for patients with high blood pressure and high blood cholesterol.
- Increase community clinical links that support systematic referrals, self-management, and lifestyle change for patients with high blood pressure and high blood cholesterol.

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Bureau of Vital Records and Health Statistics

The Bureau of Vital Records and Health Statistics is responsible for the registration, documentation, correction, and amendment of vital events that include birth, death, marriage, paternity actions, adoption, and divorce. The bureau provides bio-statistical research and analysis of health trends that can be used to develop and shape future health interventions and programs.

The bureau issues vital record certificates and produces numerous statistical reports and publications. Information for obtaining an Idaho certificate is available at www.vitalrecords.dhw.idaho.gov . For statistical reports and publications, visit www.healthstatistics.dhw.idaho.gov .

Births, Deaths, Marriages and Divorces				
CY	**Births**	**Deaths**	**Marriages**	**Divorces**
2017	22,159	14,007	13,691	6,674
2016	22,462	13,370	13,595	6,786
2015	22,832	13,031	13,500	6,817
2014	22,888	12,610	13,699	6,943

Bureau of Rural Health and Primary Care

The Bureau of Rural Health and Primary Care administers programs to improve access to healthcare in rural and underserved areas of Idaho. To accomplish this, the bureau collects data that identifies health professional shortages, provides technical assistance, administers grants, and promotes partnerships to improve healthcare in rural areas.

Health professional shortage areas (HPSAs) are federal designations that indicate healthcare provider shortages in primary care, dental health, and mental health. The Health Resources and Services Administration scores HPSAs on a scale of 0-25 for primary care and mental health, and 0-26 for dental health. Higher scores indicate greater need. HPSAs are commonly used as a qualifier for state and federal resources such as clinician loan repayment opportunities. The bureau creates and manages HPSAs in Idaho.

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Idaho Geographic Area with Health Professional Shortage Designation				
	CY 2014	CY 2015	CY 2016	CY 2017
Primary Care	96.4%	97.7%	97.7%	97.7%
Dental Care	97.0%	95.7%	95.7%	95.7%
Mental Health	100%	100%	100%	100%

Rural Health Care Access Program Grants for Primary Care and Dental Health Shortage Areas				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Grant Requests	$516,265	$419,727	$391,931	$317,025
Amount Awarded	$184,200	$180,200	$179,450	$179,350
Applicants	17	14	14	10
Awarded	8	7	9	7

Rural Physician Incentive Program

The Rural Physician Incentive Program (RPIP) is a medical education loan repayment program for qualifying physicians serving in federally-designated Health Professional Shortage Areas. Program funds are generated by fees assessed to medical students participating in state-supported programs at the University of Washington and University of Utah and state general funds.

The program began in July 2015. Physicians may receive up to $100,000 over four years ($25,000 per year) for medical education debt. In SFY 2018, 19 applications were received and eight new physician applicants were awarded RPIP grants. In total, 23 Idaho physicians received medical education loan repayment through this program in SFY 2018.

State Loan Repayment Program

The State Loan Repayment Program (SLRP) provides loan repayment for clinicians serving designated Health Professional Shortage Areas. SLRP began in September 2014 and is the first multi-discipline, state-based loan repayment program for clinicians and physicians. The loan repayment is provided through a federal grant; every award must be matched dollar-for-dollar with funds provided by the clinician's employer. Participating sites must implement a sliding-fee scale for low-income and uninsured patients. Loan repayment awards range from $10,000-$25,000 per year,

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depending on the discipline and matching contributions. Thirty-seven clinicians and physicians are currently receiving loan repayment through this program.

For more information regarding the Bureau of Rural Health and Primary Care, please visit: www.ruralhealth.dhw.idaho.gov .

Bureau of Emergency Medical Services and Preparedness

The Bureau of Emergency Medical Services and Preparedness supports the statewide system of responding to critical illness and injury situations. Services include:

- Licensing Emergency Medical Services (EMS) personnel and services.
- Operation of the statewide EMS Communications Center (StateComms).
- Providing technical assistance and resources to EMS agencies.
- Supporting a statewide Time Sensitive Emergency system of care for trauma, stroke, and heart attack.
- Planning and coordination of the public health response to acts of bioterrorism, infectious disease outbreaks, and other public health threats and emergencies.

Emergency Medical Services Program

The bureau licenses EMS agencies based on the agencies' capabilities and deployment plans. Once licensed, EMS agencies must renew their licenses every year. The renewal process includes a site visit from the bureau to ensure compliance with licensure requirements. Annual site visits also provide the bureau an opportunity to provide technical assistance and guidance.

The bureau licenses EMS personnel when minimum standards of proficiency are met. All personnel licensed in Idaho must be trained in courses that meet or exceed the national EMS education standards.

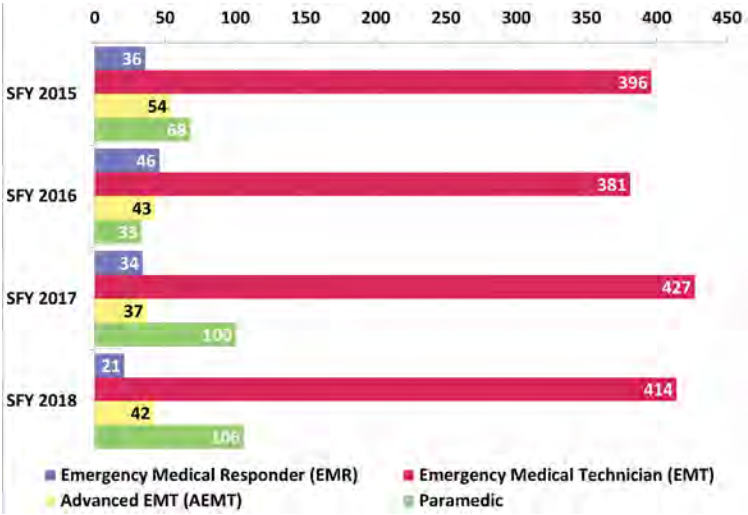
To renew an EMS personnel license, a provider must meet continuing education requirements and provide documentation of demonstrated skill proficiency. Licenses are renewed every two or three years (depending on the level of license) in either March or September.

The bureau approves instructors to teach EMS courses, evaluates EMS courses, administers certification examinations, processes applications for initial licensure and license renewals. In addition, the bureau conducts investigations into allegations of misconduct by licensed EMS personnel, licensed EMS agencies, and EMS educators.

Personnel are licensed at one of four levels:

1. **Emergency Medical Responder (EMR):** The primary focus of the EMR is to initiate immediate lifesaving care to critical patients who access the emergency medical system. The EMR is trained and licensed to provide simple, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies.
2. **Emergency Medical Technician (EMT):** The EMT provides basic emergency medical care and transportation for critical and emergency patients. The EMT is licensed to provide basic non-invasive interventions focused on the management and transportation of out-of-hospital patients with acute medical and traumatic emergencies. A major difference between the EMR and the EMT is the knowledge and skills necessary to transport emergency patients.
3. **Advanced EMT (AEMT):** The AEMT provides basic and limited advanced emergency medical care for patients. The AEMT is licensed to provide basic and limited advanced interventions that are effective and can be performed safely in an out-of-hospital setting. The major difference between the AEMT and the EMT is the ability to perform limited advanced interventions for emergency patients.
4. **Paramedic:** The paramedic's primary focus is to provide advanced emergency medical care for critical patients. The paramedic is licensed to provide basic and advanced care, including invasive and pharmacological interventions. The major difference between paramedicd and AEMTd is the ability to perform a broader range of advanced skills and use of controlled substances.

EMS Personnel Licensure



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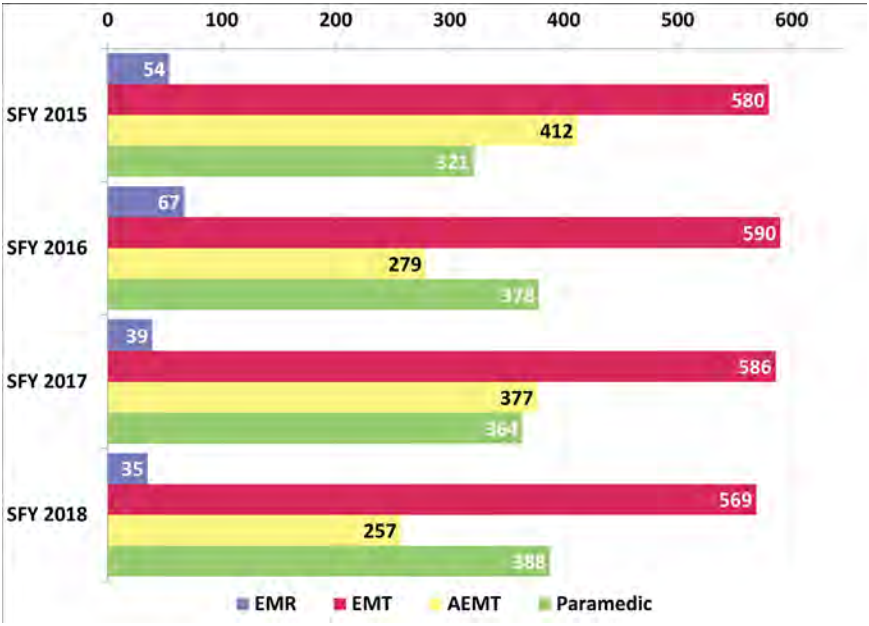
EMS Personnel Licensure Renewal



EMS Dedicated Grants

The EMS Dedicated Grant program has operated since 2001 and provides funds for EMS vehicles and equipment for use by emergency medical personnel in the performance of their duties which include highway safety and emergency response to motor vehicle accidents. Funds are collected from the purchase of Idaho driver's licenses and renewal fees.

Transport ambulances, and vehicles for non-transport quick response, search and rescue, and extrication have been funded through this program. Patient-care equipment includes items to provide airway management, cardiac monitoring and defibrillation, communications, extrication, patient assessment, lifting and moving of patients, rescue, safety, spinal immobilization, fracture management, and monitoring vital signs. For more information on Idaho EMS, please visit www.IdahoEMS.org.

See chart on next page.

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EMS Dedicated Grants				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Grant Requests	$3 M	$2.8 M	$2.9M	$3.1 M
Grants Awarded	$1.3 M	$1.4 M	$1.4M	$1.4 M
Vehicle Requests	25	23	17	19
Patient Care Equipment			113	119
Agencies Applying	48	49	64	72
Agencies Awarded	43	49	59	63

Public Health Preparedness Program

The bureau's Preparedness Program is responsible for increasing health system capacities to respond to acts of bioterrorism, infectious disease outbreaks, and other public health threats and emergencies. It coordinates local, regional and statewide planning to:

- Support infectious disease surveillance and investigation.
- Improve Idaho's surge capacity to adequately care for large numbers of patients during a public health emergency.
- Expand public health laboratory and communication capacities.
- Develop pandemic response capabilities.
- Provide for the distribution of medications, vaccines, and personal protective equipment.

The program works with many stakeholders to develop effective plans, mutual aid agreements, training, and exercises to provide coordinated and comprehensive all-hazards approaches to emergency health preparedness, response, and recovery measures.

Time Sensitive Emergencies Program

The 2014 Idaho Legislature approved and funded a plan to develop a statewide Time Sensitive Emergency (TSE) System of Care that includes three of the top five causes of deaths in Idaho: trauma, stroke, and heart attack. Studies show organized systems of care improve patient outcomes, reduce the frequency of preventable deaths, and improve the quality of life for patients.

A TSE system of evidence-based care addresses public education and prevention, 911 access, response coordination, pre-hospital response, transport, hospital emergency/acute care, rehabilitation, and quality improvement. The statewide TSE program will create a seamless transition between each level of care and integrate existing community resources to improve patient outcomes and reduce costs. It will get the patient to

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the right place in the right time with the right care.

The bureau's TSE Program provides leadership, administrative support and technical assistance to the statewide TSE system. The program designates healthcare facilities as trauma, stroke, and/or heart attack TSE centers based on the facility's capabilities. There are five levels of trauma designation, three levels of stroke designation, and two levels of heart attack designation. Learn more about Idaho's TSE system here: http://www.tse.idaho.gov.

Idaho State EMS Communications Center

The Idaho State EMS Communications Center (StateComm) is a unique public health communications resource and dispatch center available 24/7/365 for many emergency response agencies throughout Idaho. Services that StateComm provides include but are not limited to:

- EMS dispatch in 16 rural communities.
- Public health threat notification to district and state public health departments.
- Coordinating medical control from EMS unit to hospital.
- Hazardous material response coordination.
- Critical Incident Stress Management coordination.
- Idaho Transportation Department dispatch (road closures, highway incidents, Dynamic Message Sign activation, Condition Acquisition
- Reporting System (CARS), 511 data entry.
- Aircraft tracking and flight following.
- Notifications of weather situations that could pose a threat.
- Emergency Medical Dispatch: Providing pre-arrival medical instructions to callers before EMS arrives.
- Organ donor coordination.
- Primary activation point for the Emergency Alert System (civil emergencies and AMBER Alerts).
- Primary notification point for the National Alert Warning System (NAWAS).
- Notification point for Idaho National Laboratories emergencies.
- Notification point for rail incidents.
- Notification point for logging emergencies.
- Coordination of search and rescue efforts.
- Point of contact for prehospital deaths; to notify the organ procurement centers

Learn more about StateComm here: https://healthandwelfare.idaho.gov/Medical/EmergencyMedicalServicesHome/StateCommunications/tabid/1605/Default.aspx

Bureau of Public Health Business Operations

Public Health Business Operations functions as a collaborating body to connect the business of public health across all bureaus and programs in the division through policy development, performance management, business process alignment, and infrastructure building. Business Operations leads the divisions efforts in public health accreditation, strategic planning, and workforce development. The bureau also houses the Public Health Institutional Review Board. The bureau includes five staff with expertise in cross-cutting areas of health data analytics, performance management, communication, legislative affairs, and federal grant compliance.

- **Health Data Analytics:** The Division of Public Health collects, manages, and maintains large amounts of population health data. The Health Data Analytics program manager works to improve data sharing and use across the division and with partners, including the public.
- **Performance Management:** Key elements of public health accreditation are performance management and continuous quality improvement. The division has a Performance Management and Quality Improvement plan that guides staff in their efforts to consistently apply the Plan-Do-Study-Act process as they assess their programs and work to achieve their targeted goals. The Performance Improvement Manager provides staff training and technical assistance to build the quality improvement skills of our workforce.
- **Communication:** The division recognizes the importance of communicating clearly and often with internal and external stakeholders. The Community Resources Coordinator serves as a focal point in the division, crafting and distributing communications to the division. This position also serves as legislative support for the division, managing how legislation is tracked and monitored, and ensuring division leadership is informed about legislative activity that could potentially impact public health programs.
- **Federal Grant Compliance:** Over 50% of the division's funding comes from federal public health agencies. Most of these funds are then distributed to partners across the state to implement public health programs in local communities. Ensuring these funds are spent appropriately and in alignment with the grant's intent is the role of the Federal Compliance Officer. This work is vast and requires constant communication and collaboration with division programs, the department's internal control, financial services, and contracts and procurement staff.

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Suicide Prevention Program

Idaho and other mountain west states historically have some of the highest suicide rates in the nation. A total of 1,733 Idahoans completed suicide from 2013 to 2017. In 2016, the latest year for comparable state data, Idaho had the eighth highest suicide rate, after Alaska, Montana, Wyoming, New Mexico, Colorado, Nevada and Oklahoma. In 2017, Idaho's rate of 22.9 suicide deaths per 100,000 was 65% higher than the 2016 national rate of 13.9 per 100,000.

In 2017, 393 Idahoans completed suicide, which was a 10% increase from 350 suicides in 2016. Among Idaho's 10- to 34-year-olds, suicide was the second leading cause of death in 2017, with 103 suicide deaths in this age group.

From the 2017 Idaho Youth Risk Behavior Survey of high school students grades 9 - 12, a total of 20% reported seriously considering suicide, and 10% reported making at least one suicide attempt. Between 2013 and 2017, a total of 131 Idaho youth ages 19 and younger completed suicide.

Number of Completed Suicides by Age					
	10-14	15-19	20-64	65+	Total
CY 2013*	3	21	227	57	308
CY 2014	9	16	248	47	320
CY 2015	7	18	283	54	362
CY 2016	3	23	254	70	350
CY 2017	3	28	299	63	393

Rate of Completed Suicides by Age (per 100,000 population)					
	10-14	15-19	20-64	65+	Total
CY 2013*	2.5	18.5	24.7	25.5	19.1
CY 2014	7.3	13.9	26.8	20.1	19.6
CY 2015	5.7	15.4	30.3	22.2	21.9
CY 2016	2.4	19.4	26.8	27.5	20.8
CY 2017	2.3	23	31.1	23.8	22.9

**CY 2013: 10-14 includes one death younger than 10 years of age.*

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Division of Welfare

Julie Hammon, Administrator, (208) 332-7258

The Division of Welfare/Self Reliance promotes stable, healthy families by helping Idahoans meet their basic needs and gain financial and health stability.

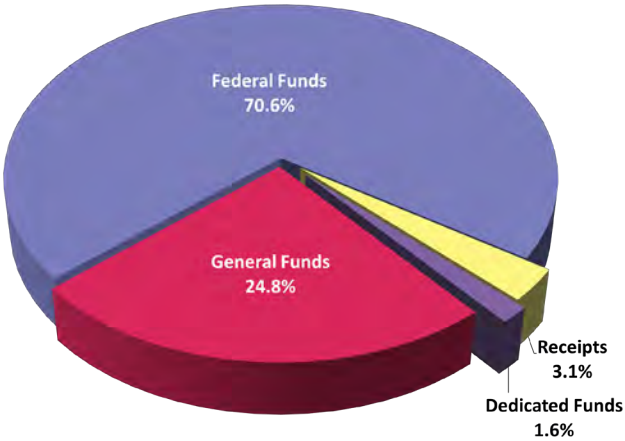
Programs administered by the division include:

- Child Support Services.
- Supplemental Nutrition Assistance Program (SNAP, or Food Stamps).
- Child Care.
- Temporary Assistance for Families in Idaho (TAFI-cash assistance).
- Aid to the Aged, Blind, and Disabled (AABD-cash assistance).
- Medicaid eligibility.
- Advanced Premium of Tax Credit to purchase private insurance.

These programs, also called Self Reliance programs, provide critical support options for low-income families and individuals while encouraging participants to improve their financial situations and become more self-reliant.

Self Reliance focuses on helping Idaho families live better through nutrition education, work and training programs, access to quality child care and early learning programs, and support services that help them be successful in the workforce. The division also administers additional programs through contracts with local partner organizations that provide food and assistance for home energy costs and home weatherization.

SFY 2019 Funding Sources



Authorized FTP: 619.5 Original Appropriation for SFY 2019 General Funds $43.5 million, Total Funds $175 million; 5.7% of Health and Welfare funding.

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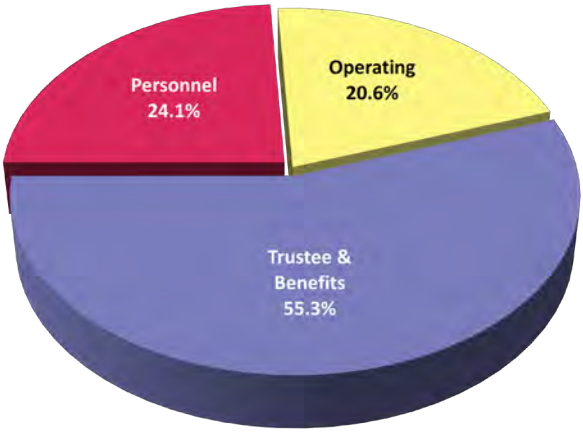
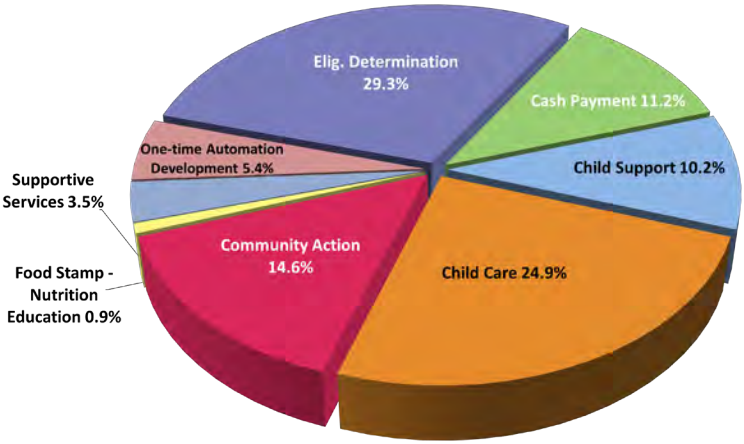
SFY 2019 Expenditure Categories



SFY 2019 Appropriation by Program



2018 Year in Review

Self Reliance programs and services

The Self Reliance programs are intended to help low-income families in Idaho gain stability and financial independence by providing critical support services. The combination of key supports such as health coverage, food and nutrition assistance, child care, child support and job search assistance helps families obtain employment or remain in the workforce as they balance their ability to pay a mortgage and utilities, and provide for their children. Helping Idaho's low-income families find and keep employment, especially during challenging times, enables them to enhance earning potential and gain stability until they no longer need the support of public assistance.

During SFY 2018, many households continued to need support during periods of unemployment or low wages to help supplement their family income for food, healthcare, and child care needs. Overall, growth in program participation is leveling as the economy has stabilized. Application and re-certification activities continue to be the division's focus as staff ensure eligibility determinations are accurate, and service delivery systems are effective.

The division currently serves about 164,000 families, who receive services from benefit programs in the following groups:

Families with children	Disabled adults	Seniors over 65	Non-disabled adults under 65
57%	21%	15%	7%

Approximately one in four participant families have at least one elderly or disabled member living in the household. About 325,000 individuals receive services through a benefit program in Idaho sometime throughout the year, with approximately 61% participating in one program and 39% participating in two or more programs.

The Division of Welfare also administers Idaho's Child Support Program. The primary focus is to ensure that children have support they need from both their parents. About 48% of families with a current child support case also participate in a benefit program.

Health Coverage for Idaho Families

A major focus over the past several years has been to ensure that Idaho families have access to health insurance, either through Medicaid services when they are eligible or through eligibility for a tax credit to help pay for private insurance purchased on the state-based exchange. The division determines eligibility for all Medicaid programs and calculates

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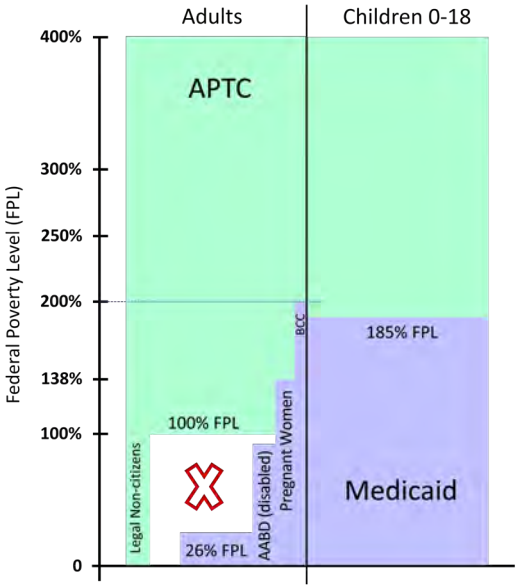
the Advanced Payment of Tax Credits (APTC) which is to be used in the purchase of a private health plan.

In 2018, DHW determined tax credit eligibility for approximately 96,000 Idahoans. Individuals eligible for the tax credit can use it to help pay for private health insurance purchased on Idaho's health insurance exchange, Your Health Idaho. The tax credit helped make health coverage affordable for many Idaho families.

Partnerships with Idaho's health insurance exchange, Idaho insurance companies, hospitals, and other stakeholders have ensured the pathway to healthcare coverage in Idaho is effective. Although the state still has a large gap in health coverage for adults who fall below 100% of the Federal Poverty Limit (FPL), Idaho has improved access to health coverage for many and has made these changes effectively, with one of the best and lowest cost systems in the nation.

Health Coverage Assistance



Generally Medicaid covers:
- Children 0% to 185% FPL
- Parents to 0% to 26% FPL

Generally APTC covers:
- Children 185% to 400% FPL
- Adults 100% to 400%

Other group coverage:
- Legal non-citizens get APTC from 0% to 100% FPL (working citizens do not)
- Aged/disabled get Medicaid from 0% to ~80 FPL
- Pregnant women get Medicaid from 0% to 138%
- Breast and cervical cancer diagnoses 0% to 200% FPL

No Medicaid/APTC coverage:
- Non-disabled adult US citizens from 0% to 100% FPL unless they are parents

Performance

The Division of Welfare met or exceeded federal standards for accuracy in all its self-reliance programs. Federal partners, other states, and national organizations continue to recognize program performance for exceptional innovation, service delivery redesign, and use of technology.

Idaho is a top-performing state for timeliness of services, accuracy in eligibility decision-making, and low administrative costs. This transformation

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has been possible because of the strong commitment from Idaho leadership, supportive community partnerships, and skilled state employees who operate these programs.

Self-Reliance Services

The Division of Welfare provides services in three categories:

1. Benefit Program services include:

- Food assistance (Supplemental Nutrition Assistance Program (SNAP), or Food Stamps).
- Child care assistance (Idaho Child Care Program).
- Eligibility determination for Health Coverage Assistance (HCA), including Medicaid and the Advanced Payment of Tax Credits (APTC), which provides help for families to pay for private insurance purchased on the state health insurance marketplace.
- Cash assistance in the form of Temporary Assistance for Families in
- Idaho (TAFI) and Aid to the Aged, Blind, and Disabled (AABD) programs.

Applications are available in field offices around the state, as well as online, by phone, and through the mail. These services have strict eligibility requirements as identified in state and federal rules. Benefit program services are delivered to those receiving food stamps, TAFI, or AABD through the Electronic Benefit Transfer (EBT) system.

2. Child Support services include:

- Locating an absent parent, conducting paternity testing, and creating a new and/or enforcing an existing child support order, or modifying a support order.
- Providing medical support enforcement to ensure children are covered by health insurance.
- Helping other states enforce orders and collect child support for parents living in Idaho, which accounts for about one-fifth of Idaho's child support cases.

The Child Support Program uses secure electronic transfer of collected funds to distribute child support funds to families.

3. Partnership Program services include:

- Community Service Block Grants, which help eliminate the causes of poverty and enable families and individuals to become self-reliant.
- Nutrition-related services and food commodities.
- Low-income home energy assistance.
- Weatherization assistance to help low-income households conserve energy and save money.

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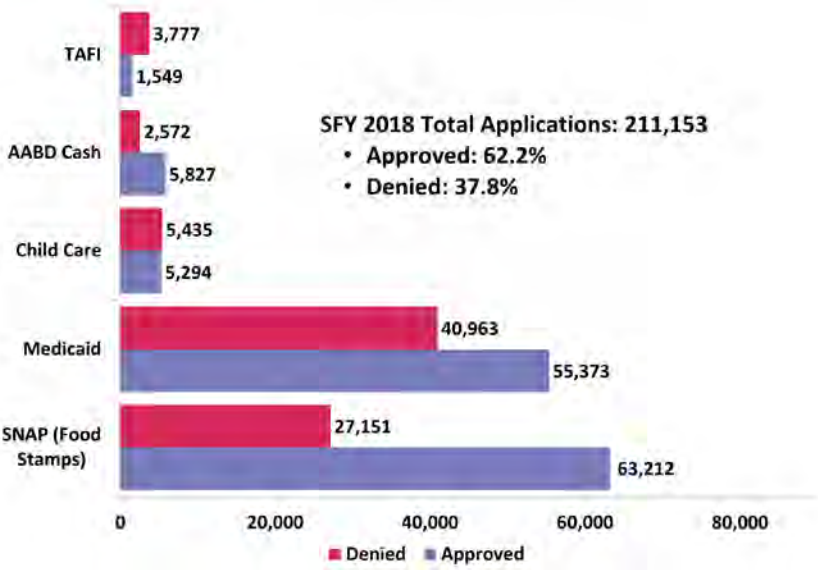
Partnership programs are supported by pass-through funds the division directs to local non-profit and community-based service providers. The division recognizes that local needs are often best met by local organizations. At the same time, local organizations throughout the state can benefit from a single entity overseeing administrative and fiscal management, rather than duplicating this function in each locale. Partnerships such as the Community Action Partnership Association of Idaho are essential in meeting needs of residents throughout the state.

Program Participation

Participation in benefit programs, the Child Support Program, and partnership programs is measured by the average monthly caseload or individuals served each month, but these numbers do not give a complete picture of the number of people served during the year. The numbers also do not give an accurate picture of the workload for the Self Reliance staff.

Processing applications for citizens seeking services is labor intensive. Welfare/Self Reliance staff process all applications for services, but not all applications are approved. People who are denied services are not reflected in program participation and caseload counts, even though significant time and effort may have been expended in the application process.

SFY 2018 Applications Approved and Denied



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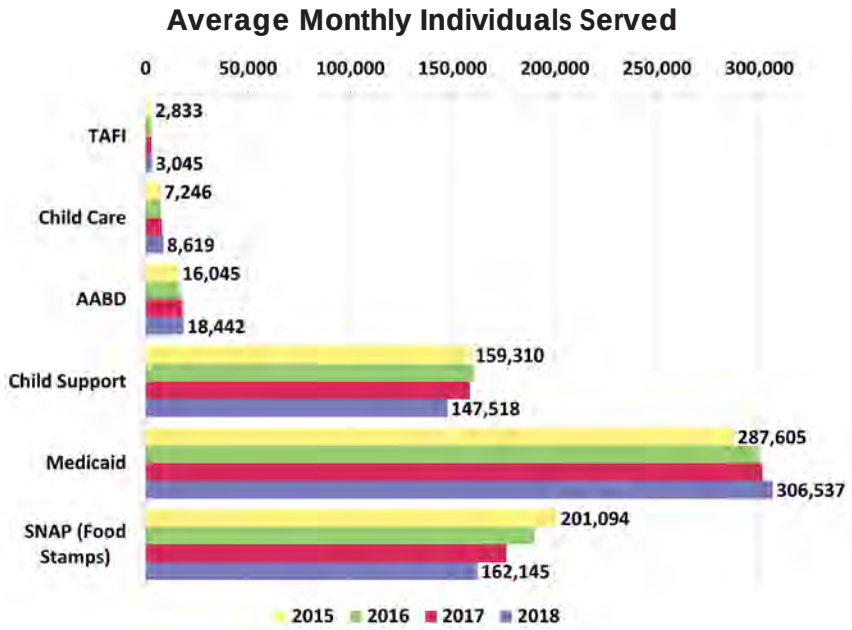
Benefit programs are designed to be work supports for low-income Idaho families. The division has designed benefit programs to encourage families to find and keep employment, and move on to higher wages and self-sufficiency. The SNAP (Food Stamps) and TAFI Programs have work participation requirements to help individuals find employment. The Idaho Child Care Program requires eligible families to have a qualifying activity, such as working, attending school or participating in training. As low-income families find success in the workplace, long-term outcomes for families and children improve.



Note: Many participants receive services from more than one program, so adding columns together will not produce the number of individuals receiving services; it includes duplicates. Child support data is a case count and does not reflect the number of individuals served. In 2018, 247,836 individuals were served in the Child Support Program. All programs are reported by State Fiscal Year except the Child Support Program, which reports by Federal Fiscal Year.

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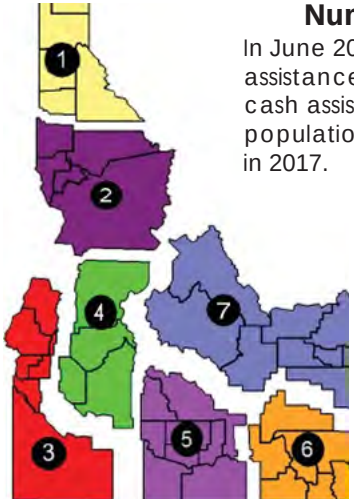

Numbers Served by Region

In June 2018, a total of 325,393 people received assistance in Medicaid, food stamps, child care, and cash assistance. This is 19 percent of the state's total population. More than 351,000 Idahoans were served in 2017.

Region 3, which includes Canyon County, has the greatest percentage of population receiving assistance services, while Region 4 has the lowest. Four of the seven regions have more than 20 percent of their populations receiving one of the four main assistance services.

Region	Estimated Population	Receiving Cash Payments	Child Care Assistance	SNAP (Food Stamps)	Medicaid	Totals
1	234,845 13.7%	3,276 1.4%	1,109 0.5%	20,776 8.8%	36,472 15.5%	42,995 18.3%
2	108,520 6.3%	1,573 1.4%	279 0.3%	7,864 7.2%	13,631 12.6%	16,012 14.8%
3	283,189 16.5%	4,638 1.6%	1,935 0.7%	35,111 12.4%	59,833 21.1%	70,022 24.7%
4	501,649 29.2%	5,431 1.1%	2,347 0.5%	35,042 7.0%	59,399 11.8%	70,457 14.0%
5	196,712 11.5%	2,255 1.1%	1,028 0.5%	18,517 9.4%	37,087 18.9%	42,815 21.8%
6	169,849 9.9%	2,548 1.5%	915 0.5%	17,946 10.6%	30,873 18.2%	36,217 21.3%
7	222,179 12.9%	1,958 0.9%	1,248 0.6%	20,238 9.1%	40,431 18.2%	46,875 21.1%
Totals	1,716,943 100.0%	21,679 1.3%	8,861 0.5%	155,494 9.1%	277,726 16.2%	325,393 19.0%

Note: Estimated population percentage (in column 2) represents regional share of the state's total population. Percentages under each program are the percentage of each region's population participating in that program. Many participants receive services through more than one program. The total (in the last column) is an unduplicated count of these four self-reliance programs.

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Use of benefit programs remained flat in all parts of the state during SFY 2018. Region 3, where 70,022 individuals participated in a Self Reliance benefit program, had the highest service usages and led the state in enrollment in all four of the benefit programs. Idaho's most populous area, Region 4, which contains more than one-quarter of the state's population, had the lowest use of benefit programs, with 14 percent of residents receiving benefits.

Benefit Program Services

The Division of Welfare manages assistance and support services in five major programs:

1. Supplemental Nutrition Assistance Program (SNAP, or food stamps)
2. Child care
3. Medicaid eligibility
4. Eligibility for Advanced Payment of Tax Credits (APTC)
5. Cash assistance (through Temporary Assistance for Families in Idaho, and Aid to the Aged, Blind, and Disabled)

Supplemental Nutrition Assistance Program (Food Stamps)

Overview: The Supplemental Nutrition Assistance Program (SNAP), also known as the Food Stamp Program, helps low-income families maintain good health and nutrition. SNAP benefits are federally funded, but the state shares the cost of administering the program with the federal government. Benefits are provided through an Electronic Benefits Transfer (EBT) card, which works like a debit card.

To qualify for SNAP, a family must meet the following eligibility requirements:

- Be an Idaho resident who is either a U.S. citizen or meets specific criteria for lawful residency.
- Provide proof of identity.
- Meet income eligibility limits of 130% or less of the Federal Poverty Limit for family size.
- Have assets of less than $5,000.
- Meet stricter eligibility requirements if applicant is a student, legal immigrant, or convicted felon.
- Participate in a work search program, unless exempt.

All eligibility requirements are verified through electronic interfaces or documentation provided by the family. Once approved for SNAP benefits, a family must participate in a semi-annual or annual re-evaluation of their household circumstances. In the re-evaluation process, all elements of eligibility are reverified using these same methods.

SNAP recipients, unless exempt, must either be employed 30 hours per

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week or participate in job-search activities to help them find or improve employment opportunities to continue receiving benefits. The primary focus of the work program is to help SNAP recipients get a job, keep a job, or find a better job. Failure to participate in this program results in the individual losing his or her SNAP benefits.

SNAP Benefit Amount: The amount depends on a variety of circumstances, such as the number of people in the household, income, and other factors. Generally, larger household sizes or lower incomes result in higher benefit amounts. In June 2018, the average SNAP allotment per person in Idaho was $105, or about $1.17 per meal.

What is available for purchase with SNAP?
Households may use SNAP benefits to purchase food to eat, such as:

- Breads and cereals.
- Fruits and vegetables.
- Meats, fish, and poultry.
- Dairy products.
- Seeds and plants that produce food for the household to eat.

Households may not use SNAP benefits to purchase alcoholic beverages, tobacco, or any nonfood items such as:

- Soaps or paper products.
- Pet foods.
- Household supplies.
- Vitamins and medicines.

SNAP benefits also may not be used for:

- Food that will be eaten in the store.
- Hot foods.

Caseload Growth:
SNAP enrollment is responsive to economic conditions, expanding during recessions and contracting during improved economic times. Idaho experienced SNAP expansion, realizing unprecedented participation growth beginning in 2007 and continuing through 2011. Over the past seven years, the state continues to see a slow, steady decline in the number of people who receive SNAP benefits as the economy improves and more jobs become available.

During SFY 2018, Idaho's SNAP caseload decreased, showing a reduction in the number of individuals receiving SNAP benefits from 168,500 in June 2017 to 155,500 in June 2018.

See chart on next page.

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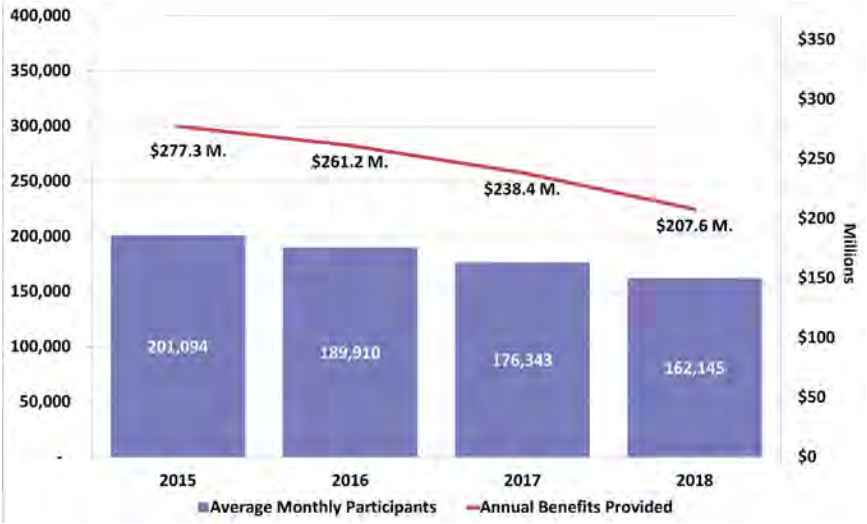
SNAP: Average Individuals Served Monthly and Total Annual Benefits Provided



Program Performance
Idaho's SNAP program continues to perform at a high level, without increases in staffing or administrative overhead costs. Over the past six years, Idaho has consistently remained one of the top states in the country for providing accurate benefits in a timely manner.

One of the goals of the Self Reliance program is to help families receive services as quickly as possible. In 2018, three out of four families eligible for food stamps received benefits the same day they applied. On average, eligible Idaho families receive benefits within two days of applying.

Idaho Child Care Program

The Idaho Child Care Program (ICCP) provides critical work supports in the form of child care subsidies to low-income families, to assist with child care expenses so parents can maintain employment or complete their higher education. Child care assistance also plays a critical role in the development of the child by focusing on ensuring children have access to high quality child care.

Because of the high costs of child care, many parents earning near minimum wage could not afford to work and pay for child care without ICCP assistance. On average, ICCP provided services for approximately 8,619 children per month during SFY 2018, with total annual payments of $36 million.

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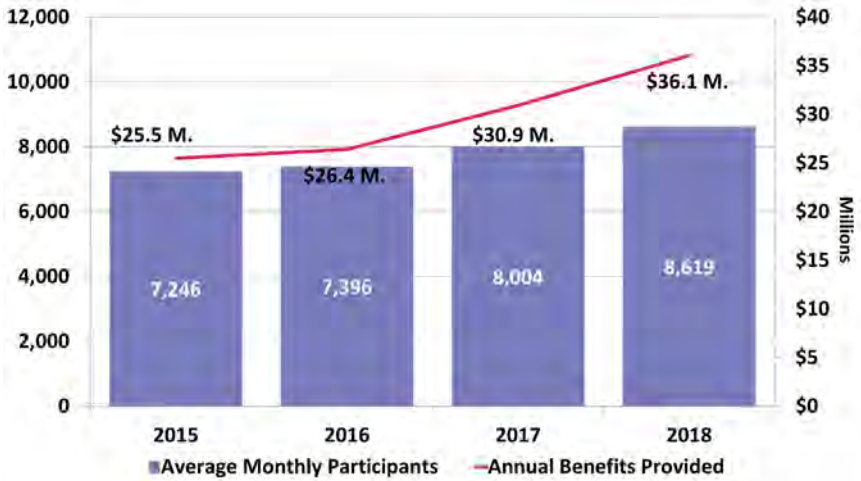
To qualify for child care assistance, a family must meet the following eligibility requirements:

- Children must be under the age of 13.
- Parents must be working or attending school or training.
- They must be a U.S. citizen or meet specific criteria for lawful residence.
- Meet income eligibility limits of 130% or less of the Federal Poverty Limit for family size.

ICCP Average Monthly Children Served and Total Annual Benefits Provided



Eighty-five percent of parents are working. About 10% are attending school and working, while about 5% are only attending school. The ICCP supports these parents on their path to self-sufficiency.

The Idaho Child Care Program also helps families find child care providers in their area through the department's referral system. Last year, 1,308 child care referrals were provided for Idaho families. The Idaho Child Care Program also invests in the quality of care to support children's healthy development and learning by supporting child care licensing, quality improvement systems to help programs meet higher standards, and support for child care workers to receive more training and education.

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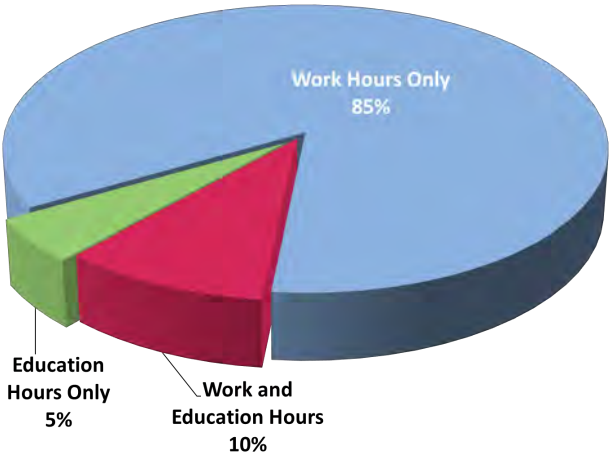
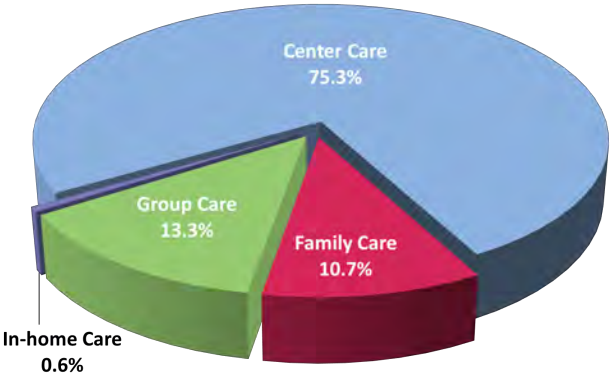
Qualified Activity Types



A provider is eligible to receive ICCP payments if they meet health and safety standards, which include annual CPR/first-aid certification, cleared background checks for all adults who have direct contact with children, and a health and safety inspection every year. Providers also must have ongoing health and safety trainings and professional development. Families may choose from the ICCP qualified providers to find the type of child care that best meets their needs.

The next chart is a breakdown of the type of child care parents receiving ICCP chose for their children in SFY 2018.

Types of Child Care Providers



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In SFY 2018, the ICCP program provided resources, training, education, scholarships, and incentives to child care providers who sought to improve the quality of their child care programs. IdahoSTARS conducted 7,099 training sessions and provided 2,510 training scholarships and 41 academic scholarships statewide, at an annual cost of $260,386 in SFY 2018. IdahoSTARS also supported providers with $512,803 in program improvement grants and incentives.

Medicaid Eligibility

The Division of Welfare determines financial and personal eligibility for Medicaid services. To receive health coverage from Idaho Medicaid, a person must meet certain eligibility requirements.

An individual must fit one of the following categories:

- Be a child under the age of 19.
- Be a pregnant woman.
- Be an adult with a child under the age of 19.
- Have participated in the Idaho Foster Care Program at age 18 and is currently younger than age 27.
- Be age 65 or older.
- Be blind or disabled based on Social Security Administration criteria.

If one of the categories above is met, the person must then meet the following eligibility criteria:

- Be a citizen or legal immigrant.
- Be a resident of the state of Idaho.
- Household income must be less than the program income limits for the household size.
- Resources must not exceed the program resource limits. (There is no resource limit for people eligible for the Modified Adjusted Gross Income (MAGI) Medicaid program.)

To receive services, all the above eligibility requirements must be verified with documentation from the family or through federal or state computer interfaces:

- For all new applications.
- For the annual eligibility re-evaluation.
- Whenever a household or income change is reported.

The MAGI Medicaid program is designed to provide Medicaid benefit programs for children, pregnant women, and parents or caretaker relatives of dependent children. This program only considers the MAGI in the eligibility calculation, and does not include any resources.

Income limits are different for the different Medicaid categories. For example, a family of four (two adults and two children) would be eligible to receive Medicaid services for their children if their income is less than

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$3,975 per month. The parents in this family would be eligible for Medicaid coverage if their income was below $439 per month. Income limits are different for individuals with disabilities and for pregnant women. Single adults with no children and no disabilities are not eligible for Medicaid coverage. A table showing eligibility income limits for Idaho Medicaid can be found at: www.benefitprograms.dhw.idaho.gov.

The average monthly Medicaid enrollment increased by 2 percent during SFY 2018. As of June 2018, nearly 278,000 people were receiving Medicaid services in Idaho. The Division of Welfare receives approximately 8,000 Medicaid applications per month. On average, an eligibility decision on a Medicaid application is made in four days. Participants must have their eligibility for Medicaid coverage reviewed every 12 months. The re-evaluation period takes place each fall to coincide with the open enrollment period for the Affordable Care Act. In SFY 2018, the department reviewed about 96,000 applications for health coverage assistance, including Medicaid and the Advanced Premium Tax Credit (APTC).

The Department of Health and Welfare partners with Your Health Idaho (YHI), the state insurance marketplace, to integrate the eligibility function in determining the Advanced Payment of Tax Credit (APTC). The APTC helps families with income between 100%-400% of the Federal Poverty Limit pay a portion of the cost of health insurance that can be purchased through the state-based exchange. These families are not eligible for Medicaid coverage. DHW processes all financial applications for YHI and determines the amount of tax credit a family is eligible to receive, and then re-determines that tax credit on an annual basis.

DHW allocates the costs for completing the eligibility function to YHI to ensure no state general funds or resources are used to pay for these services.

Cash Assistance

1. Temporary Assistance for Families in Idaho (TAFI)
The TAFI Program provides temporary cash assistance and work preparation services for families with children under the age of 18. The program serves an average of nearly 2,000 households and about 3,000 individuals.

Approximately 94% of households in the program are child-only cases. The remaining 6% are single- or two-parent households. Child-only cases are usually relatives caring for a child whose parents cannot care for them.

Idaho TAFI beneficiaries receive a maximum of $309 per month, regardless of family size. These funds help pay for food, shelter, clothing, and other essentials. Idaho has a lifetime limit of 24 months of TAFI cash assistance for adults. To qualify for TAFI cash assistance, a family must meet the following eligibility requirements:

- Be an Idaho resident who is either a U.S. citizen or meets criteria for

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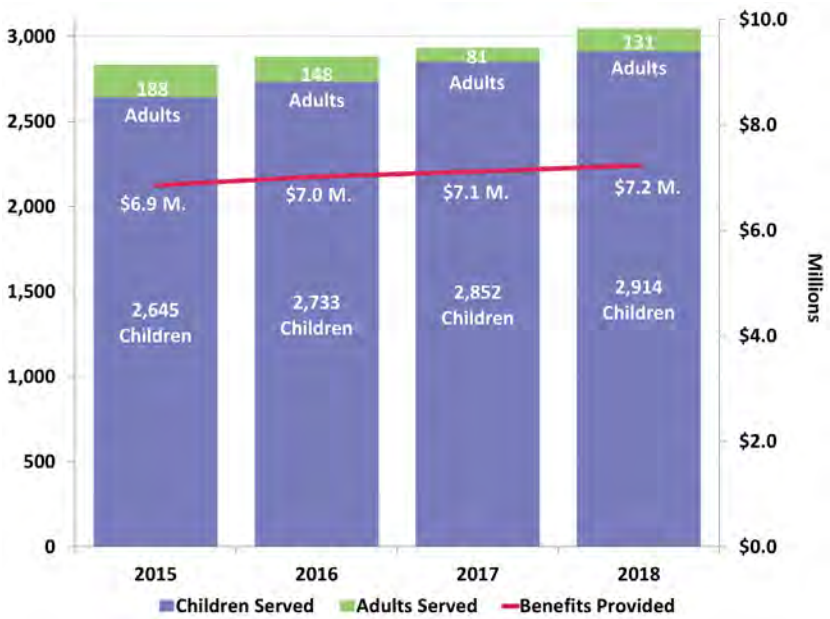
lawful residency.
- Provide proof of identity.
- Meet income eligibility limits for family size.
- Meet personal asset limits.
- Cooperate with Child Support enforcement.
- Participate in drug and alcohol abuse screening, and comply with a treatment plan if determined to be in need of treatment.
- Participate in the Enhanced Work Services program and meet strict participation requirements.

Idaho's TAFI cash assistance program requires participation in work and education preparation activities that build or enhance the skills needed to increase participants' income so they become self-sufficient. They are required to participate 20 – 40 hours per week (depending on family composition) in approved activities, including, but not limited to: searching for a job, education directly related to employment, work experience opportunities, and treatment for substance use disorders. Failure to meet these required activities results in closure of the TAFI assistance and an additional penalty period during which the family is not eligible to receive TAFI cash. Child-only cases are not subject to work participation requirements.

TAFI Monthly Enrollment and Total Annual Benefits



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2. Aid to the Aged, Blind, and Disabled (AABD)
AABD provides cash assistance to certain low-income people who also receive medical assistance because they are blind, disabled, or age 65 or older. AABD cash assistance is intended to supplement the person's income to help them meet the needs of everyday living.

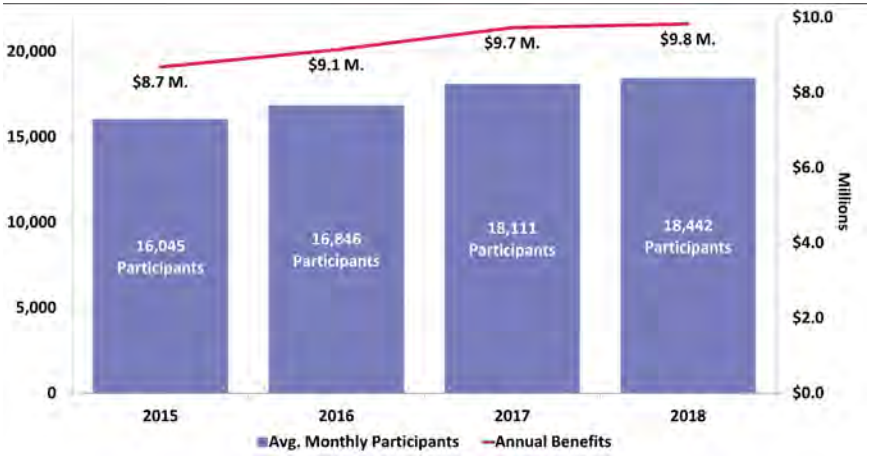
The state of Idaho currently meets the Maintenance of Effort (MOE) requirements established by the Social Security Administration to administer a State Supplemental Cash Program. The current MOE provides a monthly average cash benefit amount of $53 per enrollee. AABD cash payments are paid with 100% state general funds and can range anywhere from $18 per person to $198 per person, depending on the living arrangement of the person receiving the payment.

Individuals are eligible to receive AABD cash assistance if they meet the following requirements:

- The income limit for an individual receiving AABD cash assistance is $803 per month, or $1,145 per couple per month.
- Personal assets must not exceed $2,000 per person per month, or $3,000 per couple per month.
- An individual must be aged or disabled to qualify for the cash payment, and must receive Social Security Income or Social Security Disability Income.
- The living arrangement of the person will determine the amount of cash assistance he or she receives. People who live in a certified family home are not eligible for AABD cash benefits.

On average, 18,442 people received AABD cash payments each month during SFY 2018.

AABD Average Monthly Enrollment and Total Annual Benefits



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Child Support Services

The Division of Welfare manages Idaho's Child Support Program. The program offers two types of services:

1. Receipting-only service, which records payments in the child support automated system and distributes the payment according to the court order.
2. Enforcement service, which establishes and enforces orders to ensure both parents are financially and medically responsible for their children.

All child support orders that require payments to be made through the State Disbursement Unit qualify for receipting-only services at no cost. Any parent or guardian may apply for enforcement services for a $25 application fee. Enforcement services are required if a custodial parent is receiving cash assistance, food stamps, Medicaid, or child care; services are provided to the benefit recipient at no charge.

Enforcement services include:

- Paternity testing and paternity establishment to identify fathers.
- Locating non-custodial parents to pursue enforcement actions.
- Establishing and/or modifying court orders.
- Collecting and distributing child support payments.

In FFY 2018, the Child Support Program administered 147,518 child support cases. This includes 45,098 Receipting Services Only cases. The program collected and distributed more than $205.8 million. About 86% (or $176 million) of that is for enforced cases, and the remaining 14% (or $29 million) is from Receipting Services Only cases.

Monthly Average Caseload and Total Dollars Collected

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About 48% of families with a child support case participated in a benefit program. DHW's goal is to ensure that children have access to the support needed to help them thrive and succeed. Child support can often be the stabilizing factor in ensuring children eat healthy, have access to healthcare, and have positive educational opportunities. DHW strives to support families in making this possible by obtaining and enforcing support orders and getting payments to custodial parents quickly for the care of the child. Idaho serves about 248,000 individuals through the Child Support Program every year.

Child Support Program Participation for FFY 2018

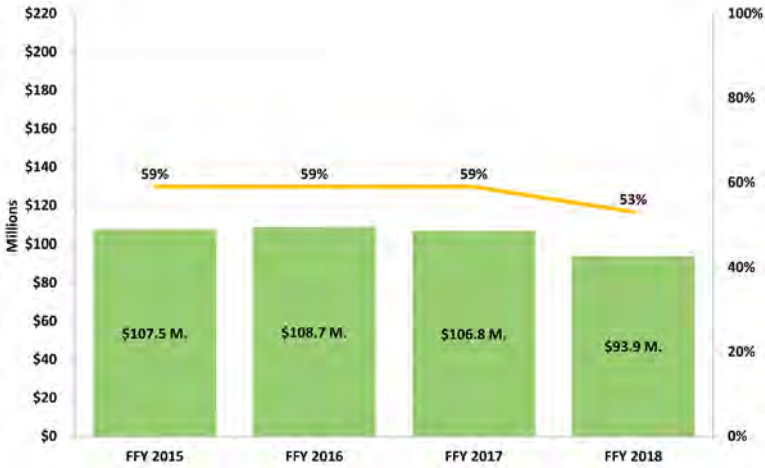
Parents and children	248,000 individuals*
Non-custodial parents	79,900
Custodial parents	78,700
Children receiving services	100,000

*Individuals may receive services from more than one case, making rows not additive to the total unduplicated count of individuals.

Child Support Enforcement Methods

The Idaho Child Support Program uses a variety of methods to enforce child support orders. Just half (50%) of Idaho child support cases owe past-due support. The primary tool for enforcing payments is wage withholding, where wages are automatically deducted from the payee's employment check. This requires coordination with employers across the state of Idaho. Other tools include new-hire reporting through electronic data matching, Social Security and Unemployment benefit income withholding, federal and state tax offsets, and direct collection methods, including financial institution data matching.

Child Support Collected Through Wage Withholding



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The Idaho Child Support Program collects $6.13 for every dollar it spends. Idaho ranks 14th nationally for cost effectiveness in child support collections.

Wage Withholding: Wage withholding is one tool the state uses to collect child support payments. A wage withholding request is sent to the noncustodial parent's employer to collect and disburse current and arrears support on behalf of the noncustodial parent. Wage withholding collections account for 53 percent of all the state's child support collections, as shown in the chart above.

Intergovernmental

Idaho provides intergovernmental services to parents living in Idaho when the other parent lives in another state, a U.S. territory, on tribal land, or a foreign country. Idaho has reciprocity with all states in the U.S. and its territories. In FFY 2018, Idaho had 21,746 interstate cases, where one parent lived in another state. Idaho has 69 international cases, where one parent lives in another country with reciprocity in Idaho:

Australia	10	Canada	38	Sweden	1
England	5	Germany	11	Poland	1
Netherlands	1	Norway	1	Slovakia	1

In 2015, Idaho passed the Uniform Interstate Family Support Act of 2008, which refined existing practices for the establishment and enforcement of support orders with foreign countries who are party to an international treaty or who have entered reciprocating agreements. This important legislation will ensure privacy, consistency, and efficiency in establishing and enforcing support orders for people living in other states as well as in certain foreign countries.

Child Support Service Fees

The Child Support Program provides services for parents who need help in making sure both parents meet their responsibilities for the health and welfare of their children. The following fees are charged for specific services in child support cases:

- Child Support Service application fee: $25
- Income tax refund-attachment-state: $25
- Income tax refund-attachment-federal: $25
- Annual noncustodial parent collection fee: $25

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Partnership Programs

Partnership programs include a variety of services delivered across the state by local organizations, both public and private. Partner organizations providing these services on the division's behalf operate under contracts with DHW. Partner programs provide participants with emergency support, transportation, employment, home utility expenses, home weatherization, and food/nutrition services.

Much of the funding for these services comes from federal grants. The services provide additional work supports for low-income families and often meet their needs so they do not have to access DHW programs. Partnership programs also can bridge the gap for individuals and households transitioning from other DHW programs and services to full self-reliance.

Members of the Community Action Partnership Association of Idaho are the division's primary partners in providing these programs. Action Agency members help eligible community members in their regions through the following programs:

The Emergency Food Assistance Program (TEFAP) helps supplement the diets of people in Idaho in low-income households. Food for TEFAP is purchased from production surpluses and distributed to the state. In Idaho, community action agencies distribute these commodities through their warehouses to local food banks and soup kitchens. In SFY 2018, TEFAP distributed 2.5 million units of food valued at $2.4 million to 231,301 households.

TEFAP: Households Served and Annual Value of Distributed Food

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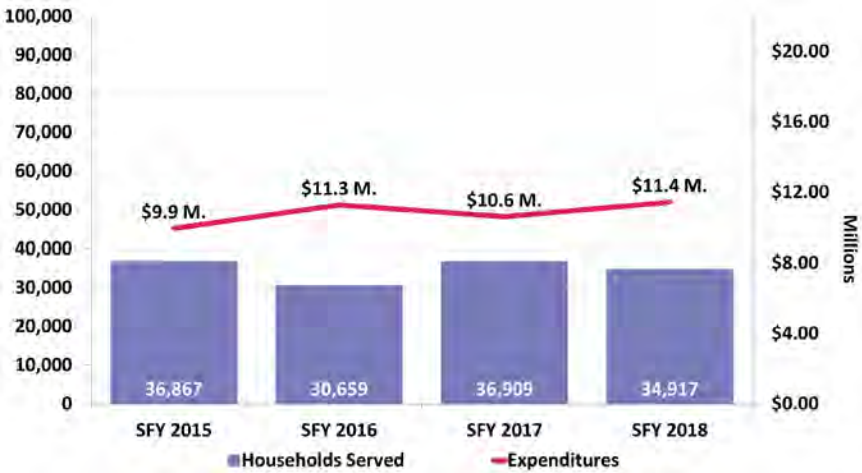
Community Services Block Grant (CSBG) funds programs that help eliminate the causes of poverty and enable families and individuals to become self-reliant. Services are delivered through locally operated and managed community action agencies and the Community Council of Idaho. Grant funds provide emergency and supportive services, employment-readiness training, individual and family development counseling, food, shelter, and transportation assistance. CSBG assisted 77,950 individuals and spent approximately $3.6 million in SFY 2018.

Low-Income Home Energy Assistance Program (LIHEAP) supports several energy conservation and education programs for low-income individuals. It also pays a portion of energy costs for qualifying households. LIHEAP is managed by local community action agencies that make utility payments directly to suppliers on behalf of eligible beneficiaries. The program helped 34,917 households pay $11.4 million in energy costs in SFY 2018. Up to $250,000 in voluntary contributions of Idaho's Grocery Tax Credit are also used to provide some funding to Idaho's LIHEAP Program.

LIHEAP Annual Participants and Expenses



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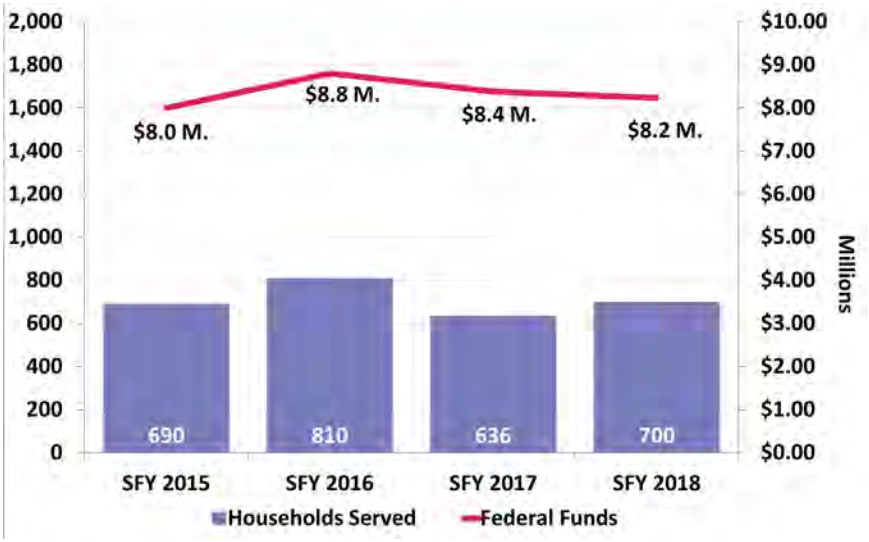
Weatherization Assistance Program helps low-income families conserve energy, save money, and improve living conditions by upgrading and weatherizing their homes. Idaho's weatherization program is funded by utility companies, the U.S. Department of Health and Human Services, the Bonneville Power Administration, and the U.S. Department of Energy. Eligible efficiency measures include air sealing (weather-stripping and caulking), wall and ceiling insulation, heating system improvements or replacement, efficiency improvements in lighting, hot water tank and pipe insulation, and appliance replacement. The Weatherization Assistance Program provided $8.2 million for efficiency improvements to 700 Idaho households in SFY 2018.

Weatherization Assistance Program: Total Households Served and Annual Expenditures (Federal)



Note: The total funds represented in this chart are federal funds allocated to the state for weatherization services. Weatherization agencies also receive private funds from utility companies that are not included in these charts. Agencies typically use a mixture of private and federal funds to weatherize homes. Annual decreases in households served is due to an annual increase in the cost per unit limit from DOE, resulting in additional energy efficiencies to be installed per dwelling.

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Glossary of Acronyms

ATR .....Access to Recovery Grant
AABD .....Aid to the Aged, Blind and Disabled
ACIP.....Advisory Committee on Immunization Practices
ACT ..... Assertive Community Treatment
ADA.....Americans with Disabilities Act
AED.....Automated External Defibrillator
AEMT.....Advanced Emergency Medical Technician
AIDS..... Auto Immune Deficiency Syndrome
AMH.....Adult Mental Health
APS.....Administrative Procedures Section
APTC.....Advanced Payment of Tax Credit
BOCAPS.....Bureau of Clinical and Preventiative Services in Public Health
BRFSS.....Behavioral Risk Factor Surveillance System
CAP..... College of American Pathologists
CCAI.....Comprehensive Cancer Alliance of Idaho
CHC ..... Criminal History Check
CDC.....Centers for Disease Control and Prevention
CFS.....Child and Family Services
CFH.....Certified Family Home
CHIP.....Children's Health Insurance Program
CLIA .....Clinical Laboratory Improvement Amendment
CMHP..... Children's Mental Health Project
CSBG.....Community Services Block Grant
CQI.....Continous Quality Improvement
CSES.....Child Support Enforcement System
CY .....Calendar Year
DD .....Developmental Disabilities
DDA .....Developmental Disability Agencies
DDI.....Design, Development, and Implementation
DIT.....Division of Information and Technology
DRA.....Deficit Reduction Act
DTaP..... Diptheria, Tetanus, acellular Pertussis
DUI..... Driving Under the Influence
EBT .....Electronic Benefits Transfer
EMR.....Emergency Medical Responder
EMS ..... Emergency Medical Services
EMT..... Emergency Medical Technician
ELT.....Executive Leadership Team
ETV.....Education and Training Voucher Program
EWS.....Enhanced Work Services

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FACS .....Division of Family and Community Services
FFY ..... Federal Fiscal Year
FMAP.....Federal Medical Assistance Percentage
FNS.....Food and Nutrition Services at USDA
FPL.....Federal Poverty Limit
FTP .....Full-time Positions
FYI.....Foster Youth Alumni of Idaho
GED.....General Education Degree
HART.....Homes with Adult Residential Treatement
HCA.....Health Coverage Assistance
HIFA.....Health Insurance Flexibility Act
HIPAA.....Health Insurance Portability and Accountability Act
HIV..... Human Immunodeficiency Virus
HPV.....Human Papilloma Virus
HPSA.....Health Professional Shortage Area
IBIS.....Idaho Benefits Information System
ICCMH ..... Idaho Council on Children's Mental Health
ICCP..... Idaho Child Care Program
ICCCP.....Idaho Comprehensive Cancer Control Program
ICDD.....Idaho Council on Developmental Disabilities
ICF/ID..... Intermediate Care Facility for People with Intellectual Disabilities
ICPC .....Interstate Compact on the Placement of Children
ICWA .....Indian Child Welfare Act
DHW ..... Idaho Department of Health and Welfare
EBT.....Electronic Benefits Transfer
IIP.....Idaho Immunization Program
IRIS .....Immunization Reminder Information System
ITP.....Infant Toddler Program
LIHEAP.....Low Income Home Energy Assistance Program
LSO .....Legislative Services Office
MAGI.....Modified Adjusted Gross Income
MMIS ..... Medicaid Management Information System
MMRV.....Mumps, Measles, Rubella and Varicella
MOE.....Maintenance of Effort
MST.....Mountain Standard Time
OPE.....Office of Performance Evaluation
PCMH.....Patient-Centered Medical Home
PHA.....Premium Health Assistance
PIO.....Public Information Office(r)
PAN.....Physical Activity and Nutrition Program
PMO.....Project Management Office
PSR.....Psychosocial Rehabilitation Services
PWC .....Pregnant Women and Children

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RAC.....Regional Advisory Committee
RALF.....Residential Care and Assisted Living Facilities
RCO.....Regional Care Organization
RFI.....Request for Information
RFP.....Request for Proposal
RMHB.....Regional Mental Health Board
RMHC.....Regional Mental Health Centers
RSO .....Receipting Services Only
SA.....Substance Abuse
SED.....Serious Emotional Disturbance
SFY..... State Fiscal Year
SHIP.....Statewide Healthcare Innovation Plan
SHN..... State Hospital North
SHS .....State Hospital South
SNAP (food stamps) .....Supplemental Nutitrition Assistance Program
SPP.....Suicide Prevention Program
SPAN.....Suicide Prevention Action Network
SRS.....Self-Reliance Services
STD.....Sexually Transmitted Diseases
STI.....Sexually Transmitted Infection
SUD.....Substance Use Disorder
SUR ..... Surveillance & Utilization Review
SWITC.....Southwest Idaho Treatment Center in Nampa
TAFI..... Temporary Assistance for Families in Idaho
TANF.....Temporary Assistance for Needy Families
TBI .....Traumatic Brain Injury
TEFAP..... The Emergency Food Assistance Program
TPC.....Tobacco Prevention and Control Program
VAERS.....Vaccine Adverse Event Reporting System
VFC.....Vaccines for Children
WAP.....Weatherization Assistance Program
WHC.....Women's Health Check
WIC.....Women, Infants and Children
WICHE.....Western Interstate Commission for Higher Education
YHI.....Your Health Idaho

(Please contact Niki Forbing-Orr at Niki.Forbing-Orr@dhw.idaho.gov to suggest additions to the acronyms glossary.)

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Youth Empowerment Services

Quality Management Improvement & Accountability

Quality Management Improvement & Accountability (QMIA)

Quarterly Report

Issue # 9 – April 2019

QMIA Council Data & Reports Subcommittee
Candace.Falsetti@dhw.idaho.gov

QMIA Quarterly Report - Issue # 9 - April 1, 2019

About this Report & Table of Contents

October 1- December 31, 2018

About This Report: The Youth Empowerment Services (YES) 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. Settlement Agreement and is a critical aspect of the YES project. The QMIA-Q report is 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 YES 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; this quarterly report is one tool being used to monitor and evaluate progress toward achieving these goals.

The QMIA-Q reports will focus on statewide and regional-level data and information to provide stakeholder groups insight into the child-serving system in Idaho, including: Profiles of Idaho's youth, workforce development, access and barriers to care such as gaps in services, youth and family experience and engagement, appropriate use of services, effectiveness of services and quality improvement projects.

The QMIA-Q report is available to all stakeholders and 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. If information provided within this report evokes questions or an interest in additional data collection, please contact **YES@dhw.idaho.gov** with your questions, concerns or suggestions. For Medicaid-specific questions or concerns, please contact MedicaidSEDProgram@dhw.idaho.gov.

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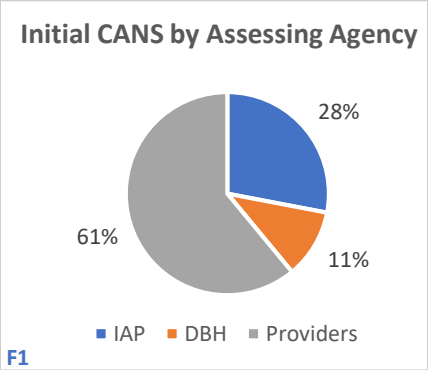
QMIA Quarterly Report - Issue # 9 - April 1, 2019

How are Children, Youth and Families Accessing YES?

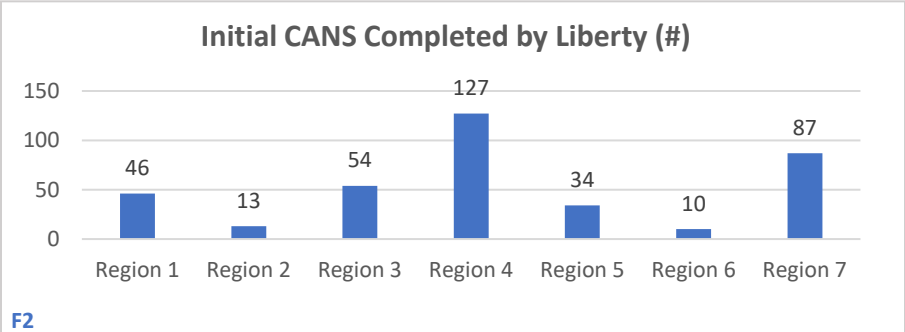
October 1- December 31, 2018

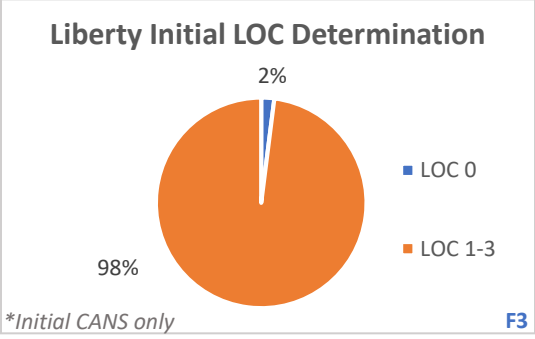
There are currently three access points within YES where a youth may have an initial Child Adolescent Needs and Strengths (CANS) completed: The Independent Assessment Provider (IAP) Liberty Healthcare, the Division of Behavioral Health (DBH), or with a Medicaid/ Optum Network community provider. **During this reporting period, a total of 1,326 youth had an initial CANS completed.** *It is important to note that all youth will receive an "Initial CANS" regardless whether they are new to services or an existing client. The designation of "Initial CANS" indicates a youth's first CANS assessment with an assessing agency. It is also important to note that some youth had an initial CANS completed by the DBH as well as another assessing agency during this reporting period and to avoid duplication will only be represented once in the report sections to follow.*



The Independent Assessment Process

To increase access to services, Medicaid eligibility was extended for YES program members with family incomes from 150-300 % of the federal poverty level. A youth who does not have Medicaid coverage, or has Medicaid coverage and would like to access Agency Respite services will be referred to the Independent Assessment Provider (IAP), Liberty Healthcare. The Independent Assessment Provider will complete a Comprehensive Diagnostic Assessment (CDA) as well as use the CANS tool to determine Youth Empowerment Services eligibility. **During this reporting period, 371 youth had an initial CANS completed through the IAP.** Of these 371 youth, 9 received a CANS recommended Level of Care (LOC) of 0 and were therefore not eligible for YES. Information on youth who received a LOC of 1-3 will be detailed in the next section of this report. The IAP also completed an update CANS for 11 youth during this reporting period.





Youth Eligible for Medicaid Coverage: Youth who are determined to be eligible for YES by the IAP and who do not already have Medicaid coverage will be referred to the state's Self Reliance program to apply for Medicaid benefits. More information about Medicaid-eligible youth has been provided in the Medicaid Services section of this report.

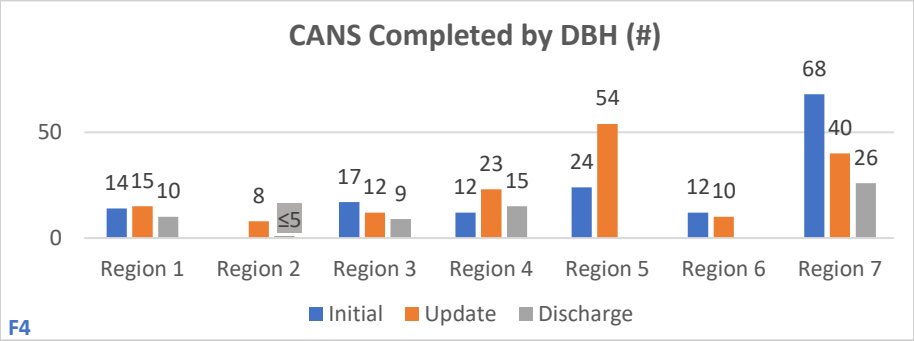
All youth who have been found to be YES-eligible through the Independent Assessment process, are YES Medicaid-eligible and/or would like to access Agency Respite services will have a **person-centered service plan**. DBH currently works with families to complete these plans. Regional information on new referrals received during the reporting period as well as plans completed has been provided in **Table 1**.

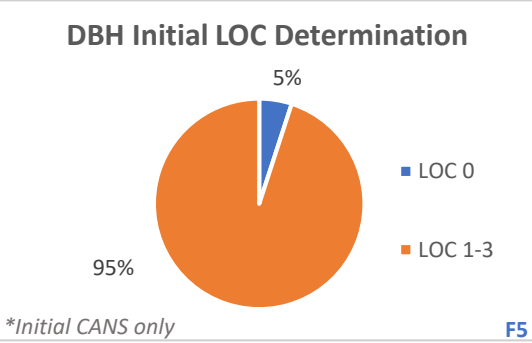
Table 1: Person-Centered Service Plans

Region	New Referrals	% of Total	# Completed during period	% of State Total	Avg. Time to Complete
1	26	17%	26	11%	65 days
2	Redacted	>1%	9	4%	71 days
3	24	16%	21	8%	64 days
4	42	28%	56	23%	84 days
5	16	11%	17	7%	63 days
6	7	5%	12	5%	72 days
7	35	23%	106	43%	81 days
State	151	100%	247	100%	75 days

CANS Completed by the Division of Behavioral Health

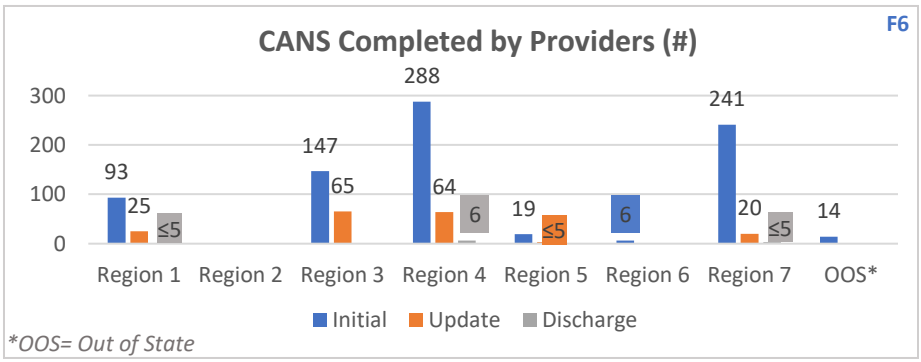
Youth who receive a CANS through the Division of Behavioral Health are typically youth who are involved in court-ordered services, are enrolled in a wraparound program or are not Medicaid-eligible. **During this reporting period, 147 youth had an initial CANS completed through DBH.** Of these 147 youth, 8 received a CANS recommended Level of Care (LOC) of 0 and were therefore not eligible for YES. Information on youth who received a LOC of 1-3 will be detailed in the next section of this report. DBH also completed an update or discharge CANS for 211 youth during this reporting period.

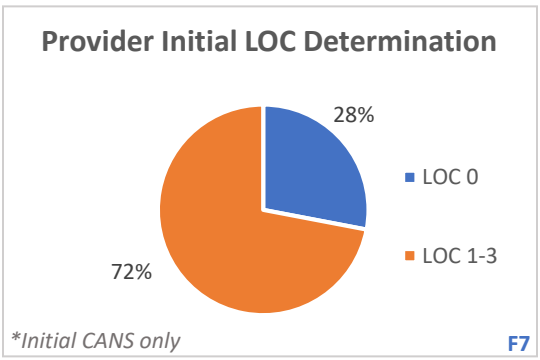




CANS Completed by Community Providers

Youth who receive a CANS through a community provider are youth who are Medicaid-eligible. **During this reporting period, 808 youth had an initial CANS completed through a community provider.** Of these 808 youth, 230 received a CANS recommended Level of Care (LOC) of 0 and were therefore not eligible for YES. Information on youth who received a LOC of 1-3 will be detailed in the next section of this report. It is important to note that some youth had an initial CANS completed by a community provider as well as another assessing agency during this reporting period and to avoid duplication will only be represented once in the report sections to follow. It is also important to note that use of the CANS tool is not mandatory for Medicaid/ Optum providers until July 2019. Community providers also completed an update or discharge CANS for 187 youth during this reporting period.

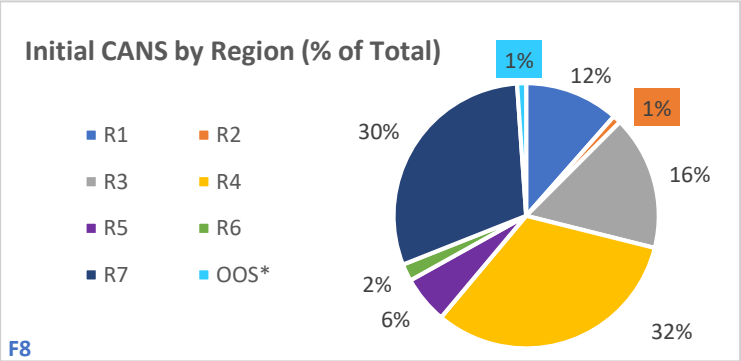




Statewide: Initial CANS Completed by Region

Of the 1,326 youth who received an initial CANS assessment within the reporting period, over 60% were in Regions 4 and 7. Regions 2 and 6 had the lowest percentages of CANS completed. Region 2 did not have any initial CANS completed by DBH or Community Providers during this period. Level of Care information for these youth has been provided below and will be detailed in the section to follow.

LOC 0	LOC 1	LOC 2	LOC 3
19%	37%	15%	29%



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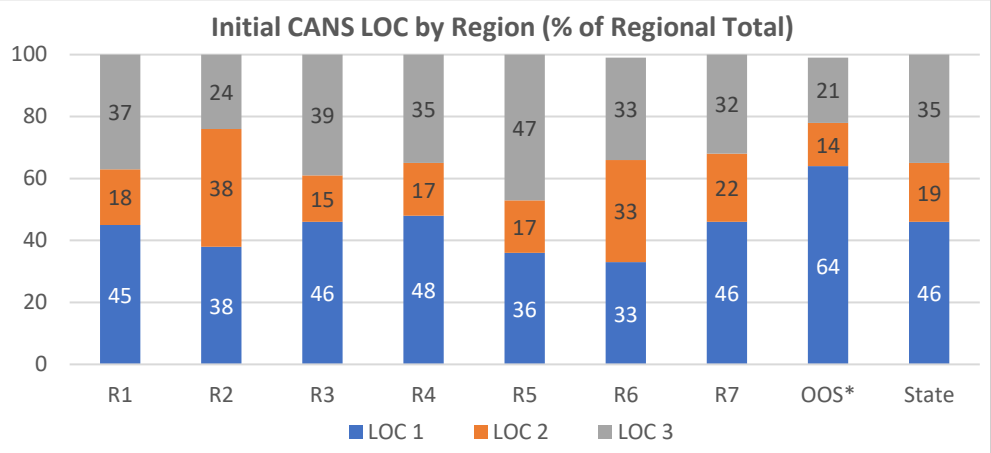
Who Met YES Eligibility Criteria?

October 1- December 31, 2018

Eligibility for the YES program is determined by a qualifying mental health diagnosis and a recommended level of care (LOC) of 1-3 on the Child Adolescent Needs and Strengths (CANS). Reviewing demographic and diagnostic information about the youth who have screened in as eligible can help us better understand the youth and families we are serving as well as identify potential population gaps. This section will provide information about the 1,079 youth who received a recommended LOC of 1-3 on their initial CANS during the reporting period. These CANS were completed by either the Independent Assessment Provider (IAP), the Division of Behavioral Health (DBH), or a Medicaid/Optum contracted community provider.

Recommended Levels of Care	
1	SED identified. Services should be coordinated, but functioning is stable
2	SED identified. Youth may be involved in multiple systems and require extensive service collaboration
3	SED identified. Youth is considered to have high treatment needs and is at risk of out-of-home placement

Recommended Levels of Care (LOC)



F1 R1- 133, R2- 13, R3- 194, R4- 302, R5- 70, R6- 27, R7- 326, *Out of State- 14

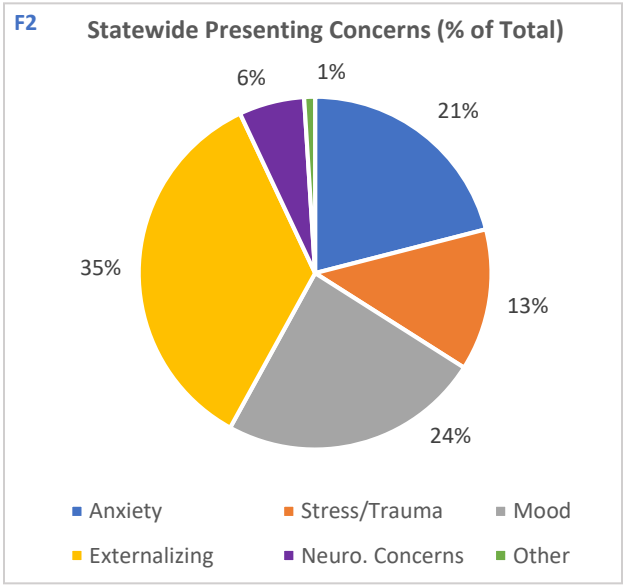
Overall, the majority of the youth statewide who had a CANS completed during this reporting period received a recommended LOC of 1. For this LOC, regional variances were minimal with the largest difference seen with CANS completed by out-of-state community providers. More pronounced variation between the regions is seen in LOC 2 and 3 with Region 2 appearing as a LOC 2 outlier and Region 5 having a significantly higher percentage of CANS completed with a LOC of 3.

Presenting Concerns: Primary Diagnoses

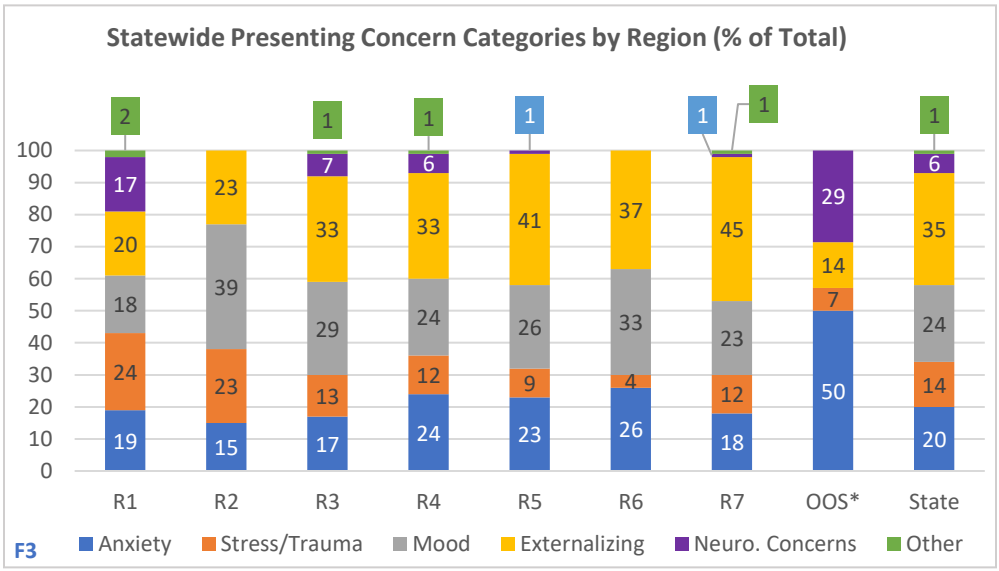
The primary diagnosis for each of the youth who had an initial CANS completed within the reporting period has been placed into one of five presenting concern categories; *Anxiety, Stress or Trauma, Mood, Externalizing, and Neurological Concerns*. These categories allow for a high-level view of the concerns youth are presenting with, both statewide and by region. Information about the presenting concern categories such as which diagnoses are grouped into which category can be found in Appendix B of the full report.

Statewide, it appears that the majority of youth who had an initial CANS completed during this period presented with a primary diagnosis in the Externalizing category. Youth who presented with a diagnosis in the Anxiety and Mood categories were almost equally represented in the statewide composition. The percent of youth presenting with Stress or Trauma and Neurological concerns was significantly lower than the other categories.

F2



When viewing the presenting concern categories by region, there are some similarities as well as significant variations. Regions 3, 4, and 7 appear to be fairly similar to the overall state presentation. Regions 1 and 2 saw a significantly higher percentage of youth with a primary diagnosis in the Stress or Trauma category. Similarly, these regions both saw a lower percentage of youth with primary diagnoses in the Externalizing category. Regions 2 also saw a higher percentage of youth with a primary diagnosis in the Mood category, as did Region 6. Region 1 saw a significantly lower percentage of youth with a diagnosis in the Mood category. Youth seen by out-of-state community providers had a very distinct categorical presentation. It is important to consider the vast differences in numbers of youth served in each region and interpret with this caution in mind.



Demographics

The following figures represent the demographic information for all 1,079 youth with a CANS completed during the reporting period, statewide and by region.

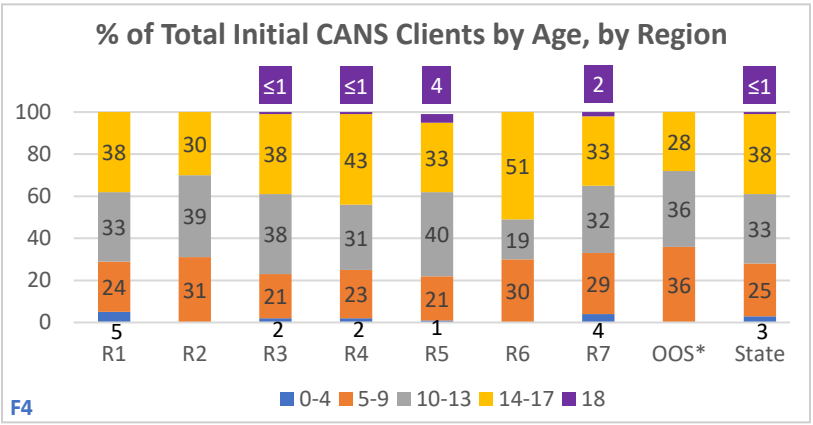
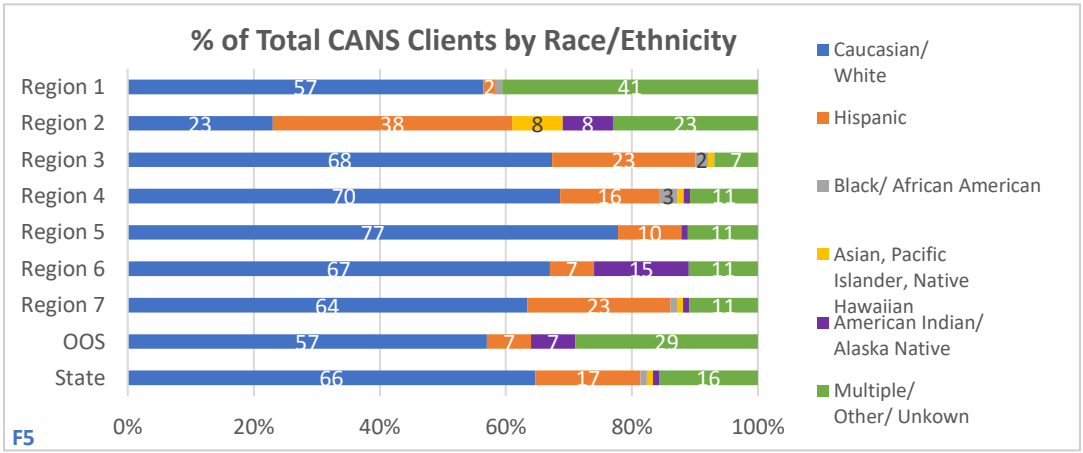


Table 1: Statewide CANS by Gender, by Region				
Region	Male	Female	Transgender	Unknown
1	57%	43%	-	-
2	46%	54%	-	-
3	61%	39%	-	-
4	58%	41%	≤1%	-
5	66%	34%	-	-
6	63%	37%	-	-
7	56%	43%	-	≤1%
OOS	64%	36%	-	-
State	59%	41%	≤1%	≤1%

There was a fairly even statewide distribution of youth between the ages of 10-17 who had a CANS completed during the reporting period, with a slight decrease in percentage of youth seen between the ages of 5-9. Overall, Region 6 appears to have the most distinct percentage distribution for age along with outside state community providers. The statewide gender distribution continues to show a higher percentage of males than females; a similar pattern is seen in Regions 1, 4, and 7. Regions 3, 5, and 6 saw significantly more males, and Region 2 was the only region that saw more females than males.

It appears that the majority of youth seen during this period identified their race as caucasian/white, however there was also a high percentage of youth who identified as more than one race, chose the other option, or their race was unknown. For ethnicity, 17% of youth statewide identified as of Hispanic or Latino origin.



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Who We're Serving: The Division of Behavioral Health

October 1- December 31, 2018

The Division of Behavioral Health (DBH) has traditionally provided services to youth in one of the three circumstances: crisis, youth involved in court-ordered services, and voluntary clients who are not Medicaid-eligible. With the implementation of Youth Empowerment Services, DBH has taken on additional roles: person-centered service planning for youth who are newly Medicaid-eligible or would like access to respite services, and wraparound. For SFY 2018, an additional 559 youth not represented in the Figure 1 engaged with DBH in person-centered service planning. More information about person-centered service planning can be found in the Access section of this report. Information about the wraparound program is included in this section of the report.

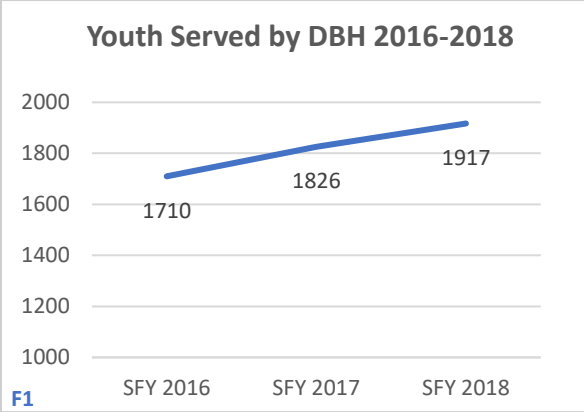


Table 1: Youth Served by DBH: SFY 2016-2019 Q2 YTD Comparison									
As of December 31 (Q2-SFYTD)	Crisis		Court Ordered		Voluntary		YES[2]		Total Clients[1]
2016	138	12%	746	66%	242	21%	N/A		1126
2017	116	9%	725	58%	400	32%	N/A		1241
2018	165	12%	703	51%	511	37%	N/A		1379
2019	137	12%	619	53%	415	35%	954	45%	1,171 (2,125)

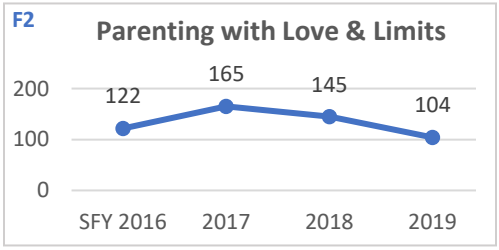
[1]Some clients may be represented twice in 2 or more regions or 2 or more client types

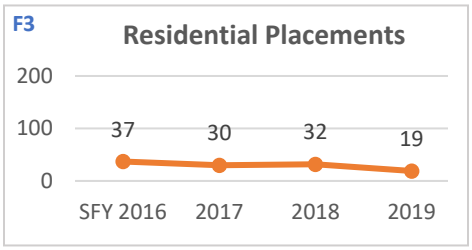
[2]YES Client type was established in late SFY 2018 and therefore is not represented in SFY 2016-2018 Q2 data

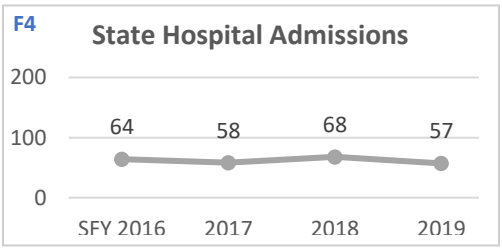
The above chart contains point-in-time data from the end of the second quarter of the State Fiscal Year (December 31) for years 2016 through 2019. This data allows for a comparison of the number and type of youth served by DBH at the same point in time across several years. It is important to reiterate that DBH began assisting youth and families with the Person-Centered Service Planning process in 2018 and the "YES" client-type designation in the chart above is representative of this work. If we were to add the "YES" client-type from the number of total clients served for Q2 2019, the number of clients would be 2,125 (45% of total clients). A re-calculation for this consideration has been provided in blue within the table.

TRENDS: It appears that DBH served slightly fewer youth at the December 31 point in time in 2019 than in the previous two years with crisis, court-ordered and voluntary client-types. When considering the percentage of total clients served throughout the four-year comparison, DBH saw a decrease in the percentage in court-ordered clients served and an increase in voluntary clients up until 2019. In 2019, a slight increase was seen in the percentage of court-ordered clients served and conversely, the percentage of voluntary clients decreased. There does not appear to be a trend pattern for crisis clients in this data set.

Program Enrollments: Figures 4-6 show the year-to-date number of youth who were assigned the designated program enrollment at the end of December 31 (SFY Q2) for SFY 2016-2019.







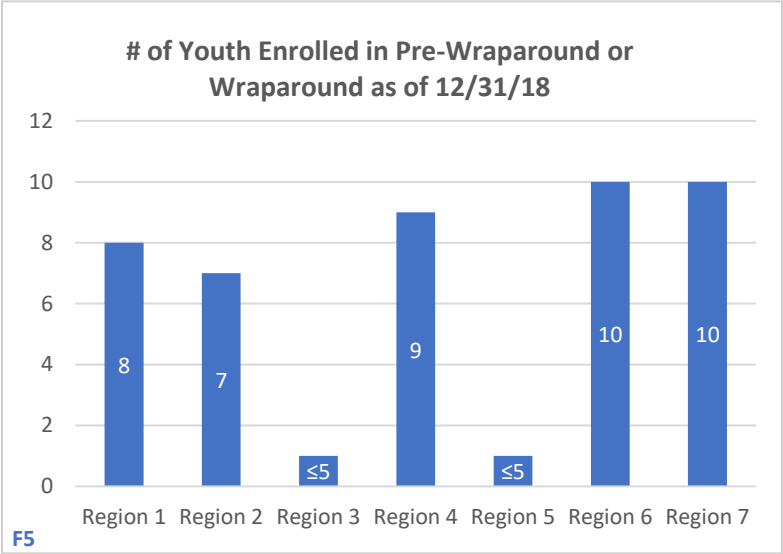
Note: Youth may have multiple program enrollments during a time-period.

Referring again to **Table 1**, excluding the "YES" client-type, DBH served 15% less youth by December 31, 2019, than in the previous year. A more significant decrease in percentage was seen when comparing program enrollments at the end of December 2018 to 2019, with 28% less youth enrolled in Parenting with Love and Limits and 41% less youth with a residential placement. There were 16% less state hospital admissions from Q2 2018 to 2019.

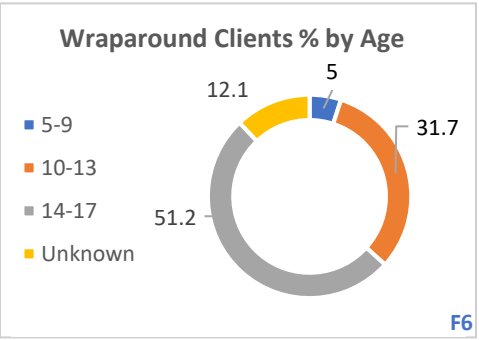
Wraparound

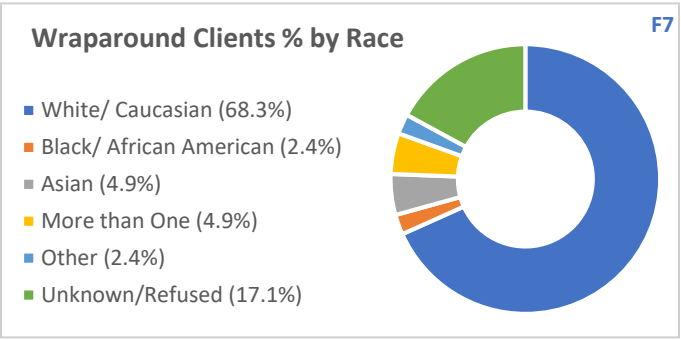
A wraparound utilization report was completed by the Boise State University (BSU) School of Social Work in February of 2018 to estimate the number of youth who are likely to need and use Intensive Care Coordination (ICC). BSU's report suggested that 1,350 Idaho youth would have benefitted from Intensive Care Coordination in 2016. This report provided target estimates for three wraparound program maturity phases: Emerging, Evolving and Established. For an emerging program, in a pilot phase or in the early stages of implementation, the target goal recommended by BSU was for Idaho to serve around 280 youth per year[1]. The full report, titled "Estimated Need for Intensive Care Coordination among Idaho Youth" is posted on the YES Website (link). *[1]It is important to note that this estimate was derived based on 2016 Idaho population data. To update this estimate and account for a growing population, additional data collection and analysis would need to be completed.*

The Division of Behavioral Health began enrolling currently served youth into wraparound programs in February of 2018. As of December 31st, there were a total of 51 youth currently enrolled in a wraparound or Pre-wraparound program, 20 of these youths were enrolled during this reporting period. Last quarter, it was reported that 40 youth were enrolled in wraparound (excluding pre-wraparound enrollments) as of September 30th; this represents an increase of 1 youth in wraparound this quarter. Demographic information for the 41-youth enrolled in wraparound at the end of the reporting period has been provided below.

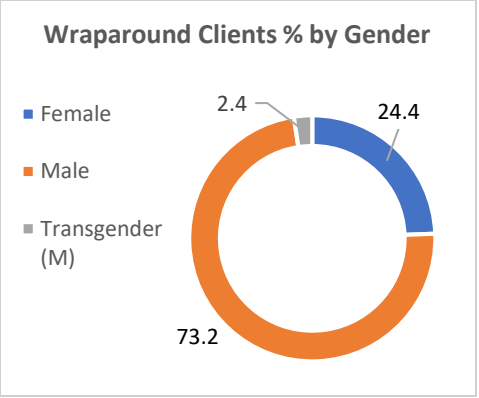


The Pre-Wraparound program designation is used when families are considering Wraparound or have agreed to Wraparound but have not started yet. To remove duplication, youth who had both a Pre-Wraparound and then a Wraparound enrollment during the reporting period were counted under Wraparound.





81% of youth were not of Hispanic or Latino origin. **7%** reported to be Hispanic or Latino. The race of the remaining **12%** was either unknown or the family/ youth chose not to disclose.



WRAPAROUND CARE COORDINATORS

Presently, there are **35** care coordinators trained in wraparound throughout the state. Two have the designation of supervisor and are not carrying a caseload.

Region 1	4	Region 2	4	Region 3	4	Region 4	4
Region 5	5	Region 6	3	Region 7	5	FACS DD	6

FACS DD= Family and Community Services; Developmental Disabilities Program

Who We're Serving: **The Division of Medicaid**

October 1- December 31, 2018

As of December 2018, there were 961 YES Medicaid-eligible Members. A total of 307 of YES-eligible children with the rate code 44 (which refers to children that obtained Medicaid over the set FPL) and 654 of YES-eligible children had the YES condition code (which refers to children that previously had Medicaid). The number of YES Medicaid eligible members increased by 97 members throughout the 4th Quarter.

Respite

In January 2018, Optum Idaho implemented respite as a billable service to members. Respite is a short-term or temporary care for a youth with Serious Emotional Disturbance provided in the least restrictive environment that provides relief for the usual caretaker and that is aimed at de-escalation of stressful situations. In April 2018, Optum Idaho created and published a 10-module online learning course to support and certify respite workers. To date, the course has been completed by 264 in-network providers ranging from paraprofessionals to agency owners. Optum Idaho also created and published a supplemental training for supervisors of respite workers, which has been completed 47 times. As of November 2018, Optum has been billed for 2,700 hours of respite. Of the billed units, 73% of all Respite was provided in a group setting, with 27% of units billed for individual respite. In January 2018, three provider agencies billed for Respite, with the number of agencies billing increasing steadily throughout 2018. In October 2018, 19 provider agencies billed for respite. Year-to- date, Optum has 27 unique provider agencies credentialed to provide respite in 62 locations throughout the state. Nine agencies have locations in multiple regions.

New and/or Enhanced Services

The Child and Adolescent Needs and Strengths (CANS) – A multi-purpose functional assessment tool developed for children's services to support decision making, including level of care and service planning; to facilitate quality improvement initiatives; and to allow for the monitoring of outcomes of services.

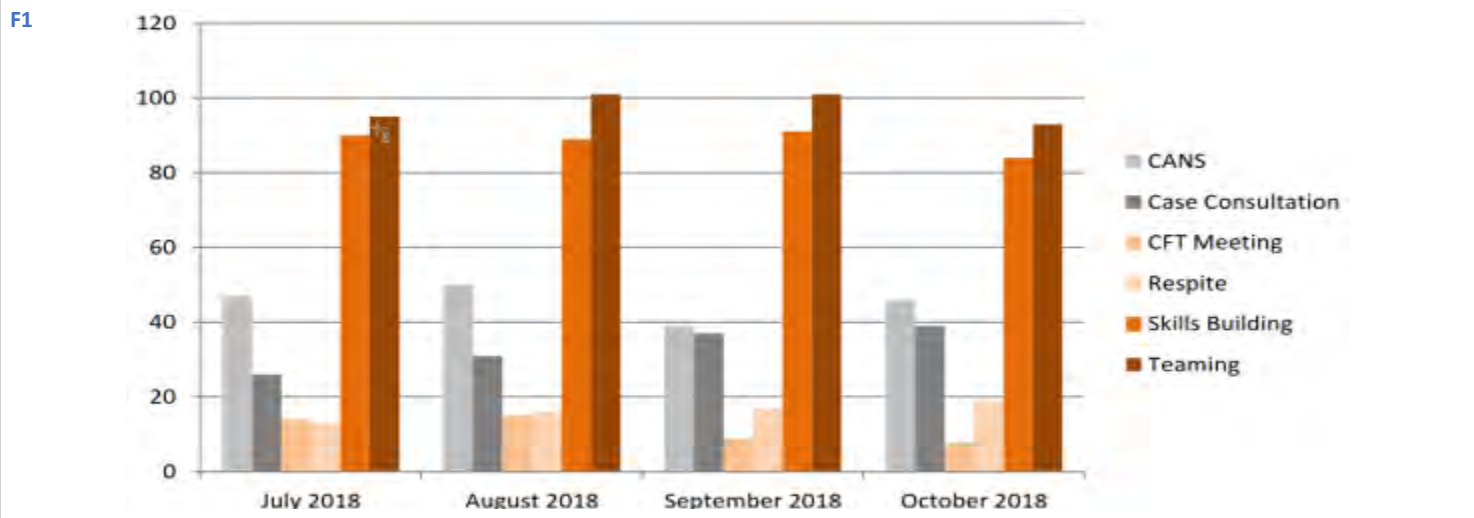
Child & Family Team (CFT) – A meeting of a team of individuals selected by the youth and their family they believe can be helpful in the development and implementation of a coordinated care plan and will assist the member in achieving treatment goals.

Skills Building/Community Based Rehabilitation Services (CBRS) – Services provided by a behavioral health professional in the home or community to help members learn and practice the skills needed to support overall wellness and independent living abilities.

Teaming (Skills Building Treatment Planning) – The process in which a master's level clinician, skills building paraprofessional, member, and family work together to develop an individualized Skills Building/CBRS treatment plan.

In October 2018, Optum Idaho implemented two new services: crisis response, and family psychoeducation. Optum provided online and in-person trainings throughout the state for providers to ask questions and gain more information on billing and service requirements.

Service Utilization for YES Eligible Medicaid Members (July 2018-October 2018*)

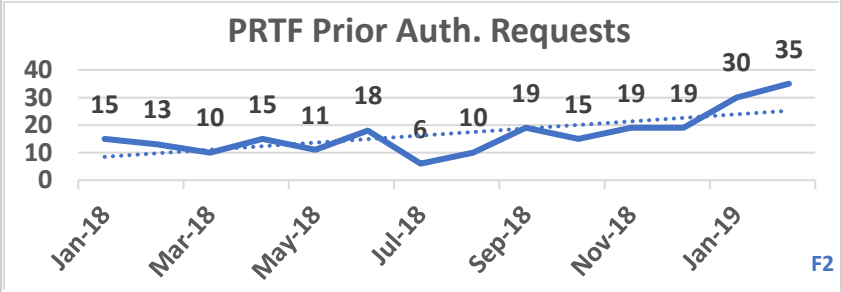


Region	CANS	CFT Meeting	Respite	Skills Building	Teaming
Region 1	23	7	11	21	38
Region 2	9	2	5	9	8
Region 3	20	8	6	28	49
Region 4	45	7	6	34	85
Region 5	9	3	5	15	16
Region 6	13	4	2	27	32
Region 7	31	7	5	32	48
Total	150	38	40	166	276

**It is important to note that this data set is from July-October of 2018 which is outside of the reporting period of SFY Q2 2019. As per Optum Idaho, Utilization rates are based on claims data. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims.*

Children's Medicaid Psychiatric Residential Treatment Overview

Children's Medicaid continues to experience increases in the average monthly number of service requests for psychiatric residential treatment. In January and February of 2019, the program received 65 new service requests. If this number of monthly requests continues, the program would be on track for over 350 in 2019. The 2018 placement rate was 60%. If this holds true in 2019, over 200 children could be placed in psychiatric residential treatment this year, which is over a 100% increase in placements from 2018.



Annual PRTF PA Requests and Placements		
Period SCY	**Total PA Request**	**Total Placements**
2018	166	94

Period SCY	Total Requests	Approved	Denied	In Process	Withdrawn
2018-Q4	53	28	15	0	10

Children's Medicaid continues to make process improvements and staffing changes to support operations. The program has implemented a new tracking and documentation method to easily manage and report key metrics around this level of care. The next QMIA report will encompass metrics from January 1, 2018 through March 31, 2019. The next report will set the standard for reporting structure moving forward. Additionally, program staff are excited to see improvements in access to services and the experience of Medicaid participants and their families.

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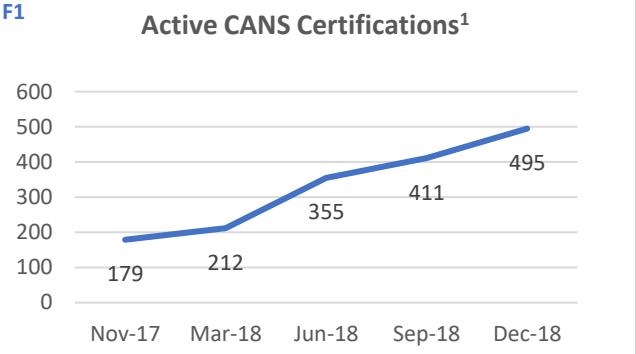
Supporting the Workforce: **CANS Certifications & Trainings**

October 1- December 31, 2018

The CANS tool is designed to facilitate an engaging and collaborative partnership between the provider, youth and family to inform planning, support decisions, and monitor outcomes. When a provider becomes CANS certified, they are trained on the TCOM Fundamental Tenets: 1) A required focus of a shared vision of the children and families receiving services, 2) Collaboration of multiple partners, 3) Communication facilitation among partners, including youth and families, 4) Shared commitment to serving youth and families despite differences, 5) Collective accountability to the youth and family. *The number of providers and key individuals who are CANS certified represents system progress toward improved youth and family engagement practices and meaningful change.*

F1



[1]Dec-18 data only captures active CMH CANS certifications in Idaho, rather than any CANS or jurisdiction.

ICANS Trainings: During the reporting period, the Division of Behavioral Health (DBH) hosted **28** ICANS training webinars for division staff (6) as well as community partners and providers (58), the Department of Juvenile Corrections (2), and agency administrators (25).

Coaching & Support: *Wraparound Care Coordinators and DBH staff working with families to complete person-centered service plans participate in weekly support calls:*

Wraparound	9 calls during report period	Average 25 attendees
Person-centered planning/ CANS Clinical Support	13 calls during report period	Average 40 attendees

In addition to the weekly support calls, four hub-based clinical wraparound coaching calls took place in November and December. North Hub (2): 20 participants, SE Hub: 10, SW Hub: 13.

The Division of Behavioral Health helped support the following learning opportunities for family members during the reporting period: *Insurance: Which One- What Services- Questions You Need to Ask, State Agencies: Who does What?*, and *Communications as Equals in the YES System for Families*. These trainings were delivered via webinar and had a total of 62 attendees.

Optum Trainings: 414 Optum Staff and Providers attended six in-person events and four webinars.

Optum: YES Navigation pt.2 (In Person)

Location	Audience	Attended
Fort Hall	Providers	41
Boise	Providers	24
Jerome	Providers	23
Lewiston	Providers	11
Post Falls	Providers	13

Optum: Webinars

Event	Audience	Attended
Understanding Disruptive Behavior Disorders	Providers, Staff	79
Assessing Disruptive Behavior	Providers, Staff	96
Teaching Skills to Support Child Clients with Disruptive Behavior Disorders	Providers, Staff	62
Teaching Skills to Support Adolescent Clients with Disruptive Behavior Disorders	Providers, Staff	65

Relias, the training platform for Optum Providers supported YES trainings throughout 2018. There were 96 new user accounts in October with 177 of the total 1,229 users active during this month.

Juvenile Corrections: Two Idaho Department of Juvenile Corrections clinicians became CANS certified during this reporting period (majority of clinicians completed their certifications last quarter). One IDJC representative attended the ICANS user group webinars and shared information with the leadership and clinical teams in each region. A total of 25 juvenile detention officers from across the state completed juvenile detention POST Academy. Courses included children's mental health, adolescent development, suicide prevention, and effective cmmunication.

CANS Subject Matter Experts: 14 DBH staff attended a 3-day CANS Subject Matter Expert training in October.

QMIA Quarterly Report - Issue # 9 - April 1, 2019

Youth and Family Experiences: **Perception of Care**

October 1- December 31, 2018

As part of the Quality Management, Improvement and Accountability Plan, described in paragraph 52 of the settlement agreement, QMIA is working toward the collection and reporting of data on written notices of action, complaints, and fair hearings requests and outcomes. Provided below is youth-specific complaints data and information from the Division of Medicaid, the Division of Behavioral Health (DBH), the Department of Juvenile Corrections (DJC) and State Department of Education (SDE) for the reporting period of October-December. Family and Community Services (FACS) did not receive any complaints during this reporting period. It is important to note that complaints reported by SDE are not necessarily complaints that are related to mental health, as these systems are not currently set up to filter these types of complaints for reporting purposes. More information about these complaints can be found in the YES Rights and Resolutions report (link).

A total of 35 complaints were received during this reporting period.

The Division of Behavioral Health received a total of 6 children's mental health-related complaints between October- December. All complaints were submitted by family members and the majority were concerning access. At the end of the reporting period, 5 complaints remained in progress and 1 was resolved. The number of days to resolve this complaint was 4.

Division of Behavioral Health: 6 Complaints				
Complaints by Location				
Region 1: **2**	Region 2: **1**	Region 3: **1**	Region 4: **1**	Region 7: **1**
Complaints by Complainant				
Family Member: **6**				
Complaints by Service				
Therapy: **2**	Respite: **2**	CANS: **1**	Medication: **1**	
Complaints by Type of Concern				
Access: **3**	Quality: **2**	Interpersonal Interaction: **1**		
Complaints by Status				
In Progress: **5**	Resolved: **1**	Days to Resolution: **4**		

The Division of Medicaid has contributed complaints information from two of their contractors; Optum Idaho and Liberty Healthcare. Optum manages outpatient behavioral health services for Medicaid members. Liberty is Medicaid's Independent Assessment Provider; they determine if youth applying for Medicaid benefits meet YES eligibility criteria. A total of 13 complaints were received by Optum for YES-eligible youth between October and December of 2018. Complaints are categorized into two complaint types, quality of service or quality of care. Concerns regarding the Optum Idaho administration of the behavioral health plan are classified as quality of service complaints, while concerns about the services received by a Member from a Provider in the Optum network are considered quality of care complaints. Medicaid reported that Liberty Healthcare received one complaint during the reporting period.

Optum Idaho: 13 Complaints				
Complaint Type	Number	Average Days to Resolve (Calendar)	Areas of Concern	
Quality of Service	5	6 days	Service	3
			Access	1
			Billing	1
Quality of Care	8	6 days	Service	5
			Clinical	2
			Billing	1

Liberty Healthcare	1 Complaint

The Department of Juvenile Corrections received 6 complaints between October and December; all have been resolved.

Idaho Department of Juvenile Corrections Complaints/Grievances (YES Class Juveniles/ Families): 5 Complaints				
Region	Complainant	Concern Type	Status (as of 12/31)	**Average Time to Resolution:** 4.4 days
1	Juvenile	Staff interaction/ Group Facilitation	Resolved	
2	Juvenile	Staff interaction	Resolved	
2	Juvenile	Staff interaction	Resolved	
2	Juvenile	Communication/ Policy/ Procedure	Resolved	
2	Juvenile	Staff interaction	Resolved	

State Department of Education: 10 Complaints							
Region of Complainant/ District	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	State
# Total Complaints	1	1	6	2	2	1	13
# Denied	1	-	1	-	1	-	3
# Cases Closed	-	-	2	2	-	-	4
Average Time to Close (days)	-	-	56 days	59 days	-	-	57 days
# Total Allegations	-	5	21	14	6	5	51
# Founded Allegations	-	-	1	3	-	-	4
# No findings/ Unfounded	-	-	10	11	-	-	21
# Allegations Pending	-	5	9	-	6	5	25
# Allegations Withdrawn	-	-	1	-	-	-	1

**Complaints reported by the State Department of Education are not necessarily complaints that are related to mental health, as this*

The State Department of Education received 10 complaints during the reporting period. Within these 10 complaints were 51 allegations. Complaints are made up of allegations, for one complaint there can be one or multiple allegations. A "denied" status refers to a complaint that is not accompanied by sufficient information to investigate.

Regional Reporting Differences*: The Department of Juvenile Corrections categorizes geographic location using three regions- Region 1: Lewiston, Region 2: Nampa, Region 3: St. Anthony. The State Department of Education's geographic regions also differs from that of the Department of Health and Welfare. The Division of Behavioral Health, although part of the Department of Health and Welfare has a slight difference in regional makeup. All regional maps have been provided in the Appendix.*

Sharing Family Stories

Youth and family stories have been an integral part of YES implementation. With each perspective, comes a unique opportunity to shape the system to best meet the needs of the children, youth and families that it serves. Family stories, like the one shared below, provide invaluable insight, perspective and information to inform our work.

From an Idaho mom, raising a teenage son with an "alphabet soup" of diagnoses and who has participated in a lengthy list of treatments and therapies that have little or limited success…

"The principles that drive Idaho's Youth Empowerment Services (YES) have changed the paradigm about how we see treatment. The professionals are no longer the only experts in the room. Families, and more importantly the individual, are now seen as the experts on themselves and their family. That means we don't focus on what the professionals are good at, we focus on what our children and families need.

After over 10 years of searching for answers and looking at each diagnosis as a way to break through the wall around his life and his potential we stopped and tried a new tactic. We asked him what he wanted. We ignored the fact that anxiety steals his desire to try new things, or that his lack of social awareness makes friendships hard. We stopped looking at therapy sessions as a way to fix his behaviors or make it easier for him to fit in. We stopped focusing on the depression that was keeping him locked in his room and not hanging out with his peers, and we asked him what he wanted. And like a completely normal 15-year-old boy, he looked at us and simply stated one goal… he wants a girlfriend.

So now we are using therapy to teach him the skills he needs to remember a girl's name and to have a conversation that isn't about the things he is interested in. We are learning about being aware of the interests of others and trying new things, so he will have something in common with those around him. We are learning about personal hygiene so that others will notice his witty sense of humor instead of his smell. If YES has given our family anything, it is a deeper understanding that we do not need to change our son, we need to listen to him and help him reach the goals that are meaningful to him. Once he started working towards the life he wants he began to see the alphabet soup of his diagnosis list not as a way to explain what is wrong with him, but a way to describe his uniqueness and the challenges he needs to face. He hasn't found his goal girlfriend yet, but he has embraced the potential, and that is one important step toward the happiness we crave for him."

LEGISLATIVE UPDATE 2019 EDITION

IDAHO DEPARTMENT OF JUVENILE CORRECTIONS - *Sharon Harrigfeld, Director*

Engaging Families

IDJC continues to prioritize family engagement as an integral part of our treatment philosophy. We strive to build collaborative relationships in which families are equal partners in the success of their children. This year, IDJC developed the following tools to help better engage families: 1. Video tours of all three state facilities. 2. An informational video on the Rule 19 screening process. 3. An aftercare smartphone app for youth returning to the community. 4. Video conferencing for family visits, counseling and monthly meetings. 5. A shuttle for families from the Nampa-Boise area with limited means to visit youth in custody now runs quarterly to the St. Anthony facility in Southeast Idaho, which the department hopes to continue.

IDAHO JUVENILE POPULATION

*Juveniles served locally with IDJC state and federal funds (CIP + MHP + REP + MIL)

JJDPA Compliance

Idaho was determined to be out of compliance with the Deinstitutionalization of Status Offenders (DSO) requirement of the Juvenile Justice and Delinquency Prevention Act (JJDPA) for federal fiscal year 2017. The DSO requirement provides juveniles who have committed an offense illegal only due to their status as a juvenile (ie. runaway, truancy, incorrigible) shall not be placed in secure confinement. Placing status offenders in detention can have serious negative impacts on mental and physical health, education, and employment, and can actually increase their risk of engaging in future delinquent behavior. Because of noncompliance, Idaho was penalized 20% of its formula grant funds; the remaining funds must be reallocated to address the DSO requirement. Current data suggests Idaho will be out of compliance with the DSO requirement for 2018, and will likely remain out of compliance each year unless system-wide changes are made. IDJC and the Idaho Juvenile Justice Commission recommend a three-pronged approach to meet needs of juvenile status offenders:

- Continue to develop and sustain community-based alternatives
- Review and revise statutes and rules related to the detainment of status offenders
- Ongoing evidence-based training for stakeholders.

Juvenile Correctional Center Average Costs

The total average cost per day [to provide services] at a Level 4 juvenile correctional center is: *$273.97*

The Department continually looks at ways to reduce lengths of custody while ensuring community protection.

Amount	Description
$119.89	Program
$49.93	Educational Services
$24.29	Security
$20.14	Medical Services
$19.64	Food Services
$18.53	Administration
$16.58	Maintenance
$3.73	Laundry/Clothing
$1.24	Janitorial/Housekeeping

Note: Based on SFY18 average costs

Juvenile Probation Standards

A work group convened by the Juvenile Training Council, comprised of IDJC and juvenile probation officers throughout the state representing various department sizes and geographic areas is updating the administrative rules for juvenile probation standards to ensure facilitation of positive outcomes for juveniles, families, victims, and communities; to reduce recidivism; and reduce liability. It is anticipated that the revised juvenile probation standards will be reviewed by communities and county commissioners in 2019 and go before the Legislature in the 2020 session.

DID YOU KNOW? IDJC Demographics 2018

Gender: Male - 83% Female - 17%

Race/Ethnicity: W - 68% H - 16% B - 4% AI - 6% Other - 6%

Average Age: 17.2 years old

Crime: Property- 34% Person- 31% Sex Offense- 20% Other- 15%

Crime Level: Felony - 54% Misdemeanor - 46%

Mental Health Diagnosis: 49%

Substance Use Disorders: 65% (drug and/or alcohol)

Co-occurring Disorders: 31% (substance use disorder and mental health diagnoses)

FY18 Avg. Length of Custody: 18.7 months

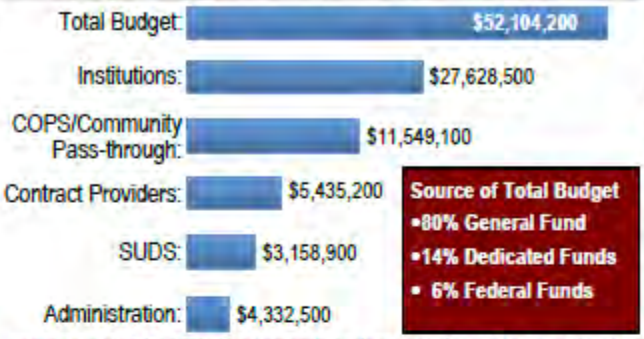
FY18 Recommitment Rate: 14%

FY18 Recidivism Rate: 29%

Receiving Wage Post-Release: 75%
Reading Scores Increased: 86%
Math Scores Increased: 90%

data date: 10.12.2018

FY19 ORIGINAL APPROPRIATION



Approximately 24% of the Department's budget goes directly to counties and local communities to support effective programming and reintegration initiatives, which results in fewer commitments.

Peace Officer Standards and Training

In the past year, POST trained and certified 37 juvenile probation and detention officers as well as 25 IDJC direct care staff.

Throughout the year POST collaborated with IDJC subject matter experts to rewrite curriculum for 15 IDJC direct care staff academy courses to include adolescent development and mental health, suicide prevention and trauma, safety and security and supervision, among others to ensure IDJC staff continue to receive relevant, research based, up-to-date training.

Additionally, POST provided training to adult detention and patrol academies as well as community based training regionally for first responders to include:

- Juvenile Procedures for adult detention and patrol academies.
- First responder strategies to minimize and deal with trauma.
- Autism training for first responders, and
- Policing the Teen Brain.

Further trainings throughout the state are currently being scheduled for Autism and Policing the Teen Brain for patrol, school resource officers, probation and others who work with youth in the community.

Youth Empowerment Services (YES)

IDJC and system partners continue implementation of the YES projects. IDJC has established an internal YES workgroup to review, develop, and implement processes related to the project. Additionally, IDJC has assigned numerous staff to multiple committees and workgroups. Agency and User agreements have been executed to access the ICANS system (data management system) to enter and review Child and Adolescent Needs and Strengths (CANS) assessments. Selected staff have completed CANS certification and ICANS system training. Further, IDJC is updating case management practices to identify how the CANS will be used to inform treatment, incorporating the Principles of Care and Practice Model language into treatment provider contracts, and focusing on reintegration planning for "class members" and other juveniles who will need services upon release.

IDJC Community Services

IDJC funding continued for community-based programs that demonstrate positive outcomes for youth and effective use of public funds. Funds focus on three populations: youth at risk of commitment to IDJC, justice involved youth with mental health issues, and youth re-entering communities after state commitment. In FY18, 459 youths were served through these community-based funds (listed below) for a total cost of $674,731 averaging $1,470 per youth with a success rate exceeding 91% (defined as the percentage of juveniles receiving services that were either not committed or recommitted to IDJC custody).

Community Incentive Program: served 181 juveniles

Mental Health Program: served 185 juveniles

Reintegration Program: served 93 juveniles

IDJC received millennium funding which supported prevention programing with education, law enforcement, and community partners. In FY18, nine school districts received sub-grant awards to train staff on restorative justice practices to improve early intervention strategies within the schools. Further, 652 juveniles participated in alcohol, tobacco, and other online prevention courses, while community-based prevention programs served an additional 821 juveniles. Millennium funding will not continue for IDJC in FY19.

Millennium Fund: served 1,473 juveniles

Juvenile Justice Substance Use Disorder System

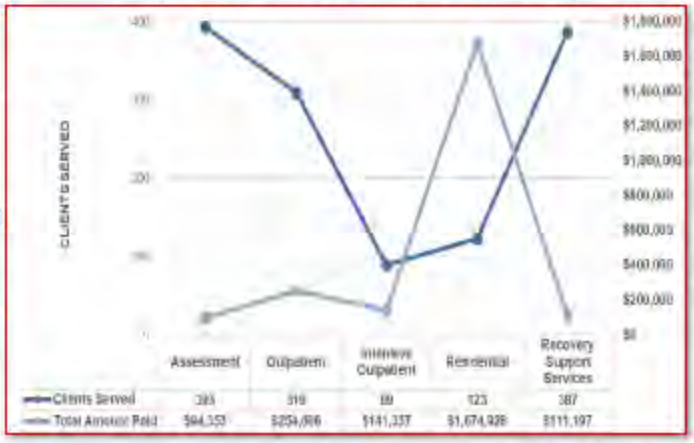
The Juvenile Justice Substance Use Disorder Services (JJ SUDS) Program continues to compliment Idaho's Behavioral Health system by maximizing IDJC's appropriation ($3.1M) which supports a full spectrum of community-based treatment for youth with substance use treatment needs in their home communities.

In SFY18 JJ SUDS spent a total of $2.6M treating 722 juveniles. Of these clients served, 96% were not committed to IDJC. In addition, 72% of adolescents accessing treatment did not go on to recidivate in the first year after receiving substance use treatment.

Expanding access to care and family engagement resources continues to be critical to the success of Idaho's youth.

AMOUNT PAID AND JUVENILES SERVED PER CATEGORY (FY18)

Some youth received services in more than one category

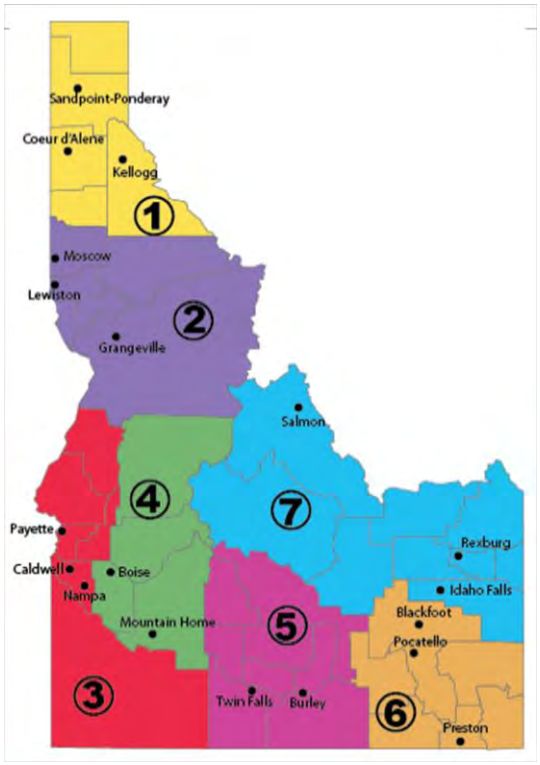


Glossary

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.
Emotional Behavioral Disorder	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 behavioral disorder. The term emotional disturbance behavioral disorder does include students who are diagnosed with schizophrenia.
EPSDT	Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. (Medicaid.gov).
IEP	The Individualized Education Plan (IEP) is a written document that spells out a child or youth's learning needs, the services the school will provide and how progress will be measured.
Intensive Care Coordination (ICC)	A case management service that provides a consistent single point of management, coordination and oversight for ensuring that children who need this level of care are provided access to medically necessary services and that such services are coordinated and delivered consistent with the Principles of Care and Practice Model.
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.
QMIA	A quality management, improvement, and accountability program.
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.
SFY	The acronym for State Fiscal Year which is July 1 to June 30 of each year.
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 YES Definitions	YES Terms to Know

Appendix A- Regional Maps

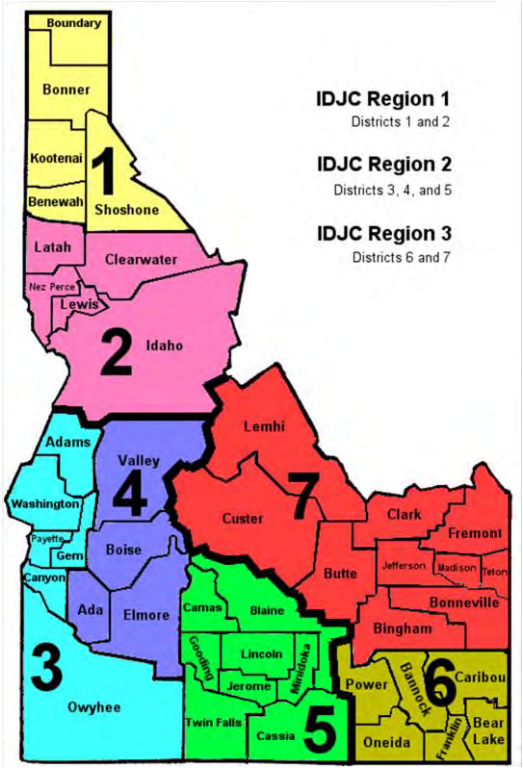
Idaho Department of Health and Welfare: Medicaid, FACS



Idaho Department of Health and Welfare: DBH

Idaho State Department of Education

Idaho Department of Juvenile Corrections



Appendix B- Presenting Concern Categories

Presenting Concern Categories Assigned based on Primary Diagnosis of Youth entered into CANS Tool	
Category	**Concern**
Anxiety	Anxiety/Generalized Anxiety
	Panic
	Phobia
	Adjustment
Stress or Trauma	Post-Traumatic Stress
	Trauma/Loss
	Reactive Attachment
Mood	Mood Disturbance
	Dysthymia
	Depression
	Bi-polar Disorder
Externalizing	Attention-Deficit Hyperactivity Disorder (ADHD)
	Conduct Disorder
	Intermittent Explosive Disorder
	Disruptive Mood Dysregulation
	Oppositional Defiant Disorder
Neurological Concerns	Psychotic Features of Disorder
	Autism Spectrum
	Intellectual Disability
	Neurological Disorder NOS
Other	Disorders of Eating
	Gender Identity Disorder
	Personality Disorders

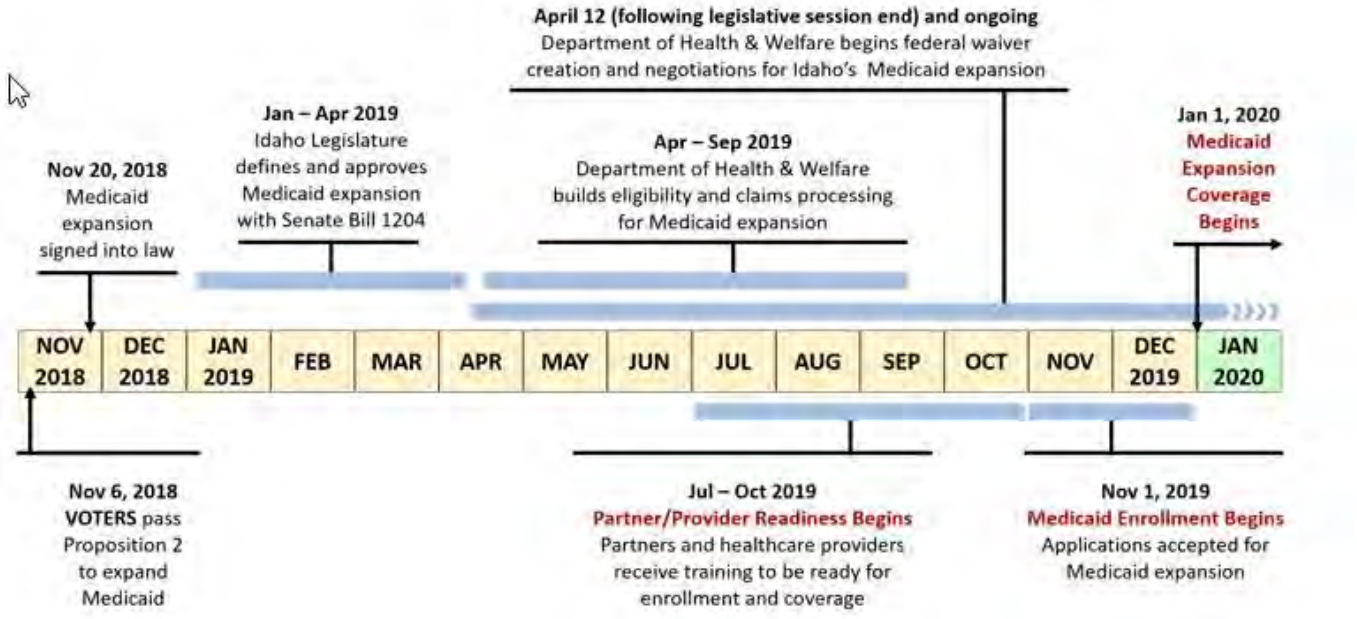
Presenting Concern Categories provided by Dr. Nathaniel Israel of Union Point Group, LLC.

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

Idaho Department of Health and Welfare, Division of Behavioral Health Services

The Idaho Department of Health and Welfare is designed to help vulnerable children and adults become self-reliant member in their communities. Idaho's programs are integrated to provide the basics of food, healthcare, job training, and assistance to help Idaho citizens become self-sufficient. The Idaho Legislature continues to designate the Department of Health and Welfare's Division of Behavioral Health (DBH) 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 federal grants.

At the writing of this application, Idaho is in the beginning stages of Medicaid Expansion and as this transition unfolds over the next several years, what is identified below as Idaho's service system could begin to look different as the updates are completed through the phase of the grant. In the attachments, the most recent Division of Behavioral Health Medicaid Expansion Project Plan is included. It is estimated that a large portion of the Idahoans who have used Division of Behavioral Health Mental Health and Substance Use Disorders (SUD) services will be Medicaid eligible under expansion, and therefore will have a health plan that will cover their behavioral health services. The Division is working with its state agency partners and providers to prepare for Medicaid enrollment and coverage. Enrollment is planned to begin Nov. 1, 2019, with Medicaid expansion coverage beginning Jan. 1, 2020.
Here is a timeline for implementation of Idaho Medicaid expansion:

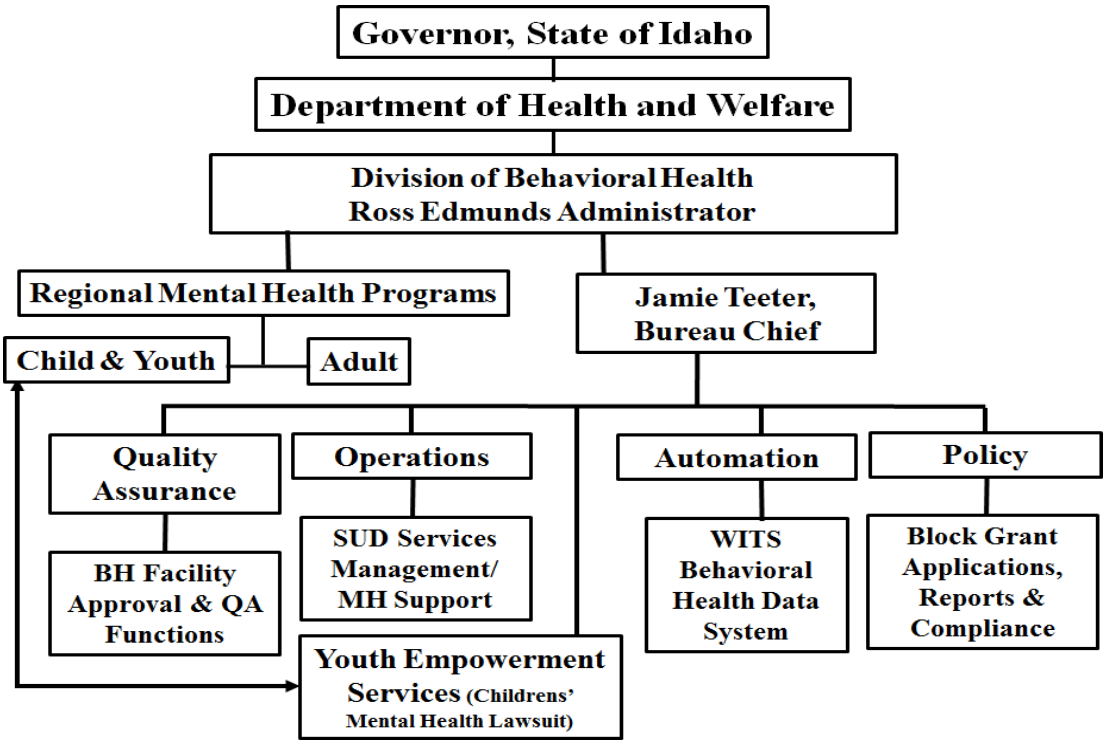


More information on Idaho Medicaid expansion is included here:
https://medicaidexpansion.idaho.gov/

Planning Step 1:

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

Below you will see the current service delivery system of the Division of Behavioral Health's organization chart that depicts the organization of the state's management system and the integration of mental health and substance use disorders systems. As depicted in the chart below, the Quality Assurance, Automation and Policy Units work on both substance use disorders and mental health programming, funding, policies, evaluation, data and compliance. The Operations Unit 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.



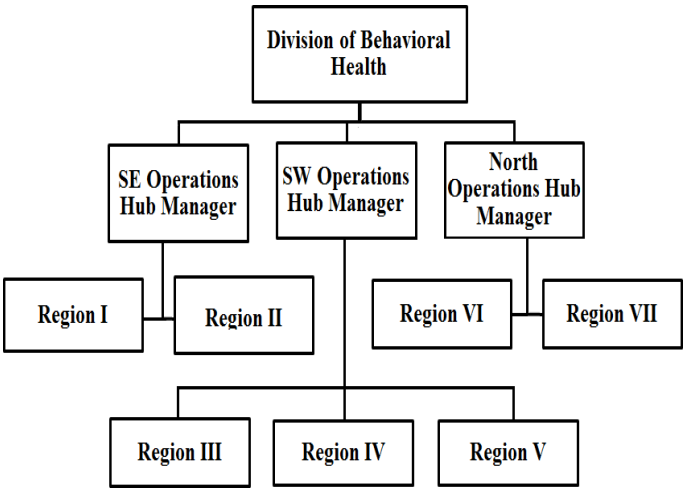
Adult and Children's Mental Health Behavioral Health Prevention, Early Identification and Recovery Support

Printed: 10/1/2019 1:25 PM - Idaho - OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

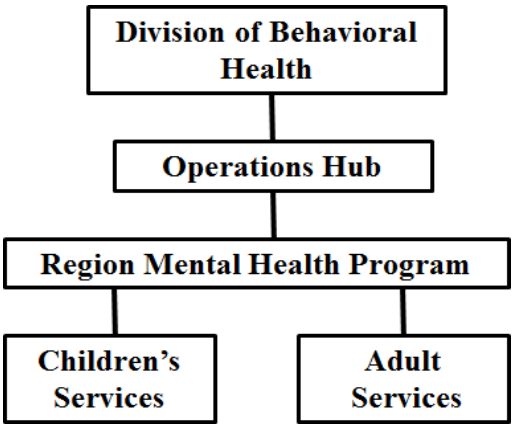
Planning Step 1:

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

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 rural and frontier locations, psychiatric services may be supplemented using tele-health video conferencing systems. A high definition video conference system is also used for statewide meetings, including meetings with the State Behavioral Health Planning Council.



State funded Adult Mental Health (AMH) and Children's Mental Health (CMH) services are provided through Regional Division of Behavioral Health 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.



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 eligible clients to Medicaid eligible private provider resources. At the writing of this application, 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. As Idaho transitions into Medicaid Expansion, the services provided by the Division of Behavioral Health could be modified.

Adult and Children's Mental Health services and SUD services are provided in each of the seven (7) Idaho Department of Health and Welfare geographically defined regions. State Mental Health Authority (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 (SMI), individuals with early serious mental illness (ESMI), children with a serious emotional disturbance (SED) and their families.

Currently there are two (2) Idaho state psychiatric hospitals, State Hospital North and State Hospital South, also under the jurisdiction of the Division of Behavioral Health Administrator. State Hospital North serves adults only, while State Hospital South serves both adults and adolescents in separate units. However, the Department of Health and Welfare was appropriated funding to construct a new adolescent state psychiatric hospital in the Treasure Valley, which is expected to be complete in July 2020. The two primary reasons for this project are: 1) Over 70% of the adolescents who go to the state hospital are from the Treasure Valley; and 2) the state needs space at State Hospital South in Blackfoot, ID for a high-risk adult unit.

Children's Mental Health Services

The Children's Mental Health Program is a partner in the development of a community-based system of care, Youth Empowerment Services (YES), for children with a serious emotional disturbance (SED) and their families. Parents and family members play an essential role in

developing a system of care at all levels of development, including the making of policies, administrative rules, and laws.

The Division of Behavioral Health has traditionally provided services to youth in one of the three circumstances: crisis, youth involved in court-ordered services, and voluntary clients who are not Medicaid-eligible. With the implementation of YES, the Division of Behavioral Health has taken on additional roles such as person-centered planning for youth newly Medicaid-eligible or who would like to access respite services and Wraparound.

The Idaho Department of Health and Welfare's Divisions of Behavioral Health, Medicaid and Family and Community Services partnered with the State Department of Education, Department of Juvenile Corrections and the Praed Foundation to host a Northwest Regional TCOM Conference in the Spring of 2019. TCOM, or Transformational Collaborative Outcomes Management has been adopted by the State of Idaho to help guide the implementation of the Children's Mental Health Youth Empowerment Services (YES) program.

TCOM is an approach grounded in the philosophy of a shared vision to help people achieve wellness goals as they navigate healthcare, child welfare, juvenile justice, behavioral health, education, and other complex systems around the world. Perhaps one of the most well-known TCOM tools, the Child Adolescent Needs and Strengths (CANS), is being used statewide in Idaho to support decision making, including level of care and service planning for youth, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

The theme for the conference was Setting the Stage: Creating a Shared Vision to Support Transformation. The conference brought together individuals in varying roles, across multiple systems to share their stories, learn from other experiences, and collaborate on how to best meet the needs of children and families served. Clinicians, supervisors, administrators, administrative staff, and family members were all encouraged to attend.

Functional Assessment Tool

The Child and Adolescent Needs and Strengths (CANS) is Idaho's tool that measures functional impairment of children and youth seeking to participate determine eligibility in Youth Empowerment Services (YES) system of care for the SED population. The CANS is a multi-purpose functional assessment tool developed for children's services to support decision making, including level of care and service planning, in order to facilitate quality improvement and allow for the monitoring of outcomes of services. This tool is backed by extensive research supporting the validity and sensitivity to measure change and progress. Data will be collected to monitor statewide outcomes progress by analyzing needs and strengths from assessment, re-assessment, and discharge CANS information.

There are currently three access points within YES where a youth may have an initial CANS completed: The Independent Assessment Provider (IAP) Liberty Healthcare, the Division of Behavioral Health (DBH), or with a Medicaid/Optum Network community provider.

Youth Empowerment Services

The Youth Empowerment Services (YES) project has made significant progress in moving from a lawsuit (Jeff D. v Otter), toward a new system of care for children with Serious Emotional Disturbance (SED). This has been a collaborative effort among the Department of Health and Welfare, Department of Education, Department of Juvenile Corrections, families, providers, and

other community stakeholders.

The YES system of care relies on a model of service delivery in which all child-serving systems operate in a coordinated manner to support parents and caretakers as the main drivers of the care and treatment they are seeking. This system of care approach that is driven by youth and families, results in greater positive outcomes for youth and families. The following accomplishments related to YES for Idaho are listed below:

- Children with an SED whose family's income amounts up to 300% of the Federal Poverty Level are now eligible for Medicaid.
- Contract was developed with Liberty Healthcare to administer independent assessments to determine eligibility for YES Services and Respite services.
- A person-centered service planning process was designed for Medicaid participants.
- Collaborative workgroups continue to meet, and stakeholder interest remains high; expert consultants continue to offer technical assistance for the improved system of care.
- The Interagency Governance Team (IGT) operates as an advisory body for the implementation efforts. This 17-member team includes representatives from three agency partners, parents, youth, advocates and providers.
- The Idaho CANS web-based tool was implemented across Idaho and all applicable Optum Network providers are to be certified and trained in CANS.
- Staff from Liberty Healthcare, Optum Healthcare, the Division of Behavioral Health, Division of Family and Community Services, and the Department of juvenile Corrections have been certified and trained in the CANS.
- The ICANS website (icans.dhw.idaho.gov) was launched to meet the needs of agency staff and providers using the ICANS/CANS.
- The YES website continues to be updated and includes collaborative materials and references and serves as a public access site for project implementation, reports, fact sheets, training and other communications.
- Ongoing training and outreach to families and community stakeholder groups is being conducted.
- Yearly Parent Workshop hosted by the Idaho Parent Network for Children's Mental Health.

Crisis Intervention

Cross system crisis system is an area of need for Idaho. Currently, the Children's Mental Health System is working to develop a collaborative community-oriented crisis system in an effort to reduce psychiatric hospitalizations, reduce death by suicide, increase access to care and community-based options, reduce arrests, and improve service coordination and quality of treatment. The current crisis systems differ across the state and among agencies. Currently there is a Crisis System Workgroup who is developing a roadmap and strategy plan to implement a coordinated crisis response system across the state of Idaho.

Crisis intervention provided through the regional offices include evaluation, assessment, intervention, stabilization and follow-up planning. They regional offices have various plans where phone and consultation services are available 24 hours a day, seven days a week.

Optum Idaho is Idaho's Medicaid managed care contractor for Behavioral Health Services. They provide Member's access to a Crisis Line that offers them immediate access to a Behavioral Health Clinician 24 hours a day, 365 days a year. Optum says that each call is regarded as a

Member potentially experiencing some degree of stress or crisis and is triaged using the Solution Focused Crisis Intervention Model.

Respite
As a result of the Youth Empowerment Services (YES) project, in January 2018 agency respite became a Medicaid 1915(i) service available through the Idaho Behavioral Health Plan (IBHP) to Medicaid-eligible members who meet SED qualifications. To maintain an effective respite care system to meet the needs of all Idaho families that children with an SED, the Division of Behavioral Health continues to issue vouchers through the regional behavioral centers for respite services that are provided by a member of the family's' natural support. Respite care is available to all qualified children and youth who are residents of Idaho, under the age of 18, and are voluntarily seeking this service. Respite services can be furnished in the child or youth's home, another home, a foster family home, or another community-based setting.

Parenting with Love and Limits
The Children's Mental Health Program of the Division of Behavioral Health, continues to provide Parenting with Love and Limits (PLL) statewide, for families and youth with disruptive behaviors and emotional disorders.

Behavioral Health and Juvenile Justice
The Division of Behavioral Health continues to work collaboratively with county juvenile justice, magistrate courts, the Idaho Department of Juvenile Corrections and parents in situation involving youth with mental health issues and the courts.

The Division of Behavioral Health continues to allocate funds to the Department of Juvenile Corrections for 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.

Adult Mental Health Services

The adult mental health system in Idaho continues to improve by offering more services, programs and resources than it has in the past. However, these enhancements to the current system of care continue to struggle with meeting the needs of a growing population that has resulted in an increase of mental health needs in Idaho. The Department of Health and Welfare is leading a collaborative steering committee to ensure the entire system has input on the strategic path moving forward. The Division of Behavioral Health works to ensure that program and services, including community-based supports, outpatient services, and inpatient hospitalizations services are available to eligible Idaho residents.

The Division of Behavioral Health determines eligibility for adult mental health services through screening and assessment. Adult mental health services may be accessed through the division either through an application for services or through a court order for services. Each regional behavioral health center is staff with a variety of licensed treatment professionals: psychiatrists, nurses, social workers, clinicians, peer support specialists, and other mental health workers. Each center offers crisis services and ongoing mental health services.

Crisis Intervention
The regional Adult Mental Health Crisis Units provide crisis interventions that include evaluation, assessment, intervention, stabilization, and follow-up planning. The Crisis Units provide phone and consultation services 24 hours a day, seven days a week. They screen all adults who are being petitioned for the court ordered commitment process.

Currently there is a Crisis System Workgroup who is developing a roadmap and strategy plan to implement a coordinated crisis response system that will be responsive to all populations across the state of Idaho.

Optum Idaho is Idaho's Medicaid managed care contractor for Behavioral Health Services. They provide Member's access to a Crisis Line that offers them immediate access to a Behavioral Health Clinician 24 hours a day, 365 days a year. Optum says that each call is regarded as a Member potentially experiencing some degree of stress or crisis and is triaged using the Solution Focused Crisis Intervention Model.

Supportive Services
Community support services are available on a limited basis. These support services include outreach, medication management, skill building, community-based rehabilitation services, benefit assistance and housing support.

The divisions regional behavioral health centers provide integrated treatment for those diagnosed with co-occurring mental health and substance use disorders by providing treatment or collaborating with private agencies to provide additional services.

Assertive Community Treatment (ACT)
The divisions regional behavioral health centers provide ACT Services for clients diagnosed with a serious and persistent mental illness (SPMI). These services provide a full array of community-based services as an alternative to hospitalization for these adults. ACT services are provided by a team of professional staff, certified peer support specialists and recovery coaches. Services include individualized treatment planning, crisis intervention, peer support services, community-based rehabilitation services, medication management, case management, individual and group therapy, co-occurring treatment and coordination of other community support services.

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

The State Behavioral Health Planning Council (BHPC) membership covers the full-spectrum of mental health and substance use disorder services, with membership from state agencies, private service providers, prevention programs, consumers, family members, and others representing the diversity of Idaho citizens. The diversity of the membership creates a unique cross-section of individuals with a broad knowledge base allowing them to work and support many aspects of the behavioral health system.

The annual Idaho Conference on Alcohol Drug Dependency (ICADD) offers a session on elements of culture throughout the conference key note presentations and break out sessions to attendees across Idaho. The Department of Health and Welfare, Division of Behavioral Health employees are provided the means through learning applications and in-service trainings on working with and

addressing the needs of diverse populations and minorities in the state of Idaho.

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 as well. The Idaho Commission on Aging unveiled a new website that includes information on the commission, program tips, FAQ's forms, documents and resources that can be filtered by county, program and type, and includes crisis resources.

Idaho has six federally recognized American Indian/Native Populations: 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). DBH continues to have a collaborative relationship with Idaho's five (5) federally recognized tribes to ensure both partners are kept up to date on treatment and recovery support resources. In addition, with the State Opioid Response (SOR) grant, DBH provided the opportunity for each tribe to receive $30,000 to address the opioid epidemic in their communities.

As previously mentioned, the Child and Adolescent Needs and Strengths (CANS) is Idaho's tool that measures functional impairment of children and youth seeking to participate determine eligibility in Youth Empowerment Services (YES) system of care for the SED population. The CANS is a multi-purpose functional assessment tool developed for children's services to support decision making, including level of care and service planning, in order to facilitate quality improvement and allow for the monitoring of outcomes of services. Training and certification is required for the use of the CANS, and while many providers use the online training platform, in Region 1, the Tribal Providers requested to have an in-person CANS Certification training. The Division of Behavioral Health used their Praed Contract to have Dr. Lyons provide this training to accommodate the request and need of those Tribal Providers.

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 communicate and coordinate services with the Duck Valley Reservation and have provided an 8-hour CIT training when requested by the Tribe, with the last one being held in July 2016. This training includes collaboration with the BH Tribal Coordinator, law enforcement and paramedics. The Department of Health and Welfare has a designated Tribal liaison.

How Systems Address Needs for diverted or released individuals from correctional facilities
DBH entered into a contract with the Community Health Center Network of Idaho (CHCNI), the umbrella organization for the Federally Qualified Health Care (FQHC) clinic network, to provide mental health services for Idaho's felony parole and probation population. All regions have at least one FQHC providing mental health services. The following services are provided under the contract: psychiatric diagnostic evaluation, mental health treatment planning, pharmacological evaluation, pharmacological management, individual counseling, group counseling, family counseling, and care coordination.

It is anticipated that by adding these services, probation and parole clients will be more successful in their reintegration into the community and less likely to re-offend and face subsequent reincarceration. Data collected from CHCNI will be cross-referenced with the Idaho Department of Correction data to determine impacts to the recidivism rates for this population as a result of these services.

Community-based Recovery Support Services

Behavioral Health Crisis Centers
Idaho currently has six crisis centers, and services available in hospitals in one of Idaho's rural region as part of an innovative collaboration to meet rural needs. The Behavioral Health Community Crisis Centers continue to meet the needs of thousands of Idahoans who suffer from behavioral health crises. These Crisis Centers have been effective in reducing unnecessary hospitalization and incarcerations and have quickly become an important part of the community's continuum of care and services for people suffering from a behavioral health crisis.

Homes with Adult Residential Treatment (HART)
Homes with Adult Residential Treatment (HART) was initiated to pilot an intensive, treatment-oriented, residential living program for individuals with as serious and persistent mental illness. The Division of Behavioral Health contracts with four HART facilities across the state to provide a safe and therapeutic homelike environment, including meals, living space, assistance with daily living, and clinical treatment services.

Each HART provider is required to be an Optum Idaho-approved Idaho Behavioral Health Plan provider and be able to deliver an array of treatment services including assessment, treatment planning, psychotherapy, community /peer supports, Community Based Rehabilitation Services (CBRS), group therapy, case management, and medication services. The hope of the HART model is to allow clinical treatment interventions better address behavioral health related issues that not been able to be addressed without evicting the resident or escalating the resident to a crisis or emergency facility.

Recovery Community Centers
The Division of Behavioral Health has a contract with Recovery Idaho to provide social support services for individuals with Opioid Use Disorder through Idaho's nine Recovery Community Centers located throughout the state. Services provided under this contract include support groups, recreational activities, and recovery coaching.

The Recovery centers also meet individuals in the hospital emergency departments who have overdosed on opioids to help them access treatment and recovery support services. They also make similar type of connections with individuals who have been discharged from a local jail.

Substance Use Disorder Recovery Support Services
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.

Partnerships with Public Health Districts

The Division of Behavioral Health continues to contract with the seven public health districts for administrative assistance and support for the regionally based Behavioral Health Boards (BHBs). These partnerships have created a venue in which local boards identify community strengths and needs and work collaboratively to capitalize on the strengths while addressing the needs of the local communities.

This collaborative approach has resulted in the funding and support of a variety of activities, including community events that promote behavioral health awareness, scholarships for conferences, and training, transitional housing needs for individuals with co-occurring disorders, as well as providing recovery coaching services.

The State Behavioral Health 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 BHBs as well as monitoring the capacity of the BHBs 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. The BHBs 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.

In addition to working collaboratively with the BHBs and the State Behavioral Health Planning Council, the Division of Behavioral Health and the Division of Public Health have partnered in the area of "prescriber education" in light of the opioid epidemic. Through a contract with the Department of Health and Welfare, the health districts are educating prescribers on best and safest practices for opioid prescriptions; improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse or overdose.

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

The CMH Division of Behavioral Health program works closely with the Department of Health and Welfare's, Division of Family and Community Services (FACS), and with the Department of Education. A memorandum between CMH and FACS describe how services will be coordinated for shared clients. These include clients in child protection, adoption, foster care, and screening and early intervention for infants and toddlers.

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 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. Resource and Service Navigation identifies and develops resources to support struggling families, so they can achieve long term stability using customized service plans focused on family strengths and community supports. The Bannock Youth Foundation (Pocatello) and Hays Shelter Home (Boise) provide federal grant funded crisis and emergency shelter to run away and homeless youth; these programs coordinate mental health care needs with CMH.

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. 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 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 other federal and SAMHSA grants such as, The Projects for Assistance in Transition from Homelessness (PATH) grant which allows for outreach to adults with serious mental illness who are homeless. The Division's Treatment and Transitions grant (SAMHSA's Treatment for Individuals Experiencing Homelessness program) allows Idaho to support the development and/or expansion of infrastructure that integrates behavioral health treatment and recovery support services for Idahoans affected by homelessness or at risk of homelessness. The funding will serve individuals who are transitioning out of one of our two psychiatric hospitals, and when vacancies are available, individuals referred by Regional Adult Mental Health staff. Idaho also received a $150,000 Transformation Transfer Initiative grant from the National Association of State Mental Health Program Directors (NASMHPD) that will fund the development of a psychiatric bed registry portal that identifies bed capacity across both publicly and privately funded hospitals. The grant will provide individuals who require inpatient care with a single centralized resource to know where to go to receive that care

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 and 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.

Substance Use Disorders Services (SUD)

The State of Idaho has established a state agency/branch of government partnership for the delivery of Substance Use Disorder (SUD) treatment and prevention services. The Idaho Department of Correction, Health and Welfare's Division of Behavioral Health and Department of Juvenile Corrections as well as the Supreme Court's Problem Solving Court Program, and the Office of Drug Policy compose this partnership. The five entities coordinate populations served and all use the services of Management Services Contractor BPA Health to manage a community-based provider network which delivers 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 SUD 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 SUD services are included in this contract. The following chart details the SUD priority populations whose services are funded by the aforementioned partnering agencies and branch of 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.

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

	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.

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 all the needs of the populations funded under the contract. One provider may deliver more than one service type and all outpatient providers also deliver intensive outpatient services. Due to Idaho's receipt of the "State Targeted Response to the Opioid Crisis Grant," BPA Health has identified 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 and serve more than one target population listed above. For instance, an outpatient provider may provide MAT services and a PWWDC specialty program as well as deliver adult outpatient services.

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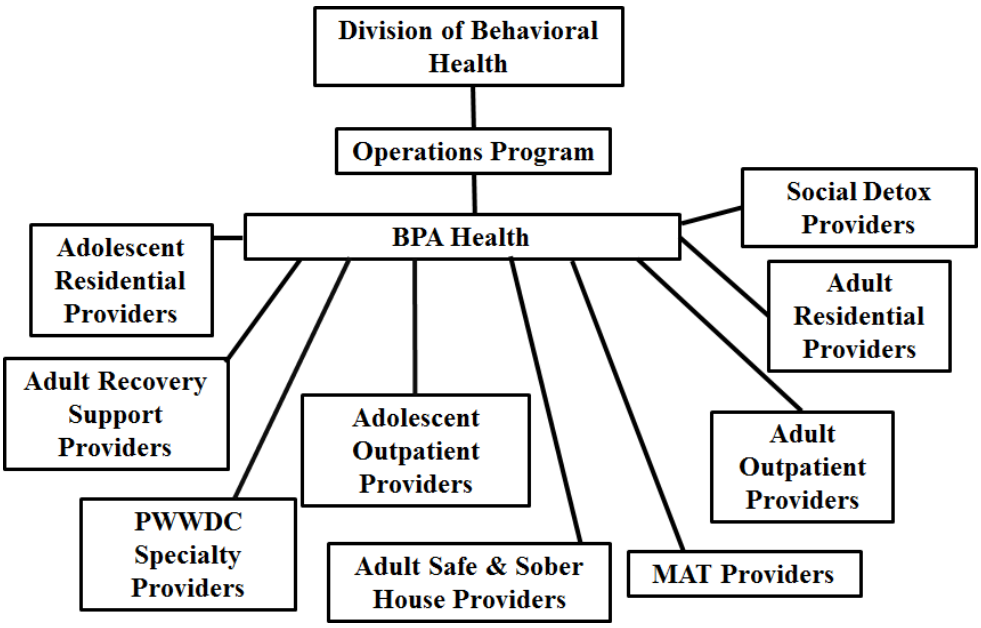
Planning Step 1:

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



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 knowledge of community resources for adolescents. They also must meet minimum standards established by the intermediary. Adolescent residential services are provided in separate facilities from those serving adults to ensure the adolescents' safety.

During the admission process, all clients are assessed for TB. Those who are at risk are referred for testing and 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 TB 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

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The BPA Health network currently includes 71 providers in their PWWDC specialty network. These providers are located throughout the State of Idaho. All pregnant women and women with minor children under the age of 5 are given the opportunity of receiving services at 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 comprehensive family assessments, gender-specific SUD services and case management, other required PWWDC services for women and children, including children's services, child care and transportation, are delivered by other community-based providers.

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 their other needs. As with women clients, these individuals are given free choice to select the provider they want to deliver their treatment services.

Substance Use Disorders Opioid Crisis Grants

The receipt of the "State Targeted Response to the Opioid Crisis Grant" has enabled Idaho to establish a special program for opioid users, injection or otherwise. Since 2017, Idaho's Response to the Opioid Crisis (IROC) project has expanded access to treatment, including Medication Assited Treatment, to over 800 Idahoans. IROC has reduced access to opioids through prescriber education and awareness campaigns and increased the statewide use of naloxone by providing over 3,000 naloxone kits to more than 130 statewide agencies. Additionally, more than 1,000 Idahoans have accessed recovery support through enhancements made to Idaho's recovery-oriented system of care using IROC funds.

In September 2018, Idaho was awarded a $4 million federal grant to continue to fight the opioid epidemic through the IROC program.
This new influx of funding provides the opportunity for Idaho to continue to support and enhance the IROC program with targeted initiatives.
Over the next two years IROC will:

- Collaborate with and provide funding to Idaho's five federally recognized tribes to address the opioid epidemic within their communities.
- Expand Idaho's recovery-oriented system of care. Specifically, the provision of recovery coaching services in emergency departments and jail/prison reentry efforts.
- Increase prevention efforts to include increasing the availability of Naloxone and disseminating materials to educate the public on the dangers of opiates and how to manage an Opioid Use Disorder (OUD) through the BSU RADAR Center.
- Launch a pre-sentencing diversion pilot program called LEAD.

The LEAD pilot, launched in November 2018, aims to divert individuals with Opioid Use Disorder (OUD) from arrest to treatment for their addiction. Ten individuals will be selected by law enforcement to be offered SUD treatment and Medication Assisted Treatment in lieu of arrest for a crime they have recently committed The participants will complete an intake into psychosocial treatment and get access to medication (either methadone or suboxone). Services will be carefully coordinated and closely monitored and provided for up to one year. Those who successfully complete the program, as determined by their treatment providers, will not face the original criminal charges.

The Idaho Tobacco Project

The Idaho Tobacco Project works with retailers to prevent youth access to tobacco products. The Tobacco Project provides retailers with educational materials, no-cost permits, and supports inspections to evaluate compliance with the state statute that prevents minors' access to tobacco. Educational materials include a monthly newsletter, a training CD, point-of-sale resources (posters near cash registers or in staff areas), and online training resources (preventthesale.com/Idaho) to help retailers educate their staff.

To encourage retailers to be vigilant against selling tobacco to minors, youth-purchase inspections are conducted annually at every retailer site where youth can legally enter. In 1998, the first year that statewide youth-purchase tobacco inspections were conducted, the violation rate was 56.2 percent. In 2017, the survey of inspections resulted in a violation rate of 8.54 percent. The chart below summarizes the outcome of the inspections conducted for the past five years.

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Permittees	1,654	1,663	1,639	1,581	1,398
Inspections	1,976	1,798	1,768	1,755	1,709
Violations	154	135	157	118	146
Non-Compliance Rate	9.1%	7.51%	8.88%	6.72%	8.54%

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 M/SUD 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 M/SUD 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.

A data-driven process must support the state's priorities and goals. 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**, 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 disorder prevention, 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.

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**[16] 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.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

A response to the Revision Request dated 9/9/2019 is attached as "Planning Step 2 Revision Request Response.docx."

The Primary Prevention Response is attached as Primary Prevention Step 2 Gaps and Needs.docx. Additional documentation is attached as Primary Prevention Workforce Development Plan.docx and Primary Prevention Needs Assessment.docx.

The CMHS and SAPT response is attached as Step 2 Gaps and Needs SAPT and MH Response.

Information about the State Epidemiological Outcomes Workgroup is included in the Primary Prevention Needs Assessment 2017 and in Primary Prevention Step 2 Gaps and Needs.

The Idaho Office of Drug Policy's Plan for Recruiting and Retaining a High Performing Prevention Workforce

May 2019-July 2024

Prepared by JBS International

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BACKGROUND

The Idaho Office of Drug Policy (ODP) was established to coordinate policy and prevention programs related to drug and substance abuse. ODP leads 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.

ODP currently administers two (2) federal substance abuse prevention grants, the PFS and SABG, through the Substance Abuse and Mental Health Services Administrations (SAMHSA) Center for Substance Abuse Prevention (CSAP) and the sub-recipients of these grants comprise much of the primary prevention workforce in Idaho.

Substance Abuse Block Grant (SABG) – This grant is for evidence-based direct service programs and environmental activities delivered by nonprofits, public agencies, and community coalitions. Programs and activities focus on primary prevention, that is, programs for individuals who do not require treatment for substance abuse and are designed to reduce the impact of substance abuse on the communities of Idaho. In SFY 2018, ODP funded forty-four (44) providers statewide delivering primary prevention programs and activities.

Partnership for Success Grant (PFS) – Idaho's seven (7) Regional Behavioral Health Boards (RBHB) are the sub-recipients. Each hired a full-time project coordinator to implement prevention activities. Each region receives a base amount of $183,500 per year, and then additional funds are added based on population size, priority areas, and severity of issues in each region as supported by data. The PFS is a five-year grant and ODP will continue to receive funding through September 30, 2023.

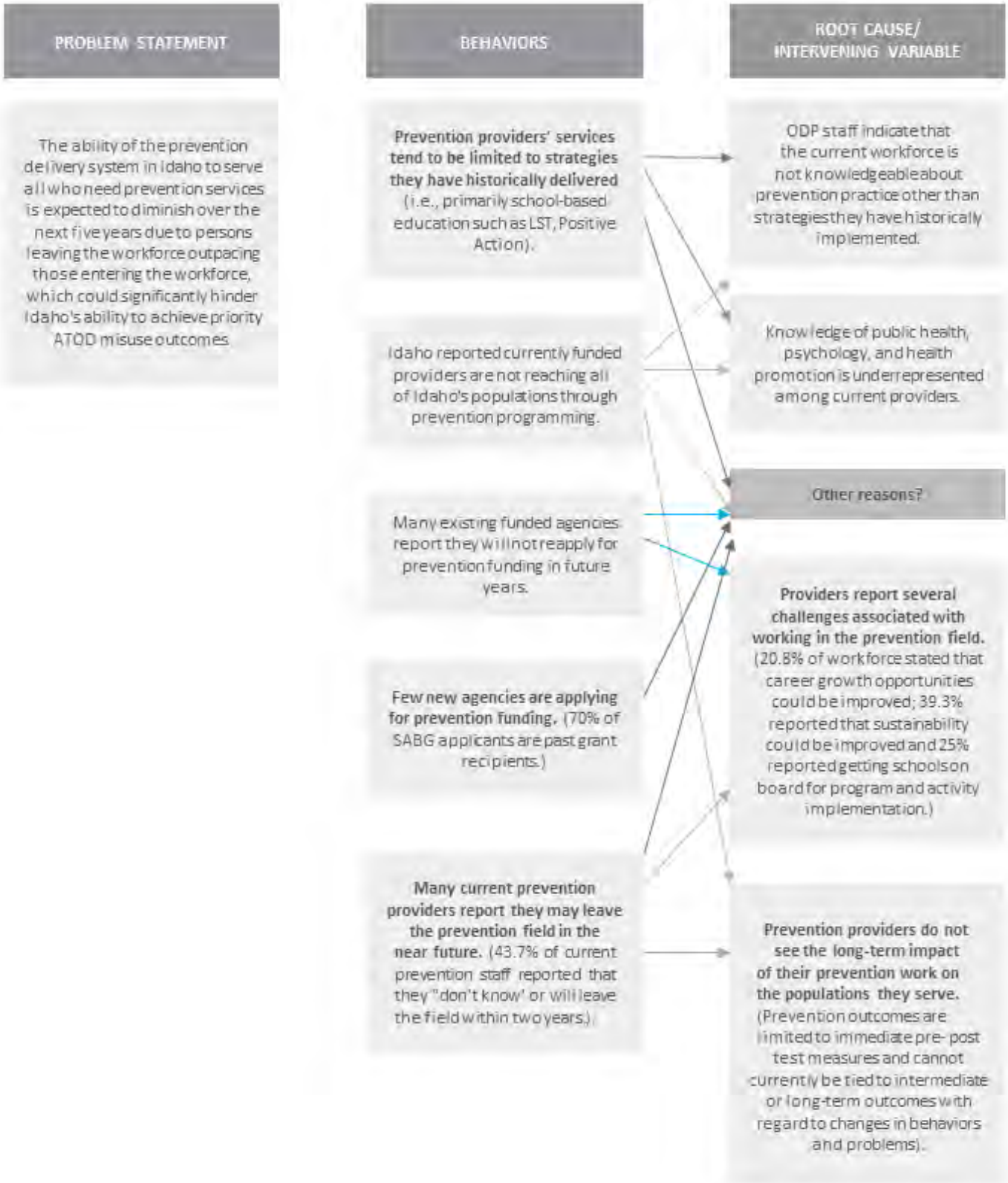
This plan was developed using the following data and other sources of information: conversations with providers; 2016 Prevention Workforce Development Survey Results Idaho; 2019 Grantee Follow Up Survey; 2018 Idaho SPF SABG Grant Program Annual Aggregate Statewide Evaluation Report; and provider program data submitted to ODP for SABG reporting. The plan identifies the steps that ODP staff will take over the next five years to recruit and retain a high-performing workforce capable of delivering the comprehensive prevention services needed to affect school and community change and prevent alcohol, tobacco, and other drug use. The plan is simple and straight forward – designed to direct action – and includes the following:

Logic model – This high-level view of Idaho's plan maps the relationship between the factors that are contributing to Idaho's prevention workforce issues. Because the planning process revealed many gaps in data specific to the prevention workforce, the logic model includes "other reasons" as a place holder for additional factors that ODP may identify in the future.

Implementation Plan – The outcomes, goals, objectives, activities, and process indicators provide a roadmap for how ODP will address prevention workforce issues. Process indicators are identified for more complex tasks. In future years, the plan should be updated to reflect mid-course corrections as needed based on new data, lessons learned, and additional insights.

Timeline – This timeline provides an "at-a-glance" workload for ODP staff over the next five years in implementing the tasks included in this plan.

LOGIC MODEL


PROBLEM STATEMENT
BEHAVIORS
ROOT CAUSE/ INTERVENING VARIABLE
The ability of the prevention delivery system in Idaho to serve all who need prevention services is expected to diminish over the next five years due to persons leaving the workforce outpacing those entering the workforce, which could significantly hinder Idaho's ability to achieve priority ATOD misuse outcomes.
Prevention providers' services tend to be limited to strategies they have historically delivered (i.e., primarily school-based education such as LST, Positive Action).
Idaho reported currently funded providers are not reaching all of Idaho's populations through prevention programming.
Many existing funded agencies report they will not reapply for prevention funding in future years.
Few new agencies are applying for prevention funding. (70% of SABG applicants are past grant recipients.)
Many current prevention providers report they may leave the prevention field in the near future. (43.7% of current prevention staff reported that they "don't know" or will leave the field within two years.)
ODP staff indicate that the current workforce is not knowledgeable about prevention practice other than strategies they have historically implemented.
Knowledge of public health, psychology, and health promotion is underrepresented among current providers.
Other reasons?
Providers report several challenges associated with working in the prevention field. (20.8% of workforce stated that career growth opportunities could be improved; 39.3% reported that sustainability could be improved and 25% reported getting schools on board for program and activity implementation.)
Prevention providers do not see the long-term impact of their prevention work on the populations they serve. (Prevention outcomes are limited to immediate pre- post test measures and cannot currently be tied to intermediate or long-term outcomes with regard to changes in behaviors and problems).

SUMMARY OF KEY ASSESSMENT FINDINGS:

Prevention workforce recruitment and retention is a significant concern in Idaho.

- Approximately 10% of existing funded agencies report they will not reapply for prevention funding in future years. (Conversation with Providers)
- 70% of SABG applicants are past grant recipients. (Grantee Follow Up Survey, 2019)
- 15% of current prevention specialists have retired in the past year or report they will retire within the next two years. (Observations/Conversation with Providers)
- 43.7% of current prevention staff reported that they "don't know" if they will leave the field within two years. (Prevention Workforce Development Survey Results Idaho, 2016)

Some of the issues identified that impact recruitment, retention, and job satisfaction include the following:

- 20.8% of workforce stated that career growth opportunities could be improved. (Prevention Workforce Development Survey Results Idaho, 2016)
- 39.3% reported that sustainability could be improved. (Idaho SPF SABG Grant Program Annual Aggregate Statewide Evaluation Report, 2018)
- 25% reported difficulty with getting schools on board for program and activity implementation. (Idaho SPF SABG Grant Program Annual Aggregate Statewide Evaluation Report, 2018)

Problem Statement:

The ability of the prevention delivery system in Idaho to serve all who need prevention services is expected to diminish over the next five years due to persons leaving the workforce outpacing those entering the workforce, which could significantly hinder Idaho's ability to achieve priority ATOD misuse outcomes.

IMPLEMENTATION PLAN

Goal 1: Increase the reach of SABG prevention programs.

Long Term Outcome: By July 1, 2024, 75% of Idaho's population will be reached through SABG prevention programming.

Baseline: 71% of Idaho's population reached through SABG prevention programming in SFY2016[1].

Objective 1.1: Educate providers about prevention science including comprehensive prevention practice.

Intermediate Outcome: By July 1, 2024, 50% of prevention providers will have received training about prevention science specifically strategies that are grounded in population-based, public-health approaches that target populations across the lifespan and reach across domains.

Baseline: According to ODP staff, 20 providers received training about prevention science in 2018.

Strategy 1.1.1: Identify gaps in providers' knowledge of prevention science specifically strategies that are grounded in population-based, public health approaches that target populations across the lifespan and reach across domains.

Short term Outcome: Understand gaps in providers' knowledge.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Review/ analyze information collected through site visits; quarterly reports; feedback from providers – to assess provider knowledge.	May 2019	June 2019	Alex	Percentage of reviews completed	Report of findings

Strategy 1.1.2.: Develop training to address gaps in providers' knowledge of prevention science.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Prioritize training needs identified through data.	June 1, 2019	July 30, 2019	Marianne (lead) Prevention team	N/A	Prioritized list of needed training topics

[1] Number of persons served by population-based programs reported in Idaho's 2018 SABG application was used to establish this baseline measure.

Determine training mechanism to address training gaps.	June 1, 2019	June 30, 2019	Marianne (lead) Prevention team	N/A	List of training topics and mechanism for training delivery including what will be available through publicly available training
Identify training provider (develop RFP).	July 1, 2019	July 30, 2019	Shaina (lead)	N/A	RFP

Strategy 1.1.3: Deliver training to providers.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Develop annual training schedule that includes competencies to be covered each year through June 2024.	Oct. 1, 2019	Nov. 30, 2019	Marianne (lead) Prevention team	N/A	Training Schedule
Develop marketing plan.	Nov. 30, 2019	Dec. 30, 2019	Shaina	N/A	Marketing Plan
Implement marketing plan.	March 2020	June 2024	Shaina (lead)	N/A	Newsletter Announcement
Deliver training.	July 2020	June 2024	Marianne (lead) Contractor(s)	• # of training events • # of persons trained • # of persons attending training • # online courses completed	• List of training topics • Training outlines including learning objectives • Training slide decks

Strategy 1.1.4: Evaluate effectiveness of training and make changes accordingly.

Short-term Outcome: Increased number of applicants proposing Environmental and Community Based Processes.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Review proposals annually to determine CSAP strategies being proposed.	June 1, 2020	June 30, 2024	Marianne	# of applicants submitting proposals by CSAP strategy.	Annual Report of applicants by CSAP strategy
Assess satisfaction with new training opportunities.	Ongoing	July 2024	Alex	N/A	• Satisfaction Survey • Satisfaction survey results compiled
Meet and review the results of evaluation metrics and make changes accordingly.	July 2020	Annually in October 2020, 2021, 2022, 2023	Alex (lead) Prevention Team (attend meeting and makes suggestions)	N/A	• Meeting agenda • Summary of what is going well and what could be improved

Objective 1.2: Increase the number of providers coming from the fields of public health, psychology, and health promotion[2].

Intermediate Outcome: By July 1, 2024 X% of the prevention workforce has experience in the fields of public health, psychology, and health promotion.

Baseline: X% of prevention workforce with experience in public health, psychology and health promotion in 2020.

[2] The intermediate outcome and baseline measure will be determined upon award of FY21 SABG grants.

Strategy 1.2.1: Conduct meetings with professional organizations, schools and programs of public health, psychology, and health promotion to discuss mechanisms for partnership.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Add question to SABG application asking about specific degrees applicant holds.	Jan 2020	March 2020	Marianne	# of applicants with experience in public health, psychology, and health promotion	Determination of baseline percentage of prevention workforce with experience in public health, psychology, and health promotion
Develop an outreach plan for schools / professional organizations (vision, goals, what is being proposed).	April 2020	May 2020	Shaina (lead) Prevention Team	N/A	Outreach plan
Identify schools/ professional orgs etc. to target for outreach efforts.	May 2020	June 2020	Shaina (lead) Prevention Team	N/A	List of schools/professional orgs
Prioritize contacts, strategize around who should make the contact, designate a lead prevention team member for each visit.	July 2020	August 2020	Shaina (lead) Prevention Team	• N/A	List of assignments i.e. lead prevention staff member and organization or school they will be targeting
Schedule meetings.	Sept. 2020	Nov. 2020	Prevention Team Member	• N/A	List of meetings scheduled
Conduct meetings.	Oct 2020	Nov 2020	Prevention Team Member	• # of meetings held • # of meetings that resulted in partnership activities	List of meetings conducted and summary of outcomes

Strategy 1.2.2: Evaluate the effectiveness of the outreach plan and make changes accordingly.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Design an evaluation plan.	March 2021	May 2021	Alex	Workforce Numbers	N/A

Goal 2: Increase the number of currently funded agencies that will reapply and are awarded prevention Block Grant funding.

Long Term Outcome: By June 30, 2024, 80% of currently funded agencies will reapply for prevention Block Grant funding.

Baseline: 2018: 70% of SABG recipients are past recipients.

Objective 2.1: Decrease the challenges associated with working in prevention.

Intermediate Outcome: By June 30, 2024, 75% of SABG recipients report they are knowledgeable about strategies to increase sustainability and no more than 10% of SABG recipients report issues getting schools on board for program and activity implementation.

Baseline:

2018: 39.3% of SABG recipients reported that in the last year sustainability could be improved.

2018: 25% of SABG recipients reported that in the last year getting schools on board for program and activity implementation had been a problem.

Strategy 2.1.1: Work with School Districts, local school boards, State DOE to identify and implement strategies to increase local school participation in prevention programming.

Short-term Outcome: Increase percentage of local schools participating in prevention programming.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Identify key decision makers in DOE.	March 2019	Ongoing	Tentative lead (Melinda)	N/A	List of key DOE decision makers
Build relationships with staff in DOE.	March 2019	Ongoing	Prevention Team	At least 3 members of prevention team have had a meeting with DOE	List of shared goals or objectives established
Based on data, geographically identify the location of School Districts in high risk regions.	April 2020	May 2020	Alex	N/A	List of high- risk LEAs
Target School Districts in high risk regions for collaboration.	Sept. 2020	Nov. 2020	N/A	# of visits/ contacts made in high risk LEAs	List of barriers and benefits from LEA perspective

Collaborate with School Districts to reduce barriers and increase benefits to schools participating in prevention programming.	Nov. 2020	Feb. 2021	Marianne	N/A	N/A

Strategy 2.1.2: Revise ODP SABG Notice of Award to extend funding terms to two years providing prevention agencies with more stability.

Short term Outcome: Increase provider's perception of stability.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Begin consideration of plan for moving to two-year Notices of Award.	June 2019	November 2020	Marianne (lead)	N/A	List of steps needed to accomplish task.
Draft plan for moving to two-year Notice of Award.	October 2020	November 2020	Marianne	N/A	Plan
Inform current grantees of change in Notice of Award.	December 2020	December 2020	Marianne (lead)	N/A	N/A
Revise Notice of Award language to indicate that funding is for two years (subject to legislative approval).	January 2021	January 2021	Marianne	N/A	Revised language
Draft a continuation application for SABG grantees for the second year of services.	December 2021	January 2022	Marianne	N/A	Continuation application
Request from SABG grantees a new budget and action plan (start of second year).	March 2022	March 2022	Marianne	N/A	N/A

Strategy 2.1.3: Develop and provide sustainability training opportunities to providers.

Short term Outcome: Increased percentage of SABG recipients report they are knowledgeable about strategies to increase sustainability.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Research sustainability best practice and existing sustainability training.	May 2019	June 30, 2019	Alex Curd	N/A	Research sustainability best practices and existing sustainability training
Develop plan for conducting sustainability training (Determine if existing training will meet needs or if new training must be developed).	Dependent on research *Note: if RFP is needed must be completed by July 2019.	N/A	Dependent on research and plan	# of trainings offered	Dependent on research and plan
Provide sustainability training to providers.	Dependent on research	N/A	Dependent on plan	# of persons attending training	N/A

Objective 2.2: Develop a career path for new/ current prevention professionals.

Intermediate Outcome: By June 30, 2024, determine if a modified PFS workforce structure is a good fit for SABG funding.

Strategy 2.2.1: Create a comprehensive evaluation plan that includes quantitative and qualitative data from PFS workforce to determine satisfaction and outcomes associated with employing individuals full time.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Develop comprehensive evaluation plan.	Sept 1, 2020	Dec. 1, 2020	Alex (lead) ODP staff Evaluation staff	N/A	Evaluation plan

Collect quantitative data (source: provider submitted documents including action plans and quarterly reports).	Ongoing	Ongoing	Evaluation contractor	TBD	Report of Findings
Collect qualitative data.	February 2021	September 2023	N/A	TBD	N/A

Note: Comprehensive evaluation plan will include perspectives from PFS coordinators as well as their supervisors, and others impacted by the system. The evaluation will determine the overall benefit of having a revised structure including whether more persons were served, there was a greater likelihood to implement environmental strategies, as well as job satisfaction and retention.

Strategy 2.2.2: Analyze quantitative and qualitative data and prepare cost/ benefit analysis of current structure compared to the modified PFS pilot structure.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Develop method for data analysis i.e. who will conduct analysis and funding for analysis.	January 1, 2022	December 2022	Alex	N/A	N/A
Data analysis and report writing.	October 2023	December 2023	Alex	N/A	Decision about workforce structure

Objective 2.3: Increase prevention providers' knowledge of the long-term impact of their prevention work on the populations they serve.

Intermediate Outcome: By July 1, 2024, 85% of prevention providers will report knowledge of how their work is part of the state's long-term prevention goals.

Baseline: 0%

Strategy 2.3.1: Develop program level reports that demonstrate impact towards state level goals and objectives.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Determine if ODP is already collecting data that the evaluator needs to make the matrices.	March 2019	June 30, 2019	Alex	N/A	N/A
If needed, modify data collection to collect additional data needed for matrices.	March 2019	June 30, 2019	Alex	N/A	Modified data collection instrument
If needed, collect new data.	July 1, 2019	June 30, 2020	Alex	N/A	Quarterly reports and pre/post tests from grantees

Strategy 2.3.2: Distribute revised program level reports to funded agencies on an annual basis.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Provide revised program level reports based on SC model.	July 1, 2020	October 30, 2020 and annually thereafter	Alex	N/A	Revised program level reports

Goal 3: Increase the number of new agencies that apply for prevention Block Grant funding.

Long Term Outcome: By July 1, 2024, 21 new agencies will apply for prevention funding.

Baseline: 2019: 14 new agencies applied for funding accounting for 30% of applicants.

Objective 3.1: Increase knowledge of high-risk populations/ locations in need of prevention SABG funding.

Intermediate Outcome: By July 1, 2024, ODP has strategically targeted high-risk populations/ locations for prevention funding.

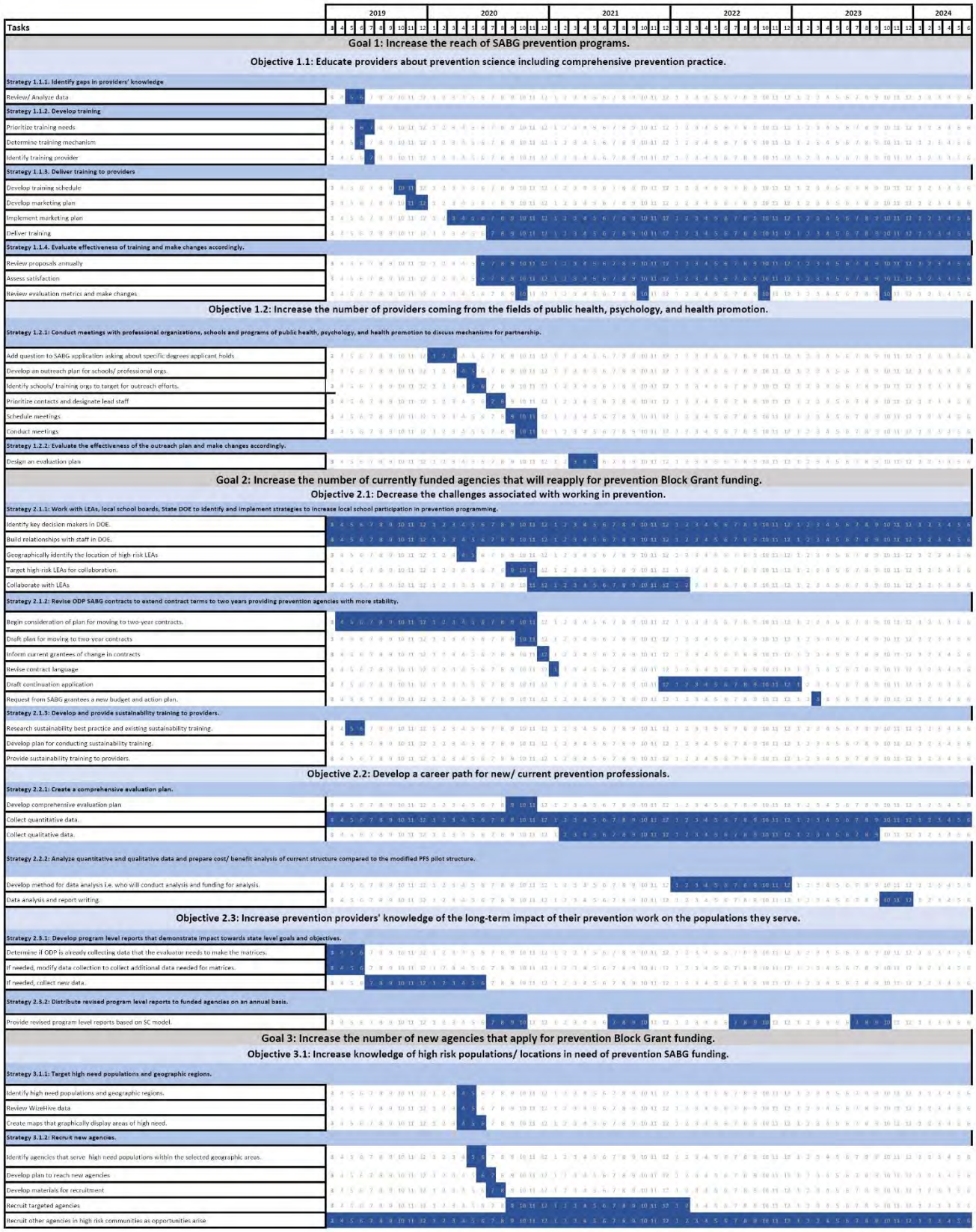
Strategy 3.1.1: Target high need populations and geographic regions

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Identify high need populations and geographic regions.	April 2020	May 2020	Alex	N/A	• Report that compares the service populations/ regions of 2019 grantees to service populations/ regions of 2020 grantees. • Data that demonstrates need at county level.
Create maps that graphically display areas of high need.	April 2020	May 2020	Alex	N/A	Map(s) of high need areas.
Review WizeHive data from FY20 and FY21 for agencies that started an application but did not finish.	April 2020	June 2020	Marianne	N/A	Report that provides information about why applicants did not complete the application.

Strategy 3.1.2: Recruit new agencies.

Activities	Timeline		Who is Responsible	Process Indicators	Outputs
	Start Date	End Date			
Based on assessment of high need areas identify agencies that serve the high need populations within the selected geographic areas.	May 2020	June 2020	Group but Marianne lead	N/A	List of agencies to target by geographic area
Develop plan to reach new agencies.	June 2020	July 2020	Group but Marianne lead	N/A	Plan
Develop materials for recruitment.	July 2020	August 2020	Shaina	N/A	Materials (post-card and one pager minimum)
Recruit targeted agencies.	Sept 2020	February 2021	Group but Marianne lead	# of contacts with targeted agencies	N/A
Recruit other agencies in high risk communities as opportunities arise.	Ongoing	Ongoing	Group but Marianne lead	# of contacts in high risk communities	N/A

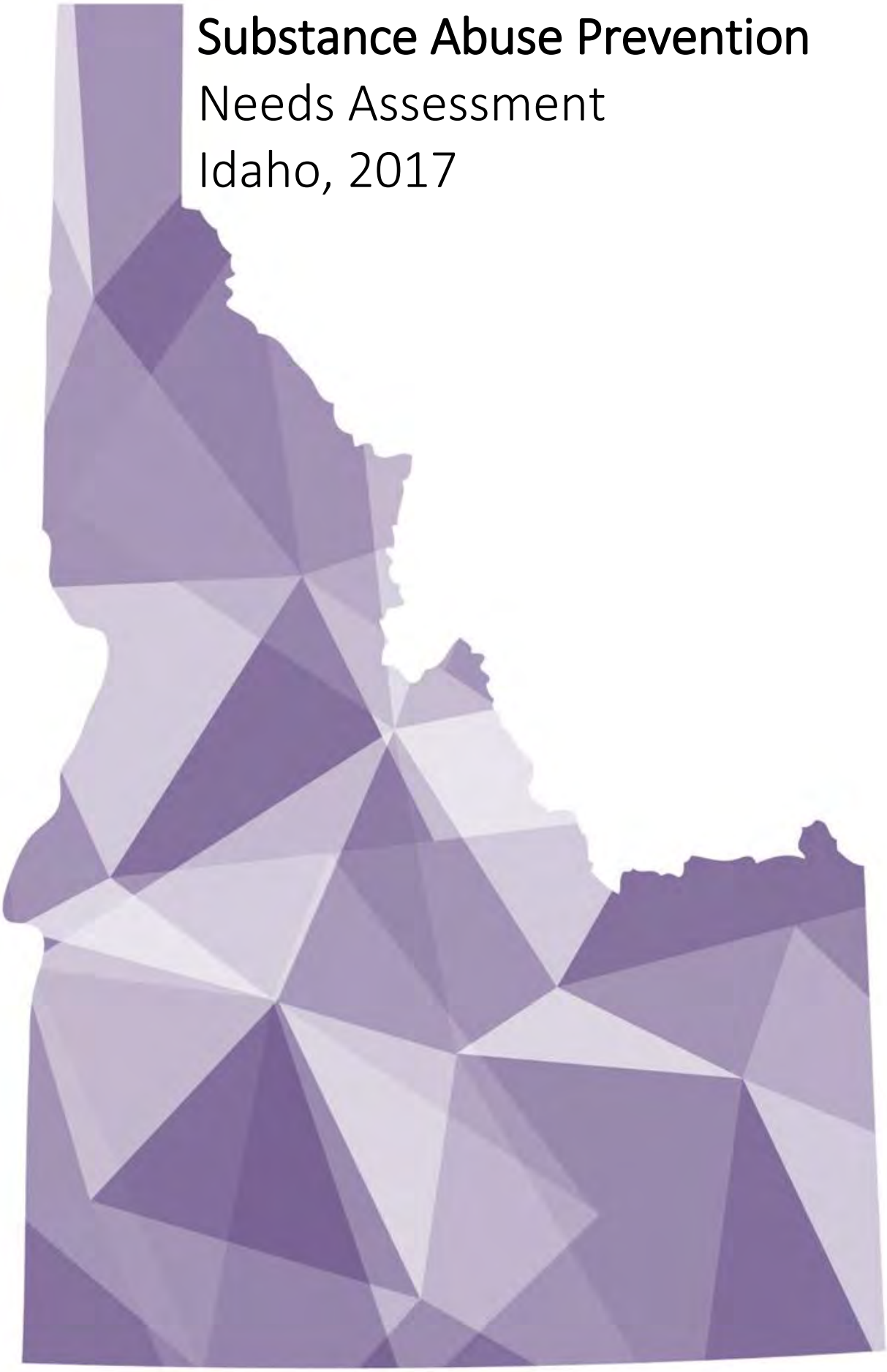
TIMELINE


2019
2020
2021
2022
2023
2024
Tasks
Goal 1: Increase the reach of SABG prevention programs.
Objective 1.1: Educate providers about prevention science including comprehensive prevention practice.
Strategy 1.1.1: Identify gaps in providers' knowledge
Review/ Analyze data
Strategy 1.1.2: Develop training
Prioritize training needs
Determine training mechanism
Identify training provider
Strategy 1.1.3: Deliver training to providers
Develop training schedule
Develop marketing plan
Implement marketing plan
Deliver training
Strategy 1.1.4: Evaluate effectiveness of training and make changes accordingly.
Review proposals annually
Assess satisfaction
Review evaluation metrics and make changes
Objective 1.2: Increase the number of providers coming from the fields of public health, psychology, and health promotion.
Strategy 1.2.1: Conduct meetings with professional organizations, schools and programs of public health, psychology, and health promotion to discuss mechanisms for partnership.
Add question to SABG application asking about specific degrees applicant holds
Develop an outreach plan for schools/ professional orgs.
Identify schools/ training orgs to target for outreach efforts.
Prioritize contacts and designate lead staff
Schedule meetings
Conduct meetings
Strategy 1.2.2: Evaluate the effectiveness of the outreach plan and make changes accordingly.
Design an evaluation plan
Goal 2: Increase the number of currently funded agencies that will reapply for prevention Block Grant funding.
Objective 2.1: Decrease the challenges associated with working in prevention.
Strategy 2.1.1: Work with LEAs, local school boards, State DOE to identify and implement strategies to increase local school participation in prevention programming.
Identify key decision makers in DOE.
Build relationships with staff in DOE.
Geographically identify the location of high risk LEAs
Target high-risk LEAs for collaboration.
Collaborate with LEAs
Strategy 2.1.2: Revise ODP SABG contracts to extend contract terms to two years providing prevention agencies with more stability.
Begin consideration of plan for moving to two-year contracts.
Draft plan for moving to two-year contracts
Inform current grantees of change in contracts
Revise contract language
Draft continuation application
Request from SABG grantees a new budget and action plan.
Strategy 2.1.3: Develop and provide sustainability training to providers.
Research sustainability best practice and existing sustainability training.
Develop plan for conducting sustainability training.
Provide sustainability training to providers.
Objective 2.2: Develop a career path for new/ current prevention professionals.
Strategy 2.2.1: Create a comprehensive evaluation plan.
Develop comprehensive evaluation plan
Collect quantitative data.
Collect qualitative data.
Strategy 2.2.2: Analyze quantitative and qualitative data and prepare cost/ benefit analysis of current structure compared to the modified PFS pilot structure.
Develop method for data analysis i.e. who will conduct analysis and funding for analysis.
Data analysis and report writing.
Objective 2.3: Increase prevention providers' knowledge of the long-term impact of their prevention work on the populations they serve.
Strategy 2.3.1: Develop program level reports that demonstrate impact towards state level goals and objectives.
Determine if ODP is already collecting data that the evaluator needs to make the matrices.
If needed, modify data collection to collect additional data needed for matrices.
If needed, collect new data.
Strategy 2.3.2: Distribute revised program level reports to funded agencies on an annual basis.
Provide revised program level reports based on SC model.
Goal 3: Increase the number of new agencies that apply for prevention Block Grant funding.
Objective 3.1: Increase knowledge of high risk populations/ locations in need of prevention SABG funding.
Strategy 3.1.1: Target high need populations and geographic regions.
Identify high need populations and geographic regions.
Review WizeHive data
Create maps that graphically display areas of high need.
Strategy 3.1.2: Recruit new agencies.
Identify agencies that serve high need populations within the selected geographic areas.
Develop plan to reach new agencies
Develop materials for recruitment
Recruit targeted agencies
Recruit other agencies in high risk communities as opportunities arise

Substance Abuse Prevention

Needs Assessment

Idaho, 2017



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Methodology

Consumption and Consequences

Consumption is defined as the use and high-risk use of alcohol, tobacco, and illicit drugs. Consumption includes patterns of use of alcohol, tobacco, and illicit drugs, including initiation of use, regular or typical use, and high-risk use. Substance-related **consequences** are defined as adverse social, health, and safety consequences associated with alcohol, tobacco, or illicit drug use. Consequences include mortality, morbidity, and other undesired events for which alcohol, tobacco, and/or illicit drugs are clearly and consistently involved.

The Idaho SEOW chose to classify substances into five categories: prescription drugs, alcohol, marijuana, other drugs, and tobacco. Organizing constructs provides a way to conceptualize key types of consumption patterns and consequences. Given ODP's focus on building and strengthening Idaho's prevention system, the Idaho SEOW concentrated on constructs and indicators that would prove most useful for prevention decision-making. Additionally, with respect to consequences, constructs with clear evidence of causation from substances abuse were used.

Indicator Selection

Step 1: Review Data Indicators

A review of the literature and existing data sources was conducted, establishing a comprehensive list of possible indicators grouped by substance and construct type. The Priority Setting Subcommittee, composed of SEOW and SPF Advisory Council members, worked together to review the data indicators.

Step 2: Incorporate 6 Criterion

The criteria established were as follows:

- **Five years** of available data for each indicator
- At least one indicator in each construct collected on a **community or regional level**
- At least one indicator in each construct regarding the key **subpopulations**:
  - Youth under 18
  - Youth aged 18-25
  - Military veterans and their families
  - American Indians/Alaska Natives
  - Hispanics/Latinos
  - Individuals exposed to adverse childhood experiences
- Indicators should be prioritized based on data sources' earliest **level of contact**
  - The level of contact is the point at which each indicator interacts with the population. For example, arrest records are document in an earlier phase of contact than court records, which precedes correctional system involvement.
- At least **three indicators** available
  - When an insufficient number of indicators were available in a construct, the SEOW created a new, broader construct. A construct with a single indicator could result in priorities that are driven by an isolated phenomenon.

Step 3: Identify Relevance and Record Type

The SEOW refined indicators to reflect a relevance rating and record type. The **relevance** rating was on a scale of one to three, 1-Very Relevant to 3-Not Relevant. After some group discussion, each indicator's relevance was scored by the SEOW member who provided the indicator. The **record type** is a classification of each indicator based on the source, administrative (A) or survey-based (S).

Step 4: Score

The SEOW further eliminated indicators by conducting multiple rounds of scoring. Recommendations were collected from each content expert regarding each indicator, these suggestions were then reviewed, and a second round of scoring was conducted by two additional content experts. The final product was reached by a consensus.

The SEOW designed the priority setting methodology by borrowing from a ranking and scoring system from Wyoming. The constructs resulting in high scores were then reviewed in the context of subpopulations and geography to select appropriate priorities for the State to address with SPF SIG funds. Under the guidance of the methodology developed by the SEOW, scoring addressed seriousness, capacity, and size.

Seriousness

A seriousness index was created by tracking the severity of the outcome for each indicator, which was used to calculate the severity score in combination with trend data associated with the indicator.

The **severity** scores were generated by analyzing the following factors in relation to the indicator in question. If an indicator's outcome:

- Was related to mortality, it was scored a 4
- Had both long term and short term health effects, it was scored a 3
- Had long term or short term health effects, it was scored a 2
- Had no effect on health, it was scored a 1

Each indicator was also assigned a score based on the **trend** of the data by the following guidelines. If the indicator was:

- Trending upward, it was assigned a score of 1.5
- Consistent, it was assigned a score of 1
- Trending downward, it was assigned as score of 0.5

These scores were then multiplied together to create the seriousness score using the formula below:

Seriousness Score = Severity Score x Trend Score

Capacity

After some discussion, it was determined that capacity was a combination of both changeability and readiness. Changeability and readiness were independently scored by each member, and then scores were discussed in a group setting. These scores were then averaged together to create a score for each construct for both changeability and readiness. The following formula was created to generate the score for capacity:

Capacity Score = Readiness Score x Changeability Score

Size

To create a score for size, the Priority Setting Subcommittee compared the indicator's effect. The indicators were then assigned a score of 1 to 4 based on which quartile they represented when compared to the other like indicators. Final Scores can be found in Appendix A.

Final Score = [Size Score + (2 x Seriousness)] x Capacity Score

State versus National Sources

The SEOW often chose to cite statewide data sources over their corresponding national aggregates. Typically, the data in national sources are simplified from data collected at the state-level. Further, using state-level data sources enhances partnerships and allows for quicker responses. When available, national metrics were included when data was gathered using the same methodology. In some cases, there was a lack of adequate national comparison.

Changing Surveillance

Throughout the years, data measures change due to many unforeseeable reasons including changing agency responsibility, changing priorities or foci, and lack of sustainability or funding. For example, the BRFSS questionnaire has been modified since the indicators were selected for the 2014 Needs Assessment, which no longer includes the item regarding illicit drug use. To fill this need, the Office of Drug Policy added questions to the BRFSS regarding marijuana use, prescription drug abuse, and the risk of underage drinking. Additionally, definitions for various indicators have changed to provide more accurate information to the public. The SEOW has opted to use the most accurate data by conforming to these definitions. For that reason, some trend data in previous Need Assessments may not be identical to the 2016 Needs Assessment. Despite the SEOW's work to identify the best substance abuse indicators available, data measurements are continuously being modified or removed. For this reason, it is important to develop and implement new data sources that may be used in the future.

Priority Areas

Prescription Drugs

On November 1, 2011, the Centers for Disease Control and Prevention declared prescription drug abuse an epidemic. The increasing arrest rates, distribution rates, and drug-induced mortality within the state clarifies that Idaho is not immune to the epidemic.

Alcohol

Although several indicators of alcohol use are falling, such as alcohol-related arrests, alcohol sales continue to rise. Despite the increase in alcohol sales, according to self-reported surveys, alcohol consumption seems to be stable or decreasing. The increase in alcohol sales may be explained, to a degree, by individuals from other states, namely Washington, traveling to Idaho to purchase alcohol at a lower price. In recent years, Washington privatized liquor, increasing alcohol prices in the Evergreen State. However, according to the Idaho State Liquor Division, even when controlling for these factors, the alcohol sales rate for Idaho residents is increasing. Alcohol-induced death rates have been steadily above the national average.

The recent reclassification the intitial underage alcohol offense from a misdemeanor to an infractions in Idaho may have some influence on alcohol indicators. It will be important in the coming years to monitor underage alcohol consumption and consequence indicators to identify the outcomes of this legislation.

Marijuana

Marijuana use and treatment seem to be slightly decreasing while arrests related to marijuana are increasing. The largest percent change among marijuana-related indicators can be seen with the marijuana trafficking arrest rate, which has nearly quadrupled since 2009. The rise in trafficking may be a result of the trend of policies relating to private cultivation, decriminalization, and marijuana legalization in neighboring states. Due to the sudden shifts in cultural attitudes, perceptions of harm, and availability, marijuana consumption and related consequences warrant particular surveillance.

Idaho Demographics

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 Bureau, Idaho's largest metropolitan area, the Treasure Valley which includes both Ada and Canyon Counties, contains 39% 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.

Population

Population density and change has been found to impact substance abuse and consequences in communities. According to Gfroerer et al.'s article *Drug Use Patterns and Trends in Rural Communities*, the types of drugs that youth use differ in rural and urban areas. Additionally, drastic population changes can leave a community with a deficit in infrastructure or leave residents with a stunted economy. Although Idaho remains below the national average for the number of residents per square mile, Idaho is growing at a faster rate than the national average. Idaho's most popuated counties, Ada County and Canyon County, also had the highest population growth. Similarly, two counties with the lowest population, Clark County and Custer County saw decreases in population.

Economic Factors

Depressed economies can influence substance abuse and related outcomes. Residents with high levels of poverty and unemployment and lower educational attainment and income may have less opportunity to engage in healthful behaviors or access behavioral health services. Although Idaho's median household income is lower than the national average, and the percentage of the population below the poverty level is similar to the national average. Idaho's unemployment rate is lower than the national average, but has a lower percentage of individuals 25 or older with a bachelor's degree or higher.

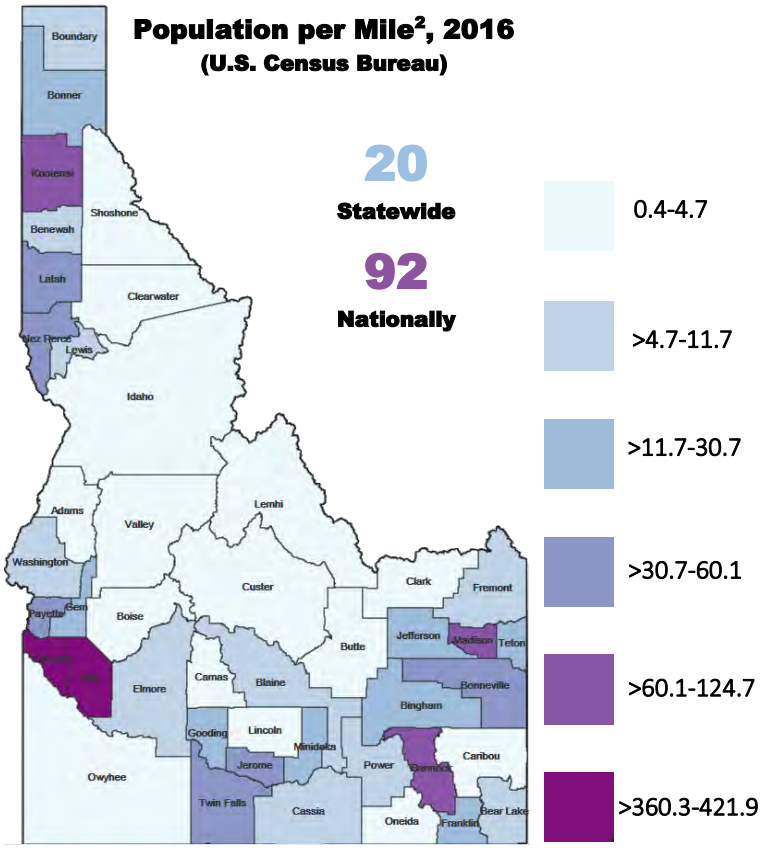
Priority Populations

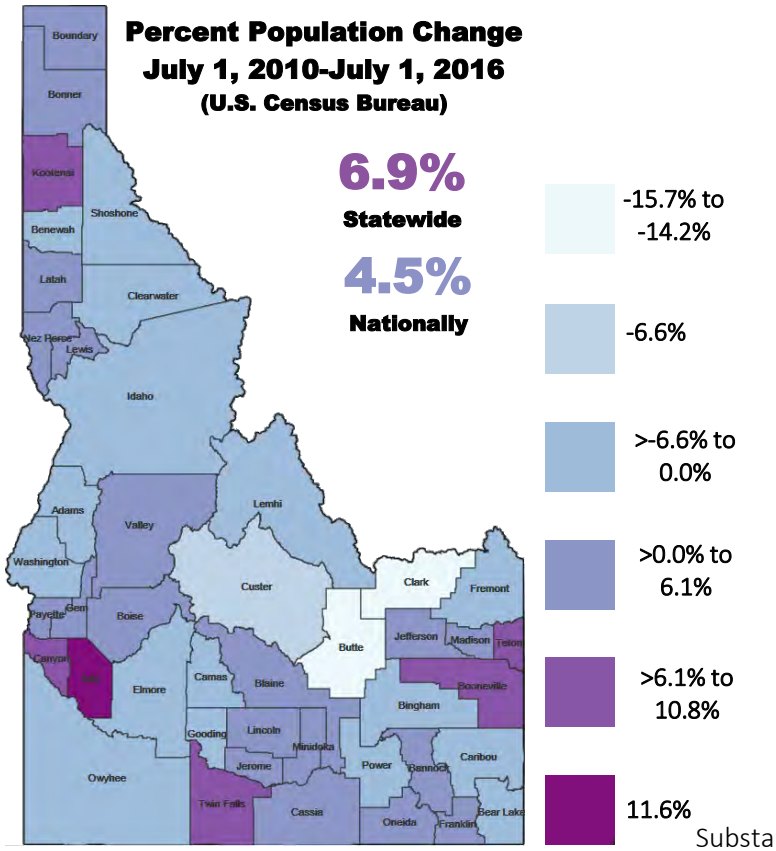
As you will read thoughout this publication and in other literature, some populations may be more at risk for substance abuse and related consequences. The SEOW has chosen to review data relating to young adults, veterans, and racial, and ethinic minority populations to determine priority populations for potential prevention or intervention services. Idaho has a higher prevalence of of American Indians or Alaska Natives than the national average, but a lower prevalence of Hispanics or Latinos, veterans, and individuals 18 to 25.

To provide a better understanding of the demographics, the following maps highlight demographic characteristics at the county level in Idaho.

Population

Idaho has a relatively small population, but it is growing at a relatively fast pace.





According to the 2016 Census estimate, the number of people per square mile nationally was 91.5, compared to 20.4 in Idaho. The percent population change between 2010 and 2016 nationally was 4.5% compared to 6.9% in Idaho.

Over the last several years, more populated areas in Idaho are increasing in population; whereas, less populated areas are declining in population.

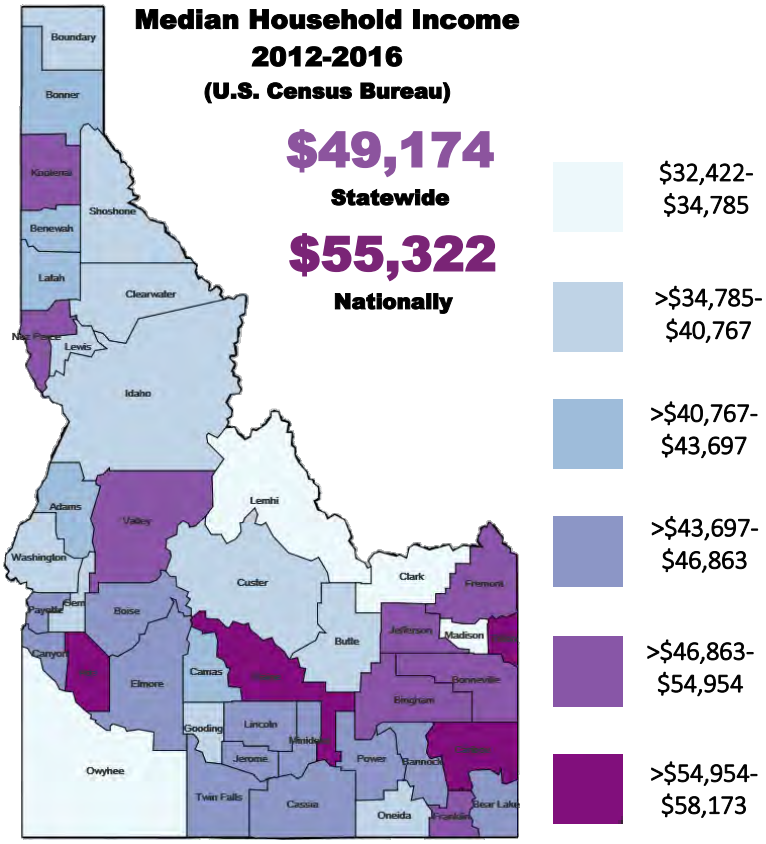
The two counties with significantly higher population per square mile also had the largest population increase. In 2016, 421.9 people per square mile lived in Ada County and the population grew 11.6% between 2010 and 2016. Over 360 people per square mile lived in Canyon County and the population grew 10.8%

Similarly, the two counties with lowest population per square mile also had substantial population decreases. In 2016, 0.5 people per square mile lived in Clark County and the population fell 14.2% between 2010 and 2016. Approximately 0.8 people per square mile lived in Custer County and the population fell 6.6%.

Butte County had the largest reduction in population between 2010 and 2016, 15.7%.

Economic Factors

Idaho has a lower median household income, but a similar percentage of individuals living in poverty as the national average.

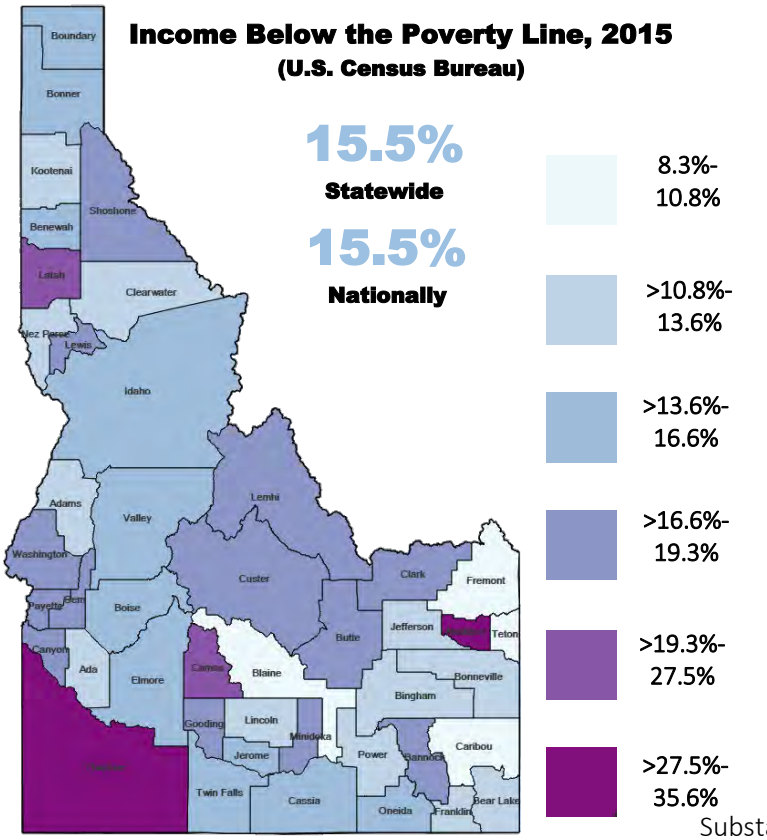


According to the 2016 five-year Census estimate, the median household income nationally was $55,322 and $49,174 in Idaho.

The counties with the highest median household incomes were Teton County ($58,173), Ada County ($58,099), and Blaine County ($58,086).

The counties with the lowest median household incomes were Clark County ($32,422), Madison County ($33,856), and Lemhi County ($34,762).

Teton County, Ada County, Blaine County, and Caribou County had significantly higher median household incomes compared to the average county in Idaho.



According to the 2015 Census estimate, the percentage of the population with a past annual income below the poverty level both nationally and in Idaho was 15.5%.

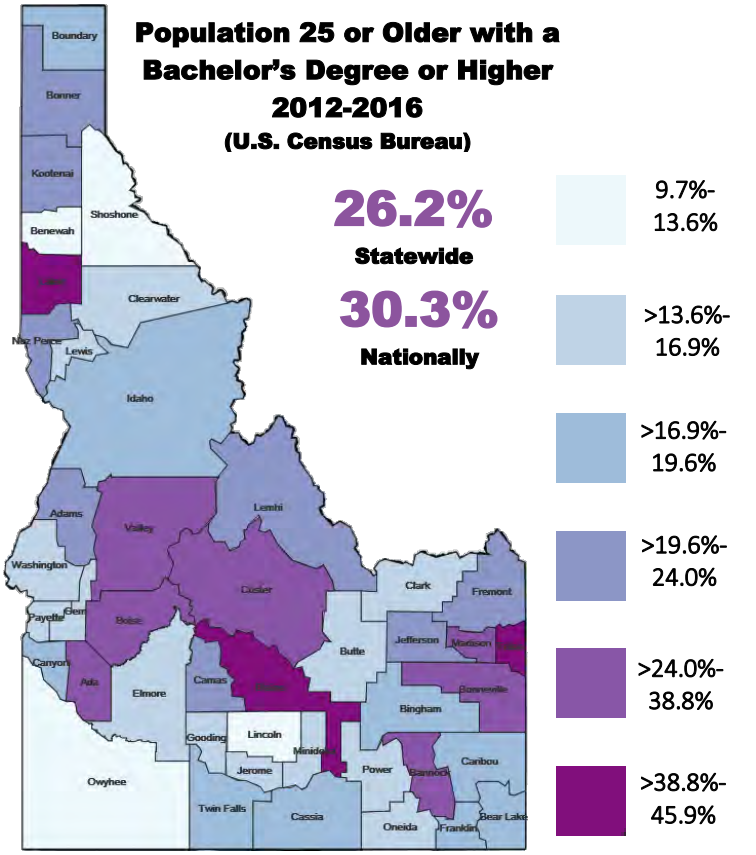
The counties with the lowest percentage of the population with a past annual income below the poverty level were Caribou County (8.3%), Fremont County (10.3%), and Blaine County (10.4%).

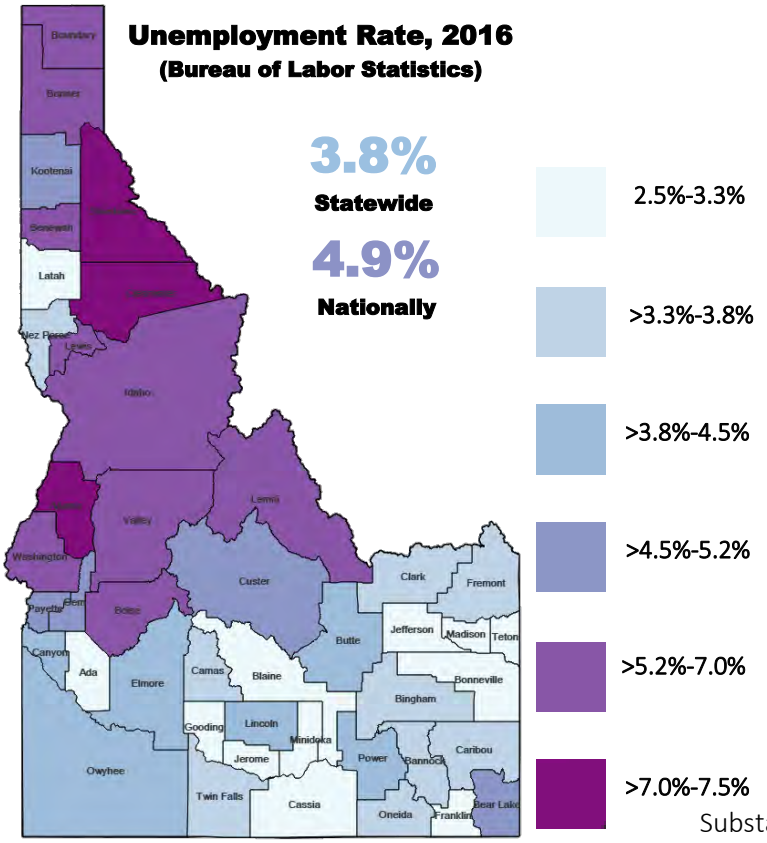
The counties with the highest percentage of the population with a past annual income below the poverty level were Madison County (35.6%), Owyhee County (27.6%), and Camas County (21.8%).

Madison County and Owyhee County had significantly higher percentages of the population with a past annual income below the poverty level compared to the average county in Idaho.

Economic Factors

Idaho has a lower percentage of individuals 25 and older with a bachelor's degree or higher, but also a lower unemployment rate compared to the national average.





According to the 2016 five-year Census estimate, the percentage of the population 25 and older with a bachelor's degree or higher nationally was 30.3% compared to 26.2% in Idaho.

The counties with the highest percentage of the population 25 and older with a bachelor's degree or higher were Latah County (45.9%), Blaine County (41.8%), and Teton County (40.0%).

The counties with the lowest percentage of the population 25 and older with a bachelor's degree or higher were Owyhee County (9.7%), Lincoln County (11.8%), and Shoshone County (12.8%).

Latah County, Blaine County, and Teton County had a significantly higher percentage of the population 25 and older with a bachelor's degree or higher compared to the average county in Idaho.

According to the 2016 Bureau of Labor Statistics estimate, the unemployment rate nationally was 4.9% compared to 3.8% in Idaho.

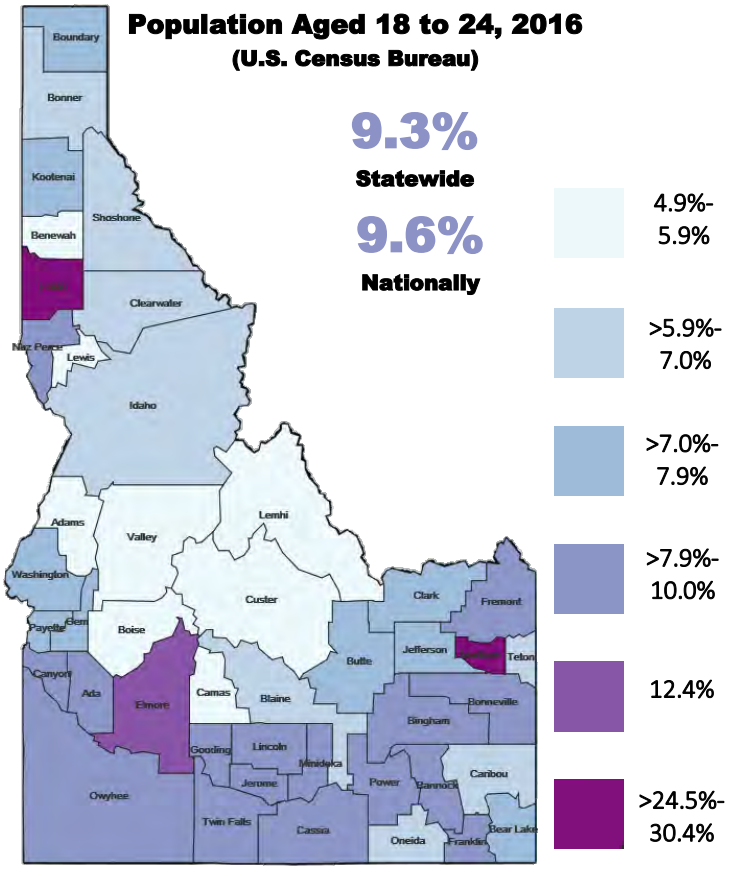
The counties with the highest unemployment rate were Clearwater County (7.5%), Shoshone County (7.3%), and Adams County (7.1%).

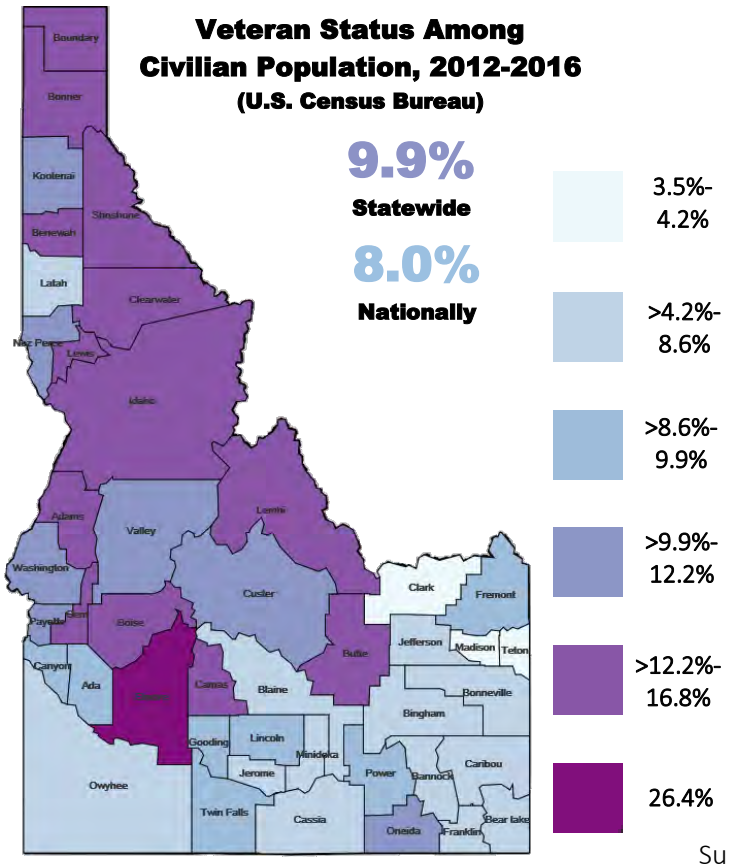
The counties with the lowest unemployment rate were Madison County (2.5%), Franklin County (3.0%), and Cassia County (3.1%).

Clearwater County, Shoshone County, and Adams County had a significantly higher unemployment rate compared to the average county in Idaho.

Priority Populations

Idaho has a smaller emerging adult population, but a higher veteran population compared to the national average.





According to the 2016 Census estimate, the percentage of the population between the ages of 18 and 24 nationally was 9.6%, compared to 9.3% in Idaho.

The counties with the highest percentage of the population between the ages of 18 and 24 were Madison County (30.4%), Latah County (24.5%), and Elmore County (12.4%).

The counties with the lowest percentage of the population between the ages of 18 and 24 were Adams County (5.0%), Camas County (5.0%), and Valley County (5.3%).

Madison County and Latah County had a significantly higher percentage of the population between the ages of 18 and 24 compared to the average county in Idaho.

According to the 2016 five-year Census estimate, the percentage of the civilian population 18 and over who were veterans nationally was 8.0%, compared to 9.9% in Idaho.

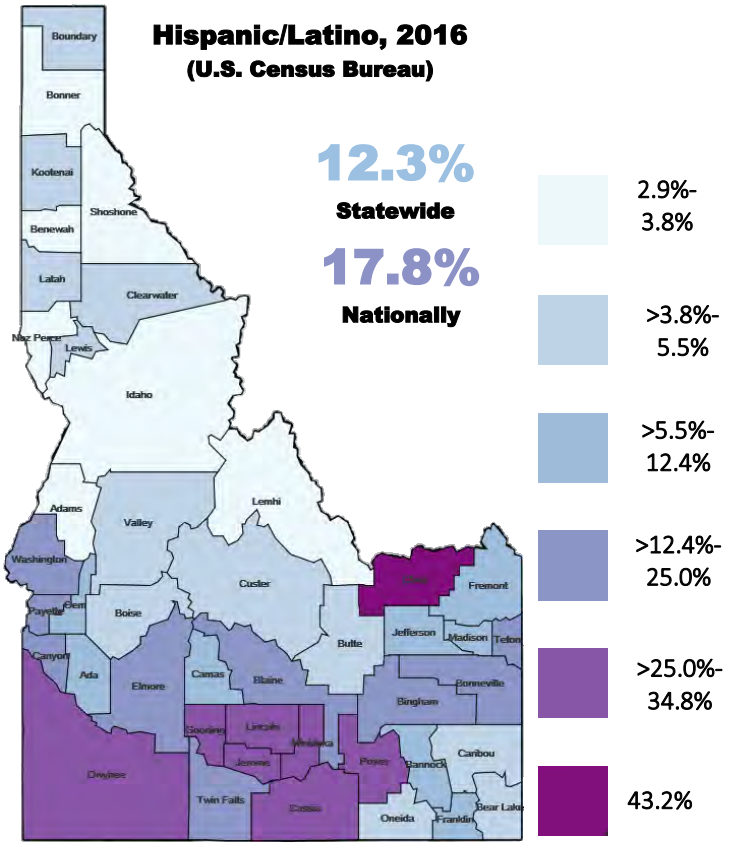
The counties with the highest percentage of veterans among the civilian population were Elmore County (26.4%), Clearwater County (16.8%), and Adams County (16.4%).

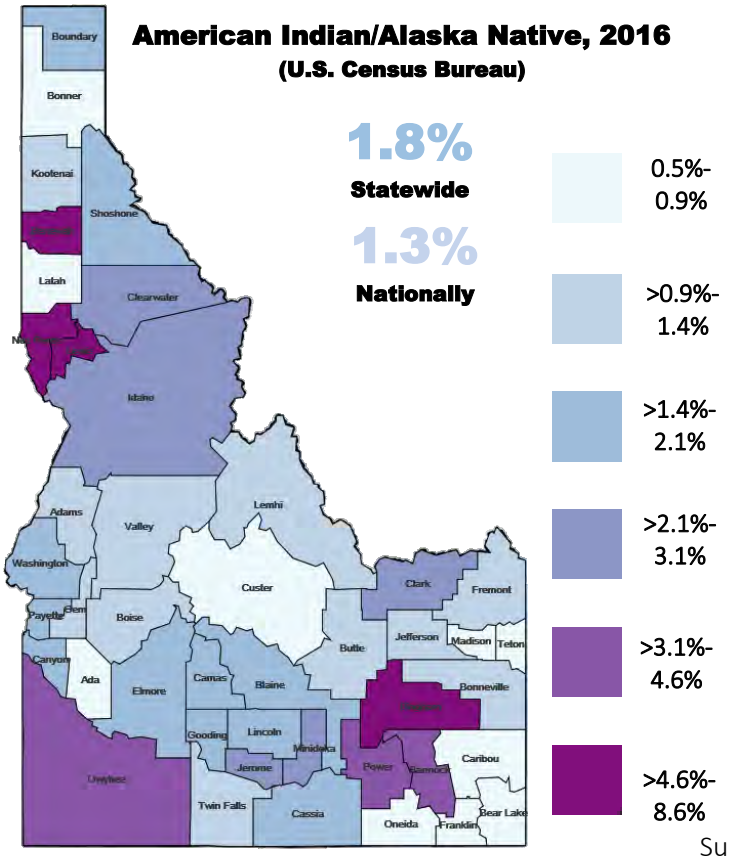
The counties with the lowest percentage of veterans among the civilian population were Madison County (3.5%), Teton County (4.1%), and Clark County (4.2%).

Elmore County had a significantly higher veteran population compared to the average county in Idaho.

Priority Populations

Idaho has a smaller Hispanic/Latino population, but a larger American Indian/Alaska Native population than the national average.





The percentage of the population identifying as Hispanic or Latino nationally was 17.8%, compared to 12.3% in Idaho.

The counties with the highest percentage of Hispanic or Latino people in the population were Clark County (43.1%), Minidoka County (34.8%), and Jerome County (34.3%).

The counties with the lowest percentage of Hispanic or Latino people in the population were Bonner County (2.9%), Lemhi County (3.1%), and Idaho County (3.3%).

Clark County had a significantly higher percentage of Hispanic or Latino people in the population compared to the average county in Idaho.

The percentage of the population identifying as American Indian or Alaska Native (AI/AN) nationally was 1.3%, compared to 1.8% in Idaho.

The counties with the highest percentage of AI/AN people in the population were Benewah County (8.6%), Bingham County (7.5%), and Lewis County (6.6%).

The counties with the lowest percentage of AI/AN people in the population were Madison County (0.5%), Oneida County (0.6%), and Latah County (0.8%).

Benewah County, Bingham County, Lewis County, and Nez Perce County had significantly higher percentages of AI/AN people in the population compared to the average county in Idaho.

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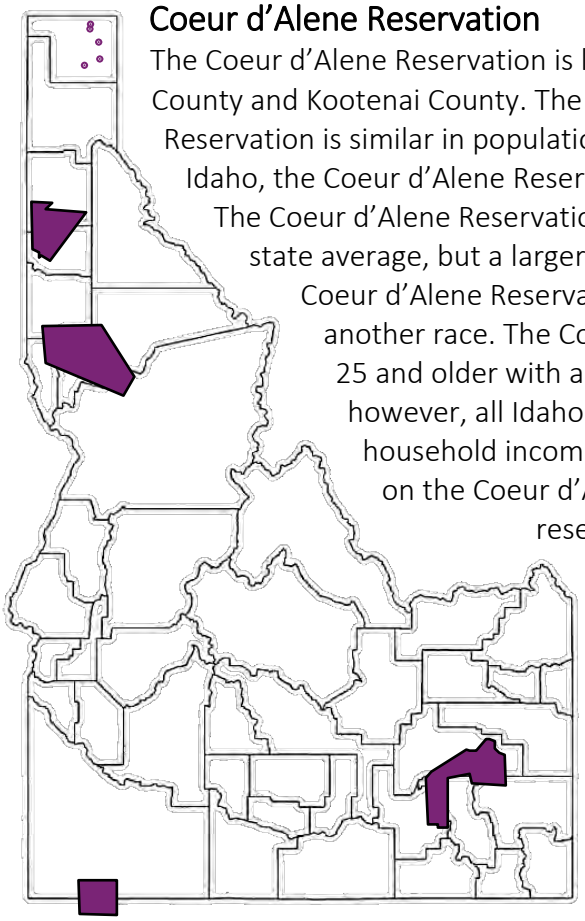
Tribal Reservation Demographics

Metric		Coeur d'Alene	Duck Valley	Fort Hall	Kootenai	Nez Perce
Population Density	Total Population	7,164	1,696	5,950	*55*	**18,739**
	Population per Square Mile	13.7	*3.8*	7.3	12.4	**15.7**
Priority Populations	Percent Hispanic Alone	4.8%	5.3%	**11.4%**	*0.0%*	5.2%
	Percent Native American Alone	20.1%	**83.1%**	64.4%	74.5%	*12.9%*
	Percent Aged 18-24	*7.1%*	9.2%	**9.9%**	9.1%	*7.1%*
	Percent Civilian Veterans	**14.5%**	10.8%	*5.9%*	12.5%	13.0%
Economic Factors	Percent 25 or Older with a Bachelor's Degree or Higher	**17.6%**	11.6%	11.3%	*5.7%*	16.9%
	Median Household Income	$42,896	*$33,203*	$41,532	**$56,250**	$39,355
	Percent Individuals Living Below the Poverty level	19.2%	24.2%	20.0%	**34.5%**	*17.2%*

There are 5 American Indian Reservations in Idaho, and one, Duck Valley, straddles the Nevada-Idaho border. The data from Fort Hall reservation and Kootenai Reservation also include off-reservation Trust Land.



Coeur d'Alene Reservation

The Coeur d'Alene Reservation is located in Northern Idaho nestled in parts of both Benewah County and Kootenai County. The second largest reservation in Idaho, the Coeur d'Alene Reservation is similar in population density to Benewah County. Like all the other reservations in Idaho, the Coeur d'Alene Reservation is below the state average in population per square mile. The Coeur d'Alene Reservation has a smaller Hispanic and young adult population than the state average, but a larger civilian veteran population. One in five individuals living on the Coeur d'Alene Reservation reported being American Indian, not in combination with another race. The Coeur d'Alene Reservation has the largest percentage of individuals 25 and older with a bachelor's degree or higher among all the reservations in Idaho; however, all Idaho reservations are below the state in this metric. The median household income and the percentage of individuals living below the poverty level on the Coeur d'Alene Reservation are similar to that of Canyon County. All reservations in Idaho have a higher poverty rate than the average for the state.

Duck Valley Reservation

The Duck Valley Reservation straddles the Idaho-Nevada border. The second smallest reservation in Idaho, the Duck Valley Reservation has the smallest population density, similar to that of Boise County. The Duck Valley Reservation has a smaller Hispanic population than the state average, but a similar young adult and civilian veteran population. The Duck Valley Reservation has the

largest percentage of residents that report being American Indian not in combination with another race among all reservations in Idaho. The percentage of those who are 25 or older with a bachelor's degree or higher is 56% lower on the Duck Valley Reservation than the average for the state. Economically, the residents of the Duck Valley Reservation have the lowest median household income among Idaho reservations with a percentage of individuals living below the poverty similar to that of Shoshone County.

Fort Hall Reservation

The Fort Hall Reservation is located in South Eastern Idaho. Similar in population density to Washington County, the Fort Hall Reservation has the largest Hispanic and young adult populations, but the smallest civilian veteran population among all reservations in Idaho. Two out of three individuals living on the Fort Hall Reservation reported being American Indian, not in combination with another race. The percentage of those who are 25 or older with a bachelor's degree or higher is 56% lower on the Fort Hall Reservation than the average for the state. The Fort Hall reservation falls in the middle of the other reservations regarding both median household income and the percentage of individuals living below the poverty level.

Kootenai Reservation

The Kootenai Reservation is located in Northern Idaho on the Kootenai River. The smallest reservation in Idaho, the Kootenai Reservation is similar in population density to Benewah County. None of the residents on the Kootenai Reservation reported being Hispanic, but the young adult and the civilian veteran population are similar to the statewide rate. Three out of four individuals living on the Kootenai Reservation reported being American Indian, not in combination with another race. With the smallest percentage of individuals 25 and older with a bachelor's degree or higher, the Kootenai Reservation has the highest median household income, similar to Ada County. Conversely, the percentage of individuals living below the poverty level on the Kootenai Reservation is the highest among reservations, and second only to Madison County.

Nez Perce Reservation

The Nez Perce Reservation is located in North Central Idaho close to the intersection of the Washington-Oregon border. The largest reservation in Idaho in both total population and population density, the Nez Perce Reservation has the lowest percentage of residents reporting being American Indian, not in combination with another race. The Nez Perce Reservation has a smaller Hispanic and young adult population than the state average, but a higher civilian veteran population. The percentage of those who are 25 or older with a bachelor's degree or higher is 35% lower on the Nez Perce Reservation than the average for the state. The median household income on the Nez Perce Reservation is similar to that of Custer County. The Nez Perce Reservation had the lowest percentage of residents living below the poverty level among all the reservations, but was still 11% higher than the state rate.

Indicators

Prescription Drugs

Consumption

According to the National Survey on Drug Use and Health (NSDUH), in 2015/2016, among all 50 states and D.C., Idaho ranked 5th, 15th, 4th, and 5th among individuals 12 and older, 12 to 17, 18 to 25, and 26 and older, respectively, for pain reliever misuse in the past year. This item on the NSDUH was revised in 2016, so estimates cannot be reliably compared to previous years. Misuse is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Approximately 5.1% of Idahoans reported past year pain reliever misuse compared to 4.5% nationally. Idahoans aged 18-25 were significantly more likely to report pain reliever misuse than other age groups; 9.8% reported misusing pain relievers in the past year.

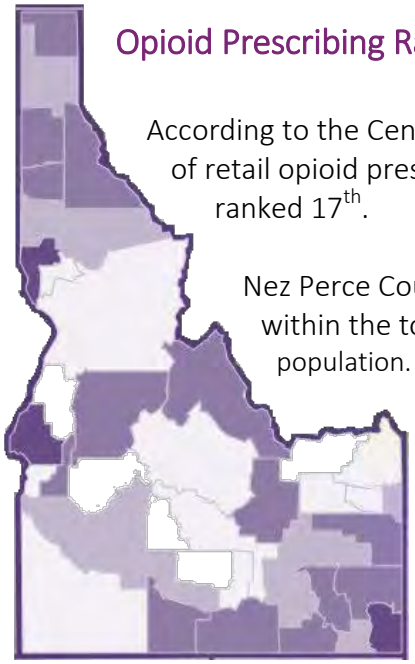
According to the Youth Risk Behavior Survey (YRBS) in 2017, the percentage of high school students in Idaho reporting ever using prescription drugs not prescribed by a doctor decreased by 31% since the item initially appeared on the survey in 2011.

According to the Automation of Reports and Consolidated System (ARCOS), which is a database of controlled substance transactions, Idaho is below the national average in the rate of retail oxycodone distributed. Following an increase over the past several years, the oxycodone distribution rate decreased by 4% between 2015 and 2016. Although Idaho is above the national average in the rate of hydrocodone distributed, the rate continues to decrease.

Consequence

According to Web Infrastructure for Treatment Services (WITS), the proportion of publically funded primary treatment admissions for some prescription drugs, including opioids, barbiturates, and sedatives, appear to be decreasing; however, there has been a slight increase in admissions for stimulants.

According the National Incidence Based Reporting System (NIBRS), prescription drug-related arrests have more than doubled between 2007 and 2016.



Opioid Prescribing Rate per 100 Population

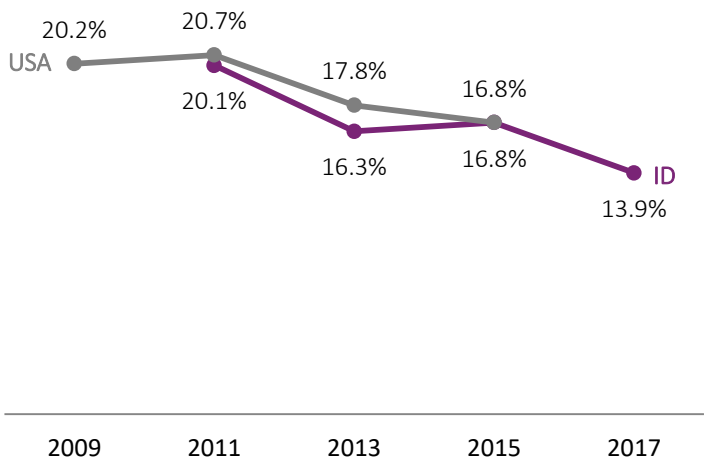
According to the Centers for Disease Control and Prevention's *U.S. Prescribing Rate Maps*, the rate of retail opioid prescriptions dispensed in Idaho was 77.6 per 100 population in 2016; Idaho ranked 17th.

Nez Perce County (127.8), Washington County (113.5), and Bear Lake County (113.3) all fall within the top 16th percentile of all counties in the nation for opioid prescribing rate per 100 population.

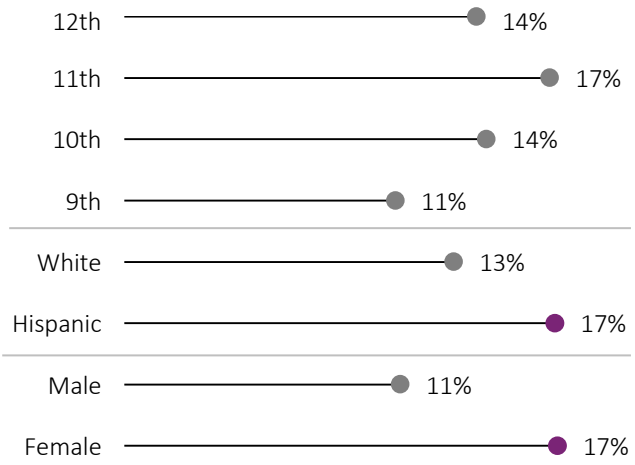
Youth Lifetime Prescription Drug Use without a Doctor's Prescription

Youth Risk Behavior Survey (YRBS)

The percentage of Idaho high school students that abused prescription drugs decreased by 31% between 2011 and 2017.



In 2017, female, Hispanic, and 11th grade students were most likely to report prescription drugs use.



Between 2011 and 2017, the percentage of Idaho high school students that reported having ever used prescription drugs without a doctor's prescription has decreased, with the percentage in Idaho hovering slightly below that of the United States. The YRBS added this prescription drug item in 2011 in Idaho.

According to the Idaho Department of Education's 2017 YRBS report, females (compared to males) and Hispanic (compared to White) students were significantly more likely to report having ever used a prescription drug without a doctor's prescription. Further, academic achievement is significantly associated with prescription drug use; those with lower grades are more likely to report using prescription drugs at least once in their lifetimes.

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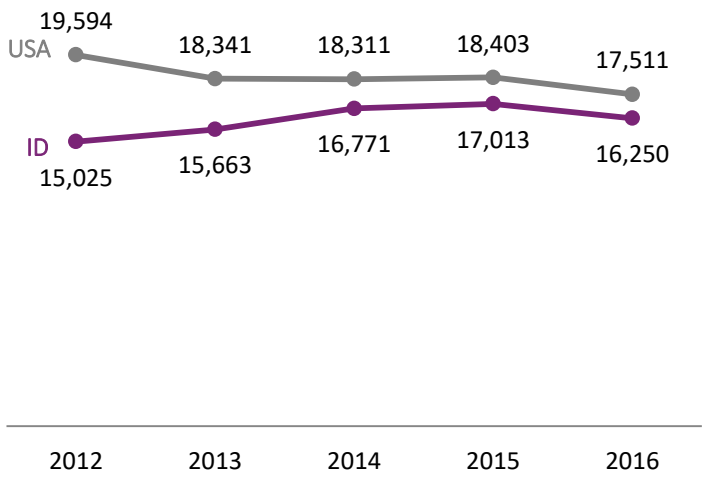
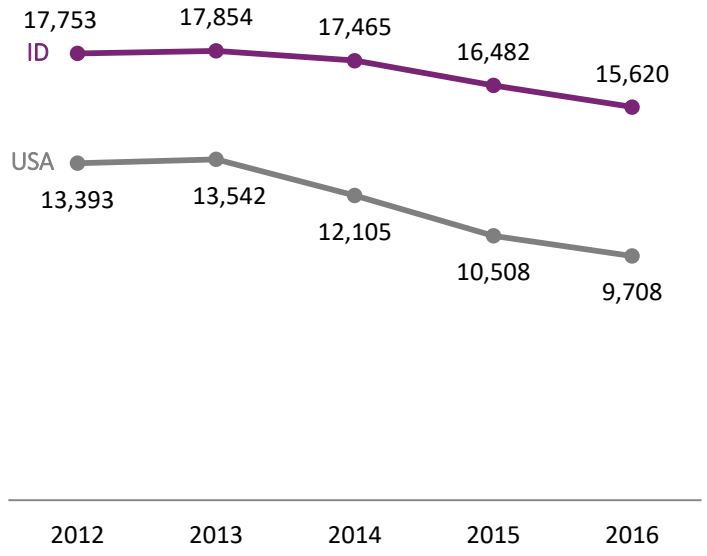
Retail Distribution Rate of Oxycodone and Hydrocodone per 100,000 Population

Automation of Reports and Consolidated Ordering System (ARCOS)

The retail distribution rate of oxycodone increased by 8% between 2012 and 2016.



The retail distribution rate of hydrocodone decreased by 12% between 2012 and 2016.



ARCOS is a database of controlled substance transactions destined for pharmacies, hospitals, or physicians' offices, collected from manufacturers and distributors and reported to the Drug Enforcement Administration (DEA).The rates reported are based on population estimates in 2010.

In 2016, over 793,700 grams of opioids were distributed to pharmacies, hospitals, and physicians' offices. Among all opioids within the ARCOS database, oxycodone and hydrocodone have the highest retail distribution per 100,000 in Idaho. In 2016, 254,733.92 grams of oxycodone and 244,856.68 grams of hydrocodone were distributed to pharmacies, hospitals, and physicians' offices in Idaho.

In 2016, Idaho ranked 38th and 9th in the nation for the highest retail distribution per 100,000 population of oxycodone and hydrocodone, respectively.

Between 2012 and 2016, the retail distribution of grams of oxycodone per 100,000 population in the United States decreased by 11%. During the same time period, in Idaho, the retail distribution of grams oxycodone per 100,000 population decreased by 8%. The rate in Idaho has been consistently lower that of the United States.

Between 2012 and 2016, the retail distribution of grams of hydrocodone per 100,000 population in the United States decreased by 28%. During the same time period, in Idaho, the retail distribution of grams hydrocodone per 100,000 population decreased by 12%. The rate in Idaho has been consistently above that of the United States.

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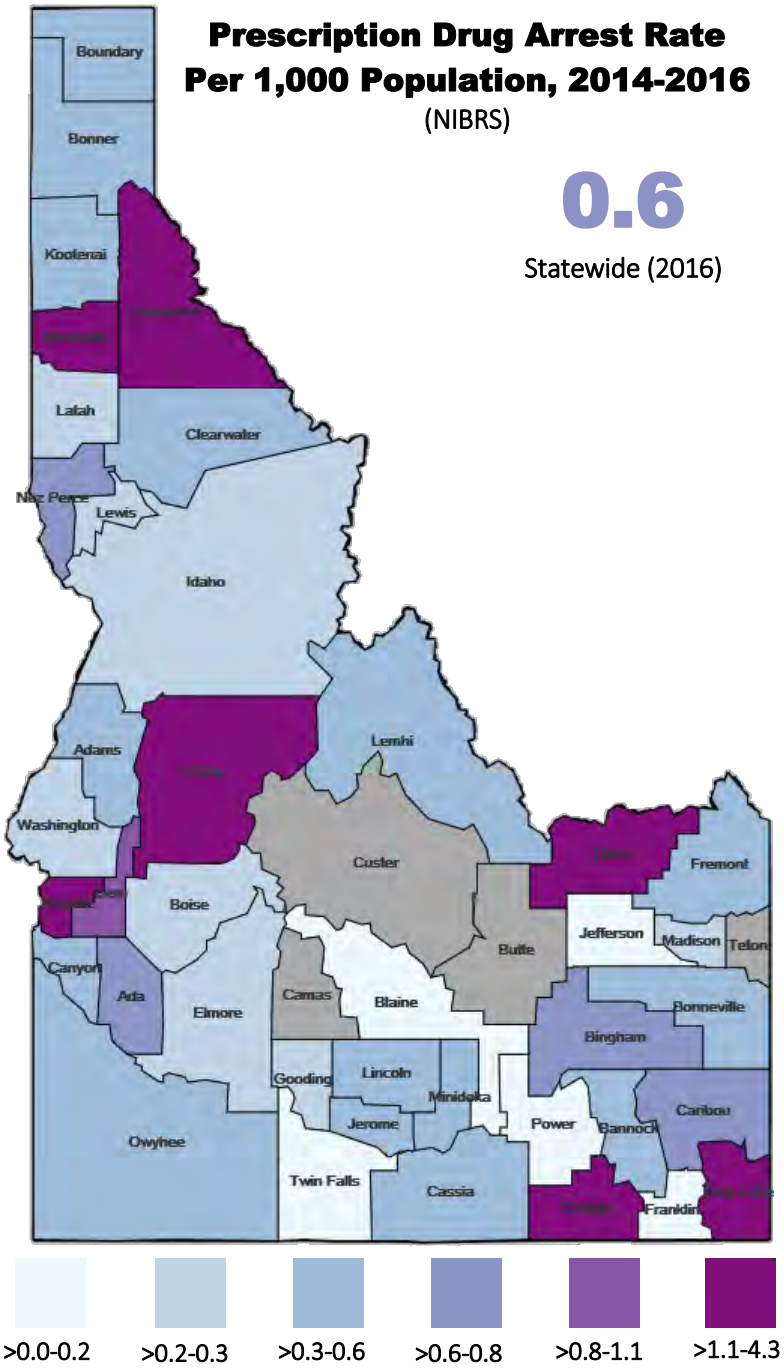
Prescription Drug Arrest Rate per 1,000 Population

National Incidence-Based Reporting System (NIBRS)



According to NIBRS, prescription drug (Rx) arrests include all illicit possession, concealing, transporting, transmitting, and importing activities. Between 2007 and 2016, the total prescription drug arrest rate more than doubled. The Rx arrest rate in Idaho in 2016 was 0.62 per 1,000 population.

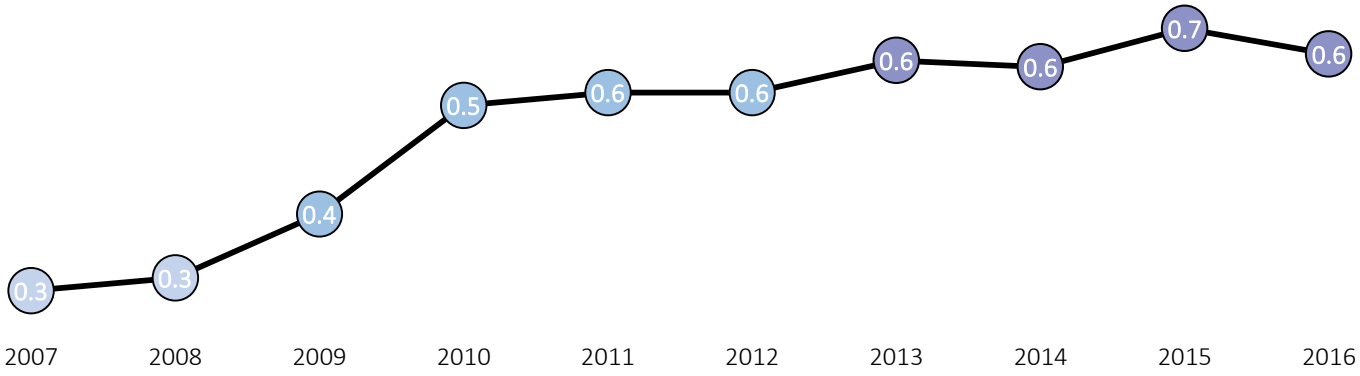
The counties with the highest Rx arrest rate were Clark County (4.30), Benewah County (1.73), and Oneida County (1.62).

The counties with the lowest Rx arrest rate were Blaine County (0.05), Power County (0.13), and Franklin County (0.15).

Camas County, Butte County, Custer County and Teton County did not have any Rx arrests between 2014 and 2016.

Benewah County, Oneida County, Payette County, Bear Lake County, Valley County, and Shoshone County had significantly higher rates of Rx arrests compared to the average county in Idaho.

Clark County also had a significantly higher rate of Rx arrests compared to the average county in Idaho; however, due to their small population, slight increases can appear more dramatic. Between 2014 and 2016, Clark County had 11 Rx arrests compared 47 in Benewah County and 985 in Ada County.



Alcohol

Consumption

According to the NSDUH in 2015/2016, among all 50 states and D.C., Idaho ranked 41st, 39th, 49th, and 40th among individuals 12 and older, 12 to 17, 18 to 25, and 26 and older, respectively, for alcohol use in the past month. These rankings are down for Idahoans 12 and older and 26 and older from 39th and 32nd, respectively, up from 45th among individuals 12 to 17, and unchanged for Idahoans 18 to 25 in 2011/2012 (before Idaho received the SPF SIG grant).

Alcohol use has decreased among high school students, but not necessarily among adults. According to the YRBS in 2017, the percentage of high school students in Idaho reporting alcohol use and binge drinking in the past 30 days decreased significantly since 2007. According to the BRFSS in 2016, the percentage of adults in Idaho reporting heavy drinking, current alcohol use, and current binge drinking have not changed significantly since 2011.
According to the Idaho State Liquor Division in 2015, an estimated 1.53 gallons of liquor were sold per Idahoan. Between 2011 and 2015, apparent per capita sales of distilled spirits increased by 9%; however, the rate has been consistently lower than that of the United States.

Consequence

According to the Web Infrastructure for Treatment Services (WITS), for every population of 1,000 in Idaho, two entered publically funded treatment for alcohol. In 2016, over 5.2% of Idahoans reported needing but not receiving treatment at a specialty facility for alcohol use in the past year. This percentage was similar to the national average (5.5%). Idahoans 18-25 were the most likely to report needing but not receiving treatment at a specialty facility for alcohol in the past year (9.5%).

Both alcohol-induced mortality and alcoholic liver disease mortality rates have not changed significantly but remain higher than the national rate. Although, according to NIBRS, DUI arrests have decreased, impaired driving fatalities continue to impact Idahoans.

In 2016, more than 1 in 5 driving fatalities in Idaho involved a driver's BAC of 0.15 or greater[1].

Impaired driving fatalities cost Idahoans over $846 million in 2016[2].

[1]U.S. Department of Transportation, National High Traffic Safety Administration. Traffic Safety Facts: 2016 Data.
[2]Office of Highway Safety, Idaho Transportation Department. Impaired Driving 2016.

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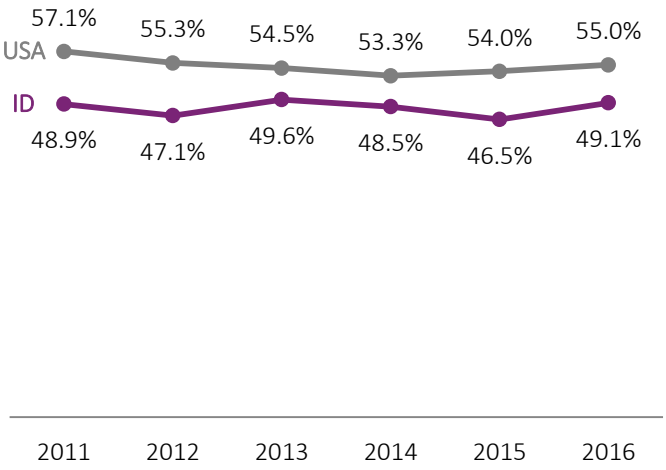
Adult and Youth Current Alcohol Use

Behavioral Risk Factor Surveillance System (BRFSS) & Youth Risk Behavior Survey (YRBS)

Current alcohol use among adults has not changed considerably between 2011 and 2016.

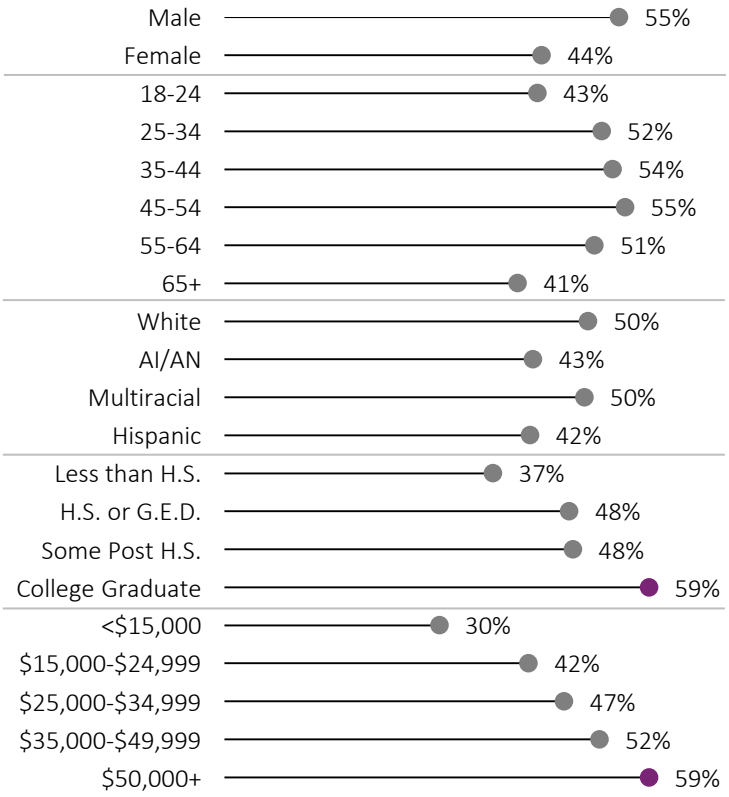


Between 2011 and 2016, the percentage of Idaho adults reporting drinking alcohol in the past 30 days was consistently below that of the United States.

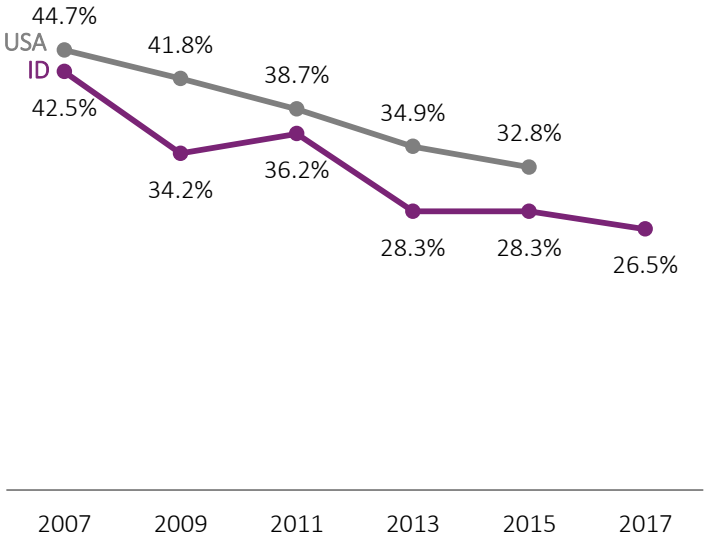
In 2016 current alcohol use was lower among those that have an annual household income below $25,000, those with less than a high school diploma, those aged 65 and older, and women. Current alcohol use was higher among college graduates and those with an annual income of $50,000 or more per year.

Between 2007 and 2017, the percentage of Idaho high school students that reported drinking alcohol in the past 30 days has significantly decreased, with the percentage in Idaho consistently lower than that of the United States. Specifically, significant decreases can be seen among males and females, White students, and students in 9th, 10th, and 12th grade.

In 2016, adults with more education and those with higher incomes were more likely to drink.



Current alcohol use has decreased by 38% among Idaho high school students from 2007 to 2017.



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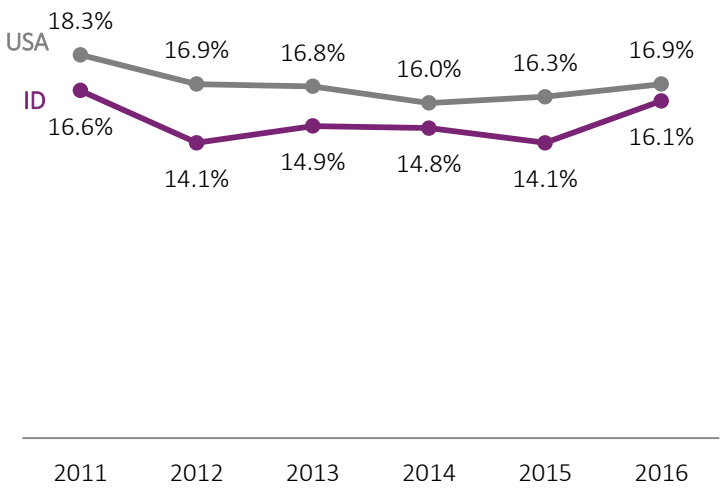
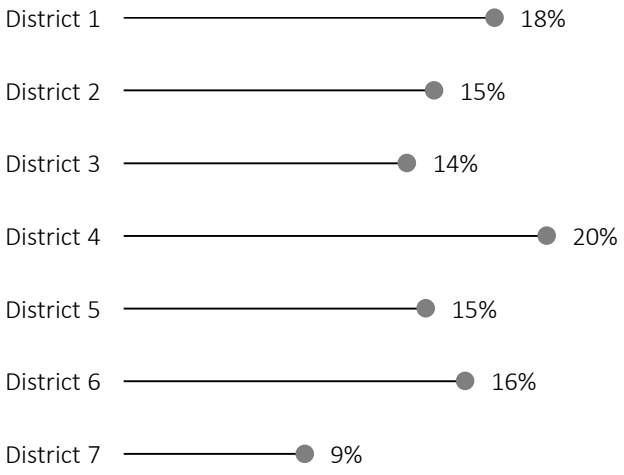
Adult Current Binge Drinking

Behavioral Risk Factor Surveillance System (BRFSS)

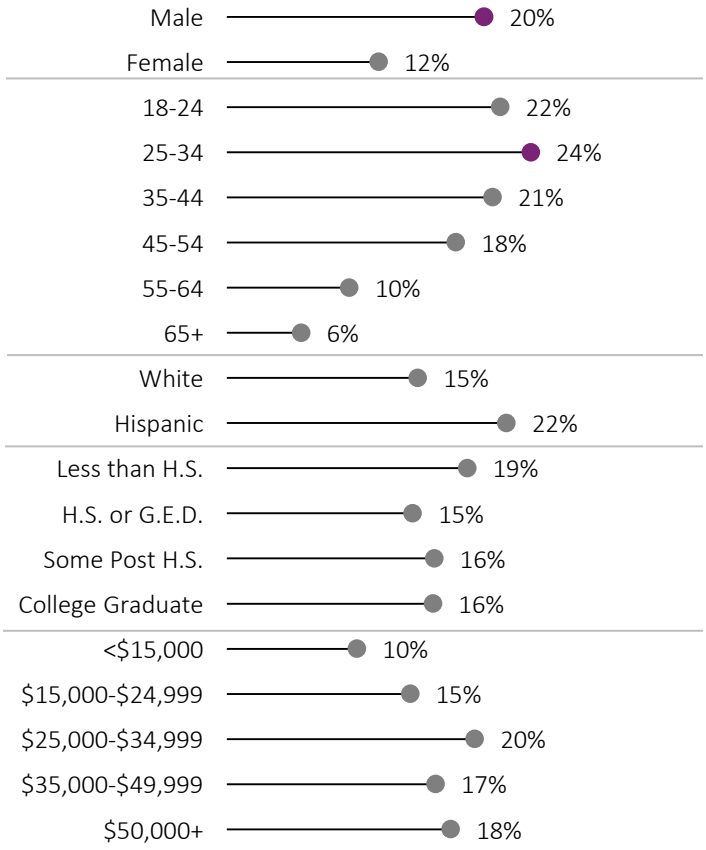
Binge drinking use has stayed consistent between 2011 and 2016.



Adults living in District 7 were significantly less likely to binge drink in 2016.



In 2016, men and those aged 25-34 were most likely to binge drink.



The BRFSS methodology uses the median, instead of the mean, to represent national estimates.

Binge drinking is defined as having four or more or five or more drinks in a row within a couple hours for females and males, respectively.

Between 2011 and 2016, the percentage of Idaho adults reporting binge drinking in the past 30 days has decreased, but not significantly, with the percentage in Idaho consistently below that of the United States.

In 2016, past 30-day binge drinking was lower among women, those 55 or older, and adults living in District 7, which includes Lemhi County, Custer County, Clark County, Jefferson County, Madison County, Bonneville County, Teton County, and Fremont County.

In 2016, past 30-day binge drinking was higher among men and adults between the ages of 25 and 34.

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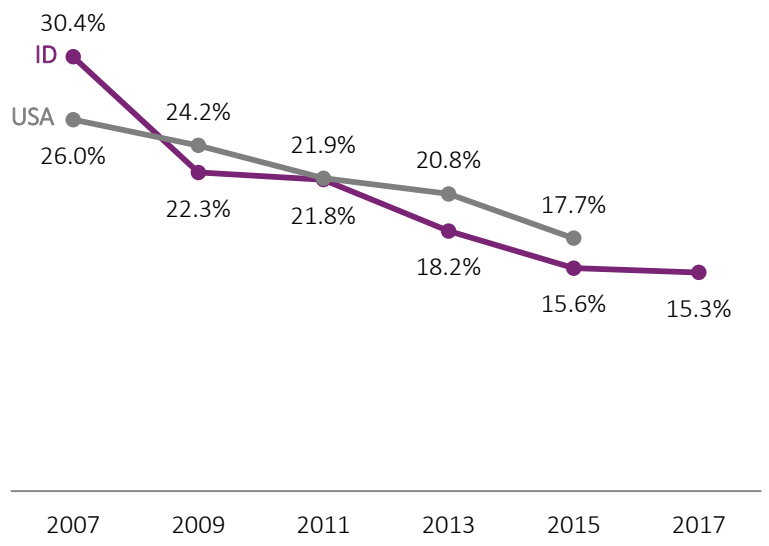
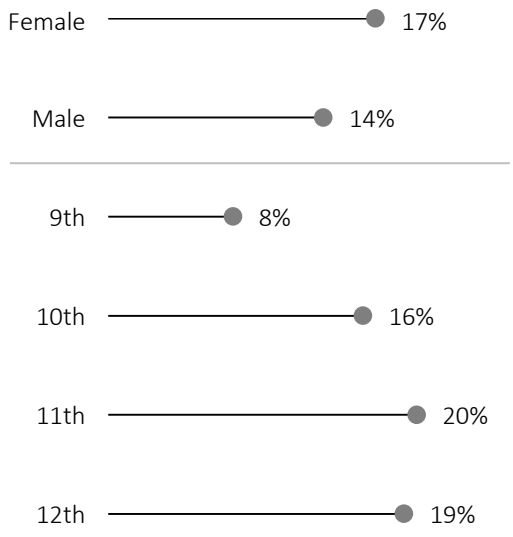
Youth Current Binge Drinking

Youth Risk Behavior Survey (YRBS)

Binge drinking among Idaho high school students decreased by 50% from 2007 to 2017.



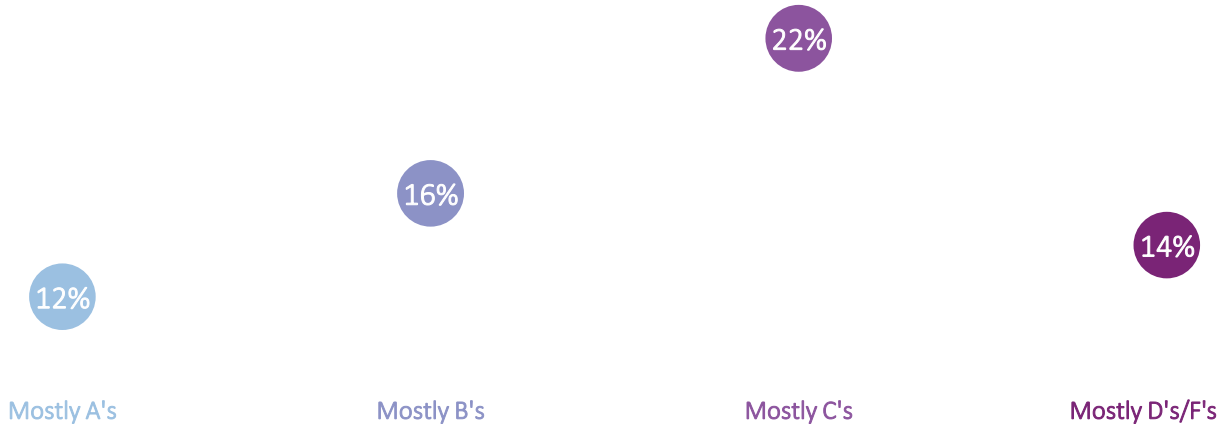
In 2017, 11th grade students were most likely to report binge drinking.



Binge drinking is defined as having four or more or five or more drinks in a row within a couple hours for females and males, respectively.

Between 2007 and 2017, the percentage of Idaho high school students that reported binge drinking in the past 30 days has significantly decreased, with the percentage in Idaho dipping below that of the United States in 2009. Significant decreases can be seen among males and females, Hispanic and White students, and students in all four grades.

According to the Idaho Department of Education's 2017 YRBS report, academic achievement is significantly associated with binge drinking. Students who earn mostly C's are most likely to binge drink.



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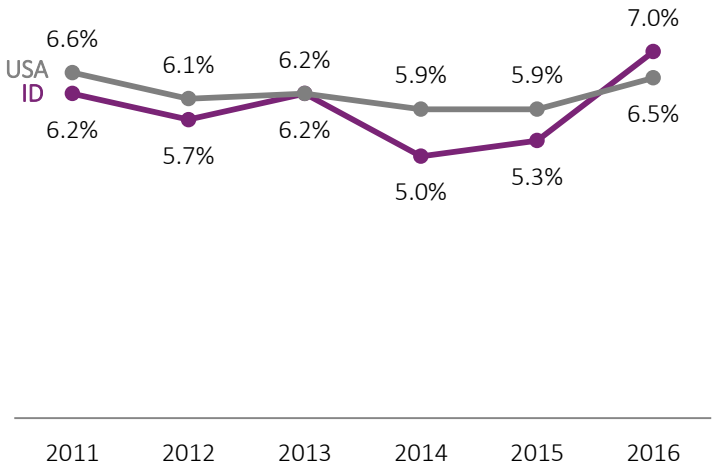
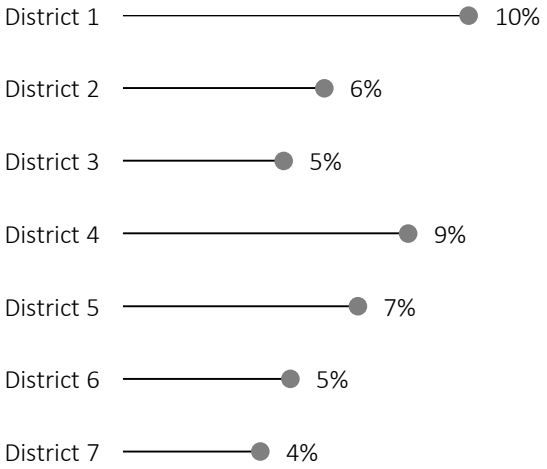
Adult Heavy Alcohol Use

Behavioral Risk Factor Surveillance System (BRFSS)

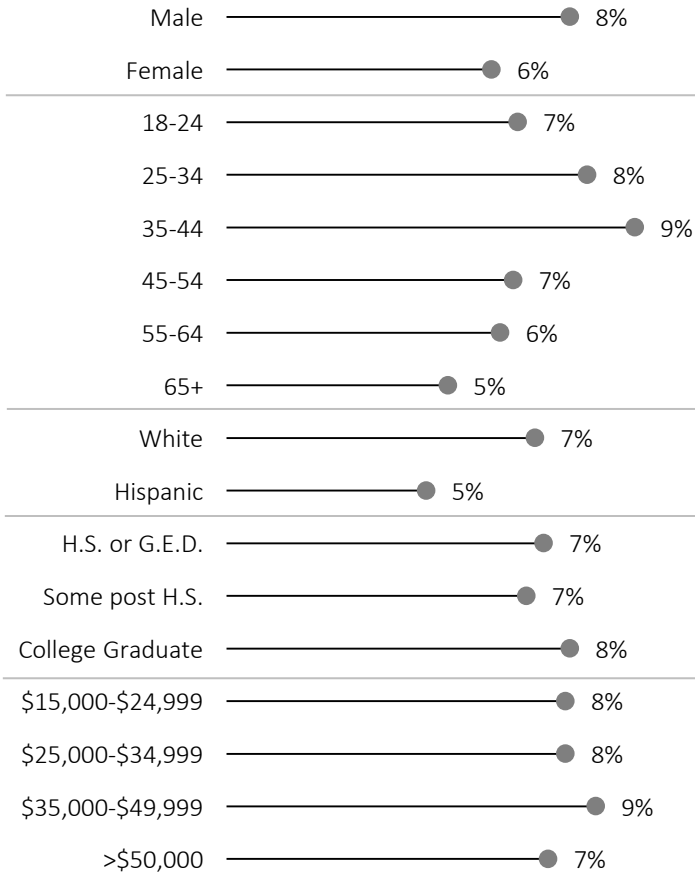
Heavy alcohol use has increased by 13% between 2011 and 2016.



In 2016, adults living in District 1 were most likely to be heavy alcohol users.



In 2016, adults aged of 35 to 44 were most likely to be heavy alcohol users.



The BRFSS methodology uses the median, instead of the mean, to represent national estimates.

Heavy drinking is defined as having 14 or more drinks per week for men or having 7 or more drinks per week for women. Prior to 2015, heavy drinking was defined as having 2 or more drinks per day for men or having 1 or more drinks per day for women.

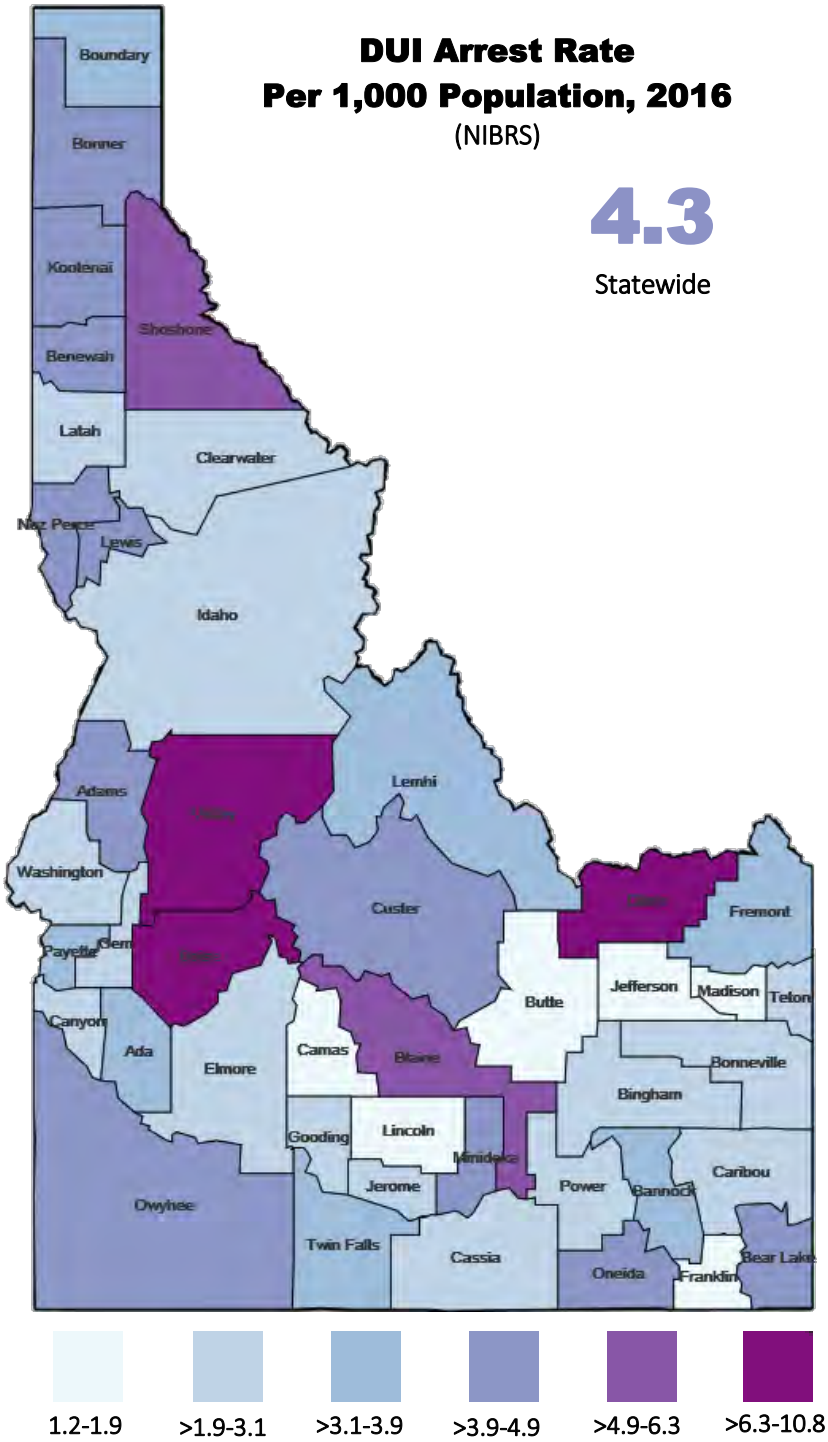
Between 2011 and 2016, the percentage of Idaho adults who met the criteria for heavy drinking increased, but not significantly, with the percentage in Idaho rising above the United States in 2016.

In 2016, there were no significant differences in heavy drinking among demographic groups. In 2016, Idaho adults between the ages of 35 and 44 were the most likely to meet the criteria for heavy drinking.

In 2016, there were no significant differences in heavy drinking among public health districts; however, Idahoans in District 1, which includes Boundary County, Bonner County, Benewah County, Shoshone County, and Kootenai County, were most likely to meet criteria for heavy alcohol use.

Driving Under the Influence Arrest Rate per 1,000 Population

National Incidence-Based Reporting System (NIBRS)



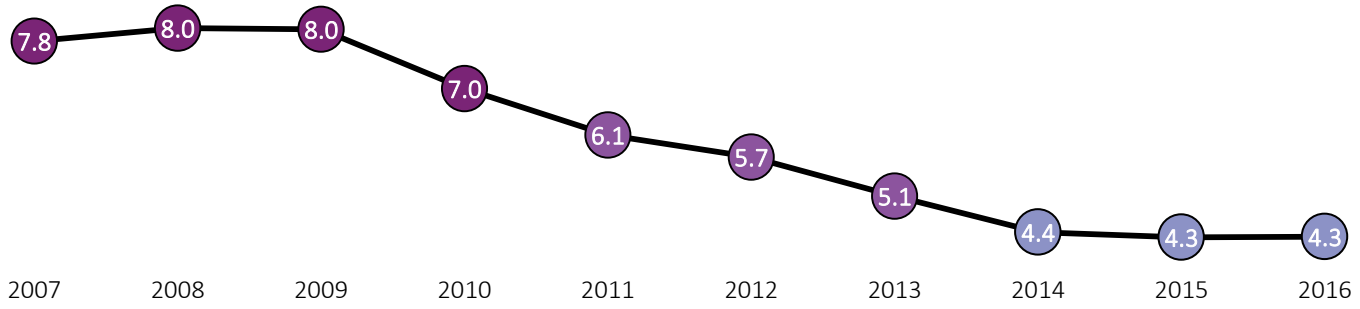
According to NIBRS in 2016, the driving under the influence (DUI) arrest rate in Idaho in 2016 was 4.33 per 1,000 population.

The counties with the highest DUI arrest rate were Valley County (10.8), Clark County (10.4), and Boise County (9.0).

The counties with the lowest DUI arrest rate were Butte County (1.2), Madison County (1.5), and Franklin County (1.5).

Valley County and Boise County had significantly higher rates of DUI arrests compared to the average county in Idaho.

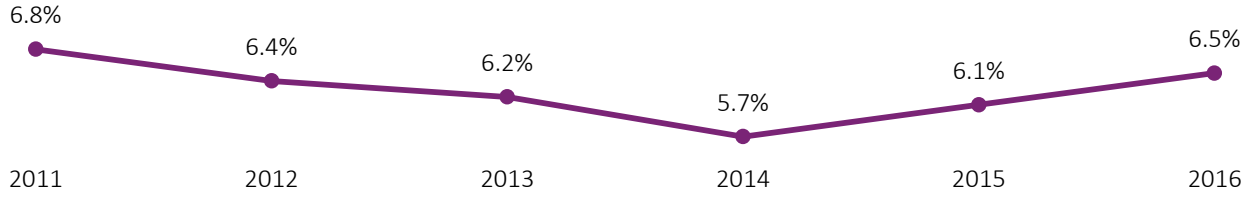
Clark County also had a significantly higher rate of DUI arrests compared to the average county in Idaho; however, due to their small population, slight increases can appear more dramatic. In 2016, Clark County had 9 DUI arrests compared 110 in Valley County and 1,624 in Ada County.

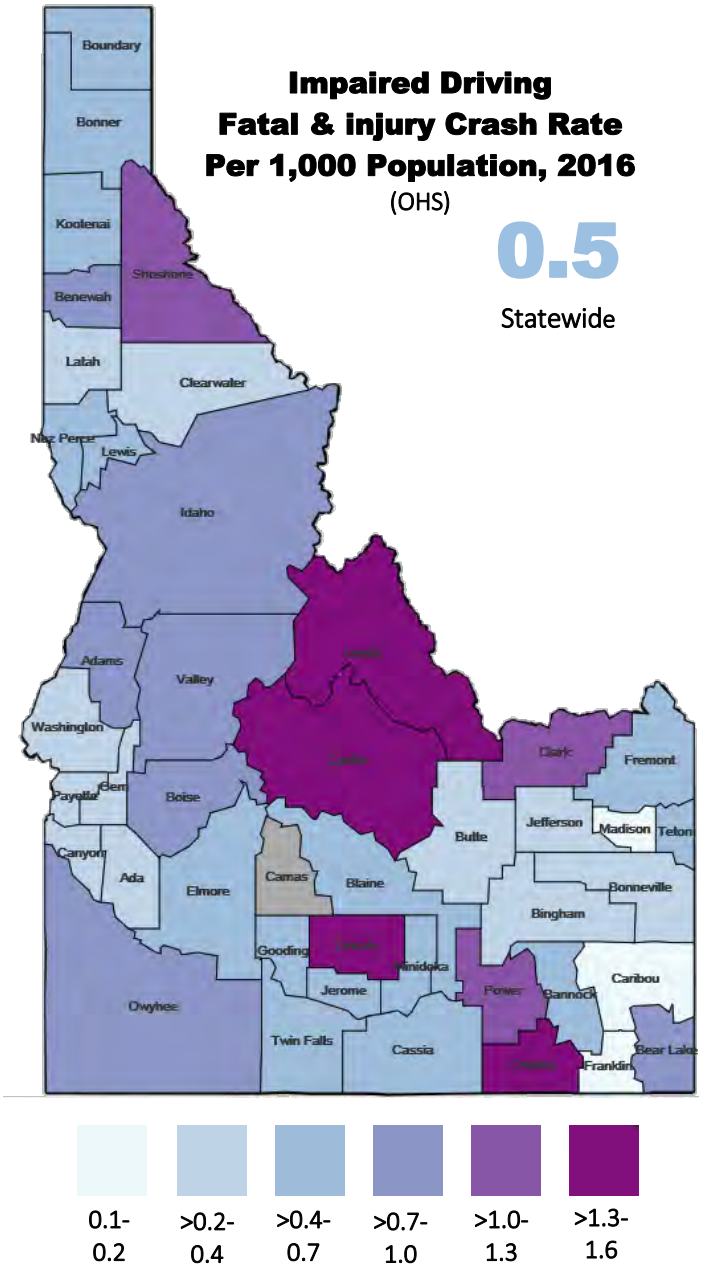


Impaired Driving Crashes

Office of Highway Safety, Idaho Transportation Department

Impaired driving crashes, as a percentage of all crashes, decreased by 4% between 2011 and 2016.





Impaired driving crashes cost Idahoans $1,035,673,537 in 2016; that's approximately $615 per Idahoan. Fatalities accounted for 82% of the cost.

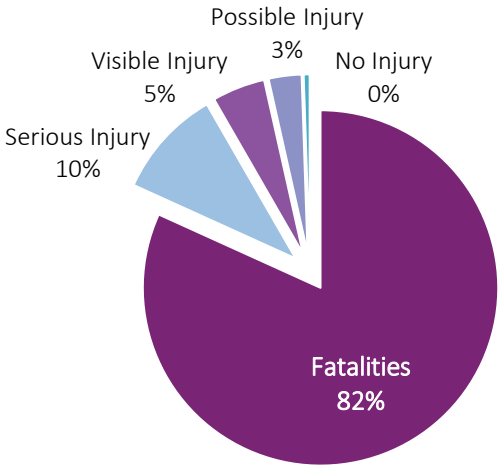
According to the Office of Highway Safety, the rate of impaired driving fatal and injury crashes per 1,000 population was 0.5 in Idaho in 2016; for every 2,000 Idaho residents, 1 person died or was injured in an impaired driving accident in 2016.

The counties with the highest impaired driving fatal and injury crash rate were Oneida County and Lemhi County (both 1.6) and Custer County and Lincoln County (both 1.5). All of these counties had significantly higher rates than the average county in Idaho.

The counties with the lowest impaired driving fatal and injury crash rate were Caribou County (0.1), Franklin County (0.2), and Payette County (0.3).

Camas County did not have any impaired driving fatalities or injuries in 2016.

Impaired driving fatalities accounted for 82% of impaired driving costs in 2016.



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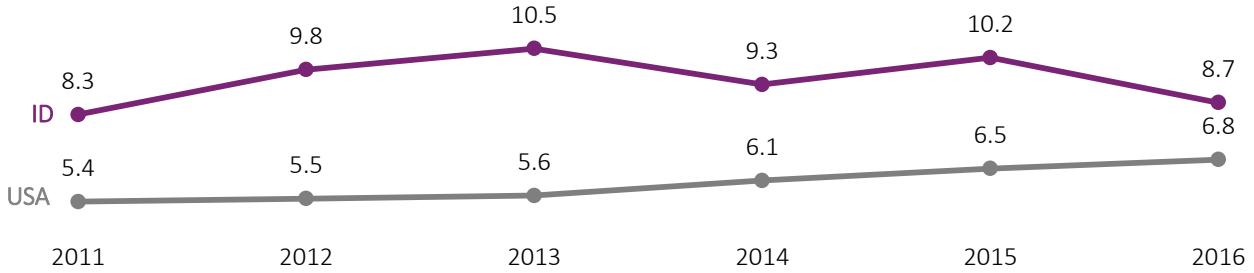
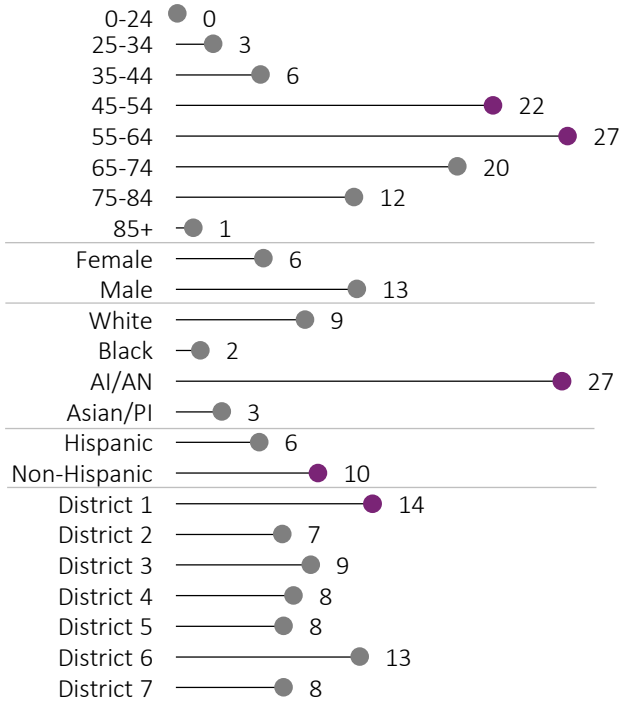
Alcoholic Liver Disease Mortality per 100,000 Population

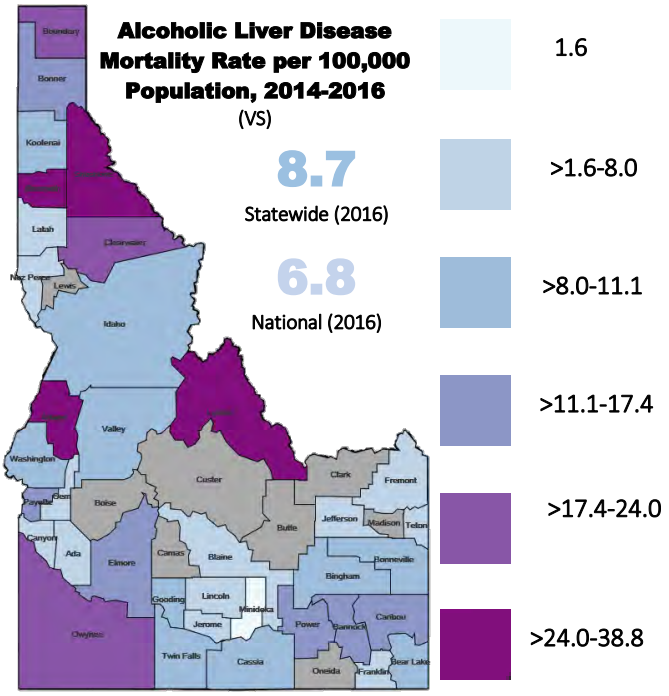
Bureau of Vital Records and Health Statistics (VS)

The crude alcoholic liver disease mortality rate in Idaho increased by 5% between 2011 and 2016.



From 2014-2016 American Indians, adults 45-64, men, non-Hispanic Idahoans, and Idahoans living in District 1, Lemhi County, Benewah County, and Shoshone County were most likely to die from alcoholic liver disease.





In 2016, the alcoholic liver disease mortality rate per 100,000 population was 6.8 nationally and 8.7 in Idaho. Between 2011 and 2016, the alcoholic liver disease mortality rate in Idaho has increased, but not significantly, with the rate in Idaho consistently higher that of the United States.

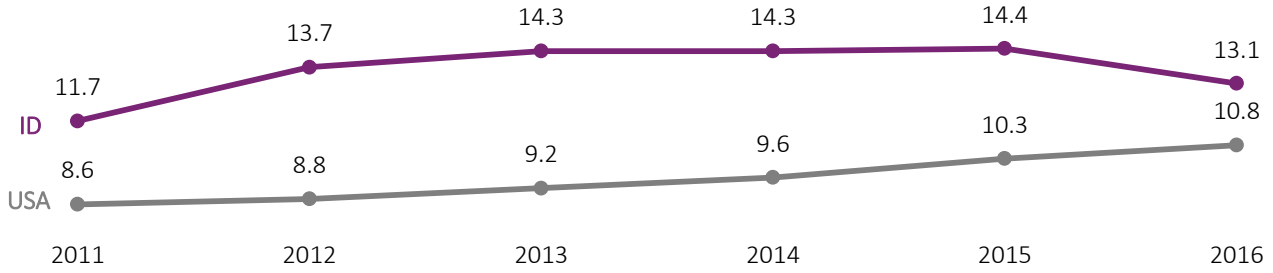
Between 2014 and 2016, the alcoholic liver disease mortality rate was significantly higher among American Indians or Alaska Natives (compared to other races), adults aged 45-64 (compared to other age groups), Idahoans living in District 1, which includes Benewah County, Bonner County, Boundary County, Kootenai County, and Shoshone County (compared to the state three-year rate), males (compared to females), and non-Hispanic (compared to Hispanic) Idahoans.

There were no alcoholic liver disease deaths in Boise County, Butte County, Camas County, Clark County, Custer County, Lewis County, Madison County, or Oneida County between 2014 and 2016. Lemhi County (38.8), Benewah County (33.0), and Shoshone County (24.1) had significantly higher alcoholic liver disease morality rates per 100,000 population compared to the state rate. Minidoka County (1.6) had a significantly lower alcoholic liver disease mortality rate per 100,000 population when compared to the state rate.

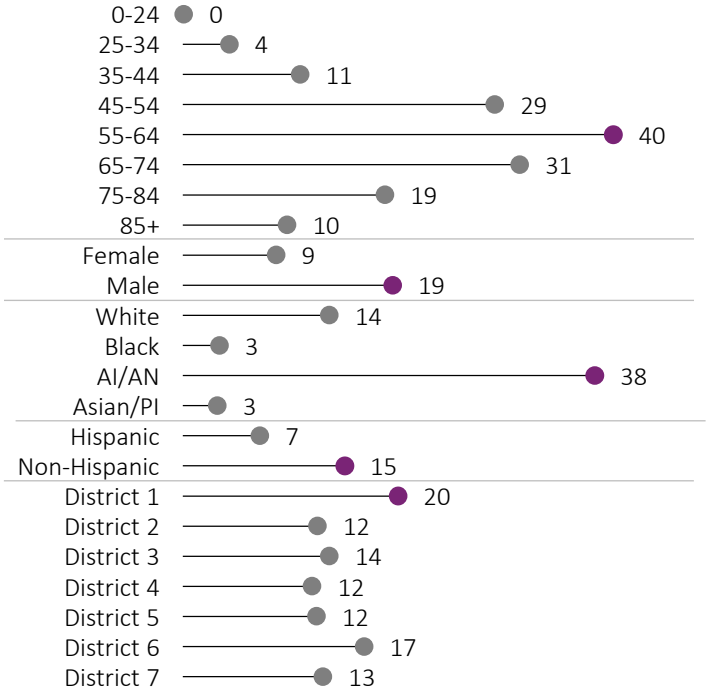
Alcohol-Induced Mortality Rate per 100,000 Population

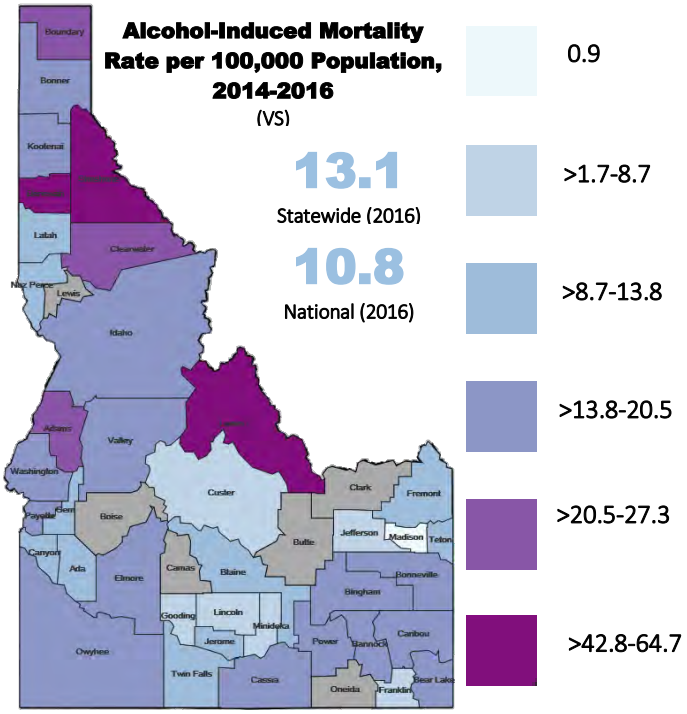
Bureau of Vital Records and Health Statistics (VS)

The crude alcohol-induced mortality rate in Idaho increased by 12% between 2011 and 2016.



From 2014-2016 American Indians, adults 45-54, men, non-Hispanic Idahoans, and Idahoans living in District 1, Lemhi County, Benewah County, and Shoshone County were most likely to die from alcohol directly.





In 2016, the alcohol-induced mortality rate per 100,000 population was 10.8 nationally in 2015 and 13.1 in Idaho. Between 2011 and 2016, the alcohol-induced mortality rate in Idaho has increased, but not significantly, with the rate in Idaho consistently higher that of the United States.

Between 2014 and 2016, the alcohol-induced mortality rate was significantly higher among adults between the ages of 55 and 64 (compared to other age groups), American Indians or Alaska Natives (compared to other races), and Idahoans living in District 1, which includes Benewah County, Bonner County, Boundary County, Kootenai County, and Shoshone County (compared to the state three-year rate), males (compared to females), and non-Hispanic (compared to Hispanic) Idahoans.

There were no alcohol-induced deaths in Boise County, Butte County, Clark County, Camas County, Lewis County, or Oneida County between 2014 and 2016. Lemhi County (64.7), Benewah County (51.4), and Shoshone County (42.9) had significantly higher alcohol-induced morality rates per 100,000 population compared to the state rate. Madison County (0.9) had a significantly lower alcohol-induced mortality rate per 100,000 population when compared to the state rate.

Marijuana

Consumption

According to the NSDUH, in 2015/2016, among all 50 states and D.C. Idaho ranked 37th, 40th, 44th, and 32th among individuals 12 and older, 12 to 17, 18 to 25, and 26 and older, respectively, for marijuana use in the past month. These rankings are up from 44th, 42nd, 47th, and 39th among individuals 12 and older, 12 to 17, 18 to 25, and 26 and older, respectively, in 2011/2012 (before Idaho received the SPF SIG grant).

According to the NSDUH, past month marijuana use has increased in every state between 2008 and 2016, except Hawaii. Significant increases have been seen nationwide, in each Census Bureau region, in the District of Columbia, and in every state except, Alabama, Arizona, Arkansas, Hawaii, Idaho, Nevada, North Dakota, Oklahoma, South Carolina, and Wyoming.

According the BRFSS between 2015 and 2016, 5.5% of Idaho adults reported using marijuana in the past 30 days prior to the survey. Characteristics of Idahoans who were more likely to report past month marijuana use include:

- HEAVY DRINKERS (20%), those AT RISK FOR BINGE DRINKING (18%), and SMOKERS (18%)
- UNMARRIED COUPLES (18%) and those who were NEVER MARRIED (12%)
- Idahoans with POOR MENTAL HEALTH (15%) or DEPRESSIVE DISORDER (12%)
- 18-34 Idahoans aged 18 to 24 (13%) or 25 to 34 (9%)
- Idahoans who are UNEMPLOYED (13%)
- Idahoans who DID NOT RECEIVE MEDICAL CARE WHEN NEEDED DUE TO COST (11%), those who DID NOT HAVE AN ANNUAL CHECKUP (8%), and those with NO USUAL HEALTH CARE PROVIDER (8%)
- Idahoans who make $15,000 OR LESS PER YEAR (11%)
- 1 Residents of DISTRICT 1 (8%) compared to those in Region 7 (4%)
- MEN (7%) compared to women (4%)

According to the YRBS, past month marijuana use has decreased among Idaho high school students, but not significantly.

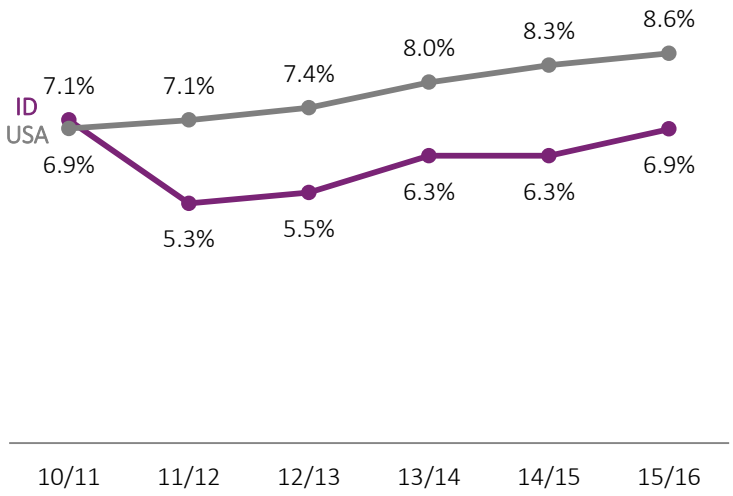
Consequence

According to WITS, the proportion of publically funded treatment admission in which the primary substance of abuse was marijuana decreased between 2014 and 2016.

According the NIBRS, between 2007 and 2016, marijuana-related arrests have increased by 26%.

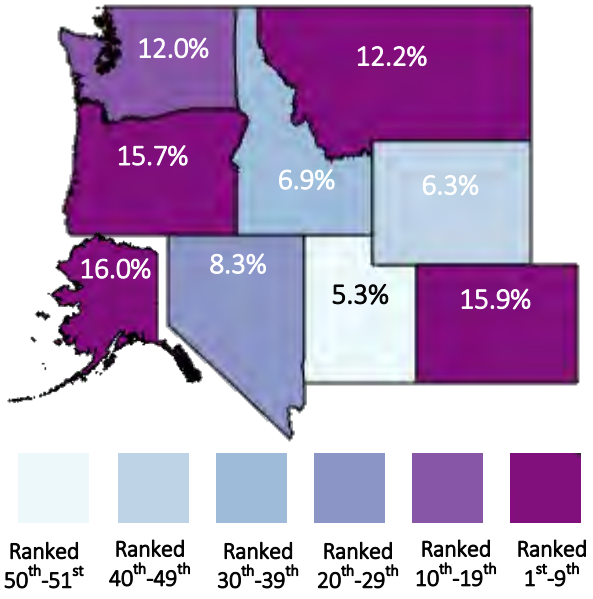
Icons were downloaded from Flaticon from Freepik. The doctor icon was created by Vectors Market.

Current marijuana use was the same in 2015/2016 as it was in 2010/2011.



Past month marijuana use among Idahoans aged 18 to 25 was over 2 times higher than use among Idahoans aged 12 to 17. Idahoans aged 12 to 17 were the least likely to report using marijuana in the past 30 days.

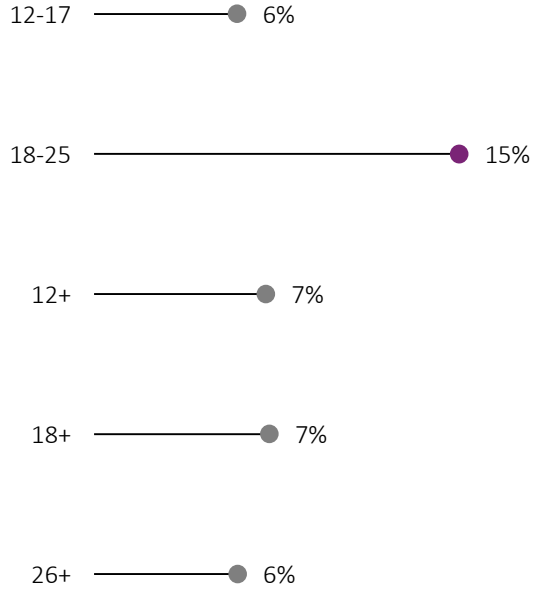
In 2015/2016, the top 19 states with the highest percentage of past month marijuana use have legalized marijuana.



Since 2008, the percentage of Idahoans reporting using marijuana in the past month has increased, especially among individuals 26 or older and 18 or older. Conversely, the percentage of those aged 12-17 reporting marijuana use has decreased.

Between 2011 and 2016, the percentage of individuals 12 and older reporting using marijuana in the past month has increased, with the percentage in Idaho dipping below that of the United States in 2011.

In 2015/2016, current marijuana use was higher among Idahoans aged 18 to 25.



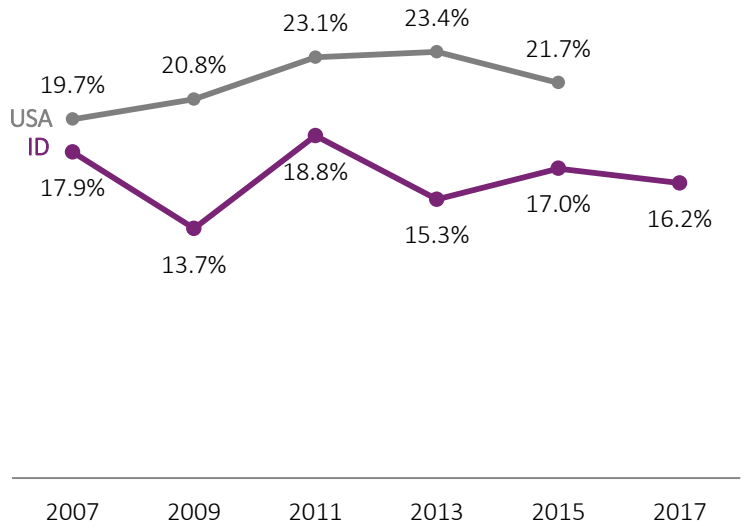
In 2015/2016, Idaho ranked 37th in the nation for past month marijuana use among individuals 12 and older.

The median percentage of individuals reporting past month marijuana use in retail marijuana, medical marijuana, and illegal marijuana states is 14%, 9%, and 7%, respectively. In regard to Idaho's border states, as of 2016, Colorado, Washington, Alaska, and Oregon have legal retail marijuana and Montana and Nevada have legal medical marijuana.

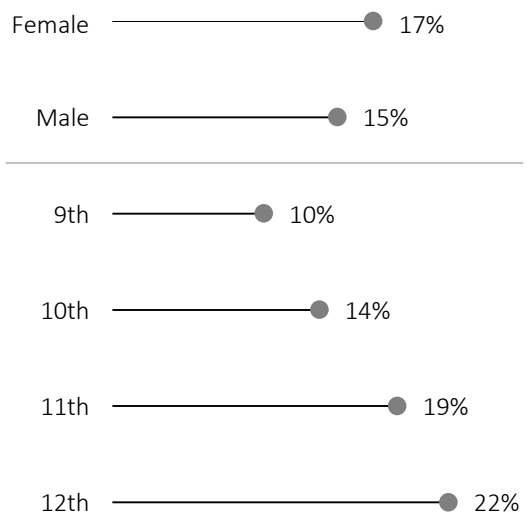
Youth Current Marijuana Use

Youth Risk Behavior Survey (YRBS)

Current marijuana use among Idaho high school students has decreased by 9% since 2007.

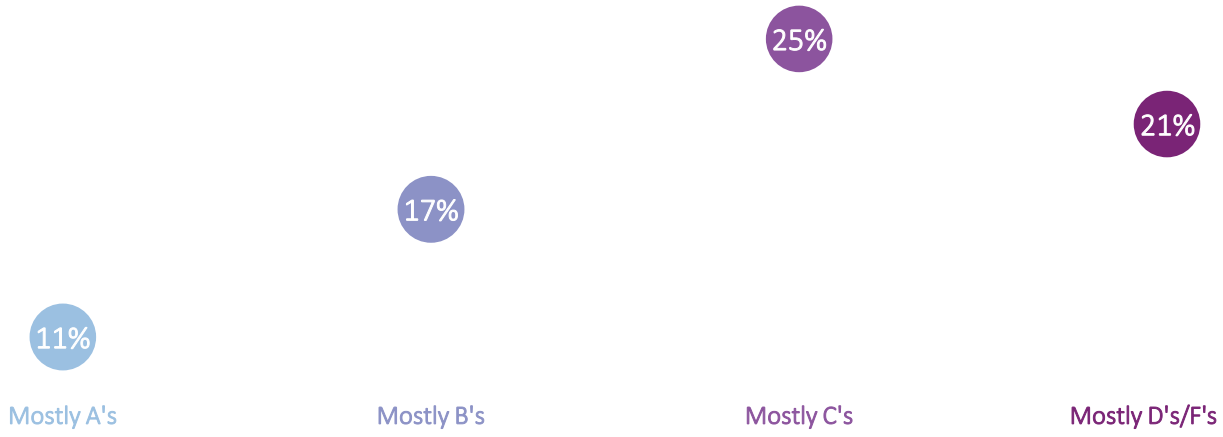


In 2017, 12th grade students were most likely to report marijuana use.



Between 2007 and 2017, the percentage of Idaho high school students that reported using marijuana in the past 30 days decreased, but not significantly, with the percentage in Idaho consistently below that of the United States. Students in 12th grade were most likely to report past 30 day marijuana use in 2017.

According to the Idaho Department of Education's 2017 YRBS report, academic achievement is significantly associated with past 30 day marijuana use. Students who earn mostly C's are most likely to report using marijuana in the past 30 days.



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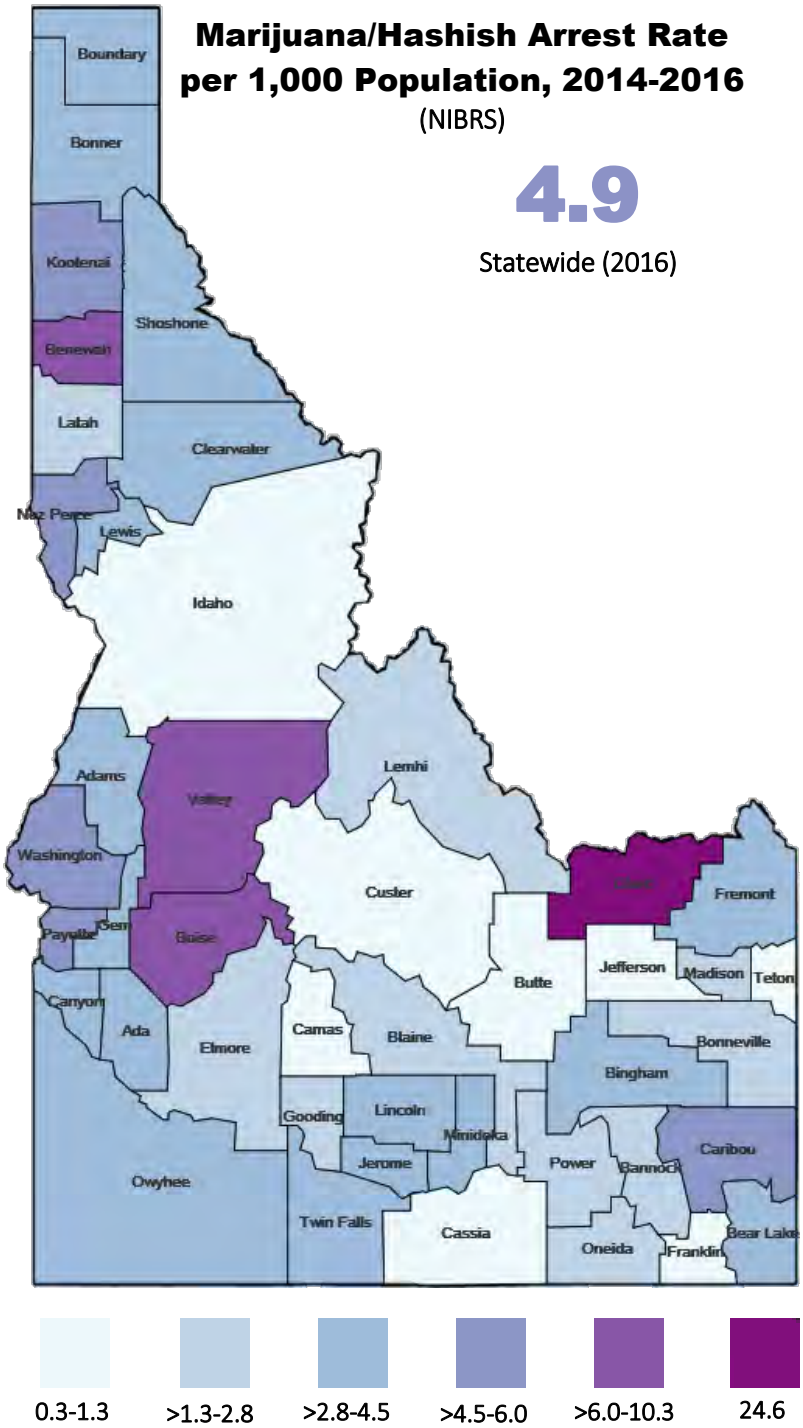
Marijuana Arrest Rate per 1,000 Population

National Incidence-Based Reporting System (NIBRS)



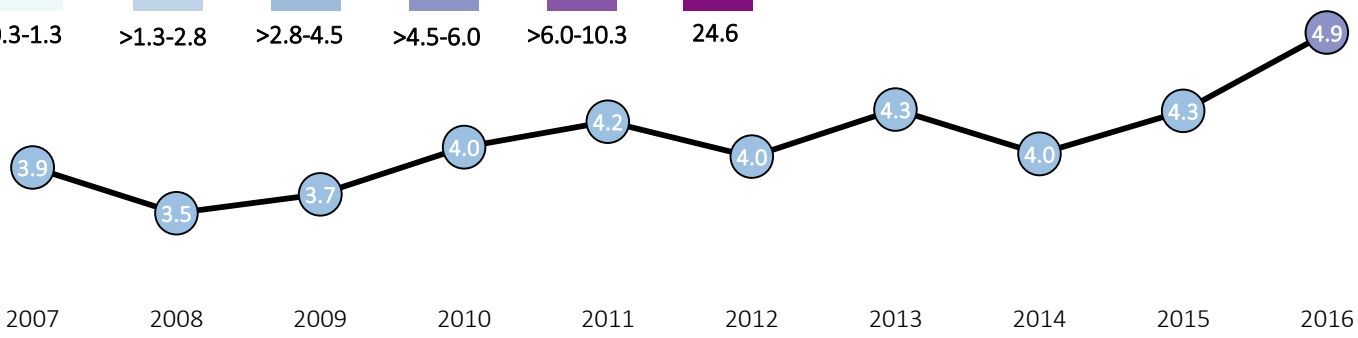
Marijuana arrests include all illicit possession, concealing, transporting, transmitting, and importing activities. Between 2007 and 2016, the total marijuana arrest rate increased by 26%.

In 2016 the marijuana/hashish arrest rate in Idaho was 4.87 per 1,000 population.

The counties with the highest marijuana arrest rate were Clark County (24.6), Boise County (10.3), and Valley County (9.2).

The counties with the lowest marijuana arrest rate were Butte County (0.3), Idaho County (0.3), and Custer County (0.6).

Clark County had a significantly higher rate of marijuana arrests compared to the average county in Idaho; however, due to their small population, slight increases can appear more dramatic. Between 2014 and 2016, Clark County had 63 marijuana arrests compared 204 in Boise County and 4,802 in Ada County.



Other Drugs

Consumption

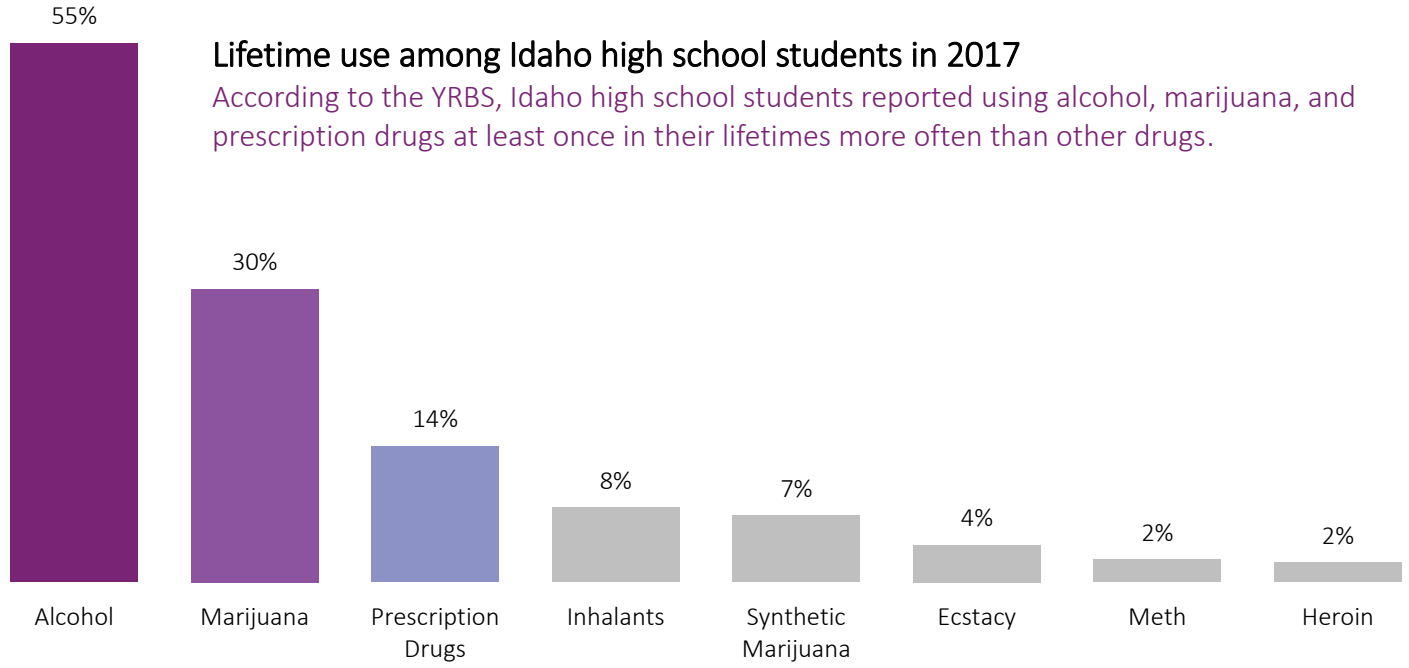
According to the NSDUH, in 2015/2016, among all 50 states and D.C., Idaho ranked 28th, 15th, 28th, and 30th among individuals 12 and older, 12 to 17, 18 to 25, and 26 and older, respectively, for illicit drug use other than marijuana in the past month. This item on the NSDUH was revised in 2016, so estimates cannot be reliably compared to previous years. Among Idahoans 12 and older, 9% reported any illicit drug use in the past month, and 3.3% reported any illicit drug use in the past month other than marijuana.

Consequence

According to the NSDUH (2015/2016), similar to the national average, 7.6% of Idahoans 12 and older had a substance use disorder in the past year. Idahoans 18-25 were most likely to have a substance use disorder in the past year (14.2%). Approximately 2.6% of Idahoans needed but did not receive treatment at a specialty facility for illicit drug use in the past year.

According to WITS, more than one-third of publically funded treatment admissions were for methamphetamine.

Both drug/narcotic violation arrest rates and drug-induced death rates have increased.



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Past Month Illicit Drug Use & Illicit Drug Use Other than Marijuana

National Survey on Drug Use and Health (NSDUH)

Illicit drug use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

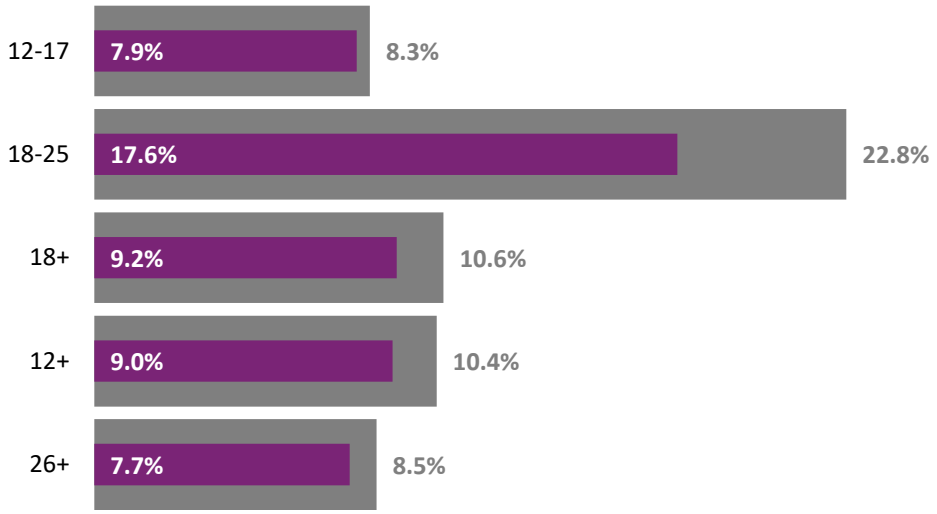
In 2015/2016, 9% of Idahoans reported using illicit drugs in the past month, compared to 10.4% nationally.

Over 3.3% of Idahoans reported using illicit drugs other than marijuana in the past month, compared to 3.4% nationally.

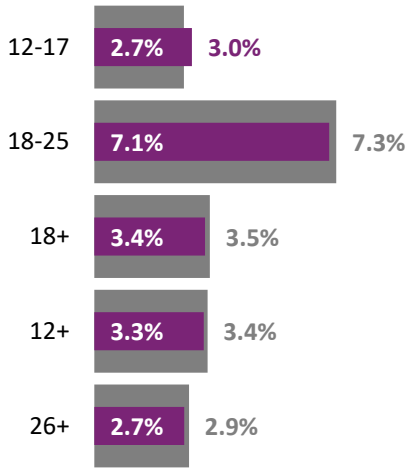
Although illicit drug use appears to be lower in Idaho than the national average, the difference is not significant.

Both nationally and in Idaho, those aged 18-25 were most likely to use illicit drugs.

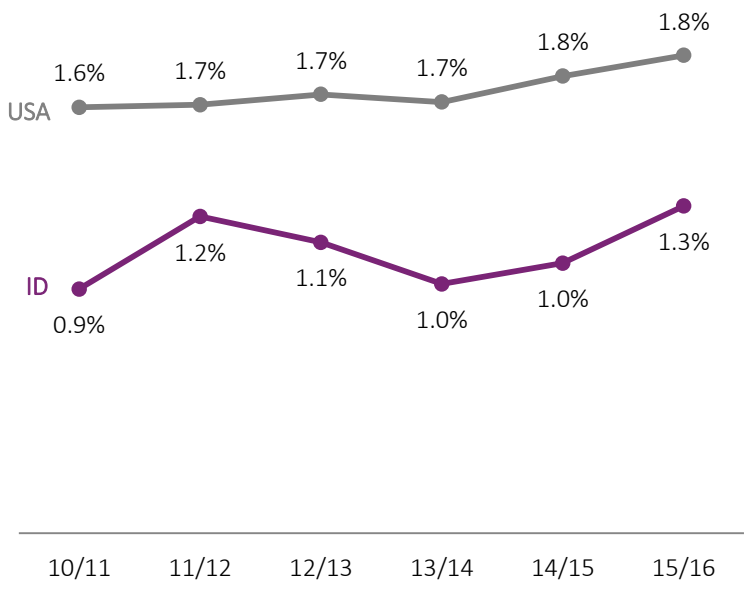
Past month illicit drug use is 13% lower in Idaho than the national average.



Past month illicit drug use other than marijuana in Idaho is 3% lower than national average.



Cocaine use increased by 44% among Idahoans between 2010 and 2016.



Since 2008, the percentage of Idahoans reporting using cocaine in the past year has not changed significantly. However, between 2013 and 2015, cocaine use in the past year increased significantly in Alaska, Delaware, Hawaii, Maine, Michigan, Minnesota, Missouri, Montana, New Hampshire, North Carolina, Rhode Island, South Carolina, Tennessee, Vermont, and West Virginia.

Between 2010 and 2015, the percentage of individuals 12 and older reporting cocaine use in the past year has increased, with the percentage in Idaho consistently below that of the United States.

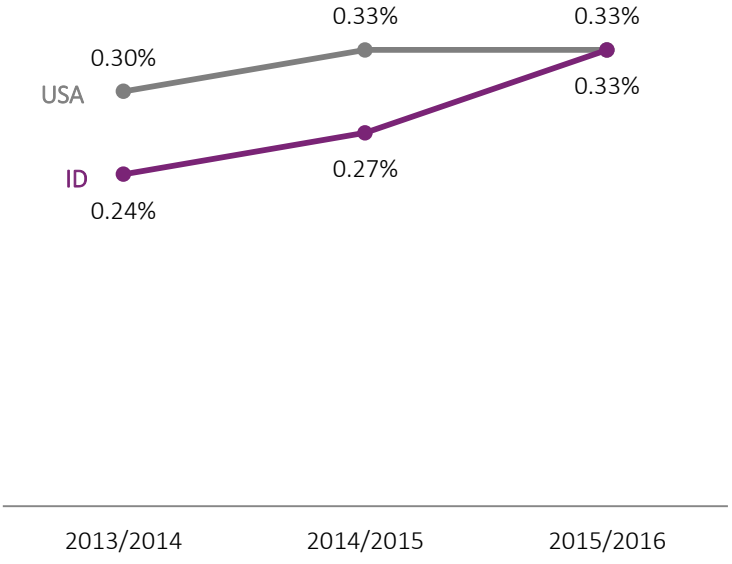
In 2015, Idaho ranked 48th in the nation for past year cocaine use among individuals 12 and older.

Since 2013, the percentage of Idahoans reporting using heroin in the past year has not changed significantly. However, heroin use has significantly increased in Alaska, Arizona, Colorado, Connecticut, Hawaii, Maryland, Minnesota, Nevada, New Jersey, New York, Rhode Island, South Dakota, Vermont, and West Virginia.

Between 2013 and 2015, the percentage of individuals 12 and older reporting heroin use in the past year has increased but not significantly.

In 2015, Idaho ranked 29th in the nation for past year heroin use among individuals 12 and older.

Heroin use increased by 38% among Idahoans between 2013 and 2016.



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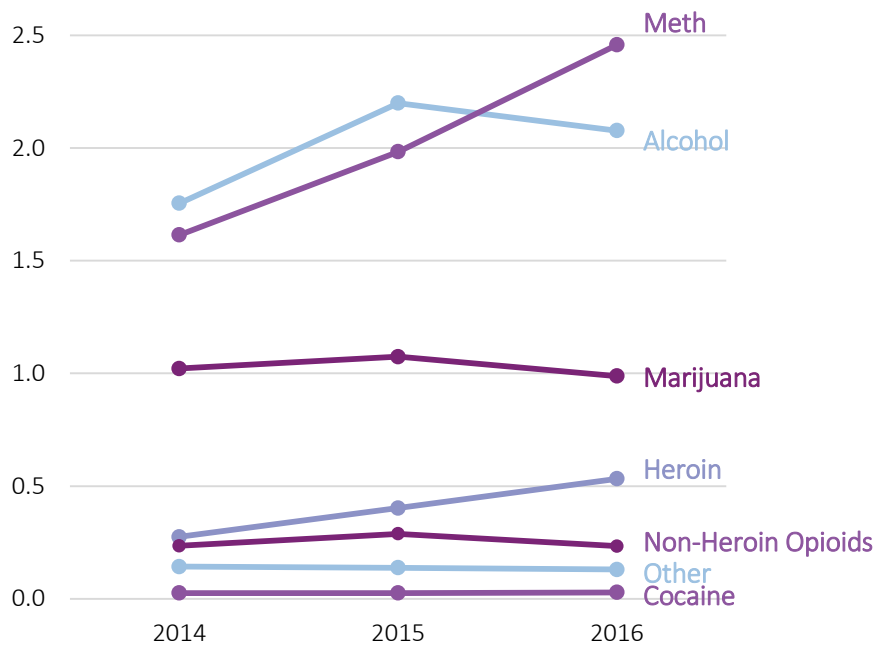
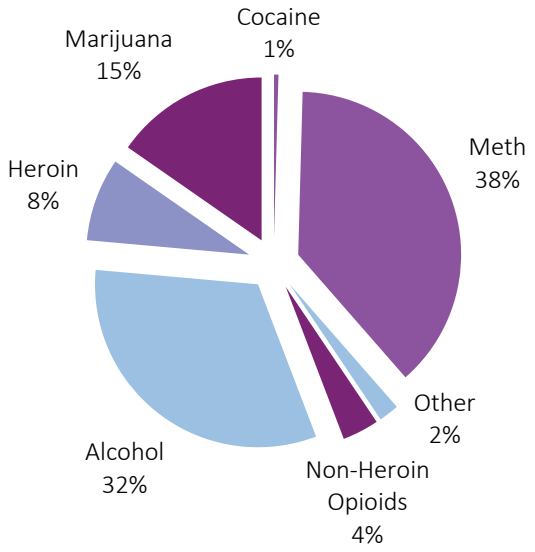
Rate of Primary Treatment Admissions per 1,000 Population

Web Infrastructure for Treatment Services (WITS)

Between 2014 and 2016, treatment admission rates have increased the most for methamphetamine.



Methamphetamine accounted for 38% of publically funded treatment admissions in 2016.



Data from WITS are based on admission records for individuals entering publically funded Substance Use Disorder Treatment. This data includes individuals that received funding for Substance Use Disorder Treatment through Idaho Department of Health and Welfare, Idaho Department of Correction, Idaho Department of Juvenile Correction, and Idaho Supreme Court.

WITS data do not include all substance abuse treatment admissions in Idaho.

Methamphetamine is the most often reported primary substance of abuse upon treatment entry, followed by alcohol. The rate of treatment admissions in which meth is the primary substance of abuse increased by 52% between 2014 and 2016. Approximately 38% of all publically funded treatment admissions are for individuals reporting meth as their primary substance.

In 2014, the rates of publically funded treatment admissions per 1,000 population for heroin and opioid pain relievers were similar, but recently, admissions for heroin are increasing, while admissions for other opioids are decreasing.

Other drugs include barbiturates, benzodiazepines, other sedatives or hypnotics, other stimulants, other tranquilizers, club drugs, hallucinogens, inhalants, nicotine, other amphetamines, over-the-counter medications, phencyclidine, and other drugs.

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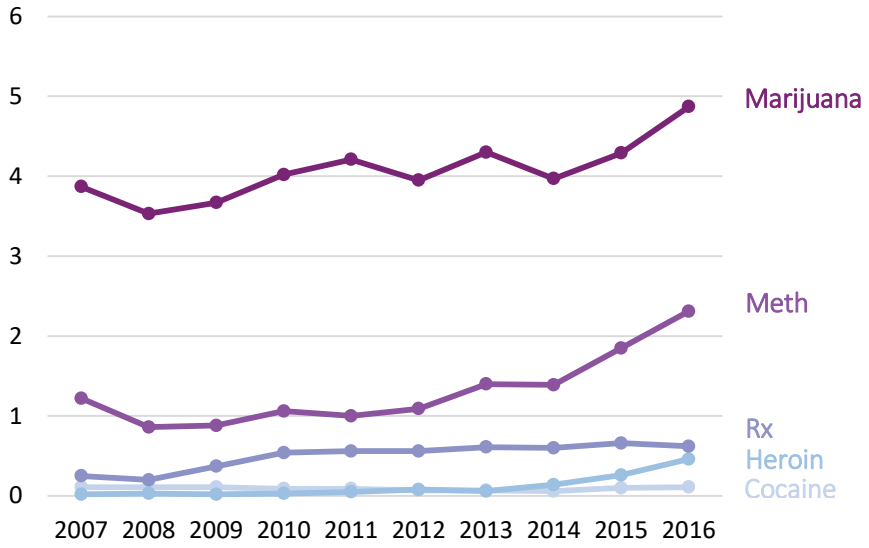
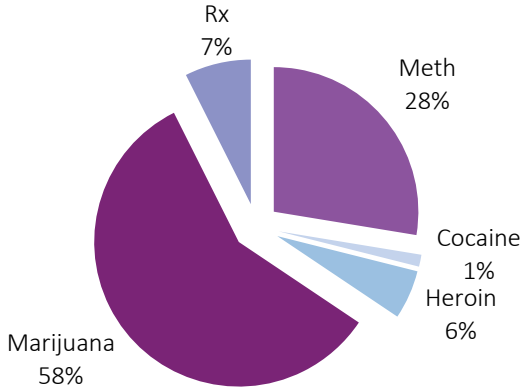
Other Drug Arrest Rate per 1,000 Population

National Incidence-Based Reporting System (NIBRS)

Between 2007 and 2016, drug arrest rates have increased for all selected drugs except cocaine.



(Meth)amphetamine accounted for 28% of drug/narcotic violation arrests in 2016.



Drug/narcotic violations include the unlawful cultivation, manufacture, distribution, sale, purchase, use, possession, transportation, or importation of any controlled drug or narcotic substance. Between 2007 and 2015, the total drug/narcotic arrest rate increased by 39% in Idaho.

The largest percent increases in drug narcotic violations were for heroin and prescription drugs which increased by 23-fold and over 2-fold, respectively. Drug/narcotic violations increased 89% for amphetamine/methamphetamine and 26% for marijuana.

Although marijuana accounts for the highest proportion of drug/narcotic arrests, more than 23 times as many people have used marijuana as meth in the past year. Approximately 12% of Idahoans reported using marijuana compared to 0.5% that reported using meth in the past year.

In 2007, marijuana represented 71% of all drug/narcotic violations, amphetamine/methamphetamine, 22%, and prescription drugs, 4%.

Drug/Narcotic Violation Arrest Rate per 1,000 and Number by Top Three Counties

	Highest Rate			2nd Highest Rate			3rd Highest Rate		
	Name	Rate	Number	Name	Rate	Number	Name	Rate	Number
Marijuana	Clark	21.9	19	Boise	12.8	91	Valley	10.2	104
(Meth)amphetamines	Clark	6.9	6	Payette	4.2	97	Bingham	4.1	185
Prescription Drugs	Clark	8.1	7	Bear Lake	2.0	12	Shoshone	1.6	20
Heroin	Clark	3.5	3	Bannock	1.0	85	Kootenai	0.88	135
Cocaine/Crack	Clark	2.3	2	Minidoka	0.3	7	Payette	0.2	5

Although Clark County has the highest rate of drug/narcotic violations, the number of violations is relatively small.

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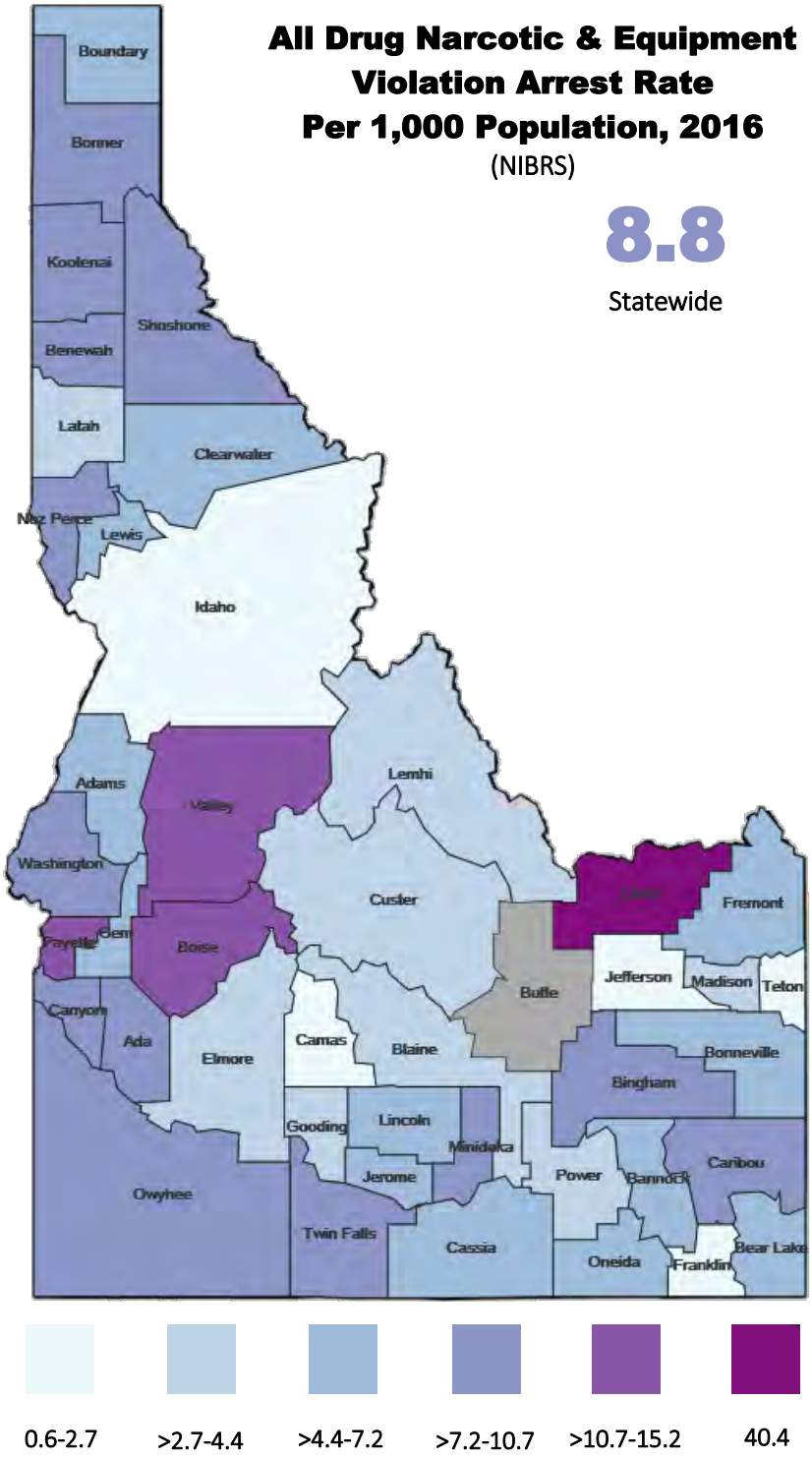
Drug Narcotic & Equipment Violation Arrest Rate per 1,000 Population

National Incidence-Based Reporting System (NIBRS)



Drug narcotic violations and drug equipment violations include the unlawful cultivation, manufacture, distribution, sale, purchase, use, possession, transportation, or importation of any controlled drug or narcotic substance. Specifically, drug equipment violations include cases involving drug paraphernalia, equipment, chemicals, illegal labs, etc. Various statutes and/or codes may vary in the description of equipment or paraphernalia involved with drugs/narcotics.

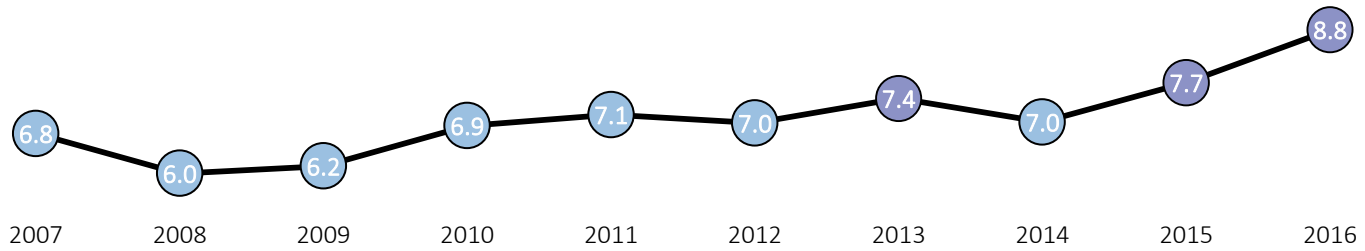
According to the 2016 NIBRS, the drug narcotic and equipment violation (DNEV) arrest rate in Idaho was 8.8 per 1,000 population.

The counties with the highest rate of all DNEV arrests were Clark County (40.4), Boise County (15.2), and Valley County (15.0).

The counties with the lowest rate of all DNEV arrests were Idaho County (0.6), Camas County (0.9), and Jefferson County (1.7).

Butte County did not have any DNEV arrests in 2016.

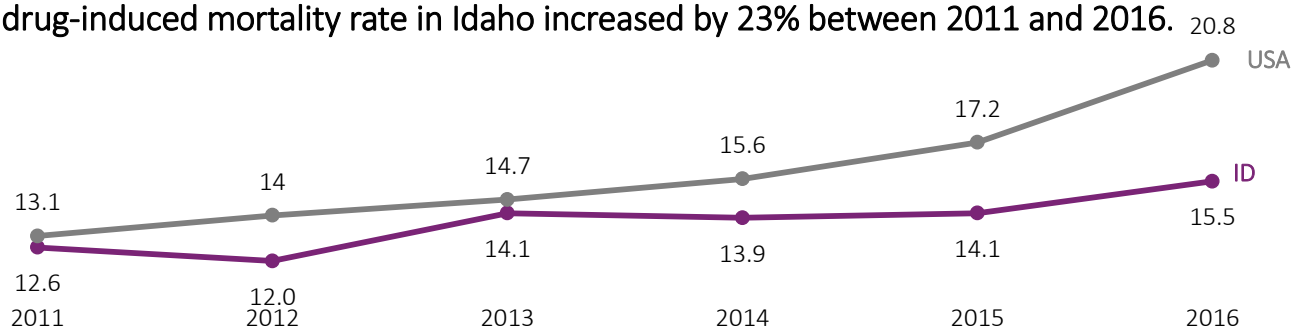
Clark County had a significantly higher rate of DNEV arrests compared to the average county in Idaho; however, due to their small population, slight increases can appear more dramatic. In 2016, Clark County had 35 DNEV arrests compared 108 in Boise County and 3,313 in Ada County.



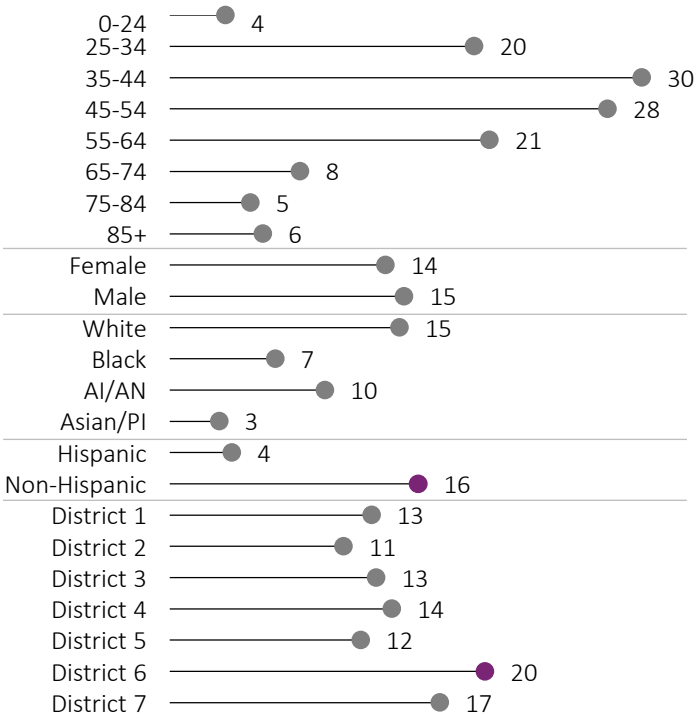
Drug-Induced Mortality per 100,000 Population

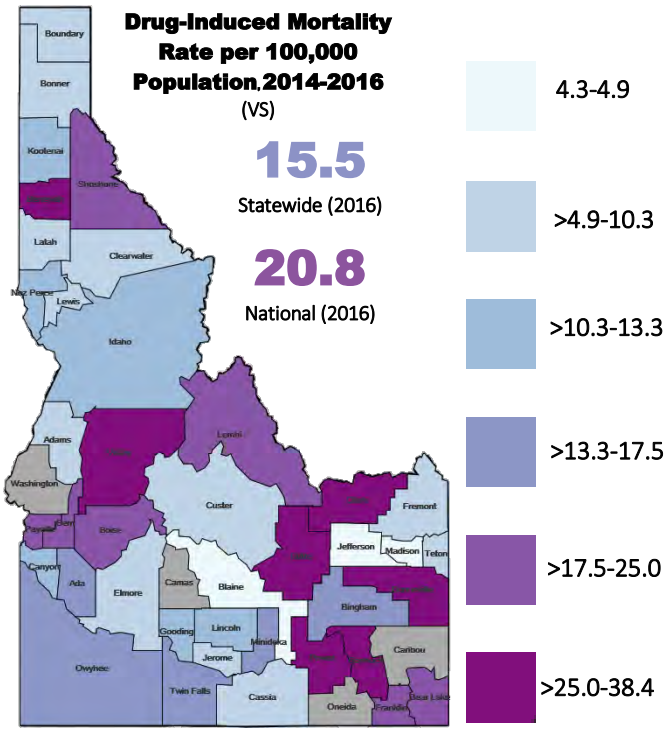
Bureau of Vital Records and Health Statistics (VS)

The drug-induced mortality rate in Idaho increased by 23% between 2011 and 2016.



Between 2014 and 2016, non-Hispanic Idahoans and those living in District 6, Bonneville County and Bannock County were more likely to die from drugs.





In 2016, the drug-induced mortality rate per 100,000 population was 20.8 nationally and 15.5 in Idaho. Between 2007 and 2016, the drug-induced mortality rate in Idaho has increased significantly, with the rate in Idaho consistently lower that of the United States.

Between 2014 and 2016, the drug-induced mortality rate was significantly higher among non-Hispanic (compared to Hispanic) Idahoans and those living in District 6 (compared to the state rate), which includes Butte County, Bingham County, Power County, Bannock County, Caribou County, Oneida County, Franklin County and Bear Lake County.

There were no drug-induced deaths in Washington County, Camas County, Oneida County, or Caribou County between 2014 and 2016. Bonneville County (26.6) and Bannock County (25.5) had significantly higher drug-induced morality rates per 100,000 population compared to the state rate. Madison County (4.3) and Jefferson County (4.9) had a significantly lower drug-induced mortality rates per 100,000 population when compared to the state rate.

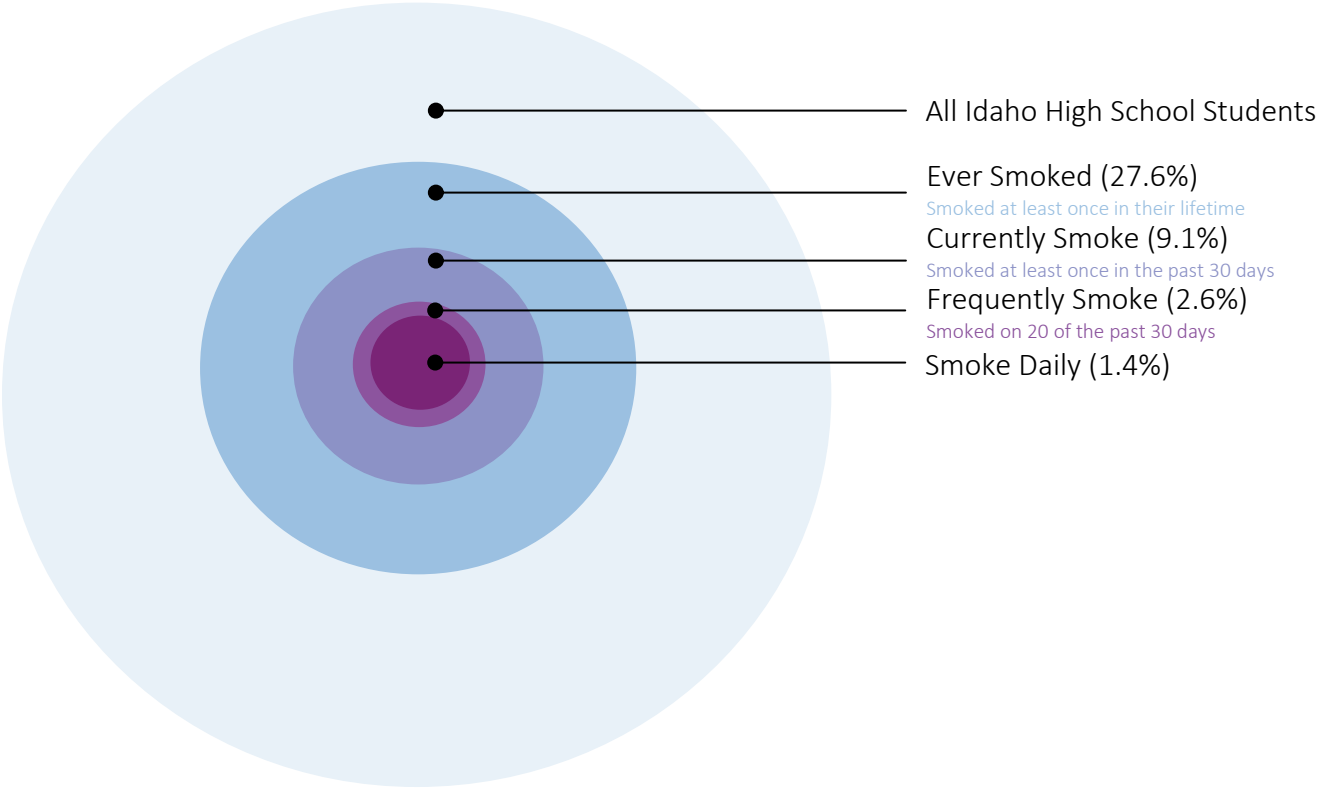
Tobacco

According to the NSDUH in 2015/2016, among all 50 states and D.C., Idaho ranked 44th, 31st, 38th, and 43rd among individuals 12 and older, 12 to 17, 18 to 25, and 26 and older, respectively, for tobacco use in the past month. These rankings are down from 38th and 30th among individuals 12 and older and 26 and older, respectively, and up from 36th, and 45th, among those 12 to 17 and 18 to 25, respectively, in 2011/2012 (before Idaho received the SPF SIG grant).

According to the BRFSS between 2011 and 2016, the percentage of Idaho adults reporting current cigarette smoking decreased significantly; however, the percentage of adults reporting current smokeless tobacco use increased. In 2016, 22.5% of Idaho adults reported ever using e-cigarettes.

Among Idaho high school students, according to the YRBS in 2017, 19% have used tobacco products in the past 30 days. More than 1 in 4 have tried smoking cigarettes and 9% reported smoking in the past 30 days. Vaping remains a large issue among high school students. More than 2 in 5 high school students have ever tried vaping, and 14% reported vaping in the past 30 days. According the Idaho YRBS report in 2017, over half of those who currently vape have attempted to quit at least once in the past 12 months. Overall though, tobacco use has decreased. Among high school students, past month tobacco use, cigarette smoking, smokeless tobacco use, lifetime cigarette use, smoking initiation, and frequent smoking have all decreased significantly between 2007 and 2017.

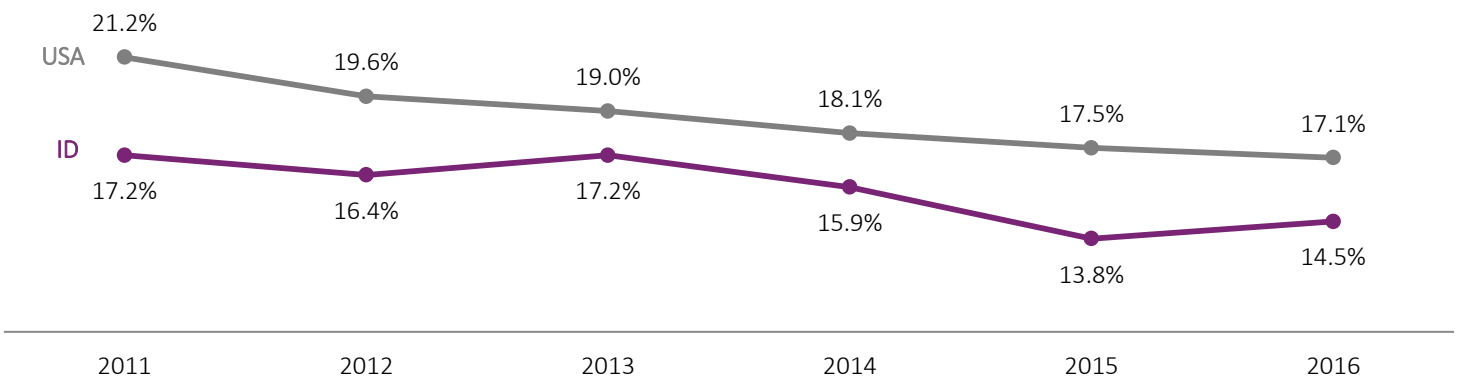
Approximately 15% of Idaho high school students who smoked in the last month smoke daily.



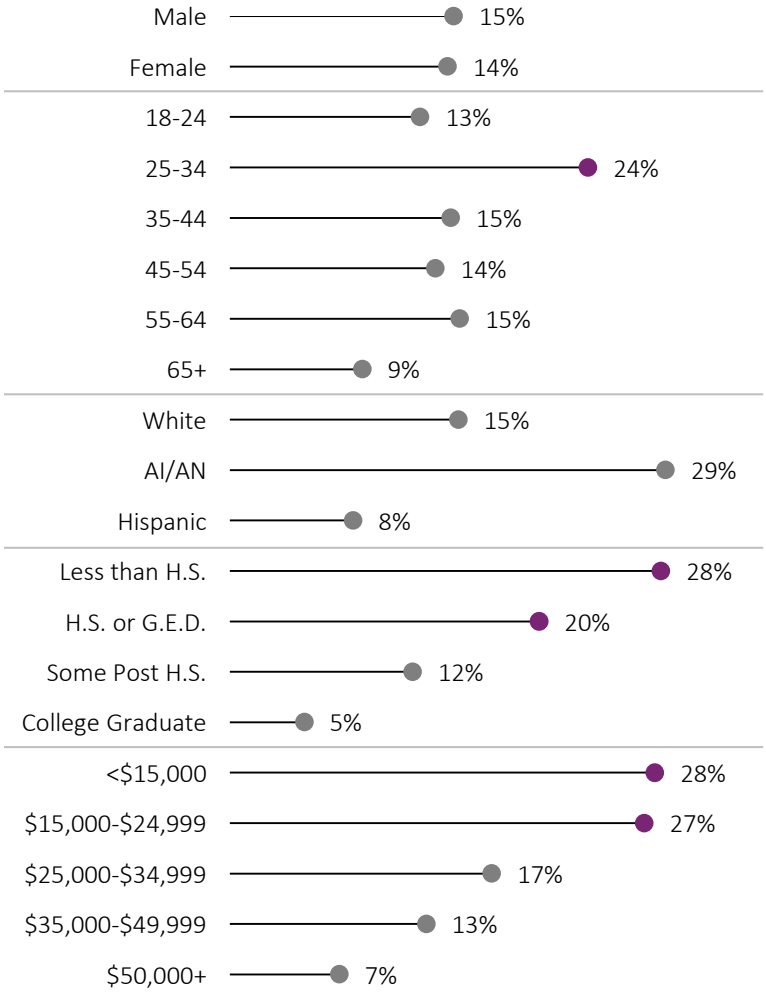
Adult Current Cigarette Smoking

Behavioral Risk Factor Surveillance System (BRFSS)

Current cigarette smoking decreased by 16% between 2011 and 2016.



In 2016, those with a lower annual income and education were most likely to smoke.



The BRFSS methodology uses the median, instead of the mean, to represent national estimates.

Between 2011 and 2016, the percentage of Idaho adults reporting current cigarette use has decreased, with the percentage in Idaho consistently below that of the United States.

In 2016, current cigarette smoking was lower among adults older than 65, Hispanic Idahoans, college graduates, and those who made more than $50,000 annually.

In 2016, current cigarette smoking was higher among Idahoans between the ages of 25 and 34, those with a high school diploma or less, and those who made less than $25,000 annually.

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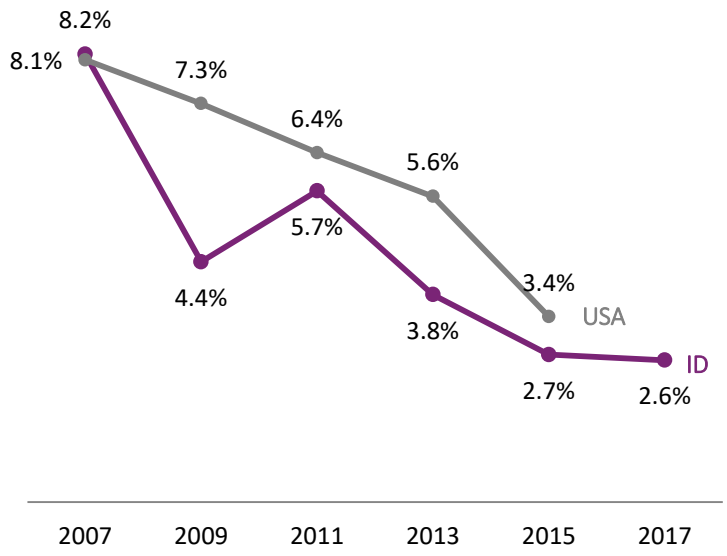
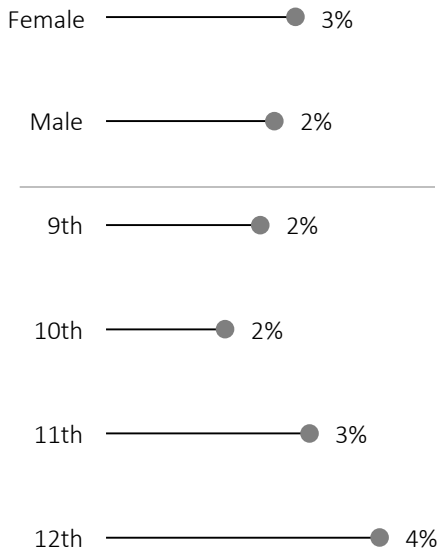
Youth Frequent Cigarette Smoking

Youth Risk Behavior Survey (YRBS)

Frequent cigarette smoking decreased by 68% between 2007 and 2017.



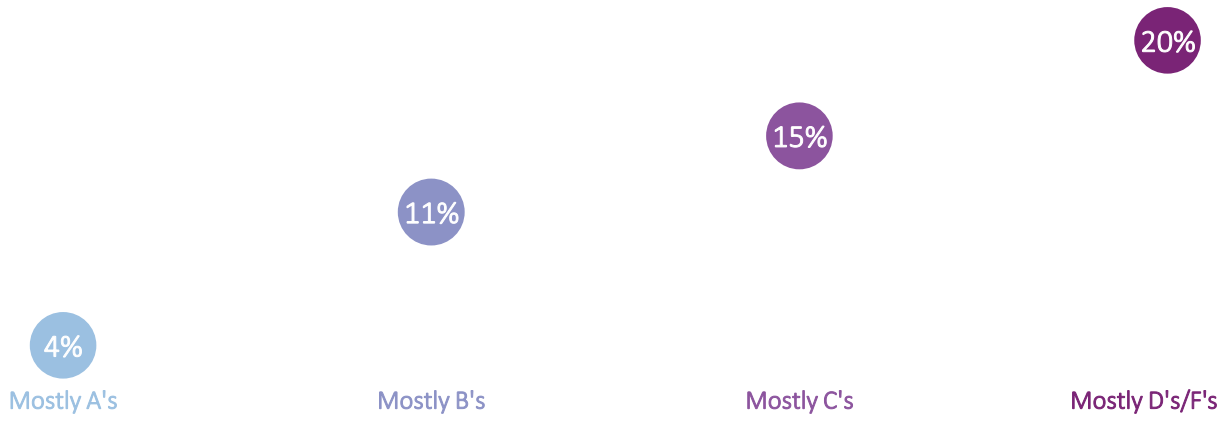
In 2017, 12th grade students were most likely to report frequent smoking.



Frequent smoking is defined as smoking on 20 of the past 30 days.

Between 2007 and 2017, the percentage of Idaho high school students that reported frequent smoking in the past 30 days has significantly decreased, with the percentage in Idaho consistently below that of the United States since 2009.

According to the Idaho Department of Education's 2017 YRBS report, academic achievement is significantly associated with past 30 day smoking. Students who earn lower grades are significantly more likely to currently smoke.



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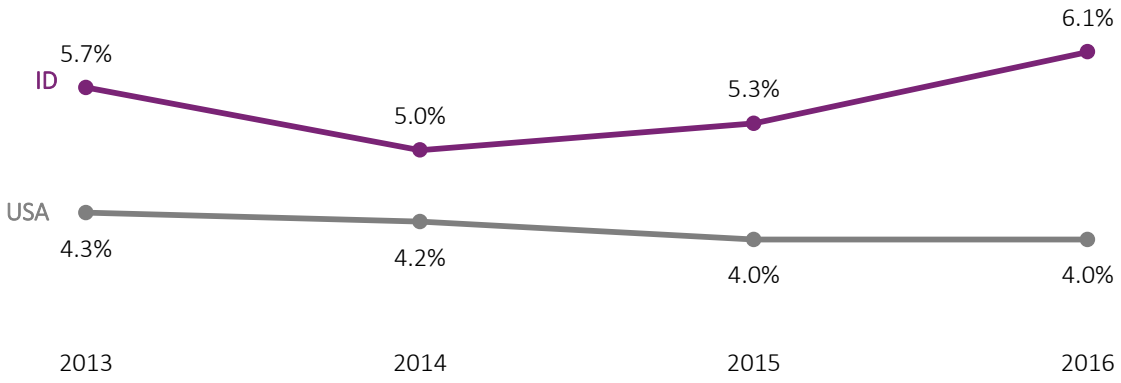
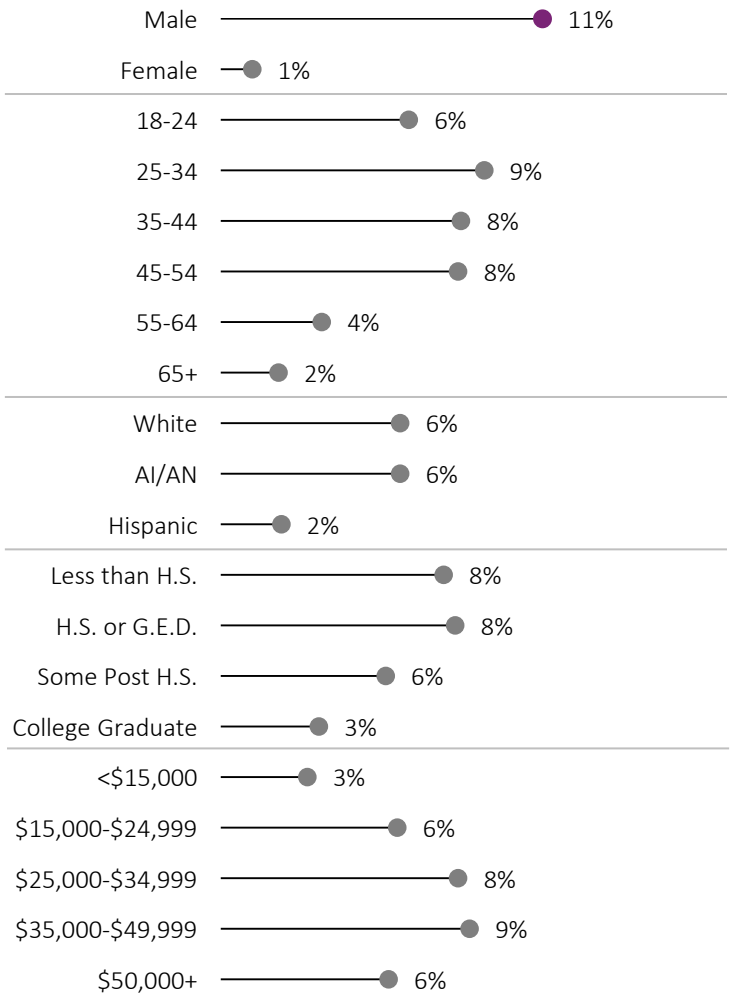
Adult Current Smokeless Tobacco Use

Behavioral Risk Factor Surveillance System (BRFSS)

Current smokeless tobacco use has increased by 7% between 2013 and 2016.



Men are most likely to use smokeless tobacco.



The BRFSS methodology uses the median, instead of the mean, to represent national estimates.

Between 2013 and 2016, the percentage of Idaho adults reporting current smokeless tobacco use has increased, but not significantly, with the percentage in Idaho consistently above that of the United States.

In 2016, current smokeless tobacco use was lower among women, adults 65 or older, Hispanic Idahoans, and college graduates. Current smokeless tobacco use was significantly higher among men.

In 2014, current smokeless tobacco use was significantly higher among adults living in District 2, which includes Clearwater County, Idaho County, Latah County, Lewis County, and Nez Perce County.

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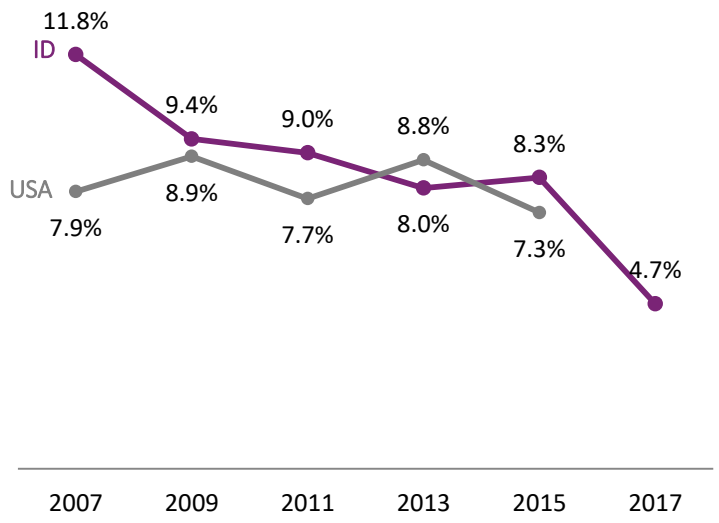
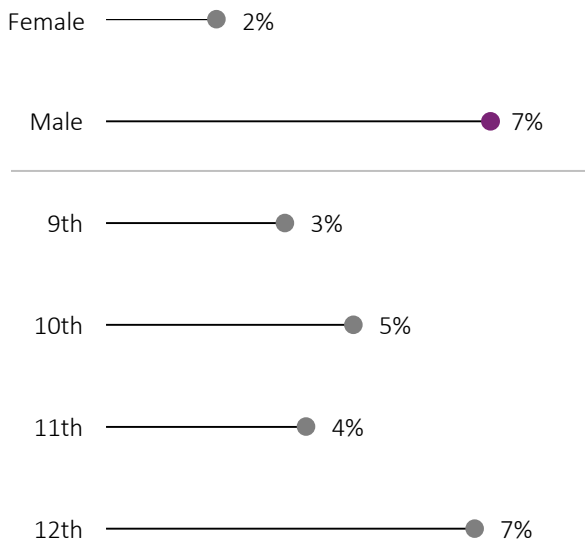
Youth Current Smokeless Tobacco Use

Youth Risk Behavior Survey (YRBS)

Current smokeless tobacco use among high school students decreased by 30%.



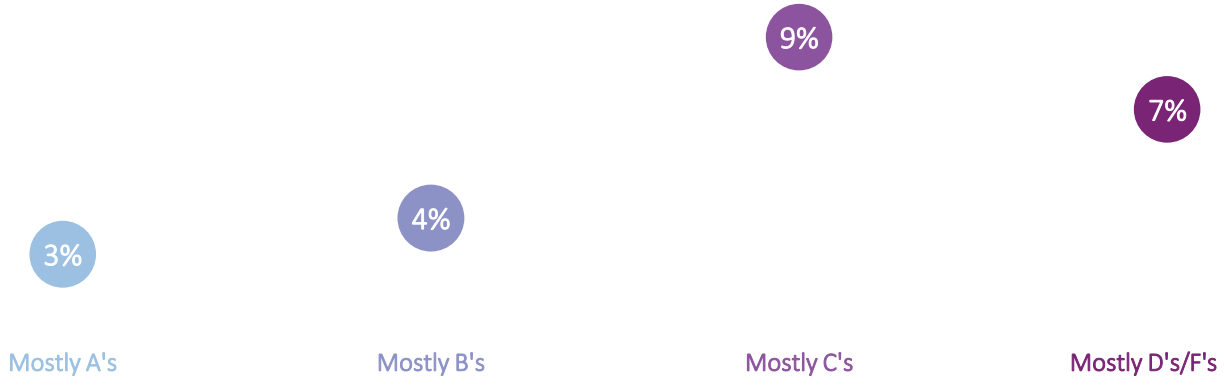
In 2017, males were most likely to report current smokeless tobacco use.



Smokeless tobacco is often referred to as chewing tobacco and includes snuff or dip.

Between 2007 and 2017, the percentage of Idaho high school students that reported smokeless tobacco use in the past 30 days has significantly decreased.

According to the Idaho Department of Education's 2017 YRBS report, academic achievement is significantly associated with past 30 day smokeless tobacco use. Students who earn mostly C's are most likely to currently use smokeless tobacco.



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Summary

To provide interested parties with a review of the progress Idaho has made regarding the selected indicators, this summary is provided. Each indicator was given a **Summary Score** based on whether rates in Idaho are below or above the national average, if the past 5 points of data resulted in an overall positive or negative trend, and if that trend resulted in a statistically significant change from the first to the last point based on agency designations and confidence intervals, if provided, or z-scores.

Each indicator was assigned a **National Comparison score**. If the last Idaho data point in the indicator was:

- Better (higher or lower depending on the desired direction) than the U.S. data point, it was scored a 1
- The same as the U.S. data point or if there was no national comparison, it was scored a 0
- Worse (higher or lower depending on the desired direction) than the U.S. data point, it was scored a -1

Each indicator was assigned a **Significance score**. If the first data point was:

- Statistically different than the last data point in the 5 point trend, it was scored a 2
- Not statistically different than the last data point in the 5 point trend, it was scored a 1

Each indicator was assigned a **Trend score**. If the slope of the 5-point trend was:

- Improving (positive or negative depending on the desired direction), it was scored a 1
- Worsening (positive or negative depending on the desired direction), it was scored a -1

Summary Score = National Comparison + (Significance x Trend)

Legend

	Idaho has Significantly Improved	Idaho has Improved, but not Significantly	No Change	Idaho has Worsened, but not Significantly	Idaho has Significantly Worsened
Idaho is Better than the National Average					
Idaho is the Same as the National Average					
Idaho is Worse than the National Average					

Prescription Drugs

Consumption:

Retail Distribution Rate of Hydrocodone per 100,000 Population

The retail distribution rate of hydrocodone per 100,000 population was higher in Idaho than the national rate but has decreased significantly between 2011 and 2016 (ARCOS, 2011-2016).

Retail Distribution Rate of Oxycodone per 100,000 Population

The retail distribution rate of oxycodone per 100,000 population was lower in Idaho than the national rate but has increased between 2011 and 2016 (ARCOS, 2011-2016).

Consequence:

Prescription Drug Arrest Rate per 1,000 Population

The prescription drug arrest rate per 1,000 population increased between 2012 and 2016 (NIBRS, 2012-2016).
Identified risk population(s): Clark County, Benewah County, Oneida County, Payette County, Bear Lake County, Valley County, and Shoshone County

The indicators below do not include 5 or more points of data:

Past Year Pain Reliever Misuse

The percentage of Idahoans 12 and older reporting past year pain reliever misuse was higher than the national average in 2015/2016 (NSDUH, 2015/2016).
Identified risk population(s): 18-25

Lifetime Prescription Drug Abuse Among High School Students

The percentage of Idaho high school students reporting ever using prescription drugs without a doctor's prescription was the same as the national average in 2015 but decreased between 2011 and 2017 (YRBS, 2011-2017).
Identified risk population(s): Female, Hispanics, and students who earn lower grades

Prescription Drug Treatment Rate per 1,000 Population

The rate of individuals entering publically funded treatment who reported prescription drugs (including barbiturates, benzodiazepines, opioids, sedatives/hypnotics, stimulants, and tranquilizers) as their primary drug upon treatment entry per 1,000 population decreased between 2014 and 2016 (WITS, 2014-2016).

Alcohol

Consumption

Current Alcohol Use Among High School Students

The percentage of Idaho high school students reporting alcohol use in the past 30 days was lower than the national average in 2015 and has decreased significantly between 2007 and 2017 (YRBS, 2007-2017).

Current Binge Drinking Among High School Students

The percentage of Idaho high school students reporting binge drinking in the past 30 days was lower than the national average in 2015 and has decreased significantly between 2007 and 2017 (YRBS, 2007-2017).
Identified risk population(s): Students who earn mostly C's

Past Month Alcohol Use

The percentage of Idahoans 12 and older reporting past month alcohol use was lower than the national average and decreased between 2011 and 2016 (NSDUH, 11/12-15/16).

Apparent Per Capita Consumption of Distilled Spirits

The number of gallons of distilled spirits sold in Idaho per capita was lower than the national average in 2015 but has increased between 2011 and 2015 (ILD, 2011-2015).

Current Alcohol Use Among Adults

The percentage of Idaho adults reporting alcohol use in the past 30 days was lower than the national median in 2016 but increased between 2012 and 2016 (BRFSS, 2012-2016).
Identified risk population(s): College graduates, Annual income greater than $50,000

Current Binge Drinking Among Adults

The percentage of Idaho adults reporting binge drinking in the past 30 days was lower than the national median in 2016 but increased between 2012 and 2016 (BRFSS, 2012-2016).
Identified risk population(s): Male, 25-34

The definition for heavy drinking was modified prior to the 2015 administration, so there are not 5 points of consistent data available:

Heavy Drinking Among Adults

The percentage of Idaho adults that met criteria for heavy drinking was higher than the national median in 2016 and increased between 2015 and 2016 (BRFSS, 2015-2016).

Alcohol

Consequence

Driving Under the Influence Arrest Rate

The DUI arrest rate in Idaho has decreased between 2012 and 2016.
Identified risk population(s): Valley County, Boise County, Clark County

Alcoholic Liver Disease Mortality Rate per 100,000 Population

The alcoholic liver disease mortality rate per 100,000 population in Idaho was higher than the national average in 2015 but decreased between 2012 and 2016 (VS, 2012-2016).
Identified risk population(s): American Indians/Alaska Natives, 45-64, non-Hispanic, Public Health District 1, Lemhi County, Benewah County, and Shoshone County

Alcohol-Induced Mortality Rate per 100,000 Population

The alcohol-induced mortality rate per 100,000 population in Idaho was higher than the national average in 2015 but decreased between 2012 and 2016 (VS, 2012-2016).
Identified risk population(s): 55-64, American Indians/Alaska Natives, Males, non-Hispanic, Public Health District 1, Benewah County, Lemhi County, and Shoshone County

Impaired Driving Crashes

The impaired driving crashes, as a percentage of all crashes, increased between 2012 and 2016. (OHS, 2016).
Identified risk population(s): Oneida County, Lemhi County, Custer County, and Lincoln County

The indicators below do not include 5 or more points of data:

Needing but not Receiving Treatment at a Specialty Facility for Alcohol Use in the Past Year

The percentage of Idahoans 12 and older that needed but did not receive treatment at a specialty facility for alcohol use in the past year was lower than the national average in 2015/2016 (NSDUH, 2015/2016).
Identified risk population(s): 18-25

Alcohol Treatment Rate per 1,000 Population

The rate of individuals entering publically funded treatment who reported alcohol as their primary drug upon treatment entry per 1,000 population increased between 2014 and 2016 (WITS, 2014-2016)

Marijuana

Consumption

Current Marijuana Use Among High School Students

The percentage of Idaho high school students reporting past 30-day marijuana use was lower than the national average in 2015 but increased between 2009 and 2017 (YRBS, 2009-2017).
Identified risk population(s): Students who earn mostly C's

Marijuana Use in the Past Month

The percentage of Idahoans 12 and older reporting marijuana use in the past month was lower than the national average in 2015/2016, but has increased between 2011 and 2016 (NSDUH, 11/12-15/16).
Identified risk population(s): 18-25

Consequence

Marijuana Arrest Rate per 1,000 Population

The marijuana arrest rate per 1,000 population has increased between 2012 and 2016 (NIBRS, 2012-2016).
Identified risk population(s): Clark County and Boise County

The indicator below does not include 5 or more points of data:

Marijuana Treatment Rate per 1,000 Population

The rate of individuals entering publically funded treatment who reported marijuana as their primary drug upon treatment entry per 1,000 population decreased between 2014 and 2016 (WITS, 2014-2016)

Other Drugs

Consumption

Cocaine Use in the Past Year

The percentage of Idahoans 12 and older reporting cocaine use in the past year was lower than the national average in 2015/2016 but increased between 2012 and 2016 (NSDUH, 11/12-15/16).
Identified risk population(s): 18-25

The indicators below do not include 5 or more points of data:

Illicit Drug Use in the Past Month

The percentage of Idahoans 12 and older reporting illicit drug use in the past month was lower than the national average in 2015/2016 (NSDUH, 2015/2016).
Identified risk population(s): 18-25

Illicit Drug Use Other than Marijuana in the Past Month

The percentage of Idahoans 12 and older reporting illicit drug use other than marijuana in the past month was lower than the national average in 2015/2016 (NSDUH, 2015/2016).
Identified risk population(s): 18-25

Methamphetamine Use in the Past Year

The percentage of Idahoans 12 and older reporting methamphetamine use in the past year was lower than the national average in 2015/2016 (NSDUH, 2015/2016).

Heroin Use in the Past Year

The percentage of Idahoans 12 and older reporting heroin use in the past year was the same as national average in 2015/2016 and has increased between 2013 and 2016 (NSDUH, 13/14-15/16).

Other Drugs

Consequence

Drug-Induced Mortality per 100,000 Population

The drug-induced mortality rate was lower than the national average but increased between 2012 and 2016.
Identified risk population(s): Public Health District 6, Bonneville County, Bannock County, and non-Hispanics

All Drug Narcotic & Equipment Violation Arrest Rate per 1,000 Population

The drug narcotic & equipment violation arrest rate increased between 2012 and 2016 (NIBRS, 2012-2016).
Identified risk population(s): Clark County, Boise County, Valley County, and Payette County

Crack/Cocaine Arrest Rate per 1,000 Population

The crack/cocaine arrest rate increased between 2012 and 2016 (NIBRS, 2012-2016).
Identified risk population(s): Minidoka County

Amphetamines/Methamphetamines Arrest Rate per 1,000 Population

The amphetamine/methamphetamine arrest rate increased between 2012 and 2016 (NIBRS, 2012-2016).
Identified risk population(s): Payette County, Bingham County, Oneida County, and Shoshone County

Heroin Arrest Rate per 1,000 Population

The heroin arrest rate has increased between 2012 and 2016 (NIBRS, 2012-2016).
Identified risk population(s): Bannock County and Kootenai County

The indicators below do not include 5 or more points of data:

Needing but Not Receiving Treatment at a Specialty Facility for Illicit Drug Use in the Past Year

The percentage of Idahoans reporting needing but not receiving treatment at a specialty facility for illicit drug use in the past year was higher than the national average in 2015/2016 (NSDUH, 2015-2016).
Identified risk population(s): 18-25

Methamphetamine Treatment Rate per 1,000 Population

The rate of individuals entering publically funded treatment who reported methamphetamine as their primary drug upon treatment entry per 1,000 population increased between 2014 and 2016 (WITS, 2014-2016).

Heroin Treatment Rate per 1,000 Population

The rate of individuals entering publically funded treatment who reported heroin as their primary drug upon treatment entry per 1,000 population increased between 2014 and 2016 (WITS, 2014-2016).

Cocaine Treatment Rate per 1,000 Population

The rate of individuals entering publically funded treatment who reported cocaine as their primary drug upon treatment entry per 1,000 population increased between 2014 and 2016 (WITS, 2014-2016).

Other Drug Treatment Rate per 1,000 Population

The rate of individuals entering publically funded treatment who reported other drugs (including amphetamine, club drugs, hallucinogens, inhalants, non-prescription methadone, over-the-counter medications phencyclidine, and other drugs) as their primary drug upon treatment entry per 1,000 population decreased between 2014 and 2016 (WITS, 2014-2016).

Tobacco

Consumption

Tobacco Use in the Past Month

The percentage of Idahoans 12 and older reporting tobacco use in the past month was lower than the national average in 2015/2016 and decrease significantly between 2011 and 2016 (NSDUH, 11/12-15/16).
Identified risk population(s): 18-25

Current Cigarette Smoking among Adults

The percentage of Idaho adults reporting cigarette smoking in the past 30 days was lower than the national median in 2016 and has decreased significantly between 2012 and 2016 (BRFSS, 2012-2016).
Identified risk population(s): 25-34, those with less than a high school diploma, and who earn less than $25,000 annually

Frequent Cigarette Smoking Among High School Students

The percentage of Idaho high school students reporting smoking cigarettes on 20 or more days of the past 30 days was lower than the national average in 2015 and decreased significantly between 2007 and 2017 (YRBS, 2007-2017).

Current Smokeless Tobacco Use Among High School Students

The percentage of Idaho high school students reporting using smokeless tobacco products in the past 30 days was higher than the national average in 2015 but decreased significantly between 2007 and 2017 (YRBS, 2007-2017).
Identified risk population(s): Males and students who earn mostly C's

The indicators below do not include 5 or more points of data:

Current Tobacco Use Among High School Students

The percentage of Idaho high school students reporting using tobacco products (including cigarettes, smokeless tobacco, cigars, or electronic vapor products) in the past 30 days was lower than the national average in 2015 and has decreased between 2015 and 2017 (YRBS, 2015-2017).

Current Smokeless Tobacco Use Among Adults

The percentage of Idaho adults reporting current smokeless tobacco use was higher than the national median in 2016 and has increased between 2013 and 2016 (BRFSS, 2013-2016).
Identified risk population(s): Men

Current e-Cigarette Use among Adults

The percentage of Idaho adults reporting past 30-day e-cigarette use was lower than the national median in 2016 (BRFSS, 2016).

Current Electronic Vapor Product use Among High School Students

The percentage of Idaho high school students reporting using electronic vapor products in the past 30 days was higher than the national average in 2015 but decreased between 2015 and 2017 (YRBS, 2015-2017).
Identified risk population(s): Hispanic students and students who earn lower grades

Limitations

Consequence Indicators

For consequence indicators such as primary treatment admissions and arrests, it is difficult to determine whether higher rates equate to negative or positive outcomes. For example, regarding treatment, a low rate of primary treatment admissions could mean that there is no great need for treatment. Conversely, it could mean that there is a great need, but limited resources available. This is also the case with arrests. Small arrest rates could mean that the issue in that particular area is minor; however, it could also mean that the issue has remained unchecked by lack of enforcement resources. Funding may also impact agencies' abilities to garner resources toward increased treatment and enforcement, which might also impact consequence data. For these reasons, all data should be regarded as a small part of a larger, complex issue.

High Risk Populations

All the data in this report are limited by access to information. For some indicators, a great breadth of information is available by demographic and geographic variables; for others, it is not. Some information is simply not available. For example, veteran status was not reported for any of the indicators, so in this report, the SEOW cannot state that rates of consumption or consequence were significantly higher for this group, although national data may demonstrates otherwise.

Despite these, and potentially other, limitations, completing an assessment of the current landscape is the necessary first step in combatting the social and economic consequences of substance abuse in Idaho.

Appendix A. Final Scores

Construct	Indicator	Data Source	Size	Seriousness	Capacity	Final Score
Alcohol Consumption						
Current use	Percent of students in grades 9-12 reporting use of alcohol in the past 30 days	YRBS	3.0	1.8	1.8	11.8
	Idaho gallons sales per capita	Liquor				
	Percent of adults (aged 18 or older) reporting use of alcohol in past 30 days	BRFSS				
Excessive Drinking	Percent of adults aged 18 and older reporting average daily alcohol consumption greater than two (male) or greater than one (female) per day in past 30 days	BRFSS	1.7	1.7	1.6	7.8
	Percent of students in grades 9-12 reporting 5+ drinks in a row within a couple of hours in the past 30 days	YRBS				
	Percent of adults (aged 18 or older) binge drinking of alcohol in past 30 days	BRFSS				
Alcohol Consequences						
Crime	DUI arrests per 1,000	IBRS	2.0	1.4	2.6	12.6
	Alcohol related arrests per 1,000	IBRS				
	Alcohol related crashes 1,000	ITD				
	Underage alcohol related arrests per 1,000	IBRS				
Alcohol Health Outcomes	Rate of alcoholic liver disease deaths per 100,000	VS	2.3	4.1	2.0	21.0
	Rate of Alcohol Induced Death per 100,000	VS				
	Percent report alcohol as primary substance of use upon treatment entry	TEDS				
	Percent of persons aged 12 and older reporting alcohol dependence/abuse	NSDUH				
Tobacco Consumption						
Use	Percent of students in grades 9-12 that smoked cigarettes on 20 or more days in the last 30 days	YRBS	2.0	1.7	2.7	14.2
	Percent of adults 18 and older who smoke everyday	BRFSS				
	Percent of adults ever using smokeless tobacco	BRFSS				

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Construct	Indicator	Data Source	Size	Seriousness	Capacity	Final Score
Prescription Drug						
Use	Nonmedical Use of Pain Relievers per 1,000	NSDUH	3.8	3.8	4.0	45.0
	Prescription drug distribution rates per 100,000 population	ARCOS				
	Number of deaths from drug induced mortality per 100,000 population	VS				
	Seizure rates per 100,000 population	IBRS				
Other Drug Consumption						
Use	Illicit drug use other than marijuana past month per 1,000	NSDUH	4.0	2.0	1.7	13.4
	Drug seizures per 100,000	IBRS				
	Lifetime illicit drug use per 1,000	BRFSS				
Other Drug Consequences						
Health Outcome	Percent report other drugs as primary substance of use upon treatment entry	TEDS	3.7	4.5	1.6	19.8
	Adult Drug Induced Mortality per 100,000	VS				
	Percent report other drugs as substance of use upon treatment entry	TEDS				
Crime	Other drug Possession Arrests per 1,000	IBRS	1.3	1.7	2.1	9.9
	Other drug Trafficking Arrests per 100,000	IBRS				
	Other Drug Seizure per 100,000	IBRS				
Marijuana Consequences						
Use	Percent report marijuana primary substance of use upon treatment entry	TEDS	2.5	3.4	2.6	24.1
	Percent of students in grades 9-12 who used marijuana one or more times during the past 30 days	YRBS				
	Marijuana trafficking arrests per 100,000	IBRS				
	Marijuana seizures per 1,000	IBRS				

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Appendix B. Definitions

Definitions

Lifetime use: Using at least once in one's lifetime.

Current use: Using at least once in the past 30 days.

Frequent smoking: Smoking on 20 or more of the past 30 days.

Heavy drinking: Drinking 7 or more drinks per week for females or drinking 14 or more drinks per week for males.

Binge drinking: drinking 4 or 5 drinks within a few hours for females and males, respectively.

Alcohol-induced death: Alcohol-induced deaths include mental and behavioral disorders due to alcohol use; degeneration of nervous system due to alcohol; alcoholic polyneuropathy; alcoholic cardiomyopathy; alcoholic gastritis; alcoholic liver disease; alcohol-induced chronic pancreatitis; alcohol-induced acute pancreatitis; findings of alcohol in blood; accidental poisoning by and exposure to alcohol; intentional self-poisoning (suicide) by exposure to alcohol; poisoning by exposure to alcohol; and poisoning by exposure to alcohol, undetermined intent.

Alcohol-induced deaths do not include homicides, accidents such as falls and motor vehicle crashes, and other causes indirectly related to alcohol use. This category also excludes newborn deaths associated with maternal alcohol use.

Drug-induced death: Drug-induced deaths include deaths due to drug psychosis; drug dependence; nondependent use of drugs not including alcohol and tobacco; drug-induced pancreatitis; drug-induced fever; accidental poisoning by drugs, medicaments, and biologicals; suicide by drugs, medicaments, and biologicals; assault from poisoning by drugs and medicaments; and poisoning by drugs, medicaments, and biologicals, undetermined whether accidental or purposely inflicted.

Drug-induced deaths do not include accidents, homicides, and other causes indirectly related to drug use. Also excluded are newborn deaths associated with maternal drug use. Types of drugs listed on the death certificate include prescriptions, over-the-counter drugs, and narcotics.

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Idaho Youth Empowerment Services (YES) Workforce Capacity and Gaps Analysis

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Nicole O'Reilly
Boise State University

Executive Summary

Objective: The State of Idaho is undergoing a comprehensive children's mental health service system transformation pursuant to the Jeff D. Settlement Agreement. Under the terms of the Agreement, Idaho is responsible for ensuring that youth with serious emotional disturbance (SED) and their families have timely access to an array of community-based mental health services and supports. The new service array is called Youth Empowerment Services (YES). As one component of this effort, Idaho is directed to develop a sustainable workforce capable of delivering YES services to youth with SED. This report provides a foundation for the State's YES workforce development efforts by assessing the current capacity of Idaho's Medicaid youth mental health services workforce. The report provides population estimates of the number of Idaho Medicaid providers who currently deliver mental health services and supports to Idaho youth and their families and assesses the gap between this workforce capacity and the capacity needed to deliver YES services and supports to youth with SED under the terms of the Settlement Agreement.

Method: Population estimates of Medicaid workforce capacity including (1) the number of mental health professionals who serve youth by role (e.g., psychiatrists, master's level clinicians, bachelor's-level staff), (2) the number of mental health professionals with specialized training in wraparound and select evidence-based practices for youth, and (3) the number of youth who received EBPs as part of their treatment, were developed using weighted survey data collected from providers. The Idaho YES Workforce Survey was an online survey of organizations and sole proprietorships that delivered Medicaid-funded mental health services to youth and their families as part of Idaho's Medicaid provider network as of January 30, 2018. The sampling frame included 407 total practices (253 organizations and 154 sole proprietorships) of which, 249 (61%) responded. Weighting class adjustments incorporating information on geographic location, practice type, and practice size were used to develop estimates of population totals. Estimates of youth need for mental health services were based on Idaho Department of Health and Welfare projections and analyses of Medicaid claims data. Workforce capacity gaps analysis was conducted for two different scenarios incorporating different assumptions about the number of youth with SED likely to need YES services and supports.

Results: In 2016, an estimated 3,603 mental health professionals delivered community-based services and supports to 27,411 Idaho youth and their families in Idaho's Medicaid-funded system. The point-in-time workforce capacity and gaps analysis indicated that Idaho's Medicaid youth mental health services workforce needed to be 15.9% to 29.5% larger in order to provide YES services and supports to youth with SED. Significant workforce deficits were observed in training and preparedness to deliver evidence-based practices and new community-based services (e.g., wraparound, respite). In addition, this report documents significant maldistribution of all provider types across Idaho's geographic areas.

Conclusions and Recommendations: Findings from this report are consistent with other analyses of Idaho's behavioral health workforce and with national studies which document significant shortages of mental health professionals for adults and youth in Idaho and across the nation. These data provide a foundation for future workforce development efforts to improve youth access to community-based services under the YES system transformation. Recommendations are provided for improving the capacity of Idaho's current Medicaid youth mental health services workforce, increasing the supply and retention of providers to deliver YES services, and improving data collection for ongoing workforce development efforts.
(July 3, 2018)

1. Introduction

This report presents the findings of the 2018 Youth Mental Health Services Workforce Capacity and Gaps Analysis commissioned by the Idaho Department of Health and Welfare (IDHW), Division of Behavioral Health and completed by Boise State University's School of Social Work to help guide Idaho's Youth Empowerment Services (YES) system transformation. The Department launched the YES transformation initiative in 2014 in response to the Jeff D. Settlement Agreement which was negotiated following the 1980 Jeff D. class action lawsuit. The goals of the Settlement Agreement and the YES transformation are to address deficits in Idaho's mental health service system for youth related to (1) the mixing of adults and juveniles at State Hospital South, and (2) the provision of community-based mental health services to children with serious emotional disturbance. Youth who experience serious emotional disturbance (SED) are those whose daily functioning is severely impaired by a mental disorder as determined by a qualified mental health professional based on established criteria. Under the terms of the Settlement Agreement, Idaho State is directed to ensure that youth with SED and their families have timely access to a full array of community-based mental health services and supports to meet their needs. The YES transformation is designed to provide these services and supports.

The foundation for any effective service system is an adequate supply of a well-trained workforce. As such, the Settlement Agreement directs Idaho State to develop a sustainable workforce to provide the new YES community-based service array. This report provides a foundation for the State's YES workforce development planning and activities by assessing the current capacity of Idaho's Medicaid youth mental health services workforce to meet the needs of Idaho youth with SED. Specifically, this Workforce Capacity and Gaps Analysis meets the Department's stated goals of (1) assessing the current statewide system capacity of the Idaho Medicaid provider network to provide YES services and supports statewide to youth with SED as defined in the Jeff D. Settlement Agreement, and (2) providing recommendations to meet the State's YES workforce goals.

2. Method

The data presented in this report come from three sources: (1) a statewide survey of Idaho's Medicaid mental health provider network conducted by Boise State University School of Social Work in partnership with Rider Consulting and IDHW, (2) Medicaid claims data and reports provided by Idaho Medicaid and IDHW, and (3) published scientific and gray literature on Idaho's mental health workforce and systems as well as literature assessing children's mental health services and workforce in other States and nationwide.

2.1 Idaho Youth Empowerment Services Workforce Survey

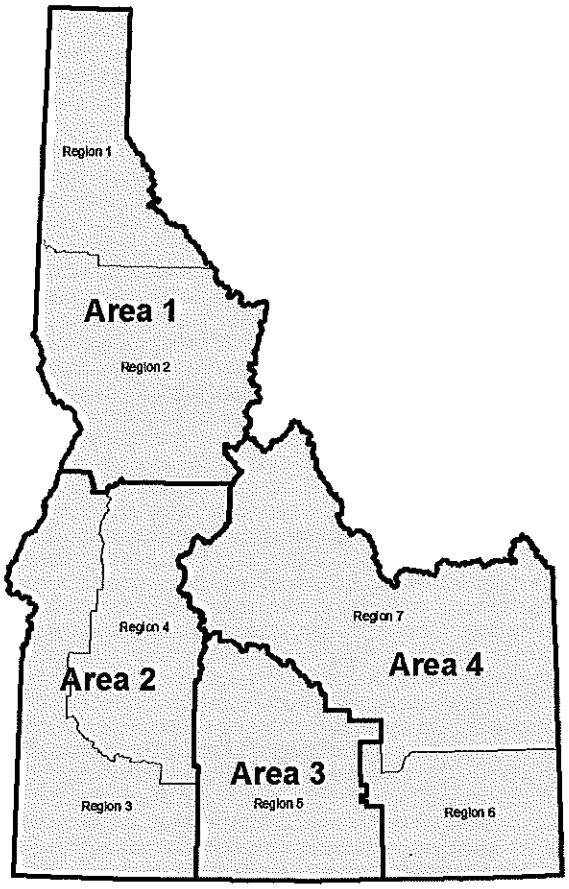
The Idaho YES Workforce Survey was an online survey of Idaho Medicaid mental health providers fielded from January 16, 2018 to February 22, 2018 by Boise State University and Rider Consulting. Full details of the survey methodology and initial analyses of the data are provided in the report *Children's Mental Health Workforce Development Plan: Provider Survey Results* submitted to IDHW on April 19, 2018. In brief, the investigators used a six-step, evidence-based process to survey Idaho Medicaid mental health providers regarding the services and supports they provide to youth and their families and the workforce they employ to deliver those services. The sampling frame for the survey included all organizations and sole proprietorships that delivered Medicaid-funded mental health services as part of Idaho's Medicaid provider network as of January 30, 2018. The original sampling frame provided by the Department included 457 unique businesses (inclusive of organizations and sole proprietorships) based on tax identification numbers. Removal of businesses that had closed or did not have email contact information reduced the sampling frame to 407 total providers (253 organizations and 154 sole proprietorships) which represent the population total for the analyses in this report. The overall response rate to the survey was 61%. A prior report to the Department, *Children's Mental Health Workforce Development Plan: Provider Survey Results*, provides full details and analysis of the unweighted data from the YES Workforce survey.

In this report, we (1) present additional analyses of the YES Workforce survey data in order to provide population estimates of Idaho's Medicaid children's mental health services workforce and capacity, and (2) compare Idaho's Medicaid workforce capacity to youths' need for YES services in order to develop a point-in-time estimate of the YES workforce capacity gap. The analyses in this report use well-established weighting class adjustment methods[1] to compensate for survey nonresponse and to generate population estimates of the total number of youth mental health service providers of various types in Idaho (e.g., psychiatrists, master's level clinicians, bachelor's-level professionals and peer support staff), the total number of youth who received select evidence-based practices (EBPs) in the State, and other workforce and service system characteristics.

Details of the weighting class adjustment procedure and the external data used to generate the weights are provided in the **Technical Appendix.** In brief, the procedure uses information that is external to the survey (e.g., number and size of organizations in each area of the State) to weight the information provided by respondents so that their answers represent their own practices as well as some proportion of similar practices in the same area of the State that did not respond. Weighting class adjustments are a well-established and frequently employed technique in survey research because they protect respondent anonymity and reduce bias in estimating population totals from survey data.[1] In the present study, the use of weighting class adjustments allowed us to estimate population totals of children's mental health providers in Idaho. These population totals provide an assessment of the service system's current workforce capacity and serve as benchmarks for future workforce development activities.

In order to better understand the geographic distribution of Idaho's children's mental health services workforce, we present population workforce estimates in four geographic areas of the state. The four areas are shown in **Figure 1** along with the seven regions used by IDHW to characterize the state. Workforce data are presented at the area level rather than by region because many provider organizations serve multiple regions of the State, particularly in the southwest and southeast areas of the State (Regions 3 and 4 which span Boise and Nampa/ Caldwell; Regions 6 and 7 which span Idaho Falls and Pocatello), and because providers indicated the range of communities they served rather than the address of their practice. The four areas represent geographic sections of the State with distinct providers and population centers.

Figure 1. Idaho Department of Health and Welfare Regions and YES Workforce Survey Areas for Analysis



2.2 Idaho Claims Data and Reports

The second source of data for this report includes Idaho Medicaid claims data and IDHW reports on the number of youth served in different regions of the State and the number of youth who experience SED. As part of the larger YES system transformation, IDHW has analyzed Medicaid claims and Division of Behavioral Health data to better understand the needs of youth who access mental health services in Idaho, the number of youth with SED who are likely to require services under the terms of the Settlement Agreement, and the service system's current capacity

Box 1. Definitions of Serious Emotional Disturbance

US Substance Abuse and Mental Health Services Administration

Pursuant to section 1912(c) of the Public Health Service Act, as amended by Public Law 102-321 "children with serious emotional disturbance" are persons:

a. From birth up to age eighteen (18),

b. who currently or at any time during the past year,

c. have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM),

d. that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Idaho Administrative Code (16.07.37)

To be eligible for children's mental health services through a voluntary application to the Department, the applicant must:

a. Be under eighteen (18) years of age,

b. reside within the State of Idaho,

c. have a DSM-IV-TR Axis I diagnosis (a substance use disorder alone, or a developmental disorder alone, does not constitute an eligible Axis I diagnosis, although one more of these conditions may coexist with an eligible Axis I diagnosis), and

d. have a substantial functional impairment as assessed by using the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Child Functional Assessment Scale (PECFAS) with a full eight (CAFAS) or seven (PECFAS) scale score of 80 or higher with "moderate" impairment in at least one of three areas including: Moods/ emotions, Thinking, or Self-harm.

to meet these needs. These reports were shared with the assessor and are incorporated into this report where appropriate.

2.3 Scientific and Gray Literature related to Mental Health Services for Youth and Workforce Development

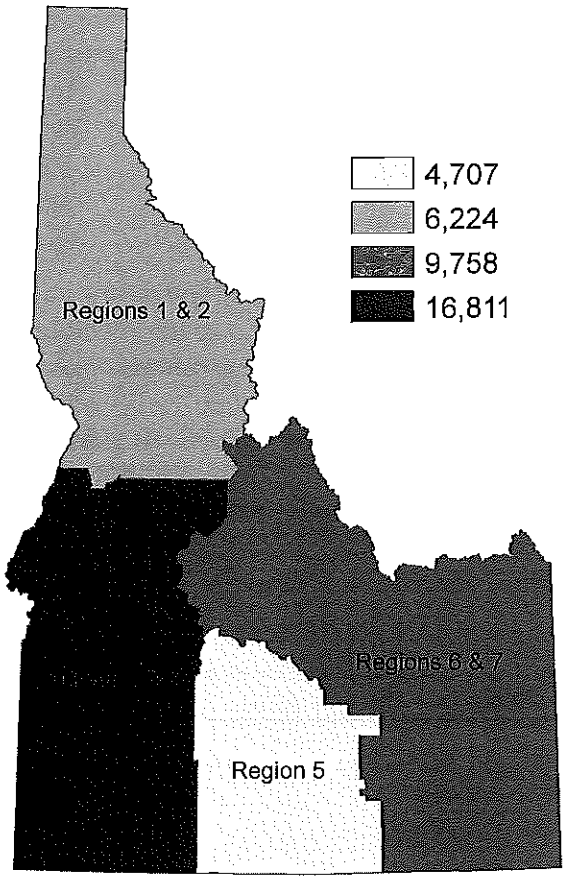
In addition to collecting original primary survey data and examining Idaho claims data and reports, the assessor also conducted a scan and literature review of published scientific reports, State and federal technical reports, and other 'grey' literature on behavioral health workforce and youth mental health services in Idaho and across the United States. This literature includes reports published by the Idaho Department of Labor and the Western Interstate Commission for Higher Education (WICHE) which have both recently analyzed Idaho's overall behavioral health workforce and system with an emphasis on services for adults. These reports provide important context for understanding the capacity of Idaho's children's mental health services workforce to meet the needs of youth with SED.

3. Defining the Target Population

The target population for the YES system transformation includes Idaho residents under the age of eighteen (18) who experience an SED. The Settlement Agreement defines SED in accordance with the definition provided by the US Substance Abuse and Mental Health Services Administration (SAMHSA) pursuant to Public Law 102-321 and as operationalized in Idaho Administrative Code (IDAPA 16.07.37). The SAMHSA and Idaho definitions of SED are presented in **Box 1**. Based on these definitions, the two essential criteria for assessing SED involve determining whether a child experiences (1) a *DSM disorder*, and (2) *substantial functional impairment* secondary to that disorder.

Under the terms of the Settlement Agreement,

Figure 2. Estimated Number of Idaho Youth with Serious Emotional Disturbance by Area (N = 37,500)



each year Idaho State is required to generate an estimate of the number of Idaho youth who experience SED. This estimate forms a basis for assessing the capacity of Idaho's children's mental health workforce in the current Workforce Capacity and Gaps Analysis.

In 2016, IDHW estimated that the number of Idaho youth with SED ranged from 35,000 to 40,000 youth (median = 37,500 youth).[2] This represents 8.1% to 9.2% of Idaho's 2016 youth population of 434,465 (median estimate of 37,500 = 8.6%). The estimate was based on a synthesis of the scientific literature, Medicaid claims data, and an analysis of previous estimates generated for the Jeff D. lawsuit. It is consistent with prior studies documenting the prevalence of SED in population representative samples of youth conducted across the United States.[3-6] **Figure 2** shows the estimated number of Idaho youth with SED in each of the four Idaho areas based on the State's analysis.

In addition to estimating the number of Idaho youth with SED, the IDHW analysis noted that nationally, only about 50% of youth who experience SED participate in mental health services. This finding has been replicated in several population-representative community studies of youth and suggests that the number of youth who are likely to access or need YES services is approximately 50% of the total number of youth with SED. Given that 37,500 Idaho youth were presumed to have experienced SED in 2016, this implies that 18,750 Idaho youth are likely to access YES community-based mental health services and supports (not accounting for population growth). These estimates of the number of Idaho youth with SED (i.e., 37,500 youth) and the number of youth who are likely to utilize or need YES services (i.e., 18,750 youth) form a basis for assessing the capacity of Idaho's mental health workforce in this report.

4. Idaho's Medicaid Youth Mental Health Workforce Capacity

In this section, we present population estimates of Idaho's Medicaid youth mental health services workforce for the State and for the four geographic areas shown in Figure 1. These estimates are based on weighted analyses of the YES Workforce Survey data. It is important to note that these analyses focus specifically on the number of workforce members who served youth and their families. Previous studies of Idaho's behavioral health workforce (e.g., Idaho Bureau of Labor reports) have not distinguished between providers who served youth and those who served adults. Thus, this section provides the first estimates we are aware of regarding Idaho's Medicaid youth mental health services workforce.

The section is broken into three parts addressing (1) the number of mental health professionals by role (e.g., psychiatrists, master's level clinicians, bachelor's-level staff), (2) the number of mental health providers with specialized training in the provision of wraparound and select EBPs, and (3) the number of youth who received EBPs as part of their treatment.

4.1 Idaho Medicaid Youth Mental Health Workforce Capacity by Role

Table 1. Number of Full-time, Part-time, and Full-time Equivalent (FTE) Specialty Mental Health Prescribers Serving Youth in Idaho

Area		Full-time psychiatrists (N)	Part-time psychiatrists (N)	FTE psychiatrists	Full-time ANPs (N)	Part-time ANPs (N)	FTE ANPs	Total FTE specialty prescribers
1	Regions 1 & 2	4	0	3.9	9	3	10.3	14.1
2	Regions 3 & 4	5	2	6.0	13	23	24.3	30.3
3	Region 5	0	1	0.5	1	0	1.0	1.5
4	Regions 6 & 7	12	9	16.4	14	1	14.5	30.8
	State Total	21	12	26.7	37	27	50.1	76.8

4.1.1 Specialty Mental Health Prescribers

Specialty mental health prescribers include child psychiatrists and advanced nurse practitioners with expertise in treating youth with SED and their families. These professionals play an important role in meeting the needs of youth with SED by conducting psychiatric diagnostic evaluations, prescribing medicine and psychosocial treatments to meet youths' needs, engaging in medication management, and directing youths' care. Respondents to the YES Workforce Survey indicated the number of Psychiatrists and Advanced Nurse Practitioner (ANP) prescribers who worked with youth and their families as well as whether these prescribers worked full-time or part-time. **Table 1** shows the number of psychiatrists and advanced nurse practitioners who work with youth and their families in Idaho by Area and statewide based on our weighted analyses of the YES Workforce data.

In order to assess the capacity of Idaho's specialty mental health prescribers to meet the needs of youth with SED, ratios were calculated to quantify the number of full-time equivalent specialty mental health prescribers available to serve youth to the number of youth with SED in each area. Specifically, the ratios indicate the number of specialty mental health prescribers per 1,000 youth with SED. For these analyses, we assumed that part-time prescribers worked 0.5 FTE (20 hours per week). Calculation of these ratios allows us to assess the availability of prescribers to youth relative to the youth population in a given area and to compare the availability of specialty youth prescribers across areas of the State.

The overall ratio of total FTE specialty prescribers per 1,000 youth with SED in Idaho was 2.05 with a range of 0.32 in Area 3 (Region 5) to 3.16 in Area 4 (Regions 6 & 7). **Figure 3** shows the distribution of total specialty prescribers (psychiatrists plus ANPs) available to treat youth per 1,000 youth with SED in each area of the State. **Figure 4** presents the contribution of FTE psychiatrists and ANPs per 1,000 youth with SED by area and across the entire State.

In order to formally compare the availability of specialty prescribers for youth across Idaho, we

Figure 3. Total Specialty Prescribers (Psychiatrists and Advanced Nurse Practitioners) Available to Treat Youth per 1,000 Youth with SED by Area

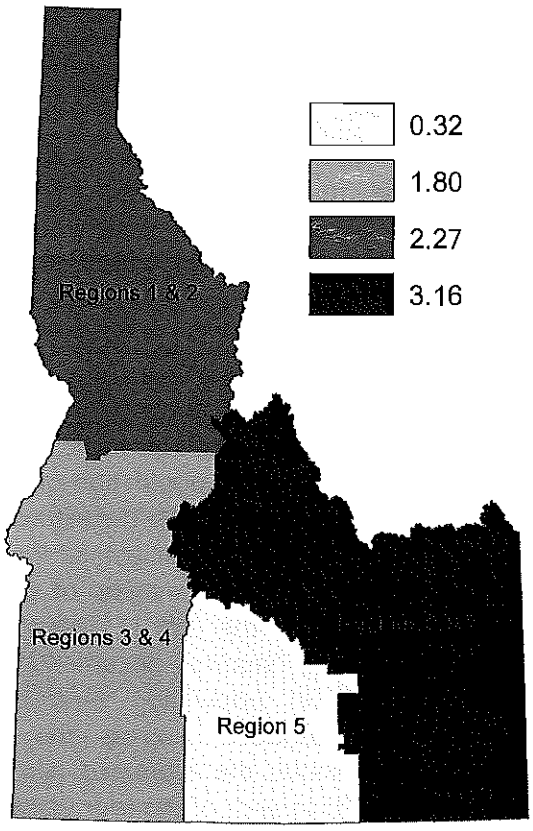
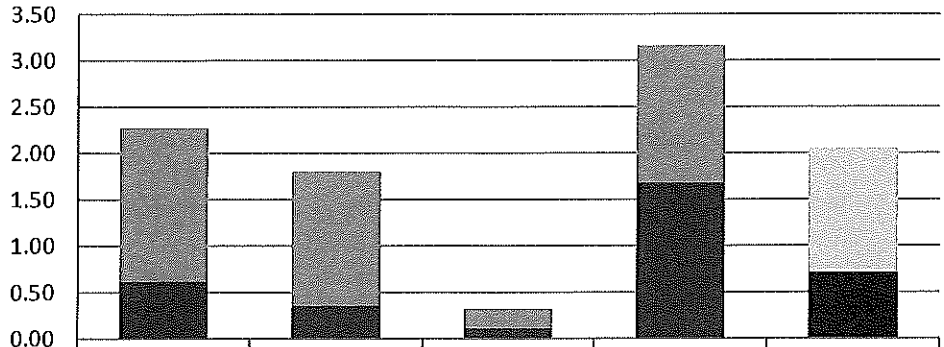


Figure 4. Full-time Equivalent Psychiatrists and Advanced Nurse Practitioners per 1,000 Youth with SED by Area



	Regions 1 & 2	Regions 3 & 4	Region 5	Regions 6 & 7	Idaho Total
FTE Advanced Nurse Practitioners per 1,000 Youth with SED	1.65	1.45	0.21	1.48	1.34
FTE Psychiatrists per 1,000 Youth with SED	0.62	0.36	0.11	1.68	0.71

conducted a chi-square goodness-of-fit test. This test evaluates whether the distribution of specialty prescribers for youth across the four areas of the state is proportionate to youth need in those areas, as measured by the number of youth with SED in each area. This analysis addresses the distribution of available prescribers across the State; it does not address whether or not the absolute number of available prescribers is adequate to meet youth need.

Results of the chi-square analysis indicated that specialty prescribers for youth in Idaho are not distributed proportionate to youth need, $p = .004$ (see **Table 2**). While there was a relatively close match between the observed and expected number of specialty youth prescribers in Regions 1, 2, 3 and 4; Region 5 emerged as an area of the State with a very low number of specialty prescribers for youth relative to youth. Furthermore, Regions 6 and 7 had a disproportionately high number of FTE prescribers relative to youth need.

4.1.2. Master's-level Mental Health Clinicians

Master's-level mental health clinicians include professionals who have a master's degree and licensure in a behavioral health profession (e.g., social work, counseling, substance use disorder treatment). These individuals are an essential part of the mental health service system for youth as they deliver the most intensive and frequently used services to youth and families including psychotherapy and other psychosocial interventions, such as diagnostic assessments, treatment planning, care coordination, and wraparound. Respondents to the YES Workforce Survey indicated the number of master's-level clinicians working in their practice setting in the following categories: social worker, counselor, mental health professional, and substance use disorder clinician. This information was provided by both organizational respondents and sole proprietorships. In this section, we present analyses of Idaho's master's-level clinical workforce including analyses of the total clinicians available and sub-analyses of mental health clinicians (social workers, counselors, and mental health professionals) and substance use disorder clinicians.

Table 3 shows the number of full-time, part-time, and full-time equivalent mental health clinicians, substance use disorder (SUD) clinicians, and total master's-level clinicians (i.e., mental health plus SUD

Table 2. Analysis of the Distribution of Specialty Mental Health Prescribers for Youth Relative to Youth Need by Idaho Area

	N of Youth with SED	Expected N of FTE specialty prescribers if proportionate to youth need	Observed N of FTE specialty prescribers
Regions 1 & 2	6224	13	14
Regions 3 & 4	16811	34	30
Region 5	4707	10	2
Regions 6 & 7	9758	20	31

Table 3. Number of Full-time, Part-time, and Full-time Equivalent (FTE) Master's-level Mental Health Clinicians Serving Youth in Idaho

		Mental Health Clinicians			Substance Use Disorder Clinicians			Total Master's-level Clinicians		
Area	IDHW Regions	Full-time (N)	Part-time (N)	Total FTE (N)	Full-time (N)	Part-time (N)	Total FTE (N)	Full-time (N)	Part-time (N)	Total FTE (N)
1	Regions 1 & 2	217	62	248.4	39	7	42.4	256	69	290.8
2	Regions 3 & 4	735	175	822.1	77	17	85.7	812	192	907.8
3	Region 5	124	63	155.2	23	6	25.5	146	69	180.7
4	Regions 6 & 7	453	109	507.4	31	8	34.7	484	116	542.2
	State Total	1,529	409	1,733.2	169	38	188.4	1,698	446	1,921.5

clinicians) who work with Idaho youth and their families by area of the State. The total number of mental health clinicians who worked with youth in Idaho in 2016 was estimated to be 1,938 (i.e., full-time plus part-time clinicians), representing 1,733 full-time equivalent (FTE) clinicians. Data provided by Idaho Medicaid indicates that a total of 4,242 mental health clinicians delivered services to all participants in the network during the same time period. Assuming comparable definitions of mental health clinicians, this suggests that 46% of mental health clinicians in the Medicaid network served youth in 2016.

Figure 5. Full-time Equivalent Master's-Level Clinicians per 1,000 Youth with SED

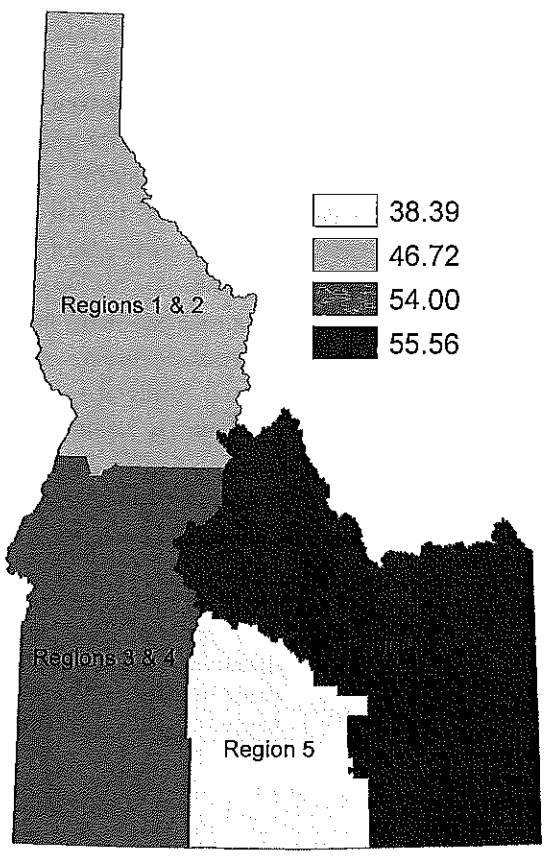


Table 4 presents the ratios of FTE master's- level mental health and substance use disorder clinicians per 1,000 youth with SED across each area of the State. **Figure 5** shows the total number of FTE master's-level clinicians per 1,000 youth with SED in each area of the State.

In order to formally compare the availability of master's-level mental health clinicians for youth with

Table 4. Full-time Equivalent (FTE) Master's Level Clinicians Available to Treat Youth in Idaho per 1,000 Youth with Serious Emotional Disturbance (SED) by Area

Area	IDHW Regions	FTE Mental Health Clinicians per 1,000 Youth with SED	FTE SUD Clinicians per 1,000 Youth with SED
1	Regions 1 & 2	39.92	6.81
2	Regions 3 & 4	48.90	5.10
3	Region 5	32.97	5.42
4	Regions 6 & 7	52.00	3.56
	State Total	46.22	5.02

Table 5. Analysis of the Distribution of Master's-level Mental Health Clinicians for Youth by Area of the State

	Expected N of FTE clinicians if proportionate to youth need	Observed N of FTE clinicians
Regions 1 & 2	288	248
Regions 3 & 4	777	822
Region 5	218	155
Regions 6 & 7	451	507

Table 6. Number of Bachelor's-level Mental Health Staff Serving Youth in Idaho

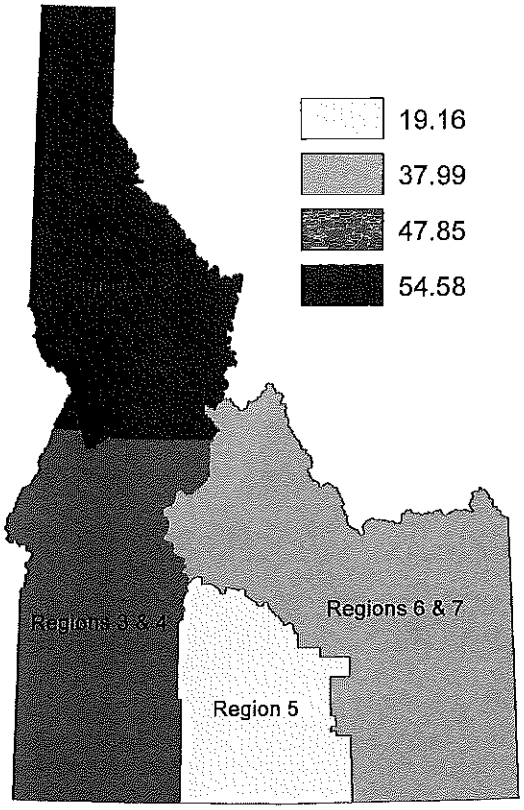
Area	IDHW Regions	N of Full-time Bachelor's-level Staff	N of Part-time Bachelor's-level Staff	FTE Bachelor's-level Staff	FTE Bachelor's-level Staff per 1,000 Youth with SED
1	Regions 1 & 2	272	136	339.7	54.58
2	Regions 3 & 4	647	314	804.3	47.85
3	Region 5	72	36	90.2	19.16
4	Regions 6 & 7	278	185	370.7	37.99
	State Total	1269	671	1604.9	42.80

Table 7. Characteristics of Bachelor's-level Mental Health Staff Serving Youth in Idaho

Area	IDHW Regions	N of Staff Delivering Case Management	N of Staff Delivering CBRS	N of CBRS staff certified to work with children	% of CBRS staff certified to work with children	N of CBRS staff working towards child certification	% of CBRS staff working toward child certification
1	Regions 1 & 2	86	109	71	65%	34	31%
2	Regions 3 & 4	510	316	87	27%	167	53%
3	Region 5	38	89	23	26%	1	1%
4	Regions 6 & 7	334	246	198	81%	38	15%
	State Total	967	759	379	50%	239	32%

SED across Idaho, we conducted a chi-square goodness-of-fit test which evaluated whether the distribution of mental health clinicians across the state was proportionate to youth need, measured as number of youth with SED in each area of the State. Similar to the analyses presented above for prescribers, this analysis does not test the absolute availability of clinicians but rather their distribution across the State. Results of the analyses indicated that mental health clinicians for youth are not distributed proportionate to youth need in Idaho, $p < .001$ (see **Table 5**). Regions 3, 4, 6, and 7 had a higher than expected number of clinicians relative to youth need whereas Regions 1 and 2 had slightly fewer than expected clinicians and Region 5 had the largest deficit in clinicians relative to youth need.

Figure 6. Full-time Equivalent Bachelor's-Level Staff per 1,000 Youth with SED



4.1.3. Bachelor's-level Staff

Bachelor's-level staff and paraprofessionals represent an important part of the mental health services workforce for youth. These individuals have special education, training, credentials, and sometimes licensure which equip them to provide a range of community-based services and supports to

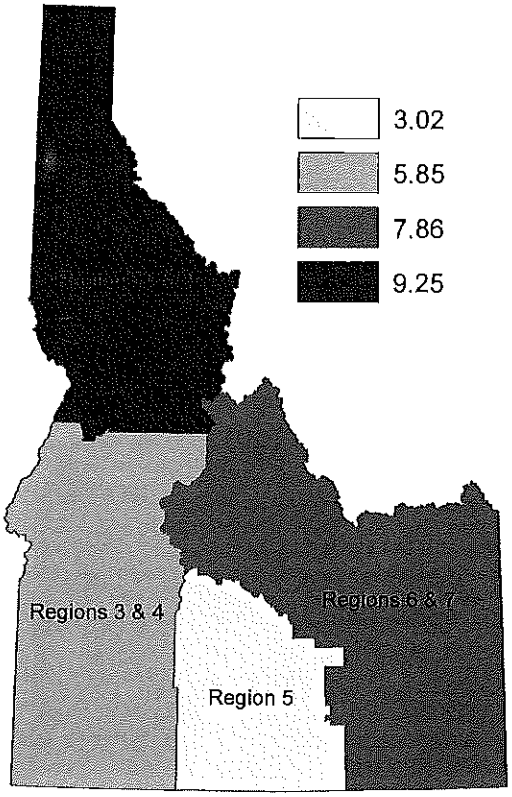
Table 8. Number of Peer-support Staff Delivering Services to Youth with SED and their Families in Idaho

Area	IDHW Regions	N of Full-time peer support staff	N of part-time peer support staff	Total FTE of Peer Support staff	FTE peer support staff per 1,000 youth with SED
1	Regions 1 & 2	30	56	57.6	9.25
2	Regions 3 &4	73	52	98.4	5.85
3	Region 5	11	6	14.2	3.02
4	Regions 6 & 7	61	32	76.7	7.86
	State Total	174	146	246.8	6.58

youth with SED and their families under the supervision of master's-level clinicians and other mental health professionals. Community-based services are a critical part of the new YES service array and having a qualified cadre of bachelor's-level staff to deliver these services is crucial to the effectiveness of the YES transformation.

Respondents to the YES Workforce Survey were asked to indicate the number of bachelor's level and paraprofessional staff who delivered services to youth and their families in the following categories: case manager, community based rehabilitation specialist, community based services provider, crisis case manager, crisis specialist, intake coordinator, mental health technician, psychiatric technician, rehabilitation technician, registered nurse, and respite care provider. These categories of staff were combined to represent the total bachelor's-level staff available to serve youth with SED; however, it is important to note that staff with higher levels of education (e.g., master's level) and/ or licensure can perform these jobs. In a separate section of the survey, respondents were also asked specifically about the number of staff delivering case management and community-based rehabilitation services (CBRS). We present these finer-grained analyses in this section as well.

Figure 7. Full-time Equivalent (FTE) Peer-Support Staff Delivering Services to Youth per 1,000 Youth with SED



The total number of full-time, part-time, and full-time equivalent bachelor's-level mental health staff who worked with youth in Idaho's Medicaid network in 2016 is shown in **Table 6**. **Figure 6** shows the ratio of FTE bachelor's level staff per 1,000 youth with SED across the four areas of Idaho.

Table 7 provides additional detail on the number of staff who provided specific community-based services that are often delivered by bachelor's-level staff—these services include community-based rehabilitation services (CBRS) as well as case management. In addition, Table 7 also shows the percentage of CBRS staff who are certified to work with youth across the entire State and within each area of the State as reported by providers. Overall, 50% of CBRS staff appear to have a special credential for working with youth and there is significant variability across areas of the State in the proportion of CBRS staff who are certified to work with youth. Regions 6 and 7 had the highest percentage of CBRS staff certified to work with youth (81%), followed by Regions 1 and 2 (65%). Regions 3 and 4 (27%) and Region 5 (26%) had much lower proportions of CBRS staff certified to work with youth.

In order to assess the extent to which Idaho's current bachelor's-level mental health staff are distributed across the State proportionate to youth need, we conducted a series of chi-square goodness-of-fit tests. These tests compared the expected number of bachelor's-level staff in each area of the State (if distribution was based on youth need) to the observed number of bachelor's-level staff in each area of the State. Results indicated that bachelor's-level staff were not distributed proportionate to youth need in Idaho (all p's < .001). Regions 6 and 7 had a higher proportion of CBRS workers relative to their expected number if CBRS staff were distributed proportionate to youth need. This suggests that CBRS staff are concentrated in the eastern regions of the State. In contrast, case management staff were disproportionately represented in Areas 2 and 4.

4.1.4. Peer Support Workforce

Peer support staff are persons with lived experience of mental illness or persons who have had a child who experienced a mental illness and who have undergone training and certification to provide mental health services to other persons with mental illness or to youth with SED and their families. These individuals represent an important and growing part of the workforce for youth with SED and their families in Idaho and across the United States as systems shift toward community-based services and supports. Respondents to the YES Workforce Survey indicated whether they employed certified family support partners or peer support specialists and the results of these analyses are presented here. **Figure 7** shows the number of FTE peer-support staff per 1,000 youth with SED in Idaho and **Table 8** presents the number of peer-support staff who worked full-time and part-time.

Analysis of the distribution of peer support staff across the state indicated that these staff were not distributed proportionate to youth need (p < .001). The northern and eastern areas of the state had higher than expected counts of peer support staff while Region 5 had an especially low count of peer support staff.

4.2. Idaho Medicaid Youth Mental Health Workforce by Training in Wraparound and EBPs

Evaluating the total number of providers available to treat youth with SED and their families in Idaho is only one part of ensuring that Idaho's mental health service system is effective. It is also crucial to ensure that the content of services is effective. Evidence-based practices (EBPs) are psychosocial interventions

Table 9. Number of Idaho Mental Health Clinicians Trained in Select Evidence-Based Practices for Youth by Area

Area of the State		N of clinicians trained in the model	Trained clinicians per 1,000 youth with SED
Cognitive-Behavioral Therapy (CBT)*			
1	Regions 1 & 2	137	22.0
2	Regions 3 &4	319	19.0
3	Region 5	55	11.7
4	Regions 6 & 7	173	17.7
	State Total	684	18.2
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)*			
1	Regions 1 & 2	85	13.6
2	Regions 3 &4	155	9.2
3	Region 5	24	5.1
4	Regions 6 & 7	98	10.0
	State Total	361	9.6
Home and Community Based Services*			
1	Regions 1 & 2	44	7.0
2	Regions 3 &4	122	7.2
3	Region 5	19	4.0
4	Regions 6 & 7	94	9.7
	State Total	278	7.4
Person-Centered Planning			
1	Regions 1 & 2	41	6.6
2	Regions 3 &4	98	5.8
3	Region 5	14	3.1
4	Regions 6 & 7	63	6.5
	State Total	217	5.8
Parenting with Love and Limits*			
1	Regions 1 & 2	50	8.1
2	Regions 3 &4	82	4.9
3	Region 5	14	2.9
4	Regions 6 & 7	44	4.5
	State Total	190	5.1

*Indicates providers were not distributed proportionate to youth need (chi-square goodness-of-fit test).

shown to improve youth well-being in randomized controlled trials.[7] Ideally, Idaho youth who receive care through the YES service array will receive EBPs that are matched to their specific diagnosis, preferences, and needs. As part of the YES Workforce Survey, organizations and sole proprietors were asked to report on the number of staff in their practice who had training and expertise in delivering select EBPs. The survey included embedded links to 10 EBPs so that respondents could confirm. Currently, there are over 1,200 psychosocial interventions that could be considered EBPs based on their effectiveness as demonstrated in randomized controlled trials.[7, 8] The specific EBPs included in the survey were selected by the Department based on their relevance and importance to Idaho youth.

The EBPs in the survey included: cognitive-behavioral therapy, trauma-focused cognitive behavioral therapy, parent child interaction therapy, eye movement desensitization and reprocessing therapy, Multisystemic therapy, Triple P Positive Parenting Program, Person-Centered Planning, Parenting with Love and Limits, Incredible Years, and Home and Community Based Services. In this section, we present data on the estimated number of Idaho clinicians who serve youth who have expertise in these practices based on weighted analyses of provider-reported data. In addition, we present information on the total number of providers with training in the wraparound service model.

Table 9 presents the number of Idaho mental health providers trained in selected EBPs by region and state totals. For all but two EBPs there was evidence that providers were not distributed across the State proportionate to youth need. Furthermore, the absolute number of trained providers per 1,000 youth with SED was quite low, indicating the need to increase the number of providers trained in these youth EBPs in Idaho.

Figure 8 visually displays the distribution of mental health professionals trained in the 10 EBPs across Idaho's four regions; each map indicates the number of clinicians trained in the EBP per 1,000 youth with SED so that comparisons can be made across areas and across EBPs. From the Figure it is apparent that Regions 1 and 2 tend to have the highest concentrations of providers trained in these EBPs for youth and that Region 5 appears to have a significant shortage of providers trained in these EBPs relative to the youth SED population.

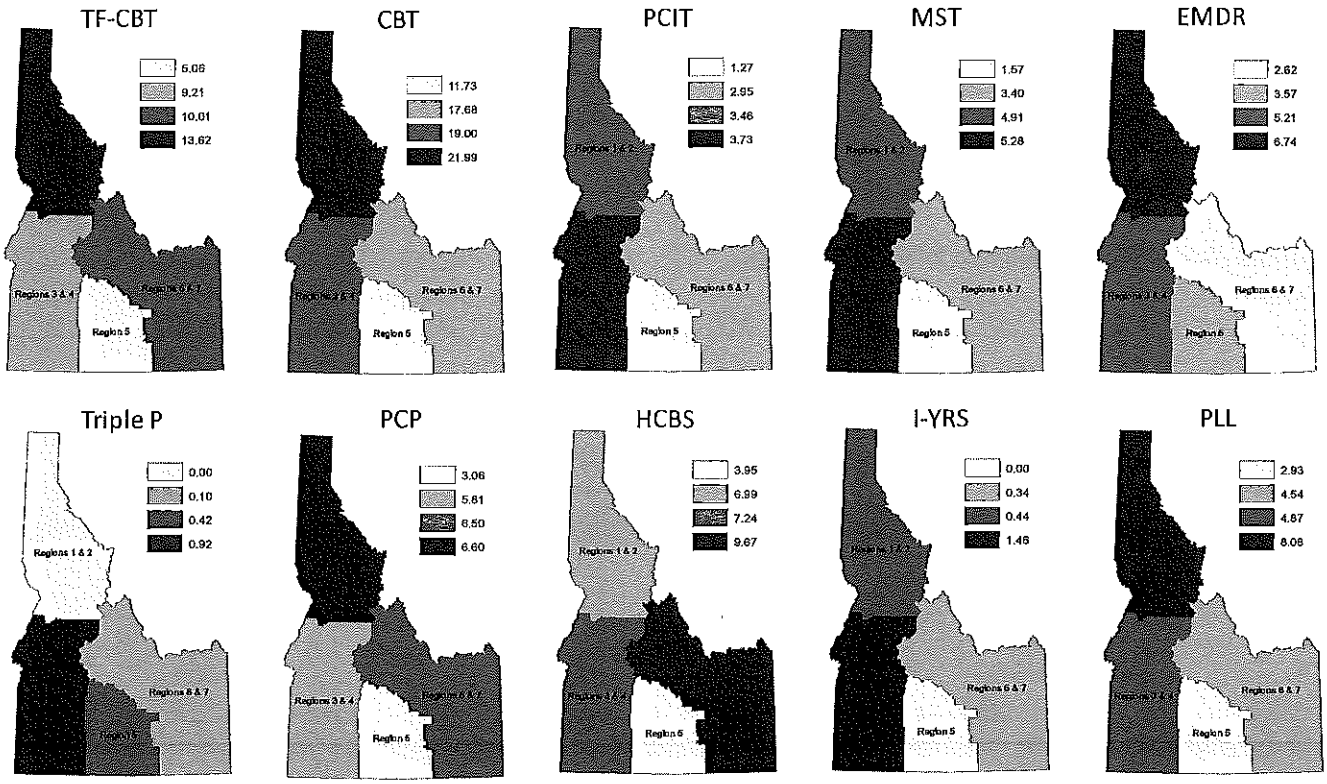
Table 9 (Continued). Number of Idaho Mental Health Clinicians Trained in Select EBPs for Youth by Area

Area of the State		N of clinicians trained in the model	Trained clinicians per 1,000 youth with SED
Eye Movement and Desensitization Therapy (EMDR)*			
1	Regions 1 & 2	42	6.7
2	Regions 3 &4	88	5.2
3	Region 5	17	3.6
4	Regions 6 & 7	26	2.6
	State Total	172	4.6
Multisystemic Therapy (MST)*			
1	Regions 1 & 2	31	4.9
2	Regions 3 &4	89	5.3
3	Region 5	7	1.6
4	Regions 6 & 7	33	3.4
	State Total	160	4.3
Parent-Child Interaction Therapy (PCIT)			
1	Regions 1 & 2	22	3.5
2	Regions 3 &4	63	3.7
3	Region 5	6	1.3
4	Regions 6 & 7	29	3.0
	State Total	119	3.2
Incredible Years*			
1	Regions 1 & 2	3	0.4
2	Regions 3 &4	25	1.5
3	Region 5	0	0.0
4	Regions 6 & 7	3	0.3
	State Total	31	0.8
Triple P (Positive Parenting Program)*			
1	Regions 1 & 2	0	0.0
2	Regions 3 &4	15	0.9
3	Region 5	2	0.4
4	Regions 6 & 7	1	0.1
	State Total	18	0.5

*Indicates providers were not distributed proportionate to youth need (chi-square goodness-of-fit test).

The number of providers who indicated they were providing wraparound services is shown in **Table 10**. The Table also indicates the number of youth who are likely to need Intensive Care Coordination using the Wraparound approach based on a previous report

Figure 8. Number of Idaho Mental Health Providers Trained in Evidence-Based Practices for Youth per 1,000 Youth with Serious Emotional Disturbance (SED) by Area



Note: TF-CBT = trauma-focused cognitive-behavioral therapy; CBT = cognitive-behavioral therapy; PCIT = parent-child interaction therapy; MST = Multisystemic therapy; EMDR = eye movement desensitization and reprocessing therapy; Triple P = Positive Parenting Program; PCP = person-centered care planning; HCBS = home and community based services; I-YRS = Incredible Years; PLL = Parenting with Love and Limits.

submitted to the State.[9] The last column in Table 11 shows the provider to youth ratio of the number of wraparound providers to the number of youth who may need this service. As is shown in the Table, the youth-to-provider ratios are much higher in Regions 1 and 2 than in other areas of the State, suggesting the need to develop wraparound services in the northern part of the State.

Wraparound developers suggest a ratio of 12 youth per provider is necessary to maintain high program fidelity and effectiveness.

4.3. Number of Idaho Youth who Received Select EBPs as Part of their Medicaid-funded Treatment

As part of the YES Workforce Survey, providers indicated the number of youth they treated in the last year using EBPs. These questions asked about the same 10 EBPs listed above and did not include other EBPs that providers may have used. **Table 11** shows

Table 10. Number of Idaho Providers who Deliver Wraparound Services

Area		N of youth with SED likely to need wraparound	N of staff providing wraparound	Youth-to-Provider Wraparound Ratio
1	Regions 1 & 2	227	8	29.1
2	Regions 3 &4	612	167	3.7
3	Region 5	171	80	2.2
4	Regions 6 & 7	355	34	10.6
	State Total	1,365	288	4.7

Note: Youth-to-provider ratio calculated as N of youth likely to need wraparound/ N of wraparound providers.

weighted statewide estimates of the total number of Idaho youth who received EBPs based on provider reports in each area of the State. The Table also shows the percentage of total youth service users (total N = 27,411 youth) who received each EBP based on our weighted analyses. These data show a pattern similar to that observed for EBP training in terms of service coverage and gaps.

5. Idaho Youth Mental Health Workforce Gaps Analysis

The estimates presented above quantify the capacity of Idaho's Medicaid mental health workforce to provide YES services and supports by indicating the number of providers available per 1,000 youth with SED and the distribution of those providers across the State. In this section, we provide additional analyses estimating the projected gap between Idaho's current Medicaid mental health services workforce for youth and the workforce needed to deliver YES services and supports to youth with SED and their families. The estimates presented here are intended to serve as one input into the State's

Table 11. Number and Geographic Distribution of Idaho Youth who Received Select Evidence-Based Practices

Area of the State		N of individual youth served	% of youth who received Medicaid MH services
Cognitive-Behavioral Therapy (CBT)			
1	Regions 1 & 2	1,427	30%
2	Regions 3 &4	2,798	22%
3	Region 5	519	18%
4	Regions 6 & 7	1,458	20%
	State Total Youth Served	6,202	23%
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)			
1	Regions 1 & 2	749	16%
2	Regions 3 &4	1,425	11%
3	Region 5	214	7%
4	Regions 6 & 7	755	11%
	State Total Youth Served	3,143	11%
Home and Community Based Services			
1	Regions 1 & 2	311	7%
2	Regions 3 &4	1,050	8%
3	Region 5	210	7%
4	Regions 6 & 7	498	7%
	State Total Youth Served	2,069	8%
Eye Movement and Desensitization Therapy (EMDR)			
1	Regions 1 & 2	353	7%
2	Regions 3 &4	1,079	9%
3	Region 5	212	7%
4	Regions 6 & 7	423	6%
	State Total Youth Served	2,066	8%
Person-Centered Planning			
1	Regions 1 & 2	501	11%
2	Regions 3 &4	898	7%
3	Region 5	125	4%
4	Regions 6 & 7	400	6%
	State Total Youth Served	1,924	7%

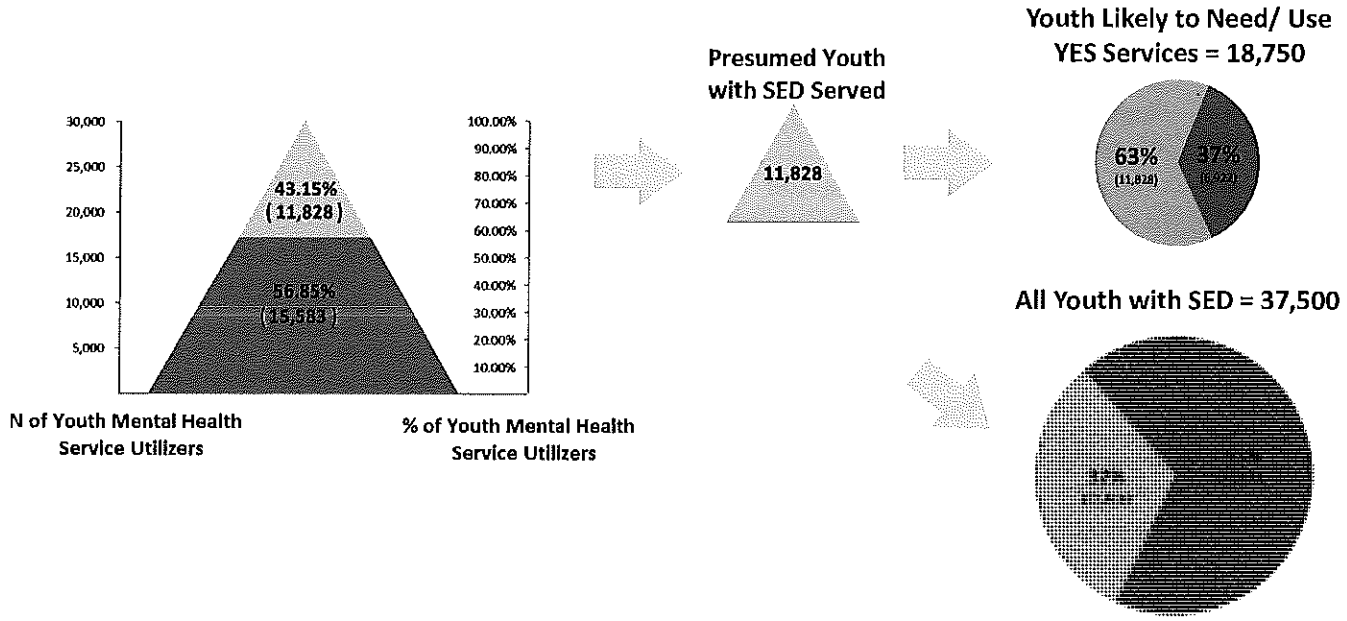
Area of the State		N of individual youth served	% of youth who received Medicaid MH services
Parenting with Love and Limits			
1	Regions 1 & 2	480	10%
2	Regions 3 &4	553	4%
3	Region 5	100	3%
4	Regions 6 & 7	368	5%
	State Total Youth Served	1,501	5%
Multisystemic Therapy (MST)			
1	Regions 1 & 2	281	6%
2	Regions 3 &4	642	5%
3	Region 5	65	2%
4	Regions 6 & 7	303	4%
	State Total Youth Served	1,290	5%
Parent-Child Interaction Therapy (PCIT)			
1	Regions 1 & 2	272	6%
2	Regions 3 &4	556	4%
3	Region 5	50	2%
4	Regions 6 & 7	363	5%
	State Total Youth Served	1,241	5%
Incredible Years			
1	Regions 1 & 2	43	1%
2	Regions 3 &4	106	1%
3	Region 5	0	0%
4	Regions 6 & 7	125	2%
	State Total Youth Served	273	1%
Triple P (Positive Parenting Program)			
1	Regions 1 & 2	0	0%
2	Regions 3 &4	89	1%
3	Region 5	50	2%
4	Regions 6 & 7	100	1%
	State Total Youth Served	239	1%

workforce planning efforts.

5.1. Method for Assessing Gaps

Several methods are available for analyzing the gap between a target population's need for services (i.e., demand) and the available stock of healthcare providers to deliver those services.[10-13] The essential ingredients in any such analysis are (a) an estimate of the available professional workforce (provided above), and (b) an estimate of the target population's need for services (i.e., demand). Some models also incorporate projections regarding changes in the workforce and the demand for services over time; however, in this report, we limit our attention to a point-in-time estimate of the current gap between Idaho's mental health services workforce for youth and the workforce needed to deliver YES services and supports to youth with SED. Furthermore, given that data are not available regarding utilization patterns for new YES services that will be made available as part of the system transformation, we make the simplifying assumption that regardless of the current stock of mental health professionals, the YES transformation will require significant re-training of the existing mental health services workforce and task shifting in order to ensure that the current stock of providers can deliver the new YES services and

Figure 9. Presumed Number of Youth with Serious Emotional Disturbance (SED) Served by Idaho Medicaid in 2016 and Proportion of Total Idaho Youth with SED and Idaho Youth Likely to Use Youth Empowerment Services



supports in accordance with the conditions set out by the Settlement Agreement. These conditions include the use of the Idaho Practice Manual, which outlines the basic principles and procedures to be used in serving youth with SED, and the integration of standardized assessments such as the Child and Adolescent Needs and Strengths (CANS) tool to guide treatment planning.

Below, we present two different estimates of Idaho's YES workforce capacity gap, based on two different assumptions or models of the target population's need for services. For both models, the estimates focus exclusively on the workforce gap related to youth with SED; the workforce gaps will be larger if the entire population of Idaho youth with mental disorders is included in estimating the need for services. That is, workforce capacity gaps presented here focus exclusively on the needs of youth with SED and omit other youths who may need mental health services.

5.2. Workforce Gaps Analysis 1: Anticipated Need Scenario

The first workforce gaps analysis assumes that (1) the existing Idaho mental health workforce for youth is currently meeting the needs of some proportion of youth with SED and their families, and (2) 50% of the total population of youth with SED in Idaho will utilize/ need YES services. Assumption 2 is based on a large and replicated body of scientific evidence showing that 50% of youths with SED (and their families) participate in formal mental health services of any kind from any service sector and 50% of youth with SED do not participate in services. Given this evidence, the first workforce analysis assumes that workforce planning for YES should ensure an adequate supply of staff to meet the needs of all youth with SED who are *likely to use YES services.*

In order to estimate the gap between Idaho's current youth mental health services workforce and that required to meet the needs of all youth with SED who are likely to use YES services, two population estimates are needed. First, an estimate is needed of the proportion of the target population that is currently being served. For this, we relied on an analysis of 2015 Medicaid claims data conducted by Optum Idaho which assessed the number of youth with SED currently served by the Idaho Medicaid system. In the report, the evaluators grouped all youth Medicaid participants who had received any mental health service in 2015 into one of nine diagnostic categories (Schizophrenia and Other Psychotic Disorders; Bipolar and Related Disorders;

Depressive Disorders; Trauma- and Stressor-Related Disorders; Disruptive, Impulse-Control and Conduct Disorders; Anxiety Disorders, and Other Behavioral Health Disorders) and partitioned the youth within each diagnostic category into quartiles based on the number of mental health claims used in 2015. The number of mental health claims was used as a proxy for the severity of functional impairment. Based on this analysis, the evaluators tabulated the total number of Idaho youth with SED who were currently served by the Idaho Medicaid system. Results of the service utilization analysis indicated that 27,367 Idaho youth received some type of mental health service through Idaho Medicaid in 2015. Of these, 11,808 youth (43.15%) were identified as likely to be experiencing SED based on their diagnostic classification and intensity of service utilization. Consequently, 43.15% of youth who participated in Medicaid-funded mental health services in 2015 were presumed youth with SED.

In order to estimate the number of youth with SED who were served by Idaho Medicaid in 2016, we assumed that the proportion of mental health service utilizers who experienced SED in 2015 (i.e., 43.15%) was equal to that of 2016. Data provided by IDHW indicated that there were 27,411 youth who received Medicaid-funded mental health services in 2016. If 43.15% of these youth experienced SED, this implies that Idaho's 2016 behavioral health workforce met the needs of 11,828 youth with SED who were *likely YES service users* (.4315 x 27,411).

The pyramid in **Figure 9** shows the proportion, and number, of presumed youth with SED served by Idaho Medicaid in 2016 based on the analysis presented above. In addition, the Figure projects the presumed number of youth with SED served onto the total population of youth with SED in Idaho (bottom pie) and onto the population of youth with SED who are likely to use/ need YES services (top pie). Based on these projections, in 2016 Idaho's mental health services workforce met the needs of 63% of all youth with SED who are likely to need/ use YES services. This implies that the workforce did not serve 37% of youth with SED who are likely to need/ use YES services. This estimate of 37% was used as one input in estimating the YES workforce service capacity gap.

The second estimate needed to calculate the YES workforce capacity gap is the number of mental health professionals who were necessary to serve the 43.15% of youth mental health service utilizers who were presumed to have SED and to need YES services in 2016. To develop this estimate, we relied on the assumption that the proportion of the workforce that served youth with SED was equivalent to the proportion of total youth service utilizers who experienced SED; that is, if 43.15% of youth service utilizers experienced SED, then 43.15% of mental health professionals who served youth were needed to meet the needs of those youth. This is likely an underestimate of the actual number of mental health staff needed to meet the needs of youth with SED because it assumes that youth with SED and those without SED require equal amounts of time in services delivered across all types of mental health professionals. However, in the absence of finer-grained data on service utilization for each youth, this assumption provides a parsimonious and reasonable basis for developing a projection of the workforce needed to deliver YES services and supports. Based on this assumption, 43.15% of Idaho's youth mental health services workforce was needed to deliver YES services and supports to youth with SED in 2016. **Table 12** shows the estimated number of FTE Idaho providers needed to meet the needs of youth with SED who are likely to need/ use YES services in each professional category in 2016.

Having developed estimates of (1) the presumed number of Medicaid mental health service utilizers who are likely to need/ use YES services, and (2) the mental health services workforce needed to meet their needs, we used this information to estimate the additional workforce needed to meet the needs of all youth with SED who are likely to utilize YES services—these estimates are shown in Column 6 of **Table 12**. As is described above, these estimates assume that the current workforce shown in Column 5 meets the needs of 63% of youth with SED who are likely YES service utilizers and therefore that 37% more staff will be needed to deliver 100% of the YES services and supports to the target population. As is shown in Table 12, this analysis suggests a total of 574 additional mental health professionals, including 276 master's-level clinicians and 256 bachelor's-level staff, will be needed to provide YES services and supports statewide.

Table 12. Estimated Idaho YES Workforce and Projected Need for Increased YES Workforce by Area

Provider Type	Area		N of Total FTE Providers Serving Youth	N of FTE Providers Serving Youth with SED	N of Additional Providers Needed to Fill YES Workforce Gap: Anticipated Need Scenario	N of Additional Providers Needed to Fill YES Workforce Gap: Extended Population Scenario
Psychiatrists		State Total	27	12	4	8
	1	Regions 1 & 2	4	2	1	1
	2	Regions 3 &4	6	3	1	2
	3	Region 5	1	0	0	0
	4	Regions 6 & 7	16	7	3	5
All specialty Prescribers		State Total	77	33	12	23
	1	Regions 1 & 2	14	6	2	4
	2	Regions 3 &4	30	13	5	9
	3	Region 5	2	1	0	0
	4	Regions 6 & 7	31	13	5	9
Mental Health Clinicians		State Total	1,733	748	276	512
	1	Regions 1 & 2	248	107	40	73
	2	Regions 3 &4	822	355	131	243
	3	Region 5	155	67	25	46
	4	Regions 6 & 7	507	219	81	150
SUD Clinicians		State Total	188	81	30	56
	1	Regions 1 & 2	42	18	7	13
	2	Regions 3 &4	86	37	14	25
	3	Region 5	26	11	4	8
	4	Regions 6 & 7	35	15	6	10
Bachelor's-level staff		State Total	1,605	693	256	474
	1	Regions 1 & 2	340	147	54	100
	2	Regions 3 &4	804	347	128	238
	3	Region 5	90	39	14	27
	4	Regions 6 & 7	371	160	59	110
All Staff (Total)			3,603	1,555	574	1,064

5.3. Workforce Gaps Analysis 2: Extended Population Scenario

The second workforce gaps analysis makes similar assumptions to the analysis presented above with one exception—this analysis assumes that all youth with SED in Idaho will utilize YES services. This analysis incorporates all youth with SED, including those who traditionally have not participated in publicly- or privately-funded mental health services through any sector. As is shown in **Figure 9**, youth with SED who were served by Medicaid in 2016 made up 32% of the total population of all youth with SED in Idaho (total projected population is based on the CSET described above = 37,500 youth). Making the same assumptions about the number of staff required to meet the needs of youth with SED, this projection suggests that the SED workforce shown in Column 5 of **Table 12** would need to be increased by 68.46%. Column 7 of **Table 12** shows the number of additional mental health professionals needed in each category and across each area of the State in order to meet the projected needs of all 37,500 Idaho youth with SED based on these assumptions.

5.4. Caveats and Limitations

The estimates presented in this report must be

interpreted in light of the data's limitations. First, although the YES Workforce Survey achieved a relatively high response rate (60%) and well-established weighting class adjustments were used to generate estimates of population totals, the estimates of workforce capacity presented in this report nonetheless represent a single data-point based on incomplete information. While useful for planning, these estimates should be treated as estimates and not as true population totals. It is also important to note that self-reported data may contain errors; for example, providers may have incorrectly reported on workforce characteristics. Furthermore, other providers outside of the Medicaid system also deliver mental health services to youth and these providers were not included in the YES Workforce Survey.

It is also important to note that these estimates represent a point-in-time analysis. They do not take into account Idaho's large population growth nor do they address changes in the supply of mental health professionals over time. Analyses of licensing data from the Idaho Bureau of Labor indicate that the number of licensed mental health professionals in Idaho has been steadily increasing across all categories of social workers and counselors for the last decade. In sum, these data provide a point-in-time estimate of Idaho's workforce capacity to deliver YES services and supports to youth with SED and highlight needs for workforce development.

6. Summary and Recommendations

The goal of this Workforce Capacity and Gaps Analysis was to assess the current capacity of Idaho's publicly-funded mental health workforce to deliver YES services and supports to Idaho youth with SED and their families under the terms of the Jeff D. Settlement Agreement. Based on a weighted analysis of survey data provided by organizations and sole proprietorships that deliver mental health services in Idaho's Medicaid network, this report provides population estimates of the current number of mental health professionals who work with youth and their families in Idaho, the number of professionals trained in high priority evidence-based practices for youth and newly emerging YES services such as Wraparound, and the geographic distribution of these professionals. The report also provides a point-in-time analysis of the workforce capacity gap based on two separate scenarios incorporating different assumptions about the capacity needed to meet the needs of the target population.

Findings from this analysis indicate that an estimated 3,603 mental health professionals currently deliver mental health services to 27,411 Idaho youth and their families in Idaho's Medicaid-funded mental health system. In order to provide YES services and supports to all youth with SED, Idaho's youth mental health services workforce is projected to require an increase of 15.9% to 29.5% depending on the underlying assumptions used to generate the model. In addition, this report highlights significant gaps in workforce training and preparedness related to evidence-based practices and the new community-based YES service array (e.g., wraparound, respite) as well as maldistribution of mental health providers for youth across Idaho's geographic areas. Findings from this report are consistent with analyses of Idaho's behavioral health workforce conducted by federal agencies and other research groups which indicate that all 44 of Idaho's counties are Health Professional Shortage Areas for mental health professionals[14] and that 31 of Idaho's 44 counties are above the national median on unmet need for mental health professionals.[10]

6.1. Developing Idaho's Current Mental Health Services Workforce for Youth

The YES system transformation will require significant task-shifting for Idaho mental health providers who serve youth as well as re-training to deliver an array of community-based services and supports based on the YES Practice Model. The following recommendations focus on developing Idaho's current mental health workforce for youth to meet these challenges.

Recommendation 1. Support the Idaho mental health provider network in developing competencies to deliver YES services by providing training within a sustainable, value-added approach built around credentialing.

For many years Idaho State has relied on community-based rehabilitation services as the sole community-based service for youth with SED.

Providers developed competence in hiring and training staff to deliver this service and in securing reimbursement. Without proper support, providers may have difficulty transitioning to the new YES service array. One way to support providers in making this transition is to make training accessible across the State and to deliver training within a credentialing framework. A credentialing process allows the State to establish and monitor fidelity to new service models while also offering providers a way to advance their own careers and strategic goals (e.g., through the acquisition of valued credentials and expertise). In order to avoid bottlenecks, training and credentialing processes will need to be made widely available.

Recommendation 2. Make YES training efforts sustainable by partnering with institutions of higher education to develop curriculum materials and certificate programs that meet the State's needs.

Training and credentialing programs for YES services can be made sustainable by working with local universities to develop curriculums that meet the State's need for new YES community-based services. This type of model has worked successfully for targeted workforce development efforts in Idaho including the development of curriculum and certification programs for providers who deliver addiction services. A similar approach could be used for the new Youth Empowerment Service models. Embedding credentialing and training within existing university systems benefits all stakeholders. Students benefit by obtaining an education and credential with real world value once they graduate; rather than having to pay for college *and* pay for credentialing after college, students can optimize their tuition dollars by obtaining actionable credentials through their college degree. Providers benefit by avoiding the high costs of pre-service and in-service training for individuals who provide YES services. The State benefits by avoiding the high costs of ongoing large-scale training efforts which would be required to make ongoing credentialing sustainable.

Recommendation 3. Support providers in delivering new YES services by providing training in practice management and billing and by ensuring that all aspects of YES services are reimbursable.

Analysis of the YES Workforce Survey data indicate that the most common reason mental health professionals leave is because of low compensation; this finding is supported by other studies of behavioral health services across the United States which indicate that financially-strapped providers often go out of business or leave the profession rather than struggling to pay for re-training as new service models are deployed. Developing a robust workforce to deliver YES services will require educating providers on strategies to effectively bill for these new services as well as ensuring that all aspects of provider time, including coordination and non-traditional services, are billable.

Recommendation 4. Provide frequent, low-cost training to providers in EBPs across the State with an emphasis on areas of low penetration.

One clear deficit documented by the YES Workforce Survey is the need for increased training of Idaho providers in EBPs for youth. In their qualitative comments on the survey, providers expressed a complimentary desire for training in EBPs that meet their goals of delivering effective and reimbursable treatment. Several States and large service systems across the country offer models for delivering training to practitioners in EBPs on a large scale. Potential sources of revenue for funding these training efforts include earmarked network re-investment funds, federal grants from SAMHSA and other federal agencies focused on increasing the delivery of EBPs and other community based services for youth, and pursuing research collaborations with institutions of higher education to study the dissemination and implementation of EBPs in Idaho. Several federal research funders including the National Institute of Mental Health and the National Institute of Drug Abuse have prioritized research to better understand how to increase the use of EBPs in community settings. Securing funding for these types of large-scale research projects can increase the penetration rate of EBPs and improve clinician fidelity to these models. Accessing these resources requires dedicated time and effort. The Department should consider developing a half-time or full-time staff position to pursue these types of grants or should

partner with institutions of higher education to access these funds.

Recommendation 5. Reduce the geographic maldistribution of mental health service providers for youth.

This report clearly indicates that mental health providers for youth are not distributed proportionate to youth need across Idaho. Research on healthcare workforce indicates that providers often 'stay where they train' rather than moving to a rural area or returning to a rural and underserved area where they lived prior to training. Several strategies can be used to address this issue. First, the State could support training sites for mental health professionals in underserved areas such as Region 5. Increasing trainees' links to underserved communities may improve recruitment and retention in these areas. Support for training could be provided by sponsoring internships for master's-level social work or counseling students in mental health sites in low access areas or by reimbursing providers in underserved areas for supervising and training graduate students who intern at their sites and deliver YES services. Alternately, the State could provide paid youth mental health internships for graduate students at its own sites in rural and underserved areas. Another option is to provide targeted financial aid to mental health professionals who work with youth in underserved areas following graduation. This can take the form of loan repayment programs, tax incentives, or tuition and stipend programs linked to years of service in targeted areas and with the target population. The State could also provide distance education programs as a standalone or in partnership with institutions of higher education to persons who reside in rural and underserved areas in order to develop the workforce in these areas.

6.2. Increasing the Supply of Mental Health Professionals to Deliver YES Services and Supports

This report documents a need to increase the supply of mental health providers to deliver YES services and supports to Idaho youth with SED with a particular emphasis on areas of the State where workforce shortages are most acute. These data should be used as a baseline and the State should set targeted goals for increasing the supply of specific provider types in specific regions of the State. Following are suggestions for improving the recruitment of professionals into careers that support community-based YES services in Idaho.

Recommendation 6. Leverage federal workforce development funds to increase the supply of mental health providers for youth in Idaho.

Increasing the supply of behavioral health providers is a high priority nationally in the United States and federal monies are available to support States in accomplishing this goal. Idaho should develop a part-time or full-time behavioral health workforce position to pursue these funds which can contribute significant resources to Idaho's workforce efforts. The U.S. Health Resources and Services Administration (HRSA) is one example of a federal agency that supports States' behavioral health workforce efforts. In 2016, HRSA's Behavioral Health Workforce Education and Training program was launched to increase the behavioral health workforce in underserved areas. This program targeted providers at all levels from physicians to bachelor's-level staff and peer providers. Another HRSA program, the Evidence-based Tele-Behavioral Health Network program uses telehealth networks to increase access to behavioral health care clinical supervision and services in rural and frontier communities. Idaho could pilot innovative approaches to healthcare delivery using funds from these programs and then use this data to inform its network development.

Recommendation 7. Create an Idaho State behavioral workforce incentive program that provides stipends, loan repayment, and/ or tax credits to professionals who deliver YES services in targeted areas of the State for a specified period of time.

Several States have enacted legislation creating State-level workforce development incentives to increase the supply of behavioral health professionals within targeted areas and for targted populations. These policies can be similar to federal loan repayment programs which provide health professionals with loan repayment in exchange for working with a targeted population or underserved

area for a specified period of time (e.g., two years). Alternately, some States have used tax incentives for professionals who deliver specific types of services in targted areas. Another option is to develop stipend programs (similar to those used in child welfare settings) in which graduate students in social work, counseling, and other behavioral health-related disciplinces receive tuition remission and/ or stipend funds in exchange for working with a target population or service system for a specified period of years following graduation. These types of financial incentives can target professionals at different levels of training and disciplinary expertise.

Recommendation 8. Incentivize clinical training sites in targeted areas to train graduate student interns and trainees in YES service delivery models.

One strategy for increasing the supply of qualified YES providers is to incentize clinical training sites to educate and supervise trainees and graduate students in the delivery of YES services. This could be accomplished by allowing reimbursement for YES mental health services that are provided by trainees or by contracting with institutions of higher education to administer targeted grant support to YES clinical training sites for graduate and undergratduate students. This recommendation might complement efforts to integrate YES training into university curriculums. Funds for these grants could be used to train clinical site supervisors in YES service delivery models and to compensate them for time supervising graduate students to deliver YES services. Altnerately, IDHW could use its own sites across the State to create paid internship opportunities for graduate students and trainees to develop competence in delivering YES services in targeted areas of the State.

Recommendation 9. Increase the non-profit behavioral health workforce by obtaining federal grants and contracts that directly deliver community-based serivces to youth.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has several programs designed to support States in developing community-based services for youth with SED. These programs have not traditionally been accessed by Idaho State but could be leveraged to increase service delivery to youths with SED in the State. Exmaples of specific SAMHSA programs that support community-based services for youth include the *Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with Serious Mental Disorders* program (https://www.samhsa.gov/grants/grant-announcements/sm-18-010) and the *Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis program* (https://www.samhsa.gov/grants/grant-announcements/sm-18-012). Idaho State should explore funding a full- or part-time position within the Division of Behavioral Health to pursue these funding opportunities.

Recommendation 10. Expand the mental health workforce for youth by increasing funds for family peer support training and supervision and by exploring service integration with schools and other service systems (e.g., juvenile justice).

The peer workforce is an important and growing sector of behavioral health providers for youth and adults. This survey highlights the opportunity to significantly expand family peer support services in Idaho. In addition, integration with other service sectors such as public schools and juvenile justice systems can aid in expanding the behavioral health workforce for youth.

Recommendation 11. Confirm the competitiveness of reimbursement rates for services so that mental health providers for youth can earn competitive salaries relative to other professions.

The YES workforce survey found that uncompetitive compensation was the most common reason professionals left their positions. Ensuring that reimbursement rates for YES services are competitive will help attract and retain qualified professionals at all levels to work with youth.

Recommendation 12. Work with licensing boards to allow telehealth for clinical supervision in remote areas and craft similar guidelines for supervision of YES services at all levels.

Obtaining access to clinical supervision can be a

barrier to developing professional experitse in remote areas of the State. This burden is amplified when practitioners need clincial supervision in specialized service models such as the new services delivered under YES. Creating guidelines that permit clincial supervision to use technology can improve the ability of providers to deliver care in remote and underserved areas. Indeed, if funds were made available to pay for this supervision it would form an incentive for providers to deliver services in areas with professional shortages.

6.3. Enhancing Future YES Workforce Development Efforts

The development of this report revealed several opportunities to improve data collection efforts to guide YES workforce development in the future.

Recommendation 13. Implement a robust, standardized workforce data-collection process that ensures timely, useful data is available for planning.

Obtaining timely, high-quality data on Idaho's mental health services workforce is a major challenge. This report respresents a first step; however, engaging in continuous workforce monitoring and development efforts will require ongoing data. One way of obtaining this data is to implement a workforce data collection system linked to licensing. In New Mexico State, legislators enacted a law requiring health professionals to provide targeted workforce data as part of their mandatory licensing processes. The resultant data is housed and managed by one of New Mexico's large public universities which also makes reports and data available to State workforce planning groups. Idaho could implement a similar system in parnterhip with boards that licsense mental health professionals. Bachelor's-level staff could be surveyed upon graduation from credentialing or curriculum programs at universities (or other institutions).

Recommendation 14. Develop sustainable methods of assessing youth need/ demand for mental health professionals that serve youth.

The workforce capacity and gaps analysis presented in this report represents only one method of assessing the need for and supply of mental health professionals to deliver YES services and supports. The State could develop other procedures for assessing youth need and workforce capacity. Other methodologies for assessing youths' need for services include: (a) developing estimates of need based on claims data (e.g., the average amount of services currently used by youth with various SED profiles), or (b) developing expected clinical profiles and service usage for each level of care within the YES system.

Recommendation 15. Develop an estimate of projected changes in the supply and demand for YES services to further aid workforce planning.

The present report provides a point-in-time assessment of Idaho's current mental health workforce capacity to deliver YES community-based services and supports to youth with SED. In order to aid workforce planning it would be valuable for the State to conduct a 'stock and flow analysis' of projected changes in demand for YES services and the supply of professionals to deliver these services over time. These projections, which take into account population growth and changes in the labor pool over time, are important for identifying specific areas of need for growth.

Recommendation 16. Partner with other Idaho State agencies, such as the Idaho Bureau of Labor to inform workforce development.

The Idaho Bureau of Labor should be included in the YES workforce development committee and integrated into efforts to develop the YES workforce. IBOL has special expertise in workforce development and has recently completed analyses of Idaho's behavioral health workforce in preparation for applications for HRSA grants. These efforts should be coordinated with the YES workforce development initiative.

7. Conclusion

This Workforce Capacity and Gaps Analysis provides population estimates of the number of Idaho providers who currently deliver mental health services and supports to Idaho youth with SED and their families and assesses the gap between the

system's current workforce and the workforce needed to deliver YES services and supports under the terms of the Jeff D. Settlement Agreement. The report finds that Idaho needs to increase its mental health services workforce for youth by approximately 16% in order to deliver YES services and supports to youth with SED. Recommendations are provided for developing Idaho's current mental health workforce, increasing the supply of well-trained professionals, and for developing data that is useful for future workforce planning efforts.

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Technical Appendix

Weighting class adjustments were developed for the YES Workforce Survey using data available in the sampling frame including: (1) the number of organizations versus sole proprietorships operating as practice entities in Idaho (based on Tax Identification Numbers), (2) the number of organizations and sole proprietorships operating in each of four areas of the State (shown in Figure 1), and (3) the number of large versus small organizations in each area of the State based on roster information provided by Idaho Medicaid. These data were combined to form 'classes' based on the type of practice, the location of the practice, and the size of the practice (if an organization). Within each class, the total population of survey units was known and this population served as the denominator in calculating the within-class response rate. Data from the survey were then used to determine the number of respondents in each class (e.g., sole proprietorship vs. organization, size of organization, and location based on respondents' reports) and to calculate the probability of survey response within each class (i.e., number of respondents within class divided by the population within each class = response probability). The inverse of the within-class response probabilities represent weights which are applied to each survey respondent. The weighting procedure was verified by ensuring that the sum of the weights equaled the total population sample size, in this case N = 407 total practices representing the total number of organizations and sole proprietorships.

YOUTH EMPOWERMENT SERVICES

CLASS SIZE ESTIMATE

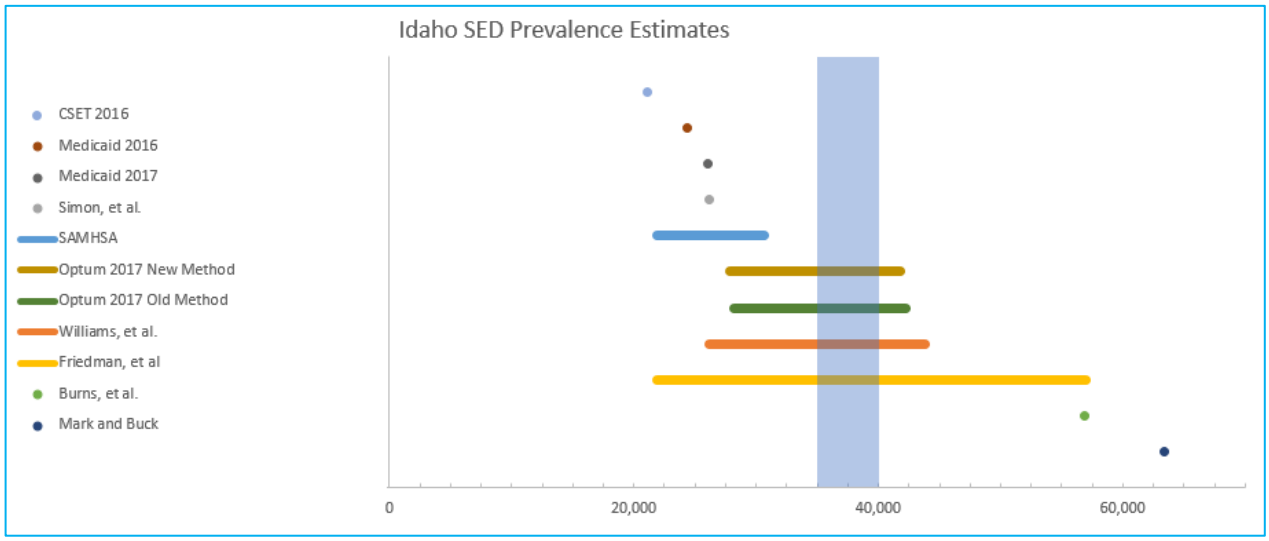
As one of the required annual deliverables to the plaintiffs in the Jeff D. lawsuit, the YES Data and Reports committee is tasked with providing an estimate of how many children in the state of Idaho have serious emotional disturbance (SED) and would be class members in the YES Project (Youth Empowerment Services). The 2017 Class Size Estimation Team (CSET), consisting of data and quality assurance team members from the Divisions of Behavioral Health and Medicaid, expanded upon the 2016 estimate and revised their methods for the 2017 edition.

Boise State University was commissioned to write a report evaluating the methodology of the first estimate of SED prevalence in Idaho (*Evaluation of a Methodology to Estimate the Prevalence of Serious Emotional Disturbance in Idaho,* Williams 2017). This report found that, though it was quite primitive and based almost solely on claims data – a flawed method for studies like these – it was acceptable considering the lack of data available to the team. The report went on to recommend for future estimates a more in-depth review of existing literature in creating the estimate. This year's team aimed to conduct a more thorough, research-centered approach to the estimation process.

Six studies and five claims-based estimates were used to inform the estimate for 2017. These studies and estimates were weighted on seven factors, including study size, reliance on claims, demographic similarity to Idaho, etc. Studies that were conducted with greater fidelity were weighted more than those that were based on claims data, those not performed by established researchers, and other limiting factors.

After combining these studies and estimates with their weighting, the CSET concluded that there are potentially 35,000-40,000 children in the state of Idaho with SED. As per other research, this is not the number of children expected to seek services through the YES Project, but the absolute number who may meet SED criteria.

Below is a forest plot of the estimate ranges of the studies and estimates consulted, with the potential number of SED children in the state of Idaho highlighted in blue.



Limitations and Interpretive Cautions

The data utilized in this report are to be taken with several assumptions and interpretive cautions. First, this is not the number of children expected to seek services through the YES Project, but the absolute number who may meet SED criteria. Second, in the state of Idaho, there is no current field in claims or electronic health record data to indicate if a child has SED. The number of children we currently assume may have SED is based on diagnostic information and claims intensity. Third, none of the studies considered involve Idaho-specific data: Two are meta-analyses of previous studies, two are nationally-representative, and one is from a region of North Carolina with a demographic similar to Idaho. As such, until we have sufficient data from several years of Child and Adolescent Needs and Strengths (CANS) assessments, Idaho's SED prevalence and service engagement rates will remain as estimates based on universal data.

Fourth, the studies consulted in this report find that in most engaged scenarios, only about half of children with serious mental health conditions will receive any mental health services, suggesting the potential maximum number of Idaho children who have SED *and receive treatment* – from any system of care – will be between 12,000 and 22,000. The levels of service engagement found in those studies included 34% (Zachrisson et al., 2006), 35% (Offer et al., 1991), 40.3% (Burns et al., 1995), 43.9% (Olfson, et al., 2015), 52.8% (Merikangas et al., 2010), 53.4% (Simon et al, 2015), and 56% (Bourdon et al., 2005) – no study yet identified has had a service engagement rate higher than 56%. The low end of this range (12,000) is calculated using the lowest engagement rate supported by research (~34%) with the lower end of the estimate (35,000), while the high end (22,000) is calculated using the highest engagement rate observed in the literature (~56%) with the higher end of the estimate (40,000). Although this is significantly lower than the statewide estimate, it is assumed to be a ceiling of service engagement amongst those with SED.

Fifth, we cannot determine how many children of the overall statewide estimate are currently receiving services for SED through private insurance as we do not have access to private insurer data. These children are also eligible for YES services – though not through Medicaid – but they may either remain in their current treatment arrangements or engage in YES services.

Last, the Simons (2014) report outlines three levels of program maturity based on Centers for Medicaid & Medicare Services (CMS) guidance: Emerging, Evolving, and Established. That report states that engagement rates increase significantly with program maturity. As the YES Project is in its infancy, it is expected that initial engagement rates will be much lower than the 12,000 – 22,000 range estimated above, but will instead mature into that range, readjusting for overall population growth and demographic shifting.

These limitations should be taken into consideration when assessing current service levels, future service engagement, and unmet need. Again, only until more Idaho- and SED-specific data are collected, longitudinally, over a period of years, will we have a much more accurate picture of the prevalence and treatment of SED.

In conclusion, this team estimates that there may be 35,000-40,000 children in the state of Idaho with SED. Of those, we estimate that 12,000-22,000 may receive mental health services at some point in the future, either through the YES Program or through the private insurance sector. Moving forward, the CSET intends to continue collecting available data, studies, and research to further inform and improve their estimates as one part of the Quality Management, Improvement, and Accountability (QMIA) Plan. Research regarding SED and treatment engagement is limited, and thanks to Boise State's assistance and guidance in their methodological validity report, the team feels more confident in the fidelity of the 2017 estimate.

For 2018, with one year's worth of CANS records, we hope to gain insights into items such as: Medicaid prevalence, Level of Care Guideline results, percentages of CANS clients that fail to qualify as class members, the demographics of the class, what our actual engagement levels will be, and drop-out rates. With this data, we'll be better prepared to estimate class size and engagement from an Idaho-specific point of view.

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Youth Empowerment Services

Visit the YES website for more information:

www.yes.idaho.gov

IDAHO DEPARTMENT OF HEALTH & WELFARE

Empowering the mental wellness of children, youth and their families.

STATE BEHAVIORAL HEALTH PLANNING COUNCIL

STATE OF MIND

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

FY2018 REPORT TO THE GOVERNOR, STATE LEGISLATURE, AND JUDICIARY

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Thank You!

The Idaho Behavioral Health Planning Council would like to express our gratitude to the Governor and the Idaho Legislature for their ongoing support of services designed to meet the behavioral health needs of Idaho citizens. Not only are these services a direct benefit to Idahoans through promoting mental and physical health and hope to individuals, but they also provide a very real indirect benefit to the health, happiness, and stability of families and communities throughout the state. Expanding medical coverage to Idaho's low-income population will further serve Idahoans by providing access to vital services and supports for those with unmet behavioral health needs. We are excited for the opportunities that Medicaid expansion provides in terms of reaching even more Idahoans with behavioral health challenges.

Legislative support and continued funding for Youth Empowerment Services (YES) is vital for making the system of care sustainable. Though we are all concerned about making fiscally responsible decisions, YES has and continues to be focused on developing a system of care that is no longer reactive and crisis-based. Crisis care is the most expensive way to run a system not only in terms of cost, but also in terms of negative impacts to individuals, families, and communities that falter under the weight of ongoing mental health crises. YES is seeking to transform youth mental health services to a proactive and recovery-based system. We commend you for seeing and understanding the long-term benefit of developing a sustainable system of care that aims to prevent individuals and families from reaching a crisis and instead focuses on achieving intervention and early recovery for the long-term health and benefit of all Idahoans.

Additionally, Medicaid expansion can assist in meeting the requirements of legislation that has already passed, such as the 1915(i) waiver. While Idaho continues to rank in the top ten worst states for suicide, the Office of Suicide Prevention supported by the legislature and Governor in 2015 continues to strive for a goal of Zero Suicides in Idaho. Reducing suicide completions and intervening early to identify and reduce suicidality is vital to the health and safety of all our communities. Using Medicaid expansion funds for appropriation beyond direct services would have a significant positive impact on this joint mission. An example of this potential benefit is the prevention and treatment of Idaho citizens struggling with substance use disorders.

Medicaid expansion will provide access to substance use disorder treatment and recovery support services to many Idaho adults who have struggled to find a life in recovery without these services. As our country and Idaho struggle with an unprecedented opioid crisis, access to treatment, including Medication Assisted Therapy (MAT), is literally the difference between life and death for many Idahoans. In this respect, we can expect to immediately start saving lives lost to opioids with expanded Medicaid coverage. However, as Idaho continues to watch the opioid-related death toll climb, methamphetamine, cocaine, and alcohol continue to plague our streets and communities. Medicaid expansion can also provide the funding necessary to provide life-saving interventions and services for Idahoans struggling with these addictions as well.

As we move forward into 2019, we have identified several proposed bills in this report that could benefit from funding associated with Medicaid expansion. The State Behavioral Health Planning Council and Idaho's citizens are confident that the Governor and Idaho Legislature have the breadth of knowledge and vision to recognize the needs for Idaho individuals, families, and communities and appropriate funds in the most effective way. We have the upmost confidence in our state representatives and appreciate your dedication and willingness to tackle complex and controversial issues for the betterment of all Idahoans.

In this report you will find our successes as a state, which could not have been achieved without your support as well as our view of current gaps and needs in the areas of behavioral health. Your compassion and support are appreciated not only by the State Behavioral Health Planning Council but by the Idahoans who receive behavioral health services, their families and their communities. Thank you for your continued support!

The State Behavioral Health Planning Council

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WHY BEHAVIORAL HEALTH AND RECOVERY MATTER TO

IDAHO

Behavioral health impacts everyone. According to the National Institute of Mental Health and the U.S. Centers for Disease Control:

- Nearly one in five (44.7 million) Americans lives with a mental illness.
- More than ten percent (10.4 million) of Americans live with a serious mental illness that severely limits one or more major life activities.
- Only 43% of those living with any mental illness and only 65% of those living with serious mental illness received mental health treatment in the past year.
- Suicide is a leading cause of death in the United States and in Idaho, with nearly 45,000 deaths nationally each year, and rates of death by suicide are increasing both nationally and in Idaho.
- Mental, developmental, and behavioral disorders begin in early childhood, with 1 in 6 children in the United States diagnosed with these life-altering disorders.

Managing behavioral health challenges can also be costly for state and local governments. But the good news is that mental health conditions are treatable, and that recovery is possible. With the right supports in place, people living with mental illness can have healthy, happy, productive lives.

Investing in mental healthcare is investing in people—in their lives and their livelihoods. Idaho individuals and families are working hard to achieve SAMHSA's defined goals of recovery:

> "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."

Behavioral health matters to all of us—and it affects all of us. By understanding the problem, engaging stakeholders, and providing access to real solutions, we can empower our citizens to live their best possible lives.

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INTRODUCTION

The State Behavioral Health Planning Council (BHPC) was established through the passage of Senate Bill 1224 in 2014. This bill amended Idaho Code 39-3125 (Appendix One), 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 disorders. 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 an annual 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.
- Establish readiness and performance criteria for the Regional Behavioral Health Boards (RBHB) to accept and maintain responsibility for family support and recovery support services.

BHPC WORKGROUPS

- CHILDREN'S MENTAL HEALTH
- CRISIS & RECOVERY CENTERS
- PREVENTION, EDUCATION & LEGISLATION
- REGIONAL BEHAVIORAL HEALTH BOARD SUPPORT

The 2018 Planning Council membership covers the full- spectrum of mental health and substance use disorder services, including 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 State Behavioral Health Planning Council (BHPC). A complete list of the membership is found in Appendix Two. The diversity of the membership creates a broad knowledge base for the BHPC, allowing us to work with and support many aspects of the behavioral health system. Most of the work done by the BHPC is completed by its workgroups. These workgroups focus on several projects including implementation of Youth Empowerment Services, continuing support for crisis and recovery centers, and suicide prevention.

The BHPC looks forward to continuing active participation in the improvement of Idaho's Behavioral Health System.

Our members are eager to collaborate 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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SYSTEMS OF BEHAVIORAL HEALTHCARE

State efforts to address the opioid crisis, suicide prevention, behavioral health crises, and children's mental health services

IDAHO'S RESPONSE TO THE OPIOID CRISIS (IROC)

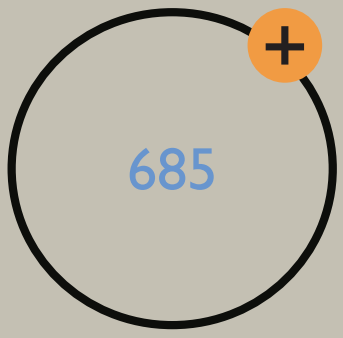
Idaho's Response to the Opioid Crisis (IROC) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is administered by the Department of Health and Welfare, Division of Behavioral Health. This grant program aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose-related deaths through the provision of prevention, treatment, and recovery activities for Opioid Use Disorders (OUD). OUD includes addiction to prescription opioids as well as illicit drugs such as heroin.

Idaho was awarded $2 million/year for two years, beginning in May 2017 and continuing through April 2019. This funding has been used to expand access to Medication-Assisted Treatment (MAT) including methadone, suboxone, and buprenorphine. Between May 2017 and October 2018, 685 individuals were able to access traditional substance use disorder treatment, and of these individuals, 244 of them received MAT.

IROC has also provided funding to multiple prevention and recovery initiatives including the following:

- Delivering 4,368 doses of naloxone, the opioid overdose reversal drug, to first responders across Idaho.
- Providing individualized reports to prescribers which depict their prescribing patterns in comparison to their peers.
- Providing funding to Recovery Idaho and Idaho's nine Recovery Community Centers to support their efforts in providing early engagement services to individuals with an OUD discharging from hospitals, crisis centers, jails, and prisons.

In October 2018, the Department of Behavioral Health (DBH) was awarded an additional $4 million/year by SAMHSA to enhance our existing IROC program. In addition to expanding access to treatment services, including MAT, this new influx of funding will expand Idaho's recovery-oriented system of care, specifically the provision of recovery coaching services in Emergency Departments and jail/prison reentry efforts. Prevention efforts will include increasing the availability of naloxone and disseminating materials to educate the public on the dangers of opiates and how to manage an Opioid Use Disorder (OUD). These funds will also be made available to qualifying individuals in a pre-sentencing diversion pilot program. This pilot will provide the opportunity for individuals to become enrolled in an OUD treatment program in lieu of the normal criminal justice system cycle. Additionally, DBH will be collaborating with and providing funding to Idaho's five federally recognized Tribes in Idaho to address the individual needs of their communities.



INDIVIDUALS STATEWIDE WHO ACCESSED SUBSTANCE USE DISORDER TREATMENT

For more information on IROC, please visit the website: www.iroc.dhw.idaho.gov or contact Rachel Gillett at (208)332-7243.

In addition to IROC, Idaho Medicaid has implemented a three-pronged plan to improve the appropriate use of opioids in Medicaid participants. These include improving prescribing practices and policies for opioids,

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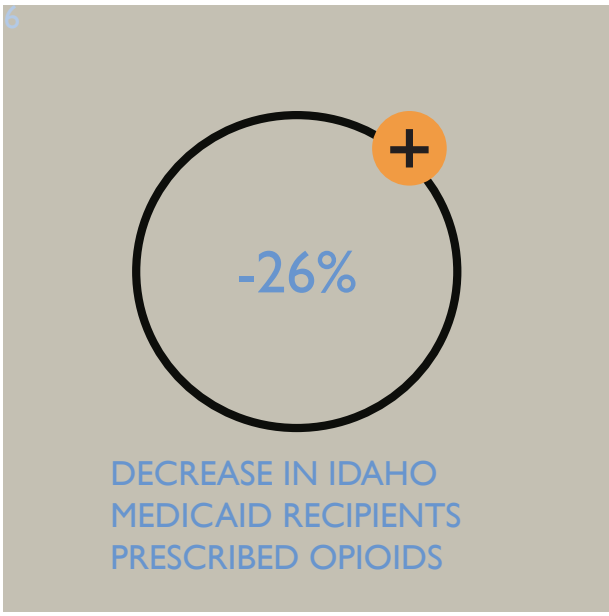
improving chronic pain management, and ensuring appropriate substance use treatment. Case management and educational outreach have been the cornerstones of interventions and program changes by the Medicaid Pharmacy Program.

Significant changes have been seen in the number of opioids prescribed and daily dosing of opioids. Between January 1, 2017 and September 30, 2018, Medicaid has seen a 26% decrease in the number of Medicaid participants receiving opioids and a 28% decrease in opioid receiving Medicaid participants receiving greater than the U.S. Centers for Disease Control recommended cumulative daily limit of 90 morphine mg equivalents.



Medicaid continues to explore non-medication and non-opioid medication alternatives to opioids and has removed restrictions on current non-opioid pain medication alternatives including duloxetine, gabapentin, pregabalin and topical lidocaine and diclofenac products.

The Pharmacy Program has continued to work with prescribers of buprenorphine-based medication assisted treatment including quarterly one-on-one case management outreach to providers to discuss any issues with concurrent opioid or benzodiazepine use prescribed by other providers identified through the Prescription Monitoring Program. The Medicaid Pharmacy and the Office of Mental Health and Substance Abuse programs continue to work together to ensure that medication-assisted treatment patients are also receiving concurrent psychotherapy services in addition to the medication.

SUICIDE PREVENTION

Thanks to the dedication of the Idaho State Legislature and Governor Butch Otter, Idaho's suicide prevention efforts have received a much-needed support in the last few years. In 2018, the Governor requested and the legislature granted more funds for the Idaho Lives Project (ILP) to support suicide prevention programs in public schools. The ILP trains school staff and students in suicide prevention and intervention, as well as guiding schools through postvention in the event of a death by suicide. Because of this increased funding, ILP was able to hire three regional coordinators to help with implementation and maintenance of Sources of Strength programs in public schools across the state.

Sources of Strength is an evidence-based prevention model that teaches youth that they have strengths to rely on when difficult times occur. The program also connects youth to adults; encourages peers to seek help for themselves and others; gives youth a voice to promote resiliency, positivity and connectedness in their school and community; and has been shown to reduce other types of risky behavior.

In 2018, the legislature also passed the Jason Flatt Act, which encourages schools to offer gatekeeper suicide prevention trainings for all staff. This new legislation has not yet been fully implemented as the State Department of Education needs time and funding to introduce ways for schools to comply with the law.

Many Idahoans received special training related to suicide prevention this year. The state's Suicide Prevention Program (SPP) provided three trainings for mental health personnel on how to intervene with and manage

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highly suicidal patients. Dr. David Rudd, a national expert on assessing and managing suicidality, and Kim Kane, manager of the SPP, conducted the trainings for 850-900 people in Boise and Coeur d'Alene.

Idahoans also attended suicide prevention conferences. These included the following:

- Suicide Prevention Action Network of Idaho (SPAN Idaho) presented a 1.5 day conference at the Idaho State Capitol Building, with several national experts headlining the event and a training from Dr. David Jobes, a leader in assessing suicidality.
- The Western States Conference on Suicide at Boise State University (BSU), a joint effort of Idaho's Suicide Prevention Coalition and the Speedy Foundation and others, also hosted several nationally known experts in the suicide prevention field and offered participants a second day of training to increase skills in intervening with suicidality with a range of options including the use of story-telling or becoming a certified trainer in Question, Persuade, Refer (QPR).

Although Idaho is still ranked in the top ten nationally and its suicide completion rates, like all other 49 states, are rising, Idahoans are working hard to prevent suicide in a number of ways and will continue to fight for the lives of our citizens.

BEHAVIORAL HEALTH CRISIS CENTERS

Crisis Centers are intended to provide immediate services to individuals experiencing a behavioral health crisis. These centers provide communities with an alternative resource to taking these individuals to the Emergency Department or jail. Crisis Centers are intended as short term (less than 24 hours) solutions to help individuals stabilize through a crisis and connect them with on-going services to help prevent future crises. Idaho has four Crisis Centers located in Coeur d'Alene, Boise, Twin Falls, and Idaho Falls, covering four of Idaho Department of Health and Welfare's (IDHW) seven regions. IDHW's goal is to have one crisis center in each region, ensuring access to these critical services statewide (Source: Idaho Department of Health and Welfare).

BEHAVIORAL HEALTH CRISIS CENTER OF EAST IDAHO (BHCC)

Fiscal year 2018 continued to show positive utilization of the Behavioral Health Crisis Center. During the fiscal year, almost 1,800 patients were admitted to the facility, bringing our total admissions since opening to nearly 8,500. In addition to admissions, during fiscal year 2017, we received approximately 750 information and referral calls and began tracking non-episode visits in 2018 with a total of 313. Approximately 45% of the population we serve report being homeless, and an average of 56% report being indigent; for this reason, we have determined that direct patient billing is not cost-effective at this time.

Though the BHCC currently covers 17 counties, we see utilization primarily from Bonneville, Bingham, Bannock, Jefferson, and Madison. Transportation to the Crisis Center remains the largest barrier to treatment

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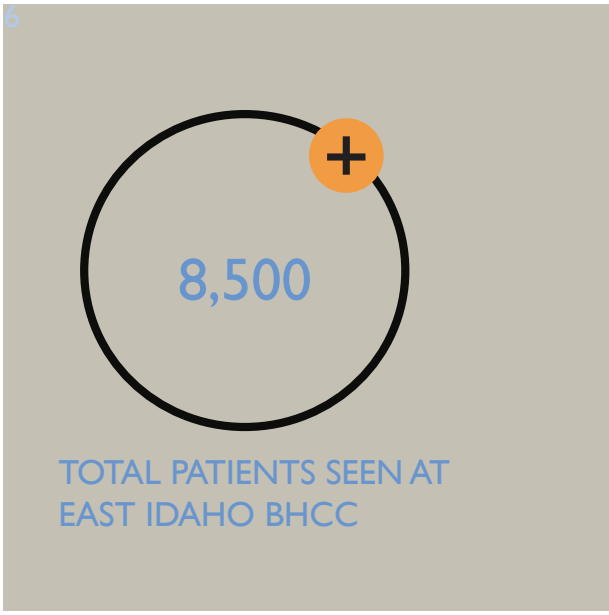
in our more rural areas. With the opening of the Pocatello Crisis Center in early 2019, we expect to see some changes in utilization, especially for Bingham County residents.

Law enforcement continues to be a strong utilizer of the BHCC. Each month, we continue to see an increase in referrals from law enforcement officers. In fiscal year 2017, over 200 clients brought in by law enforcement officers were admitted in lieu of being taken to the hospital or jail, saving a significant amount of time and money. In addition to cost savings from our partnership with law enforcement, the BHCC has done an outstanding job of keeping the vast majority of our clients in our facility, transferring less than one-fourth of our admitted patients to a higher level of care such as a medical hospital, psychiatric hospital, or jail.

Despite receiving our second 10% budget cut in January 2018, the BHCC has been successful in maintaining sustainability through careful budgeting, staffing efficiencies, grants, and donations. In fiscal year 2018, the BHCC received $44,567 in outside funds to help with sustainability.



CRISIS CENTER OF SOUTH CENTRAL IDAHO (CCOSCI)

The Crisis Center of South Central Idaho is located in Twin Falls and partners with community providers to connect adults in mental health crisis with appropriate care. We serve clients in Twin Falls, Gooding, Jerome, Lincoln, Cassia, Minidoka, Blaine, and Camas. In 2018, the Crisis Center served 3,189 people, a 120% increase over the prior year, with the third and fourth quarter experiencing our greatest number of contacts. In August of 2018 alone, we had 352 patient contacts. Our yearly average number of patients enrolled in any given week is approximately 45. As a short-term facility, our goal is to have clients discharged in 23 hours and 59 minutes or less. In 2018, our average hours of client contact per episode were 20.46, placing us well within these parameters.

Self, family, and friends comprised the largest number of 2018 referrals at 2,667. The second largest referral source was law enforcement, with 219 referrals. We continue to coordinate with law enforcement to divert behavioral health clients from jail. The Crisis Center staff tries to help individuals at risk of recidivism with recovery rather than have repeated incarcerations. We also place patients in substance abuse and co-occurring treatment programs if funding is available through BPA. We made 2,278 referrals to substance use treatment programs; however, the funding has drastically decreased in 2018. Patients without insurance were referred to Recovery In Motion where they can participate in free recovery activities.

Our primary population is middle-aged males. After the closure of Victory Home, the only homeless shelter that accepted male clients without conditions, we anticipate a surge in displaced males in our community. We often refer male clients to transitional housing, but the costs and conditions associated with rental can often be prohibitive to clients struggling with employment and mental health issues. Housing resources for women and children exist in Twin Falls, including Valley House and Voices Against Violence.

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3,189

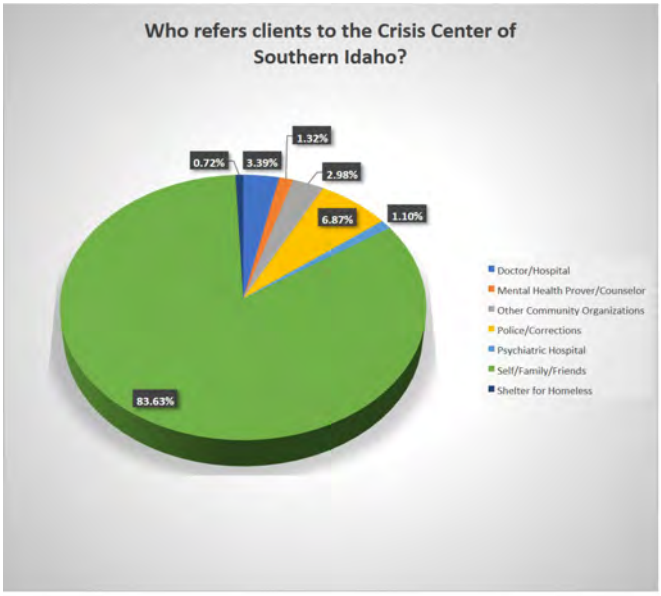
TOTAL PATIENTS SEEN AT CRISIS CENTER OF SOUTHERN IDAHO

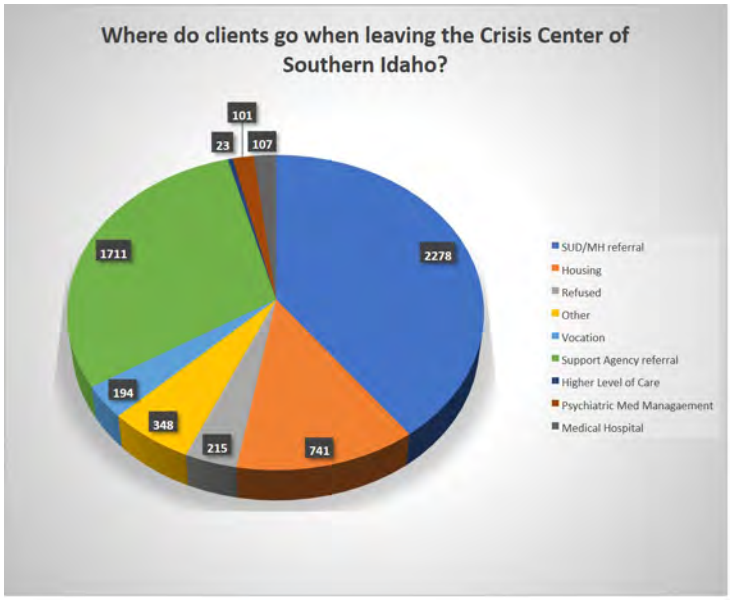
We try to assist patients in obtaining recovery support services that will aid them in acquiring safe and sober housing. The CCSCI staff networks with partners in the community that provide other services such as Vocational Rehabilitation, Deseret Industries Social Services, staffing agencies, Family Health Services, the Wellness Tree, and IDHW for food stamps. Only nine of the patients we served in 2018 were referred for psychiatric inpatient services. This low number may reflect that clients are being assessed appropriately at the Crisis Center and connected with effective stabilization services in a less costly environment.

The majority of patients served at the Crisis Center, 1,880, did not have insurance, which tallied 1,880 individuals. Of individuals with insurance, 975 had Medicaid, and 231 had Medicare, while 697 individuals listed had BPA funding or other benefits such as veteran's benefits. Lack of insurance, lack of personal finances and lack of public transportation all create obstacles for clients to stay engaged in treatment. However, if clients qualify, they may be able to work with a Peer Support Specialist or Recovery Coach, who can aid them in overcoming barriers. The Crisis Center currently employs Recovery Coaches on our 24-hour staff and is working on creating a Peer Support Specialist program as well.

Given the clear need for our services in our community, one of the most significant challenges we face is to staff the Crisis Center adequately to absorb the fluctuating census and provide safe, effective and appropriate care to our community. It takes time to build trust with individuals who struggle with serious and persistent mental illness and substance use disorder. Additionally, societal barriers such as unemployment, lack of public transportation, lack of affordable sober housing, and lack of access to medical care and medication affect our clients. As noted above, state funding for substance abuse treatment has radically declined in 2018 compared with 2017. Clients who desperately need substance abuse treatment are often denied funding unless they are addicted to opiates or have committed a felony offense that qualifies them for funding through IDOC.

Based on average costs of the legal system, emergency room visits, and other medical treatments, we estimate





that our facility realizes a cost savings of approximately $1,351,400 per year. We survey our clients about our services, and with 651 satisfaction surveys completed in 2018, our average score on a scale of one to five where five represents the best service was 4.56. We are grateful to our staff, board, and community partners for all they do to provide high quality care.

NORTHERN IDAHO CRISIS CENTER (NICC)

The Northern Idaho Crisis Center in Coeur d'Alene was the second behavioral health crisis center approved by the Idaho Legislature. Idaho Health partners, comprised of Kootenai Health, Panhandle Health District, and Heritage Health, have joined together in the center's implementation of services for men and women ages 18 and older in the ten counties of northern Idaho.

The Northern Idaho Crisis Center (NICC) served 422 clients during the first quarter of 2018. This represents a 100% increase in the number of client encounters (210) experienced during the first quarter of 2017. By the third quarter, the total number of clients seen at the center was 1,326 visits, and of the 443 clients seen in the third quarter, only 50 required referral to a higher level of care. A significant number of our clients identify as homeless (177 in quarter 3) or veterans (43). Our average length of stay over the year was less than 10 hours.

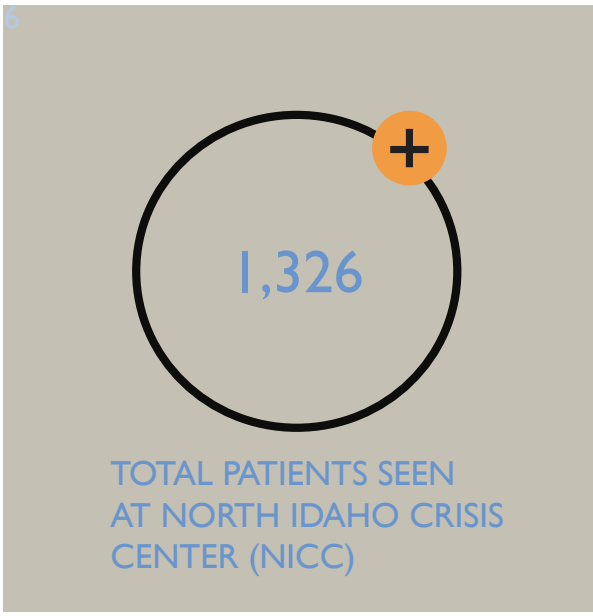
Analysis of clients seen during second quarter of 2018 has identified individual 242 clients that would have likely presented to a local Emergency Department if the NICC had not been available. This figure includes those clients presenting with suicidal ideation, hallucinations and/or severe anxiety or other acute mental health issues.

Although each case may be different, using a base line figure of $2,600 per Behavioral Health Emergency Department visit we estimate that the NICC achieved at a minimum $604,540 in cost avoidance and savings in the second quarter of 2018 alone due to 242 likely Emergency Department diversions during the second quarter of operations. Similarly, based on data from local law enforcement we conservatively estimated that the NICC was responsible for savings to local law enforcement due to a reduction in law enforcement man hours devoted to mental health calls.

It should be noted that this figure does not include cost savings from jail stays that were diverted, nor does this figure include likely savings to fire and EMS due to response to suicide calls that were averted by NICC visits. The NICC is working with fire and EMS agencies in order to develop a reliable methodology for calculating such cost savings and it is anticipated that this data will be captured in future reporting. Incorporation of these figures will increase the amount of total estimated savings.

The lack of emergency transitional housing, the chronic shortage of inpatient psychiatric beds and detox resources, as well as accessibility and transportation issues remain some of the more intractable issues encountered by the NICC staff. The lack of resources for the homeless population has been identified as a critical need by community leaders. Based on analysis of client intake data, we believe veterans may be underutilizing our services and plan to address this gap in 2019.

The NICC has initiated an aggressive provider and community outreach program. Presentations have been made to non-profit organizations, social service agencies and healthcare providers with the dual purpose of raising awareness of the NICC's operations and capabilities as well as publicizing the NICC in support of community-based fundraising efforts.



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PATHWAYS COMMUNITY CRISIS CENTER OF SOUTHWEST IDAHO

The Pathways Community Crisis Center of Southwest Idaho (PCCCSI) in Boise opened its doors on December 12, 2017 and continues to experience growth and success. In our first ten months of operation, PCCCSI has had 1,288 full admissions. Additionally, we tracked 510 non-episode contacts, which constitute a mixture of calls and visits to the center where someone is requesting referral information, for a total of 1798 interactions with individuals experiencing a behavioral health crisis.

"Lord bless all of you so very much. Thank you, you saved a life, thank you."

"You helped me see the light at the end of the darkness."

"You are all wonderful and caring people. I appreciate everything you have done for me"

"Everyone here has been concerned and cared for me. This place was a blessing to have a safe place to go right in the moment I needed help"

Client testimonials

The Crisis Center connects clients to resources within the community so that they can continue their recovery on a more long-term basis. Pathways Community Crisis Center of Southwest Idaho requires its case managers to make appointments on behalf of any clients who present to the center and consent to such appointments. We hope that this will increase compliance with the Crisis Center's recommendations for continuing care and potentially reduce participants' reliance on crisis services in the future.

Clients are referred from a variety of places throughout our community. The majority of participants state that they were self-referred. The next largest referral source was from hospitals, increasing diversions from more costly services. Community agency referrals, including physicians' offices, community mental health agencies, and other assistance organizations, were third. The next largest referral source is from law enforcement, indicating that the Crisis Center is successfully offering diversion from the jail. It is important that the Crisis Center and law enforcement continue to work together to create smooth processes for officers so that they can bring clients to the center quickly, and then return to protecting our community.

While we are clearly serving our community, tracking specific cost savings has been a challenge for us because of a lack of definitive data. Some of the barriers include not being allowed to ask law enforcement officers if they would have taken someone to jail, inconsistencies in how calls are labeled, and difficulties in interpreting sometimes conflicting data from different community entities. In order to create a consistent way to track our clients, we ask each person we serve this question: "Where would you have gone today if the Crisis Center had not been here?" This data can suggest how many clients were potentially diverted from more costly services.

To calculate savings through diversions from the Emergency Department (ED), we used research and data from Nicks and Manthey's research on the average cost to an ED to board psychiatric patients and multiplied that by the number of participants who said they would have gone to the ED had the Crisis Center not been in existence. We also add in all clients who stated that they would have hurt themselves, assuming if they hurt themselves they would need ED care.

Demonstrating a savings for law enforcement and other first responders is also important. Again, using client self-report in addition to tracking law enforcement drop offs to the Crisis Center, we determined that the average savings for a mental health call to police is roughly $1,000 per call. This estimate takes into account four officers earning $41 per hour who arrive to the call, plus additional consideration for administrative personnel (i.e., dispatch, additional back up support) and other costs (i.e., cost of operations) associated with the process.

Participants to the Crisis Center sometimes state that they would have called 911 had the Crisis Center not existed. When 911 is called for someone in distress, a fire truck and ambulance will show up to the scene in addition to two-four officers. We calculated the cost of four officers, one fire truck, and one ambulance transporting someone to the hospital. The estimated cost per 911 call for a mental health emergency is $1,825.

PATHWAYS FAST FACTS

1288 FULL ADMISSIONS

510 NON-EPISODE CONTACTS

1798 TOTAL CLIENT CONTACTS

MALE: 763 (59.24%)

FEMALE: 525 (40.76%)

HOMELESS /RISK OF HOMELESSNESS: 470 (36.49%)

VETERANS: 94 (7.3%)

AVERAGE CLIENT AGE: 39.5

TOTAL ESTIMATED COST SAVINGS: **$1,791,509.00**

The Crisis Center is having tremendous success at creating a savings to the overall community. Our data also illustrates that the Crisis Center is admitting and treating the properly targeted demographic. Information received by the Boise Police Department has equated self-referrals to the Crisis Center as an alternative to welfare checks having to be completed by the police department. BPD's estimate is based on an average of 45 minutes multiplied by two officers at $50.00 per hour. This equates to $75.00 per welfare check. The Crisis Center has had 411 self- referrals over the past 10 months, which represents considerable savings.

Finally, Pathways Community Crisis Center of Southwest Idaho takes the satisfaction of its participants very seriously. We want all of our guests to feel safe, respected, and willing to return if they need our services. Upon discharge, we ask each client to fill out an anonymous Crisis Center Client Survey to see their perception of their stay with us. The highest score that the center can receive on a survey is 30 points. In 2018, Pathways collected 381 completed surveys, with an average satisfaction score of 28.8 out of 30 possible points. Additionally, 98 % of respondents stated that they would return to the crisis center.

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YOUTH EMPOWERMENT SERVICES (YES)

The goal of YES 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 including:

- 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 to receive mental health services.

Idaho uses the Child Adolescent Needs and Strengths (CANS) assessment to identify children who need services. Since January, 790 youth have gone through the Independent Assessment Process (IAP), and 858 youth have received an assessment from one of the Division of Behavioral Health's seven regional offices. Between January and June of 2018 approximately 1,216 total youth completed the CANS assessment. Of these youth, 1,131 received a CANS recommended level of care rating of 1-3, indicating the presence of a serious emotional disturbance and need for services. For the remaining 85 youth, a serious emotional disturbance was not identified.

To increase access to services, the Division of Medicaid developed and submitted a 1915(i)-state plan option application to the Centers for Medicare and Medicaid Services (CMS) that establishes eligibility to Medicaid for YES program class members with family incomes from 150-300% of the federal poverty level (FPL). A youth who does not have Medicaid coverage, or has Medicaid coverage and would like to access Agency Respite services will be referred to the Independent Assessment Provider (IAP).

Reviewing the CANS assessments for gaps and needs, we found that statewide, 70% of the youth in this cohort identified Family as an actionable need, followed by Emotional/Physical Regulation (67% of youth), Anger

Most Prevalent Diagnoses per Region and Statewide						
State	Attention-deficit hyperactivity disorder, combined type	17%	Oppositional defiant disorder	14%	Generalized anxiety disorder	9%
Region 1	Attention-deficit hyperactivity disorder, combined type	21%	Post-traumatic stress disorder, unspecified	11%	Generalized anxiety disorder	9%
Region 2	Attention-deficit hyperactivity disorder, combined type	34%	Attention-deficit hyperactivity disorder, inattentive type	10%	Generalized anxiety disorder	9%
Region 3	Attention-deficit hyperactivity disorder, unspecified type	13%	Anxiety disorder, unspecified	11%	Major depressive disorder, recurrent severe without psychotic features	8%
Region 4	Attention-deficit hyperactivity disorder, unspecified type	12%	Major depressive disorder, recurrent severe without psychotic features	10%	Oppositional defiant disorder	10%
Region 5	Oppositional defiant disorder	24%	Generalized anxiety disorder	11%	Disruptive mood dysregulation disorder	7%
Region 6	Attention-deficit hyperactivity disorder, combined type	26%	Oppositional defiant disorder	16%	Major depressive disorder, recurrent severe without psychotic features	11%
Region 7	Attention-deficit hyperactivity disorder, combined type	23%	Oppositional defiant disorder	18%	Generalized anxiety disorder	11%

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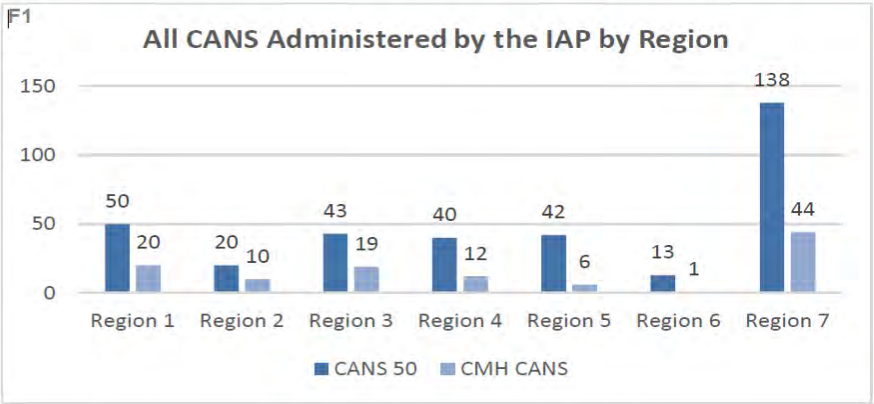
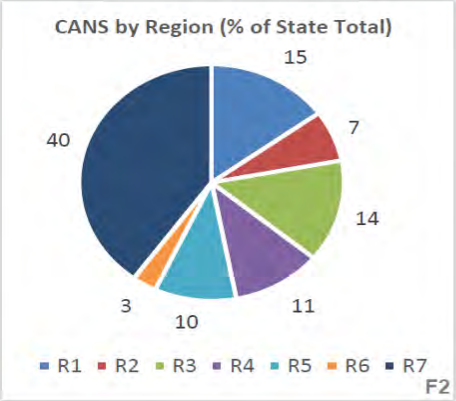
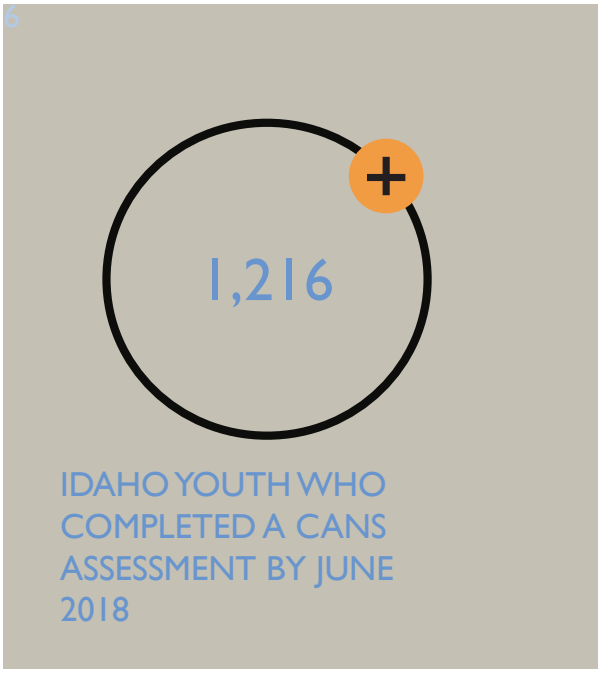




Control (66%), Impulsivity (64%) and Social Functioning (60%). All regions with the exception of Region 2 had Emotional/Physical Regulation as one of their most prevalent actionable needs. Region 2 appears to have a higher percentage of youth identifying needs such as Developmental/Intellectual, Adjustment to Trauma, and Attention/Concentration than any other region.

The CANS also assesses strengths. Statewide, 97% of the youth in this cohort had identified Legal Permanency as a useful strength. Legal Permanency was followed by Relationship Permanence (92% of youth), Family (83%), Cultural Identity (80%) and Talents/Interests (73%). These same strengths were calculated to be the most prevalent in all of the regions, although the percentage of youth that identified these strengths in each region varied significantly.

It is important to note that strengths are not the opposite of needs. The absence of an actionable need does not mean that a useful strength is present, and similarly the absence of a strength does not necessarily mean that there is a need. "Family" has been identified as both a top need and a strength statewide for this cohort of youth.



To further assess needs of youth, Boise State University's School of Social Work completed a wraparound utilization report to estimate the number of youth who are likely to need/use Intensive Care Coordination (ICC). BSU's report suggested that 1,350 Idaho youth would have benefitted from Intensive Care Coordination in 2016. For an emerging program, in a pilot phase or in the early stages of implementation, it was estimated that Idaho may serve around 65 youth per year. The "emerging program" utilization goal for the YES Wraparound program is that all seven Division of Behavioral Health Regional Program Specialists will have an initial caseload of four families. At present, there are 35 Care Coordinators trained in wraparound services throughout the state, two of whom are supervisors and are not carrying a caseload.

IDAHO DEPARTMENT OF CORRECTION (IDOC)

Many Idahoans who need behavioral health services must access them through the criminal justice system, which remains a critical component in Idaho's system of care. Community based behavioral health services available to IDOC probationers and parolees include substance use disorder (SUD) services and mental health services. Providing felony offenders with community-based services, rather than through incarceration and delivery in a state facility, reduces the risk of reoffending with a corresponding cost avoidance to the state.

THOSE ON PROBATION OR PAROLE WHO COULD BENEFIT FROM SUBSTANCE USE DISORDER SERVICES

In Idaho, as of June 30, 2018, 39.6% of offenders were on community supervision for drug crimes and 14.2% for an alcohol related offense. 43.4% of probationers and 24.3% of parolees have a current drug or alcohol problem. This equates to 5,008 probationers and 990 parolees (5,998 total) who could benefit from SUD services.

The IDOC budget for SUD services in FY18 was $7,062,100. This funding provided community-based drug & alcohol treatment services for adult felons through a statewide private provider network. Available treatment services included assessment, outpatient/intensive outpatient care, residential care and recovery support services, such as case management, drug testing, safe/sober housing, life skills and transportation. In FY18 the private provider network served 4,854 IDOC offenders.

State general funds also support IDOC clinical staff positions in all seven judicial districts. The primary job duties for IDOC clinical staff involves the delivery of SUD aftercare treatment to reentering offenders, completion of presentence alcohol & drug assessments and the monitoring of client treatment engagement via care coordination.

In FY18, the Idaho Department of Health and Welfare managed $5.4 million in state general funds to provide community based mental health services to IDOC's probation and parole population. Available services include assessment, individual and group therapy, case management, and medication management via Idaho's Federally Qualified Health Clinics. Mental health services through Department of Health and Welfare funding is not yet available statewide

SUBSTANCE ABUSE PREVENTION

The Office of Drug Policy's Substance Use Disorder Prevention Programs utilize the science of prevention to prevent alcohol and drug abuse in our communities. In State Fiscal Year 2018, funding from the Substance Abuse Prevention and Treatment (SAPT) block grant and the Strategic Prevention Framework (SPF) grant was awarded to forty-five (45) prevention providers, sixteen (16) community-based coalitions, and ten (10) law enforcement agencies to engage in a comprehensive array of prevention strategies. Grant programs capitalized on key partnerships across Idaho to disseminate educational resources and materials; provide training and technical assistance in delivering evidence-based prevention curricula in schools; facilitate parenting and family programs; support alternative, drug-and-alcohol-free activities for youth; and enhance

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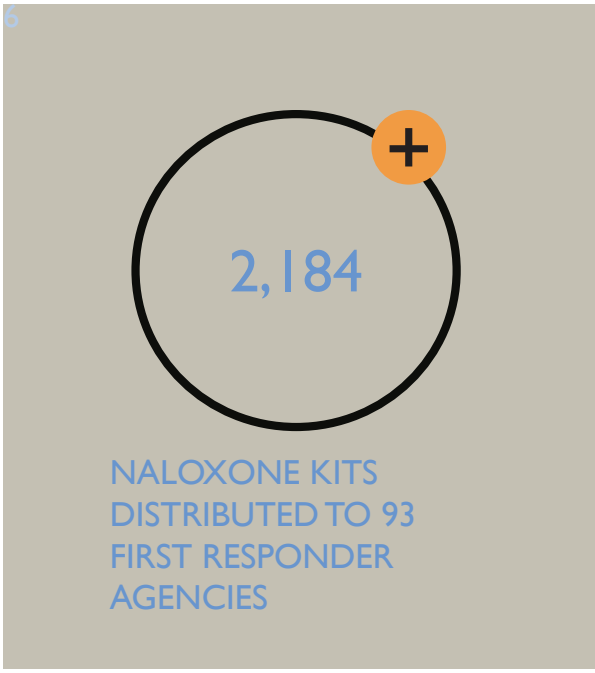
our Idaho community coalitions in mobilizing effective environmental strategies designed to change community norms and attitudes.

These partnerships also serve as the foundation in addressing growing challenges related to the opioid crisis. Implementation of Idaho's Opioid Misuse and Overdose Strategic Plan continues, with four key goal areas identified. Funding from the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Targeted Response to the Opioid Crisis grant (STR), allowed the Office of Drug Policy (ODP) to dispense 2,184 naloxone (an opioid antagonist) kits to 93 first responder agencies to reduce opioid-related overdose deaths in Idaho. Additionally, ODP and the Idaho Board of Pharmacy utilized a Millennium Fund grant to purchase and install 26 medication disposal bins in retail pharmacies across the state.



Integrating substance abuse prevention programming with behavioral health services simply makes sense. ODP has recently been awarded SAMHSA's Partnerships for Success grant to strengthen prevention capacity and infrastructure at the State, regional and community levels over the next five years. Sub-recipients of the annual $2,260,000 grant are Idaho's seven Regional Behavioral Health Boards (RBHB) located in each of the public health districts. The RBHB's will implement prevention services using the awarded funds, and each will target priority substances based on local data. Local law enforcement agencies will also receive funding to conduct compliance checks, shoulder tap operations, and increase interdiction activities.

Building off the previous Strategic Prevention Framework funding from ODP, Community Coalitions of Idaho secured Drug Free Communities (DFC) funding from the Office of National Drug Control Policy (ONDCP) and will continue to provide training and support to community coalitions in Idaho to implement environmental strategies that promote healthy and safe communities.

These activities and partnerships ensure substance use disorder prevention remains an essential component of behavioral health programs and services and will ultimately achieve ODP's vision of an Idaho free from the devastating health, social, and economic consequences of substance abuse.

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VETERANS SERVICES

As we track psychiatric illness amongst our current and former armed forces service members, which most often manifest as PTSD, depression, and increased risk of suicide, it is critical to review the underlying causes of psychiatric dysfunction. While exposure to combat-related stressors can increase the risk of negative symptoms, it is also important to account for the positive impact of constructive purpose, meaningful activity, and the development of resilience in the face of stress.

Our veterans deserve the best available care. We have adequate treatment resources, based on a review of current utilization, in the form of mental health practitioners at the VA hospitals, Veterans Centers, Army and Air National Guards, telehealth, CBOC and community mental health providers. What we lack, however, is treatment that promotes resilience and serves as a protective factor against psychiatric illness.

While there is no simple panacea, we do know that one of the more salient factors of psychiatric wellness is "connection." In the interest of forming collaborative connections, two of our state behavioral health boards worked together to bring an empirically based, effective treatment training, called ART (Accelerated Resolution Therapy) to improve the delivery of mental health care to our veterans and our service members.

Currently, Eye Movement Desensitization Reprocessing (EMDR) is one of three evidence-based practices for the treatment of trauma, along with CPT (Cognitive Processing Therapy) and PE (Prolonged Exposure). Additional research is being conducted through the Walter Reed Medical Center with an abbreviated form of EMDR called ART, which shows significantly better outcomes at 6 months and 12 months post treatment completion than the current modalities. It does this, in part, by promoting constructive behaviors and solutions, rather than focusing exclusively on eliminating negative or undesirable symptoms. Two of our regional behavioral health boards, Region 6 and Region 7, have funded ART training in an effort to "bridge the gap" between military and civilian providers and veterans. This training is empirically based and found to be effective in as little as one to three sessions, rather than the standard twelve sessions required by the other protocols; and it has better outcomes over longer periods of time post treatment completion.

If this treatment could be available to all of our regions and state as an entirety, we think that trauma, along with addictions and other mental health concerns, could be reduced dramatically, reducing costs in recidivism and the provision of care. Offering cross-sectional training to federal, state, and community providers in the best practices available will further build seamless cohesion across providers and patients alike. With the support of our Governor, Legislature and Judiciary Branches, Idaho could be among those on the offensive line promoting positive and proactive changes for our veterans' behavioral health.

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RECOVERY CENTERS

In 2018, Idaho added a ninth recovery community center in Twin Falls to the centers located in Coeur d'Alene, Moscow, Lewiston, Caldwell, Emmett, Boise, Pocatello, and Idaho Falls. Each center provides a range of recovery-oriented support services including jail and prison reentry services, hospital and crisis center connections, and an active transfer of individuals to substance use disorder and mental health treatment. The centers' staff have all received training in providing support for people during a period of detoxification and withdrawal from alcohol and other drugs and have provided this service to persons with opiate disorders in over 300 episodes in the past year. The centers also provide ongoing recovery coaching to individuals to help them make connections with needed community resources and to develop sustainable recovery and wellness plans. With recovering peer recovery coaches, centers offer a clear example of hope and healing to individuals struggling with their addiction or mental illness. In addition, the centers provide a host of sober socialization and recreation opportunities, substituting human connection for the all too common isolation of addiction or mental illness.

During 2018, the centers all provided a vital link in the continuum for persons with opioid issues. They provided for recovery from overdoses to ongoing recovery coaching as a part of the Idaho Response to the Opiate Crisis project managed by the Department of Health and Welfare Through this project, the centers served 2,076 individuals and provided 13,890 contacts in the last 6 months of 2018. These numbers reflect only those with opiate disorders and represent less than half of the centers' client population, as alcohol and methamphetamine remain major substances of abuse and dependence throughout Idaho.

Increasingly, the recovery community centers are serving as a low-barrier, crisis intervention entry point in the system. Centers work closely with the State's currently existing crisis centers, both as a referral point to the crisis center and as a follow-up and ongoing recovery support for people leaving the crisis centers. The recovery community centers have become a major safety net with open access to anyone seeking help and willing to work the most basic recovery plan.

Centers, originally funded by the state Millennium Fund, have all worked in their communities to develop local funding support. Success has varied across the state, but all centers have relied upon diverse fund-raising efforts, such as pancake breakfasts and hot soup lunches, together with grant applications. Local government funding has been limited as local government resources remain challenged to meet multiple growing demands. The federal funding provided under the Idaho Response to the Opiate Crisis funding has been essential to the centers' continued existence, and efforts to establish a stable funding base continue.

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REGIONAL BEHAVIORAL HEALTH BOARD REPORTS

Highlights from around the state

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

REGION 1

One of our region's top priorities has been to create safe housing specifically set aside for patients being released from State Hospitals North and South. We are planning to partner with St. Vincent de Paul to rent a suitable property. We are also working on a resource list to help stakeholders throughout the region to coordinate care. In suicide prevention, our partnership with SPAN of North Idaho will enable us to train five Question/Persuade/Refer (QPR) trainers in Bonner and Boundary counties. We have worked with multiple community partners on the YES transformation for youth behavioral health services, and our website with information about YES and the CANS assessment is continually updated. Finally, in the first and second quarters of 2019, Texas Christian University will visit our region to provide training.

REGION 2

Region Two is a very active and responsive group addressing the behavioral health needs in our region and communities. Training, advocacy, support, recognition and action characterize our efforts. Our ultimate goal is to identify/assess factors of mental illness, substance use disorders and co-occurring disorders to develop strategies to prevent, treat/rehabilitate those suffering from behavioral health conditions.

Our top accomplishments are:

- Growing the number of transitional homes, with two new Oxford homes, one for men, and one for women and children;
- Operating three Rising Sun Houses, two for men, and one for women and children;
- Training, including Crisis Intervention Training, Idaho Coalition for Drug Dependency, Suicide Prevention, and other related training as it comes available;
- Advocating for legislative action including funding for Rural Crisis Response service, which is a decentralized model incorporating five regional hospitals as crisis centers, Medicaid expansion to provide health care to thousands of people with behavioral health conditions, passage of Overdose Prevention law that will save lives and give opportunity for treatment;
- Providing some financial support for Recovery Centers through Idaho Response to Opioid Crisis funds;
- Filling the newly created Prevention Specialist position with a certified prevention specialist on the Behavioral Health Board;
- Receiving the PFS Grant for substance abuse prevention activities;
- Participating in Homeless Point in Time Count in late January;
- Securing Optum expanded telehealth for independently licensed therapists.

Our top needs include base funding for Recovery Centers, implementation of Medicaid expansion, additional transition housing, increased SUD treatment funds, a resource directory to provide knowledge of existing services for those in need, lack of certified prevention specialists and other professional treatment providers, transportation, lack of tele-health services in rural and frontier regions, and ongoing interest and anticipation of Youth Empowerment Services Implementation.

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REGION 3

The three most significant accomplishments of the Region Three Behavioral Health Board include the following:

- Creating a Canyon County Self Rescue Manual and working on completing the Youth Resource Guide through our Children's Mental Health and Provider Subcommittees.
- Drafting our five- year strategic plan for operations which was derived from our Gaps and Needs Analysis.
- Securing Board approval to begin a pilot Prevention Block Grant Funding opportunity for rural communities and schools.

The main identified needs in our region include the following:

- Increased communication from the State Behavioral Health Planning Council (BHPC) regarding reporting, annual/quarterly/monthly report due dates and needs, as well as a return report to the Regional BHBs regarding the activities of the BHPC.
- A "clearinghouse" placement on the BHPC website for activities/projects other BHBs are working on for potential collaboration regionally or statewide.
- Communication from Statewide agencies where the BHB can participate/collaborate as the expert in behavioral health issues/needs based on their Gaps and Needs Analysis.
- Increased communication from Recovery Idaho and how they would like to report/participate in the Regional BHBs.

The Region Three Behavioral Health Board has worked with the Recovery Centers in both Gem and Canyon Counties to accomplish these goals:

- Provided funding for promotional/donation activities.
- Placed a SUD Recovery Coach on the Board who also worked for the Canyon County Recovery Center for representation.
- Included Recovery Centers in the Strategic Plan to participate and for support where needed.

Southwest District Health has received the direct funding for the Region Three Crisis Center and has assembled a workgroup to assist with direction and feedback, and the Region Three Behavioral Health Board has included the Region Three Crisis Center in their Strategic Plan for support. Lifeways was awarded the contract by Southwest District Health to provide services for the Region Three Crisis Center which they anticipate opening in Spring of 2019.

REGION 4

Throughout fiscal year 2018, the Region IV Behavioral Health Board has made significant strides in furthering our operations, as well as efforts towards communication, networking, and education within the Region.

Our top three accomplishments include:

- Working with stakeholders, including payor sources, to support and educate the region on statewide shifts in the behavioral health system related to the YES (Youth Empowerment Services) implementation rollouts.
- Increasing overall community education and awareness about our board at major conferences within the Region, as well as our first annual Meet and Greet with legislators.
- Identifying additional needs and gaps that have been captured in our analysis and working with stakeholders to provide education to our board and its committees about existing services, expansions of available and/or new services to the behavioral health system, and new grants or pilot programs that are taking place.

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Our committees provide feedback to our Gaps and Needs analysis on an annual basis. Top needs identified include but are not limited to the following:

- Lack of affordable, accessible housing for chronically mentally ill, those with substance use disorders, offenders, and hospital releases.
- A lack of programs and funding to adequately address the homeless population in the region, including homeless youth.
- A continued need for improved coordination of care and system improvements, which means increased coordination between primary care providers and behavioral health providers, increased options needed for transitional housing between needed levels of care, and lack of supportive funding and programs to address gaps in care for higher risk populations, including offender re-entry treatments, patients released from State Hospitals, and IDOC.

REGION 5

In an attempt to focus on the prioritized needs of our region, the Board developed a process this year for awarding mini-grants to local agencies whose work sought to fill some of those existing service gaps, including the critical need for crisis and transitional housing, especially for single men. Through these mini-grants, we partnered with Men's Second Chance Living in the Wood River Valley to open a new sober/transitional living home for men in the region; In the fall of 2018, the house opened its doors and is currently serving clients in Hailey.

Our region was also able to partner with NAMI to start a program for teens in the Wood River Valley called "Bluebirds." This program provides a safe place for students in the area to discuss mental health and other related issues, as well as providing transportation and access to activities that might otherwise be unavailable to these children and teens, especially in rural areas. Currently, we are discussing the opportunity to expand these programs into Twin Falls and Jerome counties with the help of the individuals behind the NAMI Wood River programs. We also participated in the Federation of Families for Children's Mental Health 5K Fun Run in May 2018 to help reduce the stigma associated with mental health conditions.

We continue to experience a shortage in psychiatric bed availability and in providing behavioral health training for law enforcement. Additionally, we need translators and interpreters to improve access to care.

REGION 6

A behavioral health crisis center has been approved for this region, and plans are being formulated. Portneuf Health Foundation and Bannock County are collaborating on this project. Funding from the state legislature has been approved for the first three years.

Our accomplishments include the following:

- Provided education to stake holders at yearly event with legislators and presentations to the region 6 chamber of commerce and other organizations.
- Representatives from law enforcement, schools, and treatment centers attended a monthly meeting at the juvenile justice building to coordinate case management among police departments, schools, and treatment centers.
- We provided funding for Idaho conference on alcohol and drug dependency, Recovery Fest, Children's Mental Health Training, Hope & Recovery Resource Center and Accelerated Resolution Therapy all were project partners.

We continue to work with community partners to identify transitional and permanent housing solutions for men, women, and families. The Rising Sun for women and the Moore House for Men are currently operating in Bannock County for safe and sober housing. Supported employment, especially for those with a criminal record, remains a challenge. We plan to work with the Chamber of Commerce to identify "felon friendly" employers in 2019. We continue to support ISU and Hope & Recovery Resource Center in their efforts educate the community through fliers and community events.

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In children's mental health, the Department of Health & Welfare has trained staff to do the CANS assessment. The Children's Mental Health subcommittee has provided resources cards to schools within Region 6, and we hosted an annual training for children's mental health and the YES project.

REGION 7

The Region Seven Behavioral Health Board has had a busy year addressing behavioral health issues throughout our 10-county region. Although we have had great success, many behavioral health needs remain. One of our biggest accomplishments was helping to sponsor the ART (Accelerated Resolution Therapy) training in February 2018. The Region Seven Behavioral Health Board sponsored 10 mental health professionals to attend the training and learn a new mental health treatment. Research has shown ART therapy to be successful in treating post-traumatic stress disorder (PTSD) in both veterans and the general population.

Another success **was t**aking our June meeting to Challis, Idaho, which is one of the most rural areas in our region. The community was very grateful that our Board took the time to travel 3 hours to meet with them and discuss the unique needs of their community. Our meeting in Challis reaffirmed the fact that there is a lack of affordable housing in our region for individuals with behavioral health issues and for those who are re-entering our communities from the criminal justice system. We remain committed to addressing this problem and developing strategies to help address it.

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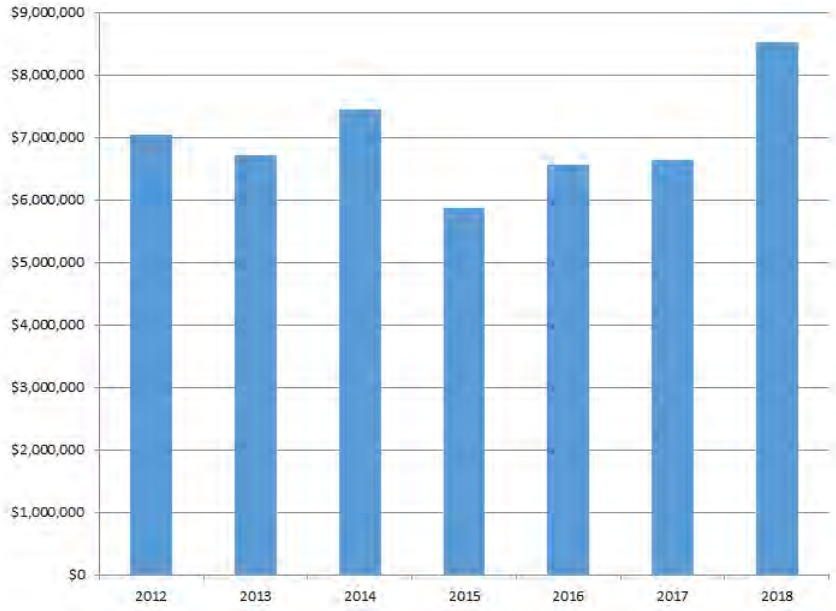
COSTS AND COMPARISONS IN BEHAVIORAL HEALTH

MENTAL HEALTH CARE COSTS
FY2017-FY2018

	FY2017	FY2018			FY2017	FY2018	
ADA	$2,799,056.87	$3,891,142.62	39.0%	GOODING	$58,485.59	$77,363.71	32.3%
ADAMS	$22,175.45	$2,850.00	(87.1%)	IDAHO	$56,435.57	$40,126.05	(28.9%)
BANNOCK	$202,182.09	$181,377.25	(10.3%)	JEFFERSON	0	0	0.0%
BEAR LAKE	$20,276.14	$1,800.00	(91.1%)	JEROME	$97,541.86	$108,016.82	10.7%
BENEWAH	$4,617.00	$15,536.84	236.5%	KOOTENAI	$386,735.32	$330,885.63	(14.4%)
BINGHAM	$55,132.79	$42,052.25	(23.7%)	LATAH	$23,822.03	$39,020.55	63.8%
BLAINE	$39,607.39	$70,982.37	79.2%	LEMHI	$6,165.76	$6,228.83	1.0%
BOISE	$9,600.00	$19,151.97	99.5%	LEWIS	$7,512.24	$26,069.88	247.0%
BONNER	$25,436.15	$65,269.82	156.6%	LINCOLN	$0.00	$1,813.55	100.0%
BONNEVILLE	$137,407.72	$226,916.55	65.1%	MADISON	$64,220.58	$12,480.83	(80.6%)
BOUNDARY	$0.00	$24,582.60	100.0%	MINIDOKA	$22,338.36	$45,296.73	102.8%
BUTTE	$10,524.95	0	(100.0%)	NEZ PERCE	$69,122.22	$106,743.75	54.4%
CAMAS	0	0	0.0%	ONEIDA	$1,585.00	$2,075.00	30.9%
CANYON	$1,735,876.55	$2,299,019.56	32.4%	OWYHEE	$100,068.98	$39,482.23	(60.5%)
CARIBOU	$0.00	$29,628.32	100.0%	PAYETTE	$93,548.16	$107,202.89	14.6%
CASSIA	$7,778.24	$35,355.20	354.5%	POWER	$15,825.00	$11,277.30	(28.7%)
CLARK	$600.00	0	(100.0%)	SHOSHONE	$3,517.57	$12,522.64	256.0%
CLEARWATER	0	0	0.0%	TETON	$0.00	$7,524	100.0%
CUSTER	$0.00	$11,504.43	100.0%	TWIN FALLS	$226,198.44	$267,354.67	18.2%
ELMORE	$144,839.32	$128,206.18	(11.5%)	VALLEY	$23,998.09	$39,103.91	62.9%
FRANKLIN	$7,899.18	$28,868.26	265.5%	WASHINGTON	$33,664.70	$44,286.49	31.6%
FREMONT	$11,175.94	$4,708.32	(57.9%)				
GEM	$116,066.26	$115,915.31	(0.1%)	TOTAL	$6,641,037.51	$8,519,743.31	28.3%

The chart above compares FY2017 and FY2018 spending by county: 27 counties increased their spending, while 14 counties decreased their spending. There was no change in three counties. The chart (right) compares total state behavioral health expenditures from 2012 through 2018.



NEEDS AND OPPORTUNITIES IN BEHAVIORAL HEALTH

Working for positive outcomes in 2019

As we move into 2019 we remain grateful for the Governor's and state legislature's commitment to improving behavioral health services in Idaho. The regional behavioral health crisis centers have provided a critical first-line resource for mental health. However, several areas continue to present significant challenges. These include lack of access to medically necessary services, a fragmented system of care, a need for education and public awareness, and housing, employment, and transportation shortages. Although these challenges exist in all regions, rural communities face even greater barriers in accessing care.

CRISIS AND RECOVERY CENTERS

Providing care and saving costs in our communities

Idaho's four behavioral health crisis centers and nine recovery community centers are integral to our recovery-based model of care, keeping people in the communities where they live. New crisis centers will provide necessary stabilization and cost savings.

SUICIDE PREVENTION

Renewing our commitment to Zero Suicides

While Idaho has historically struggled with high per capita rates of death by suicide, the Office of Suicide Prevention and community partners remain committed to ending death by suicide in our state.

EDUCATION AND OUTREACH

Communicating the importance of behavioral health and ending stigma

We will continue to partner with community organizations to provide outreach and education to parents, youth, veterans and all Idahoans who can benefit from behavior health support. Moving from a reactive to a proactive system depends on building skills and ending stigma.

YOUTH EMPOWERMENT SERVICES

Creating proactive systems of care for Idaho's at-risk children and youth

The Regional Behavioral Health Boards will continue to partner with the Department of Health and Welfare in transforming the system of care for Idaho's most at-risk youth.

ACCESS TO SERVICES

Expanding Medicaid and access to behavioral health services for all

Idaho's rural communities struggle with access to behavioral health services. Recruiting service providers and exploring telehealth options will help us to expand the reach of these services. Medicaid expansion will be a tremendous benefit for behavioral health needs.

SUBSTANCE USE DISORDERS TREATMENT

Supporting people on the road to recovery

We remain committed to fighting the opioid crisis in Idaho as well as ensuring that our citizens have access to treatment for other substance use disorders including alcohol. Supporting people on their recovery journeys will improve the lives of individuals, families, and communities.

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2018 BHPC BY THE NUMBERS

14,813

VISITS TO 4 IDAHO RECOVERY CENTERS

Average of almost 5,000 visits per center. In most cases, recovery centers operate on 1.5 staff members.

1,131

CHILDREN WITH SED SERVED IN IDAHO

It is estimated that an additional 6,000 children and youth will receive services through the YES system of care.

393

DEATHS BY SUICIDE IN IDAHO IN 2017

Suicide is the second leading cause of death in our state, and our rate is the eighth highest in the nation. Behavioral health services literally save lives.

BEHAVIORAL HEALTH MATTERS

According to SAMHSA, every $1 spent on preventative services translates into $7 in costs saved over the client's life. With access to effective treatment, including medication, therapy, and social supports, many individuals living with behavioral health challenges can have productive lives in their communities.

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CONCLUSION

The State Behavioral Planning Council is thankful to the Governor and the Legislature for ongoing support of behavioral health services in Idaho. Continued improvement depends on a continued commitment to sustainability and recovery. As we begin the next fiscal year, we express our support for the following:

- The work of Regional Behavioral Health Boards in their partnership with their communities.
- Medicaid expansion, which will increase access to behavioral health services for at-risk Idahoans.
- Continued efforts to increase access to behavioral health services, including telehealth, transportation, and provider recruitment.
- The YES program to improve services for children diagnosed with Serious Emotional Disturbance (SED).
- Ongoing use of Recovery Community Centers and Crisis Centers to provide stabilization.
- Recovery and peer support services to assist clients in all aspects of living in recovery.
- Ongoing support for suicide prevention and education efforts across the state.
- Coordinated ART trauma therapy for veterans.
- Supportive transitional housing for people living with serious persistent mental illness (SPMI).
- Access to substance use disorder treatment for individuals not involved with the criminal justice system.

The BHPC supports the continued 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. We look forward to partnering with you to improve the lives of Idahoans as together, we continue to work toward a sustainable model for recovery.

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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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Region 2 Behavioral Health Board
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Region 3 Behavioral Health Board
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Melissa Mezo, Chair mmezo@trhs.org
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Region 4 Behavioral Health Board
https://www.cdhd.idaho.gov/hl-r4bhb.php
Kim Keys, Chair https://www.cdhd.idaho.gov/cf.php
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Region 5 Behavioral Health Board
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James Brown, Chair
EJ Poston (208) 737-5947 http://www.scbhbidaho.org/contact.html

Region 6 Behavioral Health Board
https://siphidaho.org/comhealth/behavioral-health.php
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Region 7 Behavioral Health Board
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Region 1 SFY 18 Gaps and Needs Analysis

Sub-Committee/Topic	Needs/Barriers	Goal	Timeline to Accomplish Goals *(If goal has been identified, but deferred to a subsequent year, please enter "Deferred")*	Action Plan (optional)	Accomplishments	Goal Achieved
Housing	Lack of housing resources for patients being released from State Hospitals North and South	To create safe housing specifically set aside for patients being released from State Hospitals North and South	Jun-19	1. Set up meeting with St. Vincent de Paul 2. Create MOU with SVDP to manage and cover repairs to a property 3. Find and rent a suitable property	Contact with SVDP complete	
Housing	Currently there are less resources and access to housing in our outlying areas	To compile a working list of all resources in North Idaho	Dec-19			
Adult Behavioral Health	Access to care	Address lack of communication regarding what care is in place, currently	Dec-19	Compile a working list of all resources in Region 1 Reach out to Kootenai Health network, Health and Welfare, and Heritage Health to address access to care for the region		
Adult Behavioral Health	Current response is reactive to suicide and substance use prevention	Identify stargates that are in place for prevention. Identify strategies that need to be in place for prevention	Dec-19	Continued meeting with SPAN, incorporate meetings with the new prevention specialist position to be hired at Panhandle Health District in District 1. Participate with North Idaho College for any follow up from the Suicide Prevention Summit in August of 2018, next meeting March of 2019. Continue to facilitate and encourage QPR trainings across the region.	Partnership with SPAN of North Idaho 5 QPR trainers in Bonner and Boundary counties Partnering with PHD to train additional QPR trainers	
Children's Mental Health	Access to care and knowledge of resources available	To complete the System of Care/YES transformation	Dec-19	Continued training in the community and at businesses on the YES transformation	Multiple presentations to community partners regarding the YES transformation Website for YES transformation, with information on CANS, up and running and continually being updated	
Children's Mental Health	Training Education and Outreach	To implement/create more training for educators, families, and caregivers	Dec-19	1. Have Texas Christian University complete a training in our region 2. Create a CIT training for children STAT for all regional school districts 3. Reach out to school districts regarding suicide prevention training and activities	Texas Christian University will be coming to our region to provide a training in the 1-2 quarter of 2019	

Region 2 SFY 18 Gaps and Needs Analysis

Sub-Committee/Topic	Needs/Barriers	Goal	Timeline to Accomplish Goals *(If goal has been identified, but deferred to a subsequent year, please enter "Deferred")*	Action Plan (optional)	Accomplishments	Goal Achieved
Adult Behavioral Health	Lack of knowledge about resources in region 2	Develop comprehensive community guide	1a. Provide information about community resources at committee meetings. 1b. Update resources at committee meetings. 1c. Quarterly review of list of resources.	Get current guides from throughout region, put together and supplement.	Guides being collated. Additional resources being sought.	
	Lack of public awareness	Increase participation & support from community	2a. Invite programs to keep Board informed. 2b. Reach out to Programs to gather information about needs. 2c. Solicit ideas as to ways to get people connected. 2d. Annual awareness event in September. 2e. Involve NAMI in an event.		Hands Across the Bridge National Recovery Month being supported. Recovery Festival held in September in Latah County. Programs being invited regularly to present to BHB.	In Progress
	Inadequate number of Certified Prevention Specialists	Increase CPS by one in 2017	3a. Identify possible CPS candidates. 3b. Train CPS candidate.		CPS position added to the Region 2 Behavioral Health Board. CPS applied for a grant and subcommittee was created.	✓
	Limited access to care & services	a. Increase BHB awareness of funding changes/trends.	4a. Formal presentation to BHB.		Grant applied for prevention.	✓
		b. Increase access to transportation in rural areas.	4b. Network with potential transportation providers.			
	Crisis Response	Establish "Mental Health and You" Phone App	Acquire resources for Phone App in FY 18-19		Optum and Idaho Association of Counties are working together to identify and secure resources needed for start=up	In Progress
Children's Mental Health	Lack of Respite Care for Families of Children with SED	Recruit organizations to provide Group Respite Care		Met with a number of organizations in effort to recruit for Respite Care Services	A to Z Counseling in Orofino became Group Respite Provider	✓
Crisis Center	Access to BH Crisis Services across Region	Obtain State funding to launch Rural Crisis Project	Start of FY19 (July 2018)	Finalize Proposal and submit to state for approval c	Funding Approved to begin FY19	✓
			July 2018	Contract for state funding signed with DHW	In Process	
			June 2018	Meetings with Hospitals to update them on status	Held Meetings in May 2018	✓
			August 2018	Meetings with Counties to update them on status	Written communication out to Counties in August 2018	✓
			July 2018	Applications for Project Manager taken	Position posted and applications accepted in July-Aug 2018	✓
Housing Committee	Affordable housing in rural areas	Find a landlord to establish a Sober House in Orofino	8/2017- 10/2018	Contact Austin Archambeau with Rising Sun.		✓
	Veterans Housing	Develop model grant proposal for housing program for Veterans with mental illness and substance abuse disorders.	8/2018 - 10/2018	One or more potential proposals written by BSU Graduate Students.		In Progress
	Homeless Shelter in Lewiston	Involve local agencies, stakeholders and the ROC in development of a plan for a shelter	8/2018 - 10/2018	Schedule a community meeting and develop an action plan.		In Progress
Telehealth Committee	Increase flow availability of TeleHealth info in Region 2	Inform Behavioral Health Board on new developments in TeleHealth	FY2018	Identify resources for information regarding TeleHe	Subcommittee identified several sources of information on Tele Behavioral Health	✓
				Report to Region 2 Behavioral Health Board new developments in field of Tele Behavioral Health	In Progress	

Region 3 SFY 17 Gaps and Needs Analysis

Sub-Committee	Needs/Barriers	Goal	Timeline to Accomplish Goals	Action Plan (Optional)	Accomplishments	Goal Achieved
CMH & Provider	Services for non-criminal justice at-risk youth	1. Funding 2. A successful model (school disciplinary hearings) 3. Trauma education in elementary schools 4. Mentor programs 5. Parental/Caregiver Involvement	one year	1.Research funding sources such as the Juvenile Justice Commission. 2. Research an evidence based model for school to refer at-risk youth. 3. Work with Health and Welfare for crisis services (law enforcement, schools, parents and care givers) 4. Screening schools for gaps and needs. 5. Engage in community training such as trauma informed care 6. ACES education in elementary schools 7. Provide information to parents on registration nights or parent nights 8. Utilize the YES Project 9. Build a Youth Resource Guide	1. ACES - Paper Tigers and Resilency screenings at school/community events 2. United Way report/study on Canyon County 3. 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 this pilot model/outcomes 4. CIT trainings within the schools, youth mentoring program 5. Youth Court at Canyon Springs High School	

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Region 3 SFY 17 Gaps and Needs Analysis

Sub-Committee	Needs/Barriers	Goal	Timeline to Accomplish Goals	Action Plan (Optional)	Accomplishments	Goal Achieved
CMH & Provider	Crisis Assistance	1. Funding 2. Transportation 3. Lack of Providers for respite care 4. Prevention in schools. 5. Hosptial Beds 6. Sex offender placement 7. Long Term Care 8. ACT Team (only for severe mental health and adults only). 9. There is currently no Crisis Center in Region III 10. Lack of Levels of Care - Partial Hospitilization Program for juveniles.	one year	1. Shelter care for youth for short-term intervention 2. Residential respite care 3. Implement more prevention programs within schools 4. Utilize community recovery centers to assist those in recovery 5. Crisis Center to assist in stabilization and referrals to community resources 6. Utilize the YES Project 7. Add list of Respite Providers to the R3 Resource Guide 8. Inform the BHB monthly of any resources added or changed 9. Monthly Crisis Center update at the BHB meeting	1. Respite care for juveniles to include crisis respite care (however there are lack of providers) 2. Youth mental health first aid 3. Crisis Center committee 4. Youth Ranch opening another facility 5. Region 3 Self Rescue Manual 6. Increase in youth mentoring programs 7. Generations program at Intermountain Hospital and added 17 new adolescent beds.	

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Region 3 SFY 17 Gaps and Needs Analysis

Sub-Committee	Needs/Barriers	Goal	Timeline to Accomplish Goals	Action Plan (Optional)	Accomplishments	Goal Achieved
CMH & Provider	Prevention, Enrichment and Resiliency	1. Funding and connecting of current available resources	one year	1. More afterschool programs with assistance for applications for the State Department of Education 21st Century Grant 2. Increase school participation in prevention block grant funding. 3. Engagement in Mayor's Youth Advisory Council to promote healthy youth involvement. 4. Engage Behavioral Health Board to assist in writing the grant funding opportunities. 5. Utilize the YES Project 6. Youth Resource Guide provided to the schools 7. Create a survey for schools and parents to identify needs for behavioral health. 8. Policing the teenage brain.	1. CIT Trainings - provide financial support 2. Youth mentoring programs	
CMH & Provider	Youth Mental Health Court	1. Funding 2. Lack of grant writing 3. Engaging the juvenile judicial system	one year	1. Engage the BHB to assist in writing of grant funding oppportunities 2. Engage judicial system and juvenile probation 3. Review model in District 6 with data review	1. Connections Court; however, not currently running due to court availability. 2. Juvenile Drug Court	

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Region 3 SFY 17 Gaps and Needs Analysis

Sub-Committee	Needs/Barriers	Goal	Timeline to Accomplish Goals	Action Plan (Optional)	Accomplishments	Goal Achieved
CMH & Provider	Transportation	1. Funding 2. Rural areas access 3. Lack of transportation providers in SUD network 4. Adolescents and families have little to no access to transportation to treatment services or recovery support services.	one year	1. Possiblity of utilizing exiting transportation services such as those delivered in rural communities at senior centers. 2. Bringing services to the school districts where youth/adults/parents/caregivers already frequent. 3. Connection to community recovery centers and peer supports 4. Extend an invitation to COMPASS	1. The Canyon Bike Project 2. OPTUM expanding to provide reimbursment for in home therapy 3. Medicaid transportation flyer created	
CMH & Provider	Housing	1. Stable, supportive housing for individuals with mental health illness in a six counties.	one year	1. Funding for HART Homes approved. 2. BHB provide community education to facility providers about HART program and encourage enrollment as contractor. 3. Develop proposal for community providers to provide room and board housing. 4. Provide online and community training resources to housing providers to improve understanding of mental illness. 5. Get update from Idaho Housing and Finance	1. Region 3 Self Rescue Manual 2. CATCH program	

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Region 3 SFY 17 Gaps and Needs Analysis

Sub-Committee	Needs/Barriers	Goal	Timeline to Accomplish Goals	Action Plan (Optional)	Accomplishments	Goal Achieved
CMH & Provider	Employment	1. Connecting existing resources to those in need. 2. Transportation. 3. Stigma 4. Lack of access for effective funding and preparation for GED testing. 5. Lack of trades at the high school level	one year	1. Education communities and clients on employment assistance providers for individuals with disabilities. 2. Connection to employment resources available at Community Recovery Centers and Peer Supports. 3. Education community about GED preparation and testing resources and post information in the Region 3 Resource Guide. 4. Add questions about trade school options at high school level to survey. 5. Dev elop more trade school options at the high school level (ex: COSSA Academy) 6. Life skill for teens program	1. Region 3 Self Rescue Manual 2. GED preparation classes at the Canyon Clinic Wellness Recovery Center 3. Breaking Chains Academy 4. CWI GED program	
CMH & Provider	Increase collaboration with medical providers	1. Lack of awareness in regard to the options available for behavioral health services and providers. 2. Lack of communication in regards to mutual clients 3. Lack of medically managed alcohol detox	one year	1. Monthly SHIP update at BHB meeting. 2. Offer collaboration to identify ways to increase communication between medical and mental health communities. 3. Provide medical providers with Region 3 Resource Guide. 4. Continue to get updates from SHIP and invite to talk to BHB	1. SHIP representative attends BHB meetings with updates	

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Region 4 SFY 18 Gaps and Needs Analysis

Sub-Committee/Topic	Needs/Barriers	Goal	Timeline to Accomplish Goals *(If goal has been identified, but deferred to a subsequent year, please enter "Deferred")*	Action Plan (optional)	Accomplishments	Goal Achieved
YOUTH BEHAVIORAL COMITTEE						
	NEED: HOUSING /RESOURCES FOR HOMELESS YOUTH					
	Lack of support and services for homeless youth. Locating/identifying the homeless youth in need of support and services. Based on data provided by the Idaho Department of Education, in the school year 2016-2017 Region 4 school districts reported 1,585 homeless youth. This number accounts for 20% of the total homeless youth reported in the State of Idaho. Based on Data in United Way Community Assessment, 25.4% of Ada county residents are under age 18. 13.7% of those are in families with income below FPL.	To work in collaboration with agencies and programs to assist in providing supports and services to homeless youth in the Treasure Valley.	2018-2019	Identify agencies offering services to homeless youth in Region 4. Identify 2-3 areas for meaningful collaboration, as well as organizations we could collaborate with. (potential identified partners below) One Stone St. Vincent DePaul. Collaboration/education with the Youth Homelessnes Workgroup created by Housing and Community Development Continuum of Care. https://hcd.cityofboise.org/homelessness/ Suggester further actions/next steps: complete outreach services to homeless youth and families for education and connection to YES		
	NEED: SERVICES FOR NON-CRIMINAL JUSTICE AT-RISK					
	Schools in more rural areas do not have the resources to provide education or strategies for children/families with mental illness.	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 Mental Health First Aid for Youth, trauma informed care, suicide prevention, at-risk youth behavior education.	2018-2019	Continue to support Mental Health First Aid trainings targeting Jr. High and High School personnel in Garden Valley, Idaho City, and McCall/Donnelly. Increase Committee education about PLL and other supportive programs. Increase committee education regarding efforts to expand behavioral health services to schools, create ties between agencies who preform services to schools.		
	NEED: COMPREHENSIVE KNOWLEDGE OF SERVICES AVAILABLE TO YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE (SED)					
	Lack of up-to-date and latest information regarding services available to SED youth.	Establish quarterly updates regarding Youth Empowerment Services (YES) implementation. The Youth Committee will also address areas where they can get involved and provide needed feedback to the statewide process.	2018-2019	Continue Region 4, Regional Program Specialist involement in all youth behaivoral health committee meetings. This position will report all YES updates to the Committee. Continue to review and access YES project updates as available and distributed by DBH. https://youthempowermentservices.idaho.gov/Portals/105/Documents/ProjectStatusReportJuly2018.pdf	Optum has begun CANS Certification trainings and has completed a first round of in person YES Navigation training for providers in Idaho. Outlined implementation of YES Services timeline made available to the community and providers. Respite services rolled out July 1st 2018.	
	REESTABLISHMENT OF THE GRANTS WORKGROUP/GRANT SUPPORT					
	Lack of individuals who can support the committee with grant research and application process.	Recruitment of participants to support the youth behavioral health committee with grant research and application processess. Will have established tasks and a reporting role with the larger Committee.	2018-2019	Continue to work with NNU, possibly BSU to incoperate an intern into the Youth Behavioral Committee for limited Grants Support	Worked with NNU to secure intern, committee members looking into possibilities with BSU as well.	
	NEED: INCREASE AWARENESS OF THE IMPACT OF HIGH ACE SCORES ON EARLY CHILDHOOD DEVELOPMENT AND CONTINUING ISSUES IN LATER LIFE					

		Provide education to stakeholders, including physicians, teachers, counselors and court system about the role of ACES. Encourage physicians to include the ACE questionaiire in the regular office visits. Follow outcomes from ACE work in Idaho	2018 - 2020	Support movie screens of the movie Resilience and Paper Tigers to any stakeholders who request it. Help stakeholders develop action plans to incorporate ACEs and trauma informedd care in their organizations. Enlist family Physicians to include ACE questions in their office visits.	Optum worked with the CDC to include ACE questions on the annual CDC-BRFSS survery to astabilh a baseline for Idaho. Optum is showing Resilience and Paper Tigers across the state and in Region 1V, including the State Department of Education and the Idaho Academy of Family Physicians
MARKETING COMMITTEE					
	Lack of stakeholder awareness of function and puprose of Region IV Behavioral Health Board	Improve community awareness of RBHB functions and goals to improve community involvment and input.	2018-2019	Suggested action: Identify 3 things that the Board would like as a result from marketing (ie: staekholders to know we exist, increased involvement) Identify a list of stakeholders we would like involved and send flyers out, invitations to meetings. Host a meet and greet event or conference to faciliate networking and improve community awareness of RBHB functions and goals. Consider collaborating with IDHW to share table space at events and conferences.	Marketing materials created and dispersed with Region IV BHB representation at Recovery Rally 2017, Community Information Resource Fair 2017 & 2018, and at ICADD 2018. Meet and Greet event with Stakeholders Feb 2018.
	Limited involvment on RBHB committees.	Increase RBHB networking through improved committee involvement from broader community stakeholders which could help drive RBHB's broader goals	2018-2019		
GAPS AND NEEDS WORKGROUP (gaps and needs identified but not targeted by sub-committees for action)					
	NEED: HOUSING				
	Transitional Housing lacking Per WICHE report spending per day: State Psychiatric Inpatient $609, Homelessness $106, Prison $55, Perminant Supportive Housing $32	Education for the board regarding the current system for people with SPMI or SMI who are transitioning out of hospitals or correctional institutions. Opportunities for involvement	2020	Identify and work with agencies working with transitional care issues. Outreach to agencies to 1) determine number of indivuduals released/discharged homeless or become homeless within 60 days of release.2) Determine difference in recividism for those with housing compared to those homeless. 3) develop understanding of supportive services for community reintergration.	
	Lack of safe housing for sober living	Increase board education on current options for safe and sober living.		Identify organizations providing sober living services and invite to present at board meetings. encourage discussion on how the board can support expansion of these services.	
	Lack of affordable, accessible and supported housing for chronic mentally ill, offenders, and hospital releases. Affordable Hosuing Gap Analysis Data by County provides the following: (affordable units per 100 extremely low income renter households) Ada: 18 Boise: 65 Elmore: 68 Valley: 65	Establish a sustainable supported housing entity that supports independent living through medication management and life skills checks, internal access to behavioral health service and community support groups.		Suggested action: Research options and current need for an Increase in SUDS/MH daily rates for housing to allow agencies the ability to open additional houses.	HART project moving towards appropriate stable housing for mentally ill

Lack of programs and funding to adequately address the homeless population in our region. Homelessness complicates and contributes to mental health issues. Data collected by the Idaho Housing and Finance Association for their "Idaho Homelessness Community Report 2016" found that Ada County had 1,331 homeless individuals. The other 3 counties in Region 4 were combined with those from Region 3 for this particular data measurement. Point-in-Time report 2018 (https://www.idahohousing.com/documents/point-time-count-2018.pdf) Region 4: 102 total homeless	Improved funding streams and programs to reduce homelessness in our region.		Identify and support Behavioral health services being offered in this area.	In 2016 the City of Boise was joined by the Idaho Housing and Finance Association, the Boise City/Ada County Housing Authority, CATCH, Inc., and Terry Reilly Health Services, in announcing the Housing First initiative for helping the chronically homeless address the root causes of their homelessness. The program will include "wrap-around" support and services, like mental health counseling, substance abuse treatment and financial counseling. support and services. (see http://mayor.cityofboise.org/news-releases/2016/07/boise-health-systems-join-housing-first-effort-with-$100,000-commitments-for-wrap-around-services/) 2018 -Construction of New Path housing for 40 chronically homeless on permanent supported housing	
NEED: TRANSPORTATION					
Lack of transportation impedes access to services, supports, and increases no show rates. Accodring to United Way data utlization of health care services decreases as travel distance increases. 2% of homeowners and 9% of renters are noted to lack a private vechile Point-in-Time report 2018 (https://www.idahohousing.com/documents/point-time-count-2018.pdf) Region 4: 102 total homeless	1. Improve bus routes and hours of avaialiblity. 2. Improve bus pass availability for MH/SUD treatment needs 3. More direct ride options for SUD/MH clients 4. Develop transportation options in rural areas.	2018-2019	Request outcome evaluation on state non-emergency medical transportation which involves providers and consumers. Expand availability of transportation to social events and resources for those who are unable to use public transportation.	Switched to MTM from Veyo, however similar concerns continue. Planned expansion of bus routes in Ada county.	
NEED: RECOVERY SUPPORT SERVICES					
Lack of community recovery centers	Improve education and support for community Recovery Centers, Peer Wellness Centers, and Crisis Centers.		Suggested action: Research and meet with stakeholders regarding what would be needed to expand Recovery Wellness programs for SUD/MH clients.	A region IV Crisis Center is open and in use. Ada County has a Peer Wellness center, but more are needed in rural areas	Ada county crisis center opened.
Stigma which creates barriers to accessing resources, treatment, and appropriate utilization of available services	Reduce community stigma		Support trainings and empowerment workshops to raise awareness and recovery support from the community	Optum sponsored the Idaho Recovey Open Awareness Ride Labor day weekend 2018 to raise awaness about recovery, recovery centers and to reduce stigma. Annual recovery rally	
Lack of coornidated effort to combat the growning problem of opiod addiction and related deaths. Opiate related problems and deaths are on the rise in our region.	Idenify and support coordination of services to minimize opiate epdidemic.		Suggested action: Monitor data e for opiod related issues, (ie crime rates, overdose statistics, presciption rates) to better address concerns. Support education and treament options such as those identified by Idaho's Response to Opiod Crisis (IROC) program.	Idaho's Response to the Opioid Crisis (IROC) has been established. IROC is part of a federal grant with the intent of addressing the opiate crisis throughout the country. The current grant is a 1-year grant that began July 1, 2017 and started accepting referrals for treatment, recovery support services, and MAT in August 2017. (see http://healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/IROC/AccessIROCServices/tabid/3307/Default.aspx)	
NEED: IMPROVED COORDINATION OF CARE AND SYSTEM IMPROVEMENTS					
Policy and legislation requirements for behavioral health services are often redundant and in conflict.	Support increased education and coordination between services including recovery services, peer support specialists, and family support services.		Suggested action: Develop workgroup to work toward collaberation and education on current system.		

Lack of coordination of care between behavioral health care and primary health care providers. *People with serious mental illness die on average between ages 53-56. 2/3 of premature 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*	Improved communication and coordination between behavioral health providers and primary health providers.		Suggested action: Seek updates from the provider committee.	IIBHN and OPTUM provided CEU credit trinings to providers in region 4 about integrated health. IIBHN Conference presented in Boise was sold out. Optum has released the use of Health and Behavior codes so that clinicians in primary care can bill for integrated services at PCP's offices in May 2018. There was a statewide conference on integrated behavioral health and there are many community providers providing services within primary care such as Family Medicine Residency, Terry Reilly, and St. Lukes.	
Need for strong intergrated behavioral health services within all levels of health care sytsem.	Support the work of the Idaho Integrated Behavioral Health Network.		Invite IIBHN to present at the Board and identify 2-3 ways we can collobrate/support the efforts.		
Lack of transitional housing for individuals moving between levels of care.	Create sustainable transitional housing options that address MH issues, and step downs from Psychiatric Residential Treatment Facilities (PRTF)		Suggested action: To identify stakeholders and create proposals for next steps.		
Lack of insurance coverage for low income individuals who don't qualify for medicaid and earn too little to qualify for assistance through Your Health Idaho Insurance Exchange. Costs to obatain insurance are unaffordable for this population. This is resulting in increased inability to pay for inpatient psychiatric treatment. 21% of individuals ages 18-64 in Idaho are considered to be in the gap. (78,000 residents, in which 81% are in a working family) 2018- Hospitals reporting an increase in uninsured population needing care, no current available data. WICHE report concluded the following barriers to service deliver in Region 4: Lack of adequate funding 66%, Lack of flexible funding 55%	Affordable mental health care and insurance coverage to be able to meet mental health needs that arise for this gap group.		Follow medicaid expansion ballot and legislation. If laws are changed, expand education to Idahoans about expanded Medicaid coverage		
Lack of funding to address gaps in care for high risk popultations ie. offender re-entry, patients released from the state psychiatric hospitals and Idaho Department of Corrections.	Support coordination across agencies (schools, Juvenile Corrections, Correction, Courts, Medicaid and Regional mental health services).		Support the Sequencial Intercept Mapping (SIM) workgroups and use findings to improve care across treatment need settings. Explore other Evidence Based Models used in other states such as community in-reach or health information data exchange systems.	SIM updated	
NEED: ACCESS TO TREATMENT SERVICES AND INTERVENTION					
Limited Intensive Outpatient Programs (IOP) or Partial Care Services.	Increase Intensive Outpatient Programs or Partial Care Services.		Request rate study from IDHW division of Medicaid to increase fee schedule for increase providers ability to provide IOP	increase of 2 providers in Region IV providing IOP. 4 IOP providers in Region IV, only 3 have billed for services. St Luke's began a Partial Hospitalization level of care in June 20018. Current, ability to serve 8 patients at a time and will increase to 16 in September 2018.	IOP out of Pilot stage

Limited behavioral health services in rural areas	Increase tele-health utilization and recruit more providers to rural areas.		Suggested Actions: 1) Engage stakeholders in providing education to follow Rule on Tele-health services. 2) Research what it would take/who to contact/where to start to provide state-subsidies for professionals willing to work in outlying areas. Loan re-payment options. 3) Consider establishing a working group to identify methods to improve access to care in rural communities.	Optum Idaho - Distinct count of providers that serve ages 0-17 in Region IV = 88. St. Luke's began providing services for patients with Autism in McCall via telehealth for follow up care. Idaho Telehealth Council under the Statewide Healthcare Innovation Plan (SHIP) meeting and planned workgroup activities. http://ship.idaho.gov/WorkGroups/TelehealthCouncil/tabid/3059/Default.aspx Optum has a telehealth workgroup that meets regularly. Request regular updates for Optum and collaborate to implement prgrams in rural areas.	
SSI/SSDI Outreach, Access and Recovery (SOAR) needs faster accessibility to Medicaid approval. Additionally, lack of payment for SOAR services is a barrier.	Increase SOAR trained professionals in the Region. Identify methods to pay for SOAR.		Suggested Action: Gather data to support use of SOAR services and promote use of SOAR services.		
NEED: OLDER ADULT, MENTAL HEALTH, SUD AWARENESS					
Substance use disorders in adults ages 50+ are expected to double from 2.8 million in 2002–2006 to 5.7 million by 2020. Wu, L. T., & Blazer, D. G. (2011). At least one in four older adults use psychoactive medications with abuse potential. National Institute on Drug Abuse. (2006). Misuse of Prescription Drugs. Misuse of opioids and opioid use disorders among older Americans has profound effects. Prescription drug-related deaths among adults ages 60+ now surpass those of young people. Emergency department visits due to medication misuse by adults ages 50+ increased 121 percent from 2004 to 2008. Opioid-involved suicides have doubled among older adults since 1999.	Increase Region IV awareness of current issues impacting our region.	2018-2019	Suggested Action: To increase Board knowledge and awareness regarding this poulation and the needs associated.		
NEED FOR COORDINATED SUICIDE PREVENTION PROGRAM IN STATE AND REGION					
Data from the Youth Risk Behavior Survey in 2015 cites 10% of Idaho High School students had attempted suicide in the past year. 20% had seriously considered attempting, up significantly from previous years.	Increase and/or support suicide prevention programs in schools and communities to reduce the number attempted and completed suicides .		Consider or Develop sucide awareness committee to coordinate collaboration and help educate communities about suicide and prevention.		
NEED: LIMITED KNOWLEDGE AND COORDINATION WITH VETERAN MENTAL HEALTH					
	Increase Regional education on veteran specific behavioral health serving systems and access/collaboration options		Suggested Action: Education Options for the R4BHB regardinig veteran serving systems.		

Region 5 Behavioral Health Board – Gaps & Needs Analysis 2018

Identified Regional Service Needs & Gaps *(Relating to Prevention, Treatment, and Rehabilitation Services)*	**Shortfalls & Challenges**	**Project Proposals, Progress, and Accomplishments** *(Including those related to Family & Recovery Support services)*	**Improvement Strategies & Measures**	**Outcomes**
Housing (crisis, transitional, permanent)	Need for crisis/transitional housing far exceeds availability in all Region 5 counties. Barriers such as felonies, credit checks, and the need for deposit/first-month rent money screen out many individuals. Single men have minimal housing options.	• Well-managed, clean transitional housing units • Recovery housing that supports clean and sober living while providing structure and accountability • Housing opportunities that "screen in" individuals rather than "screening out" individuals	• Engage our community members while educating about the social and fiscal benefits of crisis/transitional housing • Capture sources of funding for first-months rent and deposits • Research functioning housing models in other regions/states and address hurdles encountered during start-up • Grants and funding dollars that support the unique population needs of Region 5 • Research and collaborate regarding the opportunity to renovate and use existing, vacant dwellings/structures.	*Through our mini-grants we were able to partner with Men's Second Chance Living (MSCL) to help them to establish housing for men in Blaine County. Granting them $5,700 for the purpose of:* • *building a website* • *purchasing office furniture, equipment, and supplies* • *promotional materials* • *internet service*

Region 5 Behavioral Health Board – Gaps & Needs Analysis 2018				
Transportation	Limited transportation available to serve the rural areas of Region 5. Many services\resources are only available in Twin Falls and in some cases Boise (see Access to care in rural areas), therefore citizens in outlying communities and counties have limited opportunities to even make those appointments. The lack of transportation also creates barriers to employment opportunities.	• Promotion and support of the possibility of Twin Falls having a public transportation system • Coordination of a shared ride/cost program • Combine and coordinate individual vehicle fleets from multiple organizations/agencies/providers to offer efficient public transport from a single transit organization/central dispatch	Investigate rural transportation models that have proved successful in areas with similar a geographic/population make-up • Research and address potential conditions that may affect the operation and coordination of public transit to rural areas • Seek expanding the use of Section 5311 funds to communities with populations less than 50,000	*Through our mini-grant with NAMI – Wood River Inc. we were able to help fund transportation to activities that are arranged for participants in the "Bluebird" program.*

Region 5 Behavioral Health Board – Gaps & Needs Analysis 2018				
Access to Care in Rural Areas	Many providers and services are limited only to the city of Twin Falls. This creates a lack of utilization and access (see Transportation) for citizens around Region 5 that live in the rural areas of our 8 counties.	• Enhance tele-health access by providing a facility/site to house the equipment needed. • Use of existing facilities and buildings that are not currently being used to house Community Recovery Centers, Centers for Community Health, and as satellite sites for providers. • With Twin Falls on the verge of being considered "Small Urban" and required to provide public transportation, consider the use of existing transportation sources to transition to provide services to rural/frontier areas.	Research and seek out funding sources and programs that support tele-health initiatives such as -The Healthcare Connect Fund -Agency for Healthcare Research and Quality Small Research Grant Program • Start a 'mobile clinic" to take MH services to patients in remote areas • Engage and educate community leaders and private business about the positive effects that enhanced access to behavioral health has on communities. • Reopen regional satellite offices	*Through our mini-grant with the NAMI – Wood River Inc. we were able to provide grant money of $5,000 to help establish and grow a program called "Bluebirds" that provides a safe place for students to discuss mental wellness issues*

Region 5 Behavioral Health Board – Gaps & Needs Analysis 2018				
Medication Management	Demand exceeds availability	• Increase access to med-management to reduce avoidable readmissions • Enhance communications with care-givers across the continuum of care Improve the perception of "Med. Management" and why it is a necessary component of care.	• Create awareness and provide accurate information about what men-management is. • Engage and include community providers in the conversation addressing this need • Increase access to medications by address cost and affordability.	No outcome to report.

Region 5 Behavioral Health Board – Gaps & Needs Analysis 2018				
Psychiatric Bed Availability (Plan B)	Law enforcement, providers, and consumers are lacking options when the few beds available fill.	• Increase number of bed availability for adults and youth. • Alternative resources for the waiting period until a bed becomes available. • Create transportation options to transport to the nearest available bed or crisis center.	• Enhance communications between providers and law enforcement to create a more efficient process. • Seek funding opportunities. • Increase awareness and promote the need for a crisis center	No outcome to report

Region 5 Behavioral Health Board – Gaps & Needs Analysis 2018				
Law Enforcement Training	Difficult for smaller areas to attend full trainings and keep staffed during that time.	• CIT trainings are offered and well-received by local law enforcement, however many rural areas are unable to coordinate due to the length of the course	• Propose the idea of shorter min-training sessions to reach locations that are unable to attend the week-long trainings in one block.	No outcome to report

Region 5 Behavioral Health Board – Gaps & Needs Analysis 2018				
Public Education & Outreach	There is a need to educate the general public about "behavioral health". The lack of accurate information, on top of media being the general public's main source of information about mental illness and addiction, contributes to stigma and negative perception. Parenting classes are available in region 5, however very low turn-outs are reported.	• Create mental health education – outreach programs for elementary and middle school aged children. • Mental health/addiction 101 type training for teachers. • Develop a resource for employers that addresses common questions, thoughts, and concerns when employing clients and those in recovery in an effort to support success for both parties. • Expand Mental Health First Aid trainings to all eight counties. • "Normalize" the concept of attending parenting classes in an effort to boost attendance and provide valuable tools for families.	• Include media outlets such as newspapers, local TV, and local radio in conversations about behavioral health and community wellness. • Seek funding sources for promotion and delivery of educational materials. • Collaborate with OPTUM to promote and expand the Mental Health First Aid trainings to a broader audience. • Work toward evaluating why parenting classes have low attendance and consider reevaluating how and where the cases are presented to the community.	*Through a mini-grant we were able to help the Federations of Families for Children's Mental Health buy t-shirts for the May 2018 5K Fun Run during MH Awareness Month. This was to promote Mental and Physical Health in Region 5 and to reduce the stigma associated with MH.*

Region 5 Behavioral Health Board – Gaps & Needs Analysis 2018				
OPTUM SUD Referrals	No system to refer a client through OPTUM to a Substance Abuse Provider when that need is identified.	• Increase diagnosis and TX for SUD and co-occurring disorders	• Request enhanced data reports and measures from OPTUM to ensure providers operate within scope of practice.	No outcome to report

Region 5 Behavioral Health Board – Gaps & Needs Analysis 2018				
Translation – Interpreters	Region 5 lacks interpreter/translators for languages or hearing/vision impaired persons.	• Increase access to care of individuals that require interpretation or translation • Improved quality of care and outcomes.	• Promote & educate regarding the need for this type of service in our region. • Seek funding sources that aim to address this need by promoting training, certification, and community education.	No outcome to report

Region 6 Behavioral Health Board

SFY 2019

A study and analysis of the behavioral health needs of Region 6.

Gaps and Needs Analysis

Sub-Committee/Topic	Needs/Barriers	Goal	Timeline to Accomplish Goals	Action Plan
Recovery Support	Transitional and permanent housing for men, women and families • Lack of funding sources for transitional housing • Municipal requirements (zoning, fire suppression, etc) • Lack of neighborhood acceptance; no one wants transitional housing in their neighborhood • Lack of a dependable resource to pay firs/last month rent and deposit • Lack of public education on housing options and services. • Lengthy waiting periods for public housing	Research county owned houses in Bingham County and the possibility of implementing a similar process in Region 6	In Progress	Continue exploring this option and start the discussion process for possible options. March 2019
		Explore local/regional options with treatment providers and other community partners re: the need for safe and sober housing and detox facility	Partial / In Progress	Continue collaborating with the community on the development of the crisis center. March 2019. Continue collaborating / partnering with local agencies on the development of additional transitional housing. March 2019
		Exploring PATH funding through RBHB for regional input and decision making related to housing dollars	In Progress	Continue to support funding for PATH. Procure update flier information. September 2019 Continue to educate the community through fliers and community events about Path Resources September 2019
		Utilizing PATH dollars to help with deposits or first month's rent, one time	In Progress	
		The opening of "Transitions" a faith-based transitional housing resource center, and life coaching primarily for women leaving prison	In Progress	Stay abreast of any efforts to open faith based housing for women. September 2019
		Stakeholder educational event	Yearly	Continue to sponsor stake holder educational event. SFY 2019

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Accomplishments:				Goal Achieved:
• Portneuf Health Foundation and Bannock County are collaborating on a crisis center. Funding from the state legislature has been approved for the first three years. • The Rising Sun for females and the Moore House for Men are currently operating in Bannock County for Safe and Sober housing • Increase awareness of PATH funding through community outreach and educational presentations at various community events. • Faith based leader came as guest at the region 6 behavioral health board meetings to provide updates on her efforts with transitional living . • Provided education to stake holders at yearly event with legislators and presentations to the region 6 chamber of commerce and other organizations.				**Yes** **No** **In Progress**
Recovery Support	Supported employment • Challenges with skills identification and acquisition • Difficulty obtaining employment with criminal record	Community Partners (Working Solutions, Voc. Rehab, Dept. of Labor) present/educate RBHB about services available to community members	In Progress	Assign a committee member to formulate a list of presenters to educate board members on services. January 2019
		Partner with community businesses to be more "felon" friendly. Do outreach with the Chamber of Commerce to "hire the felon" List supportive employers	In Progress	Assign a committee member to reach out to the Chamber of Commerce and others to identify companies within the region that are "felon" friendly employment January 2019
		The Center for New Directions at ISU can provide interest inventories, help with resumes, counselors, and GED testing	In Progress	Continue to support ISU and Hope & Recovery Resource Center in their efforts educate the community through fliers and community events September 2019
Accomplishments:				**Goal Achieved:**
• The Region 6 Behavioral Health Board meeting agendas now have blocked time for presenters. • Region 6 Behavioral Health Board supports Recovery Fest yearly by providing information about behavioral health / recovery resources				**Yes** **No** **In Progress**

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Recovery Support	Transportation • Dependable development of low/no cost transportation for rural areas – gas vouchers • Short bus hours • No transportation for support services; housing work, etc. for physically limited individuals and during inclement weather	Encourage CIT training for police departments who may still be reluctant to transport clients to the Idaho Falls Crisis Center Coordinate with Vocational Rehab in an effort to enhance transportation options Coordinate a meeting with Pocatello Transit on options for low cost / extended hours for transportation	In Progress In Progress New	Continue to educate police departments in Region 6 on the benefits of CIT training. September 2019 Assign a committee member to invite a representative of Vocational Rehab to speak at a BHB meeting Invite a representative from Pocatello Transit to R6BHB meeting for initial discussions.
Accomplishments: • Bus or other transportation vouchers have been implemented by the Idaho Falls Crisis Center. Region 6 supported these efforts with funding. • Hope and Recovery Resource Center offers some transportation to clients per their policy. Also through donation efforts the center now has six bicycles for client use as well. • Veteran's Services provides transportation to their Salt Lake Clinic weekly.				**Goal Achieved:** **Yes** **No** **In Progress**
Recovery Support Children's Mental Health	Access to care continuum • Limited knowledge of community resources and how to access care • Discrepancies in definitions in covered services for case management • Improve relationship between schools and providers of behavioral health services • Lack of health insurance for the working	Support and educate school districts' efforts to provide resources to youth who are in need of behavioral / recovery services Support and educate the women's prison, jails, and other community organizations on resources available on behavioral health / recovery services Educate the board on case management services that are covered by private insurance, Medicaid and other state options for those without insurance	In Progress In Progress NEW	Educate, support and disseminate information relating to the Youth Empowerment Services to each county in the region. December 2018 Provide information at community events and fliers distributed throughout region 6 Invite a representative of OPTUM as a presenter to the R6BHB May 2019

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Accomplishments:				Goal Achieved: Yes No In Progress
• Peer support and recovery coaching through the Hope and Recovery Resource Center and the Human Development Center for medical and counseling needs. • Representatives from Police Depts., schools, and treatment centers attend a monthly meeting at the juvenile justice building to coordinate case management among police departments, schools, and treatment centers.				
Children's Mental Health	Collaboration among school districts, juvenile justice, Department of Health and Welfare and provider's resources available for children • No common database/website • Rural access for parents for educational opportunities	Regional Behavioral Health Board, Children's Mental Health Subcommittee visit schools in the region with Dept. of Behavioral Health, Children's Mental Health, and Juvenile Justice and community providers	In Progress	Committee Member assignment to continue to work with schools to allow committee members to provide education in schools throughout Region 6 on behavioral health / recovery services and the YES system. June 2019
		Invite community resource workers to attend Regional Behavioral Health Board and Children's Mental Health Subcommittee meetings	In Progress	Assign a committee member to schedule dates and times for community resource, CIT and other officers to present education to the Region 6 Behavioral Health Board
		Continue to have representation from the region 6 Behavioral Health Board at monthly community meeting hosted by Judge Murray	NEW	Receive updates from any board members that attend these meeting September 2019
Accomplishments: • Health & Welfare has trained staff to do the CANS assessment. • The Children's Mental Health subcommittee has provided resources cards to schools within region 6 • Regional Behavioral Health Board members have attended community meetings hosted by Judge Murray				**Goal Achieved:** **Yes** **No** **In Progress**

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Children's Mental Health	Parent education/support – to include respite, telephonic and tele-medical • Parents are unaware of available services • Rural access for parents to educational and clinical opportunities	Use websites and newsletters to disseminate information	In Progress	Continue to provide education and support on the current system to allow telephonic and tele-medical services. December 2018
		Respite care for parents and other care providers	In Progress	Educate parents on how to access respite care currently available December 2018
		Include resources in Regional Behavioral Health Board hosted resource fair	In Progress	Attend community events and disseminate information on behavioral health / recovery services
		Host annual Children's Mental Health training	Yearly	Coordinate yearly training
		Explore possible Behavioral Health Board support for educational opportunities for parents, professionals, and clients	Yearly	Support and review grant requests for educational opportunities that are presented to the board.

Accomplishments:

- OPTUM has developed codes for group counseling without the child present
- Region6 BHB has provided information at Recovery Fest, Pocatello Farmer's Market and at the Children's Mental Health Training.
- Hosted the annual training for Children's Mental Health
- R6BHB provided funding for Idaho conference on alcohol & drug dependency, Recovery Fest, Children's Mental Health Training, Hope & Recovery Resource Center and Accelerated Resolution Therapy.

Goal Achieved:

Yes
No
In Progress

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Recovery Support Children's Mental Health	Timely access to preventative and needed ongoing medical physical health care services for both adults and children • Limited access to care for uninsured • No ongoing access to medical care • No available youth drop in/alternative activities center • No available crisis center • Not enough therapeutic foster homes • Not able to afford medications • Lack of physical/occupational therapy for uninsured • Shortage of clinicians in southeast Idaho	Research and present drop-in center models for adolescents Increase incentives for therapeutic foster homes Encourage and advocate for Medicaid expansion or similar alternative	In Progress In Progress In Progress	Assign committees to develop a plan for achievement of this goal
Accomplishments: • Crisis Center has been approved for this region and plans are being formulated				**Goal Achieved:** **Yes** **No** **In Progress**
Children's Mental Health	Family-run programs available as an option, along with the traditional approach • Lack of education and resources for families • NAMI participation is growing but doesn't cover the needs. • NAMI training funds for families and peers classes is limited.	Training by Federation of Families for Children's Mental Health for family support partners Advocate and share information about NAMI	In Progress NEW	Invite a representative from the Federation of Families to share information at a R6BHB meeting June 2019 Funding support for the Annual State NAMI Conference in Pocatello September 2018
Accomplishments: • NAMI National Conference is scheduled for September 2018.				**Goal Achieved:** **Yes** **No** **In Progress**

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Recovery Support	Providers, clergy, school counselors, and hospitals, especially in rural areas, need training when working with individuals who are contemplating suicide	Share information on the need for training on the prevention of suicide and to have community providers educated on suicide. Training by a member of SPAN to discuss their action plan and provide support Explore opportunities and options to provide QPR in the community	In Progress New New	Disseminate information on suicide training with Dr. Rudd in September. September 2018 Invite a member of SPAN to present at our R6BHB meeting. July 2019. Assign a committee member to explore costs and availability of QPR training in the community or another such program.
Accomplishments: • New Knowledge Adventures presented a class "Misconceptions of Mental Illness" on September 6, 2018 • Dr. Rudd is scheduled to train members of the community in September on suicide.				**Goal Achieved:** Yes **No** **In Progress**
Children's Mental Health	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 • Region 6 does not have an active SPAN chapter	Allow time at the annual Children's Mental Health training conference in Region 6 for suicide prevention training Utilize websites and newsletters to educate parents, consumers, and community members about risk and suicide assessment and resources for the same Activate and participate in SPAN chapter	In Progress In Progress In Progress	Assign a committee member to have a presenter discuss suicide prevention at Annual Training. Invite a member of SPAN to discuss resources and assessments. The board will help disseminate this information in the community.
Accomplishments: • Children's Mental Health resource cards have been distributed throughout Region 6				**Goal Achieved:** **Yes** **No**

				In Progress
Recovery Support	Crisis Needs • Lack of Crisis Center in Region 6 • Overcrowding of Crisis Center in Region 7 • Lack of Hospital Services • Using jails to house people in behavioral health crisis • Amount of resources being used on individuals after first point of contact with law enforcement, including court appearances, pretrial detention, etc. • Over use of Emergency Room for individuals in crisis • No way to interrupt the crisis cycle	Establishment of a Crisis Center Establish community support for Crisis Center Effective linkage with Hope and Recovery Resource Center Improvement in suicide rate Hope and Recovery Resource Center attempting to provide satellite support to rural areas	In Progress In Progress In Progress In Progress In Progress	Support the implementation and development of the Crisis Center.
Accomplishments: • Crisis Center has been approved and is in the development phase.				**Goal Achieved:** **Yes** **No** **In Progress**

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SFY 18 Gaps and Needs Analysis
Region 7 Behavioral Health Board

Subcommittee/Topic	Needs/Barriers	Goal	Timeline to Accomplish Goals *(If goal has been identified, but deferred to a subsequent year, please enter "Deferred")*	Action Plan (optional)	Accomplishments	Goal Achieved
Access to Behavioral Healthcare	1. Lack of insurance leads to limited or no access to medical, dental, vision, and psychiatric, mental health care. 2. Lack of knowledge and understanding by primary care, including urgent care centers, of how to access behavioral health services.	1. Identify/coordinate/distribute behavioral health resource lists within the region 2. Collaborate with Optum to provide primary care provider education.	Ongoing		• Linked the R7BHB's section on EIPH's website to the community resource guide on the website so people would have easier accessibility to the information. Continually reviewed the community resource guide to make sure it reflects the current behavioral health services available in the region. • Sent a letter to Russell Barron giving the Board's support to HB 464 (access to health insurance/dual waiver). Board members help educate the public on this need. • Shared information on YES and various trainings, conferences, articles, etc. through the R7BHB listserv. • To increase the knowledge of the R7BHB, Optum presented information on the System of Care Philosophy, YES, skills building/CBRS, and how to access CMH services through Medicaid. • Board member attended BH workgroup through Madison Memorial Hospital. • ART Therapy training – provided patients greater access to treatment programs. • Held the June R7BHB meeting in Challis to provide resources and education to the rural communities.	Yes; ongoing
Peer Support and Recovery Coaches	Lack of peer support and recovery coaches in the region.	1. Advocate and continue to support efforts to develop statewide certification and Medicaid reimbursement for support specialists. 2. Support trainings for peer support and recovery coaches.	Ongoing		• Promoted the Recovery and Peer Support Specialists Training in 3/2018 • Shared information on peer support and recovery coach trainings, activities, etc. through the R7BHB listserv.	Yes; ongoing
Homelessness/Housing	Lack of shelter capacity and transitional housing in the region.	Send representative from the R7BHB to Housing Coalition meetings and report back at monthly BHB meetings.	Ongoing		Identified a R7BHB member to represent the Board at Housing Coalition meetings and trainings. Any pertinent information is reported back to the Board during monthly meetings during the Community Report section on the agenda.	Yes; ongoing

Crisis Beds • Crisis Stabilization Committee	Lack of crisis beds in the community for adult, adolescent, and pediatric patients.	1. Form subcommittee on crisis stabilization to address gaps/needs 2. Engage the new BHC Director in the planning process	Ongoing		• Met with the Director of BHC about the formation of a Crisis Stabilization Committee. The formation of the committee was postponed, for now, due to the overlap of topic/information of the newly developing Crisis Intervention Team Collaborative in the region. • Meetings held between jails, courts, and DBH to collaborate on individuals in the facilities who have BH needs and helping them access inpatient services as needed. • Stepping Up Initiative is ongoing in the region (goal to divert people with BH issues away from the justice system). Efforts may be made to combine this with the Crisis Intervention Team Collaborative.	Deferred
Community Substance Use Resources	Lack of detoxification services and substance use resources and education in the community.	1. Explore options for subacute detoxification services outside hospitalization. 2. Obtain, distribute, and educate people on Naloxone and other topics relative to substance use and recovery.	Ongoing		• Obtained and distributed 8 Naloxone kits to the Behavioral Health Crisis Center of East Idaho and law enforcement and EMS personnel in rural counties. • Shared information with rural counties about the ODP grant opportunity for Naloxone kits. • Shared information to the Board about the location of prescription drug drop boxes and a patient assistance program for Naloxone implemented at a local pharmacy. • Behavioral Health Crisis Center of Eastern Idaho is providing social detox services.	Yes; ongoing
Education: Community	Lack of community knowledge of behavioral health warning signs and early detection and interventions.	Provide community outreach and education through presentations, trainings, and marketing campaigns.	Ongoing		• Provided behavioral health education via Facebook during Recovery Month (September) and Mental Health Awareness Month (May). Also, shared via Facebook, through the year, information on a variety of behavioral health topics. • Submitted and had published in The Post Register, a suicide awareness article. • Participated in the Recovery Celebration in 9/2017. • Participated in the SPAN Symposium in 9/2017. • Participated in the yearly NAMI conference in Bonneville County in 10/2017 and the Mental Health Conference in Madison County in 10/22017. • Facilitated the Center For HOPE rock painting activity in March 2017. • Disseminated, throughout the year, as it became available, information on YES and the Parent Network. • Promoted the Stewards of Children *"Darkness to Light"* training in the region in 2/2018.	Yes; ongoing

Education - Early Childhood	Lack of knowledge in early intervention programs of behavioral health resources available to them.	Maintain partnerships with early intervention programs and provide education and assistance as needed.	Ongoing		• The R7BHB liaison from EIPH is on the Board of Directors for Eastern Idaho Community Action Partnership which administers the Head Start and Early Head Start program. She frequently shares with them information about behavioral health and the activities of the R7BHB. • R7BHB Board member is on the board of the Idaho Children's Trust Fund.	Yes; ongoing
Education - School Site • Children's Mental Health Committee	Lack of knowledge within the school system of behavioral health warning signs/early detection, interventions, and available resources.	Develop a comprehensive plan to address behavioral health issues within the school/education system.	Ongoing		• Promoted and attended the Hope Squad Suicide Prevention training for middle and high schools in 3/2018. • Partnered with Compass Academy High School in Idaho Falls for a full range of CMH activities for 2 days during May 2018. Activities included a behavioral health panel discussion with students, parents, and the community, two screenings of *Screenagers,* a poster contest, community conference, and concert (proceeds were donated to local behavioral health programs).	Yes; ongoing
Family Involvement	Lack of family involvement in all aspects of behavioral health care.	1. Include family members in all aspects of systems of care including trainings, educational activities, R7BHB meetings, and support groups. 2. Maintain partnership with NAMI and Idaho Federation of Families.	Ongoing		• Invited children with behavioral health needs to attend and participate in the Children's Mental Health Committee meetings. There have been several meetings throughout the year where they have attended and provided input. • Participated in NAMI's annual conference in 10/2017. • Information from Idaho Federation of Families is a standing agenda item at the CMH Committee meeting. • Partnered with Idaho Federation of Families during CMH Awareness Week in 5/2018. • Parent Network	Yes; ongoing
Data Collection and Sharing	Lack of reliable information to make data driven decisions.	Collaborate with community partners to gather key data to inform decision making.	Ongoing		• CANS	Yes; ongoing
Assessing Gaps and Needs	Accurately capturing the gaps and needs in the community across all spectrums of behavioral health.	Develop mechanism for the community to bring identified Gaps & Needs to the R7BHB.	Ongoing		Developed a mechanism through Eastern Idaho Public Health's website where community members could provide input of their perceived gaps and needs relating to behavioral health. Promoted through Facebook.	Yes; ongoing

Cultural Competency	Lack of cultural competence while providing education and services.	All trainings, presentations, and outreach will be socially, culturally, and linguistically proper to meet the needs of the participants.	Ongoing		• Had students from Compass Academy High School present at Board meetings to get a better understanding of the needs of youth in the region. • Held our June meeting in Challis, Idaho to get a better understanding of the needs of people from rural communities. • Made attempts to provide materials in Spanish when the need arises.	Yes; ongoing
Crisis Intervention Training (CIT)	Sustainability of future training; reaching throughout the 10 county region to provide training.	Provide CIT training in the region.	Ongoing		Helped to fund a five-day CIT training in Bonneville County in April 2018. Funding was available for rural counties to send officers to be trained.	Yes; ongoing
Strategic Planning	Time needed to review and update the plan; integrating substance use and mental health needs for all ages.	Analyze the gaps and needs and review and update the R7BHB strategic plan as needed.	Ongoing		Reviewed and updated Strategic Plan during monthly R7BHB meetings.	Yes; ongoing

OPIOID NEEDS ASSESSMENT

Idaho

Prepared by: Idaho Department of Health and Welfare, Division of Behavioral Health
as a Component of Idaho's Response to the Opioid Crisis Project

OPIOID NEEDS ASSESSMENT

IDAHO

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Note to the Reader

In this assessment, we compiled data from throughout the literature and various data source systems. We strove to present the most current available data from a thorough array of sources to develop the most complete and accurate picture possible of Idaho's opioid crisis. Consequently, our data represents a variety of time periods, depending on what was available from the data source. We recognize this as a limitation and encourage the reader to take note of dates when examining figures and to consider these variations when making comparisons.

- **Indicators of Heroin and Non-Heroin Opiate/Synthetic Use, Misuse, and Dependence**
  - Since reaching a peak in 2010-2012, several indicators appear to show a modest decrease in non-heroin opiate/synthetic use in Idaho over recent years.
  - However, in 2016 Idaho was above the national average for the rate of opioids dispensed per 100,000 population and many indicators suggest that Idaho has experienced a significant increase in heroin use over the past decade.

- **Drug-Induced Deaths and Opioid-Related Mortality**
  - The most recent data available regarding drug-induced deaths appears to show that while rates have increased in Idaho since 2010, Idaho remains slightly lower than the national average. In 2016, Idaho ranked 36th in the age-adjusted rate of drug-induced deaths by state.
  - It is estimated that more than half of all drug-induced deaths were associated with an opioid (62.0%).
  - However, statewide the types of drugs involved with drug-induced deaths are underreported on death certificates and thus the true number of opioid-involved drug-induced deaths is likely higher than what is observed through analysis of vital records.

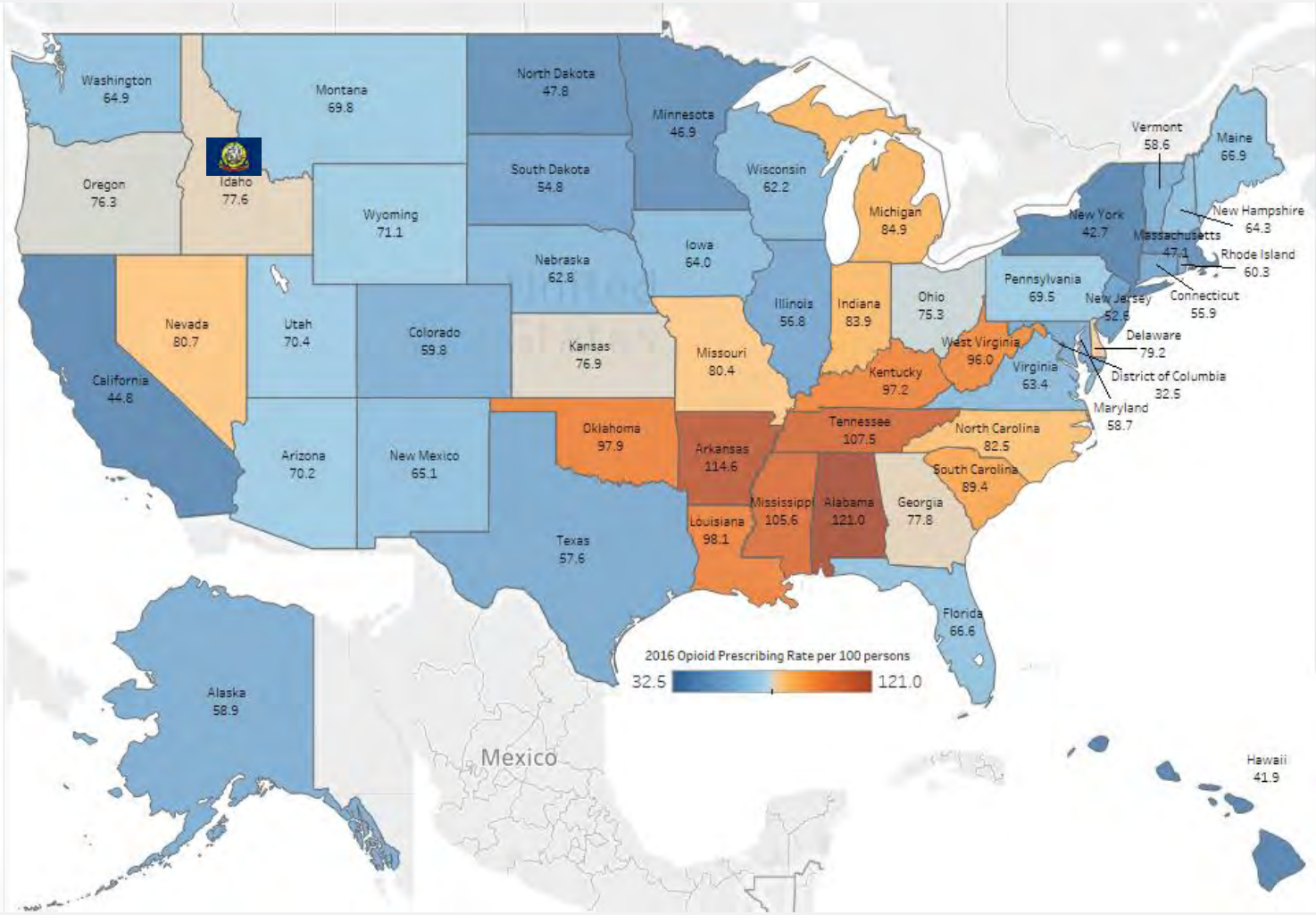
- **Gaps in Treatment and Services**
  - The current substance abuse prevention system in Idaho to address the opioid crisis is a collaborative, multi-disciplinary effort aimed at employing evidence-based prevention strategies and public policy initiatives. It has many strengths including the use of a variety of evidence-based practices in prevention education.
  - However, it is clear there is still room to improve prescribing practices.
  - Adolescents and young adults in Idaho are an important high-risk population for heroin and non-heroin opiate/synthetic use, misuse, and dependence. Attention should be directed towards improving prevention strategies aimed at Idahoans aged 18-25, a group which has been historically shown to be difficult to reach, especially those who do not choose to attend a university.
  - Idaho Hispanic youth appear to be more likely to report heroin use compared to the general population of youth in Idaho and Hispanic youth nationwide. As such, prevention strategies should be culturally competent and tailored to Idaho's Hispanic population.
  - Over half of Idaho's substance abuse prevention workforce is over the age of 45, which emphasizes a great need for recruitment.
  - Accessing MAT using public funding is difficult in Idaho. However, a recently acquired SAMHSA grant will introduce publicly-funded MAT to Idaho by adding Methadone and Suboxone to the array of treatment and recovery support services that are currently available.

While Idaho is most definitely experiencing a significant increase in opiate and heroin use, misuse, and death, the opiate epidemic here has not yet reached the proportions that other states in the Midwest and East Coast are facing. Thus, coordinated efforts to combat this epidemic are just now coming to fruition in this state.

I. Prescribing and Dispensing Opioids in Idaho

i. Prescribing Opioids in Idaho

Opioid Prescriptions Dispensed per 100 persons by State; Centers for Disease Control and Prevention (2016)



The CDC classified Idaho above the national average rate of opioid prescriptions dispensed in 2016.

- Idaho: 77.6 prescriptions per 100 persons
- United States.: 66.5 prescriptions per 100 persons

Centers for Disease Control, U.S. Prescribing Rate Maps, July 2018

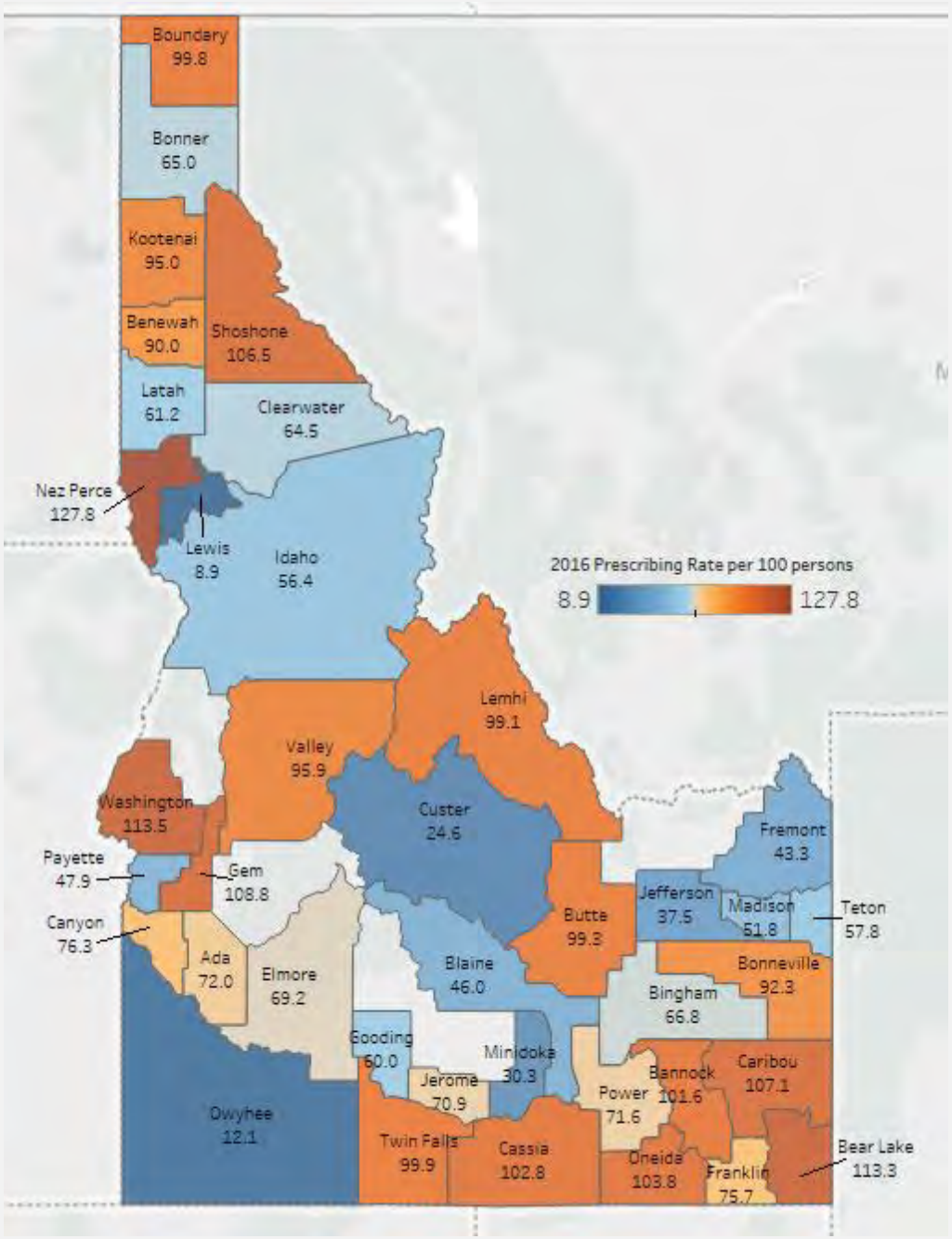
Opioid Prescriptions Dispensed per 100 Persons Over Time; Centers for Disease Control and Prevention (2006-2016)

Higher opioid prescribing puts patients at risk for addiction and overdose.

- After a steady increase in the overall national opioid prescribing rate from 2006, the total number of prescriptions dispensed peaked in 2012 at a prescribing rate of 81.3 prescriptions per 100 persons.
- The overall national opioid prescribing rate declined from 2012 to 2016, and in 2016, the prescribing rate had fallen to the lowest it had been in more than 10 years at 66.5 prescriptions per 100 persons.
- However, in 2016, prescribing rates continue to remain very high in certain areas across the country.

Centers for Disease Control, U.S. Prescribing Rate Maps, July 2018

Opioid Prescriptions Dispensed per 100 persons by County; Centers for Disease Control and Prevention (2016)



Higher opioid prescribing puts patients at risk for addiction and overdose. Following national trends, Idaho saw a wide variation in opioid prescribing among counties in 2016, suggesting a lack of consistency among providers when prescribing opioids.

- The CDC classified 24 of Idaho's 44 counties (54.5%) at a higher rate than the national average for opioids prescribed per 100 persons (66.5 prescriptions per 100 persons) including: Nez Perce, Washington, Bear Lake, Gem, Caribou, Shoshone, Oneida, Cassia, Bannock, Twin Falls, Boundary, Butte, Lemhi, Valley, Kootenai, Bonneville, Benewah, Canyon, Franklin, Ada, Power, Jerome, Elmore, and Bingham.

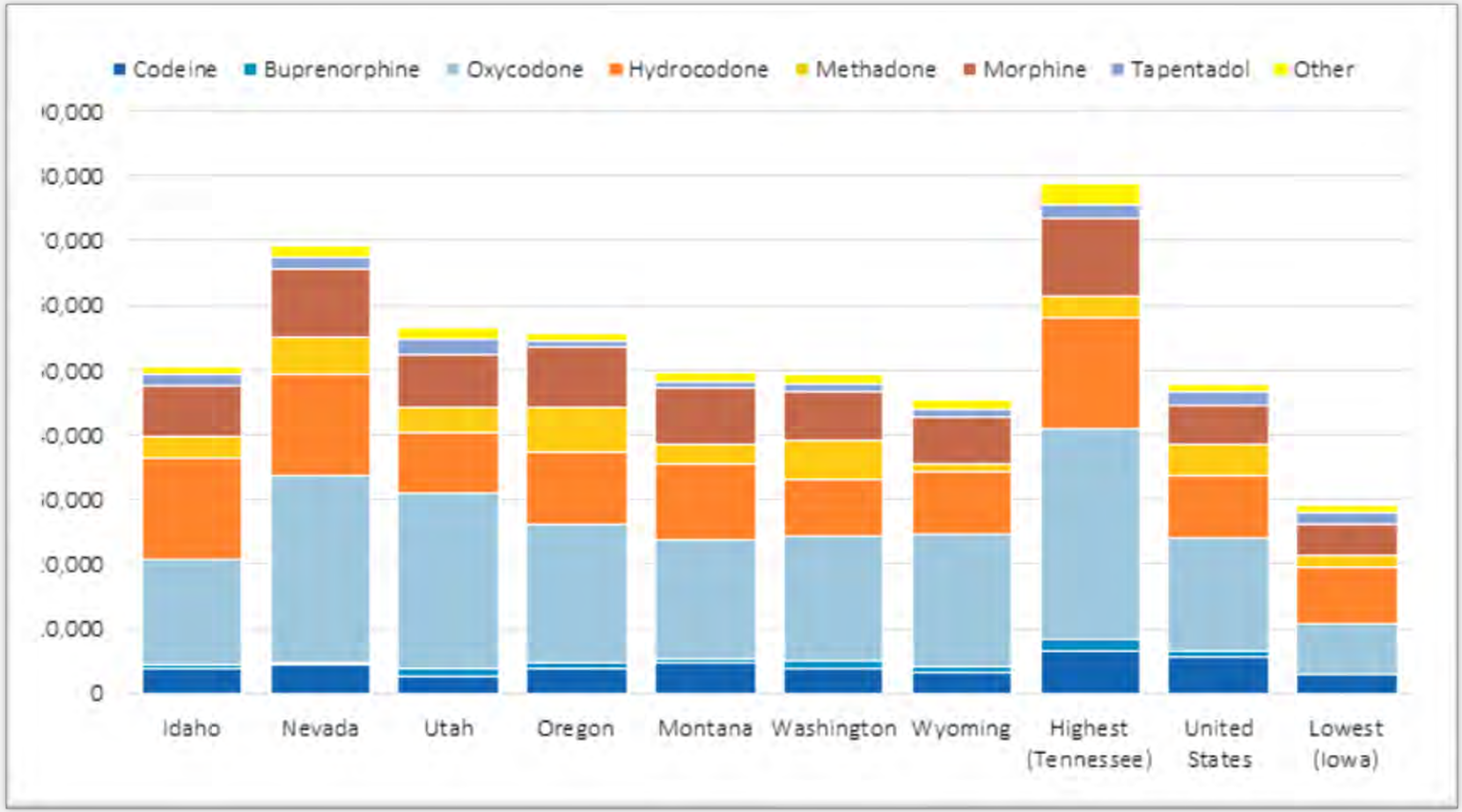
- Of these 24 counties:
  - o 9 (37.5%) are frontier (less than 7 persons per square mile).
  - o 12 (50.0%) are rural (less than 100 persons per square mile).
  - o 3 (12.5%) are urban (greater than 100 persons per square mile).

o Overall, 22 (50.0%) of Idaho's 44 counties are rural, while 19 (43.2%) of counties are frontier and 3 are urban (6.8%). As such, urban counties appear to be over-represented among those with high rates of opioid prescribing.

Centers for Disease Control, U.S. Prescribing Rate Maps, July 2018

ii. Distribution of Opioids in Idaho

Opioids Dispensed (in grams) per 100,000 Population in Idaho; Compared to Neighboring States, the Highest, and Lowest States for Opioids Dispensed (in the United States), and the US National Average (2016)



In 2016, Idaho was above the national average for the rate of opioids dispensed per 100,000 population.

The state had a slightly higher ratio of Hydrocodone to Oxycodone than other nearby states and the national average.

Cumulative Distribution by State in Grams per 100,000 Population (Run date: 2/3/2017). Automation of Reports and Consolidated Orders System (ARCOS), Drug Enforcement Administration, 2016

*ARCOS is a database of controlled substance transactions destined for pharmacies, hospitals, or physicians' offices, collected from manufacturers and distributors and reported to the Drug Enforcement Administration (DEA). The rates reported above are based on population estimates in 2010.

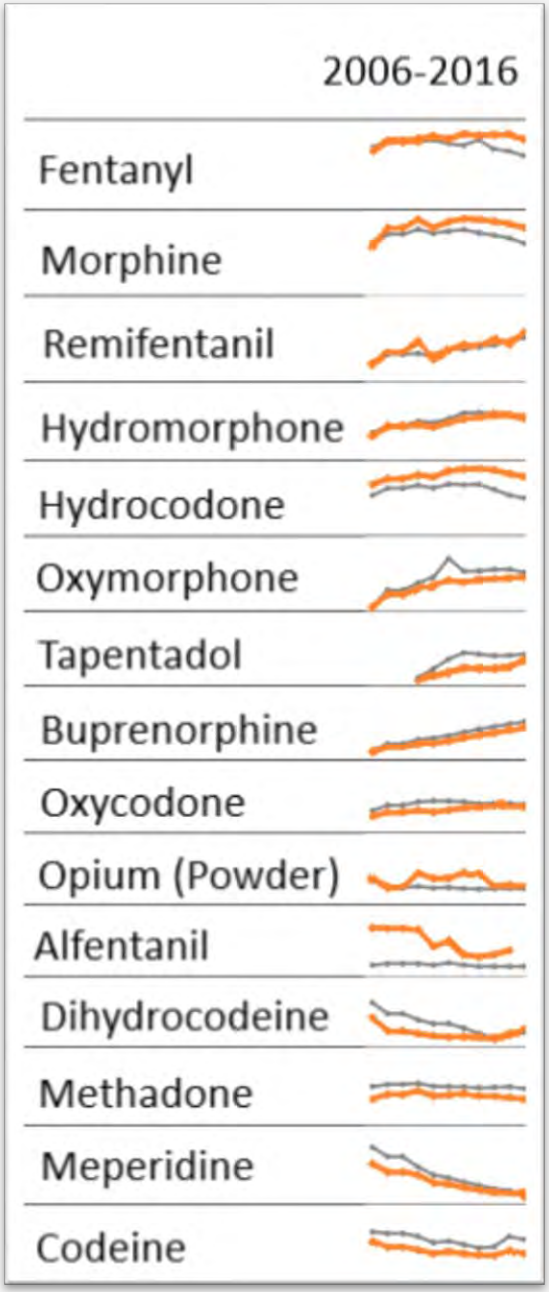
Opioid Retail Distribution, in Grams per 100,000 Population (2006-2016)

The Automation of Reports and Consolidated Order System (ARCOS) is a database of controlled substance transactions destined for pharmacies, hospitals, or physicians' offices, collected from manufacturers and distributors and reported to the Drug Enforcement Administration (DEA).

- In 2016 the distribution of Fentanyl, Morphine, Remifentanil, Hydromorphone, Hydrocodone, Opium, Alfentanil, and Dihydrocodeine were above the national average.
- From 2006-2016, the distribution of many prescription opioids has increased, mostly following national trends.
- In 2016, the opioid drug with the highest number of grams per 100,000 distributed in both Idaho and the USA was oxycodone.

Cumulative Distribution by State in Grams per 100,000 Population, Automation of Reports and Consolidated Order System, Drug Enforcement Administration, U.S. Department of Justice; Idaho Office of Drug Policy, Opioid Needs Assessment

2016	Idaho	USA
Fentanyl	172.4	126.1
Morphine	7,980.0	6,312.7
Remifentanil	0.6	0.5
Hydromorphone	526.1	508.7
Hydrocodone	15,260.0	9,707.8
Oxymorphone	432.8	500.1
Tapentadol	1,577.4	1,990.5
Buprenorphine	774.8	957.1
Oxycodone	16,250.1	17,510.7
Opium (Powder)	11.6	10.6
Alfentanil	0.3	0.1
Dihydrocodeine	13.6	10.6
Methadone	3,259.6	4,643.5
Meperidine	237.8	278.3
Codeine	3,775.1	5,571.3



II. Opioid-Related Mortality in Idaho: The Most Recent Data Available for Opioid-Involved Drug-Induced Deaths

- In Idaho, death certificates for drug-induced deaths may report one drug, more than one drug, or no drugs (i.e. only states "accidental drug overdose").

- The type of drug(s) involved with drug-induced deaths are underreported throughout the state. Certain counties (including some of Idaho's largest counties, such as Bonneville and Canyon county) have a particularly large percentage of drug deaths with no drug(s) specified on the death certificate.

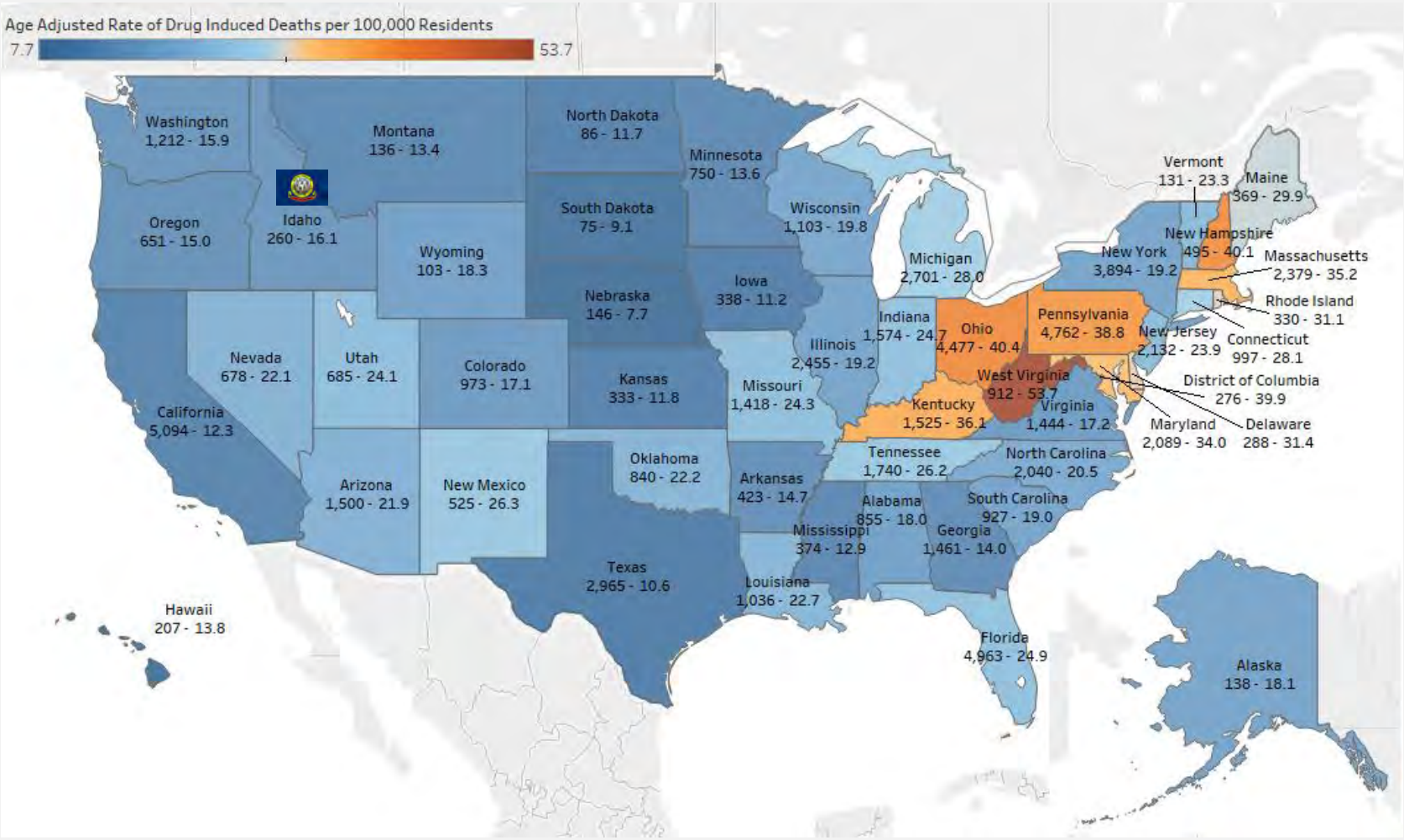
- Consequently, the number of true opioid-involved drug-induced deaths is likely higher than what is observed here.

- The lack of standard and consistent reporting of drug-induced deaths across the state also makes comparing rates across counties difficult. As well, drawing conclusions based on the rate of opioid-involved drug-induced deaths is problematic in Idaho as the small population size of many counties can cause even one death to drastically change the county's rate. As such, population-standardized rates are not presented.

- Reported deaths are based on the decedent's county of residence. The death may have occurred in their county of residence, in another county in Idaho, or out of state.

i. Drug-Induced Deaths in Idaho

Number and Age-Adjusted Rates of Drug Drug-Induced Deaths (per 100,000 Residents) by State (2016)



Per the Centers for Disease Control and Prevention, Opioids (both prescription and illicit) are the main driver of drug-induced deaths throughout the United States.

In 2016, drug-induced deaths accounted for 67,265 deaths across the country.

260 Idahoans died from drug-induced deaths in 2016. This number rose slightly from 218 and 224 deaths in 2014 and 2015, respectively.

Age-adjusted rates are rates that would have existed if the population under study had the same age distribution as the "standard" population. Age adjusting rates is a way to make fairer comparisons across groups with different age distributions. In this case, the standard population is the 2000 U.S. Standard Population. The age-adjusted rate of drug-induced deaths increased from 14.1 per 100,000 in 2014 to 14.6 in 2015 and was last reported by the CDC as 16.1 per 100,000 in 2016. However, despite the observed progressive increase in Idaho's drug-induced death rate, it remains lower than the national average of 20.8 per 100,000 in 2016.

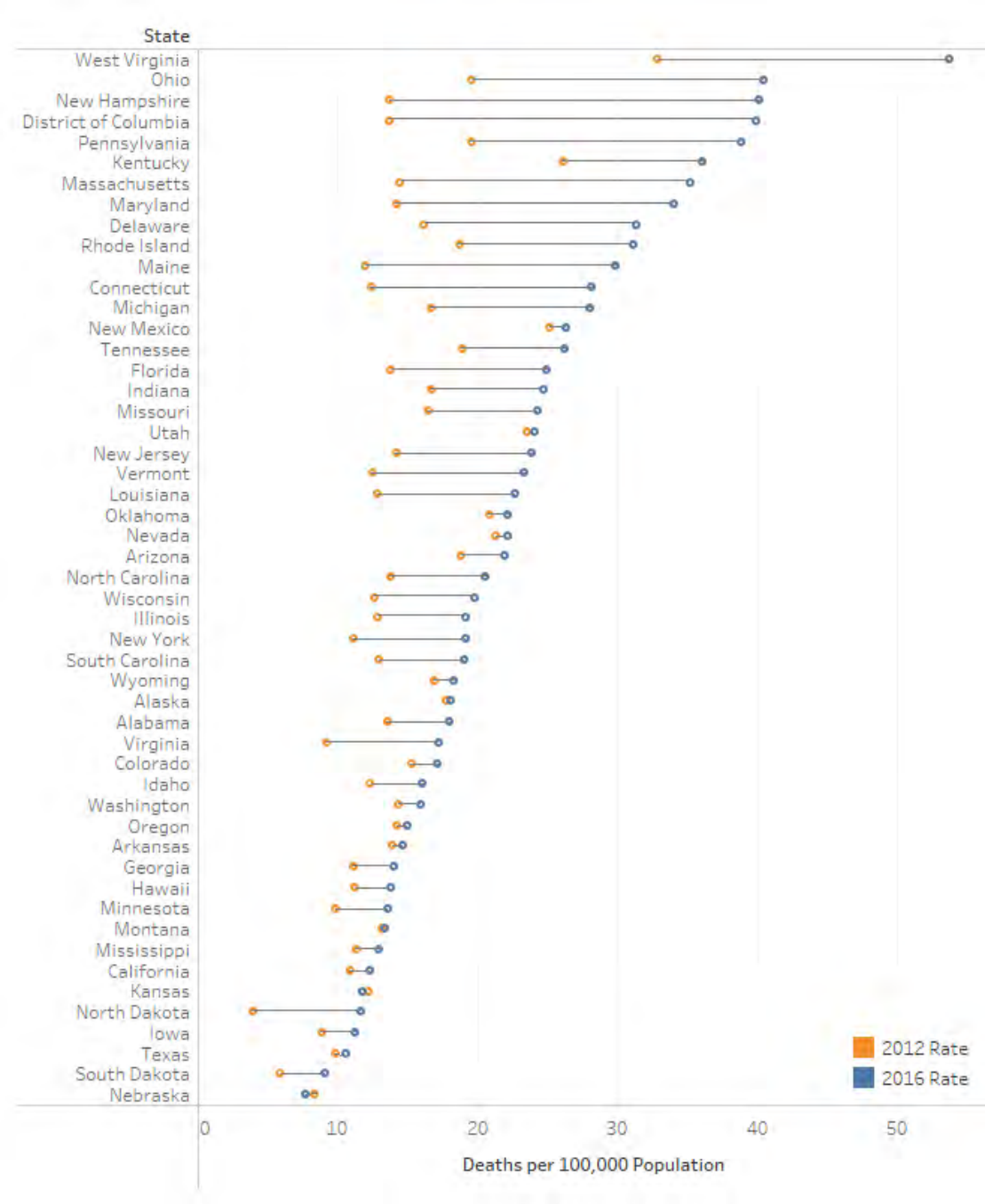
CDC/NCHS, National Vital Statistics System, Mortality, 2014-2016

Change in Age-Adjusted Rates of Drug-Induced Deaths by State (2012-2016)

Rates shown are the number of deaths per 100,000 population. Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution.

Nationally, Idaho has the 36th highest age-adjusted rate of drug-induced deaths (16.1 per 100,000 in 2016). Idaho saw a significant increase in the rate of drug-induced deaths between 2012 and 2016 (a 30.9% change), yet remains slightly below the national average rate of 20.8 per 100,000 observed in 2016.

Centers for Disease Control and Prevention, National Vital Statistics System, Mortality, CDC Wonder, 2011-2016

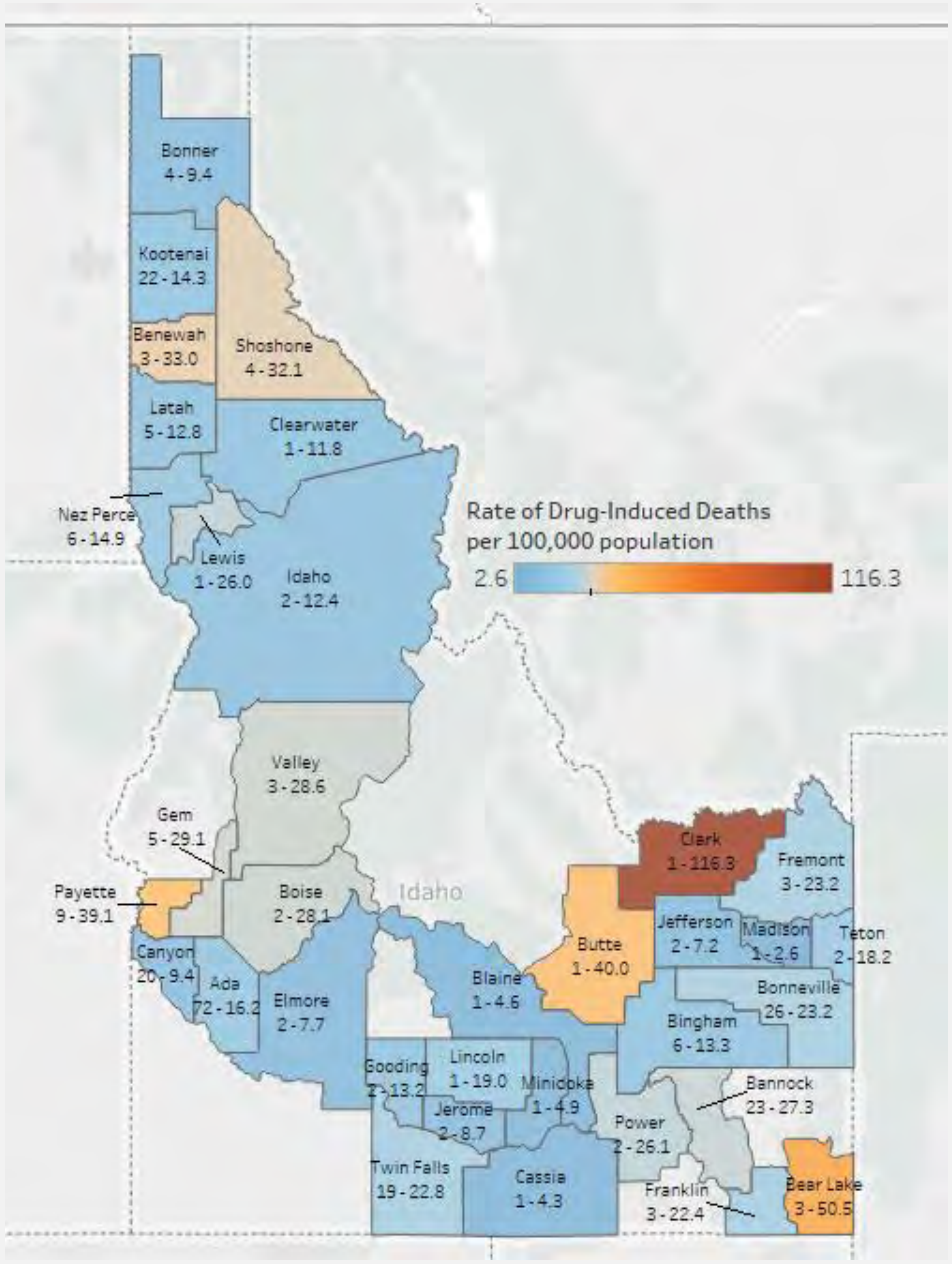


State	2012 Age Adjusted Rate	2016 Age Adjusted Rate	% Change
New Hampshire	13.7	40.1	192.7
North Dakota	4.0	11.7	192.5
District of Columt	13.7	39.9	191.2
Maine	12.0	29.9	149.2
Massachusetts	14.4	35.2	144.4
Maryland	14.2	34.0	139.4
Connecticut	12.4	28.1	126.6
Ohio	19.6	40.4	106.1
Pennsylvania	19.6	38.8	98.0
Delaware	16.2	31.4	93.8
Virginia	9.2	17.2	87.0
Vermont	12.5	23.3	86.4
Florida	13.8	24.9	80.4
Louisiana	12.8	22.7	77.3
New York	11.1	19.2	73.0
New Jersey	14.2	23.9	68.3
Michigan	16.7	28.0	67.7
Rhode Island	18.7	31.1	66.3
West Virginia	32.9	53.7	63.2
Wisconsin	12.6	19.8	57.1
South Dakota	5.9	9.1	54.2
Illinois	12.8	19.2	50.0
North Carolina	13.8	20.5	48.6
Indiana	16.7	24.7	47.9
South Carolina	12.9	19.0	47.3
Missouri	16.5	24.3	47.3
Minnesota	9.8	13.6	38.8
Tennessee	18.9	26.2	38.6
Kentucky	26.1	36.1	38.3
Alabama	13.6	18.0	32.4
Idaho	12.3	16.1	30.9
Georgia	11.1	14.0	26.1
Iowa	8.9	11.2	25.8
Hawaii	11.2	13.8	23.2
Arizona	18.8	21.9	16.5
Mississippi	11.3	12.9	14.2
California	10.9	12.3	12.8
Colorado	15.3	17.1	11.8
Washington	14.3	15.9	11.2
Wyoming	16.9	18.3	8.3
Texas	9.8	10.6	8.2
Oklahoma	20.9	22.2	6.2
Arkansas	13.9	14.7	5.8
Oregon	14.2	15.0	5.6
New Mexico	25.1	26.3	4.8
Nevada	21.3	22.1	3.8
Utah	23.5	24.1	2.6
Alaska	17.8	18.1	1.7
Montana	13.2	13.4	1.5
Kansas	12.2	11.8	-3.3
Nebraska	8.3	7.7	-7.2

Number and Rate of Drug-Induced Deaths per 100,000 Population by County (2016)

County	Number of Drug Induced Deaths	Rate of Drug-Induced Deaths per 100,000
Ada	72	16.2
Adams	0	0
Bannock	23	27.3
Bear Lake	3	50.5
Benewah	3	33
Bingham	6	13.3
Blaine	1	4.6
Boise	2	28.1
Bonner	4	9.4
Bonneville	26	23.2
Boundary	0	0
Butte	1	40
Camas	0	0
Canyon	20	9.4
Caribou	0	0
Cassia	1	4.3
Clark	1	116.3
Clearwater	1	11.8
Custer	0	0
Elmore	2	7.7
Franklin	3	22.4
Fremont	3	23.2
Gem	5	29.1
Gooding	2	13.2
Idaho	2	12.4
Jefferson	2	7.2
Jerome	2	8.7
Kootenai	22	14.3
Latah	5	12.8
Lemhi	0	0
Lewis	1	26
Lincoln	1	19
Madison	1	2.6
Minidoka	1	4.9
Nez Perce	6	14.9
Oneida	0	0
Owyhee	0	0
Payette	9	39.1
Power	2	26.1
Shoshone	4	32.1
Teton	2	18.2
Twin Falls	19	22.8
Valley	3	28.6
Washington	0	0
Total	**261**	**15.5**

Idaho counties with the highest rate of drug-induced deaths per 100,000 persons in 2016 included: Clark, Bear Lake, Butte, Payette, Benewah, Shoshone, Gem, Valley, Boise, and Bannock.



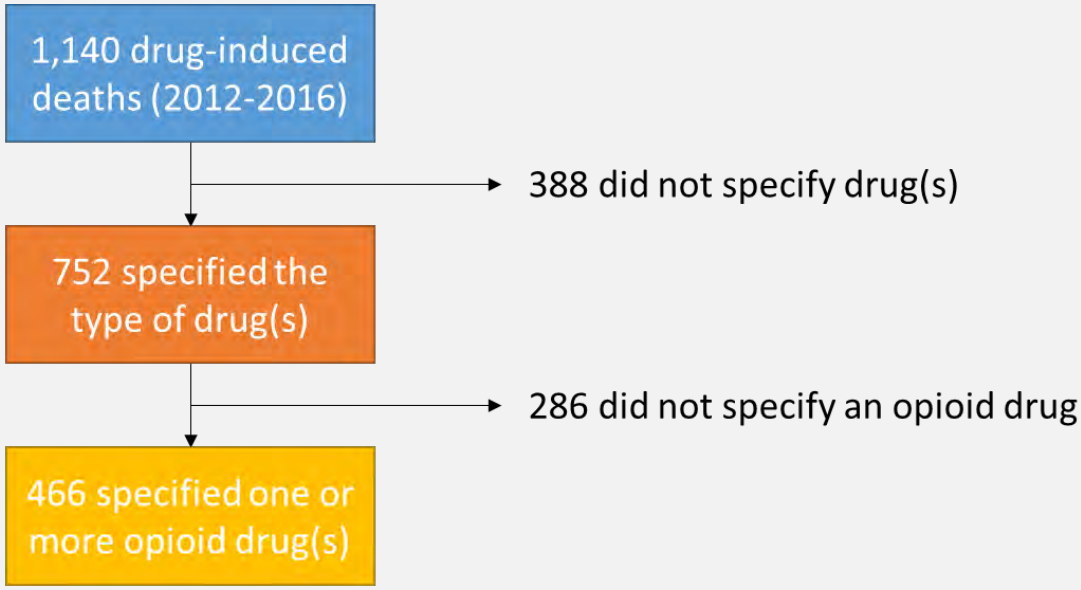
- However, in 2016 Clark and Butte counties also had just one drug death each.
- Of note: Clark, Bear Lake, Butte, Shoshone, Valley, and Boise counties have a density classifying them as Frontier (i.e., less than seven persons per square mile). Meanwhile, Payette, Benewah, Gem, and Bannock counties have a density classifying them as Rural (i.e., less than one hundred persons per square mile).

* Deaths attributed to drug-induced causes are sub-sets of mortality categories used to rank leading causes of death such as accidents, suicide, and assault. Drug-induced deaths include deaths where drugs were directly related to the cause of death regardless of the intent. Drug-induced deaths do not include accidents, homicides, and other causes indirectly related to drug use. Also excluded are newborn deaths associated with maternal drug use. Types of drugs listed on the death certificate include prescription and non-prescription drugs.

Bureau of Vital Records and Health Statistics; Division of Public Health (July 2018)

ii. Opioid-Involved Drug-Induced Deaths in Idaho

Opioid-Involved Drug-Induced Deaths in Idaho (2012-2016)



- There were 466 drug-induced deaths in Idaho with opioid drug(s) specified on the death certificate from 2012-2016.
- Among drug-induced deaths in which at least one drug was specified on the death certificate, 62.0% reported one or more opioid(s).
- As previously described, the true number of opioid-involved drug-induced deaths is likely much higher due to underreporting of the type of drug(s) involved with drug-induced deaths throughout the state.

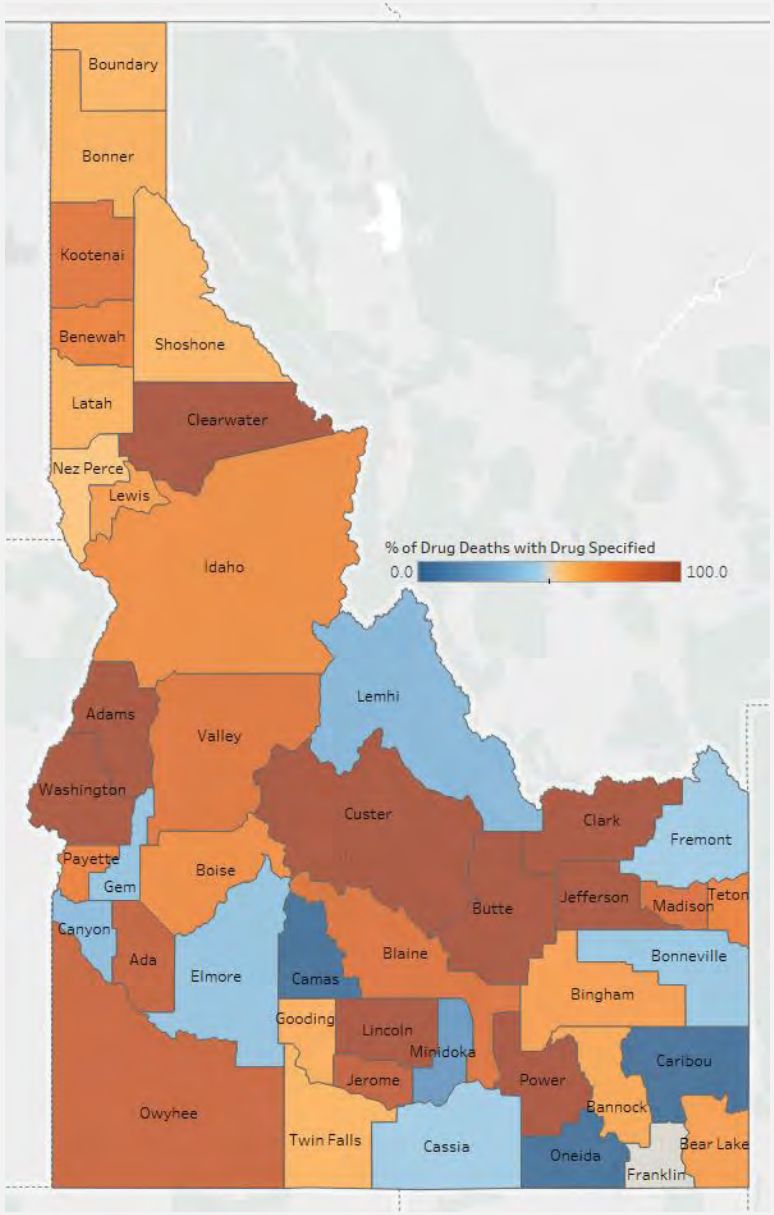
- From 2012-2016 there were 1,140 drug-induced deaths among Idaho residents.
  - Of the 1,140 deaths, 752 death certificates (66%) specified one or more drugs, while 388 records did not (34%).
  - Of the 752 drug-induced deaths in which the death certificate specified the type of drug or drugs, 466 (62%) specified one or more Opioid drug(s), while 286 (38%) did not.
    - Opioids include Opium, Heroin, natural and semisynthetic such as Codeine and Morphine, methadone, synthetic opioids other than methadone, and other and unspecified narcotics (i.e. the death certificate only reports "opioid").

- Ada county had significantly more drug-induced deaths with opioid drug(s) specified on the death certificate than any other Idaho county (154 deaths).
  - Of note, Ada county is Idaho's most populous county and home to the capital city of Boise. With a population of over 400,000 persons, it comprises more than a quarter of Idaho's total population.

Percent of Drug-Induced Deaths with a Drug Specified by State and County (2012-2016)

In 11 Idaho Counties, more than half of drug-induced deaths did not have a drug specified: Bonneville, Camas, Canyon, Caribou, Cassia, Elmore, Fremont, Gem, Lemhi, Minidoka, and Oneida.

- However, Camas, Caribou, and Oneida counties also had just one drug death each during the observation period.
- Of note, all of these counties are located in the southern portion of the state, with most in the southeast region.



[1]County of residence may or may not be the county death occurred.
[2]Drug-Induced deaths include drug deaths due to natural (chronic drug use), and drug poisoning by accident, suicide, homicide, and undetermined intent of injury.
[3]Decedents may have none, one, or more than one drug specified on the death certificate.
[4]Opioids Include Opium, Heroin, Natural and semisynthetic opioids, Methadone, Synthetic opioids other than methadone, and other and unspecified narcotics (i.e. "opioid" not specified).

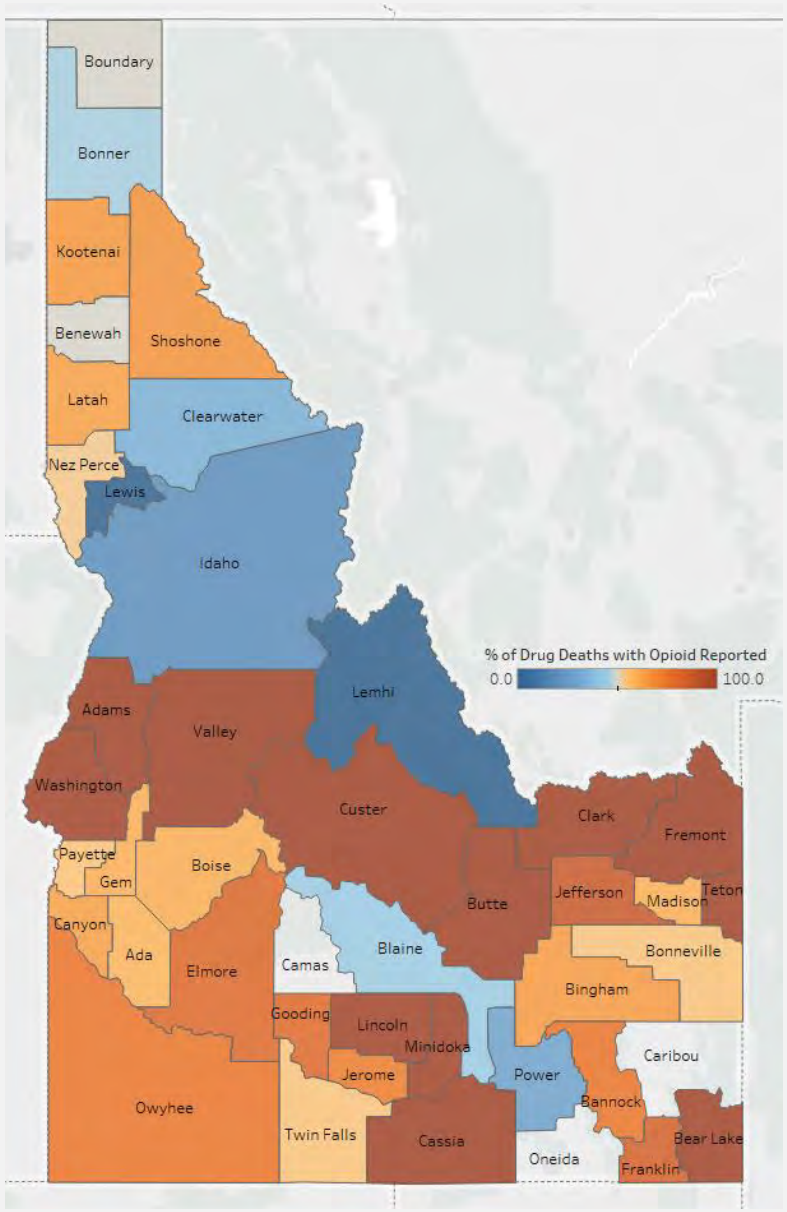
Bureau of Vital Records and Health Statistics; Division of Public Health (July 2017)

County of Residence[1]	Number of Drug-Induced Deaths[2]	Number of Drug-Induced Deaths with At Least One Drug Specified On Death Certificate[3]	Percent of Drug-Induced Deaths with Drug Specified
Ada	289	263	91.0%
Adams	1	1	100.0%
Bannock	104	67	64.4%
Bear Lake	6	4	66.7%
Benewah	8	6	75.0%
Bingham	30	20	66.7%
Blaine	11	9	81.8%
Boise	7	5	71.4%
Bonner	21	13	61.9%
Bonneville	146	59	40.4%
Boundary	10	6	60.0%
Butte	2	2	100.0%
Camas	1	-	0.0%
Canyon	115	41	35.7%
Caribou	1	-	0.0%
Cassia	7	3	42.9%
Clark	1	1	100.0%
Clearwater	3	3	100.0%
Custer	1	1	100.0%
Elmore	13	5	38.5%
Franklin	12	6	50.0%
Fremont	7	3	42.9%
Gem	13	5	38.5%
Gooding	8	5	62.5%
Idaho	7	5	71.4%
Jefferson	8	8	100.0%
Jerome	12	11	91.7%
Kootenai	80	64	80.0%
Latah	18	11	61.1%
Lemhi	9	3	33.3%
Lewis	3	2	66.7%
Lincoln	4	4	100.0%
Madison	6	5	83.3%
Minidoka	15	3	20.0%
Nez Perce	27	15	55.6%
Oneida	1	-	0.0%
Owyhee	9	8	88.9%
Payette	29	22	75.9%
Power	7	7	100.0%
Shoshone	15	9	60.0%
Teton	4	3	75.0%
Twin Falls	58	35	60.3%
Valley	10	8	80.0%
Washington	1	1	100.0%
Total	**1,140**	**752**	66.0%

Percent of Drug-Induced Deaths (Where a Drug Was Specified) That Reported One or More Opioid(s) by State and County (2012-2016)

[1]County of residence may or may not be the county death occurred.
[2]Drug-Induced deaths include drug deaths due to natural (chronic drug use), and drug poisoning by accident, suicide, homicide, and undetermined intent of injury.
[3]Decedents may have none, one, or more than one drug specified on the death certificate.
[4]Opioids Include Opium, Heroin, Natural and semisynthetic opioids, Methadone, Synthetic opioids other than methadone, and other and unspecified narcotics (i.e. "opioid" not specified).

Bureau of Vital Records and Health Statistics; Division of Public Health (July 2017)

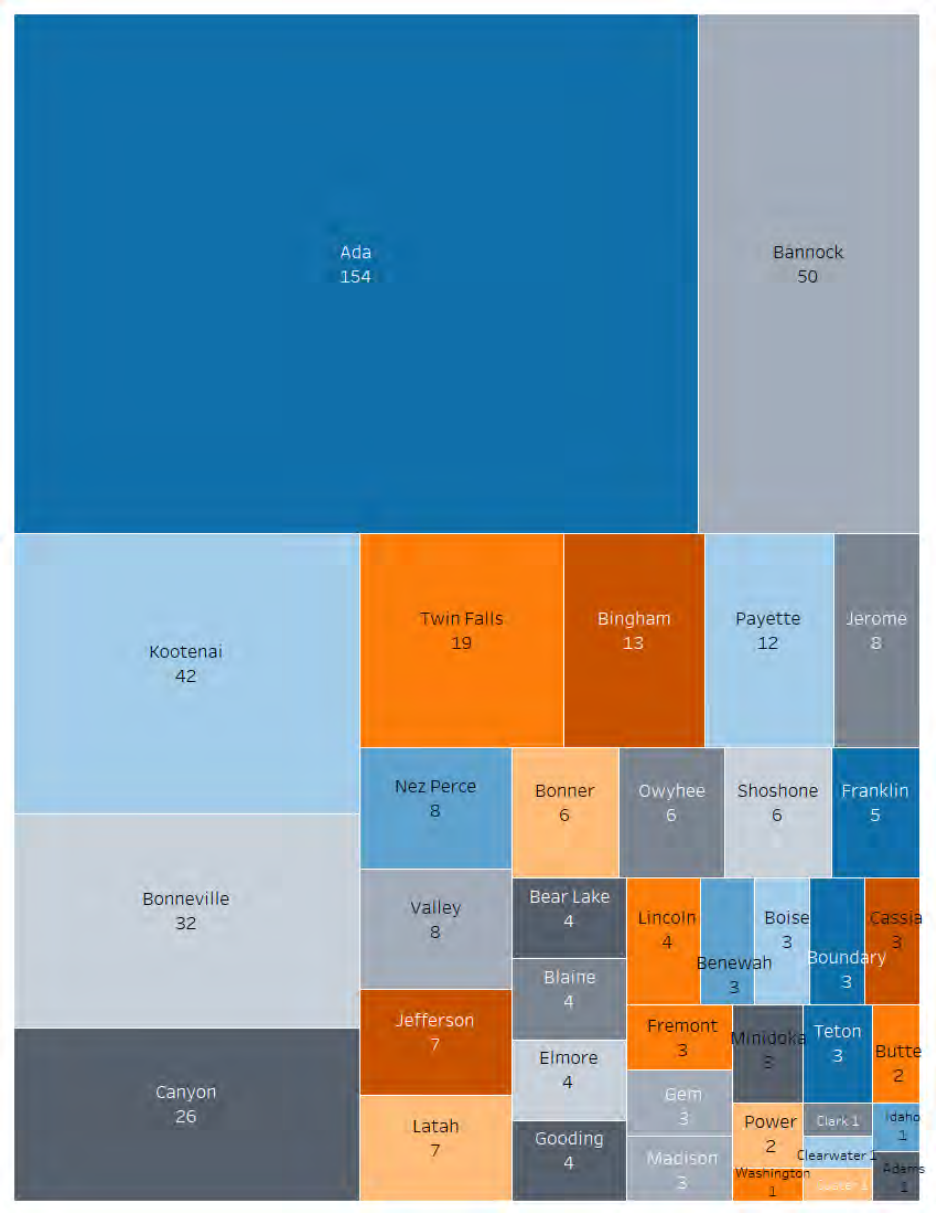


County of Residence[1]	Number of Drug-Induced Deaths with At Least One Drug Specified On Death Certificate[3]	Number of Drug-Overdose Deaths With Opioid Drug(s) Specified On Death Certificate[4]	Percent of Drug-Induced Deaths with Drug Specified That Reported One or More Opioid(s)
Ada	263	154	58.6%
Adams	1	1	100.0%
Bannock	67	50	74.6%
Bear Lake	4	4	100.0%
Benewah	6	3	50.0%
Bingham	20	13	65.0%
Blaine	9	4	44.4%
Boise	5	3	60.0%
Bonner	13	6	46.2%
Bonneville	59	32	54.2%
Boundary	6	3	50.0%
Butte	2	2	100.0%
Camas	-	-	NA
Canyon	41	26	63.4%
Caribou	-	-	NA
Cassia	3	3	100.0%
Clark	1	1	100.0%
Clearwater	3	1	33.3%
Custer	1	1	100.0%
Elmore	5	4	80.0%
Franklin	6	5	83.3%
Fremont	3	3	100.0%
Gem	5	3	60.0%
Gooding	5	4	80.0%
Idaho	5	1	20.0%
Jefferson	8	7	87.5%
Jerome	11	8	72.7%
Kootenai	64	42	65.6%
Latah	11	7	63.6%
Lemhi	3	-	0.0%
Lewis	2	-	0.0%
Lincoln	4	4	100.0%
Madison	5	3	60.0%
Minidoka	3	3	100.0%
Nez Perce	15	8	53.3%
Oneida	-	-	NA
Owyhee	8	6	75.0%
Payette	22	12	54.5%
Power	7	2	28.6%
Shoshone	9	6	66.7%
Teton	3	3	100.0%
Twin Falls	35	19	54.3%
Valley	8	8	100.0%
Washington	1	1	100.0%
Total	**752**	**466**	**62.0%**

Number of Opioid-Involved Drug-Induced Deaths by State and County (2012-2016)

County of Residence[1]	Number of Drug-Induced Deaths[2]	Number of Drug-Induced Deaths with At Least One Drug Specified On Death Certificate[3]	Number of Drug-Overdose Deaths With Opioid Drug(s) Specified On Death Certificate[4]
Ada	289	263	154
Adams	1	1	1
Bannock	104	67	50
Bear Lake	6	4	4
Benewah	8	6	3
Bingham	30	20	13
Blaine	11	9	4
Boise	7	5	3
Bonner	21	13	6
Bonneville	146	59	32
Boundary	10	6	3
Butte	2	2	2
Camas	1	-	-
Canyon	115	41	26
Caribou	1	-	-
Cassia	7	3	3
Clark	1	1	1
Clearwater	3	3	1
Custer	1	1	1
Elmore	13	5	4
Franklin	12	6	5
Fremont	7	3	3
Gem	13	5	3
Gooding	8	5	4
Idaho	7	5	1
Jefferson	8	8	7
Jerome	12	11	8
Kootenai	80	64	42
Latah	18	11	7
Lemhi	9	3	-
Lewis	3	2	-
Lincoln	4	4	4
Madison	6	5	3
Minidoka	15	3	3
Nez Perce	27	15	8
Oneida	1	-	-
Owyhee	9	8	6
Payette	29	22	12
Power	7	7	2
Shoshone	15	9	6
Teton	4	3	3
Twin Falls	58	35	19
Valley	10	8	8
Washington	1	1	1
Total	**1,140**	**752**	**466**

*This graph shows the distribution of the 466 opioid-involved drug-induced deaths recorded in Idaho from 2012-2016 by county. The size of the box is proportional to the percent of the total state deaths represented by that county.



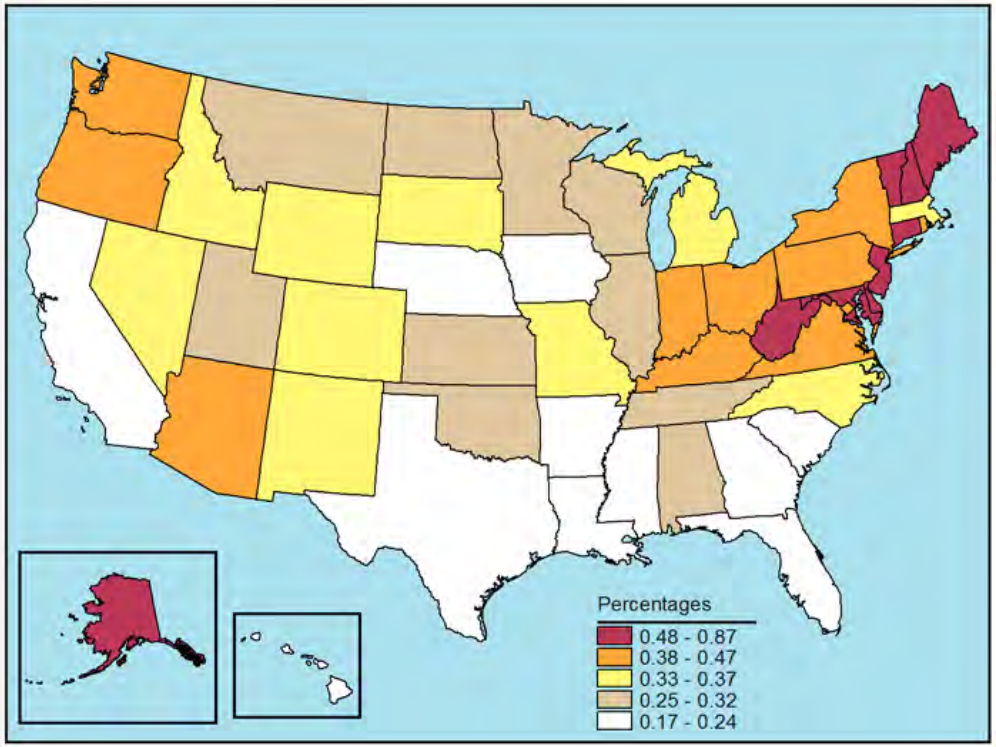
[1]County of residence may or may not be the county death occurred.
[2]Drug-Induced deaths include drug deaths due to natural (chronic drug use), and drug poisoning by accident, suicide, homicide, and undetermined intent of injury.
[3]Decedents may have none, one, or more than one drug specified on the death certificate.
[4]Opioids Include Opium, Heroin, Natural and semisynthetic opioids, Methadone, Synthetic opioids other than methadone, and other and unspecified narcotics (i.e. "opioid" not specified).

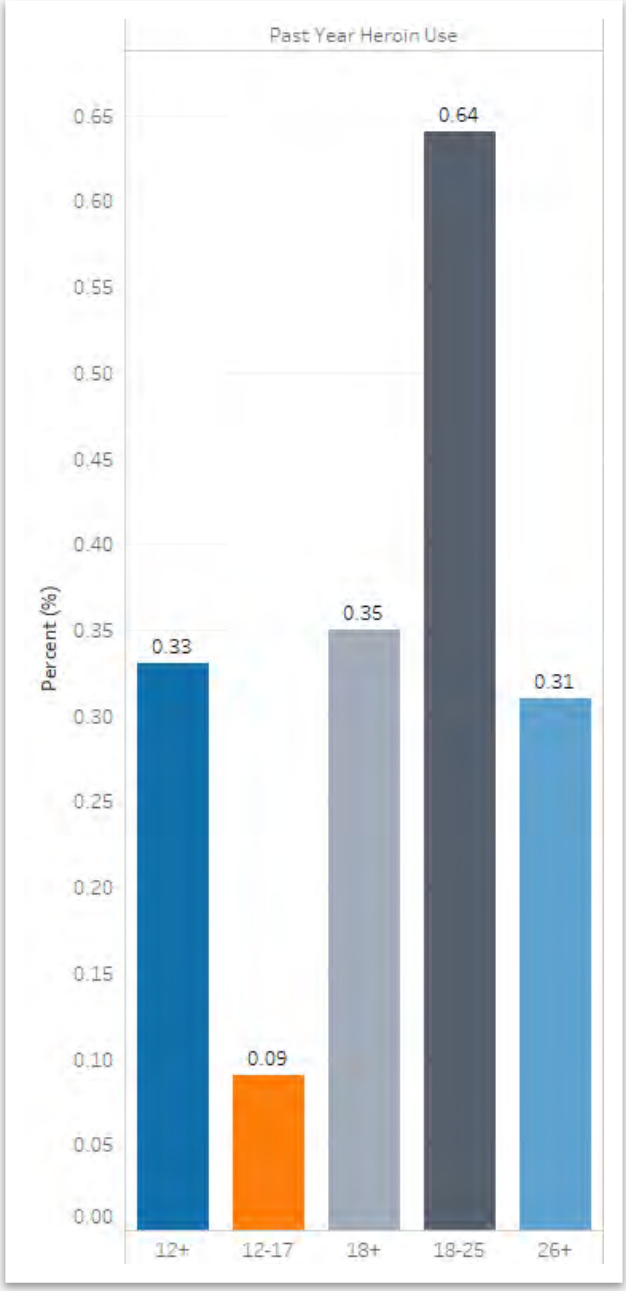
Bureau of Vital Records and Health Statistics; Division of Public Health (July 2017)

III. Estimating the Current Treatment Need in Idaho

Past Year Heroin Use (among individuals aged 12 or older); based on the National Survey on Drug Use and Health (NSDUH, 2016)

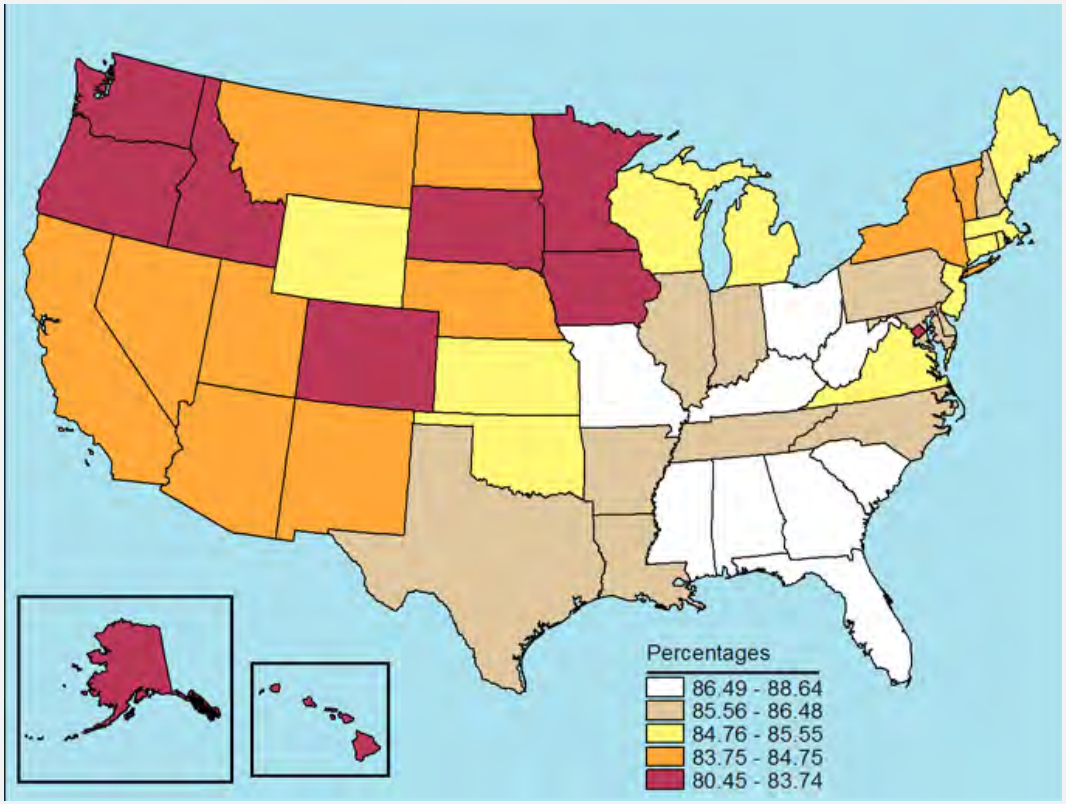
- SAMHSA categorized Idaho in their third highest category for the percentage of those aged 12 or older who used Heroin in the past year.
- In 2016, past year heroin use was most common among Idahoans 18 to 25 and least common among Idahoans 12 to 17.
- Idahoans aged 18 to 25 were 2 times more likely to use heroin in the past year than Idahoans over 26.

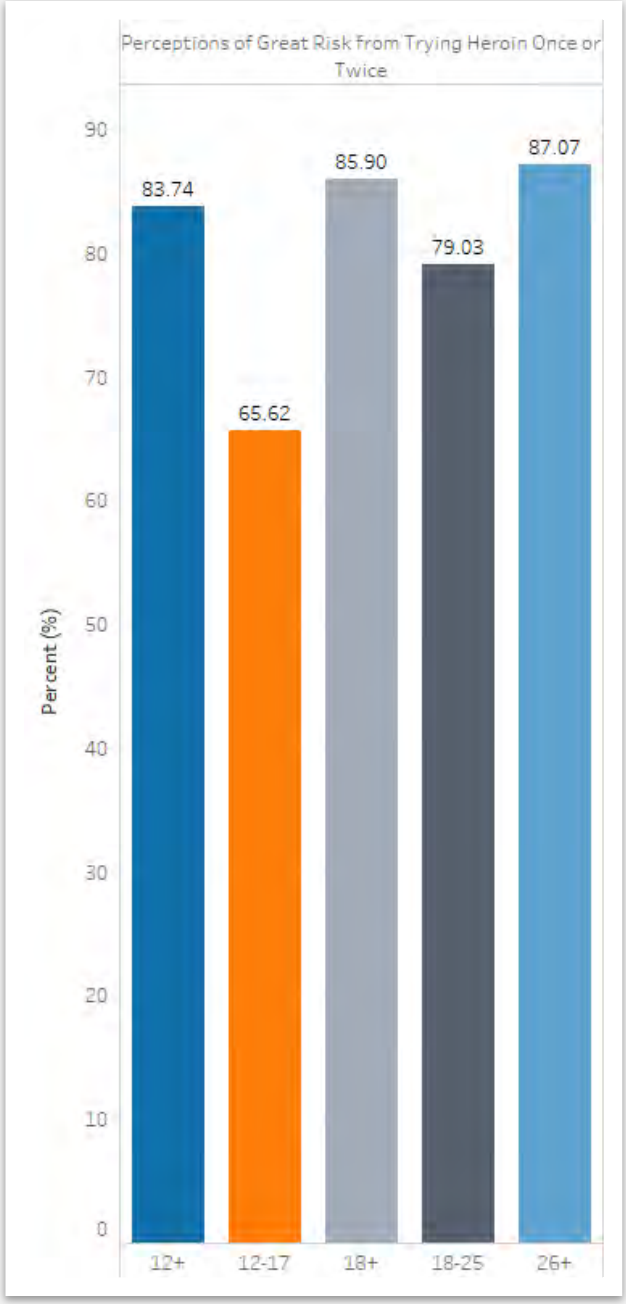




SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016

Perceptions of Great Risk from Trying Heroin Once or Twice (among individuals aged 12 or older); based on the National Survey on Drug Use and Health (NSDUH, 2016)

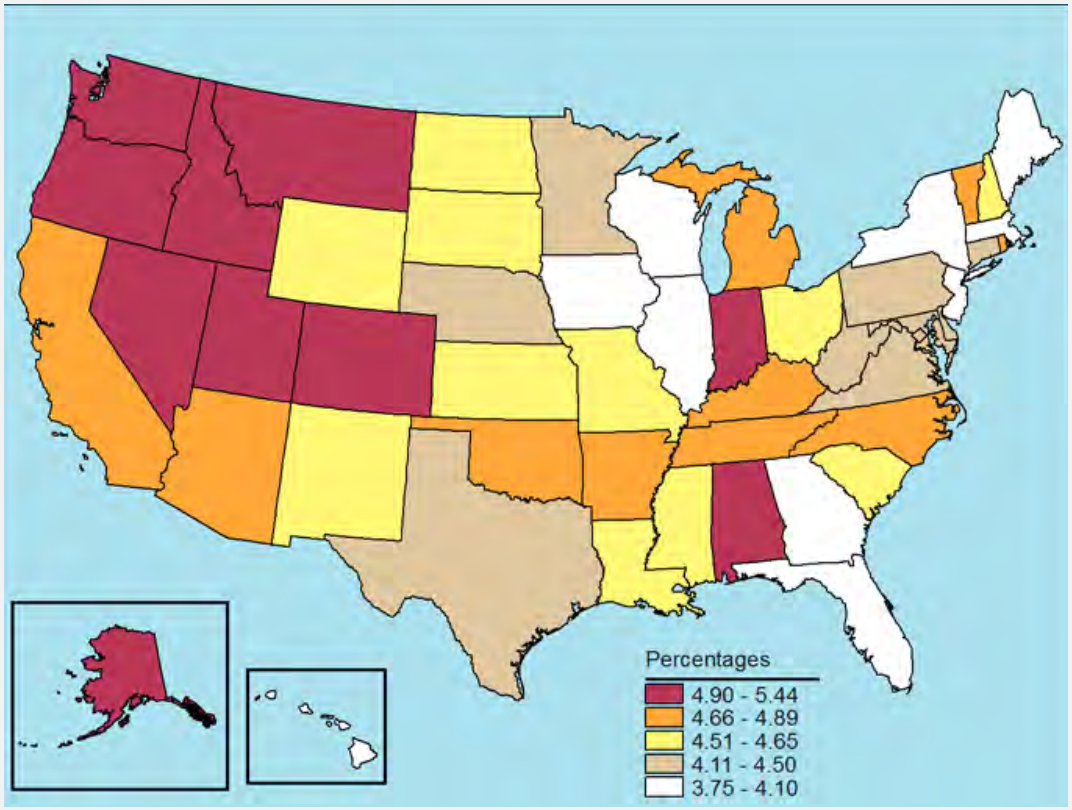




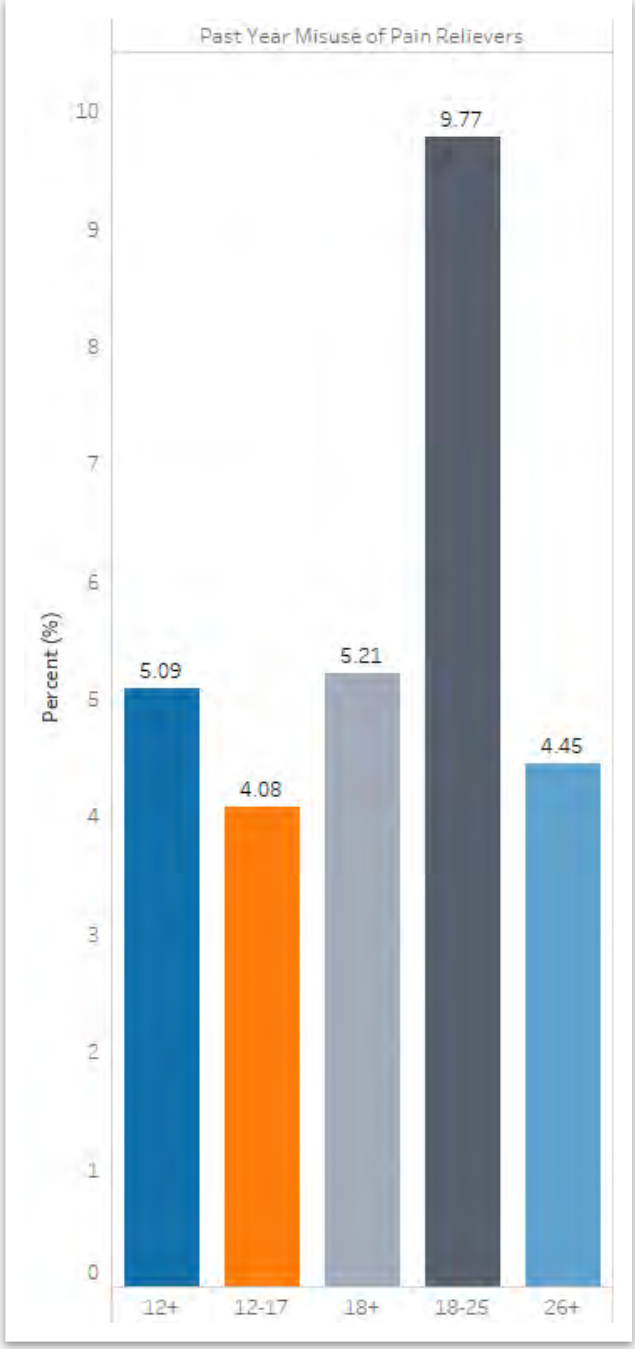
- SAMHSA categorized Idaho in their lowest category for the percentage of those aged 12 or older who perceive trying heroin once or twice as a great risk.
- In 2016, the age group that perceived trying heroin once or twice as a great risk the most was those age 26+ and it was least common among Idahoans 12 to 17.
- Idahoans aged 26+ were 1.3 times more likely to perceive trying heroin once or twice as a great risk compared to those aged 12 to 17.

SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016

Past Year Pain Reliever Misuse (among individuals aged 12 or older); based on the National Survey on Drug Use and Health (NSDUH, 2016)

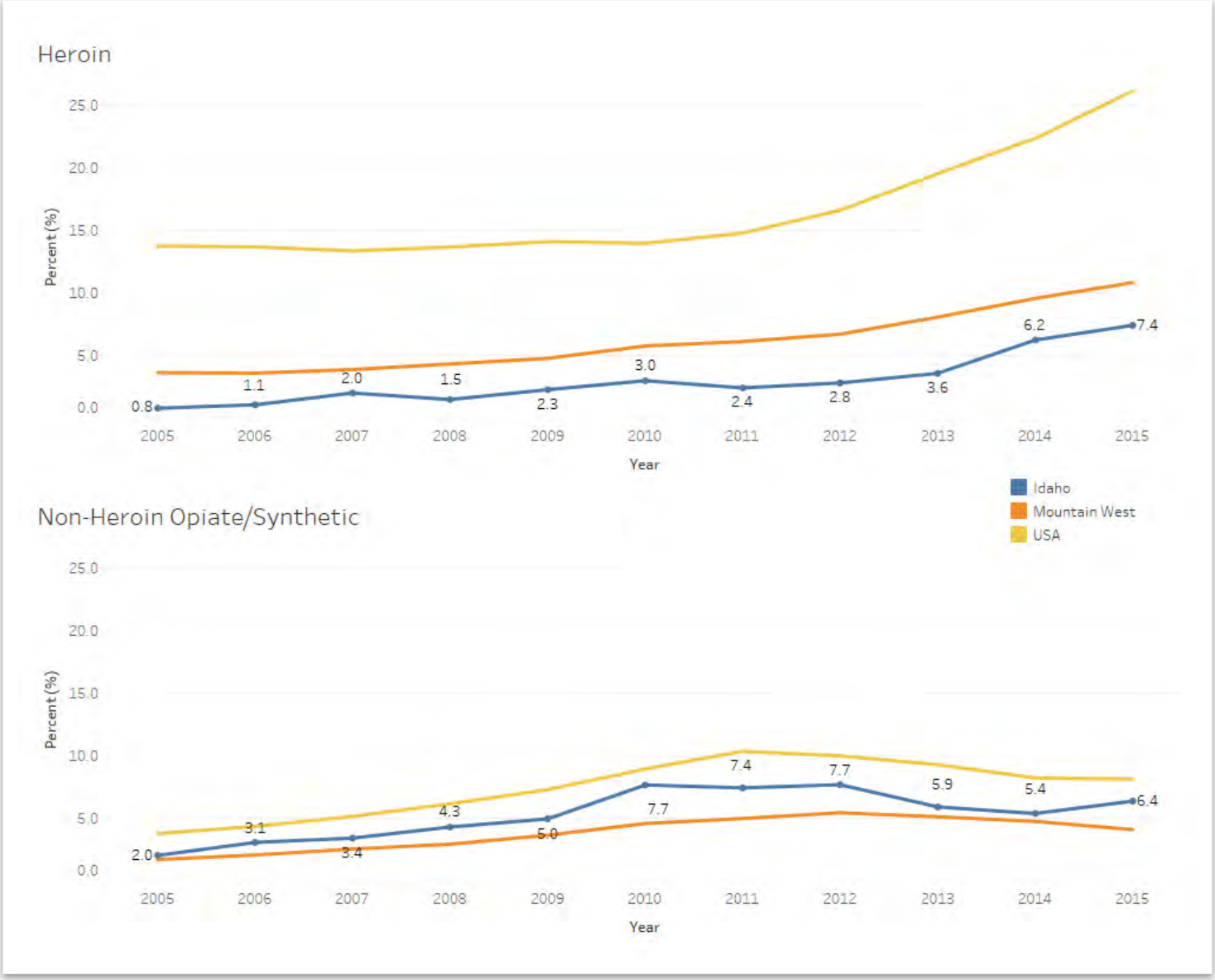


- SAMHSA categorized Idaho in their highest category for the percentage of those aged 12 or older who misused a pain reliever in the past year.
- In 2016, past year prescription drug misuse was most common among Idahoans 18 to 25 and least common among Idahoans 12 to 17.
- Idahoans aged 18 to 25 were more than 2 times more likely to misuse prescription drugs in the past year than Idahoans over 26 and those aged 12-17.



SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016

Opioid Substance Abuse Treatment; based on the Treatment Episode Data Set (TEDS, 2005-2015)[1]



Between '05 and '15, the proportion of primary treatment admissions for heroin in Idaho increased more than 9-fold.

- The proportion of primary treatment admissions for heroin in Idaho is below both the rate for the nation and the Mountain West, which includes Idaho, Montana, Wyoming, Nevada, Utah, Colorado, Arizona, New Mexico, and Alaska.
- In 2015, the proportion of primary treatment admissions for heroin in the United States was more than three times higher than in Idaho.
- Between '05 and '15, the proportion of primary treatment admissions for non-heroin opiate/synthetic treatment admissions in Idaho increased more than 3-fold.
- The proportion of primary treatment admissions for non-heroin opiates/synthetics in Idaho is below the rate for the nation but above the Mountain West.
- In Idaho in 2015, the proportion of primary treatment admissions for heroin was higher than for non-heroin opiates/synthetics.

Center for Behavioral Health Statistics and Quality, Substance Abuse Mental Health Services Administration, Treatment Episode Data Set (TEDS).

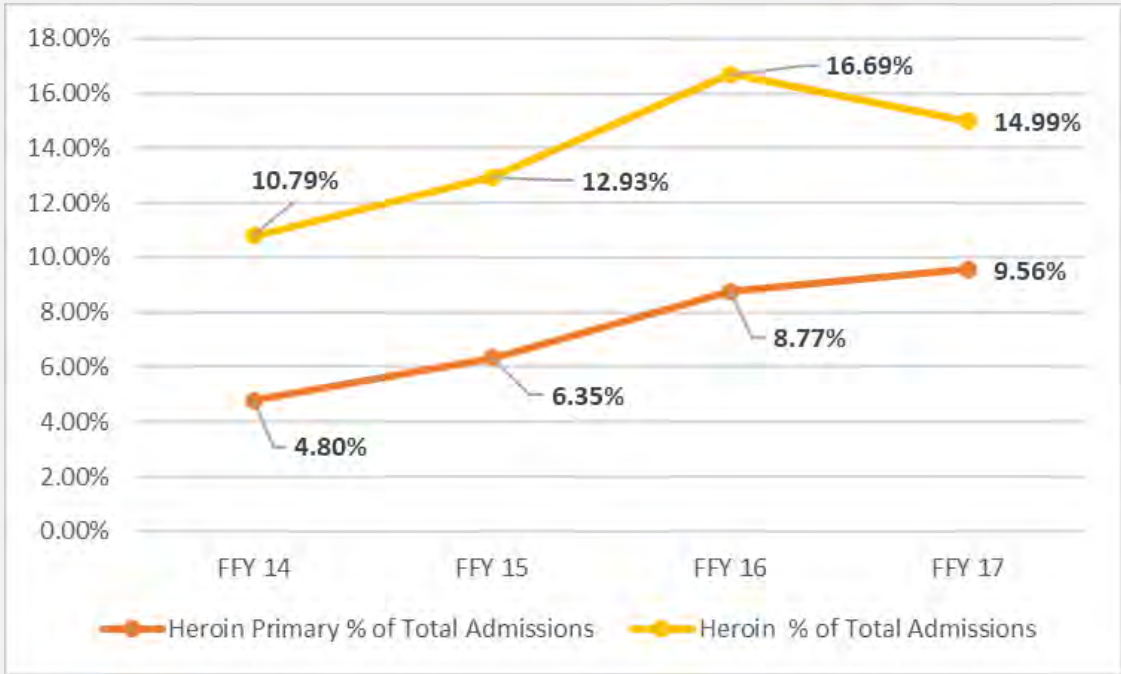
[1]Data from the TEDS are based on admission records for individuals entering publicly funded Substance Use Disorder Treatment. This data includes individuals that received funding for Substance Use Disorder Treatment through Idaho Department of Health and Welfare, Idaho Department of Correction, Idaho Department of Juvenile Correction, and Idaho Supreme Court.

Admissions Records for Individuals Entering Idaho's Publicly Funded Substance Use Disorder Treatment Network for Treatment of Heroin (FFY 2014-2017)

	FFY 14	FFY 15	FFY 16	FFY 17	14-15 Change	15-16 Change	16-17 Change	14-17 Change
Total Admissions	8,279	9,433	8,916	8,682	1,154	-517	-234	403
Heroin as Primary	397	599	782	830	202	183	48	+ 433
% of Total Admissions	4.80%	6.35%	8.77%	9.56%	1.55%	2.42%	0.79%	+ 4.76%
Heroin as Secondary	358	458	488	367	100	30	-121	+ 9
% of Total Admissions	4.32%	4.86%	5.47%	4.23%	0.54%	0.61%	-1.25%	- 0.09%
Heroin as Tertiary	138	163	218	104	25	55	-114	- 34
% of Total Admissions	1.67%	1.72%	2.45%	1.20%	0.05%	0.73%	-1.25%	- 0.47%
Heroin Total	893	1,220	1,488	1,301	327	268	-187	+ 408
% of Total Admissions	10.79%	12.93%	16.69%	14.99%	2.14%	3.76%	-1.70%	+ 4.20%

Overall, heroin was associated with 14.99% of admissions (1,301 of 8,682) to Idaho's publicly funded Substance Use Disorder Treatment Network in Fiscal Year 2017.

- This represented a 1.70% decrease from Fiscal Year 2016 [1,488 admissions (16.69%)], but a 4.20% increase from Fiscal Year 2014 [893 admissions (10.79%)].
- The percentage of total admissions in which heroin was listed as the primary reason for admission, however, increased 0.79% from 2016 to 2017 [from 782 admissions (8.77%) to 830 admissions (9.56%)] and 4.76% from 2014 to 2017 [from 397 admissions (4.80%) to 830 admissions (9.56%)].

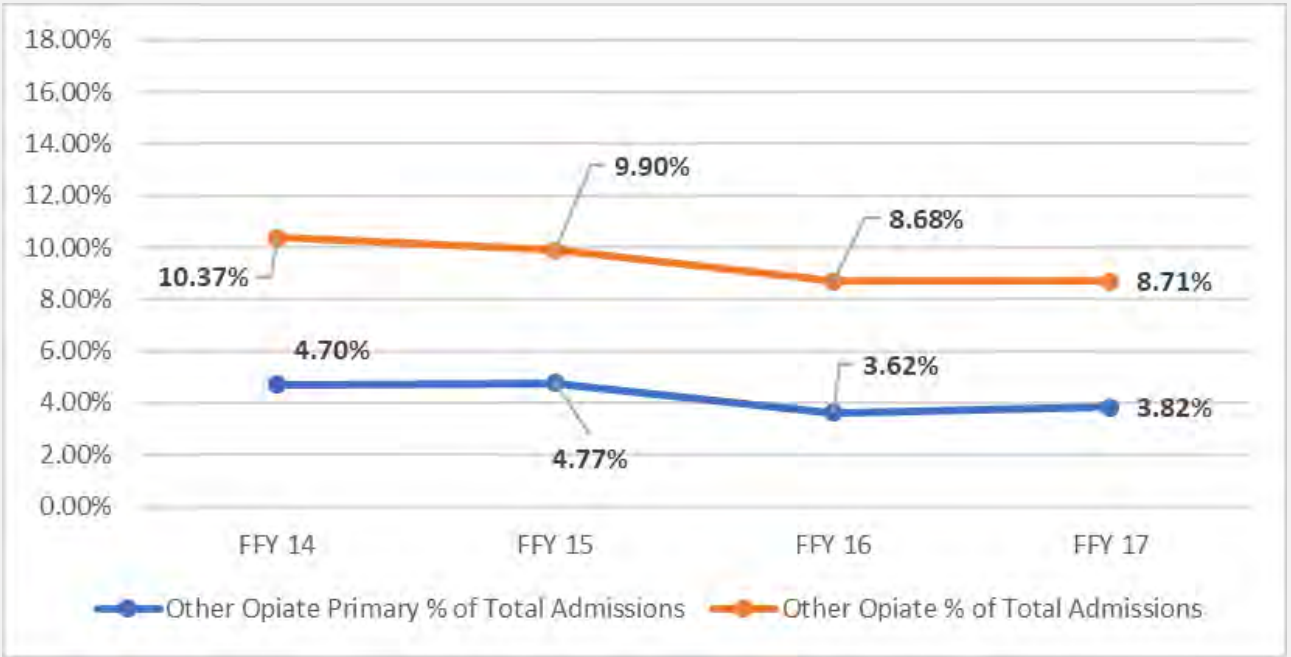


*This data is based on Admissions records for individuals entering publicly funded Substance Use Disorder Treatment Network from October 1, 2013 – September 30, 2014, compared to October 1, 2014 – September 30, 2015, October 1, 2015 – September 30, 2016 and October 1, 2016 – September 30, 2017. This data includes individuals that received funding for Substance Use Disorder Treatment through Idaho Department of Health and Welfare, Idaho Department of Correction, Idaho Department of Juvenile Corrections, and Idaho Supreme Court. Due to limited funding, these entities are not able to provide treatment for all individuals meeting financial criteria; rather, funding eligibility is also based on additional criteria including, but not limited to: Intravenous Drug Use, Pregnant and Parenting Women, Criminal Justice Involvement, individuals with mental health needs, etc. This data does not include individuals who received treatment funded by Medicaid.

Admissions Records for Individuals Entering Idaho's Publicly Funded Substance Use Disorder Treatment Network for Treatment of Opiates other than Heroin (FFY 2014-2017)

	FFY 14	FFY 15	FFY 16	FFY 17	14-15 Change	15-16 Change	16-17 Change	14-17 Change
Total Admissions	8,279	9,433	8,916	8,682	1,154	-517	-234	403
Other Opiates as Primary	389	450	323	332	61	-127	9	-57
% of Total Admissions	4.70%	4.77%	3.62%	3.82%	0.07%	-1.15%	0.20%	-0.88%
Other Opiates as Secondary	311	314	288	265	3	-26	-23	-46
% of Total Admissions	3.75%	3.33%	3.23%	3.05%	-0.42%	-0.10%	-0.18%	-0.70%
Other Opiates as Tertiary	159	170	163	159	11	-7	-4	0
% of Total Admissions	1.92%	1.80%	1.83%	1.83%	-0.12%	0.03%	0.00%	-0.09%
Other Opiates Total	859	934	774	756	75	-160	-18	-103
% of Total Admissions	10.37%	9.90%	8.68%	8.71%	-0.47%	-1.22%	0.03%	-1.66%

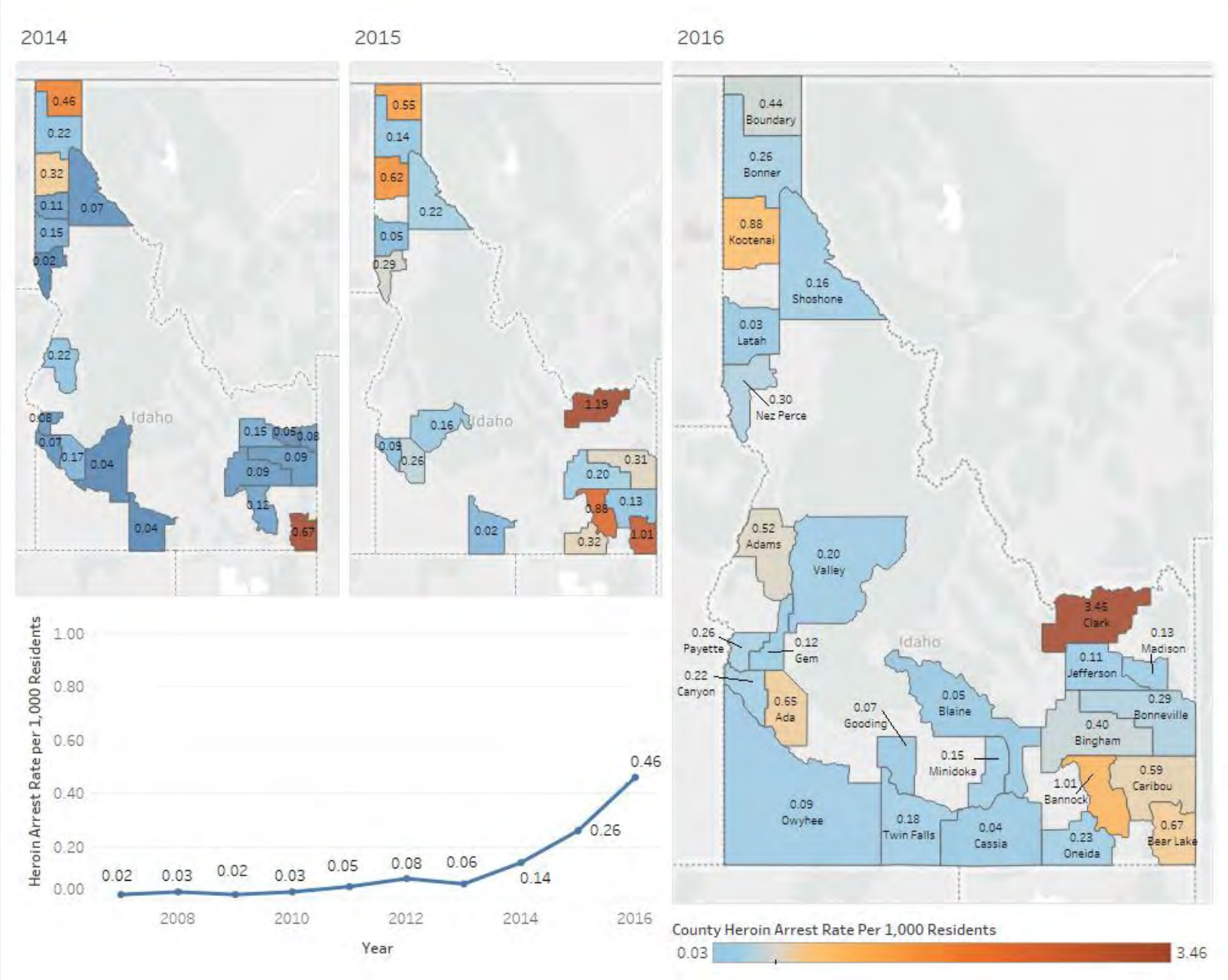
Overall, opiates other than heroin were associated with 8.71% of admissions (756 of 8,682) to Idaho's publicly funded Substance Use Disorder Treatment Network in Fiscal Year 2017.



- This represented a 0.03% increase from Fiscal Year 2016 [774 admissions (8.68%)] and a 1.66% decrease from Fiscal Year 2014 [859 admissions (10.37%)].
- The percentage of total admissions in which opiates other than heroin were listed as the primary reason for admission likewise increased 0.20% between 2016 and 2017 [from 323 admissions (3.62%) to 332 admissions (3.82%)] and decreased 0.88% from 2014 to 2017 [from 389 admissions (4.70%) to 332 admissions (3.82%)].
- However, there was a small uptick in the percentage of total admissions in which opiates other than heroin were listed as the primary reason for admission between 2014 and 2015 [from 389 admissions (4.70%) to 450 admissions (4.77%)]

*This data is based on Admissions records for individuals entering publicly funded Substance Use Disorder Treatment Network from October 1, 2013 – September 30, 2014, compared to October 1, 2014 – September 30, 2015, October 1, 2015 – September 30, 2016 and October 1, 2016 – September 30, 2017. This data includes individuals that received funding for Substance Use Disorder Treatment through Idaho Department of Health and Welfare, Idaho Department of Correction, Idaho Department of Juvenile Corrections, and Idaho Supreme Court. Due to limited funding, these entities are not able to provide treatment for all individuals meeting financial criteria; rather, funding eligibility is also based on additional criteria including, but not limited to: Intravenous Drug Use, Pregnant and Parenting Women, Criminal Justice Involvement, individuals with mental health needs, etc. This data does not include individuals who received treatment funded by Medicaid.

Heroin-Related Arrest Rate per 1,000 Residents by County (2007-2016)

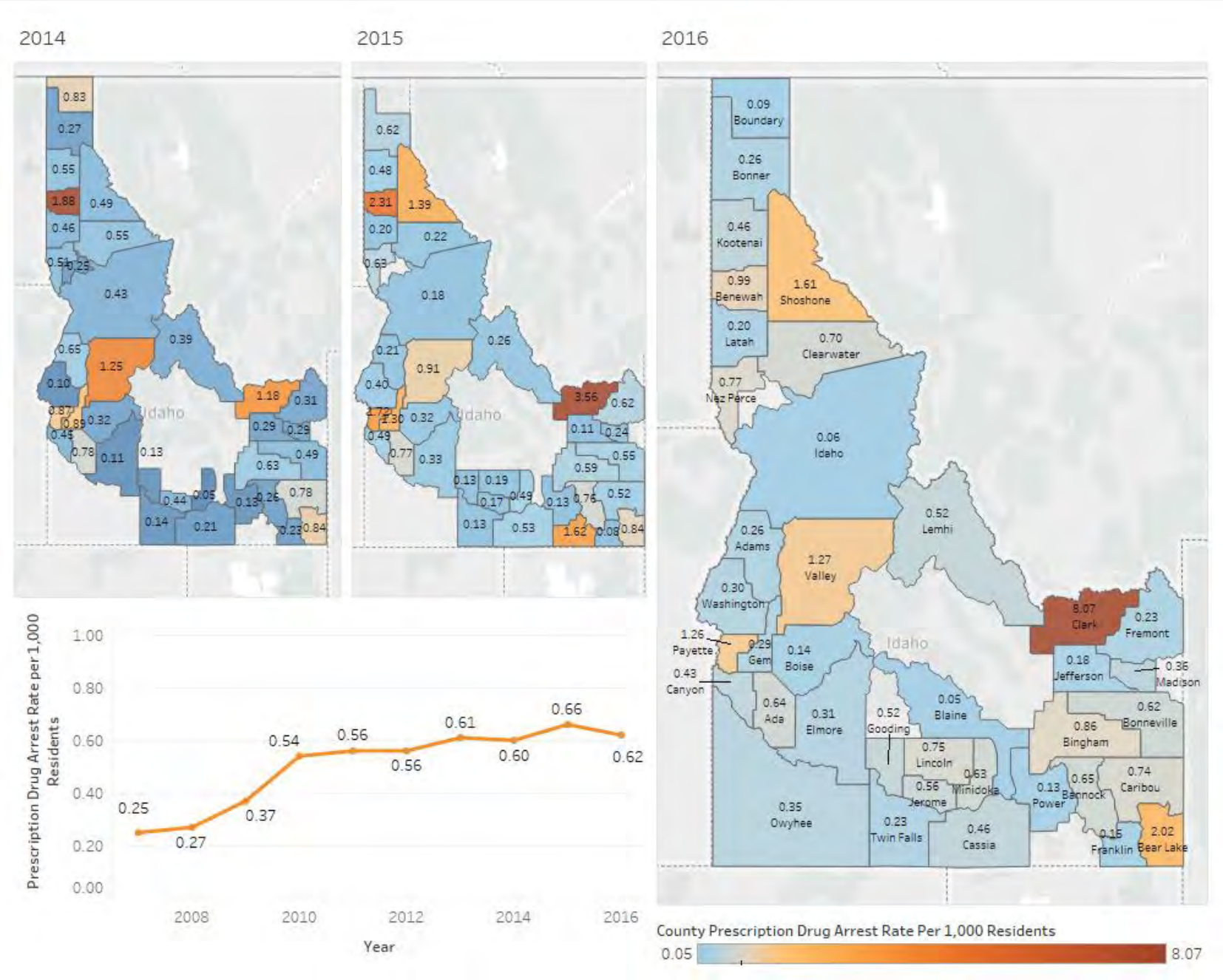


Between '07 and '16, the heroin arrest rate has increased 23-fold.

Clark County had the highest heroin arrest rate in 2016; however, due to the limited population size rates may be unstable.

Idaho Statistical Analysis Center, Idaho State Police, National Incidence-Based Reporting System, July 2018

Prescription Drug-Related Arrest Rate per 1,000 Residents by County (2007-2016)

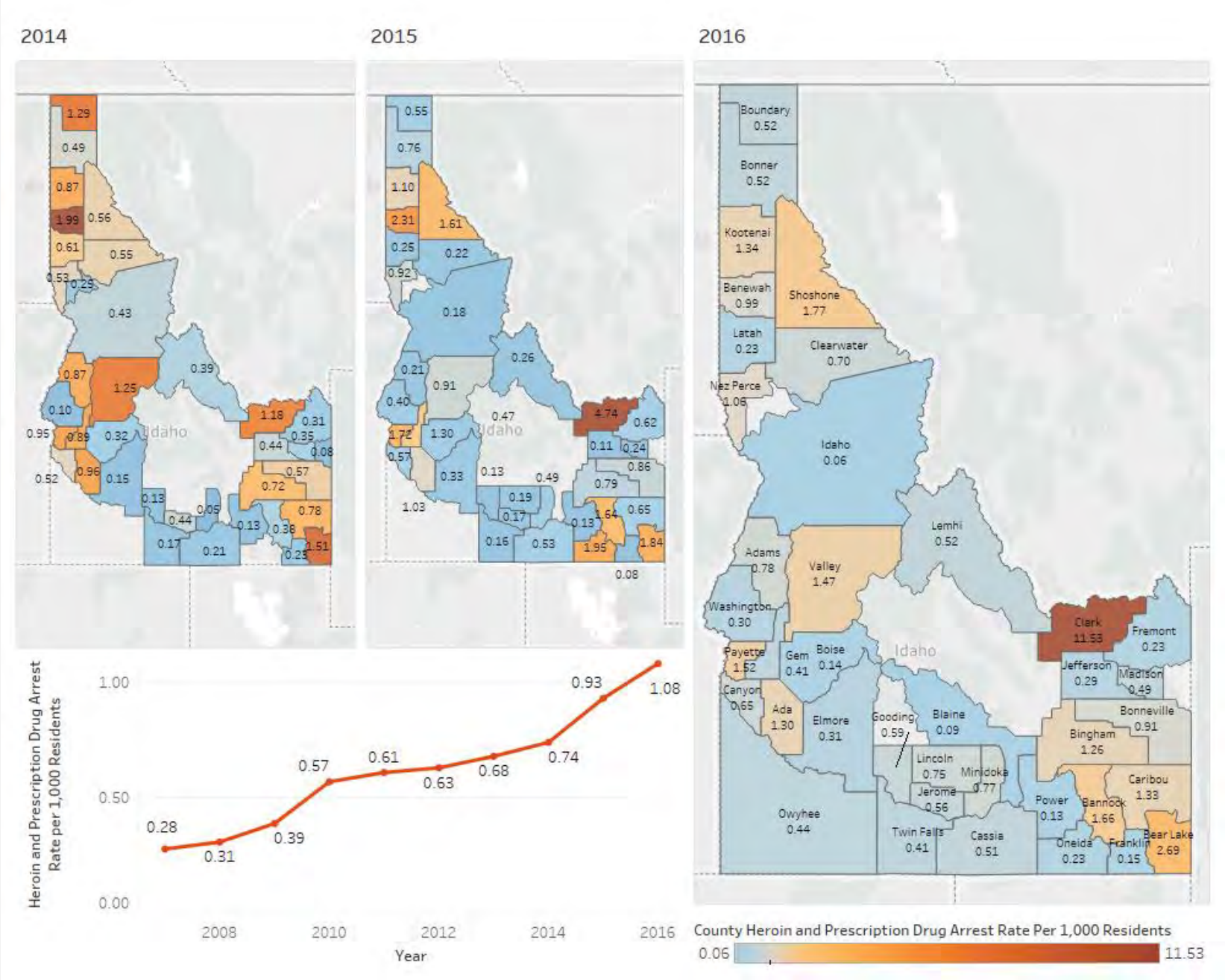


Between '07 and '16, the prescription drug arrest rate has increased 2.5-fold.

Clark County had the highest prescription drug arrest rate in 2016; however, due to the limited population size rates may be unstable.

Idaho Statistical Analysis Center, Idaho State Police, National Incidence-Based Reporting System, July 2018

Heroin and Prescription Drug-Related Arrest Rate per 1,000 Residents by County (2007-2016)



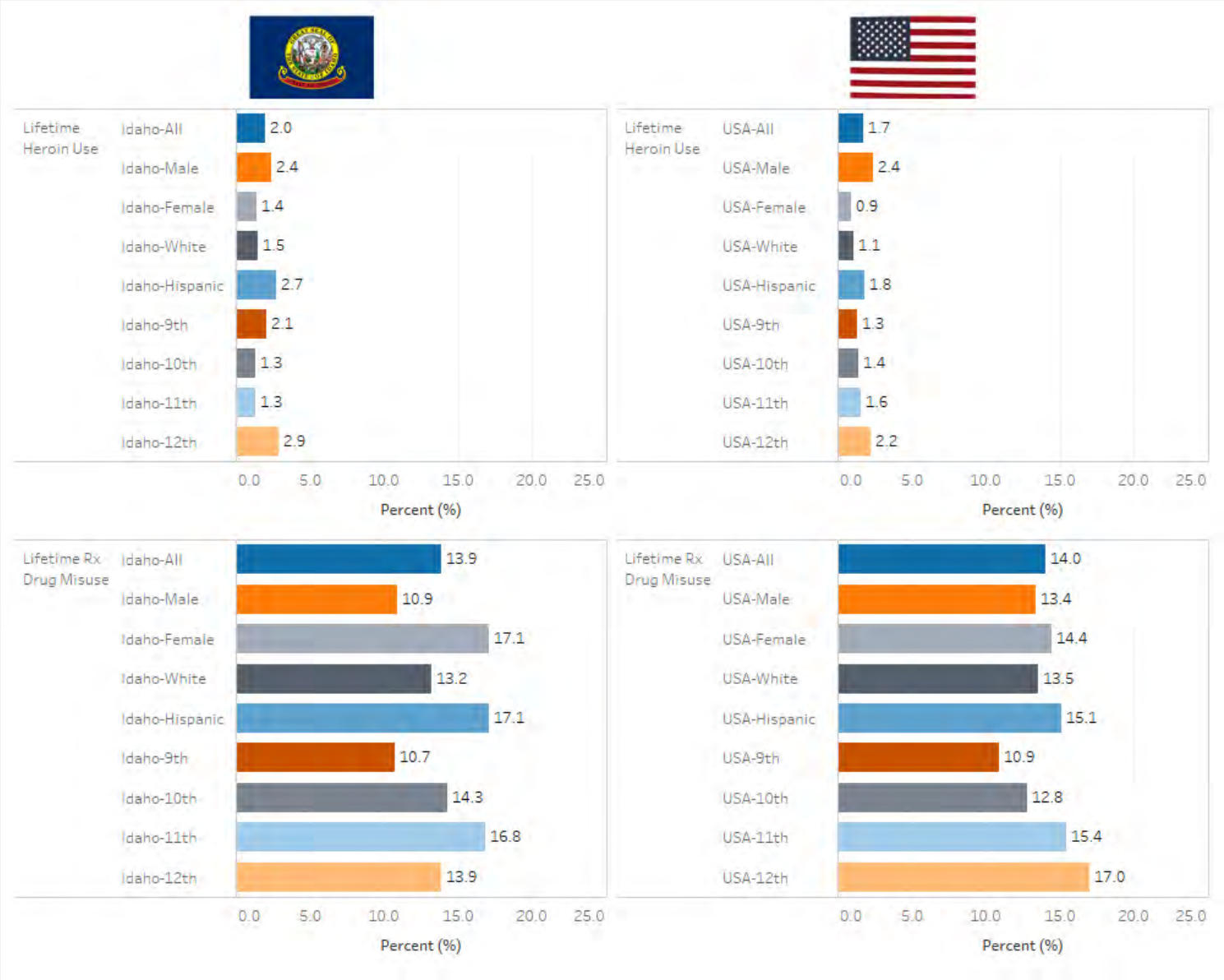
Between '07 and '16, the combined heroin and prescription drug arrest rate has increased nearly 4-fold.

Clark County had the highest heroin and prescription drug arrest rate in 2016; however, due to the limited population size rates may be unstable.

Idaho Statistical Analysis Center, Idaho State Police, National Incidence-Based Reporting System, July 2018

i. Unique Needs: Highlights Regarding Select Demographic Groups and Special Populations in Idaho

Lifetime Heroin Use and Prescription Drug Misuse Grades 9-12; based on the High School Youth Risk Behavior Survey (YRBS, 2017)



Lifetime Heroin Use, Grades 9-12 (2017)

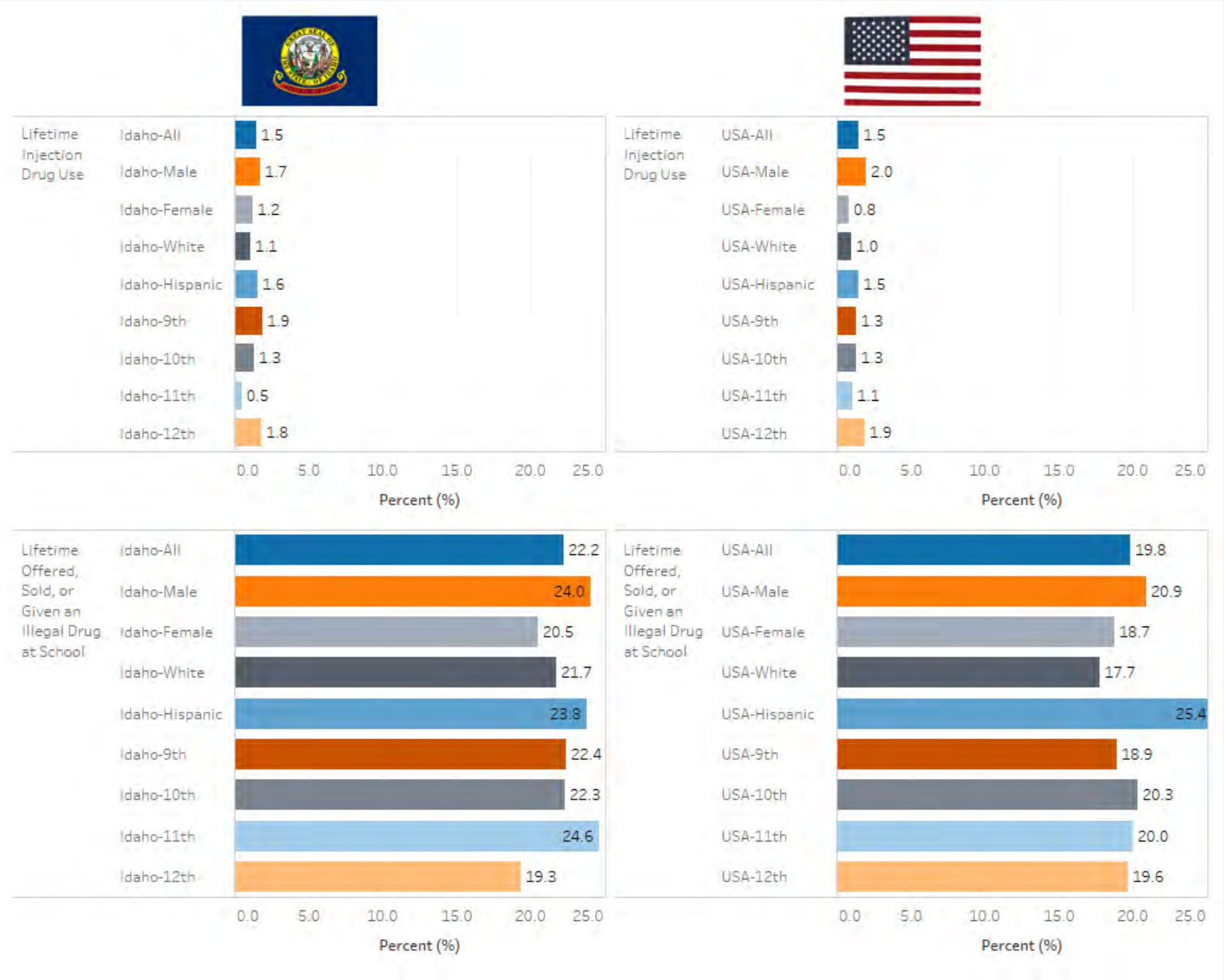
- Idaho is now slightly (but not significantly) above the national average in lifetime heroin use among high school students.
- In 2017, 2.0% of Idaho high school students reported having ever used heroin in their lifetimes.
- Idaho Hispanic youth appear more likely to report using heroin compared to Hispanic youth nationwide.

Lifetime Prescription Drug Misuse, Grades 9-12 (2017)

- Idaho has remained slightly below the national average in lifetime use of prescription drugs without a doctor's prescription, though the difference is not significant.
- In 2017, 13.9% of Idaho high school students reported having ever used prescription drugs without a doctor's prescription.
- Female youth were significantly more likely to have misused prescription drugs than male students.

Centers for Disease Control and Prevention, Adolescent and School Health, Youth Risk Behavior Surveillance System (YRBSS), 2017

Lifetime Injection Drug Use and Offered, Sold, or Given an Illegal Drug at School Grades 9-12; based on the High School Youth Risk Behavior Survey (YRBS, 2017)



Lifetime Injection Drug Use, Grades 9-12 (2017)

- Idaho was not significantly different from the national average in lifetime injection drug use among high school students.
- In 2017, 1.5% of Idaho high school students reported having ever injected an illegal drug in their lifetimes.
- There were no statistically significant differences across demographic groups.

Lifetime Offered, Sold, or Given an Illegal Drug at School, Grades 9-12 (2017)

- Idaho is slightly above the national average in youth reporting being offered, sold, or given an illegal drug at school.
- In 2017, 22.2% of Idaho high school students reported having ever been offered, sold, or given an illegal drug at school.
- Idaho males, whites, 9th graders, and 11th graders appeared more likely to report drugs at school compared to their national counterparts.

Centers for Disease Control and Prevention, Adolescent and School Health, Youth Risk Behavior Surveillance System (YRBSS), 2017

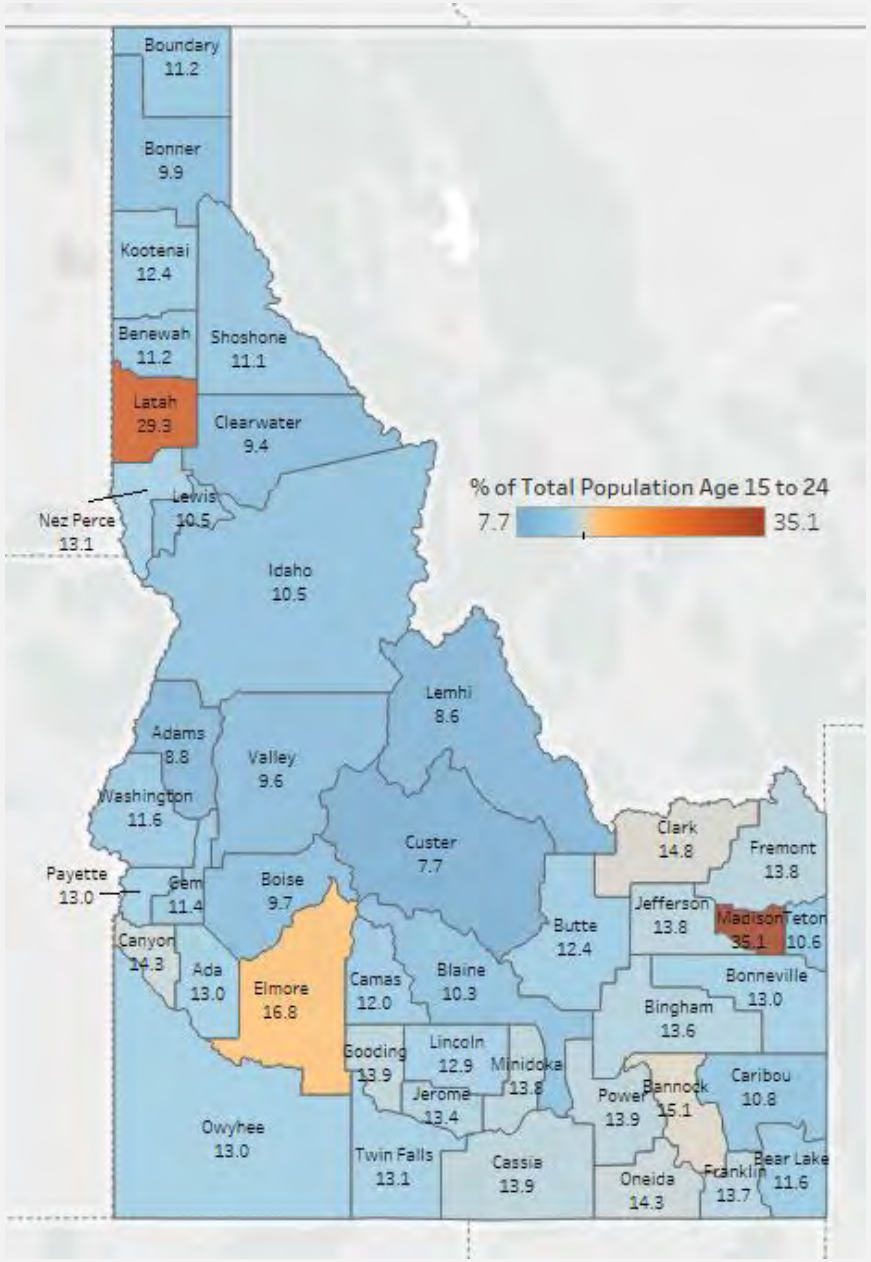
Adolescents and Young Adults in Idaho

Counties with significant populations of young Idahoans represent areas where support could potentially be particularly beneficial, based on data seen above (from the National Survey on Drug Use and Health, the High School Youth Risk Behavior Survey, and Idaho heroin arrests).

There are approximately 228,000 adolescent and young adult Idahoans age 15-24 years old, which is equal to approximately 14% of Idaho's total population.

- Ada county, home to the city of Boise, has the largest gross number of adolescents and young adults (55,354).
- Other counties with large populations age 15-24 include Bonneville, Canyon, and Kootenai.
- However, Madison county has the highest percent of adolescents and young adults (35.1%).
- A large proportion of Latah county's population is also comprised of individuals age 15-24 (29.3%).

United States Census Bureau, American FactFinder, 2016

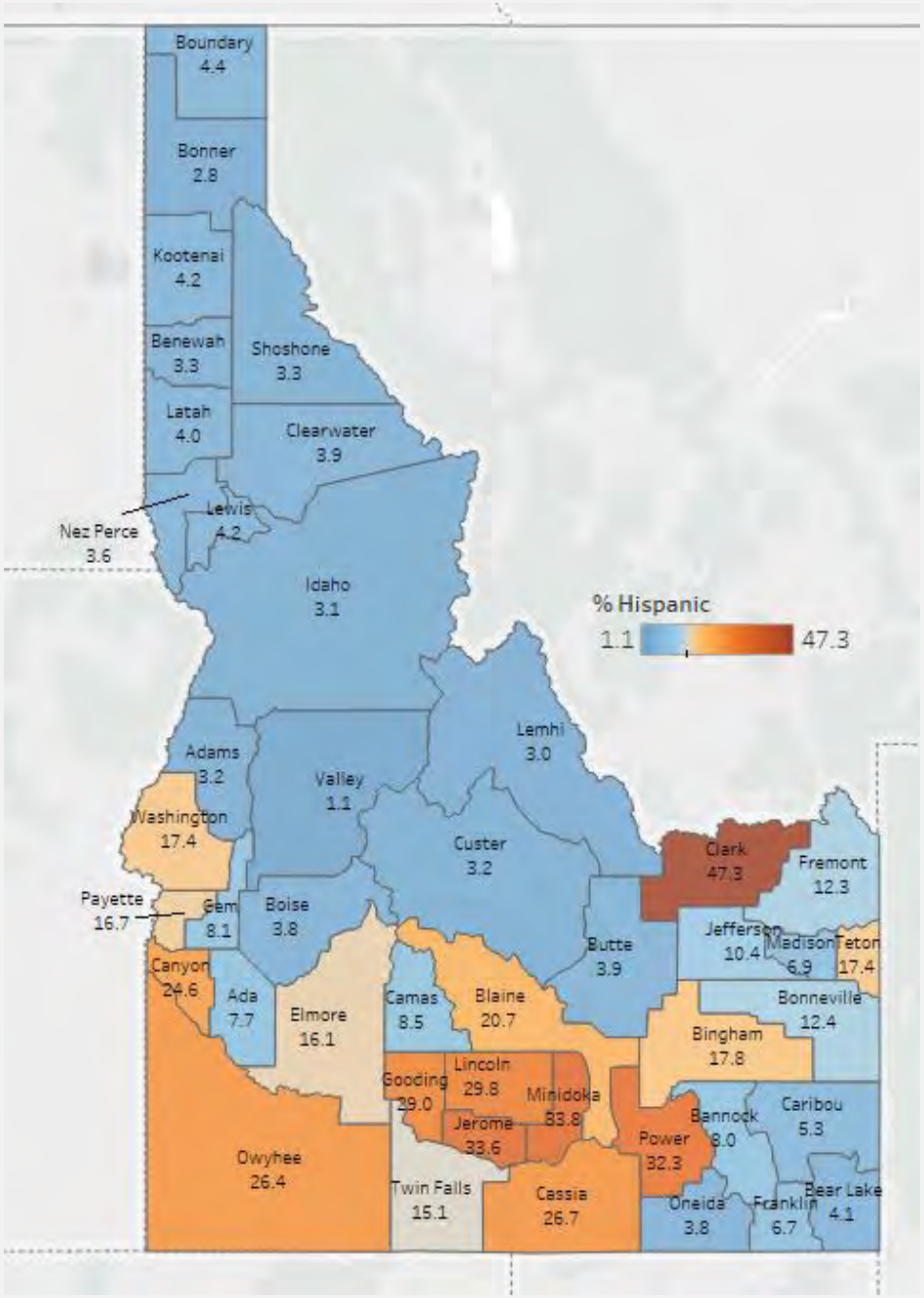


County	Total population	15 to 24 years	% of Total Population
Ada	425,798	55,354	13.0
Adams	3,865	340	8.8
Bannock	83,815	12,656	15.1
Bear Lake	5,928	688	11.6
Benewah	9,068	1,016	11.2
Bingham	45,261	6,155	13.6
Blaine	21,427	2,207	10.3
Boise	6,891	668	9.7
Bonner	41,389	4,098	9.9
Bonneville	108,989	14,169	13.0
Boundary	11,141	1,248	11.2
Butte	2,592	321	12.4
Camas	968	116	12.0
Canyon	202,782	28,998	14.3
Caribou	6,813	736	10.8
Cassia	23,441	3,258	13.9
Clark	960	142	14.8
Clearwater	8,528	802	9.4
Custer	4,185	322	7.7
Elmore	26,103	4,385	16.8
Franklin	13,013	1,783	13.7
Fremont	12,896	1,780	13.8
Gem	16,853	1,921	11.4
Gooding	15,157	2,107	13.9
Idaho	16,251	1,706	10.5
Jefferson	27,096	3,739	13.8
Jerome	22,694	3,041	13.4
Kootenai	147,716	18,317	12.4
Latah	38,593	11,308	29.3
Lemhi	7,743	666	8.6
Lewis	3,826	402	10.5
Lincoln	5,292	683	12.9
Madison	38,114	13,378	35.1
Minidoka	20,331	2,806	13.8
Nez Perce	39,995	5,239	13.1
Oneida	4,269	610	14.3
Owyhee	11,356	1,476	13.0
Payette	22,773	2,960	13.0
Power	7,696	1,070	13.9
Shoshone	12,551	1,393	11.1
Teton	10,437	1,106	10.6
Twin Falls	80,955	10,605	13.1
Valley	9,897	950	9.6
Washington	10,035	1,164	11.6
Total	**1,635,483**	**227,889**	**13.9**

b. Hispanic/Latino Population

County	Total population	Hispanic or Latino (of any race)	% of Total Population
Ada	425,798	32,905	7.7
Adams	3,865	122	3.2
Bannock	83,815	6,678	8.0
Bear Lake	5,928	243	4.1
Benewah	9,068	300	3.3
Bingham	45,261	8,037	17.8
Blaine	21,427	4,444	20.7
Boise	6,891	260	3.8
Bonner	41,389	1,143	2.8
Bonneville	108,989	13,517	12.4
Boundary	11,141	493	4.4
Butte	2,592	101	3.9
Camas	968	82	8.5
Canyon	202,782	49,941	24.6
Caribou	6,813	363	5.3
Cassia	23,441	6,248	26.7
Clark	960	454	47.3
Clearwater	8,528	329	3.9
Custer	4,185	132	3.2
Elmore	26,103	4,204	16.1
Franklin	13,013	871	6.7
Fremont	12,896	1,589	12.3
Gem	16,853	1,362	8.1
Gooding	15,157	4,388	29.0
Idaho	16,251	507	3.1
Jefferson	27,096	2,810	10.4
Jerome	22,694	7,622	33.6
Kootenai	147,716	6,219	4.2
Latah	38,593	1,559	4.0
Lemhi	7,743	231	3.0
Lewis	3,826	160	4.2
Lincoln	5,292	1,577	29.8
Madison	38,114	2,639	6.9
Minidoka	20,331	6,869	33.8
Nez Perce	39,995	1,429	3.6
Oneida	4,269	162	3.8
Owyhee	11,356	3,001	26.4
Payette	22,773	3,796	16.7
Power	7,696	2,487	32.3
Shoshone	12,551	412	3.3
Teton	10,437	1,814	17.4
Twin Falls	80,955	12,235	15.1
Valley	9,897	111	1.1
Washington	10,035	1,743	17.4
Total	**1,635,483**	**195,589**	**12.0**

According to the Youth Risk Behavior Survey, a higher percentage of Hispanic youth in Idaho reported using Heroin compared to Hispanic youth nationwide. As such, prevention strategies should be culturally competent and tailored to Idaho's Hispanic population. Areas of Idaho comprised of particularly high concentrations of Hispanic persons are identified below.



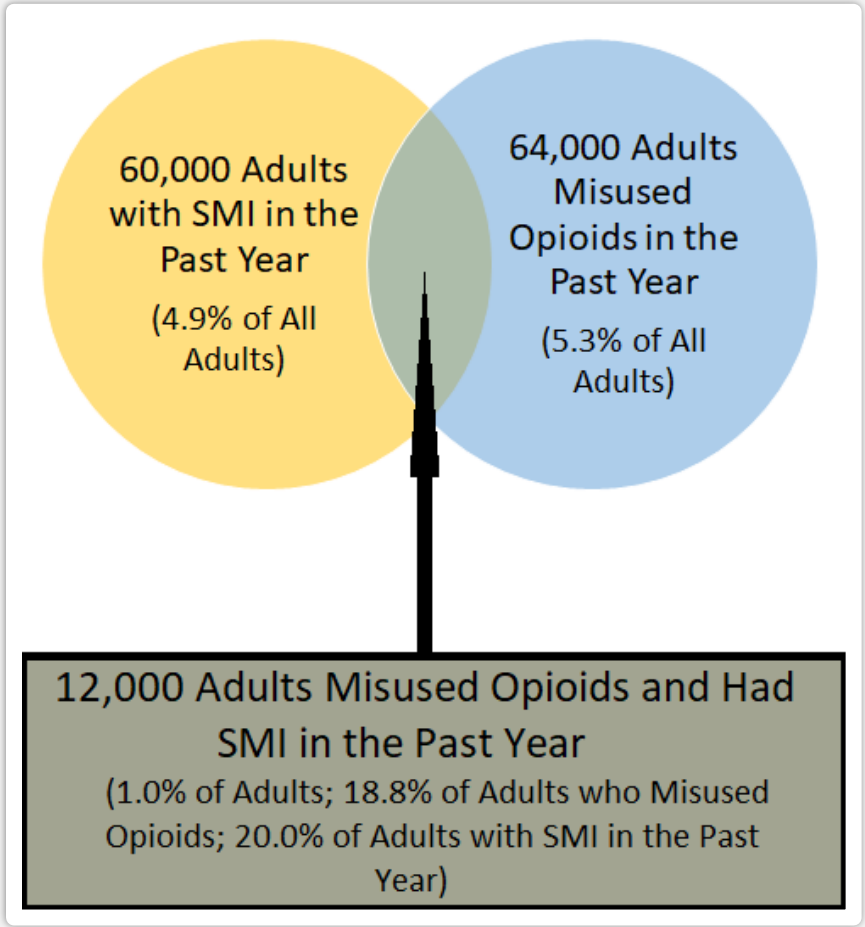
There are 196,000 persons of Hispanic or Latino ethnicity in Idaho, which is equal to approximately 12% of Idaho's total population.

- Canyon county has the largest gross number of Hispanics (489,941).
- However, Clark county has the highest percent of individuals reporting Hispanic or Latino ethnicity (47.3%).
- A large proportion of Jerome, Minidoka, and Power counties populations are also comprised of Hispanic persons.
- Clark and Power counties are Frontier counties, while Jerome and Minidoka counties are rural.

United States Census Bureau, American FactFinder, 2016

c. Mental Illness

Estimated Past Year Opioid Misuse and Serious Mental Illness (SMI) among Adults in Idaho (Aged 18 and Older); based on the NSDUH (2016)



Adults with serious mental illness appear to be at a greater risk of misusing opioids than adults in the general population. SAMHSA estimates that while only 4.6% of all adults nationally misused opioids in the past year, 15.8% of all adults with SMI misused opioids. These rates correspond to 11.3 million adults that misused opioids and 1.6 million adults that misused opioids and had SMI.

	n	%
USA		
Adults with SMI	10,058,000	4.1%
Adults who Misused Opioids	11,301,000	4.6%
Idaho		
Adults with SMI	60,000	4.9%
Adults who Misused Opioids	64,000	5.3%

	n	% of Adults	% of those with SMI	% of those who Misused Opioids
USA				
Adults who Misused Opioids and Had SMI	1,587,000	0.7%	15.8%	14.0%
Idaho				
Adults who Misused Opioids and Had SMI	12,000	1.0%	20.0%	18.8%

Based on the 2016 National Survey on Drug Use and Health, there are over 12,000 estimated adults in Idaho with both serious mental illness and opioid misuse in the past year. This corresponds to about 1.0% of all adults in Idaho, higher than the percentage seen nationally (0.7%).

SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016

IV. The Current Availability of Medication-Assisted Treatment in Idaho

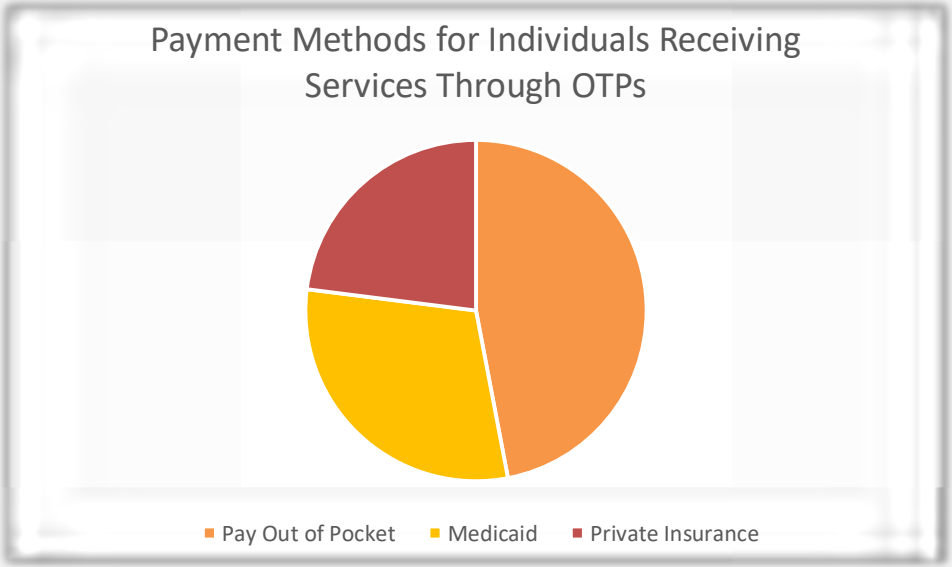
- Idaho has 2 Opioid Treatment Providers (OTP's) with a total of 3 locations which are all within Ada county.
  - Currently, one of the two agencies reports serving 541 patients with a total capacity of 675.
  - The second agency is serving 530 clients with a capacity of 800 between its 2 locations.

- In addition, Idaho has approximately 90 DATA 2000 waivered physicians.
  - We are currently in the process of determining which Office-based Opioid Treatments (OBOT's) and certified prescribers are prescribing up to their current limits and which ones are eligible to increase their limits and who has or has not and why.
  - We do not currently have a system in place to quickly gather that information due to MAT not historically being publicly funded in Idaho.

V. Current Programmatic Capacity in Idaho

In Idaho, there are only three Opioid Treatment Providers (OTPs) which provide methadone as a Medication Assisted Treatment.

- 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.
- Approximately 47 percent of the OTP clientele pay out of pocket, 30 percent have Medicaid, and 23 percent have private insurance.



Additionally, three Federally Qualified Health Centers (FQHCs) in Idaho are providing Suboxone under limited grant funding through the Health Resources and Services Administration (HRSA) but most of this funding has been exhausted. Those Centers, and the amount of funding they received are: Boundary Regional Community Health Center, Inc ($325,000); Community Health Clinics, Inc ($352,083); Dirne Health Centers ($325,000). With this funding, these three FQHCs agreed to implement Opioid Replacement Treatment Programs (ORTPs) serving a total of 90 Idahoans.

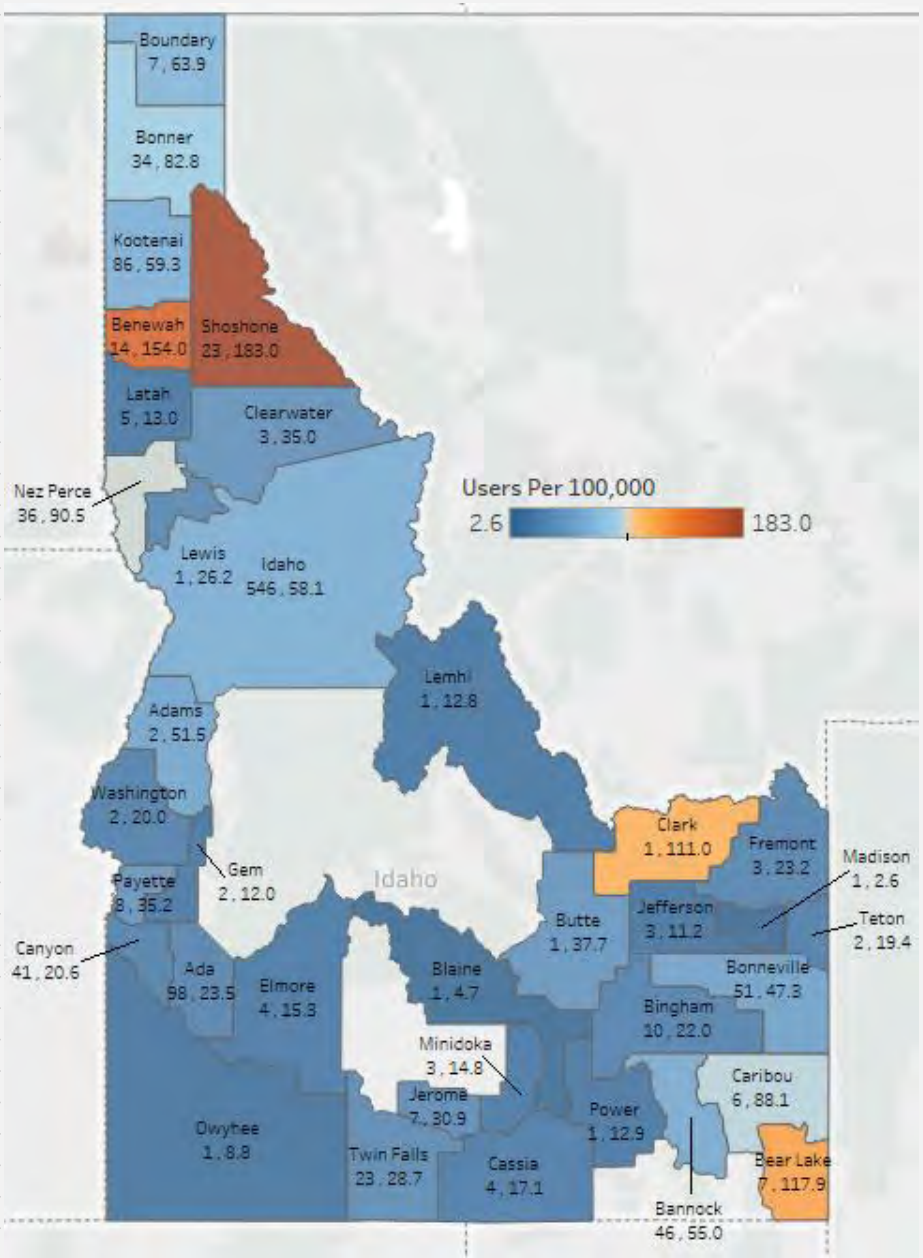
Idaho Medicaid Beneficiaries that Received Suboxone or Subutex in the Past Year by County, and Users per 100,000 Persons Based on US Census County Population Estimates (State Fiscal Year 2017)

There were 542 Idaho Medicaid beneficiaries that received Suboxone or Subutex in the past year (July 2016-July 2017) with an average of 33.5 users of Suboxone or Subutex per 100,000 persons.

- Ada county had the largest number of users (98 users), followed closely by Kootenai county (86 users).
- However, Shoshone county had the highest rate of users per 100,000 persons (183.0 per 100,000)
- The lowest rate of users per 100,000 persons was seen in Madison county (2.6 per 100,000).

Idaho Department of Health and Welfare, Medicaid Pharmacy Program; July 18-2016-July 17, 2017

COUNTY	USERS (N=542)	% (OF ALL USERS)	POPULATION	USERS PER 100,000
Ada	98	18.08%	417,501	23.5
Adams	2	0.37%	3,880	51.5
Bannock	46	8.49%	83,604	55.0
Bear Lake	7	1.29%	5,939	117.9
Benewah	14	2.58%	9,088	154.0
Bingham	10	1.85%	45,407	22.0
Blaine	1	0.18%	21,309	4.7
Bonner	34	6.27%	41,066	82.8
Bonneville	51	9.41%	107,788	47.3
Boundary	7	1.29%	10,961	63.9
Butte	1	0.18%	2,653	37.7
Canyon	41	7.56%	198,921	20.6
Caribou	6	1.11%	6,808	88.1
Cassia	4	0.74%	23,369	17.1
Clark	1	0.18%	901	111.0
Clearwater	3	0.55%	8,560	35.0
Elmore	4	0.74%	26,175	15.3
Fremont	3	0.55%	12,945	23.2
Gem	2	0.37%	16,731	12.0
Idaho	4	0.74%	16,312	24.5
Jefferson	3	0.55%	26,792	11.2
Jerome	7	1.29%	22,653	30.9
Kootenai	86	15.87%	145,046	59.3
Latah	5	0.92%	38,339	13.0
Lemhi	1	0.18%	7,790	12.8
Lewis	1	0.18%	3,812	26.2
Madison	1	0.18%	37,916	2.6
Minidoka	3	0.55%	20,279	14.8
Nez Perce	36	6.64%	39,779	90.5
Owyhee	1	0.18%	11,364	8.8
Payette	8	1.48%	22,700	35.2
Power	1	0.18%	7,731	12.9
Shoshone	23	4.24%	12,571	183.0
Teton	2	0.37%	10,285	19.4
Twin Falls	23	4.24%	80,004	28.7
Washington	2	0.37%	10,025	20.0
Idaho	542	100.00%	1,616,547	33.5



VI. Idaho's Prevention System

The current substance use prevention system in Idaho to address the opioid crisis is a collaborative, multi-disciplinary effort aimed at employing evidence-based prevention strategies and public policy initiatives to help Idaho become a state that is free from the devastating economic, health and social effects of substance misuse.

In the past several years, the Office of Drug Policy (ODP) has secured various coordinated funding streams to target opioid misuse including the Substance Abuse Block Grant, the Strategic Prevention Framework State Incentive Grant (SPF SIG), the State Targeted Response to the Opioid Crisis Grant, the Prescription Drug Overdose: Data-Driven Prevention Initiative Grant, and the Idaho Millennium Fund. Key stakeholders receiving funding for these grants have been able to work collaboratively to braid funding streams to maximize prevention and treatment support in Idaho communities.

Through these grant funds, activities conducted include administering evidence-based direct services conducted in schools, juvenile detention centers, and community centers; supporting substance abuse prevention coalitions and law enforcement prescription drug task forces; installing medication drop boxes in both law enforcement agencies and pharmacies; and collaborating with stakeholders.

i. Strengths

Idaho utilizes a variety of evidence-based practices in prevention education to support behavioral health among both youth and adults alike. Further, Idaho's Strategic Prevention Framework State Incentive (SPF SIG) Grant funded coalitions use evidence-based environmental strategies to target communities in drug prevention.

Similarly to communities relying on several partners to implement prevention strategies, the State of Idaho convenes several workgroups that include multi-sector committed partners in prevention. Although ODP and the Department of Health and Welfare (DHW), Divisions of Behavioral Health and Public Health are at the helm of the substance abuse prevention system, various other agencies' policy and activities work in concert to complete the work.

Two workgroups that facilitate improvement of opioid-related issues in the state include the Opioid Misuse and Overdose Workgroup and the State Epidemiological Outcomes Workgroup. The Opioid Misuse and Overdose Workgroup is composed of approximately 60 representatives in a variety of fields including the legislature, executive branch agencies, public health agencies, medical associations, treatment providers, law enforcement agencies, medical boards, coroners, family members, physicians, prosecutors, universities, Medicaid, and others. The mission of the workgroup is "a safe and healthy Idaho, free of opioid use and untreated opioid disorders". The workgroup has drafted a five-year strategic plan and is convening sub-committees to implement the action plans and meet the goals of the plan.

The State Epidemiological Outcomes Workgroup is a surveillance group whose mission is to assist the state through prevention assessment, planning, implementation, and monitoring effects to improve behavioral health among all Idahoans. This group is composed of various individuals employed at state agencies including ODP, DHW, the Idaho Supreme Court, the Idaho Department of Corrections, the Idaho Department of Juvenile Corrections, Idaho State Police, and Career and Technical Education, who have access to behavioral health data. Various reports have been compiled by members of this group to better understand opioid abuse and misuse in Idaho.

Collaboration is fundamental in passing policy initiatives to prevent opioid use and related consequences. Key pieces of state legislation have allowed for increased Naloxone availability to the public and first responders, a more robust prescription drug monitoring program (PMP), and partial prescription fills for patients who opt to limit their dosage of controlled substances.

ii. Areas of Improvement

In addition to Idaho's strengths, there are still areas of improvement. With an ever-changing landscape of drug prevention, continual education to key stakeholders is essential. Regarding opioid misuse, prescribers, patients, and the public should be well informed. In Idaho, prescribers could benefit from additional education regarding evidence-based prescribing guidelines, unintended consequences of inappropriate prescribing practices, effective PMP usage, and holistic or alternative options for treatment that do not include opioid prescriptions.

Patients with limited health autonomy or awareness may not have the tools to make informed decisions regarding their own pain management. Educated patients are more able to make decisions regarding their access to Naloxone, their ability to fill partial prescriptions, the consequences of opioid use, and their prerogative to choose alternative methods besides prescription opioids to reduce pain.

Improving the public's knowledge of opioid-related topics corrects perceptions of the opioid issue and improves the public's ability to influence other effective strategies, including policy change. Specific topic areas that should be addressed in public education are scope of the opioid issue, the reduction of stigma of addiction, and the opportunity for families to access support services.

There is room to improve prescribing practices. There is a large need for reinforcing prescribers who check the PMP; using PMP data strategically; maximizing value of the PMP, which may include the addition of reportable fields such as patient diagnosis; and integrating the PMP and electronic medical records. Considerations to improve prescribing practices are establishing prescriber buy-in, making compliance seamless, limiting the perception of pain as a fifth vital sign, establishing clear protocol, building in accountability standards, and improving insurers' ability to pay for alternative treatments for pain.

Regarding dispensing opioid medication, integration among prescribers, pharmacies, insurance agencies, and technology is important, but Idaho must work to integrate all behavioral health systems. Strategies to improve integration could include promoting the utilization of holistic approaches to pain management and the flexibility in insurance to cover these options, increasing the number of substance use disorder treatment providers and suboxone waivered physicians, using telemedicine to serve rural communities, incorporating recovery coach services to intervene with inmates in jails and prisons, encouraging medical professionals to practice at the upper end of their licenses, and the integrating Veteran Affairs (VA) and state public health policies and protocols.

In addition to limiting the supply of opioids through the above listed strategies, Idaho must also work to improve individual protective factors; family support services should be expanded. Faith-based and school-based resources and programs, home visiting programs, programs specifically for veteran, and other family-based programming would improve protective factors and reduce risk factors for later opioid use.

VII. Existing Prevention and Recovery Initiatives in Idaho

The state of Idaho's Naloxone access law required that ODP and DHW create and maintain an online education program for lay persons and the general public relating to opioid-related overdoses. ODP adapted four separate Naloxone training videos, two in Spanish, two in English, to provide information on both injection and nasal methods of Naloxone administration. The videos are housed on ODP's and the DHW's websites. Total view counts for the videos, as of July 13, 2018, are as follows:

Video	Views
English (Injection):	451
English (Nasal Spary):	333
Spanish (Injections):	189
Spanish (Nasal Spray):	313

ODP partnered with an internist in the Boise area to develop a Naloxone presentation that is adaptable to educate a variety of audiences. As of July 20, 2017, ODP had conducted eight (8) of these trainings for medical providers, prevention professionals, and the Idaho Behavioral Health Board leadership committee.

The state of Idaho does not house an official registry of individuals or entities trained in overdose education and Naloxone administration.

VIII. Policy & Legislation Proposed or Enacted in Idaho Related to the Opioid Overdose Crisis; including the Overall Socio-Political Environment that is Supportive of MAT

Idaho is a very conservative state. Priding itself on agriculture and the great outdoors, you will frequently hear that "Idaho is a pick-yourself-up-the-bootstraps state" in the halls and session rooms of the State Capitol. Idaho takes a very conservative approach to social service provision, emphasizing local community and faith responses to need, rather than "another government program" saving the day. In this same vein, the Idaho State Legislature is not keen on accepting federal mandates and has, more than once, fought back in the court room over such mandates. In this environment, it is no surprise that Idaho has not expanded Medicaid. IDHW, along with its many partners, has put significant amount of effort into educating lawmakers, the public and just about anyone else who will listen on the fact that addiction is a disease and we must treat it as such.

Accessing MAT using public funding is difficult in Idaho. Medicaid is currently the only public payor we are aware of that reimburses for MAT services, but they will only reimburse for Suboxone/Buprenorphine for pregnant women. The access is further limited by the number of patients a doctor can prescribe for.

A recently acquired SAMHSA grant will 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 Opioid Use Disorder (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 OUD specialty clinical 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.

i. Overview of Policies and Legislation Over the Last Several Years:

2014

- Passed legislation requiring prescribers to register for access to the Prescription Monitoring Database.

2015

- Passed legislation to enable pharmacists prescriptive authority of opioid antagonists. Any person or entity can now possess an opioid antagonist.

2016

- Passed legislation to enable delegate access to the PDMP. Delegates may search on behalf of a prescriber or dispenser in their usual course of business
- Passed legislation to enable coroner and medical examiner access to the PDMP
- Changed PDMP program policy to allow access through PMP Gateway®

2017

- Passed legislation mandating pharmacists must register to access the PDMP
- Passed legislation enabling the Board of Pharmacy to schedule drugs in rule upon a change in DEA schedule
- Adopted regulations on reporting time frame for PDMP. All controlled substances must now be reported by the end of the next business day.
- Adopted rules to require reporting of controlled substance dispensing from any outpatient drug outlet – including emergency departments and prescriber drug outlets.
- Adopted regulations allowing drug takeback programs in accordance with federal law.
- Adopted regulations allowing partial fills of schedule II drugs in accordance with federal law.

Legislation passed in 2015 made Naloxone available to anyone in Idaho by simply asking their pharmacist. The bill allows people suffering from a drug use disorder or their friends and family members to obtain Naloxone. It also allows for pharmacists to prescribe Naloxone directly so patients can access it without first having to go to a traditional prescriber. Under Idaho's Good Samaritan Law, the Naloxone statute shields anyone who administers Naloxone from liability if the person receiving it calls 911. Idaho law also affords liability protections for pharmacists and other prescribers who initiate Naloxone. As Idaho allows pharmacists to prescribe Naloxone, standing orders for Naloxone and listed guidance for it are not needed.

IROC funding will be used to increase the use of Naloxone to reverse opiate overdoses through training and provision of Naloxone to first responders and other community members (including FQHCs) 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, community and provider trainings, and by providing Naloxone kits to identified and trained entities.

The Opioid Misuse and Overdose Workgroup mentioned above was created by the governor's task force. The Workgroup met earlier this year at a two-day conference to address a Strategic Plan. The group has since met once and will be meeting monthly to address the current crisis and short and long term tactics. In addition, the ODP has established a Prescription Drug Abuse Workgroup which has worked on introducing and passing legislation surrounding the use and availability of Naloxone as well as other prevention tactics throughout the state.

IX. The Current Evidence-Based, Evidence-Informed, and Promising Practices in Place for Prevention Efforts in Idaho

i. Media Campaigns, including Intended Audiences and Messages

Lock Your Meds Idaho

ODP, in partnership with the former Prescription Drug Workgroup, secured funding for the Lock Your Meds campaign through the Millennium Fund. The campaign was delivered statewide through TV, radio, bus ads, billboards and digital advertising. The campaign targeted adults 35+ with teenagers living in the household to "be aware, don't share, lock up your meds" to prevent diversion among youth. The campaign evaluation showed that over 66 percent of Idahoans heard the message which changed storage habits for 16 percent. The evaluation also showed a statistically significant increase in concern of risk among parents of teenagers.

Naloxone Brochures

ODP developed a tri-fold brochure for anyone who may benefit from having Naloxone administration kits on hand; including but not limited to family members or friends of individuals who misuse opioids, individuals who misuse opioids, emergency medical services personnel, treatment providers, social workers, and other behavioral health workers. The brochure message includes recognizing the signs of overdose, administering Naloxone, obtaining Naloxone, and understanding opioids and their risk.

ii. Other Funded Programs Addressing the Opioid Crisis, i.e. PDO, SPF-RX, and Medication Drop Off Sites

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 to 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 costs associated with the program.

The Idaho Division of Public Health received a grant under the CDC's Prescription Drug Overdose: Data-Driven Prevention Initiative funds. The Prevention in Action component of the grant is designed to directly target the problem of prescription drug misuse and overdose, by focusing on the Idaho Prescription Drug Monitoring Program (PDMP). Both functionality and utilization of the PDMP are targeted. Improvements to the functionality of the data system include the application of software which will allow the Idaho PDMP to interact directly with prescribers' electronic health records, and a pilot trial of NARxCHECK, an analytics engine that automates access to PDMP data and analyzed it for multiple factors that are indicative of potential risk of prescription drug misuse. In addition to the improvements to the system, utilization increased by specific educational efforts to train prescribers in the use of the PDMP.

iii. Strategic Prevention Framework State Incentive Grant (SPF SIG)

The SPF grant is a pass-through grant of approximately $100,000 each year for five years awarded to 16 substance abuse prevention coalitions statewide. The funding is used to address prescription drug misuse in communities through mobilizing resources and stakeholders to implement environmental strategies. Environmental strategies utilized by the coalitions include, but are not limited to collaborating with law enforcement for DEA drug take-back days and establishing permanent drug take-back programs, educating the public via programs and campaigns, conducting town halls, and developing policy initiatives. Additionally, the SPF SIG funds eight (8) law enforcement agencies conducting a range of prevention activities. One law enforcement agency was funded to develop a prescription drug task force.

Prescription Drug Overdose: Data-Driven Prevention Initiative (funded by the Centers for Disease Control & Prevention)

The DDPI grant program aims to help states advance and evaluate actions implemented to address opioid misuse, abuse, and overdose. The Department of Health and Welfare, Division of Public Health received the DDPI grant to carry out the following actions:

- Identify currently available resources and key state-level stakeholders
- Conduct a needs assessment of key stakeholders, facilitated by ODP, to better understand the prescription opioid and heroin misuse landscape
- Convene key stakeholders for a strategic planning meeting to review and discuss gaps and to discuss prescription drug monitoring and misuse prevention. This meeting will be facilitated by the Idaho Prescription Drug Workgroup with support from ODP. The workgroup includes multiple state-level stakeholders with a strong interest in prescription drug abuse prevention (detailed in the Collaborations section below)
- Develop a strategic plan to improve public health access and use of Idaho Board of Pharmacy PMP data for public health surveillance and improving opioid prescribing practices in the state of Idaho
- Develop a plan, implemented jointly with partners, to improve PMP utilization, meaningful use, unsolicited reporting and public health application of PMP data statewide and perform routine collection, analysis, and dissemination of data from the PMP and other key sources.
- Identify areas in the state with increased opioid prescribing that can the focus of targeted interventions to change/reduce prescribing practices
- Improve coroner reporting practices
- Fund prescribers and pharmacists to implement Gateway which provides direct access to the PDMP into their electronic medical records
- Fund all Idaho local public health districts to provide prescriber education, directly by health educators, and by identifying physician champions to provide peer-to-peer education.

Millennium Fund

The State of Idaho used tobacco settlement money to create the Millennium Fund and the joint legislative Millennium Fund Committee. The Committee awards to state agencies and community organizations annually, through a competitive grant process, to carry out substance abuse prevention and treatment programs.

ODP received funding from the Millennium Fund to implement the Lock Your Meds media campaign for state fiscal year 2014. Further ODP, in collaboration with the Idaho Board of Pharmacy, was awarded a grant to develop a mini-grant program for retail pharmacies to implement drug take-back programs.

iv. School and Community Education Programs

Truth 208

Truth208 is a youth prescription drug misuse media campaign and education series that reveals the truth about prescription drug misuse. The messaging focuses on making adolescents and teens aware of the harms of prescription drugs through TV, radio, bus ads, billboards and digital advertising. Additionally, an education component is available for Idaho schools, juvenile detention facilities, and drug courts to bring in speakers to present factual information on prescription drug use.

Truth 208 has also implemented the environmental strategies of establishing drug take back programs in 46 law enforcement locations statewide, hosting take back days in each public health district, and providing free posters and rack cards in English and Spanish to the public.

v. The Location of Prevention Efforts

Geographically

To ensure funding is proportional, the Office of Drug Policy uses an established formula to determine the allocation of Substance Abuse Block Grant (SABG) Primary Prevention funds. An initial base award of $50,000 is made to each of the seven public health district regions. The remaining available trustee and benefit funds are divided based upon the most recent population data per region. For example, our least populated region receives 9% of available funds, while our most populated region receives 25% of available funds.

The Office of Drug Policy funds 16 community coalitions across the state, in each of the seven health districts, which must address prescription drug misuse in their communities. Despite regional coverage, there are areas that could benefit from additional prevention services.

Per the Bureau of Vital Records and Health Statistics, between 2013 and 2015 Bonneville and Bannock County had significantly higher drug-induced mortality rates compared to the state rate. Although not all drug-induced deaths are opioid-related, nationally approximately 6 out of 10 drug-related deaths are opioid-related (Rudd et al., 2016).

In addition to these two counties, researchers have identified rural populations being at a considerably higher risk for opioid misuse than more urban areas. These differences have been, in part, explained by greater distance to health care professional, which may increase opioid prescribing to offset burden of travel; migration of young adults to urban areas; greater opportunity for networking which may facilitate diversion; and economic stressors (Keyes et al., 2014). Idaho's rural and frontier communities warrant special consideration when planning a response to Idaho's opioid crisis

Systematically

Systematically, there are several areas of unmet needs in prevention. Methadone clinics do not report dispensed methadone to the PMP. Although division is difficult to quantify with current measures, lack of reporting to the PMP exacerbates the issue. The VA is also not required to report to Idaho's PMP. As an already vulnerable population is subject to administrative loopholes and differences in policy and procedures, it is more likely that veterans are at disproportionate risk of misusing opioids.

As previously mentioned, complementary and alternative medicine, including physical therapy, are solutions often underutilized for chronic pain. Providing a greater abundance of alternative services in rural communities and connecting pain specialists and general practitioners with the information they need to make referrals to these services would increase utilization.

Ultimately, without individuals available to implement strategies to the public, it is likely that the opioid issue will persist. Idaho has a very limited substance abuse prevention workforce. According to a workforce development survey administered by ODP in 2016, approximately 36% of the prevention workforce in Idaho provides services for less than 5 hours per week and 15% have not had any training in the last two years. Additionally, over 66% of Idaho's prevention workforce is over the age of 45, which emphasizes a great need for recruitment.

X. The Existing Recovery Support Initiatives in Idaho, including a Description of their Current Involvement and Capacity for Addressing the Opioid Crisis

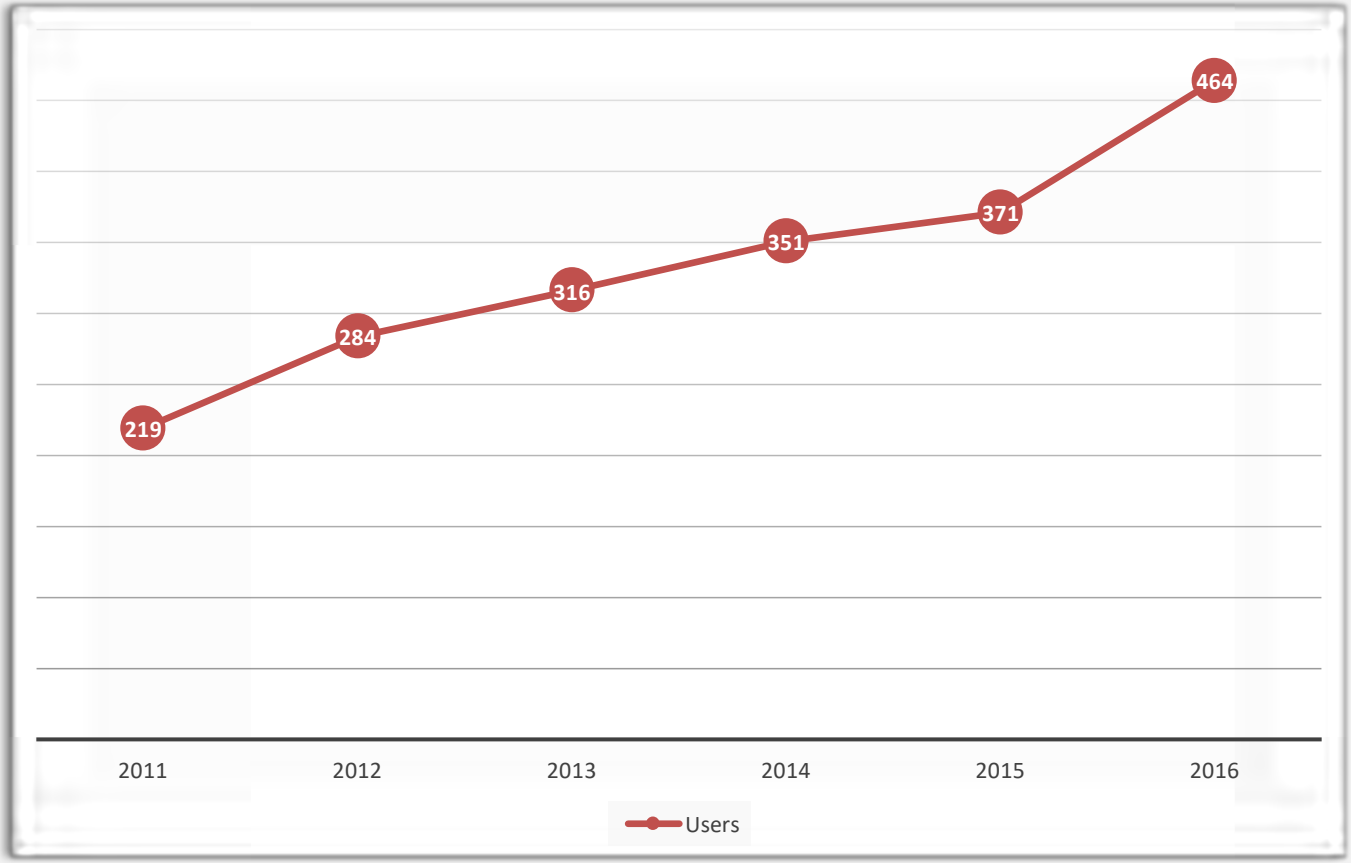
Recovery Community Organizations

Recovery Idaho (RI) is Idaho's umbrella recovery community organization. While still in its infancy, RI is working to provide Recovery Coach training across the state, support Idaho's 7 recovery centers and advocate against stigma. Idaho's seven (soon to be eight) recovery centers are in every region of the state. These centers are also very new yet already provide an immense amount of resources and support for those individuals seeking to adopt a life style of recovery. Most centers are struggling with securing on-going funding to keep the doors open. The centers are modeled after the Connecticut Community for Addiction Recovery (CCAR) centers located in Connecticut, offering services such as: support groups, networking, smoking cessation, employment support, sober activities, etc.

Idaho has over 500 trained recovery coaches. We also have a IC&RC affiliated certification for recovery coaches. The SABG, along with the Idaho Department of Corrections currently reimburse for these services; Medicaid does not.

XI. Persons Served with Public and Private Funds in DATA 2000 Buprenorphine Waiver Provider Practices (including FQHCs) in Idaho

Idaho Medicaid Buprenorphine and Buprenorphine/Naloxone Utilization (2011-2016)



Idaho Medicaid Buprenorphine and Buprenorphine/Naloxone utilization has increased consistently since 2011.

Division of Medicaid (September 2017)

Total Number of Persons Served with Private Funds

Idaho does not have the capability to track the total number of persons served with private funds at this time.

XII. Other Existing Activities and their Funding Sources in Idaho that Address Opioid Use Prevention, Treatment, and Recovery Activities

While Idaho is most definitely experiencing a significant increase in opiate and heroin use, misuse, and death, the opiate epidemic here has not yet reached the proportions that other states in the Midwest and East Coast are facing. Thus, coordinated efforts to combat this epidemic are just now coming to fruition in this state.

The funding offered through SAMHSA's State Targeted Response has shed a lot of light on this serious issue and, thus, many individuals and entities are showing an interest and wanting to become involved.

Partnerships are being formed on an on-going basis. These partnerships will be invaluable as we move forward toward getting our arms around the problem…before Idaho's epidemic hits the epic proportions that other states are experiencing.

XIII. Discussion and Conclusions

i. Indicators of Heroin and Non-Heroin Opiate/Synthetic Use, Misuse, and Dependence

Non-Heroin Opiate/Synthetic Use

Since reaching a peak in 2010-2012, much of the data we have identified appears to show a leveling off, or even a modest decrease, in non-heroin opiate/synthetic use in Idaho.

For instance, after a steady increase in the overall opioid prescribing rate from 2006, the total number of prescriptions dispensed peaked in 2012 and has fallen since to its lowest rate in more than 10 years in 2016. This trend is seen also seen clearly in the prescription-drug related arrest rate per 1,000 residents. While the prescription drug arrest rate increased 2.5 fold from 2007-2016, the arrrest rate appears to have leveled off over the past 5 years. Similarly, the percentage of total admissions to Idaho's publicly funded Substance Use Disorder Treatment Network in which opiates other than heroin were listed as the primary reason for admission decreased 0.88% from Fiscal Year 2014 to FY2017. In total, opiates other than heroin were associated with 8.71% of admissions (756 of 8,682) in Fiscal Year 2017 which represented a 1.66% decrease from FY2014. Idaho has also remained slightly below the national average in NSDUH-reported lifetime use of prescription drugs without a doctor's prescription, though the difference is not significant.

These trends suggest that it is possible some improvements in opioid prescribing practices throughout the state are being reflected in indicators of non-heroin opiate/synthetic use. Another indication of desirable opioid prescribing practices is that prescribing has been shown to increase steadily with age in Idaho, which is consistent with a general increase in the prevalence of chronic pain with age (as would be expected).

Nevertheless, as SAMHSA recently showed an increase in opioid misuse among older adults (age 50+) in The CBHSQ Report (Opioid Misuse Increases Among Older Adults; July 25, 2017), future monitoring of this age-related trend and older age-group may be warranted. Additionally, the Centers for Disease Control saw that in 2016 Idaho was above the national average for the rate of opioids dispensed per 100 population, though as previously noted this rate has decreased over time. This demonstrates that there is still work to be done in Idaho and a significant need to improve prescribing practices throughout the state.

Heroin Use, Misuse, and Dependence

While non-heroin opiate use has shown a decreasing trend since 2012, Idaho appears to have seen an even faster increase in heroin use over the same period per the data we have identified. Several indicators of heroin use, misuse, and dependence have increased alarmingly in Idaho over the past decade.

Notably, between 2007 and 2016, the heroin arrest rate in Idaho increased 23-fold. Heroin was associated with 14.99% of admissions to Idaho's publicly funded Substance Use Disorder Treatment Network in Fiscal Year 2017 which represented a 4.20% increase from FY2014. The percentage of total admissions in which heroin was listed as the primary reason for admission likewise increased 4.76% from FY2014 to FY2017.

Drug-Induced Deaths

Drawing conclusions from Idaho's opioid-involved death reporting is difficult for several reasons.

- First, the types of drugs involved with drug-induced deaths are underreported statewide and thus the true number of opioid-involved drug-induced deaths is likely higher than what is observed.
- Second, certain counties (including some of Idaho's most populated) have an especially large percentage of drug deaths with no drug(s) specified on the death certificate. Our analysis found 11 Idaho counties in which more than half of drug-induced deaths did not have a drug specified during the observation period. As a result of this substantial underreporting, the true number of opioid-involved drug-induced deaths may be particularly impacted in these counties. The lack of consistent reporting throughout the state also makes comparisons across counties difficult.
- Finally, drawing conclusions based on the rate of opioid-involved drug-induced deaths is difficult in Idaho as the small population size of many counties can cause even one death to drastically change the rates observed.

The most recent data available regarding drug-induced deaths appears to show that while rates have increased in Idaho since 2012, Idaho remains slightly lower than the national average. In 2016, Idaho ranked 36th in the age-adjusted rate of drug-induced deaths by state. It is estimated that more than half of all drug deaths were associated with an opioid (62.0%).

From 2012-2016 there were 1,140 drug-induced deaths among Idaho residents. Of the 1,140 deaths, 752 death certificates (66%) did specify one or more drugs. Of the 752 drug-induced deaths in which the death certificate specified the type of drug or drugs, 466 (62%) specified one or more opioid drug(s). Corresponding to its large population size, Ada county had the largest gross number of drug-induced deaths with opioid drugs specified on the death certificate from 2012-2016 (154 deaths).

Since 2011 the proportion of opioid-related drug-induced deaths attributed to heroin appears to have increased significantly, while overall the number of deaths per year has remained fairly consistent year-to-year. It is unclear if this trend is related to the apparent increase in heroin use described above, or possible changes in reporting resulting in an increase in documentation of heroin on the death certificate.

Providing education and resources to county coroners to improve the accuracy of reporting drugs involved in drug-induced deaths, and ensuring consistent documentation of these drugs, would improve monitoring of drug-induced deaths in Idaho and allow for more accurate analysis of data and trends.

ii. Identified Gaps in Treatment and Services

Current Programmatic Capacity and Policy/Legislation Proposed or Enacted within your State/Jurisdiction Related to the Opioid Overdose Crisis Including the Overall Socio-Political Environment that is Supportive of MAT

Accessing MAT using public funding is difficult in Idaho.

There are only three Opioid Treatment Providers which provide methadone as a Medication Assisted Treatment, all located in the same county (Ada). 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.

Medicaid is presently the only public payor that reimburses for MAT services and will only reimburse for Suboxone and Subutex for pregnant women. Access is further limited by the number of patients a doctor can prescribe for.

A recently acquired SAMHSA grant will introduce publicly-funded MAT to Idaho by adding Methadone and Suboxone to the array of treatment and recovery support services that are currently available. Through the MAT program, IROC will seek to provide services to no less than 250 Idahoans per year who are in need of medication. IROC funding will be used 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 encounter individuals at risk of opiate overdose.

Reporting to the PMP

Methadone clinics do not report dispensed methadone to the PMP, and the VA is also not required to report to Idaho's PMP. This makes many measures difficult to quantify.

Complementary and Alternative Medicine

Providing a greater abundance of alternative chronic pain solutions and services, such as physical therapy, in Idaho's rural communities and connecting pain specialists and general practitioners with the information they need to make referrals to these services would increase utilization.

Substance Abuse Prevention Workforce Shortages

Over half of Idaho's prevention workforce is over the age of 45, which emphasizes a great need for recruitment. In addition, approximately 36% of the prevention workforce in Idaho provides services for less than 5 hours per week and 15% have not had any training in the last two years. Idaho needs an expanded substance abuse workforce to implement strategies to the public.

Hispanics/Latinos

On the Youth Risk Behavior Survey, Idaho Hispanic youth appeared more likely to report heroin use compared to the general population of youth in Idaho and Hispanic youth nationwide. As such, prevention strategies should be culturally competent and tailored to Idaho's Hispanic population. Rural counties located in the southern half of Idaho are comprised of particularly high concentrations of Hispanic persons, and consequently represent areas where culturally-tailored support is principally needed. Canyon County in the southeast region of the state has the largest overall Hispanic population.

Serious Mental Illness and Opioid Misuse

Adults with serious mental illness (SMI) appear to be at a greater risk of misusing opioids than adults in the general population. Based on SAMHSA statistics and the 2016 National Survey on Drug Use and Health, there are over 12,000 adults in Idaho estimated to have both serious mental illness and opioid misuse in the past year. This corresponds to about 1.0% of all adults in Idaho, higher than the percentage seen nationally (0.7%). With 18.8% of those who misused opioids also suffering from SMI (and, alternatively, 20.0% of those with SMI misusing opioids) this small but significant population should not be neglected in Idaho's response to the opioid crisis. Again, Idaho must continue to work to integrate all behavioral health systems throughout the state.

Adolescents, Young Adults, and Public Knowledge

Our results consistently show that adolescents and young adults in Idaho are a particularly high-risk population for heroin and non-heroin opiate/synthetic use, misuse, and dependence.

Young adult Idahoans age 18-25 were the most likely age group to report past year heroin and nonmedical use of prescription pain relievers according to the 2016 National Survey on Drug Use and Health. 0.6% of those ages 18-25 in Idaho reported past year heroin use compared to just 0.4% of all adults (age 18+) and nearly 10% of those ages 18-25 reported misusing prescription pain relievers, as opposed to just 5% of the general adult population (age 18+) in Idaho.

Evidence-based practices in prevention are currently used by the substance abuse prevention system in Idaho in education targeting youth. Activities conducted include administering evidence-based direct services in schools, juvenile detention centers, and community centers. In addition, Truth208 is a youth prescription drug misuse media campaign and education series that reveals the truth about prescription drug misuse, and an education component is available for Idaho schools, juvenile detention facilities, and drug courts to bring in speakers to present factual information on prescription drug use. Lock Your Meds Idaho was a media campaign targeting adults 35+ with teenagers living in the household to prevent diversion among youth. The campaign evaluation showed that over 66 percent of Idahoans heard the message which resulted in changed storage habits for 16 percent. The evaluation also showed a statistically significant increase in concern of risk among parents of teenagers. Ideally, these results should be reflected in future YRBS and NSDUH studies.

While the above youth-targeted education practices are already making strides in addressing opioid use amongst adolescents and young adults, continued effort should be made to improve the public's knowledge of opioid-related topics to correct perceptions of the opioid issue and improve the public's ability to influence other effective strategies, including policy change. Particular attention should be directed towards improving

prevention strategies aimed at Idahoans aged 18-25, a group which has been historically shown to be difficult to reach, especially those who do not choose to attend a university.

In addition, counties with significant populations of young Idahoans represent areas where support could potentially be particularly beneficial. Ada county has the largest gross number of adolescents and young adults, while Madison county has the highest rate of adolescents and young adults per 1,000 persons.

OPIOID NEEDS ASSESSMENT

Idaho's Response to the Opioid Crisis

Planning Step #2

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

This step should identify the unmet service needs and critical gaps in the state's current M/SUD 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 M/SUD 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.

A data-driven process must support the state's priorities and goals. 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, , 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 disorder prevention, 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.

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[16] 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.

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

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

The Office of Drug Policy (ODP) completed a Substance Abuse Prevention Needs Assessment for Idaho in 2017 (https://prevention.odp.idaho.gov/wp-content/uploads/sites/33/2018/03/2017-Needs-Assessment_Final.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 Idaho Department of Education, Drug Enforcement Administration, 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 compile the following analysis of substance use disorder prevention efforts in the state of Idaho. Both quantitative and qualitative data were included in this process. Report and data-system data were supplemented by information from prevention providers' completed satisfaction surveys, and stakeholder key informant interviews (including community members, educators, and law enforcement).

According to the U.S. Census Bureau's national and state population estimates, Idaho is the nation's fastest-growing state. Our population increased 2.2 percent to 1.75 million from July 1, 2016 – July 1, 2017. "Domestic migration" is identified as the driving force behind the growth, and the Idaho Department of Labor's population model projects that the state population will continue to grow at an annual rate of 1.1% through 2026. An increasing population is one factor impacting current prevention efforts. The information below summarizes the key findings of the state's unmet prevention service needs and critical gaps within the current system considering specific populations required by the block grant:

Data Limitations

- A lack of surveillance infrastructure and limited data regarding sexual orientation data, returning veterans, young adults (ages 18-24), and racial and ethnic minority populations remains. There is often not enough known about these subpopulations in Idaho to clearly identify local-level concerns and local-level prevention responses. For example, 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.
- Data systems are often inconsistent and incomplete, resulting in gaps in terms of data available for prevention planning. ODP utilizes its own data collection system to collect basic demographic and process information as well as outcome information recommended in CSAP's core measures. All sub-recipients that receive SABG prevention grants from ODP, are required to use the reporting system. ODP uses this data to inform decisions regarding evidence-based programming. While provider compliance with data reporting has significantly improved with targeted training and technical assistance, comprehensive program outcome data is often lacking. Obtaining

comparable, consistent data across communities has proven challenging.

- A critical challenge for Idaho's 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.

Workforce Shortages

- Data collected in ODP's 2016 Workforce Survey and 2019 Grantee Satisfaction Survey indicates Idaho's prevention workforce is aging and there is a shortage of providers. Recruitment of new providers is not keeping pace with the number of those retiring. Solutions are needed to expand the workforce and support prevention. With Idaho's growing population, there is a distinct need for more information, programs, and outreach by providers, especially in languages other than English that are culturally competent.
- ODP has worked with the Idaho Board of Alcohol/Drug Counselor's Certification (IBADCC) to promote prevention knowledge and best practices in the field, as well as to increase the number of prevention professionals in Idaho. ODP requires that at least one member of each agency/organization receiving SABG funds to deliver prevention services hold a Certified Prevention Specialists (CPS) credential. However, a clear path forward obtain CPS status has been lacking. Technical assistance for participants to assist in navigating the credentialing process, exam preparation to achieve certification, and compliance with continuing education requirements is needed.
- Key informant interviews across the state indicate additional training is needed for individuals in positions that regularly encounter substance misuse who often fail to recognize the signs and symptoms, or what to do in response. This would include school personnel, youth group leaders, law enforcement, and other community professionals.

Service Gaps

- Regional key informants identified subpopulations that may have limited access and exposure to resources available for prevention. These include people speaking a language other than English, youth, and people that are lesbian, gay, bisexual, transgender and questioning (LGBTQ). The rate of older adults with dependence on opioids has also increased in recent years, pointing to the importance of surveillance to identify emerging populations and develop targeted prevention efforts.
- Continued attention and work to collaborate across behavioral health systems is important to achieve the long-term goal of successful integration. Early intervention programs are limited. Youth at high risk due to drug misuse by parents in the home require supports that are not always available. Cross-sector training and education are promising approaches to better align and integrate prevention efforts.

Changing Trends

According to the 2017 YRBS report, alcohol, marijuana and e-cigarettes/vape devices are the top three most commonly misused substances by Idaho teens.

- The percentage of Idahoans, 12 to 17, reporting alcohol use in the past month was lower than the national average in 2016/2017, 9.07% to 9.54%, and that rate remained steady from the 2015/2016 NSDUH to the 2016/2017 NSDUH.
- Legalization and the normalization of marijuana by neighboring states continues to have an impact on behavioral health and substance misuse in Idaho. The percentage of Idahoans, 12 to 17, reporting marijuana use in the past month was lower than the national average in 2016/2017, 6.34% to 6.46%, but has increased between 2012, 5.61%, and 2017, 6.34% (NSDUH, 12/13 – 16/17).
- Vaping and e-cigarettes have emerged among the youth populations as a new issue and pressing concern. The percentage of Idaho high school students reporting using electronic vapor products in the past 30 days was higher than the national average in 2017, 14.3% to 13.2%, but there was a decrease in the percentage of Idaho high school students using electronic vapor products from 2015 to 2017, 24.8% to 14.3% (YRBS, 2015-2017).

Often conflicting or uncoordinated data limits responsiveness to these emerging trends. For example, to date, data assessing past month youth use of opioids has not been available. Only past year data has been collected: The percentage of Idahoans, 12 to 17, reporting pain reliever misuse in the past year was higher than the national average in 2016/2017, 3.45% to 3.31%, but has decreased from 2015/1016 when past year use amongst Idahoans aged 12 to 17 was at 4.08%.

How the state plans to meet the unmet service needs and gaps.

To remedy **data limitations** regarding Idaho's subpopulations, ODP continues to 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. 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 young adults through community colleges and state universities.

For the 2020-2021 planning cycle, ODP will continue to assist providers and coalitions with ongoing training and technical assistance related to data collection. Introductory webinars are made available to all new and returning grantees to ensure providers understand what data collection is required and how to correctly capture and report the data.

To obtain community-level survey data, ODP formulated a behavioral health survey that would better meet our needs The Idaho Healthy Youth Survey (IHYS) was first administered in the fall of 2017. A second administration of the IHYS is scheduled for the fall of 2019. The survey includes a comprehensive listing of substance abuse-related components and indicators that

ODP will use as a guide to establish prevention priorities for the state, counties, and municipalities and guide prevention planning.

To address **workforce shortages,** ODP has recently completed a formal Prevention Workforce Development Plan using data from the 2016 Prevention Workforce Development Survey Results; 2019 Grantee Follow Up Survey; and the 2018 Idaho SPF SABG Grant Program Annual Aggregate Statewide Evaluation Report. The plan clearly identifies the steps ODP staff will take over the next five years to recruit and retain a high-performing workforce capable of delivering the comprehensive prevention services needed to affect school and community change and prevent alcohol, tobacco, and other drug use. (See attached report) Continued communications with Idaho's state credentialing board is needed to evaluate current CPS training/licensure issues is needed.

Ongoing regional and state-wide educational opportunities, including monthly webinars from the Region 10 PTTC, offer high-need communities with specific priority populations access to current information and develop skills regarding problem identification and early referral.

ODP has completed the first step in mapping areas of need and corresponding existing prevention services and is working to utilize existing data to "zero -in" on the identified **service gaps.** In 2017, 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 service gaps. 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.

Collaboration with the state's seven Public Health Districts, initiated with the PFS grant, provides opportunities to expand prevention's reach and builds capacity to address unmet service needs. Continued integration of prevention, intervention and treatment opportunities will better serve Idaho's population.

Planning Step #2

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

The numbers reported in this table are estimates of the Idaho Department of Health and Welfare's Division of Behavioral Health, based on available data. The numbers represent best estimates, which reflects the limitation of our reporting and information systems, including that Idaho does not have a data team assisting with the collection of Mental Health System Data Epidemiology at this time other than what is generated from out Electronic Health Record, Web Infrastructure for Treatment Services (WITS). The available information and estimated numbers above for SMI were calculated from the 2018 Census for Idaho, https://www.census.gov/quickfacts/ID, while the children with SED calculated numbers came from the YES Project Class Size Estimation Team in 2017. The estimated incidents are based off of figures found in the SAMHSA 2015 Idaho Behavioral Health Barometer's assessment that 47.5% of adults with any mental illness will receive treatment or counseling.

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	70, 572	33,522
2. Children with SED	35,000-40,000	12,000-22,000

The Behavioral Health Administration and Program Managers review utilization data. The data can include regional admission and discharge rates and regional hospital bed utilization patterns. Regional rates of discharged clients successfully keeping their first Children's Mental Health (CMH) appointment and the 30-day readmission rates can also be shared and reviewed. In addition, problem cases can be identified as having barriers to prompt and/or successful community placement are reviewed.

Analyses on the system capacity needs for Jeff D. Class Members has been conducted and for further study into system capacity 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 following steps are in place through workforce development to maintain and enhance system capacity are:

- Adjust the Workforce Development (WFD) Plan based on Gaps identified in the Boise State University survey with on-going analyses through the use of Praed helping us to look at our Child and Adolescent Needs and Strengths (CANS) data (See attached document titled "Idaho Youth Empowerment Services (YES) Workforce Capacity and Gaps Analysis").
- Work with the Regions to implement Transformational Collaborative Outcomes Management (TCOM) Collaborative Statewide by the fall 2019.
- Continue to provide training on practices that are effective (evidence based, evidence informed and proven practices) but are currently not utilized extensively.
- Make YES Training efforts sustainable by partnering with institutions of higher education to develop curriculum materials and certificate programs that meet the State's needs.
- Incentivize clinical training sites in targeted areas to train graduate student interns and trainees in YES service delivery models.
- Partner with other Idaho State agencies, such as the Idaho Bureau of Labor to inform workforce development.
- Develop YES Core Competencies for Workforce and Leadership.

The state of Idaho uses the estimation methodology for adults and children required by the Substance Abuse and Mental Health Service Administration's Center for Mental Health Services (CMHS) and the National Prevalence figures prepared for the Mental Health Statistics Improvement Program (MHSIP) by the National Research Institute and distributed by CHHS to determine prevalence of Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED).

The electronic health records the Idaho Department of Health and Welfare utilizes for documentation, data collection and reporting system, is the Web Infrastructure for Treatment Services (WITS). The WITS system has multiple business rules which require the completion of the data elements reported as part of the client level data submissions. Data for non-Medicaid, state-funded Mental Health and Substance Use Disorder services are entered into WITS by the treatment providers at the client, program, provider, and/or state level. The data entered into WITS is reported from the collected date through the user Sequel Server Reporting Services (SSRS) and the Idaho Department of Health and Welfare's data warehouse.

WITS is used for non-Medicaid state-funded mental health treatment, as well as substance abuse treatment provided by the Idaho Department of Health and Welfare. Individual client records in WITS are audited throughout the year.

The Mental Health records in WITS are reviewed throughout the year to ensure completeness and accuracy. This is done through a combination of clinical review of the individual records and the use of routine and ad hoc reports from the data entered into WITS. The Idaho Department of Health and Welfare's Quality Improvement/Quality Assurance Unit reviews the reports in order to address identified data quality issues.

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.

Service Type	SMHA System
Clients served through Clinic Services	638
Clients served through Med-Only Clinic Services	1926
Clients served through CBRS Services	128
Clients served through Act Services	267
Clients served through Mental Health Court Services	379
Hold and Petitions (I.C. 66-326)	6162
Civil Commitments (I.C. 66-329)	1116
% Holds Diverted from State Hospitalization	81.89%
Clients Receiving PAP Med Scholarships	1546
19-2524 Evaluations	4986
I.C. 18-211	377
I.C. 18-212	198

The Substance Use Disorder records are audited by the State's Management Services Contractor BPA Health. BPA Health performs routine file audits for accuracy and completeness. In addition to the file audits that BPA Health performs, the Idaho Department of Health and Welfare also runs various routine and ad hoc reports from the data which is entered into WITS in order to identify potential data integrity issues. The Idaho Department of Health and Welfare's Quality Improvement/Quality Assurance Unit reviews the reports in order to address identified data quality issues.

WITS allows data to be reported and collected at the individual client level. For example, the Public Mental Health Screener a public facing website to host the CMH-CANS Mental Screening Form was built to allow non-clinical users to administer a simple screener to a youth. The questions are from the full CMH CANS Assessment. The screener will result in a recommendation as to whether further actions should be

pursued. The screener will not collect any personal identifiable information (PII) but will collect question data and make it available through the WITS database for reporting purposes. The website and the screener should be mobile friendly, quick, and intuitive for any user (See attached document titled "Idaho Children's Mental Health Screener").

Behavioral Health Planning Council and Regional Behavioral Health Boards Gaps and Needs

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 2018 which was submitted to the Governor, Legislature and Judiciary in the Planning Council's SFY2018 annual report. The annual report is included as an attachment ("State Behavioral Health Planning Council Annual Report 2018"). The seven Regional Behavioral Health Boards' analyses are attached as "Regional Behavioral Health Board Gaps and Needs 2018".

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:

State Behavioral Health Planning Council Report Trends

Barriers to Accessing Services:

- Lack of access to medically necessary services
- Lack of collaboration among providers regarding mental health and medical needs (often due to system limitations, rather than the choice of professionals)
- Need for public education and public awareness

Barriers to Maintaining Recovery:

- Lack of affordable housing, including transitional housing and models with more supervision for high-risk individuals with chronic mental illness, substance use disorders, criminal records, and those transitioning out of State Hospitals
- Lack of consistent, reliable transportation
- Lack of supported employment for those with the most serious mental health challenges.

Sample of Regional Behavioral Health Board Gaps and Needs Analysis (Full analyses attached as "Regional Behavioral Health Board Gaps and Needs 2018"):

Mental Health Services:

- Limited access in rural and frontier areas
- Limited translation services to assist individuals who speak other languages or have hearing/visual impairment
- Lack of awareness/knowledge of available resources among public/community
- Lack of availability of psychiatric beds
- Need for additional Certified Prevention Specialists, especially to address suicide prevention
- Need for increased crisis response services

Children's Behavioral Health Services:

- Limited access in rural and frontier areas
- Lack of awareness/knowledge of available resources among public/community
- Limited respite care
- Need for parent education and training
- Children and youth specialty courts
- Need for increased BH crisis services
- Need for suicide prevention resources

Substance Use Disorders:

- Limited access in rural and frontier areas
- Need for additional detox facilities
- Need for additional substance use prevention specialists/resources
- Need for increase in coordinating efforts to address the opioid epidemic
- Siloed funding structure

System Concerns:

- Need for increase of public outreach and education to decrease stigma
- Need for increased education of first responders on working with children who have mental illness and their families
- Need for increased suicide prevention training
- Increase collaboration and integration of behavioral health and medical systems
- Need for urban and rural transitional services for youth and adults
- Need for enhanced crisis services, including increased psychiatric beds
- Increase in community and family awareness of and involvement in Regional Behavioral Health Boards and State Behavioral Health Planning Council
- Need for ongoing access to care for youth
- Need for increased collaboration across agencies (schools, IDOC, IDJC, Medicaid, DBH)

Gaps in Support Services:

- Limited housing options, including rural areas and transitional and supportive housing
- Limited availability of transportation options
- Need for connection to supported employment resources for individuals who have mental illness and/or substance use disorders
- Lack of respite care
- Need for additional Peer Specialists, Recovery Coaches, and Family Support Specialists

Gaps in Clinical Services:

- Need for additional crisis services
- Need for increased inpatient services
- Increase detox services
- Increase access to medication

Other Needs:

- Increase access to SOAR
- Additional resources to address stigma
- Increase community education and events to increase public awareness and knowledge of resources
- Additional translation/interpretation resources

Substance Abuse Prevention and Treatment (SAPT) Gaps and Needs

Pregnant Women and Women with Dependent Children Needs and Gaps

The chart below depicts data from Table 3 for women's populations for which the Division of Behavioral Health is responsible to serve under the SAPT Block Grant, followed by their data sources.

Population	Aggregate Number Estimated in Need	Aggregate Number in Treatment
1. Pregnant Women[1]	**7,878**	**45**
2. Women with Dependent Children[2]	**22,781**	**282**

[1]Pregnant Women in Need – Data source and methodology - Estimated in Need

According to the United States Census Bureau, Idaho's population as of July 1, 2018, was estimated at 1,754,208, with an estimated 49.9 percent of the population being women (about 875,350 people).

According to the Substance Abuse and Mental Health Data Archive, the 2017 National Survey on Drug Use and Health indicates that 0.9 percent of women nationally reported being pregnant and also reported they needed treatment for drug or alcohol use but did not receive it in the past year.

Applying the National Survey data to Idaho's census results can give us an estimation that about (875,350 women X 0.9%) **7,878.15** women were pregnant between 2017 and 2018 and needed treatment for drug or alcohol use but did not receive it in the last year.

Sources:

- **From SAMHDA** (Are You Pregnant/Needed Treatment for Drug/Alcohol Use, Not RCVD): https://pdas.samhsa.gov/#/survey/NSDUH-2017-DS0001?column=TXYNSPILAL&results_received=true&row=PREGNANT&run_chisq=false&weight=ANALWT_C
- From: www.census.gov: https://www.census.gov/quickfacts/fact/table/ID,US/PST045218

[2]Women with Dependent Children in Need – Data Source and Methodology – Estimated in Need

According to the United States Census Bureau, Idaho had an estimated 609,124 households between 2013 and 2017.

According to the Substance Abuse and Mental Health Data Archive, the 2017 National Survey on Drug Use and Health indicates that 3.74 percent of respondents who identified as Mother in Household also reported they needed treatment for drug or alcohol use but did not receive it in the past year.

Applying the National Survey data to Idaho's census can give us an estimation that about (609,124 households X 3.74%) **22,781.24** women with dependent children in Idaho needed treatment for drug or alcohol use but did not receive it in the last year.

Sources:

- **From SAMHDA:** (Mother in Household/Needed Treatment for Drug/Alcohol Use, Not RCVD): https://pdas.samhsa.gov/#/survey/NSDUH-2017-DS0001/crosstab/?column=IMOTHER&results_received=true&row=TXYNSPILAL&run_chisq=false&weight=ANALWT_C
- **From census.gov**: https://www.census.gov/quickfacts/fact/table/ID#

Aggregate Number in Treatment Data Sources:

1. Source for all Data:

a. WEB Infrastructure for Treatment Services (WITS) data obtained from/using Sequel Server Reporting Services (SSRS)

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

Idahoans wishing to access Substance Use Disorder (SUD) services funded through the Block Grant begin by calling a toll-free number operated by our Managed Services Contractor (presently BPA Health) for a screening to determine financial eligibility. Through the course of the screening, clients are funneled into funding streams based on a variety of factors such as substance of choice, legal status, whether or not they are pregnant and/or have dependent children, etc. Since pregnant women are considered a priority population, they are given priority access to SUD treatment services and are admitted to care within 48 hours of requesting services. Pregnant women and women with dependent children are provided referrals to PWWDC specialty providers though they are free to select any provider in our SUD network. Women with dependent children also have access to an array of services for their dependent children which satisfy all federal requirements.

In the case of both pregnant women and women with dependent children, the level of care placement, services delivered, and length of stay are solely dependent on their drug of choice, clinical service needs, and recovery resources.

An identifiable unmet need is pregnant women and women with dependent children living in frontier areas, which represent the majority of Idaho's landmass and results in large portions of the state with insufficient population to support a behavioral health provider.

DBH has worked diligently to expand access to tele-behavioral health services to help address this type of access issue. Several mitigating factors have contributed to a social culture that doesn't embrace tele-behavioral health. Providers may have lack of access to technology that supports the delivery of tele-behavioral health, concerns about privacy and HIPAA and preference for face-to-face delivery of services. Compounding this issue is the frontier culture of Idaho in which stigma prevents many people from asking for help and/or accessing SUD services to meet their needs.

Finally, a historical concern that has deterred pregnant and parenting women from accessing SUD treatment services is the fear of child protection taking custody of their child after they deliver and/or they will lose custody of their children by admitting they need help for the treatment of their substance use disorder. Through

the Regional Behavioral Health Boards and participation in other health related groups, the Division of Behavioral Health has expanded outreach for these women in an effort to dispel fears that accessing SUD treatment will jeopardize custody of their children.

Persons Who Inject Drugs Needs and Gaps

The chart below depicts data from Table 3 for the Persons Who Inject Drugs population for which the Division of Behavioral Health is responsible to serve under the SAPT Block Grant, followed by their data sources.

Population	Aggregate Number Estimated in Need	Aggregate Number in Treatment
4. Persons who inject drugs[4]	**5,262**	**680**

[4]Persons Who Inject Drugs – Data Source and Methodology – Estimated in Need

According to the United States Census Bureau, Idaho's population as of July 1, 2018, was estimated at 1,754,208.

Based on an article shared on the National Institute of Health US National Library of Medicine titled "Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections", 0.3 percent of the population was estimated to have been a person who injected drugs in the past year.

Applying the article data to Idaho's census data, we can estimate that (1,754,208 X .3%), **5,262.62** Idahoans have injected drugs in the past year. This estimate is limited due to the age of the article, which was conducted in 2014 compared to the census estimate dated in 2018. A more accurate estimate also would have been available if the census population estimate (all Idahoans regardless of age) matched the age of those involved in the article – individuals 13 and older. These limitations lead us to believe the actual estimate may be somewhat lower because of the inclusion of children younger than 13 in the census estimate.

Sources:

- **From: ncbi.nlm.nih.gov:** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4026524/
- **From census.gov:** https://www.census.gov/quickfacts/ID

Aggregate Number in Treatment Data Sources:

1. Source for all Data:

a. Web Infrastructure for Treatment Services (WITS) data obtained from/using Sequel Server Reporting Services (SSRS)

5. Persons who Inject Drugs

a. Count of clients served under Intravenous Drug Use (IVDU) funding

The tables below detail the percentage of admissions in 2018 by the primary substance of use reported by SSA clients, the top four drugs of choice and their primary route of administration, and the percentage of 2018 clients indicating injection as their route of drug administration. Data was collected using the Division of Behavioral Health's substance use disorder client data collected at time of admission.

For Idaho residents receiving substance use disorder treatment funded by the SSA, methamphetamine was the most often reported primary substance (35.79%) and alcohol was the second most often reported primary substance (33.2%). Heroin was the third most often reported substance (14.78%). The chart below summarized the primary substances reported by the clients receiving treatment services funded by the SSA in 2018.

SSA Clients Primary Substance	% of Admissions
Methamphetamine/Speed	35.79%
Alcohol	33.20%
Heroin	14.78%
Marijuana/Hashish/THC/Cannabis	8.09%
Other Opiates/Synthetics	6.25%
Other Amphetamines	0.47%
Cocaine/Crack	0.28%
Inhalants	0.09%
All other Drugs	0.38%

Methamphetamine and heroin being the first and third, respectively, most reported substances is significant because, as you can see in the following chart, they were also the top two drugs reported with injection as their primary route of administration by individuals receiving SSA-funded substance use disorder services. Please note, the chart percentages are per the total number of clients indicating by drug of choice.

Top Four Drugs of Choice Including Primary Route of Administration				
Route of Administration	**Alcohol**	**Heroin**	**Marijuana**	**Methamphetamine**
Inhalation	0.00%	1.21%	2.81%	5.20%
Injection	0.00%	78.76%	0.30%	54.77%
Oral	100.00%	2.43%	1.60%	2.29%
Other	0.00%	0.91%	3.21%	2.48%
Smoking	0.00%	16.69%	92.08%	35.25%

National Survey on Drug Use and Health data show that Idaho's prevalence of individuals reporting past year heroin use has risen faster than the U.S. average between the 2013-2014 reporting period and the 2016-2017 reporting periods. In 2013-2014, the rate of heroin use in the U.S. was reported as 0.30%, while in Idaho, the rate of past year heroin use was reported as 0.24%. In 2016-2017, Idaho's prevalence of past year heroin use has risen to .33%, while the U.S. rate has only risen to 0.34%.

Additionally, the same National Survey on Drug Use and Health data show Idaho's prevalence of individuals reporting past year methamphetamine use as rising between the 2015-2016 reporting period and the 2016-2017 reporting period, while the U.S. prevalence rate decreased. In 2015-2016, the rate of methamphetamine use in the U.S. was reported as 0.58%, while in Idaho, the rate of past year methamphetamine use was reported as 0.75%. In 2016-2017, Idaho's prevalence of past year methamphetamine use has risen to .87%, while the U.S. rate had decreased slightly to 0.56%.

Source: Interactive NSDUH Estimates, https://pdas.samhsa.gov/saes/state

The data shows that heroin and methamphetamine are the most commonly injected drugs in Idaho among SSA-funded Substance Use Disorder clients. Because of the Idaho data showing 78.76% of SSA-funded Substance Use Disorder clients using injection as their primary route of heroin administration and 54.77% reporting using injection as their primary route of methamphetamine administration, the increase in reported NSDUH past year use can help us estimate a rising need in Idaho for treatment of heroin and other injection drug users.

In 2018, injection needle use as a primary, secondary or tertiary route of administration was reported by 35.5% of the individuals receiving SSA-funded services. This is a significant increase over 2017, when 24.4% reported injection use as a route of administration. This single year increase further suggests a rising need for treatment for individuals who inject drugs in Idaho.

Injection Needle Administration	
% of SSA-Funded Clients Indicating Injection as Route of Administration	
% of FY 18 Treatment Clients Indicating IVDU Use	35.50%
Injection Use Reported As Primary, Secondary or Tertiary Route	
% of Clients Indicating Needle as Primary Route of Administration	88.79%
% of Clients Indicating Needle as Secondary Route of Administration	34.16%
% of Clients Indicating Needle as Tertiary Route of Administration	5.78%

The receipt of the "State Targeted Response to the Opioid Crisis Grant" has enabled Idaho to establish a special program for opioid users, injection or otherwise. Since 2017, Idaho's Response to the Opioid Crisis (IROC) project has expanded access to treatment, including Medication Assisted Treatment, to over 800 Idahoans. IROC has reduced access to opioids through prescriber education and awareness campaigns and increased the statewide use of naloxone by providing over 3,000 naloxone kits to more than 130 statewide agencies. Additionally, more than 1,000 Idahoans have accessed recovery support through enhancements made to Idaho's recovery-oriented system of care using IROC funds.

As a component of the IROC program, the Opioid Needs Assessment 2018 was completed, and is attached to this application. Among its conclusions, a number of gaps in treatment services were addressed in the Executive Summary:

Gaps in Treatment and Services

- The current substance abuse prevention system in Idaho to address the opioid crisis is a collaborative, multi-disciplinary effort aimed at employing evidence-based prevention strategies and public policy

initiatives. It has many strengths including the use of a variety of evidence-based practices in prevention education.

- However, it is clear there is still room to improve prescribing practices, especially in Frontier counties. Frontier counties, in particular, may be at risk for opioid overprescribing and could warrant special consideration when planning a response to Idaho's opioid crisis.
- Adolescents and young adults in Idaho are an important high-risk population for heroin and non-heroin opiate/synthetic use, misuse, and dependence. Attention should be provided to education addressing middle school and early-high school students and their families, as the period between 10th and 11th grade appears to be a critical time for adolescents in Idaho to begin using prescription drugs without a doctor's prescription. Attention should also be directed towards improving prevention strategies aimed at Idahoans aged 18-25, a group which has been historically shown to be difficult to reach, especially those who do not choose to attend a university.
- Although higher past 30-day use of prescription drugs was not seen among this demographic, a significantly greater percentage of Hispanics report that there is no or slight risk in using prescription drugs not prescribed by a licensed medical provider. As such, prevention strategies should be culturally competent and tailored to Idaho's Hispanic population.
- Over half of Idaho's substance abuse prevention workforce is over the age of 45, which emphasizes a great need for recruitment.
- Accessing MAT using public funding is difficult in Idaho. However, a recently acquired SAMHSA grant will introduce publicly-funded MAT to Idaho by adding Methadone and Suboxone to the array of treatment and recovery support services that are currently available.

In September 2018, Idaho was awarded a $4 million federal grant to continue to fight the opioid epidemic through the IROC program, which will help provide treatment for injection drug users who use heroin and other opiates that wasn't previously available.

This new influx of funding provides the opportunity for Idaho to continue to support and enhance the IROC program with targeted initiatives.

Over the next two years IROC will:

- Collaborate with and provide funding to Idaho's five federally recognized tribes to address the opioid epidemic within their communities.
- Expand Idaho's recovery-oriented system of care. Specifically, the provision of recovery coaching services in emergency departments and jail/prison reentry efforts.
- Increase prevention efforts to include increasing the availability of Naloxone and disseminating materials to educate the public on the dangers of opiates and how to manage an Opioid Use Disorder (OUD) through the BSU RADAR Center.
- Launch a pre-sentencing diversion pilot program called LEAD.

Individuals at risk of Tuberculosis with Tuberculosis Needs and Gaps

The Idaho Department of Health and Welfare's Division of Public Health epidemiology staff track trends in reportable diseases that impact Idahoans, including tuberculosis. They offer consultation and direction to public health districts about the investigation and prevention of diseases; develop interventions to control outbreaks and prevent future infections; and deliver tuberculosis consultation and treatment services. The Idaho Department of Health and Welfare's Division of Behavioral Health provides funding for substance use disorder treatment services, which is delivered by a network of community-based providers. BPA Health, who manages the network of providers for the Division, screens individuals seeking Division of Behavioral Health-funded treatment services for tuberculosis

risk, those who qualify for treatment services are referred to community-based providers within their network who include additional tuberculosis-related questions in their comprehensive client assessment. These providers refer high-risk clients to the Division of Public Health for testing, education, and as needed, treatment services.

The Division of Public Health is the lead entity within Idaho for health-related surveillance and evaluation. Idaho's surveillance capacity for tuberculosis as well as other communicable diseases has expanded with the use of electronic reporting systems. The use of these systems significantly reduces the time it takes to screen and test for tuberculosis and appropriately intervene. As of the start of Idaho Fiscal Year 2018, more than 95% of reports from laboratories are handled electronically. This technology enables Idaho to identify tuberculosis and other communicable disease outbreaks, intervene immediately and evaluate effectiveness of the intervention(s). This system provides the Division of Behavioral Health and community-based providers with a state-level resource that can provide.

In Idaho, the number of tuberculosis cases reported to public health has declined significantly since the early 1970's. Consistently, the number of cases reported in Idaho is below the number reported in other states, although year-to-year trends do fluctuate as demonstrated in the chart below. The chart on the next page lists the Idaho tuberculosis cases per hundred thousand from 1971-2018. (2018 data is provisional).

The incidence rate of active TB has remained relatively stable in Idaho since the mid-1990s at about 1 case per 100,000 Idahoans. The Idaho incidence rate per 100,000 people is consistently below the national incidence rate and in 2018 was 0.87 per 100,000 Idahoans.

Link to Division of Public Health Tuberculosis data:
https://public.tableau.com/profile/idaho.division.of.public.health#!/vizhome/AnnualTBSurveillanceReport/AnnualTBReport

(Chart on next page)

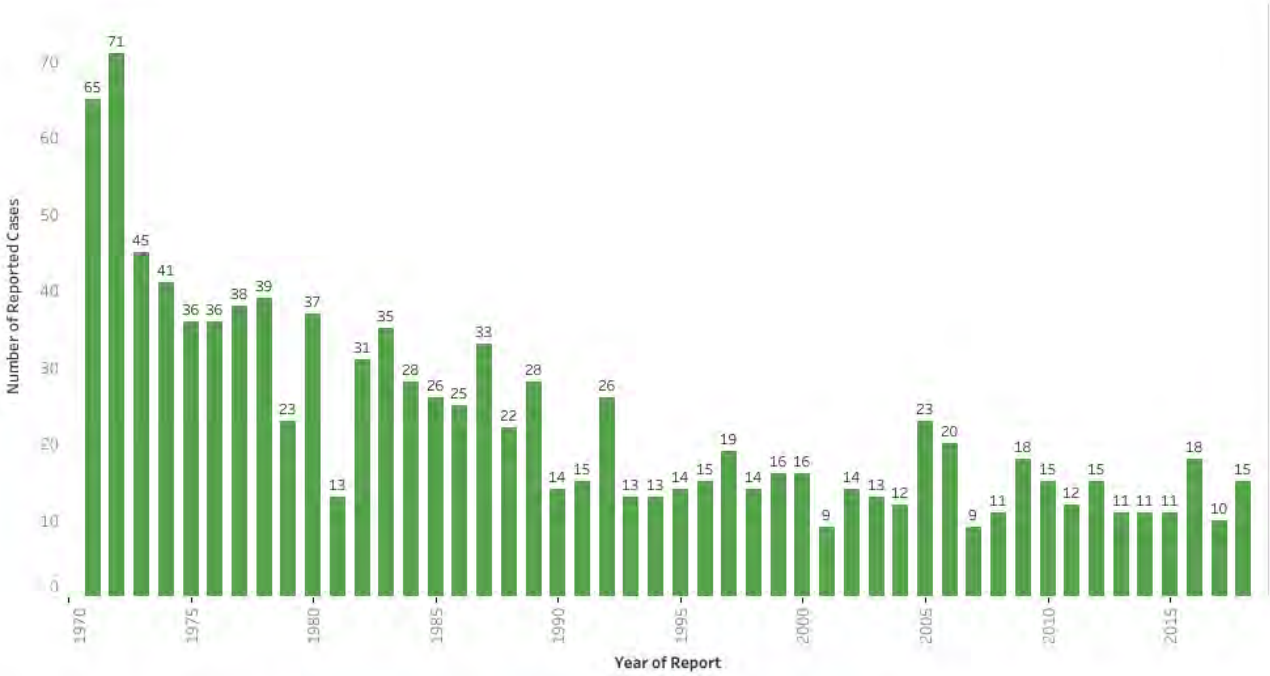
Idaho Tuberculosis (TB) Annual Surveillance Report

TB Case Counts, 1971-2018	TB Incidence Rates, 1986-2018	TB Case Counts by PHD, 2012-2018	Primary Site of Disease, 2012-2018	Age Group, 2012-2018	Reported Sex, 2012-2018	Ethnicity, 2012-2018

Reported Number of TB Cases - Idaho, 1971-2018*

*2018 data are provisional.

Although the number of persons with active tuberculosis (TB) has declined steadily in Idaho since annual reports were first published in the 1930s, the number of reported cases has remained relatively stable in recent years. In 2018, 15 persons in Idaho with active TB were reported to public health officials.



Note: National TB data can be retrieved from https://www.cdc.gov/mmwr/volumes/68/wr/mm6811a2.htm?s_cid=mm6811a2_w

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

The chart on the following page documents the number of tuberculosis cases from 2013-2018 for each of the public health substate areas of Idaho. The map following the chart depicts the boundaries

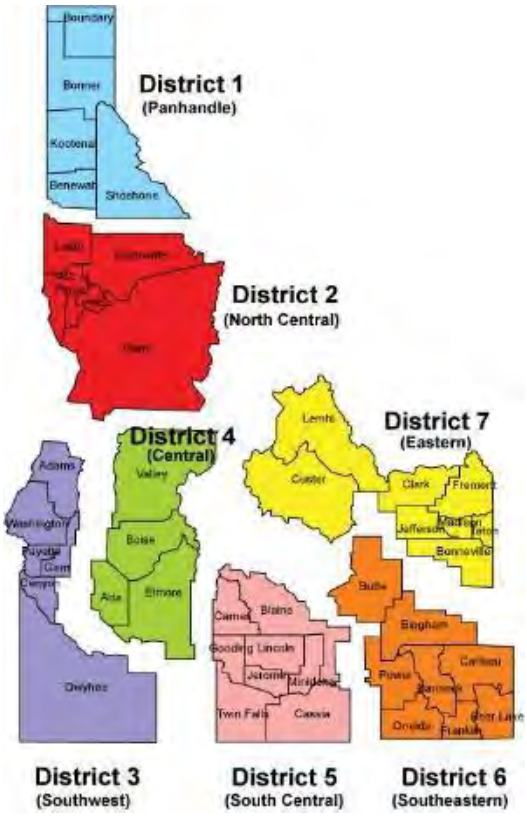
of each district. While they are not identical to the Division of Behavioral Health regions, they are close enough in population type and population density to accurately reflect the areas most at risk for increased tuberculosis activity. Since 2012, the number of TB cases reported in Idaho has been concentrated in the southern part of the state. In 2018, Southwest District Health, Central District Health Department, and South Central Public Health District collectively received 93% of TB cases in the state.

Number of Reported TB Cases by Public Health District, 2013 - 2018

Public Health District	2013	2014	2015	2016	2017	2018*
District 1	2	1	0	0	0	0
District 2	0	0	1	0	1	0
District 3	0	0	0	7	3	3
District 4	4	6	8	4	3	8
District 5	2	4	1	5	2	3
District 6	2	0	0	2	1	0
District 7	1	0	1	0	0	1
State	11	11	11	18	10	15

*Data for 2018 are provisional

Link to Division of Public Health Tuberculosis data:
https://public.tableau.com/profile/idaho.division.of.public.health#!/vizhome/AnnualTBSurveillanceReport/AnnualTBReport



Due to the low rate of tuberculosis in Idaho, there have been no service gaps identified for tuberculosis at this time. The partnership of the Division of Public Health and Behavioral Health is solid and will continue throughout the grant period. The Division of Behavioral Health has established a protocol for screening and referring all clients at risk for tuberculosis to appropriate testing and medical care. Cost for screening substance use disorder clients is covered by the Division of Behavioral Health. The Division of Public Health has established a statewide system for providing testing and treatment services when indicated. Cost for testing and treatment services for substance use disorders clients is covered by the Division of Public Health. The Division of Public Health also provides resources that are accessible to providers with the BPA Health network.

Throughout the 2020 SAPT Block Grant period, the Division of Behavioral Health and the Division of Public Health will continue to work together to ensure all Division of Behavioral Health-funded substance use disorder clients receive appropriate tuberculosis screening, testing when risk factors are identified and treatment when testing indicates.

NOTE: Please note that Idaho is not an HIV-designated state.

Planning Step 2 Revision Request Response

Revision Request Description:

Please explain any contribution that your SEOW had in the treatment planning process. Thank you.

Created by Jessica Hartman on 9/9/2019 10:29AM

Revision Request Response:

Idaho's State Epidemiological Outcomes Workgroup (SEOW) is not currently involved in treatment-specific Substance Use Disorder planning. Moving forward, after Idahoans are enrolled in expanded Medicaid Jan. 1, 2020, Idaho's Single State Agency (SSA) would like to explore the possibility of future Substance Use Disorder treatment planning collaboration with the SEOW.

The SEOW does update, with the help of other state and federal agencies, a substance abuse prevention needs assessment each year that is attached to this application in Primary Prevention Needs Assessment 2017. The Department of Health and Welfare uses this Needs Assessment and significant other stakeholder input when developing the treatment delivery system. The SEOW and its Needs Assessment are also discussed in the Primary Prevention Step 2 Gaps and Needs attachment to Planning Step 2.

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.).

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.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The Primary Prevention section is attached as "Primary Prevention Planning Steps - Quality and data collection readiness"

Planning Steps: Quality and Data Collection Readiness (2020-2021 Application and Plan)

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 electronic health records the Idaho Department of Health and Welfare utilizes for documentation, data collection and reporting system, is the Web Infrastructure for Treatment Services (WITS). The WITS system has multiple business rules which require the completion of the data elements reported as part of the client level data submissions. Data for non-Medicaid, State funded Mental Health and Substance Use Disorder services are entered into WITS by the treatment providers at the client, program, provider, and/or state level. The data entered into WITS is reported from the collected date through the user Sequel Server Reporting Services (SSRS) and the Idaho Department of Health and Welfare's data warehouse.

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?

   The state electronic health record (EHR), WITS, is used for non-Medicaid state-funded mental health treatment, as well as substance abuse treatment provided by the Idaho Department of Health and Welfare. Individual client records in WITS are audited throughout the year.

   The Mental Health records in WITS are reviewed throughout the year to ensure completeness and accuracy. This is done through a combination of clinical review of the individual records and the use of routine and ad hoc reports from the data entered into WITS. The Idaho Department of Health and Welfare's Quality Improvement/Quality Assurance Unit reviews the reports in order to address identified data quality issues.

   The Substance Use Disorder records are audited by the State's Management Services Contractor BPA Health. BPA Health performs routine file audits for accuracy and completeness. In addition to the file audits that BPA Health performs, the Idaho Department of Health and Welfare also runs various routine and ad hoc reports from the data which is entered into WITS in order to identify potential data integrity issues. The Idaho Department of Health and Welfare's Quality Improvement/Quality Assurance Unit reviews the reports in order to address identified data quality issues.

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)?.

   The electronic health record (EHR), WITS, that Idaho uses allows data to be reported and collected at the individual client level. For example, the Public Mental Health Screener a public facing website to host the CMH-CANS Mental Screening Form was built to allow non-clinical users to administer a simple screener to a youth. The questions are from the full CMH CANS Assessment. The screener will result in a recommendation as to whether further actions should be pursued. The screener will

not collect any personal identifiable information (PII) but will collect question data and make it available through the WITS database for reporting purposes. The website and the screener should be mobile friendly, quick, and intuitive for any user.

Describe your State's approach to quality and data collection and how it can be improved and result in better client level data and outcomes.

The Office of Drug Policy (ODP) is currently using a data collection and reporting system for primary prevention programs and activities that was developed in-house using Microsoft Excel. The data reporting spreadsheet is sent to providers quarterly, and client-, program-, and provider-level data are all collected.

Client-level data include 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'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. ODP does not collect or maintain any personal identifying information, besides aggregated demographics, on individuals served with block grant funding.

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

There are approximately forty-eight (48) primary prevention providers currently 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/.

ODP is committed to funding programs that are evidence-based, proven to work and identified as culturally relevant. Accurate, current data is necessary to stay in front of emerging problems and to ensure reliable outcomes measures. The following improvements are currently underway to increase quality data collection:

- *ODP is working with Pacific Institute for Research and Evaluation (PIRE), on the development of a comprehensive data and evaluation plan to document the efficacy of SABG primary prevention dollars in Idaho. In 2019, this effort began with a thorough review and revision of the pre/post survey tools used to evaluate the impact of instructional interventions and assess students', and parents', perceptions of changes in their knowledge and skills, personal attitudes, and impact on their future behavior.*
- *ODP has adopted one generalized fidelity monitoring tool for implementation to ensure prevention policies, programs and approaches are delivered within implementation guidelines*

for details such as the age range, number of sessions, length of sessions, projected outcomes, updated materials etc.

- *ODP utilizes the Idaho Healthy Youth Survey (IHYS) to gather current information on Idaho youth to promote capacity to prevent risk factors for behavioral health issues. The IHYS for 6th, 8th, 10th, and 12th grade students was modeled after other states' surveys, influenced by local needs, and refined by the Idaho State Epidemiological Outcomes Workgroup, the Idaho Criminal Justice Commission, and multiple community organizations that work with youth in each of the seven public health districts in Idaho. Survey findings are used to support the assessment of local conditions and inform prevention planning initiatives. The data also provides an opportunity to determine differences between prevention-funded communities and non-funded communities to ensure effectiveness and continuous quality improvement. IHYS data is made available in statewide outcomes reports and community-level reports.*
- *Idaho is one of 50 states conducting the Behavioral Risk Factor Surveillance System (BRFSS) with assistance from the Centers for Disease Control and Prevention (CDC). The state-based survey provides data on individual risk behaviors and preventive health practices and is used for planning and monitoring health objectives in Idaho. While marijuana currently remains fully illegal in Idaho, our state is bordered by five neighboring states which allow medical and/or recreational/decriminalized marijuana. The increased availability, access, and normalization of marijuana has prompted Idaho to include the Marijuana Use Module to the State's* BRFSS *instrument. Idaho has also opted to include an item on the BRFSS to determine the prevalence of methamphetamine usage among the adult population. Data can be stratified by region and sub-population, which can inform prevention funding decisions.*

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Primary Prevention Data Limitations

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Effectively measure primary prevention program impact and outcomes

Objective:

Revise and strengthen SABG data collection tools and evaluation capacity by June 30, 2021

Strategies to attain the objective:

Strategies to attain the objective:
Engage state evaluation contractor in the review of existing data collection tools and processes
Evaluate current data sets to determine gaps/needs
Identify partners to increase capacity to close gaps, address needs
Provide training and technical assistance to prevention provides to ensure data collection compliance
Enhance two-way communication between state and community providers to support data collection and reporting
Add formal fidelity assessment tool to required provider reporting

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of SABG funded prevention providers correctly reporting attendance, demographic and outcome data

Baseline Measurement: 75% of SABG funded prevention providers correctly reported attendance, demographic and outcome data in FY2018 in ODP's online data collection system

First-year target/outcome measurement: 85% of SABG funded prevention providers will correctly report attendance, demographic and outcome data in FY2018 in ODP's online data collection system

Second-year target/outcome measurement: 90% of SABG funded prevention providers will correctly report attendance, demographic and outcome data in FY2018 in ODP's online data collection system

Data Source:

ODP online data collection system

Description of Data:

Program Pre/Post Surveys

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Primary Prevention Workforce Development

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Build Idaho's provider capacity to implement evidence-based primary prevention programs

Objective:

Increase the number of Certified Prevention Specialists (CPS) in Idaho from 21 to 24 as measured by the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC) data base by June 30, 2021

Strategies to attain the objective:

Strategies to attain the objective:
Work with IBADDC to clarify and streamline CPS certification process
Build upon existing training opportunities to include skill development in the CPS required domains
Develop on-line Learning Management System to expand training to rural and frontier providers
Promote regional, in-person training opportunities to address barriers of travel
Engage educational institutions to assist in workforce development
Address issues of compensation for certified professionals to attract and retain workforce at the level needed

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of Certified Prevention Specialists (CPS) in Idaho as measured by the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC)
Baseline Measurement:	In June 2019, 21 credential Certified Prevention Specialists listed on IBADCC provider registry
First-year target/outcome measurement:	By July 1, 2020, 24 credential Certified Prevention Specialists listed on the IBADCC provider registry
Second-year target/outcome measurement:	By July 1, 2021, 27 credential Certified Prevention Specialists listed on the IBADCC provider registry

Data Source:

IBADCC provider registry

Description of Data:

State registry

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Primary Prevention Service Gaps

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Increase the reach of SABG prevention programs to underserved populations

Objective:

75% of Idaho's population will be reached through SABG prevention programming by July 1, 2021

Strategies to attain the objective:

. Strategies to attain the objective:
Identify gaps in providers' knowledge of prevention science specifically strategies that are grounded in population, public health approaches that target underserved communities
Develop training to address gaps in providers' knowledge of prevention science
Deliver training to providers
Evaluate training to providers and make changes accordingly
Disseminate information to providers to raise awareness of available prevention services, programs and resources in their area Facilitate targeted

outreach and support services in languages other than English that are culturally competent Encourage implementation of best practice environmental strategies

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of Idaho's population reached by SABG primary prevention programming

Baseline Measurement: 71% of Idaho's population reached through SABG prevention programming in FY16

First-year target/outcome measurement: 73% of Idaho's population reached through SABG prevention programming in FY20

Second-year target/outcome measurement: 75% of Idaho's population reached through SABG prevention programming in FY21

Data Source:

ODP online data collection system

Description of Data:

Program attendance and demographic data

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Primary Prevention Emerging Trends

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce Underage and Young Adult Substance Misuse

Objective:

Decrease past 30 day use/misuse of alcohol, marijuana, and e-cigarette use; and past year use/misuse of opioids or other prescription drugs

Strategies to attain the objective:

Strategies to attain the objective:
Deliver Evidence-based Prevention Programs and Strategies with fidelity
Deliver direct service prevention programs
Deliver community-based (Environmental) prevention programs
Provide statewide Workforce Development Training to build capacity for service delivery
Provide Signs and Symptoms training

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Past 30 day use/misuse of alcohol, marijuana, and e-cigarette use; and past year use/misuse of opioids or other prescription drugs

Baseline Measurement: Individual-based programs and strategies; Number of persons served in FY16: 17,359

First-year target/outcome measurement: Increase individual-based programs and strategies; Number of persons served in FY20: 17,532

Second-year target/outcome measurement: Increase individual-based programs and strategies; Number of persons served in FY21: 17,882

Data Source:

ODP's Online Reporting System used to report SABG performance indicators; NSDUH; YRBS: Idaho Healthy Youth Survey (IHYS)

Description of Data:

SABG performance indicators are used to measure CSAP and IOM categories for services delivered annually; NSDUH, YRBS and IHYS are used to measure substance use/misuse among Idaho youth and young adult populations

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Decrease Gaps for Priority type and population

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Implement a process that will foster a continuity of care for Adult Mental Health Clinic Clients receiving services from the state regional behavioral health offices, to a Idaho Behavioral Health Plan Network and Primary Care Provider during the Medicaid expansion transition.

Objective:

All Medicaid Expansion eligible clients receiving services at the state regional behavioral health offices, will be connected with a Medicaid primary care provider by June 30, 2020.

Strategies to attain the objective:

Division of Behavioral Health is partnering with Self-Reliance for the transition to Medicaid Expansion; Self Reliance provides a weekly report noting who has applied for Medicaid to assist with making sure all Medicaid eligible clients will receive services by 1/2/2020. Changes in the electronic health record database, WITS, were made to reflect is Medicaid eligible. Training videos will be developed for staff on how to complete the changes and direction on how to transition the clients from the DBH electronic health record system to primary care providers in the Medicaid network.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: All Medicaid Expansion eligible clients receiving services at the state regional behavioral health offices, will be connected with a Medicaid primary care provider by June 30, 2020.

Baseline Measurement: The baseline measurement are the Adult Mental Health Clinic Clients receiving services from the state regional behavioral health offices as of 7/1/2019, in addition to new clients up until 12/31/2019.

First-year target/outcome measurement: Assist Medicaid eligible Adult Mental Health Clinic Clients receiving behavioral health services from the state regional offices to apply for Medicaid and arrange services with a primary care provider in the Medicaid network for continuity of services through the Medicaid Expansion transition.

Second-year target/outcome measurement: Clients receiving Mental Health Court Ordered services through the state regional offices will be transitioning to community providers. The target of this second-year is to make sure community contracts are in place so that clients receive continued services during the Medicaid expansion transition.

Data Source:

WITS, IBES (Self Reliance data base), MMIS (Medicaid's data base).

Description of Data:

Clients who applied for Medicaid, who their primary care physician is, when initial appointment is scheduled for, and confirmation the Client attended the appointment.

Data issues/caveats that affect outcome measures::

Clients will be assisted in scheduling appointments while transitioning to a primary care provider, however, there is no guarantee the Client will attend the appointment. Regional staff across systems may not follow the guidelines for entering the data; IBES and MMIS are owned by other agencies which could impact timeliness of data.

Priority #: 6

Priority Area: Increased Access to Services

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Implement the CMH Screener statewide. This screener is based on the Child and Adolescent Needs and Strengths (CANS) tool the state of Idaho now uses for assessment and treatment planning in Children's Mental Health.

Objective:

Use the new CMH Screener, that is designed to help primary care providers identify unmet mental health needs, and to link families to further assessment and treatment.

Strategies to attain the objective:

Develop a plan for implementing the CMH Screener, including a training plan for creating and maintaining statewide capacity for the use of the tool, automation of the tool, and the screening form reference guide. The screening tool is easy to learn and has an excellent reputation as being user friendly in that it is easy to understand, user friendly, and does not requiring scoring in order to be helpful and meaningful for the youth and family.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Use the new CMH Screener, that is designed to help primary care providers identify unmet mental health needs, and to link families to further assessment and treatment.

Baseline Measurement: This is a new screening tool developed based on the Child and Adolescent Needs and Strengths (CANS) that the state of Idaho has recently implemented, which replaced the CAFAS.

First-year target/outcome measurement: Development of a statewide accessible web based application to screen and identify unmet mental health needs in children and adolescents.

Second-year target/outcome measurement: Expand the use of the CMH Screener to stakeholders, providers, and anyone that can assist in identifying unmet mental health needs in children and adolescents, while also linking families for further assessment and treatment.

Data Source:

Web based CMH Screener, WITS-SSRS

Description of Data:

- General Information (Age, Gender, Provider Type administering the screener, County of Residence)
- 6 questions from the Behavioral/Emotional Needs Domain
- 7 questions from the Life Functioning Domain
- 8 questions from the Risk Behaviors Domain
- 7 questions from the Caregiver Resources and Needs Domain
- Screener Results

Data issues/caveats that affect outcome measures::

Funding availability, possible stakeholder alignment with the intended use of the tool.

Priority #: 7

Priority Area: Decrease gaps in services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase links between primary, specialty, emergency, and rehabilitative care, with statewide availability of the Idaho Psychiatric Bed and Seat Registry

(IPBSR).

Objective:

The Idaho Psychiatric Bed and Seat Registry (IPBSR) project will include the hosting of a bed utilization portal, monitoring to ensure data entry into the portal, and the facilitation of the use of the portal statewide.

Strategies to attain the objective:

Using the TTI grant, there will be a transformation of crisis center, community psychiatric inpatient, and state psychiatric hospital bed utilization through the development of a statewide psychiatric bed registry, the Idaho Psychiatric Bed and Seat Registry (IPBSR).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The Idaho Psychiatric Bed and Seat Registry (IPBSR) project will include the hosting of a bed utilization portal, monitoring to ensure data entry into the portal, and the facilitation of the use of the portal statewide.

Baseline Measurement: The current platform for bed availability is through JUVARE.

First-year target/outcome measurement: Development and enhancement of a web-based system.

Second-year target/outcome measurement: Expand the use of the Idaho Psychiatric Bed and Seat Registry (IPBSR) by additional stakeholders statewide.

Data Source:

JUVARE (EMResource)

Description of Data:

- Number of Hospitals/Crisis Centers involved
- Number of active users
- How many events (notifications) are sent out and end users response time to events
- How often all the facilities update their #'s
- Data on the different types of beds/seats

Data issues/caveats that affect outcome measures::

System availability through public health, funding, stakeholder alignment, and system connectivity.

Priority #: 8

Priority Area: Decrease Gaps for Priority type and population

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Implement and expand access to Early Serious Mental Illness services throughout Idaho.

Objective:

Expand mental health services for individuals experiencing Early Serious Mental Illness from three to four regions in Idaho.

Strategies to attain the objective:

Idaho continues to provide state delivered Early Serious Mental Illness services in three regions, with the Idaho Strength Through Active Recovery (STAR) program, based on the ON-Track Coordinated Specialty Care (CSC). With Medicaid Expansion being approved in Idaho April 2019, many of the state provided services will be covered by Medicaid. The state will continue implementation strategies of services not covered under Medicaid, while exploring other options such as contracting with agencies to continue to provide and expand Early Serious Mental Illness services throughout Idaho.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Expand mental health services for individuals experiencing Early Serious Mental Illness from three to four regions in Idaho.

Baseline Measurement: Idaho currently has three active ESMI/FEP teams.

First-year target/outcome measurement: Identify the next region and setting in Idaho to begin implementation of a fourth team to provide ESMI/FEP services.

Second-year target/outcome measurement: Have four ESMI/FEP teams in the implementation stage.

Data Source:

WITS, Division Administration, Contract Reporting

Description of Data:

Number of clients receiving ESMI/FEP services, types of services received, outcome data.

Data issues/caveats that affect outcome measures::

Idaho will begin the process of Medicaid Expansion which will open more services to all our ESMI, SMI, SED, and SUD populations. With this transition brings significant changes to how state delivered services will look. Services once provided at the state level, will now be available through agencies. Not all ESMI/FEP services are covered through Medicaid, so other options will need to be explored to provide a collaborative and continuity of care. Idaho has rural areas, which can make accessing and providing services and transportation difficult for clients, staff, and agencies. Additionally, there are limited availability of psychiatric providers which impacts available prescriber time to dedicate to ESMI/FEP Programs.

Priority #: 9

Priority Area: Unmet needs and services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase access and retention of safe, suitable and affordable housing for individuals with a co-occurring diagnosis who experience unstable housing and/or homelessness.

Objective:

To support the development and/or expansion of an infrastructure that integrates behavioral health treatment and recovery support services for individuals with a co-occurring disorder who are experiencing homelessness or who are at risk of homelessness.

Strategies to attain the objective:

Using the TNT Grant, a collaborative approach to providing services and supports for individuals with a co-occurring diagnosis that are at risk or experiencing homelessness will be developed. A Steering Committee will be established to review project outcomes, consult, and review evaluation results. An enhanced safe and sober house will be established in each of the three Idaho hubs, providing up to six months of housing and services. Provide training for staff and work with the ID Housing and Finance for permanent vouchers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: To support the development and/or expansion of an infrastructure that integrates behavioral health treatment and recovery support services for individuals with a co-occurring disorder who are experiencing homelessness or who are at risk of homelessness.

Baseline Measurement: Services are not provided statewide. This is a new grant to the state of Idaho.

First-year target/outcome measurement: A minimum of forty-eight clients will receive services in the state of Idaho.

Second-year target/outcome measurement: Sustainment of services to serve fifty-three clients a year for the grant term.

Data Source:

WITS, Contraxx for contract monitoring GPRA

Description of Data:

ICD-10 diagnosis, ASAM criteria, and GPRA data into
WITS. Data will be collected through WITS and monthly reports that include input from participants through other informal feedback. Providers that work with state funded clients are required to use WITS to maintain client records, and to access the GAIN interface that is used to assess, monitor and guide treatment planning for those receiving services through the state system of care. WITS is the portal used by providers to access Chestnut's GAIN system and GPRA data. GPRA collects client demographics, military history, drug and alcohol use history, family and living conditions, education, employment and income, crime and criminal justice status, as well as mental and physical health problems and treatment/recovery, social connectedness, and follow up and discharge status information. It will also document the services received during the client's time in the ESSH (Enhanced Safe and Sober House).

Data issues/caveats that affect outcome measures::

Finding affordable areas in certain regions to establish the ESSH Homes. Referrals, availability, and timeliness for services could affect outcome measures. No guarantee for permanent housing vouchers after the six months at the ESSH as the funding comes from other partner agencies.

Priority #: 10

Priority Area: Unmet needs and Services

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Develop and implement a coordinated crisis response system throughout the state of Idaho as an integral piece of the System of Care.

Objective:

Develop a collaborative community-oriented crisis system to reduce psychiatric hospitalizations, reduce death by suicide, increase access to care and community-based options, reduce arrests, and improve service coordination and quality of treatment.

Strategies to attain the objective:

Explore options of having Regional or statewide crisis call lines, availability of centrally deployed Mobile Crisis services, and crisis stabilization programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Develop a collaborative community-oriented crisis system to reduce psychiatric hospitalizations, reduce death by suicide, increase access to care and community-based options, reduce arrests, and improve service coordination and quality of treatment.

Baseline Measurement: The current crisis systems across the state are region specific and differ across the state.

First-year target/outcome measurement: Develop a roadmap and strategy for a coordinated crisis response system across the state of Idaho.

Second-year target/outcome measurement: Implement the roadmap and strategy plan to move towards initiating a coordinated crisis response system throughout the state of Idaho as an integral piece of the System of Care.

Data Source:

Suicide Hotline, WITS, TTI System

Description of Data:

Types of Crises, Number of Crises, Number of Contacts, Timelines to resolution of the crises.

Data issues/caveats that affect outcome measures::

Issues possibly being able to access data across systems; possible difficulties developing a collaborative working relationship with law enforcement of the state's 44 counties; multiple stakeholders and divisions involved to have a coordinated crisis response system.

Priority #: 11

Priority Area: Pregnant Women and Women with Dependent Children (PWWDC)

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Develop PWWC programming post-Medicaid Expansion, specifically targeting pregnant women whose medical providers have identified them as extremely high risk.

Objective:

Develop programming through Block Grant funding to provide services customized specifically to pregnant women to meet their unique treatment needs and recovery goals.

Strategies to attain the objective:

Strategies to attain the objective: Convene pertinent stakeholders, including hospitals, to identify gaps in services for pregnant women with non-opioid SUD to design programming to help them achieve success in long-term recovery with a focus on providing wraparound services for the woman and her family.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of women served whose medical providers have identified them as extremely high risk.

Baseline Measurement: Serve 5 pregnant women

First-year target/outcome measurement: Serve 10 pregnant women

Second-year target/outcome measurement: Serve 15 pregnant women

Data Source:

Data source: Gaps and Needs Analysis, Web Infrastructure for Treatment Services (WITS) which is Idaho's approved Electronic Health Record for SUD

Description of Data:

Description of data: Clients who indicate they are pregnant at the time of screening.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Priority #: 12

Priority Area: Persons Who Inject Drugs (PWID)

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Ensure that PWIDs continue to have access to the full array of recovery support services (RSS) in a post-Medicaid expansion environment wherein treatment costs are already paid for by Medicaid.

Objective:

Develop processes which ensure access to RSS for all PWIDs receiving Medicaid-funded SUD treatment.

Strategies to attain the objective:

Develop a process that promotes continuity of care; communicate process to all Medicaid providers; track access rate (percentage of all PWIDs requesting RSSs will have access to those services within 30 days of initial request.)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: PWIDs requesting RSSs will have access to those services within 30 days of initial request.

Baseline Measurement: 80% of all PWIDs requesting RSSs will have access to those services within 30 days of initial request.

First-year target/outcome measurement: 85% of all PWIDs requesting RSSs will have access to those services within 30 days of initial request.

Second-year target/outcome measurement: 90% of all PWIDs requesting RSSs will have access to those services within 30 days of initial request.

Data Source:

Idaho's approved electronic health record, Web Infrastructure for Treatment Services (WITS), and reports from managed services contractor

Description of Data:

Number of PWIDs requesting RSS; number who received it; number of days from request to access.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Priority #: 13

Priority Area: Tuberculosis

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Promote screening for TB among clients served with Block Grant funded Substance Use Disorder (SUD) services.

Objective:

Ensure clients accessing services funded by the Block Grant who are at-risk are screened for TB and referrals for testing and services are made available to promote public health.

Strategies to attain the objective:

Clients who are accessing SUD and/or RSS funded by the Block Grant shall be screened for TB and have access to referrals for testing and services if needed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Clients served with Block Grant funded Substance Use Disorder (SUD) services will be screened for TB and referrals for testing and services will be made

Baseline Measurement: 80%

First-year target/outcome measurement: 85%

Second-year target/outcome measurement: 97%

Data Source:

Provider auditing conducted by our Managed Services Contractor through regular auditing.

Description of Data:

Description of data: Client chart audits will reveal whether or not the client has been screened as being at-risk for TB and will reflect

which when referrals for testing have been made and any follow-up that was conducted.

Data issues/caveats that affect outcome measures::

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

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	$13,161,622		$0	$6,643,684	$27,893,329	$0	$0
a. Pregnant Women and Women with Dependent Children**	$1,300,000		$0	$0	$0	$0	$0
b. All Other	$11,861,622		$0	$6,643,684	$27,893,329	$0	$0
2. Primary Prevention	$0		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$3,626,000		$0	$3,670,000	$159,000	$0	$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	$2,000		$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)	$280,000		$0	$0	$93,333	$0	$0
10. Total	**$17,069,622**	**$0**	**$0**	**$10,313,684**	**$28,145,662**	**$0**	**$0**

* 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:

Revision Request Response 9/17/19: We verify the column E. State Funds represents our best efforts to project state expenditures for FY 2020 and 2021 based on preliminary budget predictions for the state, when taking into account budget changes that will take effect as part of Medicaid expansion, which takes effect Jan. 1, 2020. NOTE: Column E State Funds was updated Oct. 1, 2019 to reflect an update to our state expenditure projections for FY 2020 and 2021.

As the state of Idaho is preparing for Medicaid expansion, which will take effect Jan. 1, 2020, we have done our best to project expenditures for 2021 based on preliminary budget predictions for column E.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

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							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$0	$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$791,436	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$0	$0	$0
7. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$6,727,208	$0	$0	$0	$0	$0
9. Administration (Excluding Program and Provider Level)***		$395,718	$0	$0	$0	$0	$0
10. Total	**$0**	**$7,914,362**	**$0**	**$0**	**$0**	**$0**	**$0**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

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 FY19 allocated budget.

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	7878	45
2. Women with Dependent Children	22781	282
3. Individuals with a co-occurring M/SUD	21225	1897
4. Persons who inject drugs	5262	680
5. Persons experiencing homelessness	404	236

Please provide an explanation for any data cells for which the state does not have a data source.

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Footnotes:

An explanation of the data sources used to gather this information is attached as "Table 3 SUD Data Sources.docx."

Table 3 SABG Persons in Need/Receipt of SUD Treatment – Data and Data Sources

State Identifier: Idaho		
Population	**Aggregate Number Estimated in Need**	**Aggregate Number in Treatment**
1. Pregnant Women[1]	**7,878**	**45**
2. Women with Dependent Children[2]	**22,781**	**282**
3. Individuals with co-occurring M/SUD[3]	**21,225**	**1,897**
4. Persons who inject drugs[4]	**5,262**	**680**
5. Persons experiencing homelessness[5]	**404**	**236**

Aggregate Number Estimated in Need Data Sources:

[1]Pregnant Women in Need – Data source and methodology

According to the United States Census Bureau, Idaho's population as of July 1, 2018, was estimated at 1,754,208, with an estimated 49.9 percent women (about 875,350 people).

According to the Substance Abuse and Mental Health Data Archive, the 2017 National Survey on Drug Use and Health indicates that 0.9 percent of women nationally reported being pregnant and also reported they needed treatment for drug or alcohol use but did not receive it in the past year.

Applying the National Survey data to Idaho's census can give us an estimation that about (875,350 women X 0.9%) **7,878.15** women were pregnant between 2017 and 2018 and needed treatment for drug or alcohol use but did not receive it in the last year.

Sources:

- **From SAMHDA** (Are You Pregnant/Needed Treatment for Drug/Alcohol Use, Not RCVD): https://pdas.samhsa.gov/#/survey/NSDUH-2017-DS0001?column=TXYNSPILAL&results_received=true&row=PREGNANT&run_chisq=false&weight=ANALWT_C
- From: www.census.gov: https://www.census.gov/quickfacts/fact/table/ID,US/PST045218

[2]Women with Dependent Children in Need – Data Source and Methodology

According to the United States Census Bureau, Idaho had an estimated 609,124 households between 2013 and 2017.

According to the Substance Abuse and Mental Health Data Archive, the 2017 National Survey on Drug Use and Health indicates that 3.74 percent of respondents who identified as Mother in Household also reported they needed treatment for drug or alcohol use but did not receive it in the past year.

Applying the National Survey data to Idaho's census can give us an estimation that about (609,124 households X 3.74%) **22,781.24** women with dependent children in Idaho needed treatment for drug or alcohol use but did not receive it in the last year.

Sources:

- **From SAMHDA:** (Mother in Household/Needed Treatment for Drug/Alcohol Use, Not RCVD): https://pdas.samhsa.gov/#/survey/NSDUH-2017-DS0001/crosstab/?column=IMOTHER&results_received=true&row=TXYNSPILAL&run_chisq=false&weight=ANALWT_C
- **From census.gov**: https://www.census.gov/quickfacts/fact/table/ID#

[3]Individuals with co-occurring M/SUD – Data Source and Methodology

According to the United States Census Bureau, Idaho's population as of July 1, 2018, was estimated at 1,754,208.

According to the Substance Abuse and Mental Health Data Archive 2017 National Survey on Drug Use and Health, of the individuals surveyed who reported illicit drug use in the past year, 1.21 percentreported receiving mental health treatment in the past year.

Applying the National Survey data to Idaho's census data, we can estimate that (1,754,208 X 1.21%), **21,225.91** Idahoans had a co-occurring disorder between 2017 and 2018.

Sources:

- **From SAMHDA: NSDUH, 2017 data (Illicit Drug Abuse Past Year, Received any mental health treatment last year):** https://pdas.samhsa.gov/#/survey/NSDUH-2017-DS0001?column=AMHTXRC3&results_received=true&row=ABUSEPYILL&run_chisq=false&weight=ANALWT_C
- From Census.gov: www.census.gov: https://www.census.gov/quickfacts/ID

[4]Persons Who Inject Drugs – Data Source and Methodology

According to the United States Census Bureau, Idaho's population as of July 1, 2018, was estimated at 1,754,208.

Based on an article shared on the National Institute of Health US National Library of Medicine titled "Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections", 0.3 percent of the population was estimated to have been a person who injected drugs in the past year.

Applying the article data to Idaho's census data, we can estimate that (1,754,208 X .3%), **5,262.62** Idahoans have injected drugs in the past year. This estimate is limited due to the age of the article, which was conducted in 2014 compared to the census estimate dated in 2018. A more accurate estimate also would have been available if the census population estimate (all Idahoans regardless of age) matched the age of those involved in the article – individuals 13 and older. These limitations lead us to believe the actual estimate may be somewhat lower because of the inclusion of children younger than 13 in the census estimate.

Sources:

- **From: ncbi.nlm.nih.gov:** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4026524/
- **From census.gov:** https://www.census.gov/quickfacts/ID

[5]Persons Experiencing Homelessness in Need – Data Source and Methodology

The Aggregate Number Estimated in Need was calculated using the 2019 Boise City/Ada County Continuum of Care Point In Time Count Report and the 2019 Balance of State Continuum of Care Point In Time Count Report:

Sources:

- https://www.idahohousing.com/documents/point-in-time-count-2019.pdf --pg. 21: Homeless Adults with Substance Abuse for Balance of State Continuum of Care (all counties besides Ada County): **215 total persons**
- 2019 Balance of State Continuum of Care Point In Time Count Report: https://www.icalliances.org/2019-bcac-point-in-time-housing-inventory-count --under 2019 Subpopulations tab: Total homeless adults with Substance Abuse for Boise City/Ada County Continuum of Care (Ada County only): **189 persons**

By combining the number of individuals experiencing homelessness who identified as having Substance Abuse during the 2019 Point in Time Count, it is estimated that the total aggregated number of Idahoans estimated in need who are experiencing homelessness (215 + 189) is **404 persons.**

Aggregate Number in Treatment Data Sources:

1. Source for all Data:

a. WEB Infrastructure for Treatment Services (WITS) data obtained from/using SSRS

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 Intravenous Drug Use (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 SFY2018 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

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	$6,580,811
2 . Primary Substance Abuse Prevention	$1,813,000
3 . Early Intervention Services for HIV**	
4 . Tuberculosis Services	$1,000
5 . Administration (SSA Level Only)	$140,000
6. Total	**$8,534,811**

* Prevention other than Primary Prevention

** 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.

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**
1. Information Dissemination	Universal	$259,517
	Selective	
	Indicated	
	Unspecified	
	Total	**$259,517**
2. Education	Universal	$810,290
	Selective	$127,003
	Indicated	$10,029
	Unspecified	
	Total	**$947,322**
3. Alternatives	Universal	$26,714
	Selective	$67,929
	Indicated	
	Unspecified	
	Total	**$94,643**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	$111,815
	Unspecified	
	Total	**$111,815**
	Universal	$29,551

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	**$29,551**
6. Environmental	Universal	$10,152
	Selective	
	Indicated	
	Unspecified	
	Total	**$10,152**
7. Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$1,453,000**
Total SABG Award*		**$8,534,811**
Planned Primary Prevention Percentage		**17.02 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:

Amount of primary prevention funds reported on Table 4, Row 2, that are planned to be expended on Non-Direct-Services/System Development for SABG Prevention (Table 6): $360,000

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	
Universal Indirect	
Selective	
Indicated	
Column Total	**$0**
Total SABG Award*	**$8,534,811**
Planned Primary Prevention Percentage	**0.00 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Idaho completed Table 5A for this application.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	☑
Tobacco	☐
Marijuana	☑
Prescription Drugs	☑
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☐
Military Families	☐
LGBTQ	☐
American Indians/Alaska Natives	☑
African American	☐
Hispanic	☑
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☑
Underserved Racial and Ethnic Minorities	☑

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

FY 2020			
Activity	**A. SABG Treatment**	**B. SABG Prevention**	**C. SABG Combined***
1. Information Systems	$155,654	$58,226	
2. Infrastructure Support	$25,165		
3. Partnerships, community outreach, and needs assessment	$75,494	$62,500	
4. Planning Council Activities (MHBG required, SABG optional)		$8,663	
5. Quality Assurance and Improvement	$25,165	$120,523	
6. Research and Evaluation		$82,500	
7. Training and Education		$27,588	
8. Total	**$281,478**	**$360,000**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.
0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:

This table has been completed to reflect expenditures for non-direct services/system development with that will be funded with FFY 2020 SABG funds.

Amount of primary prevention funds reported on Table 4, Row 2, that are planned to be expended on Non-Direct-Services/System Development for SABG Prevention (Table 6): $360,000

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019 MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	$69,196
2. Infrastructure Support	$495,718
3. Partnerships, community outreach, and needs assessment	$840,000
4. Planning Council Activities (MHBG required, SABG optional)	$40,000
5. Quality Assurance and Improvement	$430,800
6. Research and Evaluation	
7. Training and Education	
8. Total	**$1,875,714**

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:

MHBG State Fiscal Years- 7/1/2019-6/30/2021 Per instructions enter 24 month planning dates.
Information Systems- WITS $69,196
Infrastructure- Suicide Hotline $100,000, Administration $395,718.10; Partnerships-Consumer and Family Empowerment Contract $520,000, Suicide Prevention Council $20,000, Behavioral Health State Planning council Recommendations $300,000
Planning Council-$40,000
QA-Certification Contract $430,800

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] 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.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

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.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] 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.[27]
Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD 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.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] 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 M/SUD include: developing models for inclusion of M/SUD 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.[30] 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 M/SUD 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[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD 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.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]
One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] 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.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD 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.[39] 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 M/SUD 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.[40]
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.[41] 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.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

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[24] Comorbidity: Addiction and other mental illnesses, **http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses** Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; **http://www.samhsa.gov/co-occurring/**

[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **http://www.samhsa.gov/health-disparities/strategic-initiatives**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **http://telehealthpolicy.us/medicaid**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

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[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**; National Behavioral Health Quality Framework, Draft, August 2013, **http://samhsa.gov/data/NBHQF**

[41] 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 2015, the Idaho Health Care Coalition established a Behavioral Health Integration sub-committee headed by the Division of Behavioral Health. This committee supports the work of the Statewide 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.

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.

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. In November of 2016, a contract with Empower Idaho was established requiring specific activities around parity education. They have enhanced their website with information about parity, including an infographic 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 https://www.empoweridaho.org/parity-law/. The current contract tasks Empower Idaho with holding three face-to-face parity trainings throughout the state, one in each of the state's regionally based hubs. These have been established and unfortunately have not yielded any participants yet. Trouble-shooting around advertising has been discussed and will be followed up on as the contract monitor works with the contractor. Empower Idaho has researched 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. Empower Idaho has worked with the DOI to suggest that they update the information on the DOI's website regarding parity.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ◉ No

b) and Medicaid? ◉ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The Division of Behavioral Health collaborated closely with the Statewide Healthcare Innovation Plan (SHIP – a SIM initiative) to fund the development of and implement an interface between WITS and the Idaho Health Data Exchange (IHDE) clinical portal. The purpose of the interface is to increase treatment and service coordination between DBH and medical providers/hospitals/ERs that participate in IHDE. Upon implementation (anticipated September 2019), DBH staff will have access to client medical data on the IHDE clinical portal, and medical providers who participate in IHDE will have access to DBH client data that is transmitted to the IHDE clinical portal.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (●) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

- **a)** Prevention and wellness education ( ) Yes (●) No
- **b)** Health risks such as
  - **ii)** heart disease (●) Yes ( ) No
  - **iii)** hypertension (●) Yes ( ) No
  - **iv)** high cholesterol (●) Yes ( ) No
  - **v)** 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 with several competing projects and issues that could potentially impact the parity analysis and implementation. For one, the state is still in the middle of a settlement agreement for services for children with SED that requires compliance by May/June 2020. In addition, Idaho is in the beginning stages of Medicaid Expansion and as this transition unfolds over the next several years the service system could begin to look different. The Division of Behavioral Health is working with its state agency partners and providers to prepare for Medicaid enrollment beginning in November 2019, with expansion coverage beginning in January 1, 2020.

10. Does the state have any activities related to this section that you would like to highlight?

In November of 2016, a contract with Empower Idaho was established requiring specific activities around parity education. They have enhanced their website with information about parity, including an infographic 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 https://www.empoweridaho.org/parity-law/. The current contract tasks Empower Idaho with holding three face-to-face parity trainings throughout the state, one in each of the state's regionally based hubs. These have been established and unfortunately have not yielded any participants yet. Trouble-shooting around advertising has been discussed and will be followed up on as the contract monitor works with the contractor. Empower Idaho has researched 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. Empower Idaho 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

NO technical assistance requested at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD 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)[45].

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."[46]

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[47]. 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[48]. 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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

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

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

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, sexual orientation, gender identity, 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 M/SUD 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) Standards? ( ) Yes (●) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (●) No

7. Does the state have any activities related to this section that you would like to highlight?

Idaho's Jeff D. Lawsuit Settlement Agreement (2015) requires Workforce Training and Development for the children's mental health system of care, now called Youth Empowerment Services (YES). A work group was established, and in 2017 a plan was implemented to address gaps in the workforce capacity and deliver services to eligible Class Members.

Boise State University was contracted to research and report on the state's current workforce capacity and gaps analysis. This report targeted Medicaid network providers and not those outside the Medicaid system. The report found that although the state "appears to be on track to addressing its shortage counselors, mental health professionals, and social workers, ... Idaho needs to increase its mental health services workforce for youth by approximately 16% in order to deliver YES services and supports to youth with SED."

Boise State University was also contracted to survey provider capacity across the state. In regard to disparities as noted in this section of the Block Grant [(1) identify subpopulations (e.g., 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.], the Provider Survey Results report states that "the gender of staff is overwhelmingly female" and although "Hispanic and Latino people comprise 12%" Idaho's population, "organizations reported only 3.7% of employees are Hispanic or Latino." The same holds true for employees who identify as American Indian, Alaska Native, African American, Asian and Other; their numbers are significantly lower than those of the same race within Idaho. There are a number of organizations with Spanish speaking staff, but solo-practitioners report a much lower number of staff who can speak Spanish. Growing the mental health provider field so that it matches more closely the actual population of the state would assist in closing the disparity gap.

The YES Workforce Development Work Group and the upcoming Medicaid Expansion Project Team need to incorporate these elements into their project goals.

Please indicate areas of technical assistance needed related to this section

NO technical assistance being requested at this time.

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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.

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its 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 M/SUD 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 M/SUD 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. SAMHSA's Evidence Based Practices Resource Center 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. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. 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."[53] 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 M/SUD 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)**[54] are best practice guidelines for the SUD treatment. SAMHSA 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)**[55] was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and 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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[49] 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

[50] 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.

[51] 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.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

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)** [x] Leadership support, including investment of human and financial resources.
- **b)** [x] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** [x] Use of financial and non-financial incentives for providers or consumers.
- **d)** [x] Provider involvement in planning value-based purchasing.
- **e)** [x] 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.

3. 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.

No technical assistance is requested at this time.

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Footnotes:

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 service efforts 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 outcomes 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.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. 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 Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG 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.

3. How does the state promote the use of evidence-based practices for individuals with 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. All the three state FEP programs participate in a conference call once a month to share ideas, successes, failures and to further develop program implementation. A primary focus of the conference call 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 ESMI? (•) Yes ( ) No

5. Does the state collect data specifically related to ESMI? (•) Yes ( ) No

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. Family support, education, and supported employment are also core components of the program. Each team has an assigned prescriber (psychiatrist or physician assistant) providing medication management and education on medications and side effects. All programs are fully staffed. Region 3 and 7 are close to capacity and Region 6 is above 50% capacity.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

- Provide an annual statewide training for FEP staff. This training will focus model fidelity and training of new programs.
- Create statewide policy and guidelines for FEP teams.
- Develop and implement a dedicated FEP website.
- Develop standardized FEP data and outcome measure.
- Develop and implement process for collecting and analyzing statewide FEP data.
- Explore ways to expand services across more regions in the state of Idaho.

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.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Schizophrenia
- Schizoaffective Disorder
- Schizophreniform
- Bipolar I
- Delusional Disorder
- Psychosis NOS

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

NO Technical Assistance requested at this time.

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Footnotes:

Environmental Factors and Plan

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 team 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, education, 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 has policies about person centered planning in our Family and Community Service Developmental Disability Division and for children, youth, and families who accessing Medicaid and designated mental health services through a 195i waiver. The Division of Behavioral Health has a standard of care for Person Centered Planning that establishes a goal for behavioral health services statewide.

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, and recovery orientated.

4. Describe the person-centered planning process in your state.

In January 2018, the State of Idaho Division of Behavioral Health (DBH) implemented a high-fidelity model of Wraparound within its state-run agencies. This model is based in the National Wraparound Initiative (NWI) training and incorporates an Idaho coaching model, Idaho wraparound standards, and quality monitoring. The Idaho Wraparound program has been branded Idaho WInS (Idaho Wraparound Intensive Services). Idaho WInS is intended for those youth and family that are multi-system involved and have high needs as identified on the Idaho CANS (Child and Adolescent Strengths and Needs tool).

Wraparound is a collaborative, team-based, principles driven planning process that is supportive of the family and youth voice and choice and comprised of teams of natural, informal, and formal supports. Like person centered planning, the high-fidelity Wraparound planning process is conducted with adherence to the ten (10) principles of Wraparound ensuring it is collaborative, family driven, and youth guided, individualized, and strengths-based care. Wraparound builds on the natural supports of the youth and family, is culturally and linguistically responsive, community based, team-based, and outcomes based. In Wraparound the teaming process does not end if there are no services or supports, the Wraparound team is persistent in strategizing and identifying ways in which the youth and family can successfully meet their needs.

The Wraparound Coordinator collaborates with the youth, family and team to assist them to develop one coordinated plan of care that is grounded in the family vision for the future and supported by a team mission statement. The youth, family, and team work to prioritize needs of the youth and family and develop outcomes to meet those needs. The Wraparound team strategizes different interventions to meet those needs and assigns actions steps to all team members to support the youth and family.

Wraparound Coordinators are provided coaching in a variety of formats regarding their Wraparound practice. They are also provided clinical supervision to provide them with support regarding each family's unique needs. Coordinators are developed over the course of several years fine tuning their practice to provide high fidelity and quality Wraparound to Idaho's youth and families.

Idaho WIns will utilize multiple methods to assess for quality. Standardized fidelity measures to assess the Wraparound program statewide with the use of the Wraparound Fidelity Index, shortened version (WFI-EZ) and the TOM 2.0 (Team Observation Measure), in addition to utilization data at all decisions points in care using the CANS and outcome management principles, and on-going Continuous quality improvement (CQI_ such as record review. These standardized tools will address the adherence to the Wraparound model and the youth and family's perceptions regarding their experience in the planning process. Both measures focus upon the principles of collaborative team-based care, focuses upon the strengths of the youth and family, and the

use of natural supports and outcomes of the identified needs. These tools are also utilized in the coaching model to provide feedback for skill development of the Wraparound Coordinators.

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

No Technical Assistance requested at this time.

Footnotes:

Environmental Factors and Plan

6. 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 M/SUD 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 M/SUD 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 M/SUD 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 program requirements, including quality and safety standards? (●) Yes ( ) No

3. 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

No technical assistance is requested at this time.

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Footnotes:

Environmental Factors and Plan

7. 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**[56] 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.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

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.

3. Does the state have any activities related to this section that you would like to highlight?

Idaho is actively pursuing a new common assessment tool and the tribes were involved in the selection process.

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

No technical assistance is requested at this time.

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Footnotes:

Environmental Factors and Plan

8. 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:

1. ***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;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***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;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (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)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [ ] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [x] Archival indicators (Please list)

Alcohol-and drug-related arrest data; alcohol-and drug-related motor vehicle crashes; hospital data (e.g. alcohol- and drug-related emergency department visits); opioid prescribing rates per 100/individuals; gallons of liquor sold per capita; treatment episode data sets; and morbidity data (e.g., alcohol- and drug-related deaths).

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] 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 are routinely identified as a population that suffers disproportionately from alcohol-related harms. From this data, ODP has expanded its support of culturally-based programs specifically developed for the Native American community by funding both Project Venture, an evidence-based experiential program designed for youth; and White Bison Wellbriety, a promising practices prevention program for youth and families with the overall goal of decreasing risk factors in the community that are favorable to alcohol and substance use by youth.

Idaho's underserved Hispanic and rural populations are prioritized during the competitive annual grant review process. Seven regional grant review committees are tasked with reviewing, scoring and discussing each application received in their region. Committee members are representative of the regional population and know first- hand the gaps and needs existing in each area. Applicants are expected to use needs assessment data specific to their communities when completing their applications.

ODP has used state needs assessment data to identify the need to translate 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:

Narratve 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:

1. ***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;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***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;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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.

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) currently implements a statewide Certified Prevention Specialist (CPS) credentialing program for the SABG substance misuse prevention workforce.

ODP maintains the following expectation for all returning SABG primary prevention grant applicants: "Beginning July 1, 2018, at least one staff member in each agency or organization receiving Block Grant funds to deliver substance abuse prevention programs/services from ODP will hold a Certified Prevention Specialist (CPS) certification." IBADCC serves as the credentialing board.

To encourage new grant applicants and accommodate provider turnover, ODP also supports an entry-level certification program. A Provisional Prevention Specialist (PPS) ccrtificate allows new prevention providers to acquire the experience and education necessary to apply for certification as a CPS. ODP maintains the following expectation for all new SABG primary prevention grant applicants: "Beginning July 1, 2018, at least one staff member in each agency or organization that has not received two years of consecutive grant funding from ODP between July 1, 2016 and June 30, 2019 must hold the Provisional Prevention Specialist (PPS) credential within the first 120 days of hire or initiation of the FY2020 grant award." PPS candidates must complete the following courses: 1) Five (5) hours of Substance Abuse Specialist Training; and Four (4) hours of Prevention Ethics. ODP serves as the monitor for PPS certification compliance.

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

ODP's formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce includes: 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.

ODP hosts annual grantee web-based trainings designed to educate new grantees and update returning grantees regarding SABG guidelines, requirements and performance expectations. ODP's SABG Grant Project Director is a member of SAMSHA's Northwest Prevention Technology Transfer Center's (PTTC) Advisory Council, which has allowed ODP to make available monthly, high quality TTA services to Idaho's providers, as well as provide a path forward toward PPS & CPS certifications.

Pacific Institute for Research and Evaluation (PIRE), the State evaluators, will deliver semi-annual presentations to address compliance, fidelity and data collection as related to the statewide evaluation plan. Additionally, ODP has recently contracted with

a local agency to develop a Learning Management System (LMS) to serve as a more formal mechanism to provide, and track, training and technical assistance to Idaho's substance use disorder prevention workforce. The new LMS system is scheduled to"go live" August 1, 2019.

ODP is in the process of developing course content for five additional cohorts of training to be made available on the LMS and map directly to the required CPS domains. Courses in each of the following domains will be provided: Planning and Evaluation; Prevention Education and Service Delivery; Communication; Community Organization; Public Policy and Environmental Change; and, Professional Growth and Responsibility. LMS web-based courses will allow ODP to reach workforce members in our rural and frontier communities as well as our urban areas.

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.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

In 2019, ODP contracted with Pacific Institute for Research and Evaluation (PIRE) to evaluate both the SABG and the Partnership for Success (PFS) grant. Assessing Idaho's community readiness to implement prevention strategies is formally included in the in the Annual Statewide Evaluation Report, beginning with the 2020 report, and in the Final Statewide Evaluation Report in 2023.

Narratve 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:

1. ***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;
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5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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.

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

The Strategic Plan is attached as " Primary Prevention ODP Strategic Plan FY20_v2.docx.

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)** [x] 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. The EBP Workgroup is composed of research professionals from several state agencies. 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 Blueprints, and 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.

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.

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 SABG 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 (RADAR) Center
"Speak Out, Opt Out, Throw Out" statewide Prescription Drug Media Campaign
"Be The Parents" statewide Underage Drinking Media Campaign
Coalition Town Hall Events
Community Lunch & Learn Sessions
Health Fairs/Symposium
Idaho Drug Free Youth Leadership Conference

b) Education:

Project Alert; Nurturing Parenting Program; Second Step; Positive Action; Project Towards No Drug Abuse; Project Towards No Tobacco Use; Strengthening Families; Life Skills Training; Guiding Good Choices; Active Parenting; Too Good for Drugs; Active Parenting; Refuse, Remove, Reason; Third Millennium Classroom; and, Boomerang Project/Link Crew

c) Alternatives:

Cross Age Mentoring Program (CAMPS); Positive Action/Prime Time for Kids After School Activities; Drop-in Recreational

Activities; Community Service Activities; Project Venture.

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; Idaho Healthy Youth School Survey Design and Implementation

f) Environmental:

"Escape the Vape" Vaping Policy change; Statewide Underage Sticker Shock Campaigns; Prescription Medication Take-back Programs Social Host Ordinances; Middle School Positive Social Norms Campaign; and Rx Drug Take-Back Drop Boxes and Community Events

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. For example, a recently hired State Opioid Coordinator reports to both the Idaho Department of Health and Welfare and ODP in an effort to track all opioid -related funds received, and related programs implemented, to 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."

Narratve 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:

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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.

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

The plan is attached as "Idaho SABG PFS Statewide Evaluation Plan - Final."

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [x] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [x] 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)** [x] Numbers served
- **b)** [x] Implementation fidelity
- **c)** [x] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] 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)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [x] Heavy use
- [x] Binge use
- [x] 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):

Footnotes:

Strategic Plan & Performance Measures
Fiscal Years Ending June 30, 2019 – June 30, 2023

MISSION - The Idaho Office of Drug Policy leads Idaho's substance use and misuse policy and prevention efforts by developing and implementing strategic action plans and collaborative partnerships to reduce drug use and related consequences.

VISION - The Idaho Office of Drug Policy envisions a safe and healthy Idaho free from the devastating impact of substance use on youths, families, and communities.

AGENCY OVERVIEW – The Idaho Office of Drug Policy was established by HB 106 (Idaho Code 67-821) in 2007. The Office includes six full-time staff members. Its purpose is to coordinate policy and programs related to the prevention of substance use and misuse. In addition, the Office is committed to involving local communities and additional public and private stakeholders in the ongoing process of improving the effectiveness and availability of prevention work across all 44 of Idaho's counties.

KEY EXTERNAL FACTORS

- Legislation can alter or significantly impact the functions of the Idaho Office of Drug Policy.
- The Administrator serves the Governor; therefore, the duties and responsibilities of the Administrator are subject to change as the Governor requires.
- Economic conditions within the state and its regions are very dynamic and there is a correlation between substance use and misuse and the economy.
- The Idaho Office of Drug Policy collaborates with a wide range of stakeholders. Each stakeholder is governed by their organization's policy and procedure, needs, and priorities. Therefore, the duties and responsibilities of stakeholders on whom ODP frequently relies for coordination and implementation of prevention strategies are subject to change.
- New drug threats are frequently emerging. Therefore, it may be necessary to adapt the strategic plan and shift resources should new and immediate drug threats arise.

AUTHORITY - The Office of Drug Policy (ODP) was established under Idaho Code 67-821. The purpose of the Office is to coordinate policy and programs related to drug and substance abuse.

Idaho Code 67-821. COORDINATION OF POLICY AND PROGRAMS RELATED TO DRUG AND SUBSTANCE ABUSE.

(1) There is hereby established in the office of the governor the "Office of Drug Policy." The administrator of the office of drug policy shall be the official in the state designated to oversee and execute the coordination of all drug and substance abuse programs within the state of Idaho. The administrator shall be appointed by and shall serve at the pleasure of the governor, and shall be subject to confirmation by the state senate.

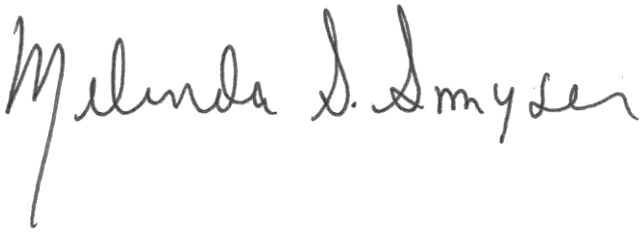
(2) The office of drug policy shall:

  (a) Cooperate and consult with counties, cities and local law enforcement on programs, policies and issues in combating Idaho's illegal drug and substance abuse problem;

  (b) Serve as a repository of agreements, contracts and plans concerning programs for combating illegal drug and substance abuse from community organizations and other relevant local, state and federal agencies and shall facilitate the exchange of this information and data with relevant interstate and intrastate entities;

  (c) Provide input and comment on community, tribal and federal plans, agreements and policies relating to illegal drug and substance abuse; and

  (d) Coordinate public and private entities to develop, create and promote statewide campaigns to reduce or eliminate substance abuse."



Melinda S. Smyser, Administrator

IDAHO CODE 67-821, 2a

"Cooperate and consult with counties, cities and local law enforcement on programs, policies and issues in combating Idaho's illegal drug and substance abuse problem"

GOAL 1

Collaborate and partner with counties, cities, and local law enforcement to combat substance use and misuse in Idaho.

Objectives	Performance Measures	Target	How Established
1. Meet with representatives of counties, cities, and local law enforcement throughout the state to share information about local, state, and national drug issues and resources.	1. Visits[1] with representatives of counties, cities, and local law enforcement officials	6 regions of the state visited each year	ODP staff
2. Provide support to law enforcement (LE) agencies seeking to establish programs to combat substance use disorders such as Rx drug take back programs, naloxone programs, and underage alcohol enforcement operations.	2. Number of LE agencies supported each year to combat substance use disorders	21 agencies per year	ODP staff

IDAHO CODE 67-821, 2b

"Serve as a repository of agreements, contracts and plans concerning programs for combating illegal drug and substance use and misuse from community organizations and other relevant local, state and federal agencies and shall facilitate the exchange of this information and data with relevant interstate and intrastate entities"

GOAL 2

Research, identify, recommend and fund plans, strategies, and evidence-based programs addressing substance use and misuse prevention and make available to stakeholders throughout Idaho.

Objectives	Performance Measures	Target	How Established
3. Administer grant programs for community substance use and misuse prevention efforts throughout the state.	3a. The percentage of action plans provided from grantees.	100% of grantees will submit annual action plans	ODP grant requirements
	3b. Data collected from funded grantees	80% of grantees will submit complete evaluation data[2]	ODP and SAMHSA grant requirements
4. Gather and distribute substance use and misuse prevention information and data to Idaho stakeholders via websites[6], newsletters, reports, social media and other communications	4a. Number of presentations[3], newsletters, booths, or reports[4] provided annually	At least 30 presentations[3], newsletters, booths, or reports[4] provided annually	ODP staff
	4b. Annual website[5] visitors and social media reach and engagement	Website[5] visits and social media engagements analytics will show an increase annually.	ODP staff
5. Provide training[2] to grantees and stakeholders to build skill development to implement prevention activities.	5. Number of courses available annually	7 online courses available and 15 trainings[6] provided	ODP staff and grantees

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6. Coordinate working groups in implementing strategic plans to address Idaho's most pressing drug issues.	6. Trend data on substance use and misuse and related data points	Idaho's substance use and misuse rates will maintain or decrease.	ODP staff

IDAHO CODE 67-821, 2c

"Provide input and comment on community, tribal and federal plans, agreements and policies relating to illegal drug and substance abuse"

GOAL 3

Consult with stakeholders regarding substance use and misuse policy issues.

Objective	Performance Measures	Target	How Established
7. Provide input to local, state, tribal and federal governments regarding drug policy as deemed appropriate by the Governor.	7. Reports[4], testimony or other communications relating to drug policy as deemed appropriate by the Governor	100% of requested reports[4], testimony, or other communications from the Governor and Legislature	Governor's staff and the ODP administrator

IDAHO CODE 87-621, 2d

"Coordinate public and private entities to develop, create and promote statewide campaigns to reduce or eliminate substance abuse"

GOAL 4

Partner with public and private entities to implement campaigns to combat substance use and misuse in Idaho.

Objectives	Performance Measures	Target	How Established
8. Coordinate public and private entities to create, develop and promote statewide communications campaigns regarding substance use and misuse.	8a. The match ratio for public service announcements placed	3:1 match	ODP staff and media contractor
	8b. Number of partner entities that distribute print and collateral materials	50 partner entities that distribute materials	ODP staff
	8c. Reach of digital media buys	Maintain or increase unique reach	ODP staff and digital analytics
	8d. Number of grantees that develop and implement community communication campaigns[7]	10 grantees	ODP staff and grantees

[1]Visits are meetings for the purpose of developing strategic planning, gathering information, conducting grantee site visits and the like. These visits are not intended for training or presentation purposes.
[2]Federal grantee NOMS data and pre/post surveys
[3]Presentations indicates one-way communication to disseminate information, these do not include trainings.
[4]Reports are documents that may include fact sheets, white papers, or evaluation or survey reports for external consumption.
[5]ODP websites include odp.idaho.gov, prevention.odp.idaho.gov, and betheparents.org.
[6]Training indicates any one-time event that is hosted or funded by ODP, either online or in-person, that aims to improve skill in components including but not limited to grant reporting and substance abuse prevention project or program delivery.
[7]A communication campaign is a broad-based communication effort to promote awareness or behavior change regarding substance use or misuse.

PACIFIC INSTITUTE FOR RESEARCH AND EVALUATION

State of Idaho
Office of Drug Policy
SABG and PFS Statewide Evaluation Plan

April 2019

SUBMITTED BY:
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INTRODUCTION

The Idaho Office of Drug Policy (ODP) manages the prevention portion (20%) of the Substance Abuse Block Grant (SABG) and the Strategic Prevention Framework Partnership for Success grant (PFS) aimed at preventing and reducing substance abuse among residents of Idaho. Both grants are funded by the U.S. Center for Substance Abuse Prevention/Substance Abuse and Mental Health Services Administration (CSAP/SAMHSA) and they represent the majority of substance abuse prevention funding received by the State of Idaho.

In 2019, ODP contracted with Pacific Institute for Research and Evaluation (PIRE) to evaluate the SABG and the PFS grant. This document provides the evaluation plans for each initiative developed by PIRE in conjunction with ODP. The document is divided into two main sections, one for the SABG and one for PFS.

SABG EVALUATION PLAN

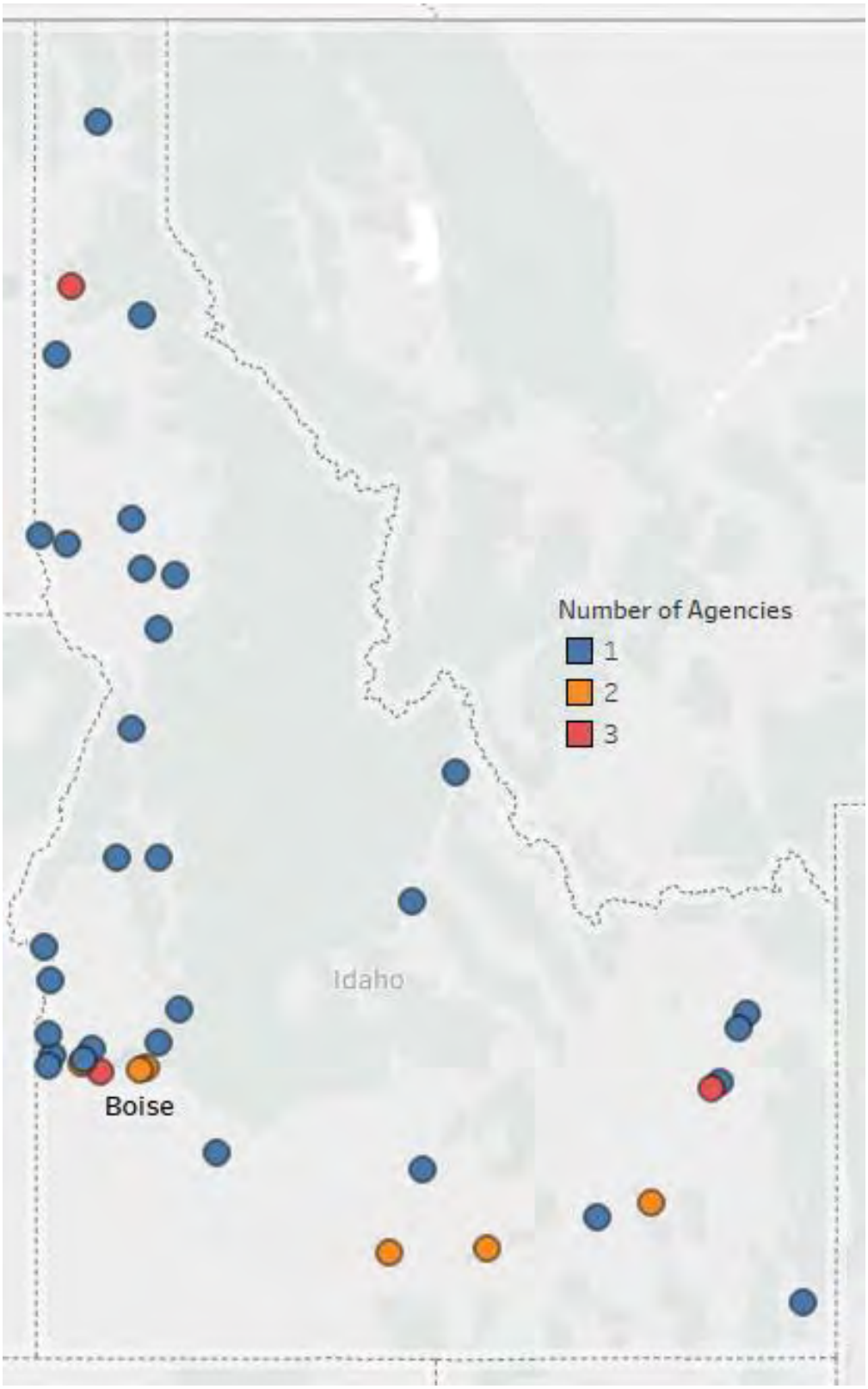
Overview

Like all states, jurisdictions, and territories, Idaho receives an annual SABG that provides resources for substance abuse prevention and treatment services throughout the state. The SABG is distributed to states using a population-based formula, and states are required to allocate at least 20% of the grant for prevention services. In Idaho, ODP undertakes a competitive bidding process for community-based providers, thus ensuring that the prevention portion of the grant is distributed across the state to provider agencies with the capacity to deliver evidence-based prevention services within their communities. In FY ’19, ODP executed contracts with 54 prevention providers. Figure 1 displays a map of these provider agencies.

The SABG requires providers to deliver services using up to six approved prevention strategy categories, often referred to as the 6 CSAP Strategies. The strategies are information dissemination, prevention education, community-based processes, environmental strategies, alternative activities, and problem identification/referral. SABG providers must engage in prevention activities drawn from these strategy categories and report their activities to ODP on a quarterly basis because ODP must, in turn, report the data to SAMHSA.

Although it is not a requirement that all prevention programs be evidence-based, CSAP and ODP strongly encourage providers to engage in practices that have been demonstrated through prior research as being effective in preventing or reducing substance abuse. In addition, although prevention services can cover the lifespan, prevention services that are delivered through SABG are often aimed at adolescents and young adults. Common substances of concern include, tobacco, e-cigarettes and other vaping devices, alcohol (e.g., underage drinking, binge drinking, and impaired driving), marijuana, prescription drugs (when used in ways not prescribed by a doctor), and other illicit drugs.

Figure 1. Idaho SABG Provider Map



ODP Evaluation Activities

ODP developed and uses the SABG Program Form to capture data about each provider's processes and outputs. Each quarter, providers report on the services they provided and the populations they served. Staff from ODP compile these data, report them to SAMHSA, and generate an annual statewide report. PIRE and ODP will also discuss the possibility of adding a module to the Provider Form that prompts providers to report their quarterly achievements, barriers to implementation, and strategies to overcome those barriers. A similar module is used for the PFS grantees and could provide an opportunity for SABG grantees to regularly inform ODP of their successes and challenges.

When the Idaho providers deliver curriculum-based education programs in their communities, they must also administer pre-test and post-test surveys of the participants to determine whether the program contributed to changes in attitudes, beliefs, and behaviors related to substance abuse. ODP compiles the data and shares provider-specific results with each provider, as well as includes the aggregate findings in its annual statewide report.

PIRE Evaluation Activities

As noted above, ODP staff have extensive involvement in the administration, analysis, and reporting for the SABG Program Form. The remainder of the SABG evaluation plan will focus on activities in which PIRE will be actively engaged. A timeline for our evaluation plan activities is provided in Table 1 at the end of this section.

Program Participant Surveys

The primary sources of data about the direct influence of prevention programs on participants are pre-post surveys for younger youth (grades 4 – 5) and older youth (grades 6 – 12), as well as post-test surveys for parents. Copies of the survey instruments can be found at https://prevention.odp.idaho.gov/provider-information/.

For the current state fiscal year (through June 30, 2019), PIRE will review the existing participant surveys and recommend potential changes to measures for substance use and risk and protective factors. Recommendations will be consistent with discussions we have had with ODP staff and will be aimed at enhancing the usefulness of the instrument for ODP and provider staff. Issues we will review will include the following:

- Substance use variables (e.g., do they reflect the substances of most interest to ODP?);
- Risk and protective factors (e.g., are the constructs included commonly addressed across a variety of substance abuse prevention programs; are the constructs able to be compared to state and national data?);
- Ability to match pre-tests with post-tests; and
- Possibility of adding a pre-test to the parent survey, recognizing that this was the practice several years ago and it was changed to the current post-test only because of

various issues. We will continue discussions with ODP to ensure that our recommendations are feasible and acceptable to the providers and the parent respondents.

For subsequent years, PIRE will obtain participant survey data from ODP and generate an annual aggregate-level (across providers) report showing differences in substance use and risk and protective factors between pre-test and post-test. If we determine that it is possible to match pre-tests with post-tests, we will also include analyses that show whether students who reported no substance use at pre-test continued to abstain at post-test—what we would characterize as the classic prevention effect. We will also examine whether those who reported substance use at pre-test reported decreased use at post-test.

Implementation Fidelity

Often, the difference between a successful intervention and an unsuccessful one is whether it was implemented the way it was intended—that is, whether it was implemented with fidelity. Interventions that were well-designed and well-intentioned will have much less chance of effecting their desired change if they are not well-implemented or are not implemented with the intended dosage or strength. And only through careful monitoring will project stakeholders know if implementation in the field is going as planned, or whether modifications or mid-course corrections need to be made to enhance the likelihood of project success. Thus, implementation monitoring not only serves the evaluation, it yields the most important pieces of information that project stakeholders should attend to for interventions to reach their desired goals.

PIRE and ODP will collaborate to develop a low burden method for providers to capture basic data about implementation fidelity for curriculum-based programs, including the following:

- Percentage of content delivered
- Responsiveness of the participants
- Whether adaptations or modifications were made and, if so, the nature of the change and why it was necessary

We will work with OPD to add the fidelity items to the existing program information spreadsheet already included in the SABG Program Form, thus fully integrating fidelity measurement into the current data collection system that providers use. Providers can then complete the fidelity items after completing each program cycle. PIRE will train providers on the use of the fidelity items through a webinar that we will host, and we will be available for ongoing technical assistance.

Extant Population-Based Surveys

PIRE will use data from the ODP-funded Idaho Healthy Youth Survey (IHYS) to monitor statewide and regional changes in risk factors, protective factors, and substance use among Idaho youth. Bach Harrison provides guidance material to teachers to facilitate the

administration of the survey, analyzes the survey data, and prepares the biennial statewide report. We will use data from the annual Idaho Behavioral Risk Factor Surveillance System (BRFSS) to monitor statewide and regional changes in substance use among Idaho adults. The BRFSS is administered by the Idaho Bureau of Vital Records and Health Statistics under a cooperative agreement with the US Centers for Disease Control and Prevention (CDC).

Administrative Data

To extent they are available, we will gather county-level data from several additional sources to monitor annual changes in risk factors, protective factors, and consequences of substance use. Such data sources may include school district data (e.g., truancy, attendance, and discipline), law enforcement data (e.g., impaired driving crashes), and morbidity data (e.g., alcohol- and drug-related deaths).

SABG Data Analysis

Participant Surveys. As per initial conversations with ODP, PIRE will be responsible for analyzing survey data aggregated across providers. ODP staff, in contrast, will be responsible for analyzing survey data at the provider-level. PIRE will review our proposed data analytic techniques with ODP to ensure we are approaching provider-level and state-level data analysis in consistent and possibly complementary manners. We anticipate that analyses of the surveys would involve the following:

- Cleaning data (e.g., removing duplicates and flagging cases in which responses seem extreme, such as reporting the highest levels of use on all variables);
- Dichotomizing substance use variables to facilitate analyses where any level of substance use is of interest;
- Constructing risk and protective factor scales (e.g., decision making);
- Matching pre- and post-tests if possible (this will not be possible for the 2018-19 data set, but may be possible for subsequent data sets depending on whether changes are made to the surveys that allow matching without relying on a sensitive identifier for participants);
- Conducting descriptive analyses (e.g., means, standard deviations, and frequencies) of pre-test and post-test demographics, substance use, and risk and protective factors scale scores;
- Conducting inferential statistical analyses (e.g., t-test and chi-squares) to determine if there were changes from pre-test to post-test on substance use and risk and protective factor scores, controlling for demographic variables; and
- Where enough data are available, we will also conduct descriptive and inferential statistics broken down by key variables of interest, including prevention program and demographic group;

- Reporting on trends in annual post-test data to highlight changes over time in risk and protective factors and substance use among program participants.

Fidelity Assessments. Because we will incorporate fidelity assessments into the SABG Program Form, we anticipate that ODP will be responsible for the analyses of these variables.

Extant Population-Based Surveys. ODP will provide PIRE with individual-level data files from the IHYS. PIRE and ODP will discuss the possibilities of analyses and reporting beyond existing reports, such as running additional cross-tabs and conducting inferential cross-year analyses. Any such analyses would begin in State Fiscal Year 2020 (SFY '20).

Administrative Data. To the extent data are available, PIRE will generate tables and graphs at the appropriate geographic level (e.g., county or region) that highlight key indicators related to the SABG goals and objectives (e.g., substance use, alcohol- and drug-related traffic crashes, and drug-related deaths). Any such use of these data will begin in SFY '20.

SABG Reports

PIRE will collaborate with ODP to generate the Statewide Evaluation Report which is to be completed by September 30 of each year. ODP will be largely responsible for reporting on data generated by the SABG Provider Form and PIRE will be largely responsible for reporting on data from the participant surveys (aggregated across provider), IHYS, BRFSS, and relevant administrative data.

Table 1. SABG Evaluation Task and Timeline (with Annual Report in Green)

Activities for Year 1 (February 11, 2019 – February 10, 2020)	Dates
Review older youth pre- and post-test surveys and provide recommended modifications to ODP in a timely fashion for COBRO to make changes.	April 1, 2019
Review younger youth pre- and post-test and parent post-test and provide recommended modifications to ODP in a timely fashion for COBRO to make changes.	May 1, 2019
Provide recommended fidelity measures in a timely fashion for ODP to add them to the SABG Provider Form.	May 28, 2019
Provide training to providers on use of the fidelity measures (and record the training for future use).	August - September 2019
Analyze data from the current participant surveys.	July – August 2019
Collaborate with ODP to deliver the Statewide Evaluation Report.	September 30, 2019
Provide ongoing data collection-related technical assistance to SABG providers to ensure we collect data necessary for the annual report.	July 1, 2019 – February 10, 2020
Review IHYS and BRFSS data and collaborate with ODP to determine whether additional analyses are desired.	October 1, 2019 – February 10, 2020
Review available administrative data with ODP to determine whether inclusion of such data for Block Grant reporting in the annual report is desired.	October 1, 2019 – February 10, 2020
Activities for Subsequent Years	**Date**
Provide evaluation-related technical assistance to SABG providers.	Ongoing
Review evaluation plan with ODP to prepare for new fiscal year.	May annually
Analyze data from the participant surveys.	July – August annually
Analyze data from other sources.	July – August annually
Collaborate with ODP to deliver the Statewide Evaluation Report.	September 30 annually

PFS EVALUATION PLAN

Overview

Idaho received a 2018 PFS grant from SAMHSA with the primary goal of reducing underage drinking across the state and secondary goals of reducing marijuana use and methamphetamine use in certain regions. ODP is distributing the PFS funds to all seven regions of the state through the state's regional public health departments (in collaboration with Regional Behavioral Health Boards [RBHBs]) and local law enforcement agencies. (See Figure 2 for a map of the PFS regions and their outcome priorities.)

The public health departments hired the regional Project Coordinators (PCs) and are responsible for strategic planning, training at least two facilitators on the *Strengthening Families* program, implementing the *Be the Parents* campaign, and delivering *Drug Impairment Training for Education Professionals* (DITEP). Public health agencies will also implement other strategies that fall within CSAP's 6 Strategies, including administering LifeSkills Training Program, facilitating Responsible Beverage Server Training, and others. More information about the grant can be found in the PFS Grant Manual available from ODP.

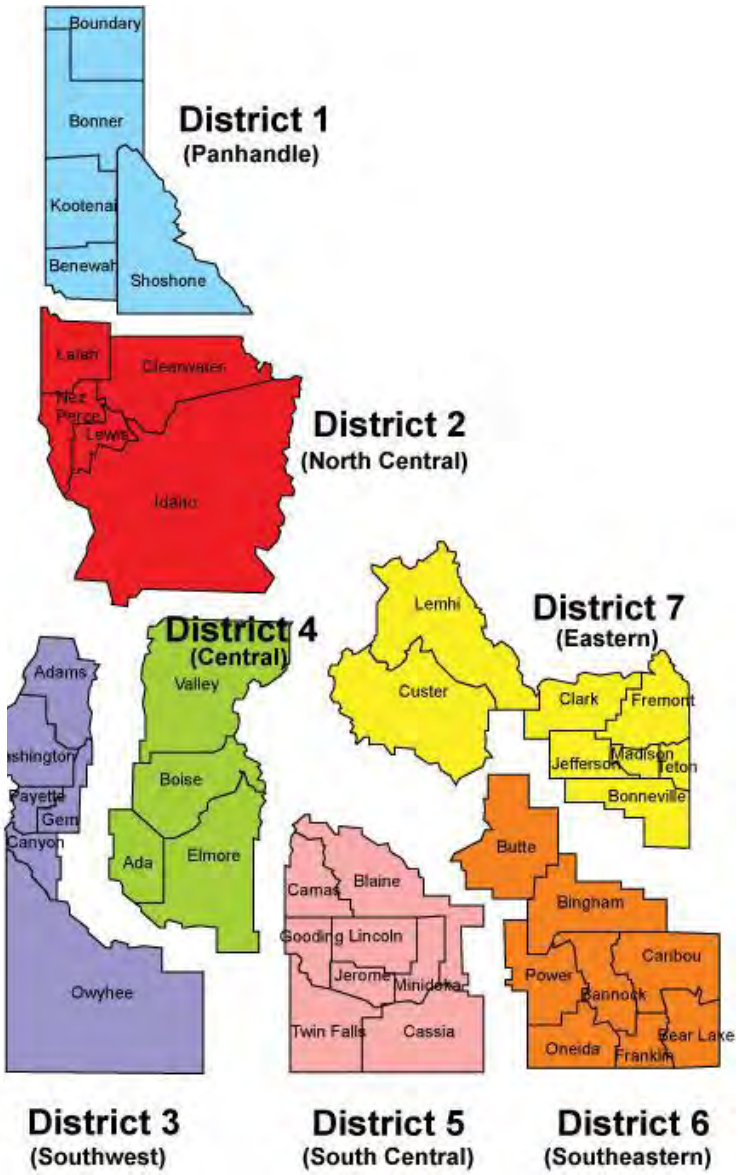
Figure 2. Idaho PFS Map

DISTRICT 1
Underage drinking
Marijuana use
Methamphetamine use
American Indians
Veterans

DISTRICT 2
Underage drinking
Methamphetamine use
American Indians
Rural Communities
Veterans

DISTRICT 4
Underage drinking
Methamphetamine use
Veterans

DISTRICT 3
Underage drinking
Marijuana use
Methamphetamine use
Hispanics
Veterans



DISTRICT 7
Underage drinking
Rural Communities

DISTRICT 6
Underage drinking
Methamphetamine use
American Indians
Rural Communities

DISTRICT 5
Underage drinking
Marijuana use
Hispanics
Rural Communities

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PIRE Evaluation Activities

ODP staff have extensive experience collecting data using Excel provider spreadsheets and will be responsible for administering the PFS Provider Form and managing the data. The remainder of the PFS evaluation plan will focus on activities in which PIRE expects to be more involved with the data collection processes. A timeline for our PFS evaluation plan activities is provided in Table 2 at the end of this section.

For the PFS, PIRE will develop comprehensive, project-wide databases that will include all grantee-level process, output, and outcome data. To compile these databases, PIRE will use a series of data collection methods that have proven successful for projects of similar size and scope as the Idaho PFS. The data collection methods are listed and described below.

- Document Review
- ODP's Provider Forms
- Key Informant Interviews/Site Visits
- Capacity Survey
- Extant Population-based Surveys
- Administrative and Archival Data

Document Review. As a preliminary activity, PIRE will review all relevant project documents to gain a better understanding of relevant state and local conditions and proposed strategies, as well as to begin to establish baseline data points and planned activities, where possible. Documents will include the SAMHSA PFS RFA, Idaho's response to the RFA, any documents that have been developed since the inception of the project (e.g., needs assessments and strategic plans), and other documents that provide background on cultural, historical, and other contextual factors related to the grant.

ODP PFS Provider Forms. ODP developed and will use PFS Provider Forms to capture data about each subrecipient's processes and outputs, as it did for the recently completed Strategic Prevention Framework State Incentive Grant (SPF SIG). Each quarter, subrecipients will report on the services they provided, the populations they served, achievements they experienced, their barriers to implementation, and strategies to overcome those barriers. Staff from ODP will forward the forms to PIRE who will, in turn, compile the data and generate Quarterly and Annual Regional Progress Reports.

Key Informant Interviews/Site Visits. Each year, PIRE will accompany the State Project Director on site visits to gain a better understanding of local conditions, conduct key informant interviews with local Project Coordinators, and provide on-site evaluation-related technical assistance if needed. The purpose of the interviews will be to capture information about the past year's activities, accomplishments, and challenges, and to elicit information about plans for future action. (For the first year, the main purpose of the site visits will be to allow PIRE and subrecipients to become better acquainted with each other and to engage in initial evaluation planning.) Each interview will last approximately one hour and will be audio recorded for accuracy. To ensure that Project Coordinators feel at ease to talk honestly about project

challenges, we will ask that the State Project Director not attend the interviews. Audio recordings will be deleted after the project ends. The interviewer will generate summary notes of each interview which will be incorporated into the Statewide Evaluation Report and we will discuss major themes that emerge collectively from the interviews

During the site visits, in addition to conducting the project director interviews, PIRE will aim to accomplish the following:

- Meet with project staff to learn more about the PFS project and the context in which it operates. This would ideally include visiting some program sites where we can observe implementation activities.
- Review and refine relevant logic models and evaluation plans.
- Review and interpret process and outcome data.
- Provide training and technical assistance on evaluation-related issues (e.g., logic models, fidelity assessment, web-based survey tools, other tools for evaluation, the distribution of evaluation findings, and the use of evaluation data for project sustainment purposes).

During Year 1, we anticipate that each visit will last 4 – 5 hours. Visits in future years may last longer, depending on the goals for the visit. PIRE will develop a summary narrative of the site visits that we will include in the Statewide Evaluation Reports.

Capacity Survey. PIRE will administer a Capacity Survey with subrecipients to help them identify their substance abuse prevention strengths and weaknesses, identify ways to enhance their capacity to meet target outcomes, and assess their capacity development over the course of the project. We will adapt a survey that we have used with coalitions in other projects of similar size and scope. The survey, based on the Coalition Capacity Checklist developed by Frances Dunn Butterfoss, measures the extent to which organizations have the capacity and community support to engage in processes that are critical for the PFS grant, such as communicating with stakeholders and supporting evidence-based practices. We will work with ODP and the Project Coordinators to refine the survey to be most relevant for the Idaho PFS project and to determine who the respondents should be (e.g., members of the Regional Behavioral Health Boards). We will administer a web-based Capacity Survey twice during the project to allow us to assess pre-post changes.

Extant Population-Based Surveys. PIRE will use data from the ODP-funded Idaho Healthy Youth Survey (IHYS) to monitor statewide and regional changes in risk factors, protective factors, and substance use among Idaho youth. Bach Harrison provides guidance material to teachers to facilitate the administration of the survey, analyzes the survey data, and prepares the biennial statewide report. We will use data from the annual Idaho Behavioral Risk Factor Surveillance System (BRFSS) to monitor statewide and regional changes in substance use among Idaho adults. The BRFSS is administered by the Idaho Bureau of Vital Records and Health Statistics under a cooperative agreement with the US Centers for Disease Control and Prevention (CDC).

Administrative and Archival Data. PIRE will work with state and local stakeholders, including the Idaho State Epidemiological Outcomes Workgroup (SEOW) to identify the most appropriate, valid, and reliable data sets that can be used to determine the effectiveness of the Idaho PFS in each region and across the state. Administrative and archival data may include traffic crash data and crime data.

PIRE's federally-approved Institutional Review Board will review all data collection and maintenance protocols to ensure that data are collected, stored, and protected in a manner that presents minimal risk of harm to project participants, and that meet all HIPPA standards. No data collection will commence until IRB approval has been rendered. All data will be maintained on password protected, secure PIRE servers and will only be accessible by PIRE's Idaho evaluation staff and by the grantees who will have access to their own data. PIRE uses triple-iteration back-up of its computer network (including storage in an outside facility) to ensure that all electronic information remains accessible in the event of system failure. Any reports we generate will aggregate data in such a way as to not allow any individuals to be identified, and we will not share any data, records, reports, or other material related to this project with any outside individuals or organizations without the permission of ODP.

PFS Data Analysis

PFS Provider Forms. On a quarterly and annual basis, PIRE will conduct descriptive analyses (e.g., means, frequencies, and counts) of output data gathered from the PFS Provider Forms for each subrecipient to provide a regular update of project activities, including services provided, significant accomplishments, and noteworthy barriers.

Project Director Interviews. Annually, we will aggregate and summarize information gathered from interviews and include them in the Annual Statewide Evaluation Report, beginning in State Fiscal Year 2020 (SFY '20).

Capacity Surveys. After the administration of each capacity survey, we will generate means and frequencies of capacity scale scores for each region and the overall state and include those descriptive analyses in the annual report. For the final report, we will conduct inferential analyses to determine whether there has been a statistically significant increase in capacity from the beginning of the project to the end.

Extant Population-Based Surveys. ODP will provide PIRE with individual-level data files from the IHYS and analyzed frequency data from the BRFSS. PIRE and ODP will discuss the possibilities of analyses and reporting beyond existing reports, such as running additional cross-tabs and conducting inferential cross-year analyses. Any such analyses would begin in SFY '20.

During the final year, we will analyze data from the surveys for statistically significant changes in behaviors, attitudes, and perceptions between the baseline year and the final year, controlling for age, sex, race/ethnicity, and nesting of students within schools (or communities). To the extent possible, we will explore differences over time by region as well. As we typically do, we will dichotomize the major outcome variables (e.g., use vs. non-use) and use a

generalized linear mixed model approach (using SAS PROC GLIMMIX). Designating community-level intercepts as a random effect, individual-level survey data will be nested within communities to accommodate clustering effects.

Administrative and Archival Data. As we compile administrative and archival data, we will report on them annually using descriptive analyses (e.g., frequencies, means, and standard deviations). Any such analyses would begin in SFY '20.

For our analyses of monthly time series data (e.g., alcohol-related crashes involving drivers under 21), we will employ time series modeling methods which examine the variability in multiple measurement points over time to determine whether there are statistically significant disruptions in trends coincident with relevant project events, such as the implementation of preventive interventions. Because time series models use the pre-intervention data points as the "control" values in assessing intervention effects, they provide a basis for attributing intervention in the absence of having comparison communities.

For all the outcome analyses listed above, we will also explore comparisons between groups of regions that address certain priority outcomes and those that do not (e.g., marijuana regions vs. non-marijuana regions and methamphetamine regions vs. non-methamphetamine regions). These analyses will allow us to enhance our ability to attribute observed changes in outcome indicators to the PFS grant. Below is a task and timeline for collecting and analyzing PFS data.

PFS Reports

PIRE will compile data from the PFS Provider Forms to generate descriptive, graphics-based reports for each subrecipient on a quarterly basis (n = 7 per quarter). Annually, we will aggregate data across the previous 12 months to generate an Annual Report for each subrecipient (n = 7). We will also compile additional data from the PFS (e.g., interview summaries, capacity surveys, and data from population-based surveys) to be included in the Annual Statewide Evaluation Report, beginning with the 2020 report, and in the Final Statewide Evaluation Report in 2023.

Table 2. PFS Evaluation Task and Timeline (with Reports in Green)

Activities for Year 1 (February 11, 2019 – February 10, 2020)	Dates
Collaborate with ODP to conduct initial round of planning site visits with subrecipients.	April – May 2019
Review PFS Provider spreadsheets to develop templates for Quarterly Progress Reports.	April – May 2019
Collaborate with ODP and subrecipients to develop and refine the capacity survey, include determining who the respondents will be.	May – September 2019
Deliver Quarterly Regional Progress Reports.	August 1, 2019 November 1, 2019 February 1, 2019
Administer capacity surveys.	October 2019
Provide evaluation-related technical assistance to subrecipients.	Ongoing
Review IHYS and BRFSS data and collaborate with ODP to determine whether additional analyses are desired.	October 1, 2019 – February 11, 2020
Activities for Subsequent Years	**Date**
Provide evaluation-related technical assistance to subrecipients.	Ongoing
Conduct site visits and key informant interviews.	April – May annually
Administer capacity surveys.	Spring 2023
Compile and analyze IHYS and BRFSS data.	May - August annually
Compile and analyze administrative and archival data.	May - August annually
Deliver Quarterly Regional Progress Reports.	May 1 annually August 1 annually November 1 annually February 1 annually
Deliver Annual Regional Reports.	September 1 annually
Compile all PFS data for inclusion in Statewide Evaluation Report.	September 30 annually

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for 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.

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 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. 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.

2. Does your state coordinate 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 or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

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. 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. Family support, education, and supported employment are also core components of the program. Each team has an assigned prescriber (psychiatrist or physician assistant) providing medication management and education on medications and side effects. All programs are fully staffed. Region 3 and 7 are close to capacity and Region 6 is above 50% capacity.

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.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Division of Behavioral Health assists to facilitate community integration and decreasing institutionalization, by focusing on developing community based housing services and developing standardized protocols for continuity of care for clients discharged from a state hospital.

The first initiative is the ongoing 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 developed a model framework identifying the core components of the HART residential services and collaborated with the Division of Medicaid and the Idaho Behavioral Health Plan contractor, Optum Idaho to develop 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. This service will allow individuals with SPMI/SMI to remain in their communities, decrease inpatient hospitalizations and re-hospitalizations and allow for greater community integration for those receiving the services.

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.

A second initiative was the establishment of the State Hospital Discharge Workgroup. This workgroup was 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 consisted 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.

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 M/SUD 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	70,572	33,522
2.Children with SED	35,000-40,000	12,000-22,000

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 numbers reported in this table are estimates of the Idaho Department of Health and Welfare's Division of Behavioral Health, based on available data. The numbers represent best estimates, which reflects the limitation of our reporting and information systems, including that Idaho does not have a data team assisting with the collection of Mental Health System Data Epidemiology. The available information and estimated numbers above for SMI were calculated from the 2018 Census for Idaho, https://www.census.gov/quickfacts/ID, while the children with SED calculated numbers came from the YES Project Class Size Estimation Team in 2017. The estimated incidents are based off of figures found in the SAMHSA 2015 Idaho Behavioral Health Barometer's assessment that 47.5% of adults with any mental illness will receive treatment or counseling.

The Behavioral Health Administration and Program Managers review utilization data. The data can include 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 can also be shared and reviewed. In addition, problem cases can be identified as having barriers to prompt and/or successful community placement are reviewed.

Analyses on the system capacity needs for Jeff D Class Members has been conducted and for further study into system capacity 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 following steps are in place through workforce development to maintain and enhance system capacity are:

• Adjust the WFD Plan based on Gaps identified in the BSU survey with on-going analyses through the use of Praed helping us to look at our CANS data.
• Work with the Regions to implement TCOM Collaborative Statewide by the fall 2019.
• Continue to provide training on practices that are effective (evidence based, evidence informed and proven practices) but are currently not utilized extensively.
• Make YES Training efforts sustainable by partnering with institutions of higher education to develop curriculum materials and certificate programs that meet the State's needs.
• Incentivize clinical training sites in targeted areas to train graduate student interns and trainees in YES service delivery models.
• Partner with other Idaho State agencies, such as the Idaho Bureau of Labor to inform workforce development.
• Develop YES Core Competencies for Workforce and Leadership.

The state of Idaho uses the estimation methodology for adults and children required by the Substance Abuse Service Administrations 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) and children with Serious Emotional Disturbance (SED)

The electronic health records the Idaho Department of Health and Welfare utilizes for documentation, data collection and reporting system, is the Web Infrastructure for Treatment Services (WITS). The WITS system has multiple business rules which require the completion of the data elements reported as part of the client level data submissions. Data for non-Medicaid, State funded Mental Health and Substance Use Disorder services are entered into WITS by the treatment providers at the client, program, provider, and/or state level. The data entered into WITS is reported from the collected date through the user Sequel Server Reporting Services (SSRS) and the Idaho Department of Health and Welfare's data warehouse.

The state electronic health record (EHR), WITS, is used for non-Medicaid state-funded mental health treatment, as well as substance abuse treatment provided by the Idaho Department of Health and Welfare. Individual client records in WITS are audited throughout the year.

The Mental Health records in WITS are reviewed throughout the year to ensure completeness and accuracy. This is done through a combination of clinical review of the individual records and the use of routine and ad hoc reports from the data entered into WITS. The Idaho Department of Health and Welfare's Quality Improvement/Quality Assurance Unit reviews the reports in order to address identified data quality issues.

The Substance Use Disorder records are audited by the State's Management Services Contractor BPA Health. BPA Health performs routine file audits for accuracy and completeness. In addition to the file audits that BPA Health performs, the Idaho Department of Health and Welfare also runs various routine and ad hoc reports from the data which is entered into WITS in order to identify potential data integrity issues. The Idaho Department of Health and Welfare's Quality Improvement/Quality Assurance Unit reviews the reports in order to address identified data quality issues.

The electronic health record (EHR), WITS, that Idaho uses allows data to be reported and collected at the individual client level. For example, the Public Mental Health Screener a public facing website to host the CMH-CANS Mental Screening Form was built to allow non-clinical users to administer a simple screener to a youth. The questions are from the full CMH CANS Assessment. The screener will result in a recommendation as to whether further actions should be pursued. The screener will not collect any personal identifiable information (PII) but will collect question data and make it available through the WITS database for reporting purposes. The website and the screener should be mobile friendly, quick, and intuitive for any user.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. 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

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

a. Describe your state's targeted services to rural population.

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 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. 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.

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. 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. Family support, education, and supported employment are also core components of the program. Each team has an assigned prescriber (psychiatrist or physician assistant) providing medication management and education on medications and side effects. All programs are fully staffed. Region 3 and 7 are close to capacity and Region 6 is above 50% capacity.

b. Describe your state's targeted services to the homeless population.

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 Jannus, Inc.

The PATH contract allows for one to two-part time PATH Certified Peer Support Specialists to be assigned to each of the seven regional DBH service areas. The PATH Certified Peer Support 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 Support Specialists have received training in evidence-based practices related to Motivational Interviewing, Supported Housing, Supported Employment and SSI/SSDI Outreach and Recovery (SOAR), and Mental Health First Aid. PATH Certified Peer Support 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 Continuums 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. Brady Ellis, Vice President, Housing Support Programs at 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.

Idaho Housing and Finance Association 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.

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.

c. Describe your state's targeted services to the older adult population.

The adult mental health system in Idaho continues to improve by offering more services, programs and resources than it has in the past. However, these enhancements to the current system of care continue to struggle with meeting the needs of a growing population that has resulted in an increase of mental health needs in Idaho. The Department of Health and Welfare is leading a collaborative steering committee to ensure the entire system has input on the strategic path moving forward. The Division of Behavioral Health works to ensure that program and services, including community-based supports, outpatient services, and inpatient hospitalizations services are available to eligible Idaho residents.

The Division of Behavioral Health determines eligibility for adult mental health services through screening and assessment. Adult mental health services may be accessed through the division either through an application for services or through a court order

for services. Each regional behavioral health center is staff with a variety of licensed treatment professionals: psychiatrists, nurses, social workers, clinicians, peer support specialists, and other mental health workers. Each center offers crisis services and ongoing mental health services.

Crisis Intervention

The regional Adult Mental Health Crisis Units provide crisis interventions that include evaluation, assessment, intervention, stabilization, and follow-up planning. The Crisis Units provide phone and consultation services 24 hours a day, seven days a week. They screen all adults who are being petitioned for the court ordered commitment process.

Currently there is a Crisis System Workgroup who is developing a roadmap and strategy plan to implement a coordinated crisis response system that will be responsive to all populations across the state of Idaho.

Optum Idaho is Idaho's Medicaid managed care contractor for Behavioral Health Services. They provide Member's access to a Crisis Line that offers them immediate access to a Behavioral Health Clinician 24 hours a day, 365 days a year. Optum says that each call is regarded as a Member potentially experiencing some degree of stress or crisis and is triaged using the Solution Focused Crisis Intervention Model.

Supportive Services

Community support services are available on a limited basis. These support services include outreach, medication management, skill building, community-based rehabilitation services, benefit assistance and housing support.

The divisions regional behavioral health centers provide integrated treatment for those diagnosed with co-occurring mental health and substance use disorders by providing treatment or collaborating with private agencies to provide additional services.

Assertive Community Treatment (ACT)

The divisions regional behavioral health centers provide ACT Services for clients diagnosed with a serious and persistent mental illness (SPMI). These services provide a full array of community-based services as an alternative to hospitalization for these adults. ACT services are provided by a team of professional staff, certified peer support specialists and recovery coaches. Services include individualized treatment planning, crisis intervention, peer support services, community-based rehabilitation services, medication management, case management, individual and group therapy, co-occurring treatment and coordination of other community support services.

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.

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.

Training for Emergency Health Services
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.

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.

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.

In Region 4's Ada County, an integrative partnership between community first responders and psychiatric treatment agencies has been established and is working to pro-actively respond to crises in the community. This partnership is the Crisis Intervention Team Collaborative (CITC) and includes the following stakeholders: Boise Police Department, Ada County Sheriff Office, Meridian Police Department, Garden City Police Department, Ada County Paramedics, Idaho Department of Health & Welfare, Idaho Suicide Prevention Hotline, VA Justice Outreach, Optum Idaho, Probation and Patrol and the Idaho Commission on Aging.

The purpose of the collaboration is to improve follow-up and continuity of care for individuals who have experienced behavioral health crisis or required emergency assistance within the community crisis system. Together, CITC members evaluate levels of care or new or re-connected services to support recovery from substance use and enhance psychiatric stability by linking individuals to accessible behavioral health and substance use disorder healthcare.

The philosophy of this collaboration prioritizes the least restrictive treatment options to ensure safety and client-centered/driven interventions that empower individuals and reduce trauma.

The Department of Health and Welfare's Division of Behavioral Health is home to the Mobile Crisis Unit, with a 24/7 crisis line, which responds to community crisis 7 days a week. The Mobile Crisis Unit and the Ada County Community Paramedics have created the Psychiatric Emergency Team (PET), which is comprised of a Community Paramedic and a Mobile Crisis Unit clinician. PET co-responds face to face to crisis calls from clients, their loved ones, and law enforcement. PET, as well as the Mobile Crisis Unit, also monitor and follow up with clients before and after hospitalization, involuntary holds, or other crisis situations including medication interruption, escalation of psychiatric symptoms and/or substance use, accidental overdoses or suicide attempts, or disconnection from healthcare services.

For the past two and a half years, the counties in Region 1, Kootenai County, Coeur d' Alene, Post Falls, Rathdrum and Spirit Lake

have all been very enthusiastic in participating in CIT Academies. This was the result of heavy marketing by the DBH Region 1 staff conducting several 4-hour courses to various counties/departments in Region 1, provided training in De-escalation and Crisis Intervention techniques, the support of the Behavioral Health Board who funded Kootenai Academies, ideas gleaned from the Chicago CIT Conference in 2016, and the support from the DBH Program Manager and leadership at Region 1. Since Bonner County has trained up to 90% of their officers, DBH has primarily conducted all academies in Kootenai, and Bonner and Boundary Counties has sent officers to the Kootenai Academy as a result.

In the past 9 months, DBH has trained up to 91 officers in Kootenai County which have included all the departments. (See the attachment of the report sent to their Behavioral Health Board outlining the three academies conducted in the past 9 months and the overall ratings to those academies, and the attached agenda to a an academy that included the Crisis Center Director, as one of our presenters and presented on Advanced De-escalation).
A lot of Region 1's work and support has come from the Program Manager and Leadership, in addition to the opportunity to present 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 the knowledge and experience from other parts of the state and in Region 1 to explain how CIT was implemented, and explained their current strategy of expanding CIT in Region 1.

In addition, CMH, community partners and the Regional Behavioral Health Board in Region 1 had Texas Christian University come to Idaho and present in April 2019, to train a total of 50 participants as train the trainers for Trauma Informed Care. This was a collective community initiative. The training cost was 3,500 per participant and our board contributed 12,000 dollars towards this training.

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 FY2020 as follows:

ADULT MENTAL HEALTH
New Allocation of Budget By Region New Allocation of Staff By Region
SFY20 Budget $ 13,800,000 SFY20 Staff Allocation % Current Established FTE SFY20 FTE Distribution Position Change
Region 1 11.9% $ 1,643,739 11.9% 23.17 23 -0.21
Region 2 10.3% $ 1,414,503 10.3% 20.00 20 -0.25

Region 3 17.5% $ 2,410,123 17.5% 33.17 34 0.49
Region 4 22.6% $ 3,112,089 22.6% 42.00 43 1.46
Region 5 11.4% $ 1,569,487 11.4% 23.77 22 -1.85

Region 6 8.9% $ 1,225,590 8.9% 16.57 17 0.55
Region 7 17.6% $ 2,425,020 17.6% 34.04 34 -0.17

CHILDREN'S MENTAL HEALTH
New Allocation of Budget By Region New Allocation of Staff By Region
*SFY20 Budget $ 5,500,000 SFY20 Staff Allocation Current Established FTE SFY19 FTE Distribution Position Change
Region 1 12.1% $ 663,693 12.1% 11.00 9 -2.07
Region 2 9.7% $ 531,851 9.7% 6.80 7 0.36

Region 3 16.2% $ 890,156 16.2% 10.67 12 1.31
Region 4 22.4% $ 1,232,625 22.4% 16.00 17 0.58
Region 5 12.0% $ 661,820 12.0% 9.00 9 -0.10

Region 6 8.2% $ 453,260 8.2% 7.15 6 -1.05
Region 7 19.4% $ 1,065,493 19.4% 13.00 14 1.34

How the state intends to expend the MHBG:

Award Dates 10/1/2019-9/30/2021
This budget SFY- 7/1/2019-6/30/2020
Adult Mental Health Services $2,148,203.85
Planning Council $20,000
Consumer and Family Empowerment Contract (AMH) $260,000
Suicide Prevention Council $10,000
Suicide Hotline $50,000
Certification Contract (AMH and CMH) $215,400
Parenting with Love and Limits (CMH) $270,000
Family Run Organization Contract (CMH) $240,000
CMH Crisis Development
Behavioral Health State Planning Council Recommendations $150,000
10% FEP Set Aside $395,718.10
Administration 5% $197,859.05
Proposed Budget Total $3,957,181

Footnotes:

Environmental Factors and Plan

10. 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) Services for special populations:

Targeted services for veterans?	( ) Yes (●) No
Adolescents?	( ) Yes (●) No
Other Adults?	( ) Yes (●) No
Medication-Assisted Treatment (MAT)?	(●) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

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. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) 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 Has your state identified a need for 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, and custody issues? (●) 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.

The Division of Behavioral Health uses a Managed Services Contractor, BPA Health (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 and specific 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.

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. Has your state identified a need for 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 (e.g., 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 BPA Health (BPAH) to manage the delivery of substance use disorder services funded by the SAPT block grant. The Division's contract with BPAH includes all SAPT block grant requirements specific to the services offered and the populations served, including those for persons who inject drugs. BPAH is responsible for ensuring all providers serving this population comply with SAPT block grant requirements. This is monitored regularly during weekly contract monitoring meetings and formal, quarterly contract monitoring with BPAH. In addition, BPAH is required to submit regularly scheduled reports to the Division evaluating compliance with these requirements. BPAH supplies weekly budget reports to the state to monitor budget compliance and allow for program capacity management.

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. Has your state identified a need for 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 BPA 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 via 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 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 have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ○ Yes ◉ No

2. Has your state identified a need for 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

Criterion 8,9&10

Service 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. Has your state identified a need for 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 services 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. Has your state identified a need for 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, such as 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. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** 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. Has your state identified a need for 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
- **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. Has your state identified a need for 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.

Five.

3. Has your state identified a need for 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) Development of 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, such as the 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)

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. Has your state identified a need for 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. Has your state identified a need for 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

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

- **a)** Prevention TTC? ◉ Yes ○ No
- **b)** Mental Health TTC? ○ Yes ◉ No
- **c)** Addiction TTC? ◉ Yes ○ No
- **d)** State Targeted Response TTC? ◉ 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 that govern the Mental Health and Substance Use Disorder Programs.

Behavioral Health
Behavioral Health Sliding Fee Schedules: https://adminrules.idaho.gov/rules/current/16/160701.pdf
Behavioral Health Programs: https://adminrules.idaho.gov/rules/current/16/160715.pdf
Behavioral Health Certification of Peer Support Specialists and Family Support Partners:
https://adminrules.idaho.gov/rules/current/16/160719.pdf

Substance Use Disorders
Substance Use Disorders Services: https://adminrules.idaho.gov/rules/current/16/160717.pdf

Mental Health
Adult Mental Health Services: https://adminrules.idaho.gov/rules/current/16/160733.pdf
Children's Mental Health Services: https://adminrules.idaho.gov/rules/current/16/160737.pdf
Appointment of Designated Examiners and Designated Dispositioners: https://adminrules.idaho.gov/rules/current/16/160739.pdf

Footnotes:

Idaho is not an HIV Designated State.

Environmental Factors and Plan

11. 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 2018-FFY 2019? ○ Yes ◉ No

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

No Technical Assistance Requested at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The Quality Improvement Plan-Quality Assurance Program Document is currently under revision and estimated to be complete by the end of SFY 2020.

Quality Assurance Program

Division of Behavioral Health

Submitted by Candace Falsetti- CO 3rd, 7-14-2017, #3

2017

Idaho Department of Health and Welfare

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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 QA plan for ensuring on-going improvement.

Quality Assurance: 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: 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: 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.

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.

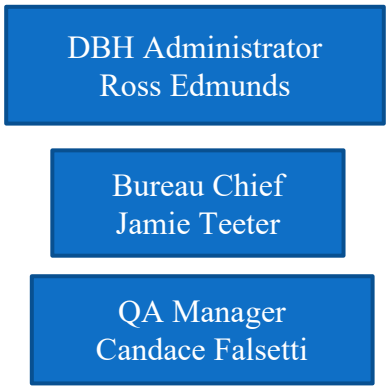
A list of key indicators of performance and outcome measures is included in Appendix A. A portion of the key measures identified are available currently through various sources of data and reports while others are aspirational and if identified as desirable would potentially require collaboration and 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



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

Preadmission Screening and Resident Review (PASRR)

Continuous Quality Improvement (CQI)

Behavioral Health Program Approval

Critical Incident Review

Jeff D – Quality Management Improvement Activity (QMIA) plan Development

Peer and Family Support Partners

Idaho Behavioral Health Plan (IBHP)

Managed Services Contractor (SUDS)

Quality Improvement (QI) Work Plan

Performance Improvement Projects (PIPs)

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

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 receive needed mental health services 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 form 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 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 SUDs provider must have facility approval by the state authority. DBH QA staff completes all initial site certifications for SUD programs and monitors the work of the Managed Care contractor (MSC) 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. 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 parties in the lawsuit. The plan includes an enhanced QA infrastructure, improved access to data that is

sued for planning and decisions 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 developemtn of an enhanced system for Due process and building a centralized complaints handling and tracking process.

Peer and Family Support Partner Certification

The DBH QA Unit has been responsible to review training records and references to 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, services coordination agencies and substance use disorder agencies into one, "behavioral health" service system

Managed Services Contractor (SUDS)

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 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

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 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.

Role of QA Unit in Contract Monitoring

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 identity 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:

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 QA unit involvement 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.

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 (includes ICC) 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

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 an 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 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

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	

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	To what extent are family strengths and needs assessed and integrated into treatment?	Items from the *CANS*, CALOCUS, CAFAS , GAIN, LOCUS Measure for Social connectivity? Wellness Assessment (Optum's WA)	Results of outcomes tools
	Clients have improved family mental health/substance abuse and relationship status			
	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	

Domain	Measure	Question	Data Elements	Data Source(s)
			Client perceptions of service availability, access post-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 re provided with appropriate care	Are risk assessment 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		

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] 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 M/SUD 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 M/SUD services. 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 M/SUD 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 M/SUD 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[58] paper.

57 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.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD 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 M/SUD providers? ◉ Yes ○ No

3. Does the state have a plan to build the capacity of M/SUD 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.

As noted in the previous application and plan, Trauma Informed Care training has been conducted and provided across the state of Idaho in the Regional Behavioral Health offices and the State Hospitals in an effort to assure staff are trained in trauma informed care approach when working with patients. Our community partnerships and contract providers also provide educational activities for consumers, family members, professionals, and providers of behavioral health services specifically for trauma informed care approaches.

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

No Technical Assistance Requested at this time.

Footnotes:

Environmental Factors and Plan

13. 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.[59]

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.[60]
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 the Health Insurance 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.

[59] 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 Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **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 M/SUD 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, M/SUD 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 M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD 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 M/SUD 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?

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.

Cross system crisis system is an area of need for Idaho. Currently, the Children's Mental Health System is working to develop a collaborative community-oriented crisis system in an effort to reduce psychiatric hospitalizations, reduce death by suicide, increase access to care and community-based options, reduce arrests, and improve service coordination and quality of treatment. The current crisis systems across the state differ across the state and among agencies. Currently there is a Crisis System Workgroup who is developing a roadmap and strategy plan to implement a coordinated crisis response system across the state of Idaho.

Crisis intervention provided through the regional offices include evaluation, assessment, intervention, stabilization and follow-up planning. They regional offices have various plans where phone and consultation services are available 24 hours a day, seven days

a week.

The Division of Behavioral Health continues to work collaboratively with county juvenile justice, magistrate courts, the Idaho Department of Juvenile Corrections and parents in situation involving youth with mental health issues and the courts.

The Division of Behavioral Health continues to allocate funds to the Department of Juvenile Corrections for 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.

DBH entered into a contract with the Community Health Center Network of Idaho (CHCNI), the umbrella organization for the Federally Qualified Health Care (FQHC) clinic network, to provide mental health services for Idaho's felony parole and probation population. All regions have at least one FQHC providing mental health services. The following services are provided under the contract: psychiatric diagnostic evaluation, mental health treatment planning, pharmacological evaluation, pharmacological management, individual counseling, group counseling, family counseling, and care coordination.

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

NO technical assistance is being requested at this time.

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Footnotes:

Year Nine Assessment of the Idaho Department of Juvenile Corrections' Clinical Services Program

Prepared for the Idaho
Department of Juvenile Corrections

by

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May 2017

Executive Summary

During the past nine years, a program known as the clinical services program (CSP) has housed a mental health clinician in each of the 12 juvenile detention centers (JDCs) in Idaho, and more recently a tribal JDC on the Fort Hall Indian Reservation in southeastern Idaho. During 2007, the CSP was conducted as a pilot program with one clinician working in the JDC in Bonneville County; on the basis of encouraging results, the program was expanded to the other 11 JDCs in Idaho and has been operational for eight years (2008-2015). In 2012, the program was further expanded to the Shoshone/Bannock Tribal JDC. The principal component of the CSP is to allow clinicians to screen detained juveniles for mental health and substance abuse problems when they are admitted into JDCs, and to make provisional diagnoses of these problems when warranted. Other key components of the CSP are for the clinicians to recommend services in the community for juveniles with provisionally diagnosed mental health or substance abuse problems when they are released, and to provide treatment recommendations to judges and juvenile probation officers (JPOs) who work directly with the juveniles. An internal evaluation of the pilot program, conducted in 2007 by clinician Brian Mecham at the JDC in Bonneville County, and formal evaluations of the expanded program, conducted in 2007-2008, 2008-2009, 2009-2010, 2010-2011, 2011-2012, 2012-2013, and 2013-2014, and 2014-2015 by researchers at the Center for Health Policy (CHP) at Boise State University (BSU), all strongly indicated a need for continued clinical services for detained juveniles. For example, all eight evaluations indicated that approximately 70% of detained juveniles, who were scored on diagnostic inventories (the mental health and substance abuse subscales of the Alaska Screening Tool, or AST) during a clinical interview with JDC clinicians, met the AST diagnostic criteria for a having a mental health problem, a substance abuse problem, or both types of problems. All eight evaluations also indicated that the program is well received and supported by the judges and Chief JPOs (CJPOs) contacted by the JDC clinicians.

The favorable evaluations from 2007-2015 supported the continued funding of the CSP, and in 2015 it continued in the 13 JDCs in Idaho (the 12 JDCs that have been a part of this evaluation since Year 1 (Y1) and the Shoshone/Bannock Tribal JDC on the Fort Hall Indian Reservation that was added in 2012). The CSP retained its collaborative nature as a partnership among the Idaho Department of Juvenile Corrections (IDJC), the Juvenile Justice Children's Mental Health Workgroup (JJCMH), and the Idaho Department of Health and Welfare (IDHW). IDJC, which continued to be responsible for oversight of the project, again contracted with researchers from the CHP to conduct the Year 9 (Y9) Assessment. Similar to the Year 1 (Y1) – Year 8 (Y8) assessments, the evaluation consisted of data collected in several waves. The first wave involved the collection of data from clinicians at the JDCs; this information included booking charges, mental health and substance abuse screening information, information on previous and provisional diagnoses of mental health and substance abuse problems, and information on service recommendations made by the clinicians. The second wave of data collection involved information gleaned from telephone surveys of parents of juveniles recently released from the JDCs; these surveys asked questions about whether the parents had been contacted by clinicians and given recommendations for services for their children, and whether their

children had accessed any recommended services. The third wave of data collection involved information captured from surveys of judges and CJPOs, which asked questions about contact by JDC clinicians, the value of recommendations made and information provided, and the value of the program as a whole. Several additional analyses of wave one and wave three data were conducted in Y9. Finally, pilot data collected on Adverse Childhood Experiences (ACEs), a measure of childhood trauma exposure, was submitted by the JDC in Kootenai County, and these data were analyzed and discussed for the first time in this report.

Key findings from each of the three waves of data collection and the additional analyses are presented below.

<u>Wave One: JDC Clinician Data</u>

- **Data submitted on 1,059 juveniles were analyzed**
    - **Data on a total of 1,080 detained juveniles were submitted. Data on 21 juveniles for whom multiple data entries were submitted were excluded from this report**
    - **Over 71% of the juveniles for whom data were included in the final analyses were boys, and nearly 29% were girls**
    - **Data on detained juveniles were submitted by clinicians at all 13 JDCs. Data from the JDCs in Lemhi, Minidoka, and Valley counties, as well as the Shoshone-Bannock Tribal JDC, were excluded from this report because there were too few cases to guarantee anonymity (thus, the data in this assessment are from nine JDCs). The JDCs that submitted the most data cases included those in Kootenai (19%), Canyon (nearly 17%), Ada (over 16%), Twin Falls (nearly 14%), Bannock (over 12%), and Bonneville (nearly 10%) counties. The JDCs in Fremont (less than 4%), Bonner (over 4%), and Nez Perce (over 4%) counties submitted the fewest cases**

- **The most common booking charges for juveniles across all 10 JDCs were "other crimes" not easily fitting one of the four Uniform Crime Recording (UCR) codes (many of these were probation violations), followed by drug crimes, crimes against persons, property crimes, and sex crimes**

- **Nearly 63% of all juveniles screened with the AST mental health and substance abuse subscales met the diagnostic criteria for having a mental health problem**
    - **Girls (at nearly 72%) were statistically significantly more likely to meet the AST criteria for a mental health problem than were boys (over 59%)**
    - **Juveniles met the AST criteria for having a mental health problem at statistically significantly different rates across the nine JDCs**
        - **Indications of mental health problems were highest among juveniles screened at the JDC in Canyon County (75%), followed by the JDCs in Fremont (nearly 68%) and Twin Falls (just over 67%) counties. Indications of mental health problems were lowest among juveniles screened at the JDCs in Kootenai (nearly 53%), Bonner (over 54%), and Bannock (nearly 59%) counties**

- **Over 37% of all juveniles screened with the AST met the diagnostic criteria for having a substance abuse problem**
    - **Juveniles met the AST criteria for having a substance abuse problem at rates that were different across the nine JDCs; however, these different rates only approached a level of statistical significance**

- **When the combination of AST indications of mental health and substance abuse problems were evaluated, it was found that nearly 70% of all screened juveniles had a mental health problem, a substance abuse problem, or both**
    - **Having indications for a mental health problem only was the most common single combination (at nearly 33%), followed by having neither a mental health nor a substance abuse problem (just over 30%), both a mental health and a substance abuse problem (30%), and a substance abuse problem only (less than 8%)**
    - **A statistically significant difference existed in the combination of mental health and substance abuse indications between boys and girls. Whereas boys were more likely than girls to have indications of neither a mental health nor a substance abuse problem (32% to 25%) and a substance abuse problem only (9% to 4%), girls were more likely than boys to have indications of both a mental health and substance abuse problem (35% to 29%) and a mental health problem only (37% to 31%)**
    - **A statistically significant difference also existed in combination of mental health and substance abuse indications as a function of JDC location**
        - **The most common combination of indications for juveniles in five JDCs (in Bonneville, Canyon, Fremont, Nez Perce, and Twin Falls counties) was having a mental health problem only. Having neither a mental health problem nor a substance abuse problem was the most common combination in three JDCs (in Ada, Bonner, and Kootenai counties); having neither a mental health problem nor a substance abuse problem tied with having both a mental health problem and a substance abuse problem as the most common combinations in the JDC in Bannock County**
        - **Having a substance abuse problem only was least common in all nine JDCs**

- **Nearly 77% of the juveniles across all JDCs were identified during a clinical interview to have been diagnosed previously with at least one mental health or substance abuse problem. The mean number of previous diagnoses for all juveniles with at least one previous diagnosis was 1.34**
    - **A statistically significant difference in mean number of previous diagnoses was found between boys and girls, with girls reporting more previous diagnoses (1.48) than boys (1.28)**
    - **A statistically significant difference in the mean number of previous diagnoses was found as a function of JDC location**
        - **Mean numbers of previous diagnoses were highest among juveniles in the JDCs in Nez Perce (1.70), Bannock (1.52), and Canyon (1.45) counties.**

Mean numbers of previous diagnoses were lowest among juveniles in the JDCs in Bonner and Fremont (both 1.00) counties, followed by the JDC in Kootenai County (1.13)

- **Nearly 56% percent of juveniles who were screened with the AST and completed a clinical interview were given at least one provisional diagnosis of a mental health or substance abuse problem. The mean number of provisional diagnoses for all juveniles with at least one provisional diagnosis was 1.55. Diagnosis was deferred for less than 3% of juveniles**
    - **A statistically significant difference in mean number of provisional diagnoses given was found between boys and girls. Girls were given more provisional diagnoses (1.70) of mental health or substance abuse problems than were boys (1.49)**
    - **A statistically significant difference in the mean number of provisional diagnoses given was found as a function of JDC location**
        - **The highest mean numbers of provisional diagnoses given were to juveniles in the JDCs in Nez Perce (3.00) and Canyon (1.85) counties. The lowest mean numbers of provisional diagnoses were given to juveniles in the JDCs in Ada (1.22) and Bonneville (1.31) counties**

- **The most common provisional diagnosis was a substance abuse disorder, which appeared to affect approximately 41% of the provisionally diagnosed juveniles. Other common provisional diagnoses included mood disorders (over 40% of those provisionally diagnosed), disruptive behavior disorders (just over 34%), anxiety disorders (just over 16%), and attention deficit disorders (over 8%)**

- **Recommendations for at least one service in the community were made for 786 juveniles. The mean number of service recommendations for juveniles who received at least one service recommendation was 1.67**
    - **Of all juveniles who received at least one service recommendation, 558 (or 71%) were given at least one provisional diagnosis and the remaining 228 (or 29%) received at least one service recommendation but were not given a provisional diagnosis. Additionally, 26 juveniles were given at least one provisional diagnosis without receiving a service recommendation**
        - **Of the 562 juveniles who received at least one provisional diagnosis, 534 (or nearly 95%) received at least one service recommendation**
    - **There was a statistically significant difference in the mean numbers of recommendations for services as a function of JDC location**
        - **The highest mean numbers of recommended services were given to juveniles in the JDCs in Bannock (2.47), Canyon (2.06), and Twin Falls (1.83) counties. The lowest mean numbers of recommended services were given to juveniles in the JDC in Fremont County (1.03), followed by the JDCs in Ada (1.12) and Bonneville (1.19) counties**

- **The most commonly given recommendations for services was continuation of prior treatment (over 40%), followed closely by individual counseling (40%). Other**

commonly received service recommendations were for substance abuse counseling/treatment (nearly 28%) and psychological/mental evaluation (nearly 17%)

- **According to information gained by clinicians during 15-45 day post-release follow-up calls, 460 juveniles, or nearly 59% of those who received at least one recommendation for a service, had accessed at least one recommended service. The mean number of accessed recommended services among juveniles who received at least one recommendation was 1.47**
    - **A statistically significant difference in mean numbers of recommended services accessed was found as a function of JDC location**
        - **The highest mean numbers of recommended services accessed were found among juveniles released from JDCs in Bannock (2.19), Twin Falls (1.59), and Bonner (1.27) counties. The lowest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Canyon and Fremont (1.00 each) counties, followed by the JDC in Nez Perce County (1.12)**

<u>Wave Two: Parent Survey Data</u>

- **A total of 123 parents were contacted via telephone by callers from the Idaho Federation of Families (IFF) for Children's Mental Health. Of those, 109 parents agreed to complete the survey, for a response rate of 89%**

- **Over 47% of the parents who provided a response reported that they had been contacted by the JDC clinician and informed that their child had been identified as a person who could benefit from community-based mental health and/or substance abuse services**

- **Of the parents who reported being informed that their child had been identified as someone who could benefit from services, 45% reported that they were given recommendations for community-based services for their child by the JDC clinician**

- **The service parents most often reported being recommended for their children was mental health counseling (over 79%). Nearly 13% of parents reported receiving a recommendation for their children for substance abuse treatment or assessment, and over 8% reported receiving a recommendation for some other service (e.g., diversion, juvenile probation)**

- **The vast majority of parents (92%) who received at least one service recommendation for their child reported that their child had accessed at least one service. Only one parent reported a barrier to accessing a recommended community-based serving (cost)**

Wave Three: Judge/Juvenile Probation Officer Survey

- **A total of 43 judges, CJPOs and JPOs completed a survey (the response rate could not be calculated because an unspecified number of invitations were unexpectedly extended to individuals other than judges and CJPOs)**
    - **Of the 43 respondents, 19% were judges and the remaining 81% were CJPOs and JPOs**
    - **The region with the highest percentage of respondents was Region 1 (nearly 35%; no other region had a higher percentage of respondents than 14%). The regions with the lowest percentage of respondents were Region 2 and Region 4 (both with 7%)**

- **Fully 95% of the judges, CJPOs and JPOs who completed a survey reported that they were aware that the JDC nearest to them had a mental health clinician working in it**

- **Of the 41 judges, CJPOs, and JPOs who reported being aware of the CSP, all provided a response when asked whether they had been contacted by or received information from a clinician regarding one of the youth they were working with. Of those, 83% reported having been contacted by a clinician**
    - **The level of satisfaction with the contact from the JDC clinicians was very high, as 89% of the judges, CJPOs and JPOs who reported having been contacted were very satisfied (65%) or satisfied (24%) with the contact**

- **Of the judges, CJPOs and JPOs who had been contacted by a JDC clinician, all provided a response when asked whether they had been given a recommendation on treatment or decisions from this clinician. Of those, 97% reported having been given a recommendation**
    - **The level of satisfaction with recommendations provided by the JDC clinicians was very high, as nearly 91% of those judges, CJPOs and JPOs who reported receiving at least one recommendation were very satisfied (nearly 61%) or satisfied (30%) with the recommendation(s)**

- **Among the judges, CJPOs and JPOs who reported having received recommendations from the clinicians, all provided a response when asked whether the recommendations they received had affected a decision or treatment advised for the youth. Of those, over 87% reported that the recommendation they received affected a decision or treatment advised for the youth**

- **When asked to assess how beneficial the CSP was, the most common response made by the judges, CJPO and JPOs was "extremely beneficial" (76%), followed by "rather beneficial" (15%)**

- **When asked whether they would like to see the CSP continue, every one (100%) of the judges, CJPOs and JPOs reported wishing to see it continue**

Additional Analysis 1: Trauma and Gender Differences in the Prevalence of MH Problems

- **Over 32% of all juveniles who completed the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) screened positive for traumatic experiences**
  - **Like most previous years (with the exception of Y8), a statistically significant association was found between gender and indication of traumatic experiences. This association was accounted for by a greater percentage of girls (over 40%) having traumatic experience indications than boys (nearly 31%)**
  - **A statistically significant association was found between the indication of mental health problems and traumatic experiences. Whereas nearly 75% of juveniles who screened positive for traumatic experiences also screened positive for a mental health problem, less than 57% of juveniles who screened negative for traumatic experiences did so**

Additional Analysis 2: Booking Charges

- **Of all juveniles for whom one of the four AST classifications was documented and for whom a booking charge was entered, 628 had a booking charge classifiable as one of the four UCR categories (drug crime, property crime, crime against persons, and sex crime)**
  - **There was a statistically significant association between whether juveniles had an AST indication (of either a mental health problem only, a substance abuse problem only, or both types of problems) or not and the type of booking charge**
    - **Juveniles with no AST indications were more likely (over 34%) than those with AST indications (nearly 25%) to be booked on property crime charges, whereas juveniles with AST indications (over 37%) were more likely than those with no AST indications (over 27%) to be booked on crimes against person charges**
  - **There was a statistically significant association between AST indications (neither type of problem and a mental health problem only, a substance abuse problem only, or both types of problems) and the type of booking charge**
    - **Juveniles who were booked on drug crime charges were most likely to meet the AST criteria for a substance abuse problem only (just over 58%) and least likely to meet the criteria for a mental health problem only (over 12%)**
    - **Juveniles who were booked on property crime charges were most likely to meet the AST criteria for having neither a mental health nor a substance abuse problem (over 34%), and least likely to meet the criteria for a substance abuse problem only (nearly 21%)**
    - **Juveniles who were booked on crimes against persons charges were most likely to meet the AST criteria for having a mental health problem only (nearly 49%), and least likely to meet the AST criteria for having a substance abuse problem only (over 16%)**

- **Juveniles who were booked on sex crimes charges were most likely to meet the AST criteria for a mental health problem only (over 14%) and least likely to meet the criteria for having both a mental health problem and a substance abuse problem (over 2%)**

Additional Analysis 3: Regional Differences in Recommended Services Accessed

- **Of the 998 juveniles who received at least one recommendation for services, 572 had accessed at least one recommended service in the 15-45 days following their release**
  - **A statistically significant difference in the rates at which at least one recommended service was accessed was found as a function of county and region**
    - **The JDCs with the highest percentages of juveniles who accessed at least one recommended service were located in Bannock (over 89%), Bonner (nearly 74%), and Twin Falls (nearly 74%) counties. The JDCs with the lowest percentage of juveniles who accessed at least one recommended service were located in Canyon (over 32%), Fremont (nearly 40%), and Bonneville (nearly 51%) counties**
    - **The JDCs with the highest percentages of juveniles who accessed at least one recommended service were located in Region 6 (over 89%), Region 5 (nearly 74%), and Region 1 (over 73%). The JDCs with the lowest percentage of juveniles who accessed at least one recommended service were located in Region 3 (over 32%), Region 7 (just over 47%), and Region 4 (over 69%)**

Additional Analysis 4: Judges/CJPOs Survey

- **Of all respondents who received a recommendation from a JDC clinician, nearly 84% reported that these recommendations had affected a decision or treatment they advised for the youth, whereas 16% reported that it had not**
  - **On average, respondents reporting that the recommendation had affected a decision or treatment they advised for the youth were significantly more satisfied with the contact they had with the JDC clinician (M = 4.63) than those reporting that it had not (M = 3.50)**
  - **On average, respondents reporting that the recommendation had affected a decision or treatment they advised for the youth were significantly more satisfied with recommendations made by the clinician (M = 4.59) than those reporting that it had not (M = 3.40)**
  - **On average, respondents reporting that the recommendation had affected a decision or treatment they advised for the youth rated the CSP as significantly more beneficial (M = 4.89) than those reporting that it had not (M = 3.40)**

Additional Analysis 5: All MAYSI-2 Subscales

- **Four of six MAYSI-2 subscale indications were found to be statistically significant predictors of AST mental health problems**
  - **Juveniles with MAYSI-2 Suicide Ideation and Thought Disturbance indications were 2.9 times more likely than those without such indications to meet AST criteria for having a mental health problem; similar findings were documented with those having positive MAYSI-2 indications for the Angry-Irritable and Traumatic Experiences subscales (both 2.2 times more likely to meet the criteria for a mental health problem)**
- **Two of six MAYSI-2 subscale indications were found to be statistically significant predictors of AST substance abuse problems**
  - **Juveniles with MAYSI-2 Alcohol/Drug Use indications were 4.2 times more likely than those without such indications to meet the AST criteria for having a substance abuse problem; a similar finding was documented for those having a positive MAYSI-2 indication for the Thought Disturbance subscale (1.6 times more likely to meet the criteria for a mental health problem)**
- **Girls were found to be statistically significantly more likely than boys to have positive MAYSI-2 indications on four of the six subscales. Girls more often than boys had positive AST indications on the Angry-Irritable (43% to 31%), Depression/Anxiety (35% to 17%), Somatic Complaints (42% to 28%) and Suicide Ideation (40% to 15%) subscales**

Additional Analysis 6: Adverse Childhood Experiences

- **Pilot data were analyzed on the prevalence of Adverse Childhood Experiences (ACEs) data for 65 boys and 33 girls detained in the JDC in Kootenai County**
  - **The mean number of ACEs per juvenile was 3.77, with a range from 0-9 ACEs**
  - **Girls (4.58) had a statistically significantly higher number of ACEs than boys (3.35)**
  - **Nearly 39% of the juveniles fell into the highest category of ACEs exposure (five or more ACEs), whereas only 5% reported no ACEs**

Overview

The clinical services program (CSP) has been housing clinicians in juvenile detention centers (JDCs) in Idaho for a decade. It first began in August 2006, when the Idaho Department of Juvenile Corrections (IDJC) and Idaho Department of Health and Welfare (IDHW) provided funding for a pilot project housing a mental health clinician in the JDC in Bonneville County (known in the Idaho juvenile justice community as the "3B Detention Center"). On the basis of a positive internal evaluation conducted by Brian Mecham, a licensed clinical social worker affiliated with Behavior Consultation Services, the pilot program was expanded to provide for clinicians in the other 11 JDCs in Idaho. These JDCs included those in Ada, Bannock, Bonner, Canyon, Fremont, Kootenai, Lemhi, Minidoka, Nez Perce, Twin Falls, and Valley counties. Clinicians began to be hired and trained in December 2007, and this process continued throughout early 2008. IDJC contracted with researchers at the Center for Health Policy (CHP) at Boise State University (BSU) to conduct an external evaluation of the expanded program. A report on the expanded program (McDonald, Williams, Osgood, & VanNess, 2009) was issued in January 2009. The expanded program continued for seven years, and reports on the continuation of the program were issued in 2010 (McDonald, Osgood, & VanNess, 2010), 2011 (McDonald & Theiler, 2011), 2012 (McDonald, Begic, & Howard, 2012), 2013 (Begic, McDonald, & Howard, 2013), 2014 (Begic, McDonald, Gazieva, & Lindsay, 2014), 2015 (Begic & McDonald, 2015), and 2016 (McDonald, Begic, & Phillips, 2016). In 2012, the CSP was expanded to an additional JDC: the Shoshone/Bannock Tribal JDC located on the Fort Hall Indian Reservation in southeastern Idaho.

In the nine years of the expanded CSP, clinicians working in the 13 JDCs (the CSP was expanded to the Shoshone/Bannock Tribal JDC in 2012, and the data from this JDC were used for the first time in the Y6 evaluation) provided mental health and substance abuse screening using the Alaska Screening Tool (AST) and clinical interviews, to determine whether or not juveniles appeared to have one or more mental health or substance abuse problems. They noted, in a comprehensive database developed in conjunction with personnel from IDJC, important information such as screened juveniles' gender, booking charges, whether or not they met the AST diagnostic criteria for a mental health and/or substance abuse problem, whether they had previously been diagnosed with a mental health and/or substance abuse problem, whether the clinician provisionally diagnosed the juvenile with a mental health and/or substance abuse problem, what any provisional diagnoses were, whether any recommendations were made for community-based services upon release, what those recommendations were, and whether or not the juveniles had accessed them. To further evaluate the value of the CSP, surveys were conducted with members of two constituencies that were considered particularly important to the success of the program: the parents of the juveniles and the judges and chief juvenile probation officers (CJPOs) who work with the youth. A survey was presented to parents (by mail in Y1 and by telephone in Y2-Y9), asking them whether they had been contacted by clinicians and informed that their child had been identified as someone who could benefit from community-based mental health and/or substance abuse services, whether the clinician had provided recommendations for such services, whether they had accessed recommended services, and whether they had experienced barriers to this access. A survey was also presented to judges and CJPOs (by mail in Y1-Y4 and through an online portal in Y5-Y9), asking them whether they were aware of the CSP, whether they had been contacted by the clinician working in the nearest

JDC, whether they had been satisfied with the contact, whether the clinicians' recommendations had affected any decisions they made involving youth, how beneficial they thought it was to have a clinician in the JDCs, and whether they would like to see the program continue. In several evaluation years, other information was collected and/or analyzed including:

- Whether recently-released juveniles had been recommended and/or accessed community-based services, through a web-based survey in Y3 and Y4
- Assessment of the merits of the CSP, though interviews of key stakeholders (such as JDC administrators, clinicians, and line staff) in Y4 and Y8
- Incident data on use of restraints and suicide attempts in the JDCs, in Y4 and Y8
- Self-reported mental health data, collected on the Massachusetts Youth Screening Inventory (MAYSI-2), were analyzed each year starting in Y5
- Differences in judges'/CJPOs perceptions, starting each year in Y5

The eight evaluations of the expanded CSP revealed a number of interesting findings. For example, it was found that high percentages of juveniles in all eight years met the AST diagnostic criteria for a mental health problem (the eight-year average for juveniles meeting the AST criteria for having a mental health problem was 60%, ranging from a low of 56% in Y6 to a high of 68% in Y1) and a substance abuse problem (the eight-year average for juveniles meeting the AST criteria for a substance abuse problem was 43%, ranging from a low of 35% in Y8 to a high of 54% in Y1). Very high percentages of juveniles were found to meet the AST criteria for at least one type of problem (the eight-year average for juveniles meeting the AST criteria for at least one type of problem was 72%, ranging from a low of 66% in Y6 to a high of 82% in Y1), and substantial percentages were found to meet the criteria for both types of problems (the eight-year average for juveniles meeting the AST criteria for both types of problems was 32%, ranging from a low of 29% in Y4 to a high of 41% in Y1). Provisional diagnoses of at least one mental health or substance abuse problem were made for a majority of the juveniles in the last five evaluation years (i.e., Y4-Y8; a comparison to provisional diagnoses for Y1-Y3 is not feasible because problems were identified in how these were calculated in those years) (the five-year average for juveniles being provisionally diagnosed with at least one mental health or substance abuse problem was 63%, ranging from a low of 55% in Y6 to a high of 73% in Y4), with the most commonly diagnosed problems in all prior years being mood disorders, substance abuse disorders, and disruptive behavior disorders. The mail survey used for parents in Y1 yielded a response rate so low (less than 6%) that the results were considered ungeneralizable (i.e., not representative of the population), but the telephone surveys used in Y2-Y8 yielded valuable results. For example, whereas in Y2 only 26% of the parents reported that they had received information from clinicians about their child's mental health and substance abuse problems, this percentage was much higher in the following years (the six-year average [Y3-Y8] was 34%, ranging from a low of 21% in Y8 to a high of 47% in Y3). Also, high percentages of the parents who reported receiving information about their child's mental health and substance abuse problems reported that their children had received at least one recommendation for a community-based service in all seven years (the seven-year average was 62%, ranging from a low of 47% in Y4 to a high of 76% in Y2). Of those parents who reported receiving a service recommendation, most reported that their child had accessed at least one recommended service (the seven-year average was 89%, ranging from a low of 74% in Y2 to a high of 100% in Y8). Responses to the judges'/CJPOs' survey indicated positive perceptions of the CSP in all seven years (Y2-Y8). Most of the respondents reported being aware of the program (the seven-year average was 90%,

ranging from a low of 79% in Y3 to a high of 96% in Y7), having had contact with JDC clinicians (the seven-year average was 80%, ranging from a low of 73% in Y2 to a high of 91% in Y3), and receiving recommendations for youth (the seven-year average was 94%, ranging from a low of 89% in Y5 to a high of 98% in Y6). A very high percentage of judges and CJPOs who were aware of the program believed it to be beneficial (the seven-year average was 91%, ranging from a low of 80% in Y5 to a high of 94% in Y8), and nearly all reported wanting to see it continue (the seven-year average was 97%, ranging from a low of 94% in Y3 to a high of 100% in Y2). An analysis conducted for the first time in Y5, and replicated in Y6-Y8, also identified prior traumatic experiences as a significant predictor of MH problems, with juveniles screening positive for traumatic experiences being approximately three times more likely to also screen positive for a MH problem than those screening negative for traumatic experiences in all four years (i.e., Y5-Y8).

The CSP was funded for a ninth year (Y9), and IDJC contracted with the same team of BSU researchers to evaluate it. The 2016 evaluation was performed on data collected at the JDCs between July 1, 2015 and June 30, 2016. The procedures for collecting data for the clinicians' and parents' portions of the 2016 evaluation were identical to those used in the 2008-2015 evaluations. The procedure for delivering the judges/CJPOs survey was identical to that used in 2012 through 2015; however it differed somewhat from those used in the 2008-2011 evaluations. Several additional analyses utilizing data collected in waves one and three, which were completed in Y5-Y8, were again completed in the Y9 evaluation. Lastly, an analysis of Adverse Childhood Experience (ACE) data collected from the JDC in Kootenai County was performed in Y9, with the hopes of continuing to analyze such data from other JDCs in future evaluation years.

Methodology

Similar to the Y1-Y8 assessments, data were collected in several separate waves in this Y9 assessment. The first wave involved personnel at IDJC collecting data directly from clinicians at the JDCs and, after removing all personally identifying information, providing the data to the researchers at BSU. This wave of data collection was virtually identical in all nine years of evaluation (i.e., Y1-Y9). The second wave involved surveying the parents of juveniles who had been recently released from JDCs after receiving recommendations from clinicians for community-based services. The survey used was virtually identical in all nine years, although, as discussed below, the methodology for delivering the survey differed by evaluation year. The third wave involved surveying judges and CJPOs who worked with juveniles recently released from the JDCs. The survey used was essentially identical in all nine evaluation years; in the Y9 assessment, similar to Y6-Y8, two questions were added to the survey to collect demographic data from the judges/CJPOs (their profession and regions in which they work/have contact with juveniles), while all other questions remained unchanged. The methodology for delivering the survey differed by evaluation year. The fourth wave of data collection, which was new to the Y9 evaluation, involved the collection of Adverse Childhood Experiences (ACEs) data from the JDC in Kootenai County. Each wave will be discussed sequentially below. Several additional analyses, conducted for the first time in Y5 and replicated in Y6-Y8, were also performed in the Y9 evaluation. Each of the four waves and the additional analyses will be discussed sequentially below.

Wave One: JDC Data

The first wave of data collection involved gathering information on detained juveniles directly from clinicians at the JDCs. When juveniles are detained at a JDC, a variety of information about them is collected at intake. Each individual piece of information is described below.

Juvenile ID: A unique ID number is assigned to each juvenile when he or she is detained in a JDC. These numbers are not linked in any meaningful way to juveniles (e.g., they are not the juveniles' social security numbers, birth dates, etc.), so providing them to the BSU researchers did not violate any confidentiality protections. The real value of the Juvenile ID numbers was twofold. First, having the ID code allowed the researchers to determine when juveniles had been booked multiple times (it was clear when juveniles had been booked several times during the study period, as the ID code was repeated in the database). Second, the booking number was preceded by a two-letter code indicating what county JDC they had been detained in (for example, the two-letter code "1A" indicated that a juvenile had been detained in the Ada County JDC), which allowed for appropriate categorizing of the data for comparisons among JDCs.

Gender: All data were coded by the gender of the detained juvenile. This information was used for demographic purposes (to describe the gender distribution of the detained juveniles) and for analytical purposes (to compare important outcome variables, such as mental health and substance abuse diagnoses, as a function of gender).

Booking Charge(s): The booking charges for all juveniles were entered into the database by clinicians. Up to two separate booking charges could be coded through a content analysis

procedure aggregating conceptually similar booking charges into common themes which corresponded to Uniform Crime Reporting (UCR) categories (for example, combining "vandalism," "destruction of property," and "theft" into a larger category of "Property Crimes") and entered into the final data set used for analysis. This information was used primarily for demographic purposes, specifically for describing what types of crimes the juveniles had been detained for.

Mental Health and Substance Abuse Screening Outcomes: As was discussed in the Y1 evaluation report (McDonald et al., 2009), Brian Mecham, in his 2007 pilot study in the Bonneville County (3B) JDC, systematically evaluated several different standardized mental health and substance abuse inventories in an effort to select the one best suited for use by JDC clinicians. Mr. Mecham reported that the AST was superior to several other available assessment inventories and the AST was ultimately used in the pilot study and all subsequent years of evaluation (i.e., Y1-Y8). Although the AST contains three subscales—one for mental health problems, one for substance abuse problems, and one for traumatic brain injury—only scores from the mental health and substance abuse subscales were used in the Y1-Y9 evaluations. All AST screening information was entered into the clinician database as "True" or "False." A designation of "True" meant that a juvenile met the criteria for the relevant problem (i.e., a mental health or substance abuse problem), whereas a designation of "False" meant that a juvenile did not meet the criteria for the problem.

Although, as described above, the AST was found to be most useful for making assessments about mental health and substance abuse problems in detained juveniles, another assessment inventory known as the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) is also used in Idaho JDCs. A computer-based self-report inventory that is completed by juveniles as they are being booked into JDCs, the MAYSI-2 generates immediate results on seven subscales including Alcohol/Drug Use, Angry-Irritable, Depressed/Anxious, Somatic Complaints, Suicide Ideation, Thought Disturbance, and Traumatic Experiences (Cauffman, 2004; Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001). MAYSI-2 results were not used in any of the first four evaluation efforts (i.e., Y1-Y4); however, results from the Traumatic Experiences subscale were used for some additional analyses in the Y5-Y9 evaluations, and results from all seven subscales were used for some additional analyses in the Y7-Y9 evaluations.

Previous Diagnoses: During the clinical interview each detained juvenile had with the JDC clinician, each juvenile was asked whether he or she had ever been diagnosed with a mental health or substance abuse problem in the past. If the juvenile reported that he or she had been diagnosed in the past, he or she was asked how many diagnoses were given. The number of diagnoses was documented in the clinician database. In some cases, even if the juveniles report they have not been previously diagnosed with a mental health problem, clinicians can detect the presence of a previous diagnosis through the use of information about prescription medicines taken by the juveniles (e.g., if a juvenile is taking an anti-depressant medication, he or she has clearly at some point been diagnosed with a mental health problem) or from other available case notes.

Provisional Diagnoses: A primary purpose of the entire clinical interview was to determine whether or not detained juveniles suffered from mental health and/or substance abuse problems.

Clinicians made decisions about provisional diagnoses based on several pieces of information. Two such items were the AST mental health and substance abuse subscales; if juveniles met the diagnostic criteria for a mental health or substance abuse problem, it was highly likely that they would be provisionally diagnosed with the relevant problem. The other pieces of information were largely responses the juveniles made to questions posed by clinicians during the clinical interviews. A combination of all pieces of information was used by the clinicians to make their provisional diagnoses. The use of the word "provisional" is key in this context, as all clinicians, IDJC personnel, and BSU researchers involved in this project understood that a full clinical diagnosis takes more time to develop than the JDC clinicians had at their disposal during the intake interview.

In the clinician database, the clinicians first simply noted the number of provisional diagnoses made for each juvenile. Then, they entered information about what the diagnosis was (or diagnoses were, in the case of multiple diagnoses). A drop-down menu featured some generic options for clinicians to use if he or she chose (these generic options included "Mood Disorder," "Substance Abuse Disorder," and the like); however, the clinicians could also elect to type in their provisional diagnoses (and some chose to do so, particularly when they thought specificity was important). Prior to tabulating the numbers and percentages for each type of mental health or substance abuse problem, the researchers used a content analysis procedure to aggregate conceptually similar diagnoses (for example, combining "depression," "major depression," and "bipolar disorder" into a larger category of "Mood Disorders"). Up to four provisional diagnoses were coded for each juvenile.

Number of Recommended Services: When juveniles were diagnosed with a mental health and/or substance abuse problem, the clinicians were to make recommendations for them (usually through letters given or sent to their parents) to access community-based services upon their release (for example, if a juvenile was provisionally diagnosed as having depression, a clinician might recommend accessing counseling upon his or her release from the JDC). In the database, clinicians were asked to list the number of services that were recommended.

Services Recommended: All clinicians were asked to input the type of service(s) they recommended for juveniles who had been given a provisional diagnosis. A drop-down menu featured some generic options for clinicians to use if he or she chose (e.g., "Individual Counseling," "Substance Abuse Treatment"), however, the clinicians could also elect to type in their service recommendations (and some chose to do so, particularly when they thought specificity was important). The researchers used a content analysis procedure to aggregate conceptually similar types of recommended services (for example, combining "complete clinical diagnosis," "full mental evaluation," and "psychiatric evaluation" into a larger category of "Psychological/Mental Evaluation"), and then tabulated the numbers and percentages for each type of recommended service. Up to four recommended services were coded for each juvenile.

Recommended Services Accessed: It was considered critical in all nine evaluations to gain some sense of how many recently released juveniles accessed at least some of the services that had been recommended for them by clinicians. To develop preliminary information on this, the clinicians asked the juveniles' parents about whether they had accessed recommended services when they placed their follow-up calls to juveniles' homes 15-45 days after the juveniles were

released from the JDC (in cases in which the juveniles' parents could not be reached, the clinicians gathered the information from a different source, such as the juveniles' JPOs). When only one service had been recommended, the clinicians simply asked if that service had been accessed; when more than one service had been recommended, the clinicians asked how many of those services had been accessed. The number of services accessed was entered into the clinician database.

The first wave of data collection took place between July 1, 2015 and June 30, 2016. Data were submitted from all 13 JDCs; however, the data from the JDCs in Lemhi, Minidoka, and Valley counties, as well as data from the Shoshone-Bannock Tribal JDC were not included in the final, aggregated dataset because too few cases were submitted by these JDCs to guarantee juveniles anonymity. Clinician data were sent directly to personnel at IDJC, who then forwarded an Excel spreadsheet containing aggregated clinician data from the remaining JDCs (with all identifying information removed) to the BSU researchers for analysis. In total, this data set consisted of 1,080 data entries. Upon realizing that multiple entries were provided for some juveniles, the BSU team and an IDJC administrator determined that the data on 21 juveniles from JDCs in several counties for whom multiple data entries were provided should be excluded from the analysis. Consequently, wave one data analyses included clinician data provided for 1,059 juveniles for whom only one data entry was provided.

Wave Two: Parent Survey Data

The second wave of data collection involved the use of a survey of parents of juveniles who were recently released from a JDC. As was discussed in the Y1 report (McDonald et al., 2009), a survey of parents had not been used in the pilot study, and because parent feedback on the CSP was deemed highly desirable, a mail survey of parents of juveniles for whom community-based mental health or substance abuse services had been recommended was used in Y1. Unfortunately, the response rate to the Y1 parent survey was very low, yielding data that were not useful for analysis. In an attempt to increase the number of responses to the parent survey in Y2, IDJC contracted with the Idaho Federation of Families for Children's Mental Health (IFF) to conduct a telephone survey of parents whose children had received recommendations for community-based services when they had recently been released from a JDC. The survey featured five questions identical to those used in the Y1 mail survey; these questions had been developed jointly by the BSU researchers and IDJC personnel. These questions asked the parents: 1) whether they had been contacted by the JDC clinician and informed that their child had been identified as a person who might benefit from community-based mental health or substance abuse treatment; 2) whether the JDC clinician had given recommendations about what services their child should access in the community; 3) what services had been recommended for their child; 4) whether their child accessed at least one service recommended for him or her; and 5) why, if the child had not accessed the recommended service, he or she had not. Slight modifications were made to the Y2 survey to accommodate the questions being asked by a second party, rather than read directly by the respondents (these slight modifications did not alter the questions themselves, but rather the directions for completing them and the wording of some of the response options). Because the telephone survey yielded a much greater number of completed surveys in Y2, the same strategy (again using IFF callers) was employed in Y3-Y9.

Personnel at IDJC, working with JDC clinicians to gather the names of parents whose children had received recommendations for community-based services prior to their release from the JDCs, sent telephone contact information for the parents to IFF. IFF workers called the parents during the winter of 2016-2017 and wrote the parents' responses directly on paper copies of the survey. IFF returned the paper copies of completed surveys to IDJC in February 2017, and IDJC personnel released these surveys to the BSU researchers for data entry and analysis. No names or other identifying information (e.g., telephone numbers, county of residence) were on the surveys, protecting the confidentiality of the respondents.

Callers from IFF successfully contacted 123 parents of recently released juveniles (the callers from IFF placed additional 107 calls; however, these calls were excluded from the analysis because there either was no response or the number was invalid). Of these, 109 parents agreed to complete the survey, for a response rate of 89%.

Wave Three: Judges/Chief Juvenile Probation Officers Survey Data

The third wave of data collected for this project involved information gathered through a survey of judges and CJPOs who worked with youth released from the county JDCs. As discussed in the Y1 report (McDonald et al., 2009), a strategy for surveying judges and CJPOs was developed by Brian Mecham and used in the pilot study in 2007, and a slightly modified version of his original survey was used in each evaluation year. In the Y6 evaluation, the survey was further modified to allow for collection of some demographic data (i.e., respondents' profession and the region in which they work/have contact with juveniles), and this version of the survey was used again in the Y7-Y9 evaluations. Thus, the judges/CJPOs survey in Y7-Y9 consisted of 10 items (several of which had follow-up questions), asking the judges/CJPOs: 1) to identify their profession (judge, CCJPO, or other); 2) to select the region in which they work/have contact with juveniles; 3) if they were aware that the nearest JDC had a mental health clinician during the past year; 4) whether they had been contacted by the JDC clinician regarding one of the youth they were working with; 5) if they had been contacted, how satisfied they were with the contact (response options to this item ranged from 1 = "Very dissatisfied" to 5 = "Very satisfied"); 6) if they received recommendations on how to help youth with mental health issues; 7) if they had received recommendations, how satisfied they were with the recommendations (again, the response options ranged from "Very dissatisfied" to "Very satisfied"); 8) whether the recommendations they received affected any of the decisions or treatment they advised for youth; 9) how beneficial they thought it was to have a mental health clinician in the JDC (response options for this item ranged from "Not at all beneficial" to "Extremely beneficial"); and 10) whether they would like to see the CSP continue. They were also invited to share comments or recommendations related to the program.

The method of survey delivery used in Y9 was identical to that used in Y5-Y8. This method of delivery is different from the method used in Y1-Y4, when an IDJC program administrator identified the judges/CJPOs for the BSU researchers to send survey packets to and provided the BSU researchers with the names and postal addresses for these judges/CJPOs. The researchers at BSU then prepared the survey packets, which included a mailing envelope, cover letter explaining the project as well as the voluntary and anonymous nature of participation, and a self-addressed, postage-paid envelope for the judges/CJPOs to return the surveys directly to the

researchers at BSU. In the Y9 evaluation, the BSU research team created an internet-based survey utilizing the Qualtrics Online Survey Software package for which BSU has a site license. The judges/CJPOs survey was programmed into Qualtrics by January 2016, and the survey link was sent to an IDJC administrator along with an initial invitation message describing the survey and a one-week reminder statement. Recruitment of the judges/CJPOs was conducted directly by the IDJC administrator, who sent an initial invitation and link to the Qualtrics survey hosted on the BSU server to eligible judges/CJPOs in mid-January 2017. Respondents began to complete the survey the same day. The IDJC administrator sent a reminder email message after one week, encouraging potential respondents to complete the survey. The survey was closed after two weeks, and at that time, a total of 43 judges, CJPOs, and others working with juveniles had completed it (the response rate could not be calculated because the invitation to complete the survey was unexpectedly forwarded to an unspecified number of individuals who were neither judges nor CJPOs; all of these individuals were JPOs).

Wave Four: Pilot ACE Data

The fourth wave of data collection involved the collection of ACE self-reported trauma exposure information from a pilot sample of juveniles detained in the JDC in Kootenai County during calendar year 2015. The ACE Questionnaire was developed by a team of researchers and clinical personnel at Kaiser Permanente Hospital in San Diego in the mid-1990s (Felitti et al., 1998). Found to reliably measure trauma experiences that were predictive of many later life outcomes (Centers for Disease Control [CDC], 2016), the ACE Questionnaire asks respondents to answer questions related to whether they had suffered any of 10 types of childhood trauma, including: 1) frequent insult, humiliation, or fear of physical harm; 2) frequent physical abuse; 3) sexual contact by an adult or person at least five years older; 4) frequent feelings of being unloved or unimportant; 5) frequently not having enough to eat, clothed or protected (for example, having parents too drunk or high to take care of them if they needed it); 6) had parents who were separated or divorced; 7) had a mother or stepmother who was a victim of domestic violence; 8) living with anyone who was a substance abuser; 9) living with a household member who was mentally ill or had attempted suicide; and 10) had a household member go to prison. The number of ACEs is summed for a total ACE score, which may range from 0-10 but is often reported in collapsed format such as zero, one, two, three, four, and five or more. Kootenai County JDC Robin Jacobson has asked juveniles detained in that facility to complete the ACE Questionnaire since the start of calendar year 2015, and provided data for that calendar year to IDJC administrators in late fall, 2016. Those data were then stripped of any identifying information and sent to the BSU evaluation team. After the removal of a small number of duplicate cases, 99 unique cases remained for analysis.

Additional Analyses

When the results of the Y4 evaluation were presented at a meeting of the Idaho Criminal Justice Commission (ICJC) in 2012, questions were raised about gender differences in the prevalence of mental health problems and the association between mental health problems and traumatic experiences. Several additional questions were raised when the preliminary results of the Y5 evaluations were presented at a meeting of the Idaho Juvenile Justice Commission (IJJC) in March 2013. These questions asked whether there existed differences in booking charges

between juveniles who met the AST criteria for either type of problem and those who met the AST criteria for neither, whether rates at which at least one recommended service was accessed differed across regions/counties, and what factors may be contributing to variations in judges/CJPOs responses. In Y9, similar to Y5-Y8 when these analyses were also completed, the BSU research team conducted several additional analyses using the wave one and wave three data sets to address these questions. Specifically, wave one data were utilized to address questions about gender differences in the prevalence of mental health problems, the association between mental health problems and trauma experiences, differences in booking charges between juveniles who met the AST criteria for either type of problem and those who met the AST criteria for neither, and differential rates at which at least one recommended service was accesses across regions/counties. Wave three data were utilized to explore factors that may be contributing to variations in judges'/CJPOs' responses. Also, as was performed for the first time in Y7 and continued in Y8, a set of analyses were conducted in Y9 to test whether indications on the MAYSI-2's subscales other than Traumatic Experience were significantly associated with AST mental health indications.

Results and Analyses

Analysis of JDC Data

Demographic Information

The data in this report are gleaned from the cases of 1,059 juveniles detained at one of nine JDCs throughout Idaho. Gender codes were entered for 1,014 juveniles. Of these, 720 (or 71%) were boys and 294 (or 29%) were girls. The total number of cases was somewhat lower than the average of the first eight years (denoted throughout the remainder of this report as the "eight-year average") of CSP evaluations, which was 1,658 juveniles (ranging from a low of 1,336 in Y7 to a high of 2,066 in Y4). The percentages of boys and girls in Y9 were nearly identical to the eight-year average of CSP evaluations, which were 72% for boys and 28% for girls.

All cases submitted for analysis were coded to reflect the JDC in which each juvenile was booked. All 13 JDCs were asked to submit data from July 1, 2015 (the period after data collection ended for the previous year's evaluation) to June 30, 2016 (the end of the fiscal year). The JDCs in Lemhi, Minidoka, and Valley counties and the Shoshone-Bannock Tribal JDC submitted data for the study but these data were not included in the report because there were too few cases at each JDC to guarantee anonymity. The nine JDCs that submitted sufficiently large amounts of data (i.e., more than 20 unique juvenile cases each) are included below in Table 1.

As seen below in Table 1, the largest percentage of cases submitted was from the JDCs in Kootenai County (with 19% of the total cases), followed by the JDCs in Canyon County (nearly 17%) and Ada County (over 16%). On the other hand, the smallest percentage of cases was submitted from the JDC in Fremont County (less than 4%), followed by the JDCs in Bonner and Nez Perce counties (both over 4%).

Table 1: Number of Cases by Juvenile Detention Center (JDC) Location

JDC Location	Number of Cases	Percentage of Total Cases
Ada County	172	**16.2**
Bannock County (District 6)	130	12.3
Bonner County	46	*4.3*
Bonneville County (3B)	101	9.5
Canyon County (Southwest Idaho)	176	**16.6**
Fremont County (5C)	40	*3.8*
Kootenai County (District 1)	201	**19.0**
Nez Perce County (District 2)	47	*4.4*
Twin Falls County (Snake River)	146	13.8

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

Clinicians were asked to note the booking charge or charges for all juveniles whose information was entered into the database. At least one booking charge was noted for 1,055 of the juveniles, or 99.6% of all juveniles on whom data were collected, and two booking charges were noted for 236 (22.3%) juveniles. All booking charges were coded in accordance with the UCR categories. As seen in Table 2, the most common class of booking charge was for "other" crimes that did not easily fit a UCR category (over 46% of the booking charges most appropriately fit in this "Other" category); a large number of these were explicitly noted to be probation violations. Also as seen in Table 2, substantial numbers of juveniles were booked for drug crimes (nearly 26%), crimes against persons (over 22%), and property crimes (over 20%). Sex crimes were relatively uncommon among booking codes (accounting for less than 5% of all codes). The research team was unable to confidently classify 30 (less than 3%) of the listed booking codes.

Table 2: Most Common Booking Charges

Booking Charge	Number of Cases	Percentage of Total Cases
"Other" crimes not easily fitting a category (e.g., probation violation, runaway, incorrigible, disturbing the peace)	490	46.4
Drug crimes	273	25.9
Crimes against persons	234	22.2
Property crimes	213	20.2
Sex crimes	51	4.8
Unable to classify (e.g., discretionary days)	30	2.8

Note. The percentages in this table are calculated out of the 1,055 juveniles who were assigned at least one booking charge in the IDJC database. Because up to two booking charges were coded for each individual, the total percentages in this table may exceed 100.

AST Scores

As discussed earlier in this report, the AST was the primary instrument used for screening for mental health and substance abuse problems in the juveniles detained in the nine JDCs. Also as discussed earlier, only data collected from the mental health and substance abuse subscales (not the traumatic brain injury subscale) were analyzed in this study and are summarized in this report.

As seen below in Table 3, nearly 63% of the juveniles who were screened using the AST met the criteria for having a mental health problem. Also as seen in Table 3, over 37% of the juveniles screened with the AST met the criteria for having a substance abuse problem. The 63% figure for the percentage of juveniles who met the AST criteria for having a mental health problem is slightly higher than the eight-year average of 60% (ranging from a low of 56% in Y6 to a high of 68% in Y1). The 37% figure for the percentage of juveniles who met the AST criteria for having a substance abuse problem is lower than in seven of the eight previous years (the eight-year average was 43%, ranging from a low of 35% in Y8 to a high of 54% in Y1).

Table 3: AST Indications of Mental Health and Substance Abuse Problems		
Condition	**Number of Cases**	**Percentage of Total Screened Cases**
Mental health problem	663	62.6
Substance abuse problem	395	37.3

Note. The percentages in this table are calculated out of the juveniles who were screened with the AST for the relevant condition.

To better understand whether boys and girls appeared to have mental health or substance abuse problems at a similar rate, we analyzed the distribution of diagnoses separately by juvenile gender. We will discuss each type of problem sequentially, beginning with mental health. As seen below in Table 4, nearly 72% of the girls who were screened using the AST met the criteria for having a mental health problem, whereas over 59% of the boys appeared to have a mental health problem. A chi-square test revealed that the difference in mental health problems was statistically significant, χ^2 (df = 1) = 13.90, $p < .001$. The pattern revealing girls significantly more often meeting the AST criteria for having a mental health problem than boys was also found in all prior years. Thus, the gender difference in meeting AST mental health criteria continues to seem a robust finding.

As seen below in Table 4, the percentages of boys and girls meeting the AST criteria for having a substance abuse disorder were quite similar, with less than one percentage point between them, and there was no statistically significant difference in meeting these criteria as a function of gender. The lack of a statistically significant difference between boys and girls in rates of meeting AST substance abuse criteria was also found in all prior years except for Y2, when boys (at 48%) met the AST criteria for having a substance abuse problem significantly more often than girls (41%). That boys and girls met the substance abuse criteria at similar rates in eight of nine evaluation years suggests that the actual prevalence of substance abuse problems in these populations is indeed similar.

Table 4: AST Indications of Mental Health and Substance Abuse Problems, by Gender				
Condition	**Number of Cases**		**Percentage of Total Screened Cases**	
	Male	**Female**	**Male**	**Female**
Mental health problem	427	211	59.3	71.8
Substance abuse problem	270	113	37.5	38.4

Note. The percentages in this table are calculated out of the juveniles who were screened with the AST for the relevant condition.

Percentages of juveniles meeting the criteria for suffering from mental health and substance abuse disorders were also separated by JDC location, to determine whether the juveniles met the diagnostic criteria at similar rates across the nine JDCs. As seen below in Table 5, the three JDCs with the highest percentages of juveniles meeting the AST criteria for having a mental health problem were in Canyon (75% of screened juveniles met the criteria for a mental health problem), Fremont (nearly 68%), and Twin Falls (over 67%) counties. The three JDCs with the

lowest percentages of juveniles meeting the AST criteria for having a mental health problem were in Kootenai (nearly 53%), Bonner (over 54%), and Bannock (nearly 59%) counties. A chi-square test revealed that the differential rate of mental health problems as a function of JDC location was statistically significant, χ^2 (df = 8) = 24.22, $p < .01$.

Table 5: AST Indications of Mental Health Problems by JDC Location		
JDC Location	**Number of Cases**	**Percentage of Total Screened Cases**
Ada County	105	61.0
Bannock County (District 6)	76	*58.5*
Bonner County	25	*54.3*
Bonneville County (3B)	65	64.4
Canyon County (Southwest Idaho)	132	**75.0**
Fremont County (5C)	27	**67.5**
Kootenai County (District 1)	106	*52.7*
Nez Perce County (District 2)	29	61.7
Twin Falls County (Snake River)	98	**67.1**

Note. The percentages in this table are calculated out of the juveniles at each JDC who were screened with the AST for the relevant condition. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

As seen below in Table 6, there were also some differences as a function of JDC location in the percentages of juveniles meeting the AST criteria for having a substance abuse problem. The JDC with the highest percentages of juveniles meeting the AST criteria for having a substance abuse problem was in Canyon County (where nearly 47% of the screened juveniles met the criteria for a substance abuse problem), followed by the JDCs in Fremont and Bannock (nearly 43% and nearly 42%, respectively) counties. The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a substance abuse problem were in Bonner (nearly 22%), Bonneville (nearly 31%), and Ada (nearly 35%) counties. A chi-square test revealed that the differential rate of substance abuse problems as a function of JDC location was just at the cusp of statistically significance, χ^2 (df = 8) = 15.43, $p = .05$. This was the first evaluation year in which there was not a marked statistically significant difference in percentages of juveniles meeting the AST criteria for having a substance abuse problem as a function of JDC location.

Table 6: AST Indications of Substance Abuse Problems by JDC Location		
JDC Location	**Number of Cases**	**Percentage of Total Screened Cases**
Ada County	60	*34.9*
Bannock County (District 6)	54	**41.5**
Bonner County	10	*21.7*
Bonneville County (3B)	31	*30.7*
Canyon County (Southwest Idaho)	82	**46.6**
Fremont County (5C)	17	**42.5**
Kootenai County (District 1)	72	35.8
Nez Perce County (District 2)	17	36.2
Twin Falls County (Snake River)	52	35.6

Note. The percentages in this table are calculated out of the juveniles at each JDC who were screened with the AST for the relevant condition. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

To gain a better understanding of the extent to which juveniles in detention in Idaho suffer from mental health problems and substance abuse problems separately and together (i.e., a dual diagnosis), we combined the information on mental health and substance abuse problems for each juvenile. In this way, juveniles were coded as having: 1) neither a mental health nor a substance abuse problem (i.e., they met the AST criteria for neither condition); 2) a mental health problem only (i.e., they met the AST criteria for a mental health problem, but not a substance abuse problem); 3) a substance abuse problem only (i.e., they met the AST criteria for a substance abuse problem, but not a mental health problem); and 4) both a mental health problem and a substance abuse problem (i.e., they met the AST criteria for both types of problems). As seen below in Table 7, the single-largest group of the juveniles (nearly 33%) who were screened with the AST met the diagnostic criteria for a mental health abuse problem only. The next largest group of juveniles (just over 30%) met the AST criteria for neither a mental health problem nor a substance abuse problem, followed by those who met the criteria for both a mental health problem and a substance abuse problem (30%). The smallest group of juveniles (over 7%) met the criteria for a substance abuse problem only.

Table 7: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both		
Condition	**Number of Cases**	**Percentage of Total Screened Cases**
Neither mental health nor substance abuse problem	319	30.1
Mental health problem only	345	**32.6**
Substance abuse problem only	77	*7.3*
Both mental health and substance abuse problem	318	30.0

Note. The percentages in this table are calculated out of the juveniles who were screened with the AST for both conditions. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. The highest percentage is presented in bold, and the lowest percentage is presented in italics.

Again to determine whether boys and girls differentially met the diagnostic criteria for mental health problems and substance abuse problems (or neither or both), we analyzed how male and female juveniles were distributed across the four diagnostic categories (neither type of problem, a mental health problem only, a substance abuse problem only, and both types of problems). As seen below in Table 8, differences in the rates at which boys and girls fell into the four categories were found, and a chi-square test revealed that these differences were statistically significant, χ^2 (df = 3) = 16.58, $p < .01$. In terms of raw percentages, the largest difference was in rates of meeting the diagnostic criteria for having neither type of problem; boys (at nearly 32%) were considerably more likely than girls (at nearly 25%) to fall into this category. On the other hand, girls (at over 37%) were considerably more likely than boys (at nearly 31%) to meet the criteria for having a mental health problem only. Girls were also considerably more likely to meet the criteria for having both types of problems (at nearly 35%) than boys (nearly 29%). Lastly, boys were found to be much more likely to meet the criteria for having a substance abuse problem only (at 9%) than girls (nearly 4%). The tendencies for girls to more often than boys meet the criteria for a mental health problem only and both types of problems, and for boys to more often meet the criteria for a substance abuse problem only and neither type of problem were found in all eight previous evaluation years. Clearly, these seem to be robust patterns in classification and categorization.

Table 8: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both, by Gender

Condition	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Neither mental health nor substance abuse problem	228	72	31.7	24.5
Mental health problem only	222	109	30.8	37.1
Substance abuse problem only	65	11	9.0	3.7
Both mental health and substance abuse problem	205	102	28.5	34.7

Note. The percentages in this table are calculated out of the juveniles who were screened with the AST for both conditions. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

The pattern by which the juveniles met the respective criteria for the same four diagnostic categories was also examined as a function of JDC location. As seen below in Table 9, differences in the rates at which juveniles at the nine JDCs fell into the four categories were found, and a chi-square test revealed that these differences were statistically significant, χ^2 (df = 24) = 62.77, $p < .001$. These differences may most easily be seen in visual analysis of the most and least common diagnostic categories that emerged for each JDC. The most common diagnostic category often differed by JDC location. Juveniles meeting the diagnostic criteria for having a mental health problem only were the single largest group in five JDCs (in Bonneville, Canyon, Fremont, Nez Perce, and Twin Falls counties), and juveniles meeting the criteria for having neither a mental health problem nor a substance abuse problem were the single largest group in three JDCs (in Ada, Bonner, and Kootenai counties); in the JDC in Bannock County, juveniles meeting the criteria for having neither a mental health problem or a substance abuse problem and juveniles meeting the criteria for having both types of problems were equal in number. The least common diagnostic category was entirely uniform across JDCs, with juveniles

meeting the criteria for having a substance abuse problem only being the single smallest group in all nine JDCs.

Table 9: AST Indications of Mental Health Problems, Substance Abuse Problems, and Comorbid Existence of Both, by JDC Location				
JDC Location	**Neither MH nor SA**	**MH only**	**SA only**	**Both MH and SA**
Ada County	**35.5 (N = 61)**	29.7 (N = 51)	*3.5 (N = 6)*	31.4 (N = 54)
Bannock County (District 6)	**31.5 (N = 41)**	26.9 (N = 35)	*10.0 (N = 13)*	**31.5 (N = 41)**
Bonner County	**45.7 (N = 21)**	32.6 (N = 15)	*0.0 (N = 0)*	27.1 (N = 10)
Bonneville County (3B)	33.7 (N = 34)	**35.6 (N = 36)**	*2.0 (N = 2)*	28.7 (N = 29)
Canyon County (Southwest Idaho)	14.8 (N = 26)	**38.6 (N = 68)**	*10.2 (N = 18)*	36.4 (N = 64)
Fremont County (5C)	20.0 (N = 8)	**37.5 (N = 15)**	*12.5 (N = 5)*	30.0 (N = 12)
Kootenai County (District 1)	**39.8 (N = 80)**	24.4 (N = 49)	*7.5 (N = 15)*	28.4 (N = 57)
Nez Perce County (District 2)	25.5 (N = 12)	**38.3 (N = 18)**	*12.8 (N = 6)*	23.4 (N = 11)
Twin Falls County (Snake River)	24.7 (N = 36)	**39.7 (N = 58)**	*8.2 (N = 12)*	27.4 (N = 40)

Note. The percentages in this table are calculated out of the juveniles at each JDC who were screened with the AST for both conditions. N denotes the number of cases in each table cell. Percentages are rounded to the first decimal place, so the total percentage across rows may not equal 100. The highest row percentages are presented in bold, and the lowest row percentages are presented in italics.

Previous and Provisional Diagnoses

During the clinical interview for each juvenile, the clinicians at each JDC asked whether the juvenile had ever been diagnosed with a mental health or substance abuse problem in the past. If the juveniles reported that they had been diagnosed with such a problem in the past, the clinicians asked them how many separate diagnoses they had been given. This information (along with, as noted in the Methodology section, information about any psychotropic medications a juvenile might be taking) was used to create a number of "previous diagnoses" for each juvenile.

At least one previous diagnosis of a mental health or substance abuse disorder was recorded for 813 juveniles, or nearly 77% of all juveniles on whom data were collected (this percentage is the second-highest of all of the previous years, which ranged from a low of 59% in Y1 to a high of 79% in Y8; the eight-year average for percentage of juveniles with at least one previous diagnosis is 69%). The mean number of previous diagnoses for juveniles (of both genders and

across the nine JDCs) with at least one previous diagnosis was 1.34, with a standard deviation of .67. The range of previous diagnoses for those juveniles for whom at least one previous diagnosis was noted spanned from one to five. In Y9, similar to Y3, Y4, Y7 and Y8 (but unlike in Y1, Y2, Y5, and Y6), girls (1.48) reported or were identified with significantly more previous diagnoses than boys (1.28), t (df = 798) = -3.86, $p < .001$. The mean number of previous diagnoses also differed significantly as a function of JDC location, F (8, 804) = 4.79, $p < .001$ (this result is similar to that found in all eight previous evaluation years). As seen below in Table 10, the JDCs with the highest number of mean previous diagnoses were those in Nez Perce (1.70), Bannock (1.52), and Canyon (1.45) counties. The JDCs with the lowest number of mean previous diagnoses were in Bonner and Fremont (both 1.00) counties, followed by Kootenai (1.13) County.

Table 10: Number of Previous Diagnoses by JDC Location

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	156	1.37	.69
Bannock County (District 6)	85	**1.52**	.73
Bonner County	5	*1.00*	.00
Bonneville County (3B)	89	1.24	.58
Canyon County (Southwest Idaho)	163	**1.45**	.85
Fremont County (5C)	5	*1.00*	.00
Kootenai County (District 1)	149	*1.13*	.36
Nez Perce County (District 2)	23	**1.70**	.70
Twin Falls County (Snake River)	138	1.30	.61

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest means are presented in bold, and the three lowest percentages are presented in italics.

Clinicians at all JDCs used the diagnostic information from each juvenile's AST scores and other information from a brief clinical interview to determine whether to make a "provisional diagnosis" of a mental health or substance abuse problem for that juvenile (the term "provisional diagnosis" was used rather than simply "diagnosis" in recognition that a full clinical diagnosis could not reasonably be made in such a short interview). In cases in which clinicians felt that more than one provisional diagnosis was warranted (for example, if a clinician believed a juvenile had depression and a substance abuse problem), they could give multiple provisional diagnoses.

At least one provisional diagnosis of a mental health or substance abuse disorder was recorded for 589 juveniles, or nearly 56% of all juveniles on whom data were collected. Twenty-seven of the juveniles (or less than 3% of all those on whom data were collected) received a provisional diagnosis indicating 'diagnosis deferred,' which meant that a clinician did not feel comfortable making a specific provisional diagnosis based on the clinical interview, but suspected an underlying mental health or substance abuse problem that could be identified in a more thorough, post-detention assessment. The mean number of provisional diagnoses for juveniles (of both genders and across the nine JDCs) with at least one provisional diagnosis (excluding 'diagnosis deferred') was 1.55, with a standard deviation of .70. The range of provisional diagnoses for

those juveniles for whom at least one provisional diagnosis was noted spanned from one to four. As was the case in all prior years except for Y6, a statistically significant difference in mean number of provisional diagnoses was found to exist between girls (1.70) and boys (1.49), with girls receiving significantly more provisional diagnoses than boys, t (df = 537) = -3.13, p <.01. As was the case in all eight previous evaluation years, the mean number of provisional diagnoses significantly differed as a function of JDC location, F (8, 553) = 6.48, p < .001. As seen below in Table 11, the JDC with the highest number of mean provisional diagnoses was in Nez Perce County (3.00), although only one juvenile was assigned any provisional diagnoses in that facility; the next highest mean was from the JDC in Canyon County (1.85). The JDCs with the lowest number of mean provisional diagnoses were in Ada (1.22), and Bonneville (1.31) counties.

Table 11: Number of Provisional Diagnoses by JDC Location

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	27	*1.22*	.51
Bannock County (District 6)	64	1.44	.64
Bonner County	23	1.56	.79
Bonneville County (3B)	60	*1.31*	.47
Canyon County (Southwest Idaho)	136	**1.85**	.79
Fremont County (5C)	36	1.56	.65
Kootenai County (District 1)	114	1.43	.56
Nez Perce County (District 2)	1	**3.00**	.00
Twin Falls County (Snake River)	101	1.56	.73

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The two highest means are presented in bold, and the two lowest percentages are presented in italics.

All clinicians who made provisional diagnoses were asked to indicate what the diagnoses were for each individual. At least one provisional diagnosis was indicated in 558 cases. A content analysis procedure was used to classify all provisional diagnoses entered by the clinicians into conceptually consistent diagnostic categories. As seen below in Table 12, the most common diagnoses given were for a substance abuse disorder (nearly 41% of the juveniles for whom a provisional diagnosis was listed were diagnosed with a substance abuse disorder) and a mood disorder (over 40% of juveniles for whom a provisional diagnosis was listed were diagnosed with a mood disorder). Two other diagnoses that were given with some frequency were for disruptive behavior disorders and anxiety disorders (e.g., post-traumatic stress disorder, panic disorder). The former (which was a broad category encompassing several more specific disorders including oppositional defiant disorder and disruptive disorder) was given to just over 34% of juveniles for whom a provisional diagnosis was listed. The latter was given to just over 16% of the juveniles for whom a provisional diagnosis was listed. One other class of disorders that was listed with some frequency was attention deficit disorders (e.g., attention deficit hyperactivity disorder), which was given to just over 8% of juveniles. Unlike the previous eight evaluation years, the order of the five most common provisional diagnoses was not the same. Whereas in earlier years, a mood disorder had always been the most common and was followed by substance abuse disorders, in Y9, these first two positions were reversed.

Table 12: Most Common Provisional Diagnoses		
Provisional Diagnosis	**Number of Cases**	**Percentage of Total Cases**
Substance abuse disorders (e.g., marijuana or alcohol abuse)	228	40.8
Mood disorders (e.g., depression, bipolar disorder)	225	40.3
Disruptive behavior disorders (e.g., oppositional defiant disorder, disruptive disorder, conduct disorder)	190	34.1
Anxiety disorders (e.g., post-traumatic stress disorder)	90	16.1
Attention deficit disorders (e.g., ADHD/ADD)	46	8.2
Other (e.g., trauma, developmental delay)	93	16.7

Note. The percentages in this table are calculated out of 558 juveniles for whom at least one provisional diagnosis (excluding 'diagnosis deferred') was noted in the IDJC database. Because up to four provisional diagnoses were coded for each individual, the total percentages in this table may exceed 100.

Recommendations for Services

At least one recommendation for services was recorded for 786 juveniles. This number is higher than the total number of juveniles who received at least one provisional diagnosis (562 juveniles received at least one provisional diagnosis). Of all juveniles who received at least one service recommendation, 558 (or 71%) were also given at least one provisional diagnosis. The remaining 228 (or 29%) received at least one service recommendation but were not given a provisional diagnosis. Additionally, 26 juveniles (or under 5% of all juveniles who received a provisional diagnosis) were given at least one provisional diagnosis without receiving a service recommendation. Perhaps the best measure of the success of clinicians in making recommendations to those who were supposed to receive them is through dividing the number of provisionally diagnosed juveniles who also received at least one service recommendation (744) by the number of juveniles who received at least one provisional diagnosis (786). The resulting figure is 95.4%, meaning over 95% of the juveniles who should have received a service recommendation did in fact receive at least one. The mean number of recommended services for those juveniles (of both genders and across the nine JDCs) who were given at least one service recommendation was 1.67, with a standard deviation of 1.09. The range of recommended services for those juveniles for whom at least one recommended service was noted spanned from one to 13. Unlike in Y1 and Y3-Y6, but similar to Y2, Y7 and Y8, no statistically significant difference in the number of recommended services was found between girls and boys (the mean number of recommended services was 1.72 for girls and 1.68 for boys). However, similar to all seven previous evaluation years, the mean number of recommended services was found to differ significantly as a function of JDC location, F (8, 988) = 22.91, $p < .001$. As seen below in Table 13, the JDC with the highest number of mean recommended services was in Bannock County (2.47), followed by the JDCs in Canyon (2.06) and Twin Falls (1.83) counties. The JDC with the lowest number of mean recommended services was in Fremont County (1.03), followed by the JDCs in Ada (1.12) and Bonneville (1.19) counties.

Table 13: Number of Recommended Services by JDC Location			
JDC Location	**Number of Cases**	**Mean**	**Standard Deviation**
Ada County	93	*1.12*	.34
Bannock County (District 6)	116	**2.47**	1.80
Bonner County	27	1.37	.63
Bonneville County (3B)	59	*1.19*	.39
Canyon County (Southwest Idaho)	156	**2.06**	.95
Fremont County (5C)	33	*1.03*	.17
Kootenai County (District 1)	119	1.29	1.29
Nez Perce County (District 2)	45	1.22	1.22
Twin Falls County (Snake River)	142	**1.83**	.99

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest means are presented in bold, and the three lowest means are presented in italics.

All clinicians who indicated that they had recommended at least one service for a juvenile were asked to indicate what the recommended service(s) was. Clinicians indicated what the recommended service was (or recommended services were, if multiple recommendations were given) for all 786 juveniles to whom service recommendations were reportedly given. A content analysis procedure was used to classify the different types of recommended services entered in the Access database by the clinicians into conceptually consistent themes. As seen below in Table 14, the most common recommendation given was for continuation of prior treatment (just over 40% of juveniles for whom a recommended service was listed were either already in treatment or recommended to continue prior treatment), followed by recommendations for individual counseling (40%), substance abuse counseling/treatment (nearly 28%), and psychological/mental evaluation (nearly 17%). A smaller number of recommendations was made for family counseling (just under 10%), followed by IDJC commitment (i.e., commitment in a state-operated Juvenile Corrections Center), medication evaluation, and residential treatment (all nearly 2%).

Table 14: Most Common Service Recommendations		
Service Recommendation	**Number of Cases**	**Percentage of Total Cases**
Continue (unspecified) prior treatment/Already in treatment	316	40.2
Individual counseling (e.g., Cognitive Behavioral Therapy)	314	40.0
Substance abuse counseling/treatment	219	27.8
Psychological/mental evaluation	131	16.7
Family counseling	78	9.9
DJC commitment	14	1.7
Medication evaluation	13	1.7
Residential treatment	12	1.5
Psychosocial rehabilitation	6	<1.0

Note. The percentages in this table are calculated out of the 786 juveniles who were assigned at least one service recommendation in the IDJC database. Because up to four service recommendations were coded for each individual, the total percentages in this table may exceed 100.

Recommended Services Accessed

All clinicians who made at least one recommendation for services were asked when they completed follow-up calls to a parent/guardian of each juvenile 15-45 days after release, whether or not the recommended service had been accessed. The clinicians reported that 460 juveniles, or nearly 59% of the 786 juveniles for whom at least one service had been recommended, had accessed at least one service. The mean number of recommended services accessed, for those juveniles (of both genders and across the nine JDCs) who were given at least one service recommendation and accessed at least one recommendation, was 1.47, with a standard deviation of 1.05. The range of recommended services accessed for those juveniles for whom at least one recommended service accessed was noted spanned from one to 13 (approximately 41% of the juveniles receiving at least one service recommendation had not yet accessed a service). Similar to all eight previous evaluation years, the mean number of recommended services accessed differed significantly as a function of JDC location, F (8, 451) = 10.39, $p < .001$. As seen below in Table 15, the JDC with the highest number of mean recommended services accessed was in Bannock County (2.19), followed by the JDCs in Twin Falls (1.59) and Bonner (1.27) counties. The JDCs with the lowest number of mean recommended services accessed were the JDC in Canyon and Fremont counties (1.00 in each), followed by the JDC in Nez Perce County (1.12).

Table 15: Number of Recommended Services Accessed by JDC Location			
JDC Location	**Number Of Cases**	**Mean**	**Standard Deviation**
Ada County	61	1.13	.34
Bannock County (District 6)	102	**2.19**	1.72
Bonner County	15	**1.27**	.46
Bonneville County (3B)	20	1.25	.44
Canyon County (Southwest Idaho)	41	*1.00*	.00
Fremont County (5C)	10	*1.00*	.00
Kootenai County (District 1)	74	1.20	.58
Nez Perce County (District 2)	33	*1.12*	.33
Twin Falls County (Snake River)	104	**1.59**	.88

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest means are presented in bold, and the three lowest means are presented in italics.

Parent Survey

As discussed earlier in this report, the second phase of data collection involved conducting a survey of parents of recently released juveniles who had been given at least one provisional diagnosis of a mental health or substance abuse problem to determine whether or not they had been contacted by JDC clinicians and provided with recommendations for services for their children. Part of the protocol used by JDC clinicians was to provide each provisionally diagnosed juvenile who was being released with at least one recommendation for services, and then to follow up with each juvenile's parent by telephone 15-45 days after release. During this follow-up contact, the JDC clinicians were to ask each parent if he or she was aware of any recommendation that had been made, and if he or she was, to inquire whether the juvenile had accessed the recommended service. A principal part of the rationale for the parent survey was to determine if the parents of recently released juveniles had been contacted by the appropriate JDC clinician and whether or not the juveniles had accessed the recommended services. Because it was recognized by the research team that not many of the juveniles would have had time to access recommended services by the time the 15-45 day follow-up call had been placed (largely due the time required to schedule an appointment), it was believed that the parent survey would provide a much more accurate portrait of the number of juveniles who accessed the recommended service.

A total of 123 calls were placed by the callers from the IFF, 109 of which were successful (i.e., they resulted in a survey completion by a parent), yielding an 89% response rate. Parenthetically, the callers from the IFF placed additional 107 calls; however, these calls were excluded from the analysis because there either was no response (97 cases) or the number was invalid (10 cases).

JDC Clinician Calls

The first question on the parent survey simply asked the respondents whether the JDC clinician had contacted them by telephone or letter to follow up on the recommendation for services made at the time their child was released from detention. All but one of parents who completed a survey answered this question. Of these parents, 52 (over 47%) responded "Yes" that they had been contacted by the JDC clinician. The callers from the IFF were instructed to inform those who responded "No" to the first question that the survey was completed. Parents who responded "Yes" were asked the next question.

The second question on the survey asked the respondents whether the JDC clinician made recommendations for what services their child should access in the community. Of the 53 parents who completed this item, 24 (or over 45%) reported that they had received recommendations for services from the JDC clinician. The callers from the IFF were instructed to inform those who responded "No" to this second question that the survey was completed. Parents who responded "Yes" were asked the next question.

Recommended Services

The third question asked the respondents what recommendations for services they received from the JDC clinicians; the callers for the IFF wrote down what the respondents reported. All written answers were analyzed with a content analysis procedure, and, when possible, were clustered into conceptually similar themes. Twenty-four parents reported at least one service recommendation. As seen below in Table 16, the most commonly reported recommendation, made for over 79% of the youth for whom a recommended service was reported, was for counseling for the juveniles. Three parents (nearly 13%) reported recommendations for a substance abuse treatment or assessment, two (over 8%) reported some other service, and one parent (over 4%) reported that he or she could not remember what service or services had been recommended for his or her child.

Table 16: Most Commonly Received Service Recommendations

Service Recommendation	Number of Cases	Percentage of Total Cases
Counseling (unspecified, mental health, family)	19	79.2
Substance abuse treatment or assessment	3	12.5
Other (e.g., diversion, juvenile probation)	2	8.3
Can't remember	1	4.2

Note. The percentages in this table are calculated out of the 24 parents who reported that their child received at least one service recommendation. Because up to two recommended services were entered for each individual, the total percentages in this table may exceed 100.

The fourth question asked parents whether or not their child had accessed the service(s) that had been recommended to them. Of the 24 parents who completed this item, 22 (or nearly 92%) reported that their child had accessed at least one recommended service.

Barriers to Access

The final question on the survey was to ask the parents who reported that their child had not accessed at least one recommended service to report the reason why their child had not done so. Only one parent responded to this question, and reported that his or her family could not afford the recommended service.

Judges and Probation Officers Survey

As discussed earlier in this report, the third phase of data collection involved a survey of judges and CJPOs who worked with youth detained in one of the JDCs. Because one of the goals of the CSP is to provide helpful information to personnel who work with detained youth, the perceptions of these judges and CJPOs were considered very important. The judges'/CJPOs' survey consisted of seven questions asking about contact with the JDC clinicians, the value of information received from JDC clinicians, and the overall value of the program. In addition, the judges/CJPOs were also asked to indicate the region in which they work or have contact with juveniles and their profession (judge, CJPO, or other). A total of 43 respondents completed this survey (a response rate could not be calculated because an unspecified number of invitations were unexpectedly extended to individuals other than judges or CJPOs); their responses are discussed below.

Demographic Information

Of the 43 respondents who completed this survey, eight (nearly 19%) identified themselves as judges and 24 (or nearly 56%) identified themselves as a CJPO. Eleven respondents (nearly 26%) identified themselves as JPOs. Similar to what was done in Y7 and Y8, the 11 JPOs were placed, for analytical purposes, with the CJPOs to form a category of 'CJPOs and JPO.'

As seen below in Table 17, judges, CJPOs, and JPOs in Region 1 (nearly 35%) accounted for the largest percentage of respondents, followed by those in Regions 3 and 5 (both 14%). On the other hand, judges, CJPOs, and JPOs in Regions 2 and 4 (both 7%) accounted for the smallest percentages of respondents.

Table 17: Number of Respondents, by Region

Region	Number of Respondents	Percentage of Total Respondents
Region 1 (Bonner and Kootenai counties)	15	34.9
Region 2 (Nez Perce County)	3	7.0
Region 3 (Canyon County)	6	14.0
Region 4 (Ada County)	3	7.0
Region 5 (Minidoka and Twin Falls counties)	6	14.0
Region 6 (Bannock County)	4	9.3
Region 7 (Bonneville, Fremont, and Lemhi counties)	4	9.3

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

Program Awareness

The first item on the survey simply asked the judges, CJPOs, and JPOs whether or not they were aware that the closest JDC had a mental health clinician in the past year. Of the 43 respondents who completed this item, 41 (or over 95%) reported that they were aware that the closest JDC had a clinician in it. A statement on the survey informed those who responded "No" to this first question that they were not required to complete the remaining items, and to simply return the survey as it was. Judges, CJPOs, and JPOs who responded "Yes" were asked to complete the next item.

Satisfaction with Contact

The second item on the survey asked the judges, CJPOs, and JPOs whether they had been contacted by the JDC clinician regarding one of the juveniles they worked with. Of the 41 respondents who completed this item, 34 (or nearly 83%) reported that they had been contacted by the JDC clinician about at least one of their juveniles. A statement on the survey informed those who responded "No" to this second question that they were not required to complete the remaining items, and to simply return the survey as it was. Those who responded "Yes" were asked to complete the remaining items.

Those judges, CJPOs, and JPOs who reported having been contacted by the JDC clinician about at least one of the youth they were working with were asked to indicate how satisfied they were with this contact. They were asked to indicate their satisfaction on a five-point Likert-type scale with values ranging from 1 = Very Dissatisfied to 5 = Very Satisfied. As seen below in Table 18, over 88% of the respondents who completed this item reported being very satisfied (nearly 65%) or satisfied (nearly 24%) with the contact with the JDC clinician. Of those who did not report satisfaction with contact from the JDC clinician, two were neither satisfied nor dissatisfied, with one being dissatisfied and one being very dissatisfied.

Table 18: Satisfaction with Contact with JDC Clinician

Item	Very Dissatisfied	Dissatisfied	Not Satisfied or Dissatisfied	Satisfied	Very Satisfied
How satisfied were you with the contact you had with the mental health clinician?	2.9% (N = 1)	2.9% (N = 1)	5.9% (N = 2)	23.5% (N = 8)	64.7% (N = 22)

Note. The percentages in this table are calculated out of the 32 judges, CJPOs, and JPOs who reported a level of satisfaction with contact with a JDC clinician. Percentages are rounded to the first decimal place, so the total row percentage may not equal 100.

Similar to prior years, no statistically significant difference in the level of satisfaction with contact with JDC clinician was found between judges and CJPOs/JPOs. There was also no statistically significant difference in levels of satisfaction with contact as a function of region. However, because the means did differ in observable ways, they are presented for inspection in Table 19 below.

Table 19: Satisfaction with Contact with JDC Clinicians, by Region		
Region	**Mean**	**Standard Deviation**
Region 1 (N = 15)	4.67	1.05
Region 2 (N = 2)	3.50	0.71
Region 3 (N = 3)	3.33	1.53
Region 4 (N = 1)	4.00	0.00
Region 5 (N = 5)	4.60	0.55
Region 6 (N = 4)	4.75	0.50
Region 7 (N = 4)	4.50	0.58

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values.

The third item asked the judges, CJPOs, and JPOs whether they received recommendations from the JDC clinicians to help youth with mental health or substance abuse problems. Of the 34 respondents who completed this item, 32 (just over 97%) reported that they had received such recommendations. All respondents who reported having received recommendations were asked to indicate on a five-point Likert-type scale how satisfied they were with the recommendations made. As seen below in Table 20, nearly 91% of the judges, CJPOs, and JPOs who completed this item reported being either very satisfied (nearly 61%) or satisfied (over 30%). Of those who did not report satisfaction with recommendations from the JDC clinician, two (representing just over 6% of the sample) reported being neither satisfied nor dissatisfied, and one (3%) reported being very dissatisfied.

Table 20: Satisfaction with Recommendations from JDC Clinicians					
Item	**Very Dissatisfied**	**Dissatisfied**	**Not Satisfied or Dissatisfied**	**Satisfied**	**Very Satisfied**
How satisfied were you with the recommendations made by the mental health clinician?	3.0% (N = 1)	0.0% (N = 0)	6.1% (N = 2)	30.3% (N = 10)	60.6% (N = 20)

Note. The percentages in this table are calculated out of the 33 judges, CJPOs, and JPOs who reported a level of satisfaction with recommendations from JDC clinicians. Percentages are rounded to the first decimal place, so the total row percentage may not equal 100.

Again, similar to previous years, no statistically significant differences in the level of satisfaction with recommendations received from the JDC clinician were found between judges and CJPOs/JPOs or by professionals working in different regions of the state.

The fourth item asked the judges, CJPOs, and JPOs who reported receiving recommendations from the JDC clinicians whether these recommendations had affected any of the decisions or treatment they advised for at least one of the youth they were working with. Of the 31 respondents who completed this item, 27 (just over 87%) reported that the recommendations they received had affected a decision or treatment advised for the youth.

No statistically significant difference in whether recommendations received from the JDC clinicians affected any of the decisions or treatment they advised for the youth were found between judges and CJPOs/JPOs. Both judges (100% of whom reported that recommendations received from JDC clinicians affected decisions or treatment made regarding youth) and CJPOs/JPOs (nearly 85%) reported using clinicians' recommendations regarding youth they worked with.

The fifth item on the survey asked the judges, CJPOs, and JPOs how beneficial they thought it was to have a clinician in the nearest JDC. They were asked to indicate how beneficial they thought it was to have clinicians in the JDCs on a five-point Likert-type scale with values ranging from 1 = Not at all beneficial to 5 = Extremely beneficial. As seen in Table 21 below, over three-quarters of the judges, CJPOs, and JPOs who completed this item reported thinking it was extremely beneficial to have a clinician in the nearest JDC, and another 15% reported it to be rather beneficial, yielding an overall beneficial rate of 91%. Of those who did not report thinking that it was beneficial to have a clinician in the JDCs, two (representing just over 6% of the respondents) reported a neutral option and one reported it was not very beneficial.

Table 21: How Beneficial It Is to Have a Clinician in the JDCs

Item	Not at all Beneficial	Not Very Beneficial	Neutral	Rather Beneficial	Extremely Beneficial
How beneficial do you think it is to have a mental health clinician in the detention center?	0.0% (N = 0)	3.0% (N = 1)	6.1% (N = 2)	15.2% (N = 5)	75.8% (N = 25)

Note. The percentages in this table are calculated out of the 33 judges, CJPOs, and JPOs who reported on how beneficial it is to have a clinician in the JDCs. Percentages are rounded to the first decimal place, so the total row percentage may not equal 100.

Once again, similar to previous years, no statistically significant difference in how beneficial they felt it was to have a clinician in the nearest JDC was found between judges and CJPOs/JPOs. No statistically significant difference was found as a function of the regions in which the professionals worked, however, a non-significant trend emerged ($p = .06$). As seen below in Table 22, this trend is perhaps best accounted for by respondents in Region 3 having a lower perception of how beneficial it is to have a clinician in the JDCs than respondents in other regions.

Table 22: How Beneficial It Is to Have a Clinician in the JDCs, by Region		
Region	**Mean**	**Standard Deviation**
Region 1 (N = 15)	5.00	0.00
Region 2 (N = 2)	4.00	1.41
Region 3 (N = 3)	3.50	0.71
Region 4 (N = 1)	4.00	0.00
Region 5 (N = 5)	4.40	0.55
Region 6 (N = 4)	4.75	0.50
Region 7 (N = 4)	4.50	0.58

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values.

The final item on the survey asked the judges, CJPOs, and JPOs whether they would like to see the program housing clinicians in the JDCs continue. All 33 respondents who completed this item reported that they would like to see the CSP continue; the only other year when 100% of the respondents reported affirmatively to this item was Y2.

Additional Analysis 1: Trauma and Gender Differences in the Prevalence of MH Problems

As noted in this and other reports (e.g., McDonald et al., 2012), it has been found in each year of CSP evaluations that a greater percentage of girls meet the AST diagnostic criteria for having a mental health problem than boys. When the results of the Y4 evaluation were presented at a meeting of the Idaho Criminal Justice Commission (ICJC), questions were raised about why the prevalence of mental health problems seemed higher in girls than in boys. One possible explanation, explored for the first time in the Y5 evaluation, was explored again in the Y6-Y9 evaluations: Differential trauma experiences.

In order to measure whether (and if so, how) traumatic experiences are related to gender and mental health problems, the researchers chose to use indications from the MAYSI-2 inventory that juveniles complete as they are processed into a JDC. One of the seven subscales on the MAYSI-2 is the Traumatic Experiences or TE subscale, which documents juveniles' exposure to a host of traumatic events over a period of time. Information from the MAYSI-2, including whether juveniles 'screened positive' for traumatic events, is included in the clinicians' databases that are provided to IDJC. Analysis of possible associations among gender, traumatic experiences, and mental health problems therefore involved determining whether boys and girls differed in their experiences of trauma, and also whether traumatic experiences varied systematically with the presence of mental health problems.

The first set of analyses revealed that there was a statistically significant association between gender and traumatic experiences, χ^2 (df = 1) = 8.80, $p < .01$. This finding was similar to what was found in Y5-Y7 (though not in Y8), when a significantly greater percentage of girls were found to screen positive for traumatic experiences on the MAYSI-2 than boys. As seen below in Table 23, a higher percentage of girls (over 40%) screened positive for traumatic experiences than boys (nearly 31%).

Table 23: MAYSI-2 Indications of History of Traumatic Experiences, by Gender				
MAYSI-2 Indication	Gender			
	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Positive screen for traumatic experiences	222	120	30.7	40.4
Negative screen for traumatic experiences	500	177	69.3	59.6

Note. The percentages in this table are calculated out of the juveniles who were screened with the MAYSI-2 for the relevant condition.

Collapsed across gender, MAYSI-2 traumatic experiences indications were, as in Y5-Y7, significantly associated with AST mental health problems, χ^2 (df = 1) = 66.91, $p < .001$. As seen below in Table 24, this finding is accounted for by a greater percentage of juveniles with traumatic experience indications (nearly 75%) meeting the AST criteria for having a mental health problem than juveniles without traumatic experience indications (nearly 57%). A binomial logistic regression procedure revealed that, without controlling for the effects of other MAYSI-2 subscales, juveniles with traumatic experience indications were 2.2 times more likely to meet the AST criteria for a mental health problem than juveniles without traumatic experience indications.

Table 24: Associations between MAYSI-2 Indications of History of Traumatic Experiences and AST Indications of Mental Health Problems				
MAYSI-2 Indication	AST Indication			
	Number of Cases		Percentage of Total Screened Cases	
	No MH Problem	MH Problem	No MH Problem	MH Problem
Positive screen for traumatic experiences	87	255	25.4	74.6
Negative screen for traumatic experiences	293	384	43.3	56.7

Note. The percentages in this table are calculated out of the juveniles who were screened with the AST for the relevant condition.

Additional Analysis 2: Booking Charges

To examine whether there were any systematic differences in booking charges between juveniles who met the AST criteria for a mental health problem, a substance abuse problem, or both types of problems and those juveniles who met the AST criteria for neither a mental health nor a substance abuse problem, a set of additional analyses was performed. In these analyses, only the first booking code was used, as over 80% of the cases had only one booking charge listed. Only those booking charges that could be classified as one of the four UCR categories were included in these analyses (the remaining booking charges that could not be classified as one of the four UCR categories were removed). Of 322 juveniles who met the AST criteria for neither a mental health nor a substance abuse problem, 61% (or 198 juveniles) had at least one booking charge that could be classified as one of the four UCR categories. Of the 738 remaining juveniles (those who met the AST criteria for a mental health problem, a substance abuse problem, or both types

of problems), 58% (or 430 juveniles) had at least one booking charge that could be classified as one of the four UCR categories. Similar to Y7, but unlike Y5, Y6, and Y8, a statistically significant difference was found in the types of booking charges between juveniles with neither AST indications of a mental health nor a substance abuse problem and juveniles with at least one AST indication, χ^2 (df = 3) = 9.49, $p < .05$. As seen below in Table 25, the significant result is primarily accounted for by juveniles with neither AST indications of a mental health problem nor a substance abuse problem (at over 34%) being more likely to be booked on property crimes than juveniles with at least one AST indication (at nearly 25%), and by juveniles with at least one AST indication (at over 37%) being more likely to be booked on crimes against persons than juveniles with neither AST indications of a mental health problem nor a substance abuse problem (at over 27%).

Table 25: AST Indications of Neither Mental Health nor Substance Abuse Problems and All Other Diagnostic Categories Combined, by Booking Charge

Condition	Booking Charge			
	Drug Crime	**Property Crime**	**Crime Against Persons**	**Sex Crime**
Neither mental health nor substance abuse problem	31.8 (63)	**34.3 (68)**	27.3 (54)	*6.6 (13)*
All other diagnostic categories combined (mental health problem only, substance abuse problem only, or both types of problems)	29.5 (127)	24.7 (106)	**37.4 (161)**	*8.4 (36)*

Note. The percentages in this table are calculated out of the juveniles for whom at least one booking charge classifiable as one of the four UCR categories was noted in the IDJC database. The actual numbers of juveniles are presented in parentheses. The highest row percentage is presented in bold, and the lowest row percentage is presented in italics.

When we analyzed how booking charges were distributed across all four diagnostic categories (this analysis was also limited to the first booking charge only), a chi-square test revealed a statistically significant association between the type of booking charge and the AST diagnostic category, χ^2 (df = 9) = 88.56, $p < .001$. As seen in Table 26 below, juveniles who were booked on drug crime charges were most likely to meet the AST criteria for a substance abuse problem only (just over 58%), and least likely to meet the criteria for a mental health problem only (over 12%). Those who were booked on property crime charges were most likely to meet the AST criteria for neither a mental health nor a substance abuse problem (at over 34%) and least likely to meet the AST criteria for a substance abuse problem only (nearly 21%). Juveniles who were booked on crime against persons charges were most likely to meet the criteria for having a mental health problem only (at nearly 49%), and least likely to meet the AST criteria for having a substance abuse problem only (over 16%). Finally, juveniles who were booked on sex crime charges were most likely to meet the AST criteria for having a mental health problem only (at over 14%), and least likely to meet the AST criteria for having both a mental health problem and a substance abuse problem (over 2%).

Table 26: Booking Charge, by AST Diagnostic Category				
Booking Charge	**AST Diagnostic Category**			
	Neither Problem	**Mental Health Problem Only**	**Substance Abuse Problem Only**	**Both Problems**
Drug crime	31.8 (63)	*12.3 (26)*	**58.1 (25)**	43.2 (76)
Property crime	**34.3 (68)**	24.6 (52)	*20.9 (9)*	25.6 (45)
Crime against person	27.3 (54)	**48.8 (103)**	*16.3 (7)*	29.0 (51)
Sex crime	6.6 (13)	**14.2 (30)**	4.7 (2)	*2.3 (4)*

Note. The percentages in this table are calculated out of the juveniles for whom at least one booking charge classifiable as one of the four UCR categories was noted in the IDJC database. The highest row percentage is presented in bold, and the lowest row percentage is presented in italics.

Additional Analysis 3: Regional Differences in Recommended Services Accessed

To determine whether there were any differences in the rates at which at least one recommended service was accessed by the time the 15-45 day follow-up call had been placed, three additional sets of analyses were conducted. First, we analyzed whether at least one recommended service was accessed at different rates by juveniles released from JDCs in urban and rural/frontier counties. The nine counties housing JDCs from which data were analyzed in this report were classified as either urban or rural/frontier using the definition provided by the state of Idaho (Idaho Division of Financial Management, 2005). According to this definition, counties with an urban area of at least 20,000 people are classified as urban, and all other counties are classified as rural/frontier. Of the nine counties housing JDCs included in this report, seven (Ada, Bannock, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls) were classified as urban, and the remaining two (Bonner and Fremont) were classified as rural/frontier. Unlike in Y7 and Y8, when a statistically significant association was found between the type of county and the rate at which at least one recommended service was accessed by juveniles, but like Y5 and Y6, when no such association was found, a chi-square test revealed no statistically significant association between these two variables in Y9. As seen in Table 27 below, juveniles released from JDCs in urban counties (nearly 65%) were somewhat more likely to access at least one recommended service than those released from JDCs in rural/frontier counties (over 58%), but because the difference was not significant it should be concluded that in Y9 juveniles released from JDCs in urban and rural/frontier counties were equally likely to access at least one recommended service.

Table 27: At Least One Recommended Service Accessed, by Type of County		
Type of County	**Recommended Services Accessed**	
	Number of Cases	**Percentage of Cases**
Urban	550	64.8
Rural/Frontier	49	58.3

Note. The percentages in this table are calculated out of the juveniles for whom information about recommended service access was available.

Next, we analyzed whether the rate at which at least one recommended service was accessed varied across counties. As seen in Table 28 below, there was a large spread of percentages of juveniles by county who accessed at least one recommended service, ranging from less than 33% to nearly 90%. The three counties housing JDCs with the highest percentage of juveniles who accessed at least one recommended service were Bannock (over 89%), Bonner and Twin Falls (both nearly 74%). The three counties housing JDCs with the lowest percentages of juveniles who accessed at least one recommended service were Canyon (over 32%), Fremont (nearly 40%), and Bonneville (nearly 51%). In Y9, similar to Y5-Y8, a chi-square test revealed that the differential rate at which at least one recommended service was accessed as a function of JDC county was statistically significant, χ^2 (df = 8) = 142.63, $p < .001$.

Table 28: At Least One Recommended Service Accessed, by County		
County	**At Least One Recommended Service Accessed**	
	Number of Cases	**Percentage of Cases**
Ada County	75	69.4
Bannock County	116	**89.2**
Bonner County	34	**73.9**
Bonneville County	41	*50.6*
Canyon County	55	*32.4*
Fremont County	15	*39.5*
Kootenai County	125	73.1
Nez Perce County	32	71.1
Twin Falls County	106	**73.6**

Note. The percentages in this table are calculated out of the juveniles who accessed at least one recommended service. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

Finally, an analysis of regional variations in rates at which at least one recommended service was accessed was conducted. For the purposes of this analysis, the nine counties housing JDCs from which data were analyzed in this report were categorized into one of the seven regions defined by the Idaho Department of Health and Welfare: Region 1 (Bonner and Kootenai counties); Region 2 (Nez Perce County), Region 3 (Canyon County), Region 4 (Ada County), Region 5 (Twin Falls counties), Region 6 (Bannock County), and Region 7 (Bonneville and Fremont counties). As seen in Table 29 below, the three regions housing JDCs with the highest percentages of juveniles who accessed at least one recommended service were Region 6 (nearly 90%), Region 5 (nearly 74%), and Region 1 (over 73%). The three regions housing JDCs with

the lowest percentages of juveniles who accessed at least one recommended service were Region 3 (over 32%), Region 7 (just over 47%), and Region 4 (over 69%). In Y9, similar to Y5-Y8, a chi-square test revealed that the differential rate at which at least one recommended service was accessed as a function of region was statistically significant, χ^2 (df = 6) = 141.22, $p < .001$.

Table 29: At Least One Recommended Service Accessed, by Region		
Type of County	**At Least One Recommended Service Accessed**	
	Number of Cases	**Percentage of Cases**
Region 1	159	**73.3**
Region 2	32	71.1
Region 3	55	*32.4*
Region 4	75	*69.4*
Region 5	106	**73.6**
Region 6	116	**89.2**
Region 7	56	*47.1*

Note. The percentages in this table are calculated out of the juveniles who accessed at least one recommended service. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

Additional Analysis 4: Judges/CJPOs Survey

In Y9, similar to Y5-Y8, several additional analyses of the judges'/CJPOs' survey data were conducted. The results of these analyses are discussed sequentially in the following paragraphs.

First, we examined whether 1) the respondents' level of satisfaction with the contact they had had with the JDC clinician; 2) their level of satisfaction with recommendations made by the clinicians; and 3) the degree to which they thought it was beneficial to have a mental health clinician in detention center differed between respondents who reported that recommendations made by the clinicians had affected their decisions or treatments advised for the youth and those who reported that it had not. In Y9, similar to Y5, Y6, and Y8, statistically significant differences on all three items listed above were found between judges, CJPOs, and JPOs who reported that recommendations made by the clinicians had affected their decisions or treatments advised and those who reported that it had not (in Y7, statistically significant differences were found on the first two items, but not the third). As seen in Table 30 below, respondents reporting that recommendations had affected a decision or treatment advised for the youth were significantly more satisfied with the contact they had with the JDC clinician ($M = 4.63$, $SD = .84$) than those reporting that recommendations had not affected a decision or treatment advised ($M = 3.50$, $SD = .58$), t (29) = 2.59, $p < .05$. As also seen in Table 30 below, respondents reporting that recommendations had affected a decision or treatment advised were significantly more satisfied with recommendations made by the clinician ($M = 4.59$, $SD = .84$) than those reporting that recommendations received had not affected a decision or treatment advised ($M = 3.50$, $SD = .58$), t (29) = 2.49, $p < .05$. Finally (again as seen below in Table 30), respondents reporting that recommendations had affected a decision or treatment advised had significantly higher perceptions of how beneficial the program housing clinicians in JDCs was ($M = 4.89$, SD

= .32) than those reporting that recommendations received had not affected a decision or treatment advised (M = 3.50, SD = .58), t (29) = 4.71, $p < .05$.

Table 30: Judges/CJPOs Ratings of Contact with JDC Clinicians, Clinicians' Recommendations, and Program's Value, by whether Recommendations Affected Decisions or Recommendations Advised for Youth		
Perception of Program Element	**Recommendations Affected Decisions or Recommendations Advised for Youth**	
	Yes	**No**
Satisfaction with contact from JDC clinicians	4.63 (.84)	3.50 (.58)
Satisfaction with recommendations from JDC clinicians	4.59 (.84)	3.50 (.58)
How beneficial is it to have a clinician in the JDCs	4.89 (.32)	3.50 (.58)

Note. The values in this table are calculated out of the judges/others working with juveniles who reported having received recommendations from a JDC clinician on how to help youth with mental health issues. All three items were rated on a five point Likert scale (1 = Very dissatisfied/Not at all beneficial to 5 = Very satisfied/Extremely beneficial). Standard deviations, provided in parentheses below the means, reflect the spread of values, with larger standard deviations indicating a wider spread of values.

Next, content analyses of the three open-ended survey items were conducted. First, comments provided by the four respondents who indicated that the recommendations from JDC clinicians had not affected any of the decisions or treatments they advised for the youth were analyzed. When asked why these recommendations did not affect their decisions or treatment advised, two of the four respondents reported that the juveniles were already receiving the recommended services or that the recommendations were in line with what the respondents were already doing. One of the remaining two respondents stated that he or she was already aware of existing issues/concerns regarding the juvenile in question, and the last stated he or she works jointly with the clinician and has "risk and needs assessments in place prior to recommendations for any mental health or substance abuse treatment. Subsequently, comments provided by 16 judges, CJPOs, and JPOs (or approximately 37% of those who indicated that they were aware that the nearby detention center had a mental health clinician) in response to the item asking why or why not they would like to see the program housing a mental health clinician in detention center continue were subjected to content analysis. The vast majority of respondents provided positive comments about the program, many stating that having a mental health clinician was extremely beneficial or even indispensable. Some of their responses are shared in bullet points below:

- During the last year the quality of information that we have received from the clinicians in detention has improved significantly. The psychological assessments that they coordinate are extremely helpful in identifying family history, trauma, developmental history, and recommendations for evidence based services.
- Excellent support and resource for our youth, extremely helpful to all of my JPOs, always available and willing to help!
- Having our local clinician involved on the Rule 19 Screening Team process has been extremely valuable regarding the youth who are in custody in the detention center. While

most clinicians only see a youth in their office for an hour or two, the detention center clinician sees them five days a week, to include seeing their interactions with peers and authority figures.

- Helpful for connecting with local resources.
- Helps determine in making recommendations for the child and family.
- In today's work mental health issues are prevalent among youth and having a master's level clinician at the detention center to properly assess and start a treatment plan has been very beneficial and starts the process of progression quicker.
- It is beneficial to have a heads up of issues prior to final disposition to refer families to services sooner rather than later.
- It is extremely beneficial to have a liaison in the detention center who is attentive to the youth's needs and who is able to articulate their needs to the probation officer and family. We really appreciate our clinician and feel she is a very valuable resource.
- It is very helpful to me, the juvenile, and their family.
- It supplies a service this small county does not have.
- Lots of youth are struggling with mental health, some are only sober while in detention. Having a mental health professional available in a secure setting is extremely beneficial for the youth to talk to and also for us as probation officers to utilize.
- Our clinician goes above and beyond. She really helps with the stress load at detention. She is a wealth of knowledge for POs for other types of treatment or other facilities we haven't utilized. She is also a big asset in getting GAIN assessments started if our youth get detained. It is nice to have a "Team" unit and feel we can work together.
- Robin Jacobson is an amazing clinician. She helps the youth she works with and this benefits JDC staff and JPOs.
- She is a great resource to have. Very helpful. I respect the recommendations.
- She is very helpful to us and the kids in our detention center.
- The clinician at our detention facility provides excellent support, expertise, and resources to our youth and line staff.
- The clinician is very valuable. Helps with assessing suicidality while juvenile is incarcerated and helps connect them to resources upon release.
- The clinician's role in JDC is extremely important and youth would not get the high level of care without her help.
- The juvenile is, most likely, in need of interim counseling while in detention, and it seems to calm the juvenile down so that he/she is more willing to continue with treatment. Most of the juveniles who have visited with a mental health counselor in detention establish a connection to that clinician and would like to continue seeing them once outside. I would like to see more clinicians placed in detention to help these youth.
- There seems to be a shift in that we are seeing a lot of mentally ill youth placed in juvenile detention. A lot of their behavior stems from their mental illness and we are criminalizing these juveniles. It is helpful for us to have this resource to help us address the challenging issues we are facing when working with mentally ill youth.

Three respondents commented somewhat less positively on the program. These comments are presented below:

- Accessibility. Need more time on the job. Part timer with very few hours. Need coverage when she is gone. Thank you!
- If our SWIJDC clinician was allowed to work with probation and participate in providing input into case management that would be immensely helpful. However, the current clinician does not believe she can share information or work collaboratively with probation due to HIPAA rules.
- There may be value with youth who are just entering the system and have not been identified yet as having drug and alcohol or mental health issues. However, merely giving individuals info on a piece of paper is only identifying the issue and not linking them with the needed resources that meet their current needs. The reason many of our clients are entering/or in the system is because they have not addressed these needs in the past. Without linkage the majority will not follow up.

Finally, content analysis was conducted on the written comments entered in response to the closing survey item asking the respondents to provide recommendations that could help improve the mental health services in detention centers. Of the 43 respondents who indicated that they had been contacted by a mental health clinician, 12 (or nearly 28%) provided a comment when asked whether they had any recommendations that would help improve the mental health services in detention centers. Four comments simply conveyed satisfaction with the program or a desire for it to be continued. The remaining comments are presented below.

- Actual mental health treatment being available in the detention center. Many youth are receiving services in the community, however, if funded by Medicaid the providers are unwilling to continue to see the youth as Medicaid will not continue to cover the cost of treatment while the juvenile is in custody. Most local providers are willing to go into the detention center, however they prefer not to do it pro bono
- Give this person more time.
- Have more clinicians available. There are more kids in need of this service than there are clinicians to handle the job.
- I believe our clinician needs some clarification on what their role is. It does not make sense to have them work with the kids if there is no collaboration or continuum of care.
- I recommend the clinician focus on those with identified needs, and not just those seeking attention.
- It would be great if we had an on call or contract doctor who could prescribe Psych meds if needed.
- The clinician needs to be more available to suicidal youth.
- Would like to see the clinician run more groups in detention (i.e., anger management, thinking errors, victim impact). These are the types of groups that participants can jump in at any time, since detention can be a very transient population. Also, if group participation is started while in custody and they become aware of the process they may be more likely to continue with the service when they return to the community.

Additional Analysis 5: MAYSI-2 Subscale Indications as Predictors of AST Mental Health and Substance Abuse Problems

The next set of analyses involved two binomial logistic regression tests to determine which, if any, MAYSI-2 subscale indications were significant predictors of juveniles meeting the AST diagnostic criteria for having a mental health and/or substance abuse problem. As seen below in Table 31, four of the seven MAYSI-2 subscale indications were found to be predictive of whether juveniles met the AST criteria for having a mental health problem. The strongest predictors were Suicide Ideation and Though Disturbance subscale indications; juveniles who had positive indications on these subscales were 2.9 times more likely than those with negative indications to meet the AST diagnostic criteria for a mental health problem. Odds ratios were less large, but still impressive (and statistically significant), for the Angry-Irritable and Traumatic Experiences subscale indications; juveniles who had positive indications on these subscales were 2.2 times more likely than those with negative indications to meet the AST criteria for a mental health problem.

Table 31: MAYSI-2 Subscale Indications as Predictors of AST Mental Health Problems

MAYSI-2 Indications	Significance Level	Odds Ratio
Alcohol/Drug Use	None	N.A.
Angry-Irritable	$p < .001$	2.2
Depressed-Anxious	None	N.A.
Somatic Complaints	None	N.A.
Suicide Ideation	$p < .001$	2.9
Thought Disturbance	$p < .01$	2.9
Traumatic Experiences	$p < .001$	2.2

Note. N.A. denotes "not applicable" as when a MAYSI-2 subscale indication is not significantly predictive of an AST problem, any observed odds ratio is considered spurious in nature.

Two of the seven MAYSI-2 subscale indications were also found to be predictive of whether or not juveniles met the AST criteria for having a substance abuse problem. As seen below in Table 32, unsurprisingly the strongest predictor was the Alcohol/Drug Use subscale; juveniles who had a positive indication of alcohol or drug use were 4.2 times more likely than those with a negative indication to meet the AST criteria for having a substance abuse problem. The other significant predictor was the Thought Disturbance subscale; juveniles with a positive indication of thought disturbance were 1.6 times more likely than those with a negative indication to meet the AST criteria for having a substance abuse problem.

Table 32: MAYSI-2 Subscale Indications as Predictors of AST Substance Abuse Problems		
MAYSI-2 Indications	**Significance Level**	**Odds Ratio**
Alcohol/Drug Use	$p < .001$	4.2
Angry-Irritable	None	N.A.
Depressed-Anxious	None	N.A.
Somatic Complaints	None	N.A.
Suicide Ideation	None	N.A.
Thought Disturbance	$p < .05$	1.6
Traumatic Experiences	None	N.A.

Note. N.A. denotes "not applicable" as when a MAYSI-2 subscale indication is not significantly predictive of an AST problem, any observed odds ratio is considered spurious in nature.

A final analysis in this set, which has not been included in previous evaluation reports, involved assessing the relative percentages of boys and girls who had positive indications on each of the remaining MAYSI-2 subscales (in the first additional analysis, it had already been established that girls met the MAYSI-2 Traumatic Experiences subscales more often than boys). As seen below in Table 33, a statistically significant difference was found in the distribution of percentages of boys and girls with positive subscale indications on four of the six subscales. Specifically, it was found that a greater percentage of girls than boys had positive indications on the Angry/Irritable (over 43% to 31%; χ^2 [df = 1] = 14.31, $p < .001$), Depression/Anxiety (nearly 35% to 17%; χ^2 [df = 1] = 37.96, $p < .001$), Somatic Complaints (nearly 42% to nearly 28%; χ^2 [df = 1] = 19.61, $p < .001$), and Suicide Ideation (nearly 40% to nearly 15%; χ^2 [df = 1] = 78.10, $p < .001$) subscales. Also as seen in Table 33, girls had somewhat more positive indications than boys on the Alcohol/Drug Use and Thought Disturbance subscales, but the percentages were not statistically significantly different and therefore girls and boys should be considered similar in terms of the extent to which they experience these phenomena.

Table 34: MAYSI-2 Subscale Indications by Gender		
MAYSI-2 Indications	**Positive Percentage of Total Screened Cases**	
	Male	**Female**
Alcohol/Drug Use	16.2	21.2
Angry-Irritable	**31.0**	**43.4**
Depressed-Anxious	**17.0**	**34.7**
Somatic Complaints	**27.7**	**41.8**
Suicide Ideation	**14.5**	**39.7**
Thought Disturbance	8.3	10.1

Note. The percentages in this table were calculated out of the total number of boys and girls for whom MAYSI-2 indications were documented. Highlighted rows denote statistically significant differences between groups.

Additional Analysis 6: Adverse Childhood Experiences (ACEs)

As discussed earlier, Y9 was the first year that ACEs data were available for analysis. The IDJC administrator who was the key liaison between the JDCs and the evaluation team provided pilot

data from one JDC, that in Kootenai County. These data were collected during CY 2015, and included unique data for 99 juveniles, 65 of whom were boys (66.3%) and 33 of whom were girls (33.7%). The mean number of ACEs for all juveniles in the pilot sample was 3.77, with a range from no (i.e., zero) ACEs to nine ACES. Given the consistent finding that girls more often meet the MAYSI-2 criteria for traumatic experiences, it is perhaps unsurprising that girls (M = 4.58) reported significantly more ACEs than boys (3.35), t (df = 96) = -2.29, $p < .05$. A distribution of percentages of juveniles in the sample who fell into the six categories ordinarily employed by the CDC is presented in Table 34; these data are presented in the "% in Sample" column, with the percentage of adolescents in the general population fitting the same categories (from the 2011/2012 National Survey of Children's Health; Moore, Sacks, Bandy, & Murphey, 2014) presented in the "% in Adolescents Ages 12-17" column. With respect to the sample data, the single-largest category of ACEs met by the juveniles in Kootenai County was five or more ACEs (nearly 39% of the pilot sample), the highest category ordinarily employed by the CDC, followed by two ACEs (over 18%), one ACE (over 17%), three ACEs (over 12%), and four ACEs (over 8%). The single-smallest category of ACEs met by the juveniles in Kootenai County was no ACEs (just over 5%). These results are particularly stark when compared with the percentages of adolescents in the general population fitting the same categories (Moore et al., 2014). As seen in Table 35, the single-largest category of ACEs met by the juveniles in the general population was no ACEs (nearly 46%), followed by one ACE (26%), two ACEs (nearly 13%), three ACEs (nearly 7%), and five or more ACEs (nearly 5%). The single-smallest category of ACES met by the adolescents in the general population was four ACEs (just over 4%). A visual inspection of the percentages in the two groups (i.e., the sample in the JDC in Kootenai County and the general population) shows that the percentage of juveniles fitting each category tends to rise as the number of ACEs become greater for juveniles in the sample in Kootenai County, whereas the percentage of juveniles fitting each category tends to decrease as the number of ACEs become greater for juveniles in the general populations. Indeed, whereas nearly 60% of juveniles in the Kootenai County JDC sample had at least three ACEs, less than 16% of juveniles in the general population had so many ACEs. From the opposite perspective, whereas nearly 85% of juveniles in the general population had fewer than three ACEs, less than 41% of the juveniles in the Kootenai County JDC sample had fewer than three ACEs.

Table 35: Adverse Childhood Experiences in the Kootenai County JDC Sample and Among Adolescents in the General Population

Number of ACEs	% in Sample	% in Adolescents Ages 12-17
None	*5.1*	**45.8**
One	17.3	**26.0**
Two	**18.4**	12.8
Three	12.2	6.6
Four	*8.2*	*4.1*
Five or more	**38.8**	*4.7*

Note. The percentages in the sample column are drawn from 99 juveniles who completed the ACEs survey in the JDC Kootenai County. The percentages in the Adolescents Aged 12-17 column are from the 2011/2012 National Survey of Children's Health. The two highest percentages in each column are in bold, and the two lowest percentages in each column are in italics.

Summary and Conclusions

The material in this report describes the results of the ninth-year, multimodal evaluation of the CSP. In this report, the evaluation methodology and results generated through the four waves of data collection and several additional analyses are presented. To this point, the results have been discussed with a focus on individual findings, without much attempt to understand them as a more coherent whole. In the final section of this report, a more comprehensive overview of the results and their implications will be presented, with special emphasis on several themes, including the methodology, mental health and substance abuse issues, service recommendations and service access, stakeholder perceptions, and the results of the additional analyses, with a special focus on childhood trauma as measured by the MAYSI-2 and the ACE Questionnaire.

Methodology

In many respects, the methodology utilized in Y9 was virtually identical to that employed in the past several evaluation years. The first wave data submitted by clinicians and provided by IDJC to the BSU research team were the same elements as in all other years, however it is noteworthy that they were much easier to work with in several regards. Specifically, a newer data system developed by IDJC allowed clinicians to use more comprehensive drop-down menus for provisional diagnoses and community-based service recommendations, which decreased the amount of typing clinicians had to do and the amount of coding the research team had to do (in order to categorize typed information into conceptually-similar themes). There were fewer inappropriate multiple entries in the data set as well. Thus, the wave one data were cleaner and easier to work with than in previous years. The only difficulty regarding the methodology involved a lack of data for the JDC in Minidoka County. Ordinarily, there are dozens of analyzable data cases from that JDC, but there were two few to analyze this year. It is likely that, due to an oversight, the IDJC administrator in charge of transferring the data to the evaluation team did not provide all cases. Sadly, this administrator passed away unexpectedly so it was not possible to address the missing data for the JDC in Minidoka County.

No changes were made to the second wave data collection process between Y8 and Y9. Following a pattern first seen in Y7, however, the number of calls that resulted in a survey being completed was down significantly from the historic average. Whereas between Y2-Y6 there had been an annual average of 202 completed surveys, the number fell to 111 and 91 in Y7 and Y8, respectively. In Y9, the number increased somewhat to 109, however, this still remains at barely more than half of the average of the earlier years. There remains a perception that the parent survey is not yielding the kinds of information that are helpful in the evaluation of the CSP. Plans to modify efforts to gather parent feedback were initiated prior to the Y9 evaluation, and it seems sensible to consider modifications further.

The methodology for data collection for the Judges'/CJPOs' survey was identical to that used in Y6-Y8 (prior to this, several demographic questions did not exist on the survey and prior to Y5, a mail survey was used rather than an internet-based survey). The number of respondents to the survey was very similar to that in Y8. As was the case in Y7 and Y8, there were some respondents to the survey who were not judges or CJPOs (in Y9, all of these were JPOs); these

individuals were forwarded the invitation from an original recipient. The number of respondents who were not judges or CJPOs was (as in Y8) much lower than in Y7, suggesting that the invitation was not inappropriately shared as often as in that evaluation year.

Mental Health and Substance Abuse Issues

As has been discussed in previous reports on the CSP, a striking finding of all evaluations of this program is the high prevalence of both mental health and substance abuse problems among juveniles detained in the JDCs across Idaho. As seen in Table A2 in Appendix A, the average annual percentage of juveniles in JDCs throughout the state who met the AST criteria for having a mental health problem was 60% across all nine years of the CSP, ranging from a low of 56% in Y6 to a high of 68% in Y1. As seen in Table A3 in Appendix A, the average annual percentage of juveniles in JDCs throughout the state who met the AST criteria for having a substance abuse problem was 43% across all nine years of the CSP, ranging from a low of 35% in Y8 to a high of 54% in Y1. As has been noted in other evaluation reports (e.g., Begic & McDonald, 2015), one interesting discrepancy between the average annual prevalence rates for AST mental health and substance abuse problems is that, in most years, mental health problem prevalence rates have clustered closely around the overall mean of 60%, substance abuse problem prevalence rates have fallen in a fairly linear pattern, with each year's prevalence rate lower than the prior year through Y8 before rising slightly in Y9 (see Table A3 in Appendix A) (possible explanations for this discrepancy will be discussed later in this section of the report). As seen in Table A4 in Appendix A, the percentage of juveniles with at least one AST indication across the nine evaluation years was 72%, ranging from a low of 66% in Y6 to a high of 82% in Y1. That more than 70% of juveniles detained in Idaho between 2008-2016 have been found to meet the screening criteria for having a mental health and/or substance abuse problem is perhaps the most noteworthy result of the entire CSP evaluation. This finding, and the enormous implications it has for policy and practice, will be elaborated on later in this section of the report.

In each evaluation year, it has been found that a fairly large minority of the juveniles has met the criteria for having both a mental health problem and a substance abuse problem, which is often referred to as having a dual diagnosis (or co-occurring disorders). As seen in Table A8 in Appendix A, the prevalence of dual diagnosis in the nine years of the CSP was 31%, ranging from a low of 27% in Y8 to 41% in Y1. As noted in earlier reports and throughout the scientific literature (e.g., Horsfall, Cleary, Hunt, & Walter, 2009; Kelly, Daley, & Douaihy, 2012; Peters, Lurigio, & Wexler, 2015) the high degree of complexity and difficulty in treating dual diagnoses or co-occurring disorders means that comprehensive and coordinated treatment strategies will be needed to assist juveniles who are released from JDCs with indications of both mental health and substance abuse problems.

Another of the most striking findings (and one with many policy and practice implications), across all nine years of CSP evaluation, is that detained girls meet the AST screening criteria for a mental health problem at a much higher rate than boys. As seen in Table A6 in Appendix A, in each of the nine years, the mental health problem prevalence rates for girls have been statistically significantly greater than for boys; the nine-year mental health problem prevalence has averaged 70% for girls (ranging from a low of 67% in Y4, Y5, and Y6 to a high of 76% in Y1) versus 57% for boys (ranging from a low of 53% in Y6 to a high of 65% in Y1). When observing the data at

a finer level, as depicted in Table A9 in Appendix A, girls have historically met the criteria for a mental health problem only, and both a mental health problem and a substance abuse problem, more often than boys (who in turn have historically met the criteria for having neither type of problem or a substance abuse problem only more than girls). As discussed in previous reports (e.g., Begic et al., 2013), there is a large national literature on how females (i.e., both girls and women) more often meet the diagnostic criteria for many (though not all) mental health problems than males (i.e., both boys and men), and this has been reported in both the general population (e.g., Doherty & Kartalova-O'Doherty, 2010; Eaton et al., 2012; Kessler, Chiu, Demler, & Walters, 2005) and in detained populations (e.g., Steadman, Osher, Clark-Robbins, Case, & Samuels, 2009). There have been a number of different explanations for this phenomenon, including that females are more likely to self-disclose symptoms of mental health problems (e.g., Mackenzie, Gekoski, & Knox, 2006) and that they are also more likely to internalize difficulties so that they manifest in symptoms of mental health problems rather than externalize them so that they manifest themselves in behavioral problems (Eaton et al., 2012). Whatever the reason for the discrepancy between prevalence rates in AST mental health indications between girls and boys in Idaho's JDCs, the phenomenon itself has important implications that will be discussed later in this section of the report.

Several other important findings noted in previous CSP evaluations were found again in Y9. One was that a high percentage of detained juveniles were found to have previous diagnoses of mental health and/or substance abuse problems. Across the previous eight years of evaluation, the percentage of juveniles with a previous diagnosis was 70%, ranging from a low of 59% in Y1 to a high of 79% in Y8. The percentage of detained juveniles with a previous diagnosis in Y9 was the second-highest yet, at 79%; this raised the eight-year average to 71%. One reason the percentage may be increasing over time is that JDC clinicians may be the ones previously diagnosing juveniles (e.g., a juvenile first diagnosed by a clinician in an earlier evaluation year may be detained again in a later evaluation year), however, in any case, it is very likely that many of the juveniles were first diagnosed in the community (e.g., by family physicians, child therapists, or school counselors), prior to their first detention. The implications of this finding will be discussed later in this section of the report. The second important finding regarding diagnoses was that, for the ninth consecutive year, the most common clusters of disorders were mood disorders, substance abuse disorders, disruptive behavior disorders, anxiety disorders, and attention deficit disorders. For the first time, in Y9 substance abuse disorders emerged as slightly (i.e., less than 1%) more common than mood disorders; otherwise, the order of frequency in reporting was the same as it was in all eight previous evaluation years.

Service Recommendations and Access

Over the first eight years of CSP evaluations, JDC clinicians have appeared to be very successful in recommending community-based services to juveniles who are provisionally diagnosed with mental health and/or substance abuse problems. Y9 was no exception, as nearly 95% of the 562 juveniles who received at least one provisional diagnosis (other than 'diagnosis deferred') received at least one community-based service recommendation. According to clinicians' records, nearly 59% of those juveniles who received at least one community-based service recommendation had accessed at least one such service by the time of the 15-45 day follow-up call. As has been the case in other evaluations, parents' reports of receiving recommendations are

inconsistent with the clinicians' reports about providing such recommendations, but the veracity of parents' reports has always been in question due to recall error, lack of understanding what the recommendations are, and so forth. As documented earlier, 92% of parents who reported receiving a community-based service recommendation reported that their child had accessed that service, and that certainly seems a positive development.

Stakeholder Perceptions

Historically, the stakeholder group that has contributed the most to CSP evaluations has been the judges/CJPOs. Whether surveys were distributed by mail or in a web-based format, the response rate has consistently been acceptable, and because the vast majority of respondents have reported an awareness of the CSP, they have been able to provide important feedback about it. Similar to previous years, the judges and CJPOs/JPOs who completed surveys in Y9 responded very positively regarding the CSP, with the vast majority being aware of the program (95%), being satisfied with contact from a JDC clinician (89%), having received recommendations from the JDC clinician (97%), and being satisfied with the recommendation received from the clinician (91%). A majority also reported that recommendations received from the JDC clinician affected decisions they made regarding their youth (87%) and felt that the CSP program was beneficial (91%), and all (i.e., 100%) wanted to see it continue. Overall, it is very clear that judges and CJPOs/JPOs in Y9, as in all eight previous years, are convinced of the value of the CSP and the effect it has on juveniles processed in Idaho's JDCs.

Additional Analyses

As discussed earlier in this report, starting in Y5, a number of analyses additional to the initial ones (i.e., the analyses conducted through Y4) have been conducted to flesh out possible patterns of differences in data collected through the first three waves. The results of these analyses in Y9 are discussed below, ending with what we believe to be the most interesting and important results—those involving traumatic experiences as measured through the MAYSI-2 and the ACE Questionnaire.

An assessment of whether juveniles who met the criteria for at least one AST problem (i.e., met the criteria for a mental health problem, a substance abuse problem, or both types of problems) differed from juveniles who met the criteria for neither type of problem with respect to types of booking charges revealed a statistically significant difference. This finding was consistent with what was found in Y7, but inconsistent with what was found in Y5 (the first year this analysis was performed), Y6, and Y8, when no such difference was found. In Y7, a significant difference was found suggesting that juveniles who met neither criteria more often were booked on property crimes, whereas juveniles who met at least one criterion more often were more often booked on drug crimes. The pattern was somewhat similar in the Y9 results, in which juveniles who met neither criteria were more often booked on property crimes, whereas juveniles who met at least one criterion were more often booked on crimes against persons. The reason for the discrepancies between what was found in Y5, Y6, and Y8 and what was found in Y7 and Y9 is not clear, but will continue to be assessed in future evaluations. When a separate analysis of how booking charges were distributed against all four diagnostic categories (i.e., neither type of problem, mental health problem only, substance abuse problem only, and both types of

problems) was conducted, a statistically significant association between booking charges and AST diagnostic category was found. This association was accounted for by juveniles booked for drug crimes being most likely to meet the criteria for having a substance abuse problem only, whereas juveniles who were booked for property crimes were most likely to meet the criteria for neither type of problem, and juveniles booked for crimes against persons and sex crimes were most likely to meet the criteria for having a mental health problem only.

Several additional analyses were performed to better understand factors related to whether juveniles access the community-based services that are recommended for them. The first analysis showed no statistically significant difference in recommended service access as a function of whether the JDC the juveniles were housed in was in an urban or rural county. This result was similar to what was found in both Y5 and Y6, but not in Y7 and Y8, when juveniles residing in urban counties were found to access at least one recommended community-based service more often than juveniles residing in rural counties. The reason for this discrepancy in results is not clear, but will continue to be assessed in future evaluations.

Additional analyses of the responses provided by judges and CJPOs/JPOs revealed that whether they felt that recommendations made by the clinicians had affected their decisions or treatments advised for the youth was highly predictive of their level of satisfaction with the contact with and recommendations made by JDC clinicians; it was also predictive of how beneficial they felt it is to have clinicians in the JDCs. This finding suggests that changes may be needed in the information exchange processes that are presently occurring between JDC clinicians and judges and CJPOs/CJPOs. Additionally, based on comments provided by judges and CJPOs/JPOs in response to the three open-ended survey items, it appears that in addition to maintaining ongoing communication between JDC clinicians and judges and CJPOs/JPOs, some comprehensible specifications of the duties and responsibilities of JDC clinicians and expectations of judges and CJPOs/JPOs in terms of what type of information is most useful to them in making decisions and providing recommendations for youth may be warranted.

Content analysis of comments provided by judges and CJPOs/JPOs revealed that most had positive views of the CSP. They expressed that the services JDC clinicians provide to juveniles in detention are invaluable in terms of providing training to line staff about how to interact with high need juveniles in best and safest ways, being available to youth to talk about their feelings and problems they may be experiencing, providing firsthand information about youth to judges and probation offices, providing information about resources available to youth and their families, and completing a mental health assessment with youth, identifying mental health problems they may be experiencing and recommending appropriate treatments and services in the community. Eight judges and CJPOs/JPOs provided recommendations for how the CSP program could be improved in the future. Recommendations included offering mental health treatment (as opposed to only screening) in the JDCs, and having more clinicians available or giving current ones more hours. Others included clarifying the role of the clinicians, having clinicians focus on juveniles with identified problems rather than just those seeking attention, and having an on-call or contract doctor who could prescribe psychotropic medications.

Starting in Y5, members of the BSU research team began exploring whether differential experiences of trauma exposure (as measured by the MAYSI-2 Traumatic Experiences, or TE,

subscale) could partially explain why girls meet the AST screening criteria for mental health problems more often than boys. In the Y9 analyses (as in Y5-Y7 but not Y8), an interesting pattern of results consistently appeared. This pattern showed that girls did report traumatic experiences at a statistically significantly higher rate than boys, but that this difference in traumatic experience exposure did not completely explain the difference in mental health prevalence rates; in short, traumatic experience exposure was a stronger predictor of mental health problems, however, when controlling for the effects of traumatic experience exposure, a significant difference simply as a function of gender remained. In Y8, a deviation from the previous pattern was found. For the first time, girls and boys being processed into a JDC did not differ significantly in terms of the rates to which they reported traumatic experiences. Traumatic experience exposure, independent of gender, did continue to predict AST mental health indications. It is likely that the Y8 results were an anomaly, however, because in Y9, girls again were found to report traumatic experiences at a statistically significant higher rate than boys (thus, in four of five years, such a difference has been found). In any case, it is very clear that traumatic experience exposure is a consistent predictor of AST mental health indications. Given that traumatic life experiences have been found to predict the frequency and the depth of penetration into the justice system (e.g., Gunter, Chibnall, Antoniak, McCormick, & Black, 2012), however, it seems wise that clinicians focus closely on juveniles who have MAYSI-2 TE indications, and be particularly diligent in recommending appropriate community-based services to remediate the effects of the traumatic experience exposure.

Although trauma exposure has been explored in previous evaluations, this exploration has only focused on MAYSI-2 TE indications; never has measurement of trauma exposure utilized the more sensitive, CDC-endorsed (CDC, 2016) ACE Questionnaire. Strictly assessing data from Y9, it seems that the MAYSI-2 underestimates the magnitude of trauma that may be clinically significant in juveniles detained in Idaho's JDCs. For example, whereas slightly more than 34% of the juveniles evaluated with the MAYSI-2 in Y9 met the scoring criteria for having traumatic experiences, just under 95% of the juveniles evaluated with the ACE Questionnaire in the JDC in Kootenai County in calendar year 2015 had at least one ACE, and nearly 60% had at least three ACEs. The results from the pilot data in Y9 are similar to those reported elsewhere; for example, in Baglivio, Epps, Swartz, Huq, Sheer, and Hardt's (2014) assessment of ACE scores on over 64,000 juveniles detained in Florida, over 97% had at least one ACE, and over 70% had more than three. Because ACEs have been reported to have a dose-response relationship with negative health and social outcomes (i.e., as the number of ACEs increases, the number of negative outcomes increases in a fairly linear pattern (Baglivio et al., 2014; Felitti et al., 1998), their prevalence in Idaho's detained juveniles should be a major cause for concern.

Concluding Comments

As in the final section of most previous years' CSP evaluation reports, we must call attention to the stark challenge that administrators, clinicians, and line staff in Idaho's JDC face annually: Most of the juveniles who are detained in their facilities have not only committed criminal offenses, but a large majority of them are struggling with a mental health problem, a substance abuse problem, or both types of problems. As seen in Tables A2, A3, A4 and A8, as well as in the corresponding figures that better highlight trends, in Appendix A, there has been some level of variation in the prevalence rates of these problems across the years, however most years

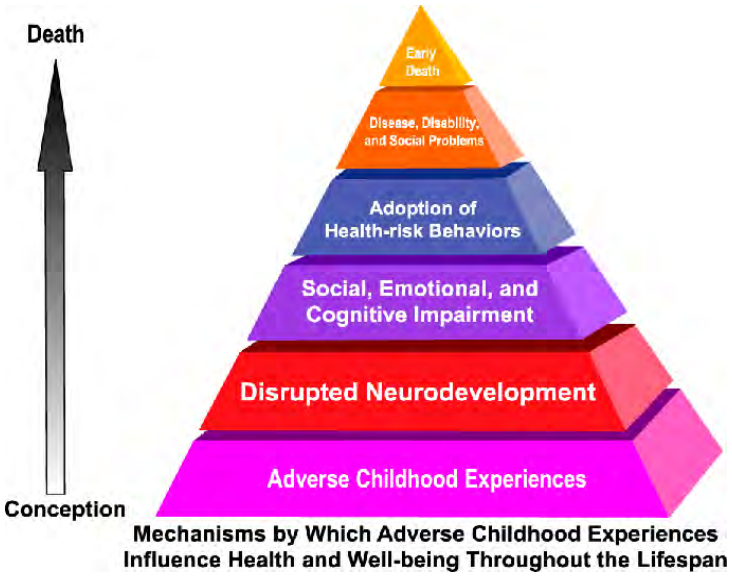
cluster closely around the eight-year averages of 60% of juveniles meeting the AST screening criteria for a mental health problem, 43% of juveniles meeting the AST screening criteria for having a substance abuse problem, 72% of juveniles meeting the AST criteria for having at least one of these problems, and 31% of juveniles meeting the AST criteria for both types of problems. Idaho's prevalence rates of these problems in detained juveniles are comparable to or slightly higher than the rates reported in studies in other states (e.g., Cauffman et al., 2007; Fazel, Doll, & Langstrom, 2008; Wasserman et al., 2003). As has been noted elsewhere, having a high percentage of detained persons with mental health and or substance abuse issues is a serious problem for detention/correctional centers (Anthony et al., 2010). Quite simply, these types of facilities were not designed to serve as inpatient mental health or substance abuse treatment centers. Although the CSP has, by nearly all stakeholder accounts, helped serve detained juveniles with these types of problems, the fact remains that juveniles' mental health and substance abuse problems should be treated in mental health and substance abuse centers—not JDCs.

Juvenile crime has many social and economic costs, and these costs tend to amplify greatly if juvenile offenders become adult offenders and continue their criminal behavior. As noted in earlier evaluation reports (e.g., Begic et al., 2013), it seems to make great sense to engage in efforts that reduce the likelihood that juveniles become involved with the justice system to begin with. There is a plethora of research suggesting that there are measurable factors that steer juveniles toward criminal behavior (often through the development of mental health and/or substance abuse problems), and that many of these (including ACEs) are rooted in the family system. In the two years (i.e., Y4 and Y8) that formal interviews of JDC administrators and clinicians were conducted, such personnel mentioned repeatedly that many of their detained juveniles have parents and/or home environments that are more seriously disordered than the juveniles themselves. These administrators and clinicians have noted that many of the juveniles would have never materialized in a JDC had their parents and/or home environments not been such toxic influences, and they have also noted that many juveniles likely do not access or receive recommended community-based services because their parents struggle so seriously with mental health and/or substance abuse problems that they are unable or unwilling to facilitate it.

Given that the family systems of juveniles are so closely linked with their likelihood of being involved with the juvenile justice system, interventions that target the family system seem the best suited to deter future juvenile crime. As noted in previous CSP evaluation reports (e.g., Begic et al., 2013) and in the national literature (e.g., Piquero, Farrington, Welsh, Tremblay, & Jennings, 2009), many of the best, evidence-based, interventions focus as much on the mental health and substance abuse needs of the parents as they do on those of children. It is axiomatic that preventing problems is preferable to treating them, regardless of whether the problems are related to mental health, substance abuse, and/or criminal behavior. If the State of Idaho wishes to reduce or avoid the costs of these problems, it would be well advised to invest in the types of early-identification and -intervention programs (e.g., pediatric screening, evidence-based home visiting, school counseling) that could help remediate toxic family environments that are associated with future juvenile delinquency.

An examination of the ACE pyramid (CDC, 2016) depicted below shows how such early intervention might take place. In laypersons' terms, the chain of events that occurs when

childhood trauma is unremediated involves the following: 1) exposure to childhood trauma often leads to changes in the development of the brain, typically involving maladaptive neuronal development in the parts of the brain that regulate stress responding and higher reasoning (e.g., McEwen, 1999; van der Kolk, 2014); 2) changes in the brain, coupled with difficulty coping with memories of trauma, lead to changes in the way a traumatized child thinks and feels about himself or herself (e.g., that he or she has no value), other people (e.g., that other people are dangerous and cannot be trusted), and the world (e.g., that the world is not a safe place and he or she is not safe in it); 3) maladaptive ways of thinking about oneself, other people, and the world, lead to engagement in behaviors that are risky, both for the child and the community (e.g., substance abuse, unsafe sex, criminal activity); 4) engagement in risky behaviors leads to health problems (e.g., brain or organ damage from toxic alcohol consumption or illegal drugs), and perhaps most importantly given the context of this report, social problems such as those that involve juveniles with the justice system; and 5) early death (Felitti et al., 1998). Although interventions to prevent ACEs exist in Idaho (e.g., the evidence-based home visiting services administered by IDHW), most feasible interventions would occur after children experience some trauma and are identified as such. Identification of trauma could occur in preschool or school environments, through pediatric screening, school or community counseling, or even first contact with the juvenile justice system. It seems axiomatic that earlier identification and intervention are more efficacious than later ones, however, even at first contact with the juvenile justice system the chain of events leading from ACE exposure to more serious consequences (e.g., disability, long-term incarceration, early death) can be disrupted or broken. Juveniles coming into contact with the justice system for the first time are likely still in the early stages of the progression through the ACE pyramid; trauma exposure and maladaptive brain wiring (e.g., increasing responses to stress, inhibiting impulse control) may have occurred, however, the brain continues to develop throughout adolescence (indeed, the brain continues to develop and can change through a person's mid-20s; Johnson, Blum, & Giedd, 2009) and maladaptive brain development can be reversed through cognitive-behavior and other therapies, even for the most serious mental health problems such as psychosis (e.g., Mason, Peters, Williams, & Kumari, 2017). Therefore, interventions at this point (including those initiated by JDC clinicians) may enable mental health and other personnel to help change the negative thoughts and feelings traumatized youth have about themselves, the other people, and the world. These changes, ideally, could alter the trajectory depicted in the ACE pyramid, decreasing the likelihood that juveniles engage in the types of behaviors that not only impair their own health, but also will bring them into future contact with the justice system.



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Also alluded to above, the work that the JDC clinicians already do through the CSP (namely, screening for mental health and substance abuse problems, screening for childhood trauma experiences [now both through the MAYSI-2 and the ACE Questionnaire], and making appropriate referrals for community-based services) is an effort to disrupt the trajectory from childhood trauma to highly undesirable life outcomes. Given that it was found in the pilot ACE data from the JDC in Kootenai County that nearly all screened juveniles have experienced at least one ACE, this is a very important element to note. In future evaluation years, it seems that it would be valuable to track, even in a few "case study" examples, how the CSP intervention has changed the life trajectories of traumatized youth. It would also be desirable to assess ways that the CSP can interface with other programs throughout the state to explore how joint efforts might result in the early identification and remediation of childhood trauma, to help ensure that Idaho's juveniles avoid the negative life experiences known to result from such trauma.

In conclusion, after nine years of evaluation, the BSU research team remains highly impressed with the way the CSP seems to positively affect juveniles in Idaho's JDCs. Although we have learned that how clinicians define the scope of their duties and perform those duties varies somewhat across JDCs (e.g., some perform therapeutic interventions with juveniles and even their parents, whereas others focus more closely on screening and service coordination), the program itself seems genuinely supported by administrators and staff. The need for the program is evident; if approximately 70% of the juveniles entering a JDC in any given year suffer from a mental health problem, a substance abuse problem, or both types of problems, it seems it would be negligent not to have a program such as the CSP in place. In Y9, as in previous years, the CSP appears successful in identifying detained juveniles with likely mental health and substance abuse problems, providing recommendations for community-based services (which are usually accessed with the 15-45 day follow-up period), and providing critical information to guide the decisions made by judges and CJPOs. As a result, continuing efforts to support the CSP, or expand the scope further, seem warranted.

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Appendix A

Table A1: Number of Detained Juveniles in Analyzed Database by Evaluation Year	
Evaluation Year	**Number of Juveniles**
Year 1	2,060
Year 2	1,941
Year 3	1,669
Year 4	2,066
Year 5	1,481
Year 6	1,366
Year 7	1,336
Year 8	1,342
Year 9	1,059
Years 1-8 Average (Comparison Years for Year 9)	*1,658*
Years 1-9 Average	*1,591*

Figure A1: Number of Detained Juveniles in Analyzed Database, by Evaluation Year

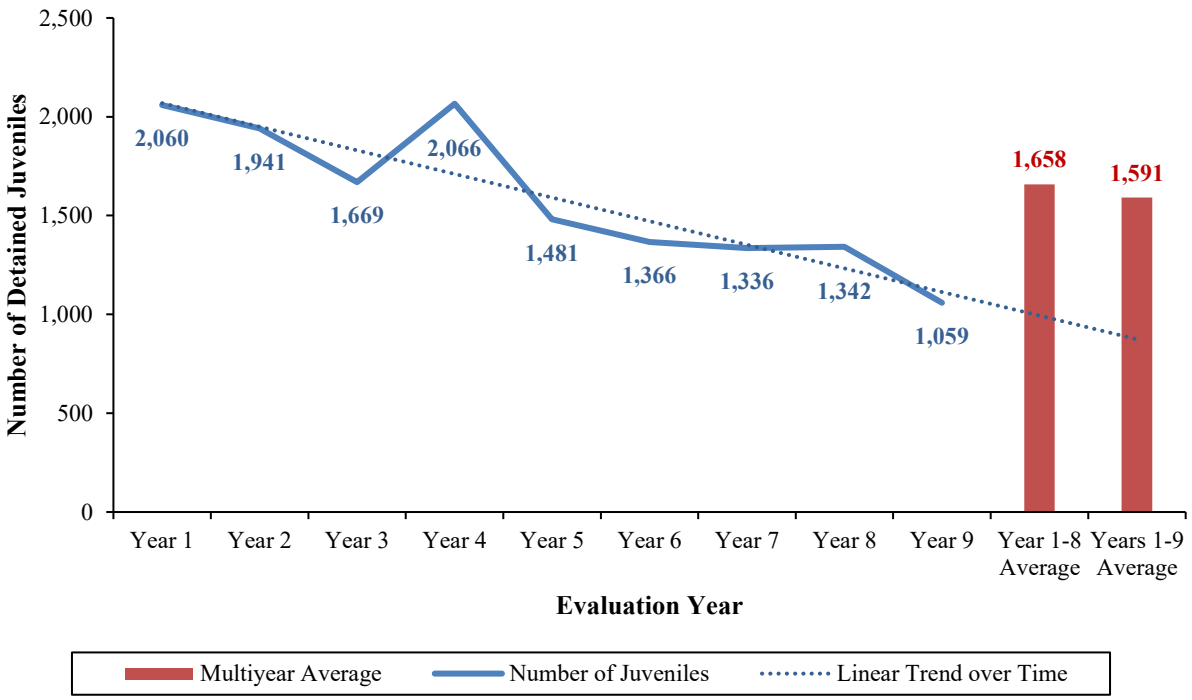


Table A2: Percentage of Juveniles with AST Mental Health Indications by Evaluation Year	
Evaluation Year	**Percentage of Juveniles**
Year 1	68
Year 2	59
Year 3	62
Year 4	59
Year 5	59
Year 6	56
Year 7	59
Year 8	60
Year 9	63
Years 1-8 Average (Comparison Years for Year 9)	*60*
Years 1-9 Average	*60*

Note. Percentages are rounded to whole numbers.

Figure A2: Percentage of Juveniles with AST Mental Health Indications, by Evaluation Year

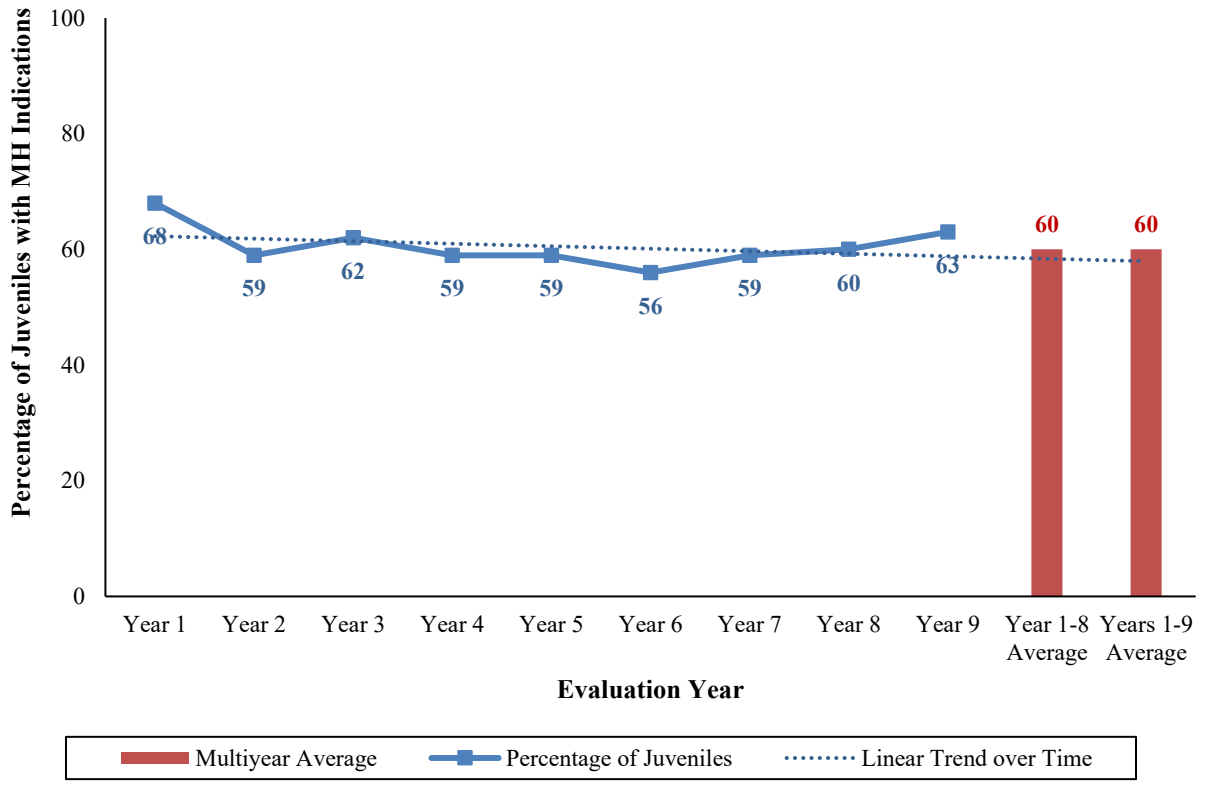


Table A3: Percentage of Juveniles with AST Substance Abuse Indications by Evaluation Year	
Evaluation Year	**Percentage of Juveniles**
Year 1	54
Year 2	46
Year 3	44
Year 4	43
Year 5	41
Year 6	40
Year 7	38
Year 8	35
Year 9	37
Years 1-8 Average (Comparison Years for Year 9)	*43*
Years 1-9 Average	*43*

Note. Percentages are rounded to whole numbers.

Figure A3: Percentage of Juveniles with AST Substance Abuse Indications, by Evaluation Year

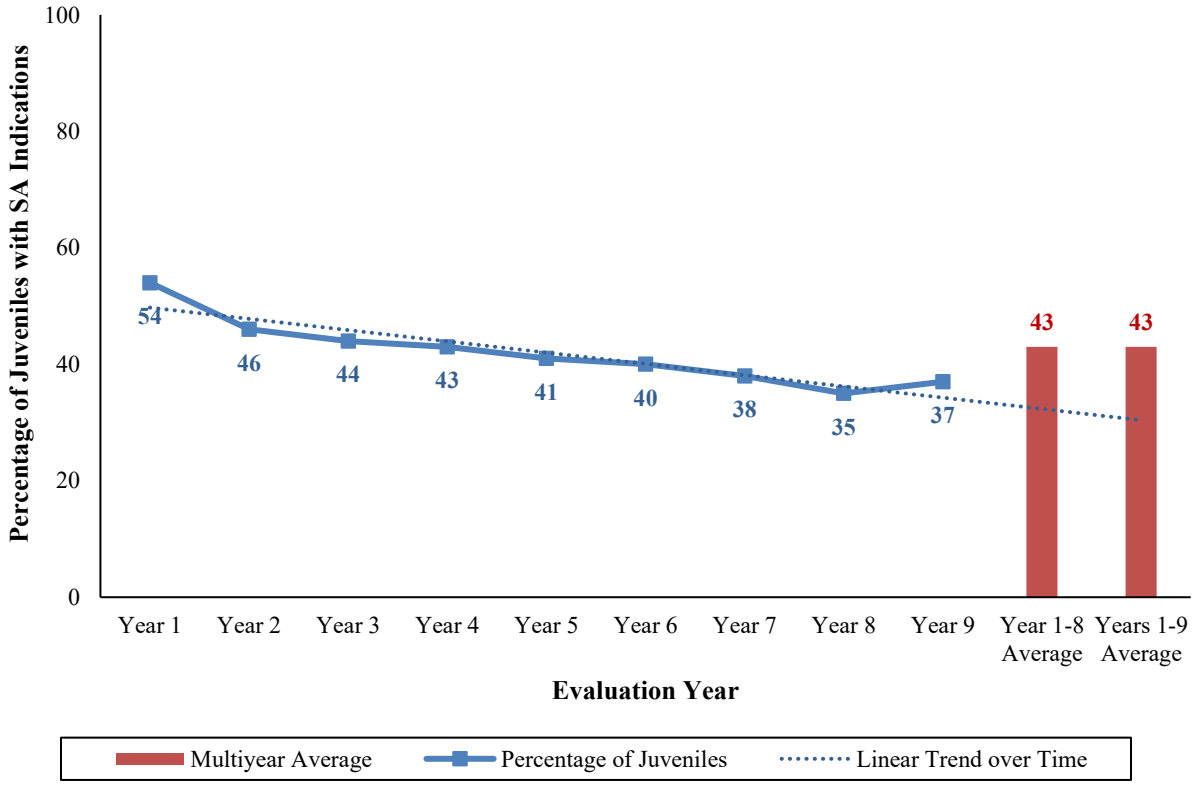


Table A4: Percentage of Juveniles with at Least One AST Indication by Evaluation Year	
Evaluation Year	**Percentage of Juveniles**
Year 1	82
Year 2	75
Year 3	76
Year 4	72
Year 5	69
Year 6	66
Year 7	67
Year 8	69
Year 9	70
Years 1-8 Average (Comparison Years for Year 9)	*72*
Years 1-9 Average	*72*

Note. Percentages are rounded to whole numbers.

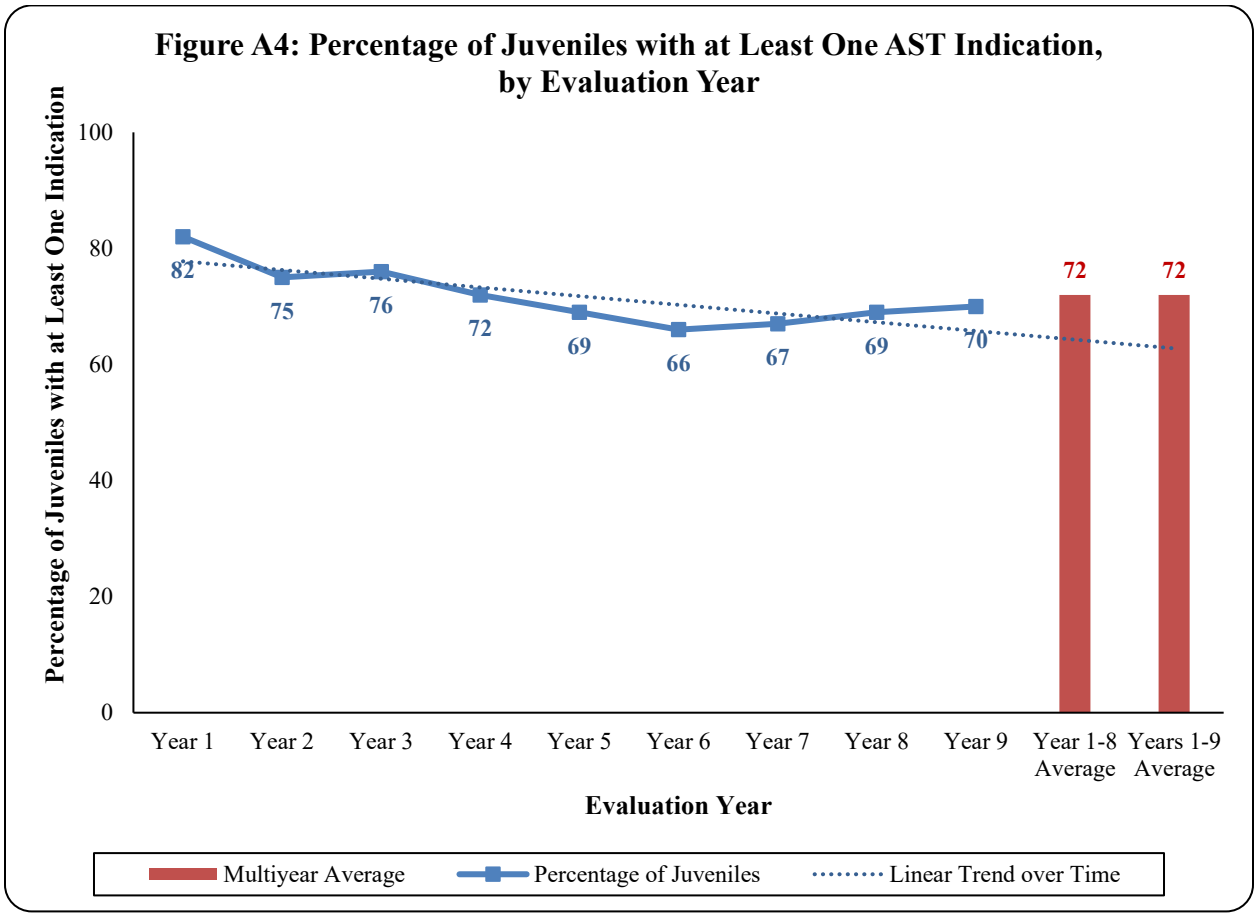


Table A5: Percentage of Boys and Girls with AST Mental Health Indications by Evaluation Year	
Evaluation Year	**Percentage of Juveniles**
Year 1: Boys	65
Year 1: Girls	76
Year 2: Boys	54
Year 2: Girls	71
Year 3: Boys	59
Year 3: Girls	73
Year 4: Boys	56
Year 4: Girls	67
Year 5: Boys	55
Year 5: Girls	67
Year 6: Boys	53
Year 6: Girls	67
Year 7: Boys	54
Year 7: Girls	71
Year 8: Boys	56
Year 8: Girls	69
Year 9: Boys	59
Year 9: Girls	72
Years 1-8 Average (Comparison Years for Year 9): Boys	*57*
Years 1-8 Average (Comparison Years for Year 9): Girls	*70*
Years 1-9 Average: Boys	*57*
Years 1-9 Average: Girls	*70*

Note. Percentages are rounded to whole numbers.

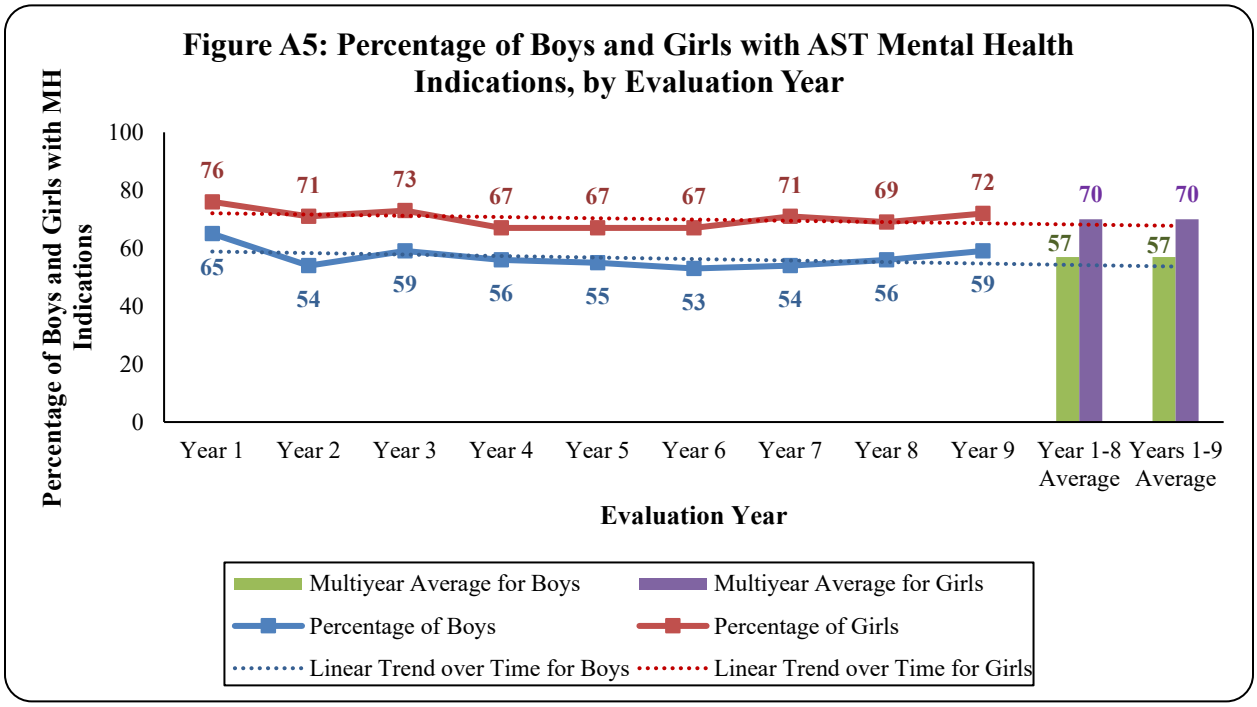


Table A6: Percentage of Boys and Girls with at Least One AST Indication by Evaluation Year	
Evaluation Year	**Percentage of Juveniles**
Year 1: Boys	81
Year 1: Girls	85
Year 2: Boys	73
Year 2: Girls	79
Year 3: Boys	74
Year 3: Girls	81
Year 4: Boys	71
Year 4: Girls	76
Year 5: Boys	68
Year 5: Girls	73
Year 6: Boys	63
Year 6: Girls	73
Year 7: Boys	65
Year 7: Girls	72
Year 8: Boys	66
Year 8: Girls	75
Year 9: Boys	68
Year 9: Girls	75
Years 1-8 Average (Comparison Years for Year 9): Boys	*70*
Years 1-8 Average (Comparison Years for Year 9): Girls	*77*
Years 1-9 Average: Boys	*70*
Years 1-9 Average: Girls	*77*

Note. Percentages are rounded to whole numbers.

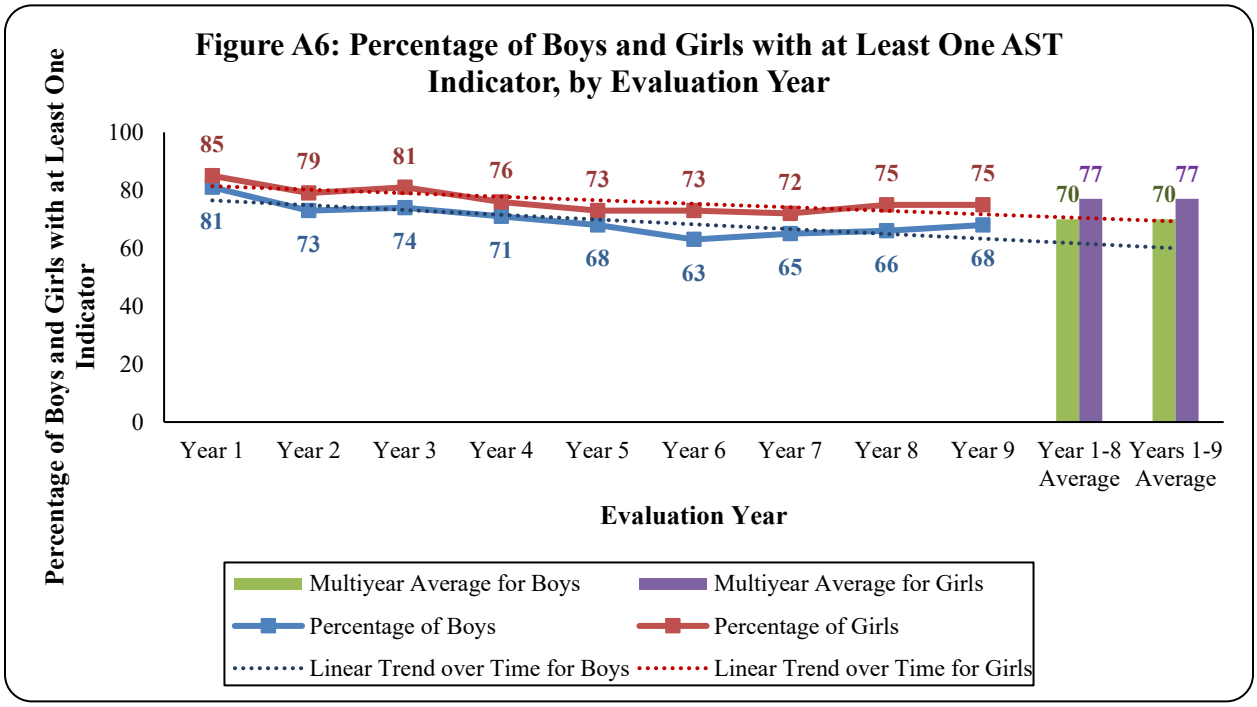


Table A7: Percentage of Boys and Girls with AST Substance Abuse Indications by Evaluation Year	
Evaluation Year	**Percentage of Juveniles**
Year 1: Boys	55
Year 1: Girls	53
Year 2: Boys	48
Year 2: Girls	41
Year 3: Boys	45
Year 3: Girls	44
Year 4: Boys	44
Year 4: Girls	40
Year 5: Boys	42
Year 5: Girls	38
Year 6: Boys	39
Year 6: Girls	42
Year 7: Boys	36
Year 7: Girls	40
Year 8: Boys	34
Year 8: Girls	37
Year 9: Boys	38
Year 9: Girls	38
Years 1-8 Average (Comparison Years for Year 9): Boys	*43*
Years 1-8 Average (Comparison Years for Year 9): Girls	*42*
Years 1-9 Average: Boys	*42*
Years 1-9 Average: Girls	*42*

Note. Percentages are rounded to whole numbers.

Figure A7: Percentage of Boys and Girls with AST Substance Abuse Indications, by Evaluation Year

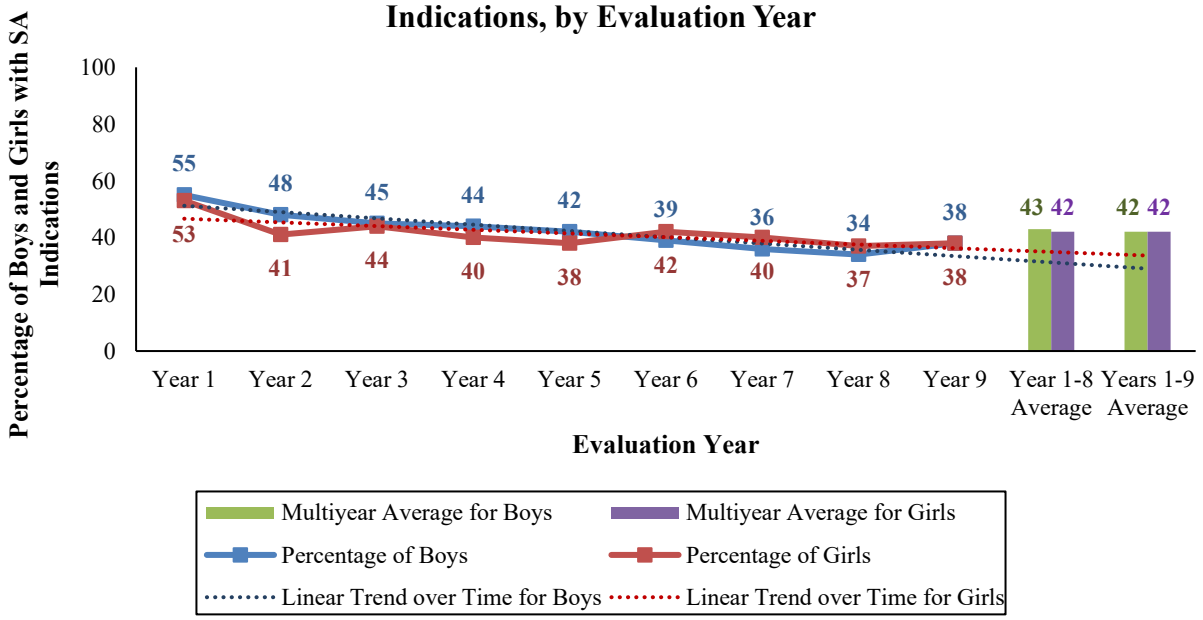


Table A8: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both Indications by Evaluation Year				
Evaluation Year	**Percentage of Juveniles**			
	Neither MH nor SA	**MH only**	**SA only**	**Both MH and SA**
Year 1	18	28	*14*	**41**
Year 2	25	29	*16*	**30**
Year 3	24	**32**	*13*	31
Year 4	28	**30**	*13*	29
Year 5	**31**	29	*11*	30
Year 6	**34**	26	*9*	31
Year 7	**33**	29	*8*	29
Year 8:	31	**34**	*8*	27
Year 9:	30	**33**	*7*	30
Years 1-8 Average (Comparison Years for Year 9)	28	30	12	31
Years 1-9 Average	28	30	11	31

Note. Percentages are rounded to whole numbers, so total row percentages may not equal 100.

Figure A8: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both Indications, by Evaluation Year

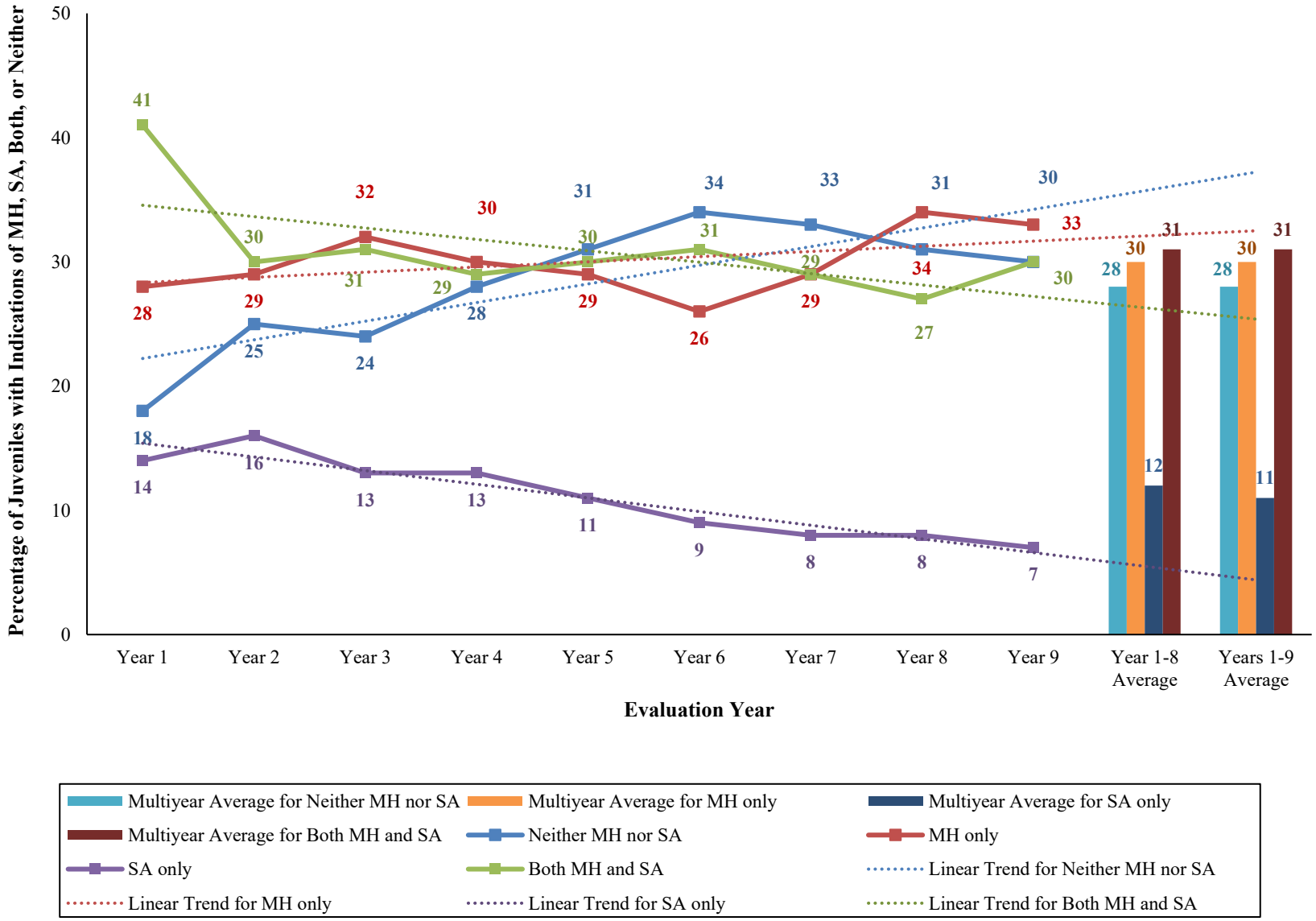


Table A9: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both Indications by Evaluation Year, by Gender				
Evaluation Year	**Percentage of Juveniles**			
	Neither MH nor SA	**MH only**	**SA only**	**Both MH and SA**
Year 1: Boys	19	26	*16*	**39**
Year 1: Girls	15	32	*9*	**44**
Year 2: Boys	27	25	*19*	**29**
Year 2: Girls	21	**39**	*8*	33
Year 3: Boys	26	**29**	*16*	29
Year 3: Girls	19	**37**	*8*	36
Year 4: Boys	**29**	27	*15*	29
Year 4: Girls	24	**36**	*9*	31
Year 5: Boys	**32**	26	*13*	29
Year 5: Girls	27	**34**	*6*	32
Year 6: Boys	**37**	24	*10*	29
Year 6: Girls	27	31	*6*	**35**
Year 7: Boys	**36**	28	*10*	26
Year 7: Girls	28	35	*4*	**36**
Year 8: Boys	**34**	33	*10*	24
Year 8: Girls	25	**38**	*5*	31
Year 9: Boys	**32**	31	*9*	29
Year 9: Girls	25	**37**	*4*	35
Years 1-8 Average (Comparison Years for Year 9): Boys	*30*	*27*	*14*	*29*
Years 1-8 Average (Comparison Years for Year 8): Girls	*23*	*35*	*7*	*35*
Years 1-9 Average: Boys	*30*	*27*	*13*	*29*
Years 1-9 Average: Girls	*23*	*35*	*7*	*35*

Note. Percentages are rounded to whole numbers, so total row percentages may not equal 100.

Figure A9a: AST Indications of Mental Helath, Substance Abuse, and Dual Diagnosis of Both Indications for Boys, by Evaluation Year

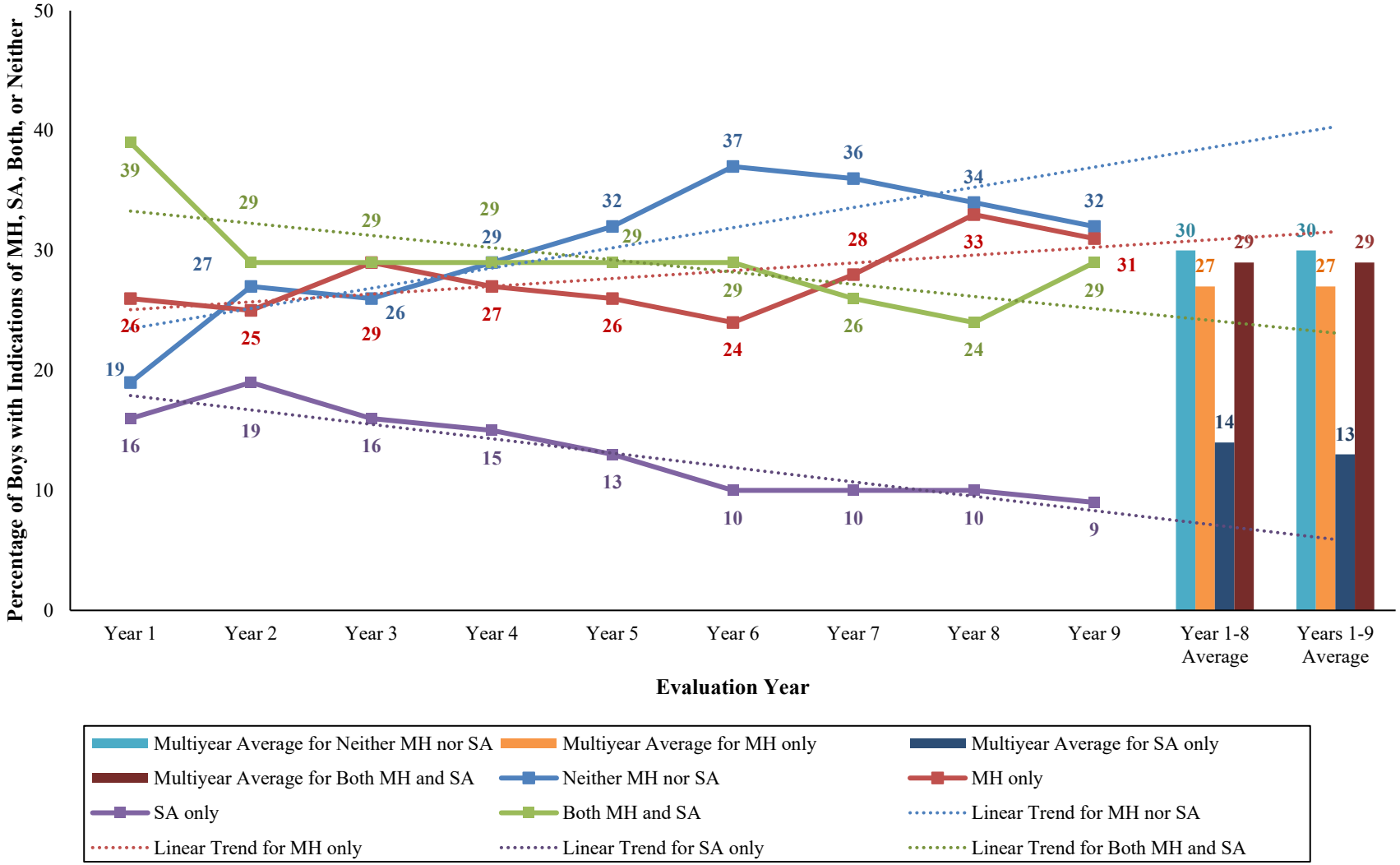
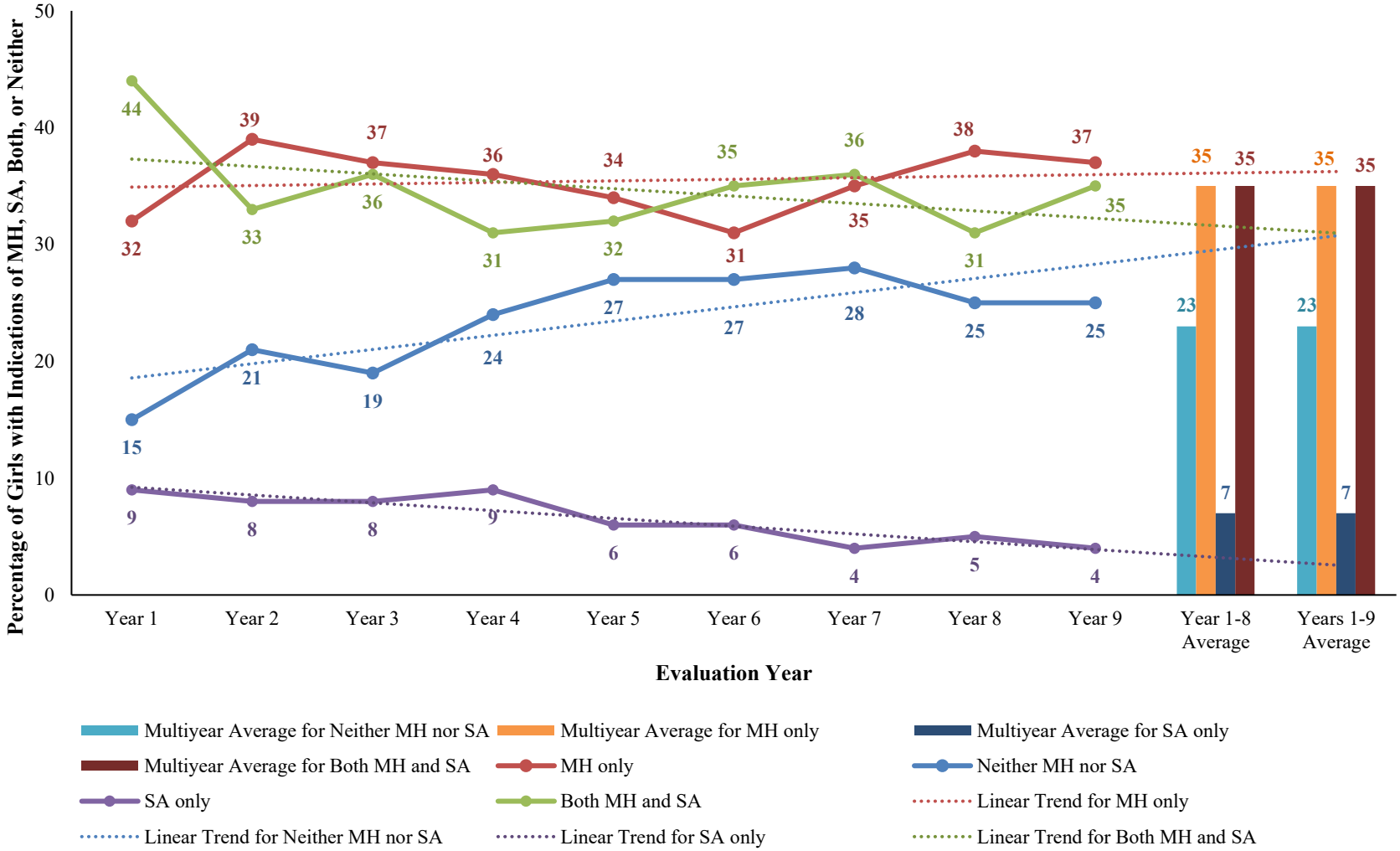


Figure 9b: AST Indications of Mental Health, Substance Abuse, and Dual Diagnosis of Both Indications for Girls, by Evaluation Year



Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

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)** [ ] Naltrexone (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?

Idaho has used the State Targeted Response (STR) and State Opioid Response (SOR) grants to provide opioid use disorder treatment, including Medication-Assisted Treatment (MAT) (buprenorphine, suboxone, and methadone), to over 1,000 Idahoans. The STR and SOR grants were also used to disseminate over 2,000 naloxone kits to first responders and treatment providers across Idaho.

**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.*

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Footnotes:

Environmental Factors and Plan

15. 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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] 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 M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"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 M/SUD 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.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. 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 check those that are used in your state:

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)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Cross system crisis system is an area of need for Idaho. Currently, the Children's Mental Health System is working to develop a collaborative community-oriented crisis system in an effort to reduce psychiatric hospitalizations, reduce death by suicide, increase access to care and community-based options, reduce arrests, and improve service coordination and quality of treatment. The current crisis systems differ across the state and among agencies. Currently there is a Crisis System Workgroup who is developing a roadmap and strategy plan to implement a coordinated crisis response system across the state of Idaho.

Crisis intervention provided through the regional offices include evaluation, assessment, intervention, stabilization and follow-up planning. They regional offices have various plans where phone and consultation services are available 24 hours a day, seven days a week.

Optum Idaho is Idaho's Medicaid managed care contractor for Behavioral Health Services. They provide Member's access to a Crisis Line that offers them immediate access to a Behavioral Health Clinician 24 hours a day, 365 days a year. Optum says that each call is regarded as a Member potentially experiencing some degree of stress or crisis and is triaged using the Solution Focused Crisis Intervention Model.

The regional Adult Mental Health Crisis Units provide crisis interventions that include evaluation, assessment, intervention, stabilization, and follow-up planning. The Crisis Units provide phone and consultation services 24 hours a day, seven days a week. They screen all adults who are being petitioned for the court ordered commitment process.

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.

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.

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.

In Region 4's Ada County, an integrative partnership between community first responders and psychiatric treatment agencies has been established and is working to pro-actively respond to crises in the community. This partnership is the Crisis Intervention Team Collaborative (CITC) and includes the following stakeholders: Boise Police Department, Ada County Sheriff Office, Meridian Police Department, Garden City Police Department, Ada County Paramedics, Idaho Department of Health & Welfare, Idaho Suicide Prevention Hotline, VA Justice Outreach, Optum Idaho, Probation and Patrol and the Idaho Commission on Aging.

The purpose of the collaboration is to improve follow-up and continuity of care for individuals who have experienced behavioral health crisis or required emergency assistance within the community crisis system. Together, CITC members evaluate levels of care or new or re-connected services to support recovery from substance use and enhance psychiatric stability by linking individuals to accessible behavioral health and substance use disorder healthcare.

The philosophy of this collaboration prioritizes the least restrictive treatment options to ensure safety and client-centered/driven interventions that empower individuals and reduce trauma.

The Department of Health and Welfare's Division of Behavioral Health is home to the Mobile Crisis Unit, with a 24/7 crisis line, which responds to community crisis 7 days a week. The Mobile Crisis Unit and the Ada County Community Paramedics have created the Psychiatric Emergency Team (PET), which is comprised of a Community Paramedic and a Mobile Crisis Unit clinician. PET co-responds face to face to crisis calls from clients, their loved ones, and law enforcement. PET, as well as the Mobile Crisis Unit, also monitor and follow up with clients before and after hospitalization, involuntary holds, or other crisis situations including medication interruption, escalation of psychiatric symptoms and/or substance use, accidental overdoses or suicide attempts, or disconnection from healthcare services.

For the past two and a half years, the counties in Region 1, Kootenai County, Coeur d' Alene, Post Falls, Rathdrum and Spirit Lake have all been very enthusiastic in participating in CIT Academies. This was the result of heavy marketing by the DBH Region 1 staff

conducting several 4-hour courses to various counties/departments in Region 1, provided training in De-escalation and Crisis Intervention techniques, the support of the Behavioral Health Board who funded Kootenai Academies, ideas gleaned from the Chicago CIT Conference in 2016, and the support from the DBH Program Manager and leadership at Region 1. Since Bonner County has trained up to 90% of their officers, DBH has primarily conducted all academies in Kootenai, and Bonner and Boundary Counties has sent officers to the Kootenai Academy as a result.

In the past 9 months, DBH has trained up to 91 officers in Kootenai County which have included all the departments. (See the attachment of the report sent to their Behavioral Health Board outlining the three academies conducted in the past 9 months and the overall ratings to those academies, and the attached agenda to a an academy that included the Crisis Center Director, as one of our presenters and presented on Advanced De-escalation).
A lot of Region 1's work and support has come from the Program Manager and Leadership, in addition to the opportunity to present 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 the knowledge and experience from other parts of the state and in Region 1 to explain how CIT was implemented, and explained their current strategy of expanding CIT in Region 1.

In addition, CMH, community partners and the Regional Behavioral Health Board in Region 1 had Texas Christian University come to Idaho and present in April 2019, to train a total of 50 participants as train the trainers for Trauma Informed Care. This was a collective community initiative. The training cost was 3,500 per participant and our board contributed 12,000 dollars towards this training.

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

No Technical Assistance is being requested at this time.

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 M/SUD 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 to the greatest extent possible, 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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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 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?	◉ Yes	○ No

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.

For the past several years, the Division has worked with families, youth, clients, advocates, community partners, and other stakeholders to establish certification, as well as standards and IDAPA rule to support the development and implementation of peer services in Idaho. In SFY2016, the Division focused efforts on workforce development for certified peer support specialists and certified family support partners. These efforts included the development of a certified family support partner training curriculum contract, sponsoring trainings for certified peer support specialists and certified family support partners which are now performed by the community, and providing agency readiness trainings to employers which is also administered by community agencies.

In September 2015, the Division implemented certification requirements for peer support specialists. Implementation of certification requirements for family support partners began in February 2016. Currently, peer support is a Medicaid reimbursed service through the Idaho Behavioral Health Plan. The Division of Behavioral Health employs approximately one peer recovery specialist on each of the regional ACT teams, as well as two at the State Hospital South psychiatric hospital . Many providers in the Optum Network (managed care) provide peer services for their clients who want it.

As of June 7, 2019, Idaho currently has a total of 538 certified peer support specialists and 117 certified family support partners. Five out-of-state certifications have been awarded. In addition, through a contract with Empower Idaho and partnering with the Idaho Peer Support Association, the Division supports an annual Peer Connections Conference for all types of peer workers to earn CEUs for their annual certification requirements.

Although Idaho has come a long way with peer support, oversight of trainings and the system, as well as quality assurance are needed to find out if peer services are having positive outcomes for our clientele and how many certified peer workers are employed. Learning the needs and strengths of this service system would be useful.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Idaho embraces the Recovery Oriented System of Care model in our delivery and funding for substance use disorder treatment and recovery support services. We provide an array of recovery support services designed to supplement a person's treatment with these beneficial, ancillary services. Services provided include case management (including specific case management for the Pregnant Women and Women with Dependent Children (PWWC) population), safe and sober housing, child care, transportation, recovery coaching (provided by certified Recovery Coaches), life skills, and transportation. These services can be accessed by eligible individuals through our Managed Services Contract with BPA Health.
Recovery Coaching is also embraced by Idaho's Recovery Community Centers. Recovery Community Centers are peer-operated centers that serve as resources for community based recovery support. People do not reside at these centers, rather these centers can help individuals build recovery capital at the community level by providing advocacy training, recovery information and resource mobilization, mutual support group meetings, peer supports, social activities and other community based services. Idaho currently has 9 Recovery Community Centers statewide.

5. Does the state have any activities that it would like to highlight?

Not at this time.

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

No technical assistance is requested at this time.

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Footnotes:

Environmental Factors and Plan

17. 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 M/SUD 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 M/SUD 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.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

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 U.S. Supreme Court decided Olmstead v. L.C. 527 U.S. 581 (1999) (Olmstead), granted states protection from individual litigation if they developed a reasonable plan for compliance (Olmstead plan), and made consistent progress implementing it. At that time, the Idaho Attorney General's opinion was that Idaho was in full compliance with Olmstead, and that no specific plan was indicated. At that time there was widespread disagreement with this position, so 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 submitted its last report in 2004.

The mental health system in Idaho has improved significantly in the past five years, despite the struggle with meeting the needs of a growing population with increases in the diagnosis of mental illness in Idaho. Idaho's Division of Behavioral Health includes Children's Mental Health Services, Adult Mental Health Services, Substance Use Disorders Program, and the Idaho Tobac¬co Project. 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 inte¬grating services for these co-occurring disorders to improve outcomes.
In relation to community living, the Division of Behavioral Health has budgeted $2 million dollars to continue the safe and stable housing supplemental payments to assisted living facilities that provide care for adults with serious and persistent mental illnesses as well as to pilot the Homes with Adult Residential Treatment (HART) model.

Supplemental Safe and Stable payments were continued to support approximately 35 assisted living facilities with the provision of critical resi¬dential services. The HART demonstration project was initiated to pilot an intensive, treatment-oriented, residential

living program for individuals with a serious and persistent mental illness. Contracts have been implemented with four HART facilities across the state.

The HART provides a safe and therapeutic homelike environment that includes meals, living space, assistance with daily living, and clinical treat¬ment services. Each HART provider is required to be an Optum-approved Idaho Behavioral Health Plan provider and able to deliver an array of treatment services including assessment, treatment planning, psychother¬apy, community/peer supports, Community Based Rehabilitation Services (CBRS), group therapy, case management, and medication services.
The intent of the HART model will allow for the provision of clinical treatment interventions to better address behavioral health-related issues that have not been able to be addressed without evicting the resident or escalating the resident to a crisis or emergency facility. The division will gather out¬come data to determine whether the HART model is a more effective ap¬proach to the care of Idahoans with serious and persistent mental illness.

The department contracted with the Western Interstate Commission for Higher Education (WICHE) to update and make recommendations to a decade-old gap and resource analysis that WICHE completed under commission from the Legislature. The updated report explains the progress made since the original report in 2008. However, there is still a need for more effective use of the current resources provided for mental health care in Idaho as well as for additional resources. It is clear there needs to be a strategic path forward in Idaho, with broad stakeholder input. The department is leading the collaborative WICHE Steering Committee to ensure the entire system has input on the strategic path forward.

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

No technical assistance requested at this time.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD 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.[63]. 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.[64]. 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.[65].

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.[66]. 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.[67].

According to data from the 2015 Report to Congress[68] 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 M/SUD 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

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]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.

[65]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.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]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 **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

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 M/SUD 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 M/SUD 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 following was reported in the YES Second Annual Implementation Progress Report published in May 2019, which is attached. The Third Annual Implementation Progress Report is under review and will publish this fall.

On June 12, 2015, the State of Idaho finalized a Settlement Agreement with Plaintiffs regarding the Jeff D. et al. vs. C.L. "Butch" Otter et al., Case No. 4:80-CV-04091-BLW class action lawsuit. The Settlement Agreement required that an Implementation Plan be developed and an annual Progress Report be delivered to the Court and Plaintiff's counsel on progress the State has made operationalizing the Plan. On April 29, 2016, the State submitted the required Idaho Implementation Plan to the Court, which was subsequently approved. The Idaho Implementation Plan describes how the State will develop and implement sustainable, accessible, comprehensive and coordinated service delivery of publicly funded community based mental health services to children and youth with serious emotional disturbances in Idaho. Working with youth to help brand the effort, the state chose the name, "Youth Empowerment Services" (YES) for the new system. This report, the Second Annual Implementation Progress Report, attached as "YES Second Annual Implementation Progress Report" details the ways in which the State of Idaho, including the Idaho Department of Health and Welfare (DHW), State Department of Education (SDE), and Idaho Department of Juvenile Corrections (IDJC), are working together to meet the requirements in the Settlement Agreement and transform the mental health service systems for children and youth into an integrated system of care. The report provides information on accomplishments and progress on meeting obligations under the Settlement Agreement, remaining tasks, challenges to completing the objectives, and

next steps in achieving the objectives of the Implementation Plan. The Idaho Implementation Plan was organized around seven objectives necessary to accomplish the required outcomes of the Settlement Agreement and meet to the exit criteria. This report follows those seven objectives so that both progress and concerns are tracked and reported as the YES program evolves over time. Idaho's YES system partners are committed to developing statewide capacity to provide services and supports that are capable of meeting the needs of children, youth, and families in scope, intensity and duration. The development of the YES system is based on the requirements in the Settlement Agreement for establishment of YES Principles of Care and Practice Model, the YES Access Model, and the YES Workforce Development Plan (WFD). Additional elements of the YES system that will be transformed include building or enhancing the infrastructure that is needed to sustain the YES system such as due process, an interagency governance structure, and a coordinated collaborative process for quality management improvement and accountability. The transformation of the child serving system into the YES system will take place over the next two years, with services and supports to be available within four years of the Settlement Agreement and a period of three years of sustainability which will begin in 2020.
The planned transformation of children's mental health services in Idaho into the YES System requires the development of infrastructure to support the goal of implementing a sustainable, accessible, comprehensive and coordinated system. A majority of the work and resources have been focused in establishing that framework. There have also been changes made that directly impact children, youth and families that will result in improved outcomes. Highlights of the achievement of transformation goals over the past year and significant work ahead are noted below.
Highlights of Achievements:

1. Enhanced collaboration and coordination between DHW, IDJC, and SDE to reduce fragmentation.

Key to the state's operationalization of YES has been continued collaboration across state administrative divisions and agencies. There are several collaborative workgroups that have been implemented over the past year that are working to establish the foundations for a system of care that is operating to reduce barriers for children, youth and families. The workgroups and committees include the Interagency Governance Team (IGT), the Quality Management Improvement and Accountability (QMIA) Council, the Communications workgroup, the Practice Manual Workgroup, the Due Process Workgroup, and the Workforce Development Workgroup. There is a Memoranda of Understanding (MOU) which has not been fully executed that will formalize the relationship between the various components of the child serving systems. With each success and challenge the YES system partners are learning more about how best to transform the system so that it reflects the desires of the community, as well as what is sustainable and achievable in operations, and will meet the requirements of the Settlement Agreement. The State has also developed the Idaho Transformational Collaborative Outcomes Management (TCOM) Model describing how data will be used to assess and improve the system of care. TCOM is described as a conceptual and practical framework for managing complex systems.

2. Enhanced access to Medicaid benefits to increase access to mental health services.
To increase access to services Medicaid developed and submitted a 1915(i)-state plan option application to the Centers for Medicare and Medicaid Services (CMS) that establishes eligibility to Medicaid for YES program class members with family incomes from 150-300% of the federal poverty level (FPL). As part of the 1915(i) option, Medicaid-reimbursed respite services were initiated. Full implementation of the Medicaid reimbursed agency-based respite services and companion certification requirements is scheduled for July 2018.
In addition, Medicaid is improving access to Psychiatric Residential Treatment Facilities (PRTF) services by streamlining the review process to better meet its obligations under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements for Medicaid programs. The Department of Juvenile Corrections has advanced its Behavioral Health Referral pilot that promotes identification of youth mental health needs to assist staff in determining appropriate placement/treatment as early as possible. IDJC staff is also being trained on how the CANS can help staff improve outcomes for involved youth.

3. Implementation of the Child and Adolescent Needs and Strengths (CANS) assessment to identify and screen potential class members and link them to care according to consistent procedures.
The CANS and ICANS, the automated system for documenting CANS assessments, are operational in all seven regions of the state. As of March 31, 2018, there were 212 individual active CANS certifications. As of April 30, 2018, there were 521 Children's Mental Health CANS administered by Division of Behavioral Health (DBH) staff, and 484 CANS 50s administered by the Independent Assessment Provider. Idaho expects to meet its goal for beginning to use the CANS statewide by July 1, 2018.

4. Engagement and involvement of youth and families of Class Members in system improvement and planning efforts. Of significant note is the ongoing development of the relationship among the partners and the families in Idaho in the work to build the YES system of care. Organized and branded as the "Parent Network," parents of children with serious emotional disturbance (SED) have joined the project as partners in achieving this transformation. In recognition of the value of parents' and youth voice in the project the state has developed a method for compensation for their time. The state designated a Family Liaison, and has provided opportunities to youth and parents to participate in developing training content and deliver YES-related trainings that are reflective of family voice. The state is also engaging the Parent Network and youth organizations to help create content for YES materials, and to review content of informational materials to improve readability and comprehension. Youth have assisted with creating content for the Introduction to Youth Empowerment Services guide, Youth Frequently Asked Questions document, and have begun working on a preliminary checklist that youth can use to pre-screen themselves and start the conversation about their mental health needs. Youth have also provided feedback on training content and are currently assisting with the development of a youth-targeted training plan. Information for parents, youth and other stakeholders about YES have been developed and communicated through:
• YES website (yes.idaho.gov) with Parent and Youth voice, addition of Spanish translation site, training page for training

information and registration links, training videos, calendar of events, and downloadable YES materials (http://youthempowermentservices.idaho.gov/Project/Communications/tabid/3855/Default.aspx)
• ICANS website (http://youthempowermentservices.idaho.gov/Project/Communications/tabid/3855/Default.aspx) for CANS users which includes announcements, training information, resources and user guides, FAQ's and information for families
• YES Training playlist on Idaho Department of Health and Welfare's YouTube Channel (https://www.youtube.com/user/IDHWmedia)
• Idaho Department of Health and Welfare (DHW) Social Media blog post regarding the Independent Assessment process and Mental Health Assessments available
• Idaho DHW Twitter messaging

5. Established a collaborative governance structure that includes Defendants agencies, Class Member's families and other stakeholders.
The Interagency Governance Team (IGT) began meeting in October of 2016 and continues to meet monthly. The IGT is intended to facilitate collaboration among agencies and stakeholders, increase transparency and accountability, and afford opportunities for team trouble-shooting and problem-solving. The IGT membership includes parents, a former Class Member, family/youth advocacy representatives, providers, and agency representatives from Medicaid, DBH, SDE and IDJC. During this past year, the IGT members have formed both the Family Engagement Subcommittee and the Clinical and Training Subcommittee. The IGT also drafted and approved Operational Guidelines that outline the team's processes and procedures.

6. Implemented Legislative Changes
The 2017 legislative session was successful in terms of advancing the Idaho infrastructure in support of the new system of care. Legislative allocations were secured for adding staffing resources to the Division of Behavioral Health (DBH) needed to implement the project objectives and operate the new system. Further, the legislature approved a modification of state statute to allow children with serious emotional disturbance access to Medicaid up to 300% of the federal poverty level. The Divisions of Medicaid and Welfare developed and presented Idaho Administrative Procedure Act (IDAPA) rule changes to implement this statute change, these rules were approved. Since increased of traditional income limits will enable larger numbers of families to become eligible for Medicaid coverage, the state anticipates that this change will allow additional children with SED in Idaho increased access to care.

7. Planning for a new Adolescent State Hospital Facility4 The Idaho State Hospital System is a government not-for-profit healthcare system that serves as a safety net for those who are unable to get their behavioral health needs met in Idaho's community psychiatric hospitals. The goal is to improve the Behavioral Health and wellbeing of individuals emphasizing care that is trauma informed, patient centered and physician led. Idaho State Hospitals are under the Division of Behavioral Health (DBH) within Idaho Department of Health and Welfare. The current adolescent unit is on the State Hospital South campus located in Blackfoot Idaho. The unit is a 16-bed facility that cares for youth age 12-17. Approximately 65% of the adolescents admitted come from the Treasure Valley. Locating the adolescent care in a new hospital in Nampa Idaho will offer care and treatment closer to most patient families and increase the ability to have family involvement. The location of the of the new hospital will also give greater ability for families to be part of the transition services for the youth. The new hospitals' planned opening is the summer of 2020.

To read more about Idaho's Youth Empowerment Services Implementation Progress, see the attachment "YES Second Annual Implementation Progress Report" and "Yes Project Status Report January 2019".

7. Does the state have any activities related to this section that you would like to highlight?

The YES system of care relies on a model of service delivery in which all child-serving systems operate in a coordinated manner to support parents and caretakers as the main drivers of the care and treatment they are seeking. This system of care approach that is driven by youth and families, results in greater positive outcomes for youth and families. The following accomplishments related to YES for Idaho are listed below:
• Children with an SED whose family's income amounts up to 300% of the Federal Poverty Level are now eligible for Medicaid.
• Contract was developed with Liberty Healthcare to administer independent assessments to determine eligibility for YES Services and Respite services.
• A person-centered service planning process was designed for Medicaid participants.
• Collaborative workgroups continue to meet, and stakeholder interest remains high; expert consultants continue to offer technical assistance for the improved system of care.
• The Interagency Governance Team (IGT) operates as an advisory body for the implementation efforts. This 17-member team includes representatives from three agency partners, parents, youth, advocates and providers.
• The Idaho CANS web-based tool was implemented across Idaho and all applicable Optum Network providers are to be certified and trained in CANS.
• Staff from Liberty Healthcare, Optum Healthcare, the Division of Behavioral Health, Division of Family and Community Services, and the Department of juvenile Corrections have been certified and trained in the CANS.
• The ICANS website (icans.dhw.idaho.gov) was launched to meet the needs of agency staff and providers using the ICANS/CANS.
• The YES website continues to be updated and includes collaborative materials and references and serves as a public access site for project implementation, reports, fact sheets, training and other communications.
• Ongoing training and outreach to families and community stakeholder groups is being conducted.
• Yearly Parent Workshop hosted by the Idaho Parent Network for Children's Mental Health.

More information on YES is available at yes.idaho.gov and in the JeffD SettlementAgreement.pdf attachment.

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

No technical assistance is requested at this time.

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Footnotes:

YOUTH EMPOWERMENT SERVICES

Wraparound for Families

Youth Empowerment Services

Still Need a CANS Done For Your Child?

The Child and Adolescent Needs and Strengths (CANS) is a tool used to identify if your child has a functional impairment and assist in treatment planning. You can contact your existing mental health provider or talk to your local Children'
more information. T
Line by dialing 211 or 1-800-926-2588.

Understanding the Layout of This Handbook

This Wraparound Family Handbook has been broken into two parts.
tells you a little bit about the Wraparound process itself, and the second part helps you understand how your family will participate in the Wraparound process.

Definitions to Know

- The terms "child" and "youth" are used interchangeably.
- "Family" refers to biological and adoptive family as well as primary caregivers for the child.
- The terms "Wraparound Care Coordinator" and "coordinator" are used interchangeably.

YES Questions or Complaints: 1-855-643-7233

Youth Empowerment Services (YES) is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, and in some cases, religions or political beliefs.

We provide free services to help you communicate with us, such as, text in other languages, large print, or you can ask for an interpreter. To ask for help, please call 211.

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 211.

*"Wraparound teams see a family's **strengths** and **struggles**, and let them know that **both** are **important**."*

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What is Wraparound?

What Wraparound Does

Wraparound is a team-based, family-driven, and youth-guided planning process that is driven by a set of guiding principles, has a structured format, and is implemented with facilitated activities. The Wraparound process is used to address complex needs for your child and your family. Wraparound creates relationships by bringing a team of involved people together to support you, your child, and your family. While building relationships of trust and understanding, you will work together to create a system of supports that help your family

Is Wraparound Right for My Family?

The Wraparound process is one of the supports included in Idaho's **Youth Empowerment Services** (YES) system of care. A child YES when they have **serious emotional disturbance** (SED) which is the combination of a mental health diagnosis and a **Child and Adolescent Needs and Strengths** (CANS) tool. A **Intensive Care Coordination** (Wraparound is one form of Intensive Care Coordination) services as part of

- When the coordinated care plan written by your **Child and Family Team**

  facilitated planning process.
- When a child is transitioning home from an out of home placement such as therapeutic foster care, an acute psychiatric treatment facility, or a psychiatric residential treatment facility (PRTF).
- When intervention is needed to keep a child from being moved to an out of home placement.

Terms to Know

Youth Empowerment Services (YES):
A system of care for Idaho children with mental health needs.

Serious Emotional Disturbance (SED):
A mental health diagnosis with a functional impairment.

Child and Adolescent Needs and Strengths (CANS):
A tool used to identify if your child has a functional impairment and assist in treatment planning.

Intensive Care Coordination:
A type of case management for youth whose CANS score indicates they need a high level of care.

"Relationships. Wraparound is all about developing relationships, both with people and systems. Relationships change lives."

How Wraparound Can Benefit Your Child

The W
individuals and services in your child's life and giving them the chance to work together on common goals. Together this Wraparound team will identify your child's **strengths** and build upon them to help stabilize their **needs**. Your child and your family's voice is at the center of everything your team will do. Each **Wraparound team** and plan is unique because each child and family is unique. **Wraparound plans**

Terms to Know

Child and Family Team (CFT):
A group that does treatment planning for your child and family. This group includes people selected by your family such as doctors, therapists, extended family, coaches, and other involved individuals.

Strengths:
Areas where your child or family have a source of power that can resist stress or strain.

Needs:
Areas that your child or family requires help to reach your goals.

Wraparound Team:
May include members of the Child and Family Team (CFT), but is specifically invited to develop the Wraparound plan.

Wraparound Plan:
A living document that describes your child's needs and the services and supports that will meet those needs.

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Getting Started

Methods of Entry into the Wraparound Process

Wraparound is a part of the YES system of care in Idaho. It is intended to help children who may be at risk for needing more intense and restrictive services, including out of home placements. It is also intended to help youth who are transitioning home from more intense and restrictive services. If your child is currently in treatment out of your home, you may work with your treatment facility to discuss including the Wraparound process in your discharge plan.

> If your child is not currently in treatment out of your home and your Child and Family Team (CFT) believes that the Wraparound process may be appropriate, you may contact your local Children'
> about accessing your local Wraparound Care Coordinator.

Meeting Your Wraparound Care Coordinator

Once W
assigned a **Wraparound Care Coordinator**. Within a few days you will receive a call from your new coordinator to schedule a time to meet in person so that you and your child can help them understand your family's strengths and needs.
identify your **Family Vision Statement** to help your Wraparound team work towards the goals you have for your child and family.

When you meet with your Wraparound Care Coordinator for the
youth and family partners.
Together with your coordinator, these team members will get to know your child and your family. Their role on the Wraparound team is to make sure your unique voices are heard and understood throughout the process. You can think of these team members as your advocates in Wraparound.

Terms to Know

Wraparound Care Coordinator:
A trained member of the Wraparound team who is responsible for engaging families, facilitating meetings, and tracking progress.

Family Vision Statement:
A sentence or two that describes how the family wants things to be in the future.

Youth and Family Partners:
Individuals with lived experience who support the youth and families during the Wraparound process.

*"They say you can't burn out if your fire has never been lit. A Wraparound Care Coordinator keeps a family's hope safe until they have developed the strengths, skills, and resources they need to take their fire back **and keep it lit forever.**"*

Scheduling to Fit Your Life

When your Wraparound Care Coordinator meets with you and your
s
schedule, which may include evening or weekend meetings. If your
choose to consider their schedules as well.

How is the Wraparound Process Different from Other Treatment Planning?

Many treatment planning methods, such as individual treatment plans, coordinated care plans, and person-centered service plans, may focus on identifying formal and natural supports to provide treatment for current needs. The Wraparound process is a driven planning process that adheres to a structured model to ensure that all members of the
new relationships and strengthening existing relationships to increase a family's resources and skill network. While treatment planning is an important step towards addressing needs, traditional plans may leave youth and their families dependent on an existing limited professional
Wraparound builds on youth and family strengths to develop a larger natural support system to complement any required formal supports.

- Many treatment plans create a list of all the services and supports your child needs. They may also try and integrate your child's services, but most focus on the formal supports your child needs to reach their goals.
- The Wraparound process is anchored in your family values and works to balance formal and natural supports to help your family learn the skills, develop the relationships, and practice the lessons you learned so you can successfully reach your vision of what you want in life.

Remember

The Wraparound process is built around your family values, and that means your Wraparound plan will work with your family, and your Wraparound team is there to help you along the way.

Terms to Know

Formal Supports:
Individuals or organizations that provide a paid service to the family.

Natural Supports:
People who are part of the family's personal social network. Sometimes known as informal supports.

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Guiding Principles for Wraparound

Family Voice and Choice
Recognizes the expertise of youth and their families and prioritizes their preferences in care

Team-Based
Brings families and supports together to work towards consensus, not majority-rule

Natural Supports
Utilizes people and programs in your family's personal social network, sometimes called informal supports

Community-Based
Creates a plan that can be carried out where you live; identifies services where you can access them

Collaboration
Contributes ideas from all team members who then take responsibility for action steps in the plan

Culturally Competent
Considers your family's unique cultural needs and preferences

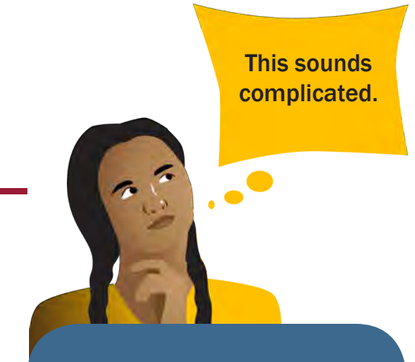
Individualized
Customizes care specifically for your youth and family's strengths and needs

Strengths-Based
Identifies and builds on strengths to improve functioning

Outcome-Based
Contains measurable goals to assess change, not compliance

Persistence
Commits to achieving the goals of the wraparound plan

Introduction to the Wraparound Process



Engagement and Team Preparation

While it might feel like getting started right away with a plan to help

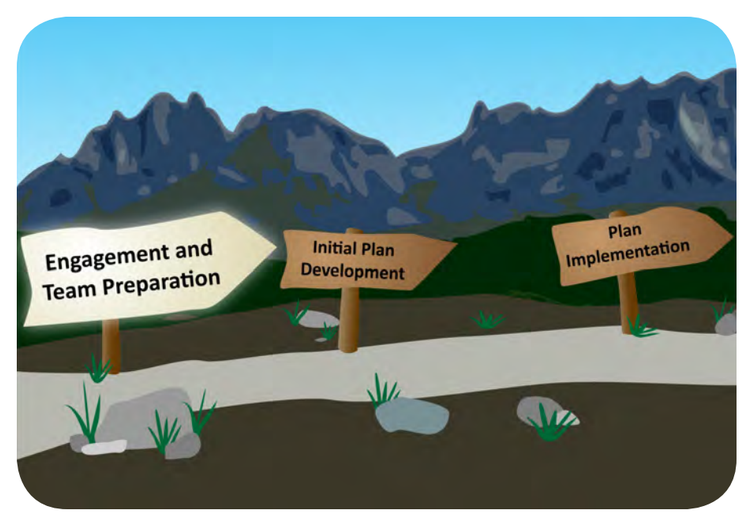
the Wraparound process is designed to build a solid foundation of trust and support between the family and facilitator.

In this phase, your family will:

- Meet your Wraparound Care Coordinator
- Meet any family and youth partners assigned to your Wraparound team
- Learn about the Wraparound process and what you will need to do
- Identify any urgent needs (such as crisis situations) and act to stabilize your family
- Discuss strengths, needs, family and individual cultural identities;
- create a family vision of how you want your family to live and function
- Talk about the people you would like on your team
- Look at scheduling options for team meetings
- Complete any required agency paperwork
- Verify the coordinator has access to all important documents such

Remember

- It is the coordinator's job to guide you through this process. You do not need to do these things by yourself.
- As you share more of your thoughts and preferences with your coordinator and family and youth partners they will be able to structure the Wraparound process to meet your needs. So the more you share, the better the experience will be!



*"Planning at the **speed of trust.**"*

Terms to Know

Team Mission Statement:
A one or two sentence description of the long term goal the team is working towards.

Action Steps:
Small steps assigned to team members needed to put a plan or strategy into place.

Safety and Crisis Plan:
A plan that identifies triggers and methods to prevent potential problems. This plan also identifies ways to respond if a crisis cannot be prevented.

Remember

If at any time during the Wraparound process you don't feel like your preferences are understood or included, tell your Wraparound Care Coordinator or your Family and Youth Partners. This is your family's plan, so your voice is important!

Initial Plan Development

After the Wraparound Care Coordinator understands your child and family's needs and preferences, they will gather a team of involved people to help you create a Wraparound plan. These individuals are selected by your family and each will have a unique perspective that Wraparound plan. If your family has previously created a Child and Family Team (CFT) many of the same people may participate in the Wraparound process, but families are free to include other members as well.

The team creates a **Team Mission Statement** that summarizes the goals the team is working on. Team members identify ground rules, , and talk about how meetings will operate.

Once the team understands the strengths and needs of the family, they will work together to prioritize the skills and strengths they wish to develop and the needs they need to support. It is important to remember that the Wraparound process works to develop a consensus and not make decisions based on "majority rule."

A key part of building a Wraparound plan is identifying the results you want to achieve. The team will document outcomes that will show successful completion as part of developing strategies to meet each goal. These strategies may include formal supports combined with natural supports.

Each team member will take responsibility for **action steps** in the plan. This distributes the work of implementing the plan among a larger group of people and reduces the stress on families.

The Wraparound team will also discuss potential risks to the safety of the youth and their family and develop a plan to keep everyone safe. This **safety and crisis plan** will include any responsibilities assigned to team members.

*"When you start with **needs** you get **programs.** When you start with **strengths** you get **possibilities.**"*

-Lupe Serrano

Plan Implementation

Once the initial plan has been developed, team members will start to complete their assigned action steps. Progress will be measured and evaluated to see if the plan is helping your child and family achieve your goals. The team will meet to discuss any changes needed to the plan or individual action steps based on the results observed.

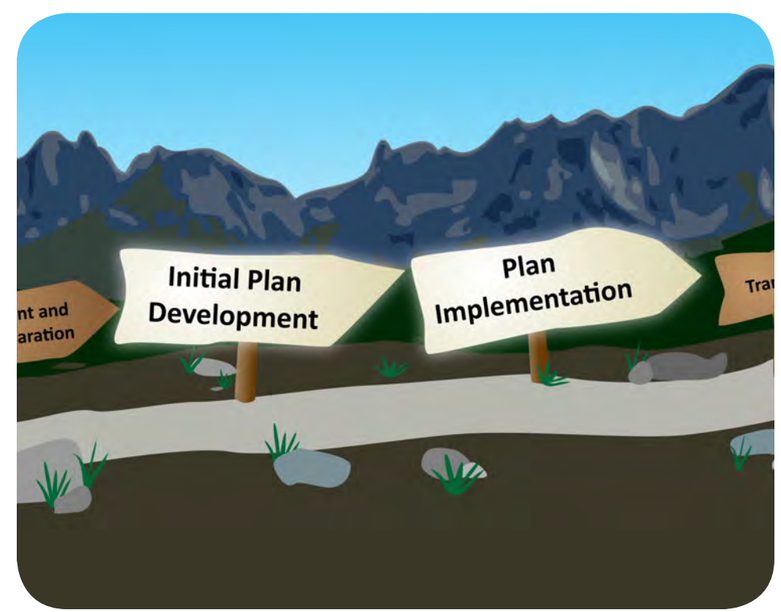
As the Wraparound process continues, team members will continue to work together to complete action steps. Each team member will be given the chance to give feedback about the plan and suggestions to improve the plan.

A very important part of the Wraparound process is identifying and celebrating individual successes along the way. The Wraparound Care

acknowledge and enjoy progress.

Questions to Ask

- Does the current plan help my family move towards our goals?
- Are there any changes that I think would help this plan work better for our family?
- Have we had any successes that we can celebrate?



"Never quit one moment before the miracle."

-Michael Pritchard

Terms to Know

Transition:
The shift away from a formal Wraparound process and towards formal and natural supports in the community.

Remember

- Transition plans are updated throughout the Wraparound process and can be changed as your family's needs change.
- Families ready for transition are able to independently implement what they learned during the Wraparound process with their CFT.

Transition

Transition planning begins at the very beginning of the Wraparound As the youth and family

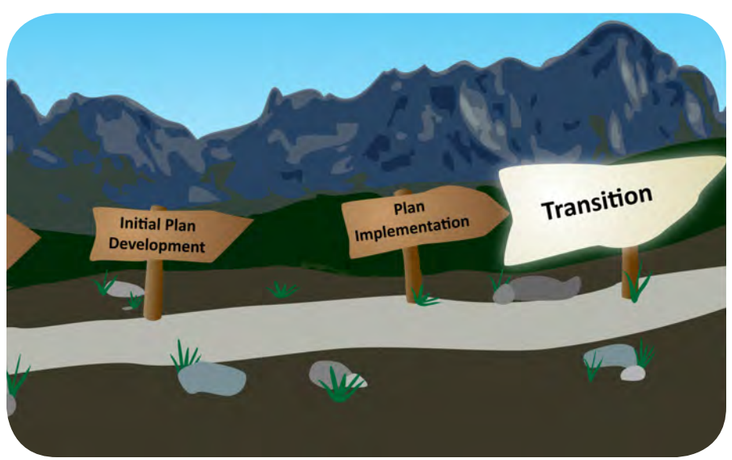
more attention is given to creating a sustainable system of formal and natural supports to maintain any progress made during the Wraparound process.

As part of transition planning, the safety and crisis plan is updated to The plan also includes action steps

community.

It is important for families to know that transition isn't the end of services, just the end of the formal planning process known as Wraparound. Families will transition back to their Child and Family Team (CFT) and will use the formal and natural supports developed by the Wraparound process. The Wraparound Care Coordinator will check in with the family after the Wraparound process has ended to see if they have any new needs that may require support. If the Wraparound process is needed again, the transition plan will identify how a youth and family can restart the process.

Many Wraparound teams choose to celebrate the end of the Wraparound process with a graduation or commencement activity, although it is not required.



Preparing for Wraparound

Information to Gather

Your Wraparound Care Coordinator will spend time getting to know your family and helping you identify your Family Vision Statement. To make this process smoother YES Family Workbook.

coordinator can help you as you work through the engagement portion of the Wraparound process.

The YES Family Workbook will help you:

- Describe your strengths
- Explain your needs
- Gather information about current formal supports
- List strategies that have worked in the past and those that have not
- Identify goals for your child and family
- Create a Family Vision Statement
- Document your current crisis plan

Remember

- To find the YES Family Workbook, go to yes.idaho.gov and look under Parents or ask your Wraparound Care Coordinator for a copy.
- It is always a good idea to keep copies of assessment results and mental health and medical testing. If your provider does not offer you a copy it is okay to ask for one!
- If at all possible, get your child involved in this process. Ask them to tell you about their goals and what they want their life to look like. Gathering this honest feedback will help the Wraparound team create a more meaningful plan.

"Silent has the same letters as Listen.

Reactive has the same letters as Creative."

Things to Think About

- What is the best possible future for your family?
- How will you know when you have reached your goals?
- Do you have any cultural traditions your Wraparound team should know about?
- Do you have any supports that are helping your family now?
- Do you have supports that you have tried and did not work?
- Are there any supports that you wish you had?
- What does a crisis look like to you?

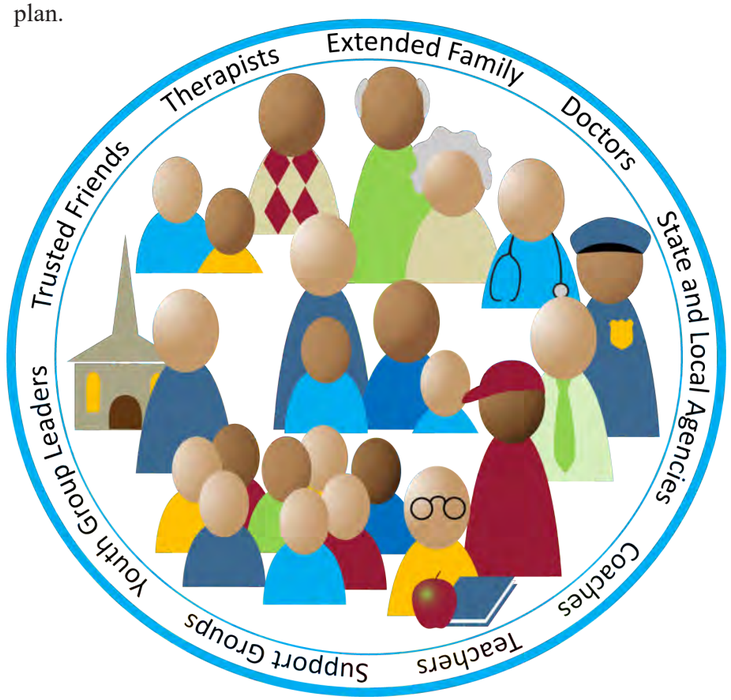
People to Include

Generally it is up to you and your child to decide who you want to include on the Wraparound team. For many families, the existing Child and Family Team (CFT) is included, but it is not required to include everyone. It is also possible to include other members that are not on your current CFT. Your Wraparound Care Coordinator

participate on your team. It is important to identify team members

s needs change.

Some families may be involved in many systems, such as children's mental health, developmental disabilities, special education, juvenile justice, and/or child protection. Families may choose to have representatives from each of the involved agencies participate on the Wraparound team to help create goals that include their unique perspectives. If your family chooses not to include representatives from these agencies, you will need to work with those agencies individually and their goals may not be included in your Wraparound plan.



The Wraparound Team

Roles of the Wraparound Care Coordinator

The Wraparound Care Coordinator is trained to help you and your child create a unique plan to reach your long term goals. They are

- Getting to know you and your child
- Helping you create an initial safety and crisis plan
- Helping you select members for your Wraparound team
- Managing meetings
- Assisting the team in creating the Wraparound plan
- Doing the paperwork
- Getting plans approved

Roles of Youth and Family

Your child is responsible for communicating their wishes to the Wraparound team to the best of their ability. Supported by a youth partner*, your child will be an active member of the Wraparound team and help identify desired goals and strategies to reach those goals.

As a parent or caregiver, you are responsible for participating in the Wraparound process by identifying goals, strengths, family preferences, and desired supports. Supported by a family partner*, you will be an active member of the Wraparound team and will work with the Wraparound Care Coordinator to create the plan.

The Wraparound team will assign action items to both you and your child during the Wraparound process.

*If youth or family partners are not available to participate on your Wraparound team, your Wraparound Care Coordinator can facilitate these duties.

Roles of Other Team Members

You will select people to be on your Wraparound team if they are involved with your child's care or if they are currently (or could be) a natural support to your family. They will participate in team meetings,

responsible for action items.

Remember

- Your coordinator will do many of the administrative tasks so that you can focus on your goals.
- Your voice is very important, so let your coordinator know if you have any questions or concerns.
- Involving your child in the process helps your Wraparound plan be more successful. If your child is having a hard time participating, talk to your coordinator.
- Don't forget the people who are already involved in your family's life. Many times they will have unique perspectives that can help you find unexpected strategies to reach your goals.

*Every **behavior** is the result of an **unmet need.** Your Wraparound team is there to help you find **creative** ways to meet those **needs.***

Remember

- Every Wraparound plan is unique because every child and family is unique. That means the time it takes to reach the goals on your plan will be different than other families, and that is okay.
- Your Wraparound team is here to support your family. As you move through the Wraparound planning process the number of meetings will reflect your family's changing needs.
- If you are working with any child serving agencies, be sure to know how they will use the information gathered from the Wraparound process.
- The Wraparound model gives families the chance to give feedback on their experiences. You can use this opportunity to make the Wraparound process better for your family and your team.

Respect for Family

Your family is viewed as essential part of the Wraparound team and is supported, valued, and respected during the process. All members of the team will communicate openly and honestly with you and support your family's culture and dynamic.

Typical Wraparound Length

Wraparound teams usually last between six and eighteen months before transitioning to less formal planning methods. Each child and

depends on your needs and the success of the strategies you select.

Typical Meeting Frequency

Meeting frequency will change over time. In the beginning your team will meet frequently to create a plan and start to implement it. As the team monitors progress and adapts the plan to meet your child's

As the plan stabilizes you may require fewer meetings until you need to

Confidentiality

The W
discuss the circumstances where information can be shared during the

please ask your Wraparound Care Coordinator.

Following the Guiding Principles

Each W
earlier in this handbook. During the teaming process there will be opportunities to give feedback to your Wraparound Care Coordinator and other members of the team to make sure your team is committed to the Wraparound model.

Creating a Wraparound Plan

Steps to Creation

During the Initial Plan Development phase, the Wraparound Care Coordinator will help you and your child identify goals and desired outcomes. Based on the feedback from the CANS, you will identify **life domains** you would like to improve and the type of support you will need to achieve those goals.

Life Domains

Your Wraparound team may choose which life domains need to be supported by goals. The following list is an example of frequently used life domains, although your team may identify items that are not on this list.

- Family & Relationships
- Home & a Place to Live
- Emotional
- Behavior
- Health & Medical
- Crisis & Safety
- Work
- School
- Legal
- Cultural & Spiritual
- Social & Recreational

Questions to Answer

need to ask yourself two questions:

- How will I know if this area has improved?
  - For example, in the school domain: "My child will attend all of his classes each week with no more than one absence."
- What type of support do we need to reach this goal?
  - For example, in the school domain: "My child will carpool with his best friend to school each morning," (logistical

    (service support)

Y
have a deadline.

Terms to Know

Life Domains:
Areas which are critical to the growth and development of a child and success of a family.

Types of Support

Based on your family's needs, there are four areas of support that are considered in Wraparound plans, namely:

- emotional support (love and understanding)
- behavioral support (mentoring or modeling)
- logistical support (organization and planning)
- service support (formal or natural)

Printed: 10/1/2019 1:25 PM - Idaho - OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

So how do we benefit exactly?

Goals of Wraparound

The W
supports and builds new relationships to increase your family's resource network. Wraparound plans are action plans that help your family learn the skills, develop the relationships, and practice the lessons you learned so you can successfully reach your vision of what you want in life.

It is not expected that your family will have resolved every challenge you face, or corrected every behavior you do not like when you transition away from Wraparound services. Instead, your family will transition to a less intensive planning process when you have learned the skills you need to create and manage your own network of successful formal and natural supports.

Remember

- Families that have used the Wraparound process learn how to seek out and develop natural supports to complement their formal supports.
- Having confidence in your ability to make and reach meaningful goals increases your likelihood of success.

Transitioning from Wraparound

How long do we have to do this?

Desired Outcomes

Your Wraparound team will continue to meet until your family has reached its goals or you make a decision to stop. Typically this will take between six and eighteen months.

If you complete the Wraparound process, you should have reached the

and natural supports.

Celebrations

Many families choose to hold a celebration when they have reached their goals and are ready to transition away from the Wraparound teaming process. This is an optional activity and can be tailored
s needs. Some families choose to have a party, while some prefer a much smaller way to acknowledge their success. You will plan this with your Wraparound Care Coordinator to be meaningful to your family.

Re-Entry if Needed

Your Wraparound transition plan will include information to help you decide if your child should re-start the Wraparound process in the future. When you complete your transition, you will be given a copy of your planning documents to assist you in starting the process again if needed.

Remember

- Every Wraparound plan is unique and the time it takes to reach all of the goals will vary.
- Reaching the goals of your Wraparound plan is an accomplishment to be celebrated. Take time to talk with your Wraparound Care Coordinator about a meaningful way to mark the occasion. For some families a small party is appropriate, but there are other ways to celebrate and your coordinator can help you find the method that best suits your family.

Notes and Contacts

Wraparound Care Coordinator: _____

Youth and Family Partners: _____

_____

Other Team Members: _____

_____

_____

_____

_____

_____

_____

_____

Notes: _____

_____

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_____

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_____

_____

YOUTH EMPOWERMENT SERVICES

Wraparound for Families AT A GLANCE

What is Wraparound?

Wraparound is a team-based, family-driven, and youth-guided planning process that is driven by a set of guiding principles:

- Family Voice & Choice
- Team-based
- Natural Supports
- Collaboration
- Community-based
- Culturally competent
- Individualized
- Strengths-based
- Outcome-based
- Persistence

Using these principles, a Wraparound Care Coordinator will provide a structured planning process that supports your family's vision and desired outcomes utilizing strengths and needs specific to your child and family. Wraparound is structured into four distinct phases with facilitated components and activities:

- Phase 1: Engagement
- Phase 2: Initial Plan Development
- Phase 3: Plan Implementation
- Phase 4: Transition

FOR MORE INFORMATION

Visit the Youth Empowerment Services (YES) website to learn more about YES and Wraparound

yes.idaho.gov

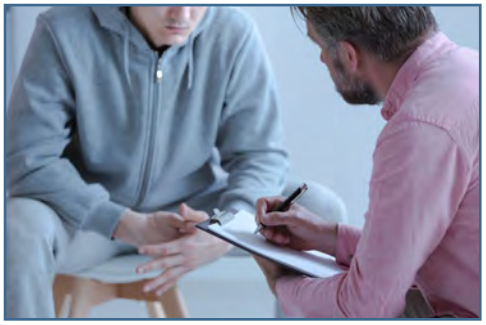
How Can Wraparound Help Me?

The Wraparound planning process benefits your family by identifying a support team that works together to find solutions for your family. Your child and family's voice is at the center of everything your team will do.

Should you decide to participate in Wraparound, the Wraparound Care Coordinator will work closely with you to begin your Wraparound planning process. The Wraparound planning process is anchored in your family values and works to balance formal and natural supports to help your family learn the skills, develop the relationships, and practice the lessons you learned so you can successfully reach your vision of what you want in life.

How Do I Get Started?

Wraparound is part of the Youth Empowerment Services (YES) system of care in Idaho.



Wraparound is intended to assist youth and families who may be experiencing a high level of needs or are at risk of more intensive services, including out of home placement.

To get started with Wraparound, contact your Child & Family Team (CFT) and have a Child and Adolescent Needs and Strengths tool (CANS) completed.

Based on the outcome of the CANS, your CFT and you can identify the supports and services that may be beneficial for you and your child.

If the CANS indicates a need for Wraparound, contact your local Children's Mental Health regional office to start the Wraparound process. Your child and your family will be screened for Wraparound and a Wraparound Care Coordinator will begin to discuss with you and your child the Wraparound planning process.

IDAHO DEPARTMENT OF HEALTH & WELFARE

Brad Little – Governor
David Jeppesen – Director

ROSS D. EDMUNDS– Administrator
DIVISION OF BEHAVIORAL HEALTH
450 West State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-6997

Title: Idaho Children's Mental Health Screener is available for use!
The Idaho Children's Mental Health Screener is available! You can access it online at www.IdahoCMHScreener.com

What is it?
The Idaho Children's Mental Health Screener can be used to help identify youth with unmet mental health needs.

This screener was developed from the Child and Adolescent Needs and Strengths (CANS) tool. CANS Certification is not required to use the screener. The Idaho Children's Mental Health Screener cannot be used in place of a complete CANS assessment. It is one of many tools a provider can use to identify unmet needs.

Who can use the Screener?
The screener was specifically designed for practitioners in a non-mental health setting. Family doctors, mental health providers, probation officers, and others may use the screener if there is an indication that the youth may need help with their mental health.

Where to find the Screener
The Idaho Children's Mental Health Screener is available online at www.IdahoCMHScreener.com

Resources
You can also use a paper version, and view this and other resources here on the YES Website/Healthcare Providers page.
Weekly Q&A Sessions are being held at the dates and times below. All times are in Mountain Standard Time. Please be sure to click the link and register for the session you wish to attend. The Q&A Sessions will go over how to administer the Idaho Children's Mental Health Screener and answer any questions. If you have any questions, please contact the Automation Help Desk at: 208-332-7316 or Toll-free: 844-726-7493 or via email: IDAutomationHelpDesk@dhw.idaho.gov

Date	Start Time	End Time	Registration Link
7/15/19	1PM MST	2PM MST	https://idhw.webex.com/idhw/k2/j.php?MTID=te7fd223f14f1cd525558ba61b7675a2b
7/18/19	3PM MST	4PM MST	https://idhw.webex.com/idhw/k2/j.php?MTID=t7c8e08cd646e295eab1636af8bda44c7
7/23/19	1PM MST	2PM MST	https://idhw.webex.com/idhw/k2/j.php?MTID=td55463b8eeb055f5522332cd32938f4a
7/30/19	10AM MST	11AM MST	https://idhw.webex.com/idhw/k2/j.php?MTID=t03059e8ece3b3dc210b107ce49026e1d
8/8/19	10AM MST	11AM MST	https://idhw.webex.com/idhw/k2/j.php?MTID=t5fa7aa7cdb68c2c919303f5ab923d428

Date	Start Time	End Time	Registration Link
8/16/19	2PM MST	3PM MST	https://idhw.webex.com/idhw/k2/j.php?MTID=t96269fd486d06963ec7a8d0afbdede06
8/20/19	10AM MST	11AM MST	https://idhw.webex.com/idhw/k2/j.php?MTID=t91f508e6a82a169a75bcca6975cf13d0

YES Project Status Report

Goals & Accomplishments: July 2018 - June 2019

JULY - SEPTEMBER 2018

ACCOMPLISHMENTS

- Continued CANS training and certification for providers
- Improved existing services and supports to meet YES standards
- Standardized agency use of YES Principles of Care and Practice Model
- Approved plan for development of centralized complaint process
- Released mental health checklists in schools statewide
- Released mental health screening tool for medical/mental health providers statewide
- Released RFP for Youth and Family Involvement
- Released RFP for Voucher Respite for families over 300% Federal Poverty Level (FPL)
- Expanded Wraparound operations
- Continued provider training on YES services, System of Care requirements
- Initiated judicial outreach

OCTOBER - DECEMBER 2018

ACCOMPLISHMENTS

- Completed transition from CAFAS to CANS
- Statewide access to CANS
- Published Workforce Development Plan Annual Report
- Continued CANS training and certification for providers
- Improved existing services and supports to meet YES standards
- IDJC staff certified in CANS
- Implemented centralized complaint system (short term)
- Continued family and community outreach and training
- Continued provider training on YES services, System of Care requirements
- Initiated tribal outreach
- CANS for Families video available to physicians, assessors, families
- Published Youth version of Mental Health Checklist

JANUARY - MARCH 2019

GOALS

- Publish Practice Manual
- Award contract for Youth and Family Involvement
- Award Voucher Respite contract
- Implement YES Access Model and Developmental Disabilities (DD) integration
- Initiate outreach to detention and probation
- Launch e-learning training on Principles of Care and Practice Model for agency partners and DBH staff
- Continue Wraparound operation expansion
- Complete planning for implementing over 300% FPL solution
- Continue family and community outreach and training
- Continue provider training on YES services, System of Care requirements
- Complete planning for May Transformational Collaborative Outcomes Management (TCOM) Conference
- Continue judicial and tribal outreach
- Continue CANS training and certification for providers
- Continue to keep Idaho School Districts informed of YES

APRIL - JUNE 2019

GOALS

- Approved model for Treatment Foster Care (not billable)
- Practice Model and Principles of Care added to Optum provider and member manuals
- All providers treating children use CANS (by 7/1/19)
- Implement new and existing services and supports to meet YES standards
- Implement Statewide Access Model
- Deliver online Children's Mental Health Screener
- Develop long term plan for centralized complaint system
- Hold Northwest Transformational Collaborative Outcomes Management (TCOM) Conference
- Developmental Disabilities process aligns dual eligibility with Liberty
- Implement solution for serving families over 300% FPL
- Continuous Quality Improvement Monitoring developed
- System to administer Flex Funds in place
- DBH Plan for Crisis System Development
- Criteria for Medicaid programs (3): Day Treatment, Intensive Home and Community based Services and Therapeutic After School & Summer Programs

Visit the YES website for more information:

www.yes.idaho.gov

Empowering the mental wellness of children, youth and their families.

Second Annual Implementation Progress Report

May 31, 2018

Submitted under the
Settlement Agreement in
Jeff D. et al. vs. C.L. "Butch" Otter et al.

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Youth Empowerment Services
Second Annual Implementation Progress Report

I. Introduction

On June 12, 2015, the State of Idaho finalized a Settlement Agreement with Plaintiffs regarding the *Jeff D. et al. vs. C.L. "Butch" Otter et al.*, Case No. 4:80-CV-04091-BLW class action lawsuit[1]. The Settlement Agreement required that an Implementation Plan be developed and an annual Progress Report be delivered to the Court and Plaintiff's counsel on progress the State has made operationalizing the Plan.

On April 29, 2016, the State submitted the required Idaho Implementation Plan[2] to the Court, which was subsequently approved. The Idaho Implementation Plan describes how the State will develop and implement sustainable, accessible, comprehensive and coordinated service delivery of publicly funded community based mental health services to children and youth with serious emotional disturbances in Idaho. Working with youth to help brand the effort, the state chose the name, "Youth Empowerment Services" (YES) for the new system.

This report, the Second Annual Implementation Progress Report, details the ways in which the State of Idaho, including the Idaho Department of Health and Welfare (DHW), State Department of Education (SDE), and Idaho Department of Juvenile Corrections (IDJC), are working together to meet the requirements in the Settlement Agreement and transform the mental health service systems for children and youth into an integrated system of care. The report provides information on accomplishments and progress on meeting obligations under the Settlement Agreement, remaining tasks, challenges to completing the objectives, and next steps in achieving the objectives of the Implementation Plan.

The Idaho Implementation Plan was organized around seven objectives necessary to accomplish the required outcomes of the Settlement Agreement and meet to the exit criteria. This report follows those seven objectives so that both progress and concerns are tracked and reported as the YES program evolves over time.

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[1] A full description of the history of the Jeff D. class action lawsuit is contained in Appendix A of this progress report.

[2] . Click here to access the full Idaho Implementation Plan. Additionally, some Strategies were reported on in last year's Annual Implementation Progress Report. That report can be accessed here.

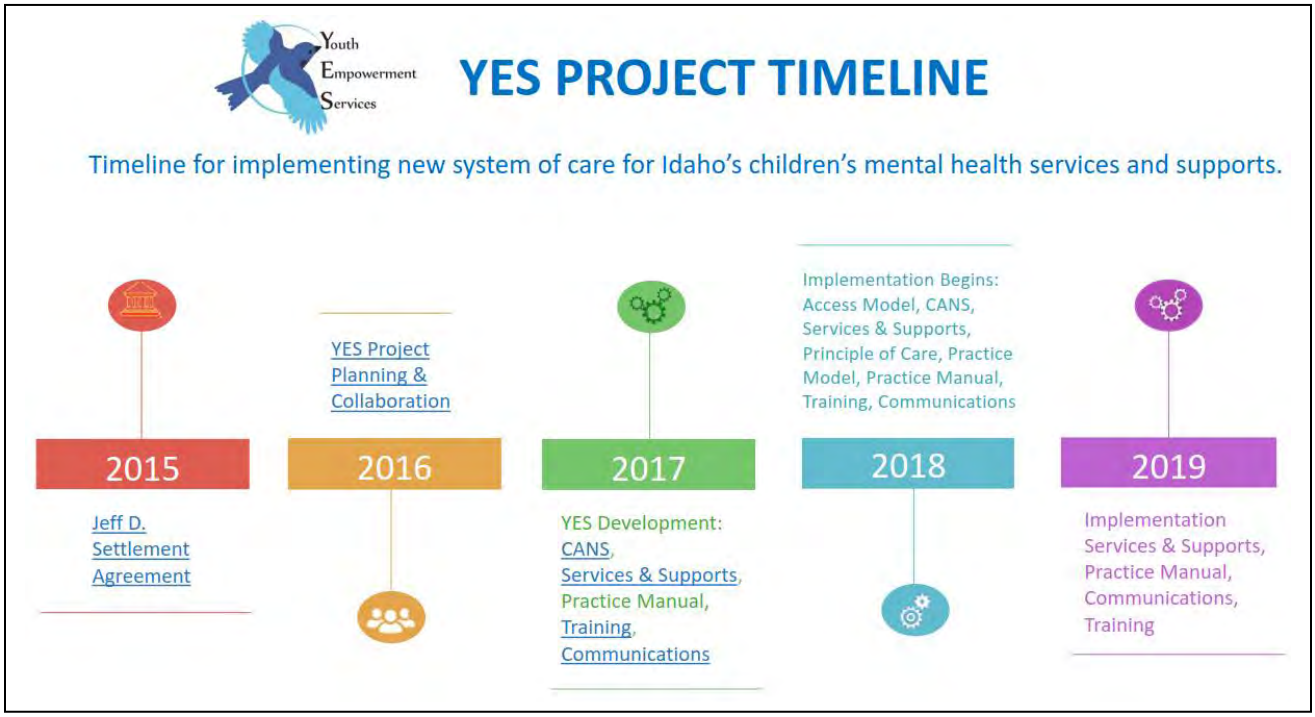
***If you are reviewing this report via printed copy, please visit the YES website to access the digital version/ for quick links to referenced documents provided within the report: www.yes.idaho.gov**

II. Executive Summary

Idaho's YES system partners are committed to developing statewide capacity to provide services and supports that are capable of meeting the needs of children, youth, and families in scope, intensity and duration. The development of the YES system is based on the requirements in the Settlement Agreement for establishment of YES Principles of Care and Practice Model, the YES Access Model, and the YES Workforce Development Plan (WFD). Additional elements of the YES system that will be transformed include building or enhancing the infrastructure that is needed to sustain the YES system such as due process, an interagency governance structure, and a coordinated collaborative process for quality management improvement and accountability.

The transformation of the child serving system into the YES system will take place over the next two years, with services and supports to be available within four years of the Settlement Agreement and a period of three years of sustainability which will begin in 2020.

The following diagram is a high-level overview of planned timelines to implement the YES system:



The planned transformation of children's mental health services in Idaho into the YES System requires the development of infrastructure to support the goal of implementing a sustainable, accessible, comprehensive and coordinated system. A majority of the work and resources have been focused in establishing that framework. There have also been changes made that directly impact children, youth and families that will result in

improved outcomes. Highlights of the achievement of transformation goals over the past year and significant work ahead are noted below.

Highlights of Achievements:

1. Enhanced collaboration and coordination between DHW, IDJC, and SDE to reduce fragmentation.

Key to the state's operationalization of YES has been continued collaboration across state administrative divisions and agencies. There are several collaborative workgroups that have been implemented over the past year that are working to establish the foundations for a system of care that is operating to reduce barriers for children, youth and families. The workgroups and committees include the Interagency Governance Team (IGT), the Quality Management Improvement and Accountability (QMIA) Council, the Communications workgroup, the Practice Manual Workgroup, the Due Process Workgroup, and the Workforce Development Workgroup.

There is a Memoranda of Understanding (MOU) which has not been fully executed[3] that will formalize the relationship between the various components of the child serving systems. With each success and challenge the YES system partners are learning more about how best to transform the system so that it reflects the desires of the community, as well as what is sustainable and achievable in operations, and will meet the requirements of the Settlement Agreement.

The State has also developed the Idaho Transformational Collaborative Outcomes Management (TCOM) Model describing how data will be used to assess and improve the system of care. TCOM is described as a conceptual and practical framework for managing complex systems.

2. Enhanced access to Medicaid benefits to increase access to mental health services.

To increase access to services Medicaid developed and submitted a 1915(i)-state plan option application to the Centers for Medicare and Medicaid Services (CMS) that establishes eligibility to Medicaid for YES program class members with family incomes from 150-300% of the federal poverty level (FPL).

As part of the 1915(i) option, Medicaid-reimbursed respite services were initiated. Full implementation of the Medicaid reimbursed agency-based respite services and companion certification requirements is scheduled for July 2018.

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[3] The MOU has been signed by IDJC and SDE and is currently being reviewed by the Director of DHW.

In addition, Medicaid is improving access to Psychiatric Residential Treatment Facilities (PRTF) services by streamlining the review process to better meet its obligations under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements for Medicaid programs. The Department of Juvenile Corrections has advanced its Behavioral Health Referral pilot that promotes identification of youth mental health needs to assist staff in determining appropriate placement/treatment as early as possible. IDJC staff is also being trained on how the CANS can help staff improve outcomes for involved youth.

3. Implementation of the Child and Adolescent Needs and Strengths (CANS) assessment to identify and screen potential class members and link them to care according to consistent procedures.

The CANS and ICANS, the automated system for documenting CANS assessments, are operational in all seven regions of the state. As of March 31, 2018, there were 212 individual active CANS certifications. As of April 30, 2018, there were 521 Children's Mental Health CANS administered by Division of Behavioral Health (DBH) staff, and 484 CANS 50s administered by the Independent Assessment Provider. Idaho expects to meet its goal for beginning to use the CANS statewide by July 1, 2018.

4. Engagement and involvement of youth and families of Class Members in system improvement and planning efforts.

Of significant note is the ongoing development of the relationship among the partners and the families in Idaho in the work to build the YES system of care. Organized and branded as the "Parent Network," parents of children with serious emotional disturbance (SED) have joined the project as partners in achieving this transformation.

In recognition of the value of parents' and youth voice in the project the state has developed a method for compensation for their time. The state designated a Family Liaison, and has provided opportunities to youth and parents to participate in developing training content and deliver YES-related trainings that are reflective of family voice. The state is also engaging the Parent Network and youth organizations to help create content for YES materials, and to review content of informational materials to improve readability and comprehension.

Youth have assisted with creating content for the *Introduction to Youth Empowerment Services* guide, Youth Frequently Asked Questions document, and have begun working on a preliminary checklist that youth can use to pre-screen themselves and start the conversation about their mental health needs. Youth have also provided feedback on training content and are currently assisting with the development of a youth-targeted training plan.

Information for parents, youth and other stakeholders about YES have been developed and communicated through:

- YES website with Parent and Youth voice, addition of Spanish translation site, training page for training information and registration links, training videos, calendar of events, and downloadable YES materials
- ICANS website for CANS users which includes announcements, training information, resources and user guides, FAQ's and information for families
- YES Training playlist on Idaho Department of Health and Welfare's YouTube Channel
- Idaho Department of Health and Welfare (DHW) Social Media blog post regarding the Independent Assessment process and Mental Health Assessments available
- Idaho DHW Twitter messaging

To build a program that supports and sustains family and youth involvement at all levels of the YES program, the Department of Health and Welfare's Division of Behavioral Health is developing a *Family Youth Involvement and Support* contract. Details regarding this contract can be found in Appendix G.

5. Established a collaborative governance structure that includes Defendants agencies, Class Member's families and other stakeholders.

The Interagency Governance Team (IGT) began meeting in October of 2016 and continues to meet monthly. The IGT is intended to facilitate collaboration among agencies and stakeholders, increase transparency and accountability, and afford opportunities for team trouble-shooting and problem-solving. The IGT membership includes parents, a former Class Member, family/youth advocacy representatives, providers, and agency representatives from Medicaid, DBH, SDE and IDJC. During this past year, the IGT members have formed both the Family Engagement Subcommittee and the Clinical and Training Subcommittee. The IGT also drafted and approved Operational Guidelines that outline the team's processes and procedures.

6. Implemented Legislative Changes

The 2017 legislative session was successful in terms of advancing the Idaho infrastructure in support of the new system of care. Legislative allocations were secured for adding staffing resources to the Division of Behavioral Health (DBH) needed to implement the project objectives and operate the new system. Further, the legislature approved a modification of state statute to allow children with serious emotional disturbance access to Medicaid up to 300% of the federal poverty level. The Divisions of Medicaid and Welfare developed and presented Idaho Administrative Procedure Act (IDAPA) rule changes to implement this statute change, these rules were approved. Since increased of traditional income limits will enable larger numbers of families to become eligible for Medicaid coverage, the state anticipates that this change will allow additional children with SED in Idaho increased access to care.

7. Planning for a new Adolescent State Hospital Facility[4]

The Idaho State Hospital System is a government not-for-profit healthcare system that serves as a safety net for those who are unable to get their behavioral health needs met in Idaho's community psychiatric hospitals. The goal is to improve the Behavioral Health and wellbeing of individuals emphasizing care that is trauma informed, patient centered and physician led. Idaho State Hospitals are under the Division of Behavioral Health (DBH) within Idaho Department of Health and Welfare.

The current adolescent unit is on the State Hospital South campus located in Blackfoot Idaho. The unit is a 16-bed facility that cares for youth age 12-17. Approximately 65% of the adolescents admitted come from the Treasure Valley. Locating the adolescent care in a new hospital in Nampa Idaho will offer care and treatment closer to most patient families and increase the ability to have family involvement. The location of the of the new hospital will also give greater ability for families to be part of the transition services for the youth.

The new hospitals' planned opening is the summer of 2020.

Idaho still has significant work ahead, including:

1. Developing a comprehensive and collaborative system of care.

Developing and implementing a comprehensive system of care that connects multiple, fragmented service systems operated by a diverse array of state agencies (State Department of Education, Idaho Department of Juvenile Corrections, and within the Idaho Department of Health and Welfare, the Divisions of Medicaid, Behavioral Health and Family and Community Services) in compliance with the deadlines required by the Settlement Agreement was always expected to be a big lift. The leading challenges involve system design and integration, payment mechanisms, and ensuring fidelity to the YES principles of care and practice model.

Children and families who need access to agency respite, or who have income between 185 and 300 percent of the federal poverty line, must use the 1915(i) procedures to access YES. Families and youth who already have Medicaid, and those who are over income, access services in other ways. Moreover, each of these pathways has different funding characteristics, mixing federal, state and, private resources. Managing these multiple access pathways and funding streams poses many challenges that are still being worked out.

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[4] While not specifically related to the Implementation Plan the Adolescent Unit of the State Hospital System will improve children's mental health services and was therefore included in the report.

In addition, existing mental health services provided in Idaho—to say nothing of new services—are not yet consistently compliant with the YES Principles of Care or the YES Practice Model, as called for in the Settlement Agreement. Steps to resolve this challenge, including, developing operational policy and standards for provider contracts and provider manuals and training, remain to be completed.

2. Timely delivery of the full array of services required in the Settlement Agreement.

Development of the full array of services for Medicaid is underway, although not all of the required YES services are certain to be fully available statewide by July 1, 2019. The state does intend to have each Medicaid reimbursable service operationally defined and billable by then, as required.

Many YES services will require provider development and business diversification stretching the provider network both in their business and clinical models. As a state with many rural areas it is important to understand that some of the services require a population base and specialty network that is not realistic nor sustainable in those areas. This will require considerations and adaptations to meet the members where they are in their communities, working with the families to fill the gaps and/or linking to services in neighboring areas.

For services that require intensive development and adoption by the network, Medicaid will work with Optum Idaho to ensure availability in the highly populated areas that are likely to have providers with the ability to adopt and implement them. Work will continue to expand service availability based on network capacity and workforce development.

Education and training are key components to prepare the network to provide the services beginning with the foundations of the Practice Model and Principles of Care to support the service delivery. Optum Idaho has contracted with the Praed Foundation to train and support the network for the CANS implementation and changes to the treatment planning process. Implementation of Child and Family Teaming will begin July 1, 2018 and evolve with inclusion of the ICC and Wraparound models in January 2019. Medicaid is working closely with Optum to offer trainings with no/to low cost to support the network in engagement and attendance. Additional considerations include scholarships and financial support for providers in rural areas that could not sustain absences to participate in trainings which would result in significant loss of billable time.

Detail to support the service implementation plan can be found under Strategy 1.J within this report.

3. Workforce issues, such as training, recruitment and retention will be an on-going challenge.

Implementation of the Workforce Development Plan will continue. Included in this plan is the development and training of an adequate workforce and provider network to support and implement the YES compliant array of services, and meet the needs of children, youth, and families.

Foundational trainings about the YES program were attended by 94 agencies and more than 290 individual providers. Topic areas included: introduction to the Settlement Agreement, a high-level introduction of the Principles of Care, Practice Model, Child Family Teams, Wraparound, CANS, and the Access Model.

As the system evolves and develops, evaluating service gaps and reimbursement methodologies will continue. Network capacity reports, utilization data, and provider readiness surveys can assist in informing next steps needed to increase access. Alternative reimbursement methodologies will support quality outcomes and provider development. Also, work continues regarding provider recruitment and the use of telehealth, especially for rural areas.

4. Guidance and Communications about the nature and purpose of services and how to access them.

The intended purpose of the YES Practice Manual is to provide information to all Stakeholders about YES services and supports and how they can be accessed. There were several challenges which delayed the publication of this document, however a smaller introductory guide was developed to satisfy the immediate need for information. Going forward, the state will make amendments to the guide periodically as more services come on line and as managers, providers, and families test and work to improve the system. More information regarding Practice Manual progress, challenges and next steps can be found here.

5. Developing quality monitoring of mental health services for children and youth.

The YES quality monitoring processes are covered in the Quality Management Improvement and Accountability Plan (QMIA). In accord with that plan, the QMIA Council has been established and has implemented the Data and Report (D&R) Subcommittee. The D&R Subcommittee is working on identifying methods for collecting meaningful collaborative system data to inform quality improvement, measure processes, outcomes and impact, and communicate about system performance. Reports on YES system quality (QMIA- Quarterly) have been published on the YES website. Reports on system capacity, projected numbers of class members, and the potential need for Intensive Care Coordination/Wraparound are available on the website as well. The data

collection based on CANS is in development and reports are in the early stages of development.

6. Due Process

It is the goal and obligation of the state to operate a Constitutionally and federally-compliant fair hearing system, in part by creating and operating a centralized complaint routing and tracking system. Furthermore, each child-serving agency will implement a process for reviewing compliance to applicable regulations, rules, and policies regarding due process requirements, and periodically report on the metrics of operating this system. This entire process will be included in the Practice Manual and will be coordinated with the Quality Management, Improvement, and Accountability (QMIA) goals, plans, or results.

In seeking to achieve these results, a few challenges have arisen, including a changing federal landscape relating to Medicaid regulations. As a result, there appear to be conflicting requirements in the law and the terms of the Settlement Agreement and Implementation Plan. In addition, procedural variances among agencies need to be ironed out, the fix for which may require changes to Idaho Administrative Code (IDAPA) rules. Finally, improving the notice and appeals process through more family-friendly language and procedures is needed.

III. Structure of the Annual Implementation Progress Report

The Annual Implementation Progress Report is organized as follows.

Sections I and II provide an Introduction and Executive Summary. The Executive Summary provides a brief overview of the State's progress in developing and implementing YES.

This section, Section III describes how the Report is structured.

Section IV reports the progress towards achieving the Objectives of the Court approved Implementation Plan, challenges, and next steps to address any identified problems. The section is organized into the following chapters which correspond with the Implementation Plan Objectives:

1. Services & Supports
2. Principles of Care and Practice Model
3. Access Model
4. Workforce Training and Development
5. Due Process
6. Governance and Interagency Collaboration

7. Quality Management, Improvement, and Accountability

Each of the seven chapters contains information about the implementation progress and accomplishments, challenges and next steps. The narrative provides a summary of activities taken to achieve the Objective. The Challenge sections describe issues or barriers that have impacted progress, and the Next Step sections include plans to resolve challenges and/or facilitate continued progress toward implementation.

Section V of the Report provides information on the progress towards achieving the Settlement Agreement Outcomes which are the expected results from completing the Implementation Plan. The Outcomes are listed within the table and there is a link provided to narrative that is associated with the section in the Court approved Implementation Plan.

Following Section V is a Glossary and Appendices providing additional information relevant to the Report.

IV. Progress in Achieving Implementation Plan Objectives

This section of the Report addresses each Objective in the Court approved Implementation Plan and detail the progress toward achieving the strategies listed in the plan.

Each **Objective** below is written as stated in the Court approved Implementation Plan and is accompanied by a brief description. The *Strategies* under each objective (bolded) are stated in a summarized version. Some *Strategies* may be grouped together since they may build upon each other or are otherwise connected.

Objective 1: Provide Services and Supports to Class Members consistent with the Agreement

The agencies will progressively make available to Class Members and their families the medically necessary services/supports as described in the Agreement to match the Class Members' strengths and needs in a timely manner.

Strategies 1.A- 1.D

A. Operationally define the array of services and supports.

As noted in the first Implementation Progress Report, a team of agency staff, parents and other stakeholders (the Services and Support Workgroup) reviewed the 26 services listed in the Settlement Agreement Appendix C in 2016, researched what was being provided, looked at how other states were providing services, and made some recommendations about how to improve services in Idaho. A second group (the Clinical Advisory Workgroup), also reviewed the services to add clinical details to the service definitions.

These service definitions and clinical recommendations were provided to Medicaid to determine which of the services, as defined, could be reimbursed through Medicaid and if there are any parts of the services that cannot be reimbursed under Medicaid authority. The result of Medicaid's analysis was a determination that most of the services and supports will be Medicaid reimbursable, and the services or parts of services that cannot be reimbursed by Medicaid will be developed by the other partners.

The Medicaid reimbursable services include:

1. Child and Adolescent Needs and Strengths (CANS)
2. Comprehensive Diagnostic Assessment
3. Neuropsychological
4. Psychological Testing
5. Case Management
6. Integrated Substance Use Disorder Services
7. Treatment Planning
8. Case Consultation
9. Intensive Care Coordination
10. Medication Management
11. Psychotherapy
12. Respite
13. Transportation
14. Psychoeducation
15. Family Support
16. Youth Support
17. Skill building
18. Behavioral Therapeutic Aide
19. Therapeutic After School and Summer Programs
20. Intensive Home and Community Based Services
21. Day Treatment
22. Inpatient Hospitalization
23. Treatment Foster Care (partial coverage)
24. Psychiatric Residential Treatment Facility (PRTF)
25. Crisis Response
26. Crisis Intervention
27. Crisis Respite

The non-Medicaid reimbursable services include:

1. Flex funds
2. Respite provided by family members
3. Treatment Foster Care (partial coverage)

B. Determine which services and supports are currently available

The following mental health services are currently available to children and youth when they will correct or ameliorate the child's behavioral health condition:

- Comprehensive Diagnostic Assessment
- Neuropsychological Testing
- Psychological Testing
- Medication Management
- Psychotherapy (Individual, Group and Family)
- Case Management
- Community Based Rehabilitation Services (CBRS)
- Respite
- Family Support Services
- Intensive Outpatient Services/Day Treatment
- Wraparound
- Inpatient Hospital Services
- Psychiatric Residential Treatment Facility (PRTF)
- Treatment Foster Care
- Transportation of Participant (or Participant and Family)

Not all services are available in all regions. PRTF is currently only available at an out-of-state facility. There are no Psychiatric Residential Treatment Facilities licensed or certified in the State of Idaho, although we expect one facility to become licensed in Summer 2018.

These services will not be YES compliant until implementation of the Practice Model and Principles of Care is complete, June 2019.

C. Determine which existing services and supports need to be modified

The mental health services provided in Idaho (e.g. those listed above) are not consistently compliant with the YES Principles of Care or the YES Practice Model, as called for in the Settlement Agreement.

In order to assure that services are YES compliant The Divisions of Medicaid and Behavioral Health (DBH) plan the following:

- Develop operational policy and standards for application of the Practice Model and Principles of Care to be referenced in contracts and incorporated into provider manuals, practice standards, and training.
    - Medicaid collaborated with DBH and the State's consultant, Dr. Lynn Thull, a contractor of the Praed Foundation, to create operational documents to support the education and implementation of the Practice Model and Principles of Care
    - Optum Idaho's provider manual will include the reference and requirements for providers to adopt these in their practices

    - Optum Idaho will include these components in their training curriculum
- Implement CANS as the required assessment and communication tool for mental health providers serving children and youth.
    - Optum Idaho has contracted with the Praed Foundation to provide CANS training over the next year with the goal for all providers serving youth to utilize the CANS by June 2019
    - Optum has collaborated with DBH to focus on high volume providers serving youth to become compliant in use of the CANS on the web-based ICANS platform beginning July 1 2018
- Provide CANS Training for all qualified providers (CANS training details here)
    - To support the network fully utilizing the CANS by July 2019, Optum Idaho has contracted with the Praed Foundation to conduct trainings throughout the next year and with DBH to provide ongoing trainings for the ICANS platform. Plans also include how to maintain training availability based on growth and addition of new providers in the network.
- Provide training for DBH Children's Mental Health Regional Clinic staff
    - 2nd session of 4-day Wraparound Coordinator training by Portland State University (June 25-28)
- Provide training for all Medicaid contracted mental health providers
    - 2017 and planned 2018 training to improve current and implement new services include;
        - YES Navigation Series (YES foundation, services, level of care guidelines, Treatment Planning, Provider Manual, Practice Manual, Reimbursement)
        - Child and Family Team, Person-Centered Planning, and Wraparound participation
        - Skill Building/Community Based Rehabilitation Services Series
        - Respite Series
        - Crisis Intervention
        - Psychoeducation
    - 2019 Planned training to improve current and implement new services include;
        - Case Management
        - ICC
        - Child and Family Team, Person-Centered Planning, and Wraparound participation and facilitation
        - Crisis Response
        - Crisis Respite
        - Family and Youth Support
        - Day Treatment
        - Therapeutic After school and summer based programs
        - Integrated Substance Use Disorders
        - Behavioral Therapeutic Aide
        - Intensive Home and Community Based Services

- Develop the Medicaid Provider Manuals, Medicaid Member Handbooks, and the YES Practice Manual.
- Conduct QA including Fidelity based on the Quality Management Improvement and Accountability (QMIA) Plan, the Transformational Collaborative Outcomes Management (TCOM) Model, and the Quality Review.

YES Focus on Case Management

Medicaid is working to develop a new service coordination and case management model with requirements for the case management network serving children with mental health needs. Medicaid has issued an Request for Information (RFI) regarding System of Care navigation, person-centered plan development, child and family team facilitation, case management, service coordination, Intensive Care Coordination, and monthly monitoring of Medicaid SED Program participants to gain information for implementation in early 2019.

D. Determine which services and supports need to be added

The Medicaid implementation team has been developing strategies for the implementation of additional Medicaid Mental Health services and supports based on technical assistance provided through interactions with The Centers for Medicare & Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA) and the Technical Assistance Network (TAN). As explained above, Medicaid is working on the development of the new services that will meet Medicaid authority and reimbursement requirements. These include:

1. Psychoeducation
2. Youth Support
3. Behavioral Therapeutic Aide
4. Day Treatment
5. Therapeutic After School and Summer Programs
6. Intensive Home and Community Based Services
7. Crisis Respite
8. Crisis Response

YES Focus on adding Respite and Wraparound

Respite

In the Fall of 2017, Medicaid focused on implementation of the new Medicaid reimbursable respite service for initial rollout in January 2018. This required collaboration with DBH to transition agency-based respite from DBH to a Medicaid-reimbursable service. This work will continue for a full launch of respite in July 2018.

Wraparound

Wraparound is a collaborative, team based, principles driven, planning process. Through the wraparound process teams create one individualized plan of care to meet the needs and improve the lives of multisystem involved youth and their families.

Wraparound

"Wraparound is a planning process that follow a series of steps to help children and their families realize a life that reflects their hopes and Dreams. Wraparound also helps to make sure children and youth grow up in their homes and communities. It is a planning process that brings people together from difference parts of the family's life. With help from one or more facilitators, people from the family's life work together, coordinate their activities, and move closer together in their view of the family's situation. The process of coming together always includes the family as a central partner in building as coordinated view. "

National Wraparound Initiative, Wraparound Implementation Guide

A sub-committee was created by the YES Clinical Advisory Committee in early 2017 which included parents, Regional Clinicians, and Children's Mental Health Chiefs to assess viable wraparound models to consider for the YES Program. The sub-committee identified the model of the National Wraparound Initiative (NWI) as an option for YES. The sub-committee presented their findings to the Clinical Advisory Committee and DBH leadership to inform decision making for implementing Intensive Care Coordination (ICC).

In July of 2017, seven Regional Program Specialists were hired by DBH as the first step to developing the workforce of Wraparound Coordinators. These Program Specialists were also selected to be the regional subject matter experts on the upcoming changes in the system of care.

DBH led the development of a contract with Portland State University (PSU) System of Care Institute (SOC-I) to provide a series of trainings on Wraparound, Child and Family Teams (CFT), and System of Care. In August of 2017, a contract was in place for the trainings, and the first System of Care trainings occurred in September for the Regional Program Specialists, Children's Mental Health Chiefs, Regional Managers, and other YES stakeholders.

The training phase for Wraparound began in February of 2018. During the training phase:

- The Wraparound roll-out started with offering services to existing DBH Children's Mental Health children, youth and families.
- Each Regional Program Specialist trained in Wraround coordination skills began with a target to serve 2 -4 families by the end of May.

Within two to three months of being trained, all seven Program Specialists are expected to be serving at least 4 families, and within 6 months up to 8 families. Additional DBH

staff (15 staff) will be trained to provide Wraparound June 25-28. This will increase the capacity for Wraparound services to approximately 130 families by the end of December.

Challenges

1. In order for YES services to be Medicaid payable, the following prerequisites must be met:
    - CMS approval of authority documents,
    - Legislature approval of rule changes,
    - Medicaid contracts or amendments to meet requirements,
    - Network capacity, access, qualification, and training.
    - As these conditions evolve and information is gleaned from reports and surveys, implementation timelines may accelerate or be delayed based on the network's readiness.
2. Medicaid and DBH are working together to identify all services that are required and which will not be Medicaid payable by June 2019. If required services are not Medicaid payable, DBH along with YES System partners will evaluate alternative funding options.
3. Access to Respite services is not Statewide as there are limited number of providers.

An additional challenge was contributed by parents working within the YES project:

- Making sure services are available to both Medicaid and non-Medicaid Class Members, including those over the 300% Federal Poverty Limit (FPL). Thus far, only a piece of this has been part of the discussion which is the sliding fee scale concept. There is more work to be done to be able to deliver coordinated services for all children.

Next steps

- Medicaid is developing a crosswalk that compares services that are payable or will be payable by Medicaid as of June 2019 with services that are required in the Settlement Agreement. This crosswalk will assist in identifying services that require alternative funding mechanisms.
- Medicaid is gathering the feedback received from families, providers and vendors regarding the Person-Centered Plan/ Case Management/ Monthly Monitoring Request for Information. Medicaid will discuss that information with both the IGT and IWG and, based on their feedback, will proceed with the development of a Request for Proposal for these services. Target implementation date is January of 2019.
- In concert with the Praed Foundation and Optum Idaho, the behavioral health managed care entity, Medicaid is developing targeted training and communications for all stakeholders, including Medicaid participants and the provider network.

- Optum Idaho, is working to increase the number of respite providers.
- An addendum to the contract with PSU to be completed by the end of June 2018 offers an opportunity to increase the trained wraround workforce so the DBH can expand access to Wraparound. The goal is to train 45 additional DBH staff by the end June of 2019.
- DBH will co-train Wraparound trainings with PSU beginning in early 2019 and will be the primary trainers for Idaho Wraround by fall of 2019.
- Work to align services and supports with the CANS (i.e., refining algorithms to improve accuracy) began in late Fall of 2017 after the CANS algorithms were finalized. This work continues as new information becomes available. Medicaid engaged the behavioral health managed care entity and the Praed Foundation to create a CANS/Level of Care Guidelines (LOCGs) crosswalk to assist DBH staff in developing the person-centered plan. This work will continue throughout the implementation of Medicaid YES services.

Services and Supports: Parent Perspective

"The Jeff D. settlement requires that all children with SED have access to the services and supports listed in the agreement. While many of these children will access services through Medicaid, others will access through Division of Behavioral Health or even through private providers. Meeting this requirement of the settlement agreement, a coordinated system of care that involves multiple payers, will require an intense level of collaboration among divisions and agencies that hasn't historically occurred in Idaho's children's mental health system. While much progress has been made in getting all of the partners to the table, the project faces challenges in making sure everyone is communicating in a way that encourages a coordinated system of care for ALL of the children represented by the Jeff D. settlement agreement."

Strategy 1.E

Determine reimbursement methodology and guidance to providers 60 to 120 days prior to rollout of each service

The service reimbursement methodology and guidance will be available to the provider network through the following process. 60-120 days in advance.

- Provider Alerts distributed via Fax, e-mail and website notifications to contracted providers
- Provider Newsletter Updates
- Training Announcement: Training overview, type and objectives of training certification/credentials/CEUs, and logistic details provided
- Service Notification: Service overview, reimbursement detail, service requirements, and level of care guideline

- Additional communication and support is provided by Optum staff statewide when interacting with providers in a variety of supportive roles

30-60 days prior to service implementation:

- Provider Manual Update Notification: Includes the updated provider manual content for review which is a contractually binding document
- Provider Agreement Update (if required): Provider contract updates if necessary
- Distribution of updated provider fee schedules

Next Steps:

- Quarterly provider training scheduled for June 2018 on YES services, Level of Care Guidelines, Provider Manual, /Reimbursement.
- Optum will implement an Evidenced Based Program (EBP) Library on-demand for Skills building topics, July 2018.
- Optum plans to provide training on Crisis Intervention September 2018.
- During the fourth quarter of 2018 Optum plans to provide training on Multi Family Therapy, Crisis Respite, and Psychoeducation.
- Additional training is planned for Quarters 1-4 of 2019.

Strategy 1.F

Reevaluate gaps and reimbursement methodologies to increase access to services statewide over time.

Plaintiffs requested that a crosswalk of all required services be developed to evaluate gaps in planned implementation of services, and the reimbursement methodologies to which the Defendants agreed. The crosswalk will delineate variations between the services required by the Settlement Agreement and the services that are billable by Medicaid. Once the differences between the requirements and the payable services have been identified the YES system partners will assess options for funding the remaining services.

As the system evolves and develops, evaluating gaps and reimbursement methodologies will continue. Network capacity reports, utilization data, and provider readiness surveys can assist in informing next steps needed to increase access. Reimbursement methodologies will support quality outcomes and provider development. Also, work continues for provider recruitment and the use of telehealth, especially for rural areas.

Strategy 1.G

Estimate and report the number of Class Members on an annual basis.

The Department of Health and Welfare (DHW) contracted with Boise State University (BSU) School of Social Work to evaluate the methodology used by the DHW to estimate Class Member potential service utilization in 2017. BSU's evaluation ultimately recommended that DHW continue using the 2016 estimation methodology as an interim strategy for monitoring progress toward meeting the needs of youth with a serious emotional disturbance (SED). Additionally, BSU recommended the Department work to

leverage data collected by national surveys to eventually develop a more robust Idaho estimate of SED. The full report, titled *Evaluation of a Methodology to Estimate the Prevalence of Serious Emotional Disturbance in Idaho*, can be found on the Idaho YES website. Click here to view this report.

The Class Size Estimation Team (CSET), made up of both DBH and Medicaid staff, have developed an updated Class Membership estimation report utilizing recommendations from BSU when possible.

The CSET estimated that there may be 35,000-40,000 children in the state of Idaho with SED. Of those, they estimated that 12,000-22,000 may seek to access mental health services at some point, either through the YES Program or through private insurance sector. It is expected that the initial engagement rates may be substantially lower based on many studies that have found that engagement rates vary between 34% (Zachrisson et al., 20006) to 56% (Bourdon et al., 2005) of eligible youth.

Intensive Care Coordination Utilization Estimate

To monitor progress toward meeting the needs of Idaho youth with serious emotional disturbance (SED), an estimate was needed of the number of youth who are likely to need/ utilize Intensive Care Coordination (ICC). The Department of Health and Welfare (DHW) contracted with BSU School of Social Work to estimate the need for ICC. For this projection, one of BSU's two methodologies utilized clients-served data from DBH, Medicaid and Family and Community Services (FACS). The second methodology resulted in three different projected levels of ICC utilization. This subsequent methodology was based on ICC utilization data from 11 other states and criteria outlined by the Centers for Medicare and Medicaid Services (CMS). The CMS criteria categorizes ICC programs into three phases of implementation, from newly emerging to well-established.

Projected number Youth to utilize ICC per year[5]

Level of Program Implementation	*Implementation Benchmarks*	*Projected # of Idaho Youth to utilize ICC per year, per 100,000*	*Projected # of Idaho Youth to utilize ICC per year*
Emerging	*High quality wraproud being piloted or in early stages*	*65*	*284*
Evolving	*Program is established and expanding Statewide*	*144*	*628*
Established	*Program is fully established and includes a full array of services and supports*	*318*	*1,389*

[5] Extracted from BSU report: *Estimated Need for Intensive Care Coordination among Idaho Youth*.

Based on BSU's full analysis, in 2016 there are approximately 1,400 Idaho youth who likely need ICC. The full report, titled *Estimated Need for Intensive Care Coordination among Idaho Youth*, can be found here.

Challenges

1. The defendant agencies do not share an electronic health record system and do not identify data variables in the same way, therefore data from each agency indicative of Class Membership status could not be consolidated or unduplicated.

Next Steps

- Continue to refine the methodology for estimating the expected number of Class Members. Refined methodology will need to consider ways to avoid duplicated counts of clients served across agencies.
- Explore the National Health Interview Survey (NHIS) restricted release data files application process to develop an Idaho-specific SED prevalence estimate based on Idaho state data.
- Use the Class Membership estimate to routinely evaluate system progress in meeting the needs of Idaho youth with SED.
- Develop reports addressing the current utilization of "intensive services" in order to establish a baseline for comparison as the YES system develop over time.

Strategy 1.H

Assess system capacity.

Building statewide capacity for services and supports began with understanding what the capacity is now in Idaho. The Workforce Development Team identified the methodology for this assessment would be in-depth provider survey and report on provider profiles. The purpose of the research was to assess current behavioral health workforce capacity and gaps in publicly funded services, synthesize the findings, and include this synthesis in a final Workforce Capacity and Gaps Analysis report.

To perform the work of analyzing the system capacity DBH contracted with BSU School of Social Work. Medicaid agreed to collaborate and utilize the results of that survey as a baseline before creating additional capacity studies specific to the Idaho Behavioral Health Plan (IBHP) network. A draft report has been delivered to DHW, and the final report will be published by the end of June 2018.

The survey that was conducted reached 250 organizational leaders of mental health programs and 142 solo practitioners. The response rate was 60%+ for both groups. Of the 152 organizational providers that responded 125 serve children and youth between the ages of 4-18, and of those 47 provide services to children between the ages of 0-3. Of the 92 solo providers 69 provided services to serve children and youth 4-18, and only 20 provide services to children 0-3. A large majority of the providers were white and female.

The BSU Provider Survey Report also has information about the communities they serve, types of services they provide, the languages they speak, how they provide services, how they conduct recruitment and what they do to retain staff at their programs. BSU's report includes recommendations that will be reviewed by the Workforce Development Team.

Next Steps

- DHW will utilize the gap analysis information to make informed decisions about what is needed to close gaps and improve workforce and service availability as the YES system continues to develop.
- The QMIA Plan includes measures to assess network capacity specific to services with provider-scarcity challenges (e.g., residential care, treatment foster care, therapeutic after-school and summer programs, etc.), as well as to evaluate the training needs, the impact on access to those services and identify the support the provider agencies need in growing and diversifying their businesses.

Strategy 1.I

Draft a Project Plan

The YES Project Plan was completed in 2016 and reported in the 2017 Annual Implementation Progress Report.

Strategy 1.J

Implement the full array of services and supports based upon prior Strategies by June 30, 2019.

The order in which the services will be implemented has been in flux. The information provided below is the current anticipated order of service implementation (as of May 31, 2018) and was built with input from the Plaintiffs and consultant Lynn Thull as well as considering clinical and network readiness concerns. The implementation timeline below targets all Medicaid reimbursed services being *available* by June 30, 2019; *this is a compressed timeline as the Defendants have consistently reported to the Plaintiffs and the Court that Medicaid reimbursed services would be rolled out through June 30, 2020. Based on the definition of available below*, Medicaid is working to make all Medicaid reimbursable services available by June 30, 2019.

Each service will be considered *available* when the following tasks are complete:

1. The service has been updated in or added to Medicaid authority documents,
2. Contracts and provider agreements have been updated to include the service,
3. Medicaid providers have access to the training,
4. The service has been added to the provider manuals and fee schedules,
5. Providers are able to enroll to bill for the service.

The actual *availability* of Medicaid-funded services shown below will depend on each provider's ability to engage in training and add these services to their scope of practice. Providers in the urban areas of Idaho are much more likely to be early adopters as they

serve larger populations, are more likely to be agencies rather than sole proprietors, and most likely have more resources available to expend on new service implementations. Medicaid and Optum Idaho have considered these challenges and are providing the following incentives to encourage the provider network to participate in training and provide the new services as quickly as possible.

- Training modules will be available through in-person classes, webinars, and online self-paced courses
- Training modules will provide Continuing Education Units (CEU)s at little or no cost to the provider network
- Some trainings and certifications may allow the provider to be eligible for a higher service reimbursement rate

Medicaid Service Implementation Timeline:

July 2018 – October 2018:

- Child and Adolescent Needs and Strengths (CANS)
- Comprehensive Diagnostic Assessment
- Neuropsychological & Psychological Testing
- Respite
- Medication Management
- Psychotherapy
- Treatment Planning
- Case Consultation
- Child and Family Team Interdisciplinary
- Skill building/Community Based Rehabilitation Services
- Crisis Intervention
- Psychoeducation

January 2019:

- Crisis Respite
- Case Management
- Intensive Care Coordination
- Multi-Family Therapy
- Crisis Response

April 2019:

- Family and Youth Support
- Integrated Substance Use Disorder Services
- Therapeutic After School and Summer Programs

June 2019:

- Transportation
- Day Treatment

- Inpatient Hospitalization
- School Based Skill building
- School Based Case Consultation
- Behavioral Therapeutic Aide
- Intensive Home and Community Based Services
- Treatment Foster Care (therapeutic portion)
- Psychiatric Residential Treatment Facility

Crisis Services

Several crisis services are required by the Settlement Agreement including Crisis Intervention, Crisis Response, Crisis Respite, and Inpatient services. These services are planned to be rolled out as YES compliant services as follows:

- Crisis Intervention- Fall 2018
- Crisis Respite- January 1, 2019
- Crisis Response- January 1 2019, and
- Inpatient services (not under Optum)- June 2019

At the Implementation Work Group (IWG) meeting in April of 2018, the Plaintiff attorneys expressed a specific concern about Idaho's plans for a Crisis System. The Implementation Plan does not identify strategies about how the YES partners will implement a system for Crisis Response. There was some initial work done by the Clinical Advisory Committee to identify the core elements of services currently available in Idaho and to recommend additional services that would have to be developed to augment the current system.

Core elements in Idaho currently include:

- Idaho rule IDAPA 16.07.30 Outpatient Crisis Services, and Behavioral Health Standards
- Requirements in the Optum contract,
- Statewide Suicide Hotline
- Statewide Crisis Text Line
- Mobile Crisis Response (not available statewide)
- Crisis Intervention Teams (CIT)
- Crisis Triage
- Emergency Rooms and Hospitals
- Residential programs

The Defendants Workgroup (DWG) has implemented monthly planning sessions to finalize an initial plan for the development of the YES Crisis System, to be completed by December 31, 2018. The DWG will utilize SAMHSA's manual on Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies, the US Dept. of Health and Human Services Practice Guidelines: Core Elements in Responding to Mental Health Crises, and other nationally recognized best practices for enhancing the current services and developing YES Crisis System for children, youth and families.

Challenges

1. The service implementation timeline is significantly impacted by the provider network's availability to engage in training and ability to add these services to their scope of practice. Medicaid's contractors have considered these challenges and are proactively evaluating the use of incentives to encourage the provider network to participate in training and provide the new services.
2. The original plan to utilize a SAMHSA System of Care grant to fund the development of a system for Crisis Response was eliminated when SAMHSA changed their grant to a focus on First Episode Psychosis. The state will have to seek alternative funding to support the development of a YES Crisis System.
3. Regional differences in access to crisis services will impact the local options for crisis services.

Next Steps

- YES system partners will work together building upon Medicaid crisis services to develop a plan for the YES Crisis System by December 31, 2018.

Objective 2: Principles of Care and Practice Model

The agencies adopt, implement and, once implemented, consistently provide services statewide in accord with the Principles of Care and the Practice Model, as amended over time.

2.A **Each agency, when serving Class Members, will use the Principles of Care and the Practice Model as practice standards for their agencies, contractors, and providers by June 30, 2018.**

2.B: **Class Members, their families, agencies, and other stakeholders participate in the System of Care consistent with the Principles of Care and Practice Model.**

The Principles of Care and Practice Model(POCPM) plays the foundation for a transformative shift in the children's mental health system toward the concept of Child and Family Teams (CFT). The YES system partners have adopted the POCPM as their practice standard.

The Principles of Care and Practice Model have been included in YES Foundational trainings that are being presented to DBH staff, Optum providers, as well as families and other stakeholders. Please see Workforce Training for more information on the YES Foundations trainings.

The implementation of Medicaid's 1915(i) and federal requirements for Person-Centered Planning, which were implemented in January of 2018, aligns with the Child Family Team

(CFT) model in engaging the family and treatment providers in the development of the plan. Training for the Medicaid network on CFT is planned for July 2018-October 2018.

Medicaid introduced the Principles of Care and Practice Model to the provider network in the Foundational trainings conducted in November 2017. This laid the groundwork to build on in the spring of 2018 toward moving the network to YES compliant services. It is recognized that many of these components exist in the service system today, and additional training and support will be provided to ensure the network attains full compliance.

An *Introduction to Youth Empowerment Services* guide has been developed. Within this guide, there is a section dedicated to explaining the Principles of Care and Practice Model and how these elements are applied to practice. Providers, family members and youth are each provided with an audience-specific description of what the Principles of Care and Practice Model might mean to them. Also found in this guide are legal definitions of the Principles of Care and Practice Model accompanied by narrative descriptions that highlight how each Principle and Practice Model component will apply within the YES system. More information about the *Introduction to Youth Empowerment Services* guide can be found within this report, under Objective 4: Sustainable Workforce and Community Stakeholder Development.

In April of 2018, a Principles of Care and Practice Model guidance document was created. The purpose of the document is two-fold. Most immediately the document will be used for training the provider network on how to incorporate the Principles of Care and Practice Model into their current practice. Long term, the document will be used as a reference document in agency contracts and to measure compliance through the Quality Review (QR) process.

Challenges

1. Questions remain concerning what the partners need to have in place to require contractors to adhere to the Principles of Care and Practice Model.

2. Implementing a system of care that requires the inclusion of the youth, family, and other treatment providers in the development of a holistic treatment plan is foreign to the Idaho Behavioral Health Provider network. Although the philosophy is well received, it will take significant time and effort to fully realize and implement this change.

Next Steps

- Operationalize the Principles of Care and Practice Model by including language in service contracts.
- Develop training materials for providers specific to the Principles of Care and Practice Model and Child Family Teams.
- In 2018 Medicaid will increase the network providers' capacity for providing compliant services by working closely with the IBHP contractor to train its current

network providers as well as to recruit additional providers into the network who may already be delivering comparable services to clients.

- Optum will provide training on Child and Family Teams beginning summer of 2018
- Medicaid and Optum Idaho are working to develop key indicators to measure network providers compliance to the Principles of Care and Practice Model.

Strategy 2.C

Develop methodologies to assess attainment of the purposes of the Settlement Agreement, practice improvement, and accountability by June 30, 2018.

The Division of Behavioral Health is in the process of identifying how to measure and manage fidelity to the Principles of Care and Practice Model. The Division has been conducting research on how the Principles of Care and Practice Model concepts are operationalized and measured in other states and is working with a consultant on drafting operational measures.

A large part of the methodology to assess attainment of purposes of the Settlement Agreement are based on the use of the CANS and ICANS systems. The QMIA Council has adopted a protocol called the Transformational Collaborative Outcomes Management (TCOM) Model that is focused on key decision points in care.

Transformational Collaborative Outcomes Management (TCOM)

"Transformational Collaborative Outcomes Management is a conceptual framework for managing complex systems. Within this framework there is a philosophy, a strategy, and a set of tactics all designed to facilitate an effective and integrated approach to addressing the needs of people."

-The John Praed Foundation

The YES TCOM Model contains information about the data and reports that will be utilized to identify system needs and strengths and to better meet the needs of the children, youth and families that it serves. The model was developed based on the five key decision points that have been identified within the TCOM framework to capture the full picture of a child, youth and family's transit through the system of care. These key decision points represent major activities of the system, and represent areas of high potential impact in improving the child, youth and family's experience, as well as outcomes of care.

Reports contained in the TCOM Model will:

- Identify which areas or key decision points within the system are successful

- Identify where there are areas that need improvement
- Identify which practices and procedures are most effective, and create a feedback mechanism that allows different parts of the system to learn from one another

The YES TCOM Model can be found in Appendix C of this report.

Challenges

1. The CANS tool will not be used statewide until June 30th, 2019. As the full implementation of the TCOM system will be based primarily on reports from the CANS this will impact the timing to have TCOM fully operational.
2. The Quality Review plan must be developed and then approved by the Plaintiffs prior to implementation.

Next Steps

- Once concepts are operationalized, fidelity measures will be developed with Quality Management Improvement and Accountability (QMIA), including Quality Review.
- The Division of Medicaid is developing and documenting examples of how the IBHP network can demonstrate the implementation of the Principles of Care and Practice Model in the delivery of services and supports.

Objective 3: Access Model

The agencies establish and operate statewide an access system or protocols for Class Members and their families that timely identify, assess, and link them to the services/supports they need and are entitled to under the Agreement. The work of this Objective will be accomplished through the Services/Supports Workgroup, chaired by the DHW. The work of operating an access process, as described in the following Strategies and Tasks will be described in the Practice Manual.

Strategy 3. A

Progressively implement the Access Model to identify and serve Class Members.

Full implementation of the Access Model occurred in January of 2018. Full implementation of the CANS will occur by June 30, 2019.

Division of Medicaid Access

The Division of Medicaid has worked with defendants to put in place a targeted access model for both currently Medicaid-eligible and potentially Medicaid-eligible Class Members to access YES services effective January 1, 2018.

As part of the YES System of Care, Medicaid has developed the Medicaid SED Program that allows children in families with income up to 300% of the Federal Poverty Level, diagnosed with a Serious Emotional Disturbance (SED) and confirmed through Medicaid's independent assessment process access to Medicaid eligibility and 1915(i)

services. Services available under the 1915(i) State Plan option (i.e. Respite) are services not traditionally covered by Medicaid dollars.

Children that may have SED can be referred to the Medicaid independent assessment process by anyone. However, Medicaid expects most referrals will come from existing Medicaid providers, education, juvenile justice professionals, and families. If a child already has Medicaid and the family does not want 1915(i) services, there is no need for this family to go through the independent assessment process.

There are two reasons a child should be referred to the Medicaid independent assessment process:

1. If the child currently has Medicaid and the family needs 1915(i) services
2. If the child does not currently have Medicaid and needs mental health services

Once a child is referred, the Independent assessor will conduct a face-to-face assessment with the child and family to determine whether the child meets Medicaid SED Program criteria. After the determination has been made all non-Medicaid applicants will be referred to Self-Reliance to apply for Medicaid. Individuals who meet Medicaid SED criteria can qualify for Medicaid with a family income up to 300% of the FPL. Those who do not meet Medicaid SED criteria can qualify for Medicaid up to 185% of the FPL.

All children who meet Medicaid SED Program criteria and have been determined to be Medicaid eligible will be contacted by a DHW Person-Centered Plan Facilitator to begin the person-centered planning process.

Children who have gone through the independent assessment process and meet Medicaid SED Program criteria will have access to all Medicaid State Plan services and 1915(i) services. To remain in the Medicaid SED Program the child and family must maintain a person-centered plan and complete the independent assessment process annually.

The 'Access to Medicaid Mental Health Services and the Medicaid SED Program' diagram can be found here.

The CANS 50 is a subset of the Children's Mental Health CANS used to determine YES Class Membership and subsequent Medicaid eligibility. The CANS 50 in conjunction with a Comprehensive Diagnostic Assessment (CDA) was implemented January 1, 2018, as part of the access model for children/youth interested in Medicaid SED services and supports. The CANS 50 and CDA are provided by the Division of Medicaid's Independent Assessment Provider, Liberty Healthcare.

CANS 50 data through April 30th have been provided on following page.

CANS 50

January 1, 2018-April 30, 2018

CANS Taken

484

CANS Clients

471

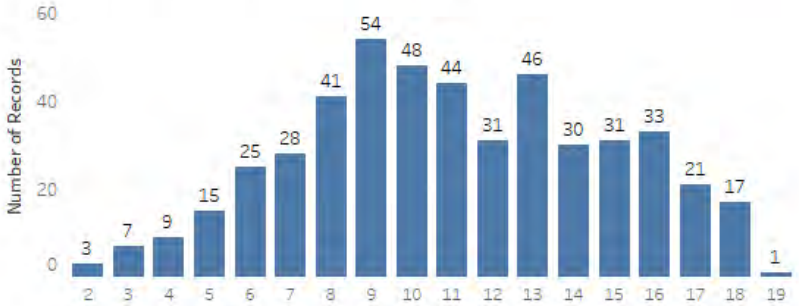
Race

American Indian and Alaska Native	2.27%
Asian and Pacific Islander	1.03%
Black/African American	3.10%
Other and Unknown	20.45%
White/Caucasian	73.14%

Ethnicity

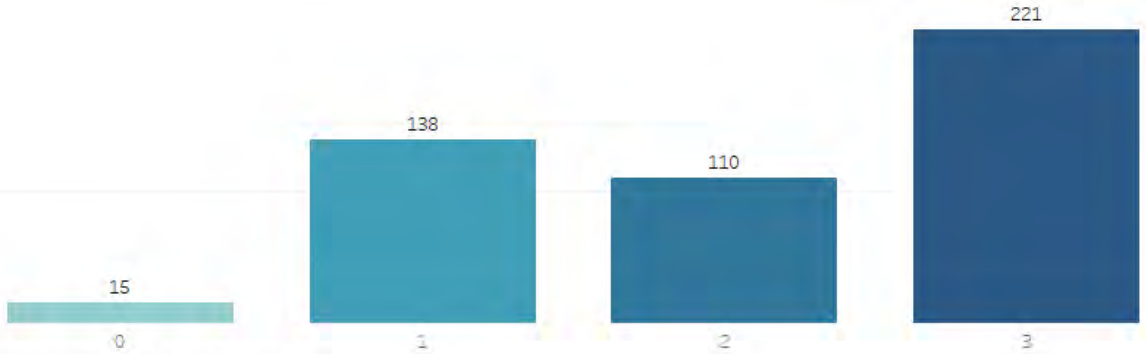
Hispanic or Latino	19.63%
Not of Hispanic or Latino Origin	76.65%
Unknown/Refused	3.72%

Age at Assessment Date (Years)

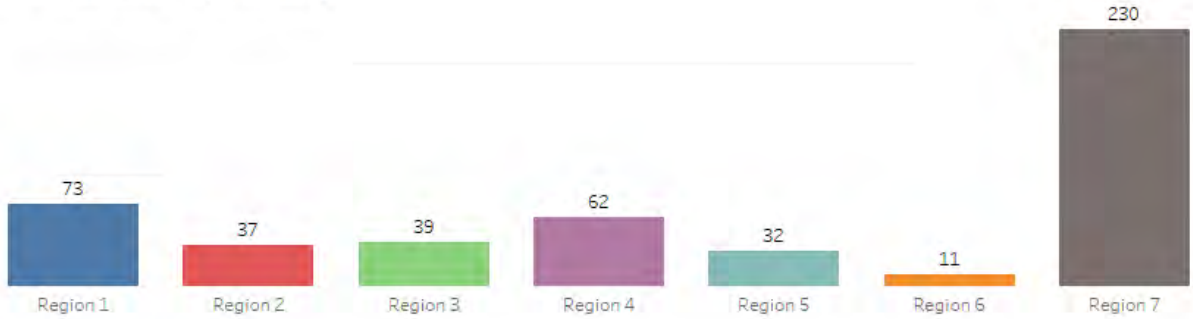


LoC Outputs

Recommended LoC Output: a recommended level of care output is generated by the ICANS. The recommended level of care is calculated according to established algorithms, developed by the IDHW. *Null* values indicated here represent an assessment that has not yet been completed (status of In Progress or Incomplete). A recommended level of care is generated only after a CMH CANS is signed and finalized.



Assessments by Facility



Interpretive Guidance: Idaho CMH CANS-50

The Children's Mental Health Child and Adolescent Needs and Strengths-50 (CANS-50) is administered by the contracted independent assessment provider (Liberty Healthcare) staff within in the determination process for Medicaid eligibility. Clients may be administered more than one CANS-50.

Division of Behavioral Health (DBH) Access

Families seeking mental health services can contact the Department of Health and Welfare Division of Behavioral Health regional clinics. If the family and child have Medicaid they will be referred to the Medicaid network by calling the Optum member line at 1-855-202-0983. If the family does not have Medicaid they will be referred to Liberty Healthcare at 1-877-305-3469. If the family requests that DBH Children's Mental Health (CMH) complete an assessment, CMH staff will schedule an appointment and conduct the assessment, to include the CANS, to help determine the child and family's eligibility for services. Based on results of the assessment CMH staff will work with the family and child to provide services or refer to the community or (if they become Medicaid eligible) to the Medicaid network to provide services.

For families who are not eligible for Medicaid or other insurance, a sliding fee scale is used to determine their share of costs.

Division of Family and Community Services (FACS) Access - Developmental Disabilities

The Developmental Disabilities program within FACS will identify potential YES Class Members in two ways:

1. FACS will review reports from the Independent Assessment Provider to identify children and youth who are also currently receiving developmental disability services. The Developmental Disabilities program will assist families of these children and youth in accessing mental health services, working collaboratively with a mental health provider and DBH staff.
2. FACS Case Managers will identify children and youth currently on developmental disability caseloads who have a mental health diagnosis, or who may need a mental health assessment. If needed, the Case Manager will refer the child or youth to the Independent Assessment Provider for eligibility determination and will collaborate with DBH staff to assist the family in finding a community mental health provider for services.

Department of Juvenile Corrections (IDJC) Access

Outreach to the Idaho Association of Counties Juvenile Justice Administrators, IDJC detention centers, the Idaho Supreme Court, and defense attorneys has been conducted. This outreach has included providing educational material on the foundations of YES, how children youth and families can access the YES system, how IDJC can utilize the CANS and ICANS system, and how YES can be integrated into the current juvenile justice court rooms. Our overall goal for judicial outreach is to build the judicial systems' confidence in the new children's mental health system of care. We plan to educate on how the system we are currently building can successfully be integrated into their current practices; and ensure that family and youth are using the enhanced access to care and receiving appropriate services.

Regional IDJC staff will be certified in the CANS tool to include Juvenile Service Coordinators, Clinical staff, or a combination of the above. Juvenile Corrections will have access to the ICANS system at each regional state institution. The CANS assessment will be administered as needed during the juvenile's reintegration to assist with discharge planning and service eligibility. The CANS tool will be administered to youth prior to returning to the community; this will facilitate connecting them to services, allow for continuity of care, and prevent gaps in services.

State Department of Education (SDE) Access

The Individuals with Disabilities Education Act (IDEA) includes emotional disturbance in the definition of a disability. Children ages 3-21 evaluated as having an emotional disturbance and who, because of the disability, need special education and related services are eligible for services under the IDEA. A referral for a special education evaluation for a child suspected of having a disability may be made by anyone involved in the child's education, including the parent. Signed parental consent is required before any evaluations are conducted. The parent must be involved in decisions once a formal referral has been made. After receiving consent, the evaluation team shall schedule assessments and ensure they are conducted. The evaluation must be sufficiently comprehensive to identify all of the child's special education and related-service needs. Next, the evaluation team reviews the assessment data, the response to general education targeted interventions, and parent/adult student input and recommendations, to determine whether the student is eligible for special education services.

The Child Find system involves three basic steps leading to the determination of whether or not a student has a disability and requires special education. The steps are location, identification, and evaluation. The local school district is responsible for establishing and implementing an ongoing Child Find system to locate, identify, and evaluate students suspected of having disabilities, ages three (3) through the semester they turn twenty-one (21), who may need special education, regardless of the severity of the disabilities. For infants and toddlers, birth through two (2) years of age, Child Find is provided by the Idaho Infant/ Toddler Program (ITP). Although lead responsibility for the ITP has been designated to the Department of Health and Welfare, interagency agreements provide for collaboration and coordination. The identification component of Child Find includes screening, early intervening through a problem-solving process, and referral to consider a special education evaluation. The procedural rights under the IDEA are afforded when the student is referred for a special education evaluation by the parent/legal guardian/adult student or the district.

The 'State Department of Education- Reevaluation Guidance Document Flow Chart' can be found here.

Next Steps

- DHW will continue to monitor the Access Model and seek member feedback utilizing process data indicators and a Quality Review (QR) process. The Quality Review process is planned to be implemented in 2019.
- DBH will continue to work with IDJC to ensure our two systems are collaborating successfully. DBH will also be providing live webinars to judges, providing outreach material to the Western Juvenile Defender Center Leadership Summit in May, presenting at the Idaho Juvenile Justice Association Conference in September, and the Idaho Judicial Conference in September. Additionally, outreach efforts have begun which targets prosecuting attorneys.

Person-Centered Planning

The Division of Medicaid worked with DBH and Optum Idaho to create a Person-Centered Planning process that meets the Code of Federal Regulations (CFR) requirements for utilizing a 1915(i). The Division of Medicaid recognizes this is an additional step class members need to go through to access 1915(i) services or Medicaid eligibility at the expanded Federal Poverty Level (FPL). This is a mandatory requirement when utilizing the 1915(i), and it also ensures there is collaboration to ensure treatment plans are aligned and there is no duplication of services.

In August 2017, it was determined that DBH Regional Children's Mental Health Clinicians would complete person-centered plans on behalf of all youth/families in Idaho requiring these plans.[6]

In October 2017, a workgroup consisting of representatives from the Divisions of Medicaid and Behavioral Health, and Optum Idaho began meeting for collaboration and work related to Person-Centered Planning. During this time, much of the operational groundwork for Person-Centered Planning was laid down.

In November 2017, an initial training was presented to DBH representatives throughout the state by Dr. Lynn Thull, a contractor with the Praed Foundation. Workgroups also began developing the automation support needed to complete the Person-Centered Planning work, including electronic health records requirements and developing a Person-Centered Planning coordination site. Additionally, Dr. Nate Israel from the Praed Foundation presented essential information on the incorporation of the CANS into person-centered plans.

In December 2017 Person-Centered Planning process flows were finalized. Additionally, fifty-seven (57) Regional DBH staff were trained by DBH Central Office staff on both process flow requirements and clinical guidance, and the first statewide Person-Centered Planning support call was held for all staff trained on completing person-centered plans.

[6] DBH will transition this function in the future.

Finally, a Person-Centered Planning toolkit for Regional DBH staff was developed. The person-centered plan template belonging to Medicaid was finalized in collaboration between DBH, Optum and Medicaid, and Person-Centered Planning became a topic in the YES Foundations training.

The Person-Centered Planning process launched in January of 2018.

More recently, the Divisions of Medicaid, Behavioral Health, and Family and Community Services began working to implement the Person-Centered Planning workflow for children/youth who are dually diagnosed with both mental health and developmental disabilities. This process will be piloted during the spring and summer of 2018.

Challenges

1. Feedback from families indicates that the Release of Information and Informed Consent paperwork may not be easily understood or family-friendly. Additionally, some families reported that they wanted more information about the process, while others reported feeling overwhelmed by the amount of information that they had received.

2. Four points have been identified within the process where families may disengage, either by choice or other circumstances.

3. Family led and Person-Centered Planning is a new concept which requires consistent implementation and practice. Early plans required additional documentation to ensure strengths capacities, preferences, needs, and desired outcomes were clearly and thoroughly documented.

4. As with any new process, there have been automation and operational challenges, such as methods that will be used for receiving a referral, confirming Medicaid eligibility, and the submission of the completed plan. A variety of sub-processes and automation systems are utilized that staff must become familiar with.

5. Developing and implementing appropriate need-based service descriptions is difficult. Documentation to assist plan developers to request services and supports evidenced to meet specific mental health needs has been developed and will be updated regularly to reflect effective treatment options.

Next Steps

- Medicaid is working collaboratively with CMS and DBH on closure guidance and letters to send to families to re-engage them in the Person-Centered Planning process. This is part of the continued development of efforts to keep families engaged and to ultimately receive needed services.
- Assessment of the Person-Centered Planning process which deployed 1/1/2018.
- Exploration and development of a Request for Proposal for community based Person-Centered Planning, monthly monitoring, Intensive Care Coordination, and Wraparound.

Strategy 3.B

Inform and guide the delivery of services and supports by providers and contractors consistent with the Access Model, Principles of Care and Practice Model by December 30, 2017.

A Foundational training was delivered to DBH staff in December of 2017. Foundational training on YES includes the current Access Model, Principles of Care and Practice Model Overview.

The Divisions of Behavioral Health and Medicaid provided more in-depth Access Model training to DBH clinicians in December as part of their Person-Centered Planning training. This training was provided in-person around the state.

YES Foundations, CANS, and Person-Centered Planning trainings have been recorded to provide a sustainable training approach. Recordings are in the editing process and will begin rolling out, along with training materials, to appropriate audiences for training at their convenience. Frequently Asked Questions (FAQ's) for each training topic are in development and will accompany online training materials.

For more information about YES trainings, please see Objective 4; Strategy Part I 4:C.

For more information on the Principles of Care and Practice Model guidance for providers and contractors, please see Objective 2.

An *Introduction to Youth Empowerment Services* guide has been published. This document explains changes to the access model and introduces the purpose and concepts of the Principles of Care and Practice Model. More information on the *Introduction to Youth Empowerment Services* guide can be found here.

Strategy 3.C

Develop an identification and referral process across child serving systems to link potential Class Members with the assessment process for the identification of Class Members by December 30, 2017. Activities under this Strategy include the using the CANS algorithm, screening, and checklist.

The Division of Behavioral Health worked with Praed Foundation on the updating and refinement of the initial level of care (LOC) decision-support algorithms (eligibility threshold levels). The threshold levels were revised and finalized on 5/22/2017.

Current LOC algorithms are in place for the following levels of care:

- 1 Serious Emotional Disturbance (SED) identified. Services should be coordinated but functioning is stable
- 2 Serious Emotional Disturbance (SED) identified. Child/youth generally involved in multiple systems and require extensive service collaboration

- 3 Serious Emotional Disturbance (SED) identified. Child/youth is considered to have high treatment needs and is at risk of out of home placement

Initial review of CANS Pilot data on December 1, 2017 with Dr. Nate Israel of the Praed Foundation indicated that the Youth Empowerment Services LOC decision-support algorithms are identifying LOCs as expected; therefore, no revisions are anticipated within the next 12 months.

Algorithms have been integrated into the ICANS system to facilitate eligibility determinations for Class Membership by the Independent Assessment Provider and DBH clinical staff.

A CANS Screener was developed to identify potential YES Class Members. The algorithm for the CANS Screener was developed by Dr. Nate Israel of the Praed Foundation and finalized on May 22,17.

The YES Youth Mental Health Checklist is a tool that can be used by parents and caregivers to help determine if a youth may benefit from a full mental health assessment. Use of this Checklist is not mandatory and a full mental health assessment can be requested without the Checklist being completed.

This checklist will be promoted within the schools as well as on the YES website and other public-facing avenues such as conferences and events. In addition, school problem solving teams may present this tool to further communicate with parents the importance of seeking additional services outside of the school setting.

The Youth Mental Health Checklist Workgroup, launched in May of 2017, consisting of school counselors, Department of Health and Welfare staff, school psychologists, teachers, school social workers, Special Education Directors and parents.

In July of 2017 a draft checklist for families was developed. The Checklist content was informed by 'needs' items from the CANS tool. If one or more boxes are checked, the Checklist indicates that a more comprehensive assessment through YES should be considered. The draft Checklist can be found in Appendix F.

The state has also been working with parents and youth to develop a youth-facing version of the Checklist that can be completed by the youth themselves.

Challenges

1. Challenges with the CANS Screener thus far lie in determining the most effective channels to engage Primary Care Providers, and other targeted users of the CANS Screener.
2. For the Youth Mental Health Checklist, the most significant challenge has been determining how families and youth connect to the YES program if the Checklist indicates that there is a need for a full mental health assessment. Not all families

will choose to access YES through the Independent Assessment process. There is not a universal YES contact entity in place at this time.

Next Steps

The next steps that will be taken to advance development of the CANS Screener include:

1. Refine and publish online and paper versions.
2. Establish guidance materials for use.
3. Involve Medicaid and other YES system partners in the development of the Screener
4. Engage Primary Care Providers and other stakeholders in the adoption and integration of the Screener into practice.
    - Paper-based Screener (Phase 1)
        - Primary Care Physicians
        - Developmental Disabilities providers
        - Juvenile Justice personnel (Probation, Detention, Corrections)
    - Web-based Screener (Phase 2)
        - Implementation plan development to begin 6/1/2018.
        - Phase 2 will focus on the procurement of a web-based screening platform.

CANS Screener Projected Timeline for Next Steps	
Finalize CANS Screener implementation plan	4/15/2018
Develop and release informing materials for the CANS Screener	6/1/2018
Explore automated platform for the CANS Screener	7/1/2018
Initiate procurement process for web-based Screener platform	7/1/2018
Release paper-based version of the CANS Screener	7/1/2018

Next steps regarding eligibility and level of care determination:

1. Decision-support algorithms will be integrated into the method for determining Medicaid SED program Class Membership beginning 1/1/18 through the Independent Assessment Process. This method will expand to the provider network throughout 2018.
2. Level of care (LOC) recommendations generated from ICANS will also be integrated into existing DBH Children's Mental Health (CMH) processes to determine eligibility for existing Children's Mental Health Services

Next steps regarding the Youth Mental Health Checklist:

1. Determine contact information for families seeking a mental health assessment.

2. Publish the Youth Mental Health Checklist family and youth-facing versions (Timeline TBD).

Strategy 3.D

Department of Health and Welfare will develop and implement an assessment process to identify Class Members by January 1, 2018.

Medicaid's behavioral health provider network must meet standard requirements in the completion and documentation of the Comprehensive Diagnostic Assessment (CDA). The CDA will be utilized in conjunction with the CANS to determine whether a youth's mental health diagnosis and functional impairment meets the requirements for class membership.

Strategy 3.E

Use the CANS tool statewide beginning January 1, 2018.

The Department made considerable progress toward the implementation of the CANS statewide in Idaho but did not meet its goal for use of the CANS statewide by January 1, 2018. However, statewide deployment is scheduled to be in place July 1, 2018.

The state did implement CANS for all DBH Regional Clinics and the Independent Assessor so CANS is available across the state, but implementation for the Optum network providers was delayed. There were several reasons for the delay:

- Informing providers of the requirements was delayed until the timing for training was determined.
- The need to train providers on the CANS and the ICANs required substantial planning, including having the Praed staff do in person training which has shown to be more effective.
- The amount of other training that providers needed prior to the CANS Training

A web-based CANS assessment platform for the administration, scoring and sharing of CANS data has been developed; this platform is called the ICANS.

A three-phase implementation plan was established to facilitate the deployment of the ICANS. Phases 1 and 2 have been completed. Key elements and more detail of each phase can be found in Appendix D.

The ICANS pilot started on 9/11/2017 and continued through 11/14/2017.

Key components of the ICANS pilot included:

- Training and CANS certification of all pilot members and related staff
- ICANS training for all pilot members and automation helpdesk staff
- ICANS user documentation for phase 1 functionality completed and posted online for ICANS users

- Weekly ICANS Pilot Group technical coaching calls
- Weekly CANS Coaching calls with Praed consultant Dr. April Fernando

Family and Community Services (FACS) CANS Implementation

The Child and Family Services state-led CANS workgroup has representation from all regions, and all levels of the program, including social workers, supervisors, regional chiefs, program managers, policy team staff, and a representative from Casey Family Programs. The primary goals of this workgroup are to identify the phases of the updated statewide rollout plan, and determine how the CANS can be utilized throughout the lifetime of a child or youth's case. The following are topics of workgroup discussion regarding the rollout plan:

1. Identifying priority populations
2. Identifying how, when and where phases will occur
3. Identifying who will be included in each phase
4. Determining training needs associated with the rollout

The goal of the workgroup is that every child in FACS care will have a CANS by December of 2020, including new entries and children and youth that are already in care.

An overview of the Child and Family Services CANS workgroup planned phases is below:

Phase	Expected Timeframe	Target Population
Phase 1	September 2018- October 2019	30% of population- identified
Phase 2	November 2019- May 2020	35% of population- not yet identified
Phase 3	June 2020- December 2020	35% of population- not yet identified

Children's Mental Health (CMH) CANS data through April 30th have been provided on following page.

CMH CANS

January 1, 2018-April 30, 2018

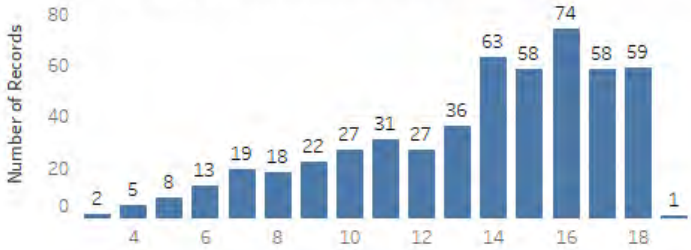
CANS Taken

521

CANS Clients

477

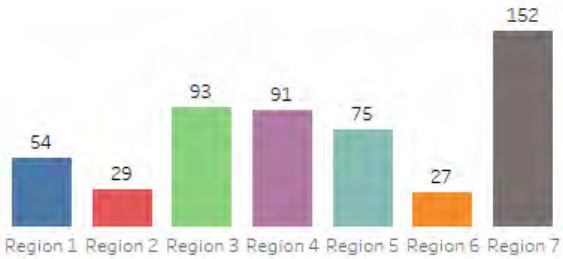
Age at Assessment Date (Years)

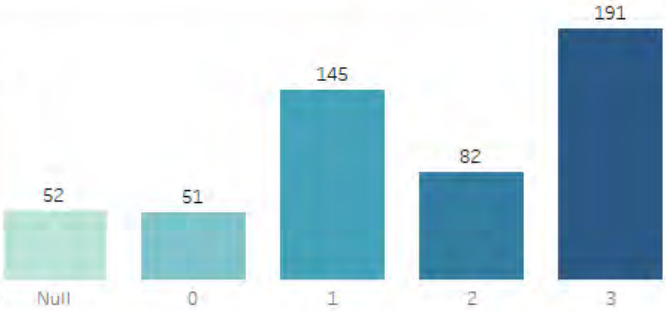


LoC Outputs

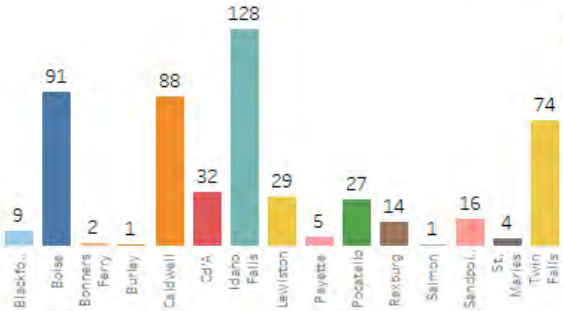
Recommended LoC Output: a recommended level of care output is generated by the ICANS. The recommended level of care is calculated according to established algorithms, developed by the IDHW. *Null* values indicated here represent an assessment that has not yet been completed (status of In Progress or Incomplete). A recommended level of care is generated only after a CMH CANS is signed and finalized.

Assessments by Agency





Assessments by Facility



Assessment Status

Finalized: an assessment is completed, signed by a CANS Certified assessor, and is no longer editable in the record.
In Progress: an assessment is in the process of being completed
Incomplete: an in-progress assessment will transition to a status of "incomplete" if a new CANS is initiated prior to the finalization of the in-progress assessment. Assessments with a status of *Incomplete* are no longer editable.

Race

American Indian and Alaska Native	2.50%
Asian and Pacific Islander	1.54%
Black/African American	2.50%
Other and Unknown/Refused	19.58%
White/Caucasian	73.90%

Ethnicity

Hispanic	17.47%
Not of Hispanic or Latino Origin	68.33%
Unknown/ Refused	14.20%

Assessment Type

Initial: the first CANS completed for a client in the ICANS episode.
Update: any CANS completed for a child after the initial CANS.
Annual: the CANS completed 12 months after the initial CANS for a child.
Discharge: a CANS completed at the time when a child exits current services.

Interpretive Guidance: Idaho CMH CANS
The Children's Mental Health Child and Adolescent Needs and Strengths (CMH-CANS) is administered by IDHW staff within the Division of Behavioral Health and Developmental Disabilities Program. Clients may be administered more than one CANS.

Challenges

1. The ICANS pilot identified key issues with the existing Idaho CANS Manual developed by the Praed Foundation. A comprehensive revision of the manual by Praed was completed on 10/31/2017, however revisions to the manual required significant modifications to existing ICANS functionality to address discrepancies between versions of the manual. System accommodations were required due to the changes which are currently under review by the DBH Automation unit.

Next Steps

- Plan for a second ICANS Pilot to test and evaluate ICANS system and related processes with all stakeholders related to the 7/1/2018 deployment. Pilot group will likely include representatives of DBH, FACS, Medicaid contracted provider network and independent assessment providers, IDJC and County Detention Facilities.
- Deploy ICANS Phase 3 functionality across the state by July 1, 2018.

CANS/ICANS Projected Timeline for Next Steps	
All existing Division of Behavioral Health Children's Mental Health Clients administered a CANS	Beginning 2/1/2018
Use of Idaho Children's Mental Health (CMH) CANS within the Developmental Disabilities program	3/1/2018
Deployment of the ICANS to the Developmental Disabilities user group	3/9/2018
Beta version of Idaho CMH CANS reporting completed	3/15/2018
ICANS Phase 3 A-D final technical requirements completed	4/1/2018
Deployment of the Idaho CMH CANS to the Medicaid network of providers	7/1/2018
All existing CMH clients will have a CANS completed	7/1/2018
Idaho Department of Juvenile Corrections (IDJC) Clinicians trained, certified in the CANS	7/1/2018
IDJC access to ICANS for all identified authorized users (if indicated)	7/1/2018
Division of Behavioral Health training of all identified authorized ICANS users	7/1/2018
ICANS Phase 3 completed	12/31/2018

- FACS Child and Family Services CANS workgroup will work with leadership to set timelines
- FACS Child and Family Services CANS workgroup will continue to work to develop a statewide workflow that will specifically guide when and how the CANS will be utilized at key junctures; including how the information is utilized to inform planning and decision-making for youth involved in Child Welfare.
- FACS Child and Family Services CANS workgroup will determine what training components are needed to meet the individualized needs of the FACS program

Strategy 3.F

Develop and implement a statewide Communication Plan that includes outreach and education of the community, stakeholders, and families by January 1, 2017.

A statewide communication plan was developed and implemented by January 1, 2017. The Communications Plan included the following information:

- How and when communication needs are being addressed for the YES transition.
- A distribution protocol identifying partner and stakeholder roles in communication distribution.

In 2017, Medicaid worked closely with the partners to support communication plans and efforts in the early stages of the YES implementation, including using consistent content for the development of communication and training materials.

As 2018 brings forth additional communication needs to implement and support, Medicaid is tailoring its communication plan to support its internal and external customers. A major component is working with the behavioral health managed care entity to align all Idaho Behavioral Health Plan (IBHP) provider communications with the implementation of services and supports.

YES stakeholders were identified for communication and outreach activities. Stakeholder groups were broken out into three types: 1) direct impact, 2) information and referral and 3) future opportunity role. Initial outreach included messaging and materials on 'what is YES', a general transition timeline, how to access services, who to contact, and YES website resources and training available.

The Communication Workgroup, made up of agency and stakeholder representatives, contributed to the enhanced YES website content and the development and distribution of YES communication pieces.

The parent representative within the Communications Workgroup is an active member of the team; she has been involved in writing content, worked on the YES communications and style guide, and continues to provide valuable feedback that is incorporated into final communication materials. Additionally, part of her role is sharing materials with other parents and providing their feedback to the Workgroup.

An engagement strategy for the stakeholder groups is in development. The engagement strategy for types one and two has been developed, while the type three engagement strategy is in process. Stakeholder groups were contacted to seek understanding of impact, role and needs.

A YES Communications and Style Guide was developed to require that workgroups are using YES brand guidelines, styles and terminology.

A monthly YES Outreach and Training Report has been developed to record the events, number, and type of stakeholders reached in each event. The events include stakeholder meetings and formal trainings. Additionally, tracking of how frequently the YES website

is visited is now possible. The YES Communications Team worked with partners and stakeholders to develop communication materials that describe and explain the Settlement Agreement and its components.

Youth Empowerment Services information is distributed through the YES website, http://yes.idaho.gov. This website was redesigned in 2017 to deliver user-friendly navigation and provide a forum for family, youth and provider voice, along with an easy Contact Us form to submit questions and comments directly to the YES team.

Communication items can be found on the YES website and include:

- YES 101 Brochure – 12-page booklet (English and Spanish versions)
- YES Trifold brochure
- CANS description
- YES: From a Lawsuit to a System of Care
- Frequently Asked Questions (FAQs) for Families and Youth
- Definitions of YES terms
- YES Talking Points for information and referral agencies
- Principles of Care and Practice Model handout for providers

Click here to view the Communications page of the YES website where the materials can be found.

Information is also shared through presentations, meetings, workshops and trainings. Additionally, printed YES brochures and handouts were distributed at community events and conferences.

A variety of communication and outreach and education activities occurred during the reporting period, including:

- Outreach at the Governor's Task Force on Children at Risk conference
- Outreach at SDE's Family and Community Engagement Conference
- Presentations to SDE Directors, Special Education Advisory Panel (SEAP)
- Outreach at the Idaho Association of Juvenile Justice Administrators

Challenges

Challenges regarding implementation of the statewide Communication Plan included the following:

1. There are more than 150 stakeholder groups characterized by various levels of impact and involvement. Identifying their communication needs and how best to reach these groups with information on YES is time-consuming, but is underway.

2. Ongoing program changes that need to be communicated, requiring frequent updates to the same outreach and education materials.

3. The stakeholder engagement model includes all partners and community representatives. While the Department remains committed to this model, it takes

significant amounts of time to route content through the review and approval process.

4. Agency operations and communication plans regarding resource availability and timing vary widely among partners. Acknowledging that communications need to be tailored to each audience, and having the ability to operationalize the communications for this purpose.

5. Sequencing of communications with respect to the impact area of the other stakeholders.

Challenges regarding communication materials have also been identified:

1. The number of stakeholders involved in communication development, review and feedback to 1) create communications that follow the Principles of Care and Practice Model and 2) incorporate the needs and voice of various groups has greatly extended the timelines necessary to create and complete communications pieces.

2. Stakeholders have identified a need to create a consistent brand and identity for Youth Empowerment Services, which has also required additional time to gather input and finalize design decisions. Consistent messaging regarding YES information to prevent stakeholders from receiving outdated or misrepresentative messages from partners.

3. Maintaining independent provider representation on the Communication Workgroup. It has been difficult for providers to meet during the workday and devote time needed to contribute to work products.

Next Steps

- Updating the Communication Strategy, incorporating lessons learned and decisions made, ongoing communications and outreach.
- Updating the YES website based on feedback, and adding new materials.
- Ongoing outreach activities.
- Continuing to develop and update communications and materials, presentations and outreach activities to stakeholder groups as the system of care is developed, including:
    - Handouts that provide easy to understand information on what is next for Youth Empowerment Services, access model, CANS for families.
    - Communications regarding materials available on the website such as:
        - Practice Manual availability.
        - Recorded trainings availability.
        - Other YES materials focused on System of Care.
        - Communication Catalog listing all materials and where to access them.

    - Family-friendly short videos to provide alternatives to written materials about Youth Empowerment Services, and CANS for families, available on the DHW YouTube channel with links from the YES website.
    - Additional updates to the YES website that incorporate user feedback and increase usability and access to resources and training information.
- Continue to use the YES Outreach & Training Report.
- Develop a periodic report on access and use of the YES website.

Objective 4: Sustainable Workforce and Community Stakeholder Development

The agencies participate in workforce development and stakeholder education to create the infrastructure necessary to provide education, training, coaching, supervision, technical assistance and mentoring to providers and community stakeholders to enable them to consistently and sustainably provide quality care in accord with the Practice Manual as described in the Agreement. The work of this Objective will be led by the Workforce Development Workgroup.

Strategy Part I 4.A

Establish a Workforce Development Workgroup by June 30, 2016.

The Workforce Development Workgroup was established in November of 2015. Progress and accomplishments are detailed in the previously published Annual Implementation Progress Report, which can be found here.

Strategy Part I 4.B

Develop an initial Workforce Development Plan by February 28, 2017.

The previous Annual Implementation Progress Report addressed the progress of strategy B, indicating that the Workforce Development and Training Plan Workgroup would finalize input on the initial Workforce Development and Training Plan by February 28, 2017. The Workforce Development and Training Plan would then be edited into a final draft in March and sent out to stakeholders for comment and review. The finalized Workforce Development and Training Plan was expected to be published by May 1, 2017.

The Workforce Development and Training Plan was completed and finalized May 1, 2017 and posted to the YES website. Please click here to access this document.

Part II of the Workforce Development and Training Plan is in development and is expected to be published in July of 2018.

Challenges

1. Identifying individuals to participate in the Workforce Development Workgroup with knowledge of the systems needs statewide.

2. Resolving the workforce gaps reported by BSU in the IBHP network will involve extensive training and subject matter expertise, changes in rules and finances to shore up issues with recruitment and retention, and cultural disparities.

Next Steps

- Adjust the Workforce Development Plan based on Gaps identified in the BSU Survey.
- Formalize Family and Youth Education and Training Plan.
- Develop YES Core Competencies for Workforce and Leadership.

Strategy Part I 4:C

Implement the Workforce Development Plan beginning May 1, 2017.

Phase 1 training of the Workforce Development Plan has begun. YES Foundational Training for the Optum Network was developed and provided in collaboration with the Divisions of Behavioral Health and Medicaid in November 2017. The training content was split into two sections, with each section offered twice to accommodate the providers' schedules. The first training covered the History of YES, System of Care, Principles of Care and Practice Model. The second training covered the Access Model, CANS, Child Family Teams, Person-Centered Planning, and Wraparound. The trainings were attended by 94 agencies and more than 290 individuals. These counts do not include additional attendees that were not formally logged in and were participating in a larger group setting. Feedback from the trainings was positive and a subsequent FAQ was developed and posted on the Optum website.

The Foundational training was delivered to DBH Staff in December of 2017. Foundational training on YES includes the current Access Model, Principles of Care and Practice Model Overview. Based on training surveys, the audience felt the information was important and relevant but it was not new information and most had already heard it. Many participants asked for less philosophy and more operational training specific to Person-Centered Planning. Independent Assessors received the Foundational Training in December 2017. Families and community stakeholders had the opportunity to attend Foundational and CANS training beginning January 18th through February 2nd, 2018.

The Divisions of Behavioral Health and Medicaid provided more in-depth Access Model training to 63 DBH clinicians in December 2017 as part of their Person-Centered Planning training. This training was provided in-person around the state. Training surveys revealed that participants appreciated receiving the long-awaited information and training. All four Person-Centered Planning surveys indicated the attendees would benefit from more practice vignettes.

YES Foundations, CANS and Person-Centered Planning trainings have been recorded to provide a sustainable training approach. Recordings are in the editing process and will begin rolling out, along with training materials, to appropriate audiences for training at

their convenience. FAQ's for each training topic are in development and will accompany online training materials.

The Division of Behavioral Health completed training and certification of all DBH staff on the use of the CANS prior to December 2017.

Details on CANS training and certifications are listed below:

- As of 5/8/18, DBH provided 577 DBH, Medicaid, and other individuals access to the CANS Certification at no cost
    - As of 5/8/18, there were 245 active registered Praed Training/Certification Accounts for agencies listed in Idaho
    - As of 5/8/18, there were 147 individuals actively certified in the Idaho Children's Mental Health CANS

Several DBH-sponsored trainings, which were provided by the Praed Foundation, took place throughout the state:

- Dr. Lyons presented CANS training to providers, parents, and others in Idaho Falls in May 2017.
- Dr. Lyons presented CANS training to all Children's Mental Health Staff in Lewiston in September 2017.

Dr. April Fernando provided statewide CANS Training (including CANS informed treatment planning) to DBH Staff and members of the Independent Assessment Contractor staff. Optum and Medicaid personnel were also invited to attend. Training sessions were delivered in Boise, Idaho Falls, and Coeur D'Alene in November and December of 2017. CANS training sessions for youth, parents and stakeholders were scheduled for January 2018; these trainings took place in Coeur D'Alene and Boise. An additional CANS training for youth, parents and stakeholders was held in February of 2018 in Idaho Falls. A broadcast webinar was available for some of these trainings. These trainings opened with a parent perspective and the importance of the use of the CANS. Those in a supervisory role received an additional CANS in Supervision training. The survey data from these trainings revealed most attendees benefitted from the training. There were several suggestions for a more interactive learning experience with requests for videos and activities to engage all learning types. Another suggestion was to provide more direction in CANS implementation for multiple cultures.

The DBH Automation Helpdesk team began providing ongoing ICANS technical training in November 2017, for DBH users, Independent Assessors, and non-DBH users. Additional ICANS technical trainings were provided in December 2017.

Division of Behavioral Health Hosted Trainings Summary

YES - DBH Hosted Training Schedule

	Date	Time	Training	Presenter	Presenter Location
Complete	11/14/2017	8:00AM-4:00PM	PCP: Pilot	Janelle J/Jeniffer B/David W	Boise, PTC 05 Rm 5
Complete	11/16/2017	9:00AM - 4:00PM	CANS Intro/CANS Clinical DAY 1	Pat Martelle/Janet Hoeke/Dr Fernando	Boise, Westgate
Complete	11/17/2017	9:00AM - 4:00PM	CANS Clinical/Supervisory DAY 2	Dr. Fernando	Boise, Westgate
Complete	11/30/2017	9:00AM - 4:00PM	CANS Intro/CANS Clinical DAY 1	Pat Martelle/Janet Hoeke/Dr Fernando	Idaho Falls,150 Shoup Ave CFS Lg Conf Rm
Complete	12/1/2017	9:00AM - 4:00PM	CANS Clinical/Supervisory DAY 2	Dr. Fernando	Idaho Falls,150 Shoup Ave CFS Lg Conf Rm
Complete	12/5/2017	8:30AM - 5:00PM	PCP: Operationalization	Janelle J/Jeniffer B/David W	Lewiston, 16th Ave Conf Rm
Complete	12/7/2017	9:30AM - 11:00AM	DBH Staff Foundations Webinar Part 1	Pat/Janet/Jeniffer B/Janelle J	Boise, PTC 7th Floor Training Rm
Complete	12/11/2017	8:30AM - 5:00PM	PCP: Operationalization	Janelle J/Jeniffer B/David W	Pocatello, HDC Conf Rm 124
Complete	12/13/2017	9:30AM - 11:00AM	DBH Staff Foundations Webinar Part 2	Pat/Janet/Jennifer B/David W	Boise, PTC 7th Floor Training Rm
Complete	12/14/2017	8:30AM - 5:00PM	PCP: Operationalization	Janelle J/Jeniffer B/David W	Boise, Westgate D Mtng Rm 207 VCE
Complete	1/18/2018	9:00AM - 12:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Boise, Westgate Rm 131
Complete	1/18/2018	1:00PM - 4:00PM	CANS for Stakeholders	Dr. Lyons	Boise, Westgate Rm 131
Complete	1/19/2018	9:00AM - 12:00PM	CANS for Stakeholders	Dr. Lyons	Boise, Westgate Rm 131
Complete	1/19/2018	1:00PM - 4:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Boise, Westgate Rm 131
Complete	1/25/2018	9:00AM - 12:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Coeur d'Alene, 1120 Ironwood LG Conf Rm
Complete	1/25/2018	1:00PM - 4:00PM	CANS for Stakeholders	Dr. Lyons	Coeur d'Alene, 1120 Ironwood LG Conf Rm
Complete	1/26/2018	9:00AM - 12:00PM	CANS for Stakeholders	Dr. Lyons	Coeur d'Alene, 1120 Ironwood LG Conf Rm
Complete	1/26/2018	1:00PM - 4:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Coeur d'Alene, 1120 Ironwood LG Conf Rm
Complete	1/29-2/2/18	9:00AM - 4:00PM	Clinical Wraparound	SOCI	Boise, Westgate D Mtng Conf Rm Side B
Complete	2/6/2018	1:00PM	CANS/YES Update (IACJJA)	Seth/Pat	Boise
Complete	2/12/2018	3:00PM - 4:00PM	PCP Optum LOCG	Optum	Webinar broadcast
Complete	2/14/2018	9:00AM - 12:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Idaho Falls, 150 Shoup Ave 2nd floor LG Conf Rm
Complete	2/14/2018	1:00PM - 4:00PM	CANS for Stakeholders	Dr. Lyons	Idaho Falls, 150 Shoup Ave 2nd floor LG Conf Rm
Complete	2/15/2018	9:00AM - 12:00PM	CANS for Stakeholders	Dr. Lyons	Idaho Falls, 150 Shoup Ave 2nd floor LG Conf Rm
Complete	2/15/2018	1:00PM - 4:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Idaho Falls, 150 Shoup Ave 2nd floor LG Conf Rm
Scheduled	2/20/2018	2:00PM - 3:00PM	ICANS Training for DBH Staff	DBH Automation	Boise CO - Webinar
Scheduled	3/8/2018	10:00AM - 11:00AM	ICANS Training for DBH Staff	DBH Automation	Boise CO - Webinar
Scheduled	3/15/2018	2:00PM - 3:00PM	ICANS Conference Call for ALL USERS	Seth Schreiber	Boise CO

*Trainings listed on this schedule are DBH hosted trainings only

As of: February 20, 2018

Medicaid, in collaboration with Optum Idaho and the Independent Assessment Contractor Liberty Healthcare, conducted many trainings to educate and inform providers about the new Access Model and YES foundational components to include the Practice Model for the January 2018 changes. Medicaid's contractors have participated in CANS training both for direct use in the independent assessment process and for knowledge and implementation for the Idaho Behavioral Health Plan (IBHP) network.

In collaboration with DBH, Medicaid has supported the plan for the statewide network capacity survey that will assist in informing workforce training and development needs. In addition, the Optum Idaho continues to address network capacity and needs throughout the project-planning phases in relation to development of services and supports.

IDJC is in the process of revising Peace Officer Standards Training (POST) updates to include more emphasis on adolescent development, brain development, trauma and mental health concerns. The following classes have been implemented in all IDJC State Facilities and now will be a formal piece of the POST training curriculum:

- Mental Health for Juvenile Justice
- Think Trauma
- Shield of Care- Self-harm and Suicide Prevention

Additionally, IDJC has implemented a Case Management University as well as a Juvenile Service Coordinator Workshop. Community partnerships have allowed for the following trainings to be provided:

- Policing the Teen Brain
- Acing the ACEs (Adverse Childhood Experiences)
- Youth Level of Service Case Management Inventory
- Resilience Training
- Restorative Justice

Challenges

1. Medicaid has noted the challenges of multiple trainings, opportunities and venues for providers to receive information in the context to which it applies. For example, an Idaho Behavioral Health Plan (IBHP) provider may attend a training that is not a part of the Optum training and may not understand the area of impact in relation to both contractual and reimbursement requirements.

2. There are also challenges involved in gathering the necessary information to assess network training and development needs without burdening the providers in responding to multiple surveys and inquiries.

3. Idaho's diverse geographic areas create challenges in developing provider capacity, and sustainability in certain areas of the state.

Next Steps

- The initial YES Foundations and Person-Centered Planning trainings have been recorded with the intent to make them available on the YES website. Training recordings are going through an editing process and are being prepared for web-based delivery.
- ICANS user trainings will take place on an ongoing basis in 2018.
- Optum is developing Respite training for existing network providers to be delivered in Spring of 2018.
- All YES planned trainings will be listed in the YES Training Plan which is scheduled to be posted on the YES website in early 2018.
- A plan for a YES training team in support of sustainability is being developed. The goal is to develop individual role training plans to support all staff who participate in YES and work toward regional training plans to support those individuals. Training related to the use of CANS reports and a Train the Trainer model is being planned for agency sustainability.
- Medicaid is revising and enhancing the 2018 training plan for its internal and external stakeholders. Optum Idaho is finalizing the Praed contract and revising their training plan to coincide with anticipated rollout dates for services.

- Utilize the BSU Workforce Capacity and Gaps Analysis report to develop next steps.
- Continue network capacity and training evaluations throughout the duration of implementation.

Strategy Part I 4.D

Evaluate the Workforce Development Plan over time for adherence to the Settlement Agreement and to adjust the Plan for system improvement.

The Workforce Development Workgroup reviews the plan during their meetings to assure that the plan is followed and is adequate to meet the needs of the developing system of care. The Workforce Development Plan will be formally evaluated every two years, beginning July 2018.

Challenges

1. Identifying the appropriate resources to evaluate the plan as the plan covers a variety of systems and stakeholders statewide.
2. Using data and outcomes to monitor the results and impact of the Workforce Development Plan on children, youth and families.

Next Steps

- Create a plan for evaluation of the Workforce Development Plan which includes timelines, resources, and a protocol. The Plan should address the development of or outline solutions for expected workforce gaps or shortages.
- Work with Praed and Portland State University to develop the protocols and utilize the TCOM Model in the evaluation process.

Strategies Part II 4.A-B

A. Develop the Practice Manual utilizing workgroups. Publish the first version of the Practice Manual by July 1, 2017.

B. Begin development of the Practice Manual by July 30, 2016.

The Annual Implementation Progress Report addressed the progress of strategy A, indicating that the Practice Manual workgroup would begin meeting in March 2017. This workgroup would review the approval process for the Practice Manual and provide input on any necessary changes to the process. Additionally, this workgroup would coordinate with other project workgroups such as Clinical Advisory, Workforce Development and CANS, by including members from those workgroups in the Practice Manual workgroup.

The first Practice Manual Workgroup was held in March of 2017 and then met every other Wednesday from April to November. The workgroup was led by a Clinical Advisory Workgroup lead from DBH and co-facilitated by a representative from Medicaid. The

workgroup currently has robust participation by stakeholders, including the Division of Medicaid, DBH, State Department of Education, parents and providers.

The Practice Manual Workgroup drafted a final charter, content review process and a workgroup task plan. The workgroup also developed a vision of the core principles that they wanted to see reflected in the manual, including incorporating youth and parent voice in each section.

Work toward the drafting of the Practice Manual began when subject matter experts were identified for each content area and tasked with developing content with input from parents, providers and other stakeholders.

DBH contracted with Idaho State University (ISU) in June of 2017 to assist with initial development of a ready-to-publish manual. Contracted work included format mock-ups, vignettes, and content review surveys for Practice Manual Workgroup members. Subject matter expert Dr. Lynn Thull, a contractor of the Praed Foundation was also onboarded as a consultant in mid-June.

A Practice Manual sub-team was created in August of 2017 to help finalize key decisions. Membership on the initial sub-team included staff from the Divisions of Behavioral Health and Medicaid and consultant Dr. Lynn Thull. Additionally, a parent and a provider were added to the sub-team in October.

In early 2018 it was determined that publishing the full Practice Manual was impractical because the full array of YES services are being developed and implemented in phases over the next few years with the first services beginning in July 2018. Therefore, the Practice Manual could not be developed or published until the system changes were developed and ready to implement. The IWG agreed this was an appropriate step under the circumstances.

Instead, An *Introduction to Youth Empowerment Services* guide has been published. Prior to publishing, the guide was distributed to the Implementation Workgroup, Defendant's Workgroup and Interagency Governance Team for comment and feedback. The guide was revised to incorporate the feedback that was received and a final draft was submitted to the Implementation Workgroup. The *Introduction to Youth Empowerment Services* guide can be found here.

Medicaid participated on both the Practice Manual Workgroup and sub-team to meet the requirements of providing documentation for the first version of the guide. Medicaid offered support through a project manager in the Fall of 2017 to assist in tracking the outstanding items, and version and content control. Medicaid engaged the behavioral health managed care entity for review and input specific to services and supports in conjunction with parent and provider feedback.

Challenges

The Implementation Plan required the publication of an initial version of the Practice Manual by July 1, 2017. The publication has not yet been accomplished for several

reasons. The initial plan to publish a full version of the Practice Manual was rejected as being confusing if it addressed services that were not yet available. The full array of YES services are being developed and implemented in phases over the next few years with the first services beginning in July 2018. Therefore, the Practice Manual could not be developed or published until the system changes were developed and ready to implement. The first publication will be the *Introduction to Youth Empowerment Services* which will explain changes to the access model and introduce the purpose and concepts of YES. A subsequent version is scheduled to be published in October of 2018 to introduce the services launching later this year with additional versions to be published as each new system change is happening.

Additional challenges included the following:

1. Writing a single guidance document with multiple authors, systems, and for multiple audiences is a continuing challenge. To produce the *Introduction*, the team overcame this by assigning smaller sub-teams to draft and review content. In addition, DBH hired a technical writer who started March 2018, to compile the information and finalize the Practice Manual to address these concerns.

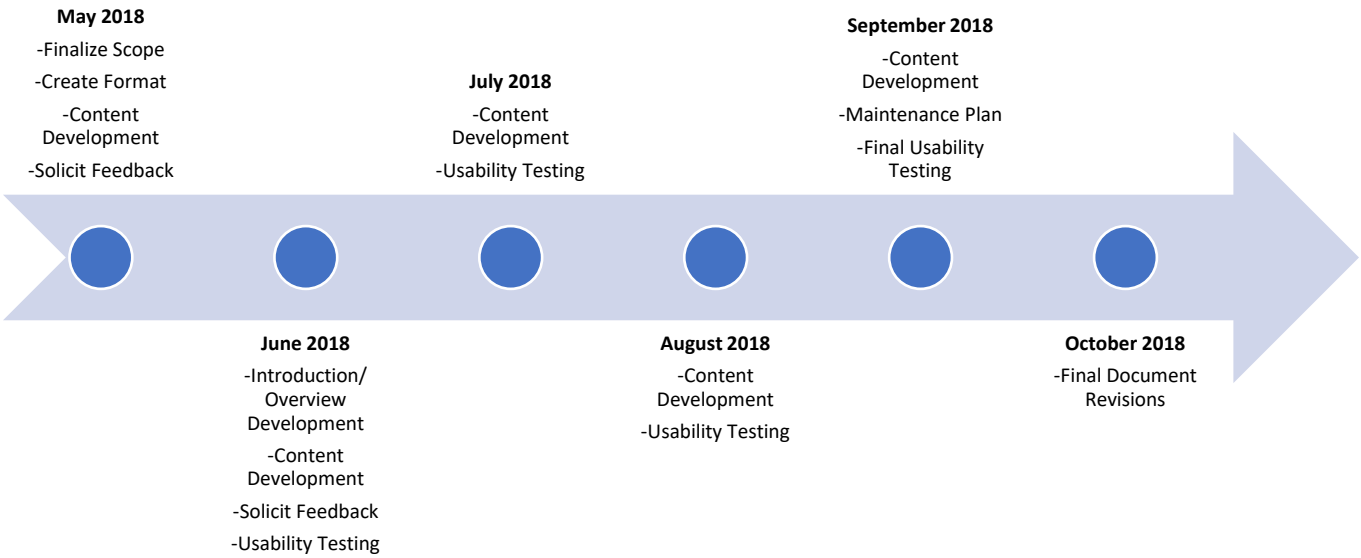
2. Decision making process and authority over the Practice Manual were often unclear or changed based on content topic. In the future, the team will establish clear roles, responsibilities, and authority prior to routing the document.

3. Content is dependent on system development and project decisions, as these are delayed or changed, manual content timelines are necessarily pushed back.

Next Steps

- Develop training and testing plan.
- Review first draft for material relevant for second draft:
    - Identify areas of Paragraph 40 A-K of the Settlement Agreement that need to be added or improved.
    - Identify subject matter experts and authors for each section.
- Publish the next version of the Practice Manual and establish a routine for publishing amendments/updates.

YES Practice Manual Planned Development Schedule



Strategy Part II 4.C

Update the Practice Manual until completed on June 30, 2019. Train and provide technical assistance on the Practice Manual.

The Practice Manual will be updated periodically until completed. Training and technical assistance will continue to be provided. Practice Manual updates will follow the Provider Network training schedule.

Objective 5: Due Process

The agencies will develop and operate constitutionally and federally-compliant fair hearing systems, and will create and operate a centralized complaint routing and tracking system. Furthermore, the agencies will implement a process for reviewing compliance to applicable regulations, rules, and policies regarding due process requirements, and periodically report on the metrics of operating this system. The work of this objective will be led by IDHW in consultation with Idaho Deputies Attorney General. The work of this Objective does not apply to services provided to Class Members on an involuntary basis, such as services provided involuntarily to Class Members in the custody of the state or those services required by a Court Order. See Agreement paragraph 3 and Appendix B, third introductory paragraph. This entire process will be included in the Practice Manual and will be coordinated with the Quality Management, Improvement, and Accountability (QMIA) goals, plans, or results listed in Objective 7 to avoid a duplication of efforts with this Objective.

Strategy 5.A

Operate a standardized complaint and administrative hearing system beginning October 1, 2018.

Idaho's child and youth serving mental health systems have begun to develop, adopt and consistently use systems for complaints and due process that reflect the YES Practice Model approach. The Due Process Workgroup, which includes representation of all parties including families, has been meeting throughout the year to address the requirements for establishing due process associated with YES.

It was determined by the Due Process Workgroup that all parties had a complaint process that was established. It was also determined that Medicaid's complaint process meets CFR and YES requirements as outlined in the objective above, with the exception that recent Medicaid regulations required the Medicaid complaint system to be utilized prior to requesting a State fair hearing. Both the Settlement Agreement and Implementation Plan requires the complaint process to run concurrently with appeals process which contradicts the new Medicaid regulations.

The Division of Behavioral Health enhanced its existing complaint system by adding a toll-free number and new resources within the Division's Quality Assurance Unit to address concerns about behavioral health services for children and youth. The toll-free number, 855-643-7233, is answered by DBH staff between 8:30 am and 4:30 pm (MST) each business day. DBH has also added its complaint process to the language to the Idaho Administrative Code (IDAPA) rules to formalize its process and to align it Medicaid practices to make the process look similar and less confusing to participants.

There is a Memorandum of Understanding (MOU) that is in the process of being signed by YES system partners that will allow collaboration regarding complaints across all child-serving systems.

All system partners are required to have an appeal process, DBH, Medicaid and SDE, currently have processes in place that meet their specific state and federal requirements.

Medicaid has systems in place for appeals and fair hearings. A link to requests for Fair Hearings are posted on the Medicaid Idaho Behavioral Health Plan (IBHP) website: http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/OMHSAFairHearingRequestForm.pdf

While DBH utilized these procedures for appeals of its children's mental health program, it was identified that these rules did not always align with Medicaid requirements for fair hearings. DBH determined that they would more closely align their notices and procedures to Medicaid requirements so that the process would look similar and therefore less confusing to participants.

State Department of Education has systems in place. On the SDE website under link for Special Education there is information about the processes for dispute resolution, including mediation and hearings: https://www.sde.idaho.gov/sped/dispute/

The Due Process Workgroup began reviewing the written notices of action that are currently in use by DBH, Optum, and Medicaid. It is expected that compliant and family friendly notices will be finalized by October 2018.

Challenges

1. Idaho's Medicaid program must follow federal Medicaid regulations requiring utilization of the complaint process prior to accessing a formal appeals process. As stated above, this conflicts with both the Settlement Agreement and Implementation Plan which allow for the complaint process and appeals process to be used concurrently. Since the federal regulations cannot be changed, it is suggested that the Implementation Plan may need be amended to accurately reflect federal Medicaid regulations.

2. DBH had existing processes in place for complaints at the regional level, but did not have informing materials that were distributed to families as part of the intake process. As work began, it came to the attention of the Due Process Workgroup that families may not be aware of the existence of a complaints process. DBH complaints and due process informational materials are currently under development and are expected to be completed by October 2018.

3. IDAPA 16.05.03 governs administrative appeals of public benefits administered through the Idaho Department of Health and Welfare. DBH had appeal process in place, but the process did not match the Medicaid process. DBH has made the necessary process changes, including adding language to the Idaho Administrative Code (IDAPA) rules to establish the authority to provide for "expedited appeals" for "non-Medicaid eligible YES individuals".

4. Although the Settlement Agreement requires Idaho to allow people to appeal and request Fair Hearings concurrently, the appeals process as required in Federal Medicaid regulations (42 CFR 438) has changed to allow states to require exhaustion of the first-level appeal process prior to fair hearing. Because of this change in Federal Medicaid regulations and the determination that Idaho will require exhaustion of the grievance process prior to appealing, the processes that have been implemented will not align with the Settlement Agreement. It is suggested that the Implementation Plan be amended to accurately reflect Medicaid regulations.

5. There are various federal and state rules that each party must follow, which has made it difficult to streamline processes. While DBH did change the language in the Idaho Administrative Code (IDAPA) rules to more closely align with Medicaid practices, Federal regulations governing both State Department of Education and Medicaid do not align. Discussions within DHW continue to look for methods to streamline the processes whenever possible.

6. Although the existing written notices of action comply with rule criteria, it was determined that these notices are not family-centered. Written notices will need

to be enhanced to better meet the needs of children, youth and families. There have also been challenges in revising written notices of action, which are embedded into electronic systems that cannot be easily changed. The Due Process Workgroup continues to review all notices and make recommendations for improvements.

Next Steps

The goal is for the complaint and due process system required by the Settlement Agreement to be fully operational on 10/1/2018. The following are next steps that have been identified to meet this goal:

- The Defendants Workgroup (DWG) formed a workgroup to review options for a centralized complaints process, which will include the possibility of using parents in a role of liaison for families as recommended by the Due Process Workgroup. The DWG will evaluate the option and make a recommendation with the potential for a short term and longer-term solution, The goal is to complete the process and implement the system by October 1, 2018.
- The Due Process Workgroup to complete the review of written notices using criteria from the Settlement Agreement paragraph 45 items A-I by Sept 1, 2018.
- Identify which electronic systems allow for changes to be made to written notices by Sept 1, 2018.
- Identify any contracts that require modification to establish the complaint and due process protocols.
- Develop, adopt, and use a process to monitor and periodically report on compliance with the complaint and due process protocols.
- Publish a link for the YES complaints process and appeal procedures.

Strategy 5.B

Implement a due process tracking and reporting system beginning October 1, 2018.

The Data and Reports Team is working collaboratively to develop standardized terms to be used in tracking and reporting complaints and appeals by Oct 1, 2018. The focus for the reports will be based on the key decision points in care established by Dr. Lyons and Dr. Israel: screening, engagement, appropriateness, effectiveness, and linkages. The reports will be mainly targeted to DHW.

Challenges

1. Each system has their own existing method for tracking and reporting complaints and appeals. Changes to the existing systems are limited by State and federal rules that mandate reporting.
2. Systemwide information will be limited to systems that are required to report. School districts are not required to report complaints or appeals to SDE.

Next Steps

- Complete and implement the plan for a centralized objective process for tracking and addressing complaints by October of 2018.
- Collect and report data on complaints and outcomes from all five parties by October of 2018.
- Collect and report data on appeals and fair hearing requests and outcomes. The QMIA Data and Reports Subcommittee have set a goal for reporting on this data by July of 2019.

Objective 6: Governance and Interagency Collaboration

Establish governance and interagency collaboration within the authority of the Idaho Behavioral Health Cooperative (IBHC) to collaboratively coordinate and oversee the implementation of the Agreement.

Strategy 6.A

The Department of Health and Welfare authorizes a Project team and Project sponsorship to provide structure and framework for initiating, planning, executing, controlling, and closing the Project work needed to achieve the Settlement Agreement outcomes and exit criteria.

The previous Annual Implementation Progress Report addressed the progress of strategy A, indicating that pending legislative approval, staff hired by the CMH program would assist with carrying out the activities outlined in the project plan. In addition, identification of inter-dependencies and critical path for updates of the project plan would be completed. Updates were to be drafted in February of 2017 and delivered for review and stakeholder feedback in March of 2017. It was also indicated that staffing requests would be sent to the legislature for approval in 2017.

Strategy 6.B

Establish and implement the Interagency Governance Team (IGT) by July 30, 2016.

The Interagency Governance Team (IGT) has met monthly since July 30, 2016. The IGT held several extended meetings designed to promote education and improve understanding of the Youth Empowerment Services (YES) project, the Settlement Agreement, Implementation Plan, and IGT Charter. Extended half day meetings included the following:

- March 2017- Meeting to begin work on completing the Transformational Collaborative Outcomes Management (TCOM) Team Development Guide. Dr. Nate Israel of the Praed Foundation provided consultation. The work from this meeting was used to update and revise the IGT charter.
- May 2017- Training with Dr. John Lyons from the Praed Foundation on the CANS tool.
- December 2017- Meeting focused on drafting an Operational Governance Plan and developing the purpose of the Training and Clinical Subcommittees.

- April 2018- Meeting focused on the Principles of Care and Practice Model, Services and Supports timeline, access for non-Medicaid Class Members, Case Management, and the Independent Assessment process.

The initial IGT membership appointments expired in October 2017. The Idaho Behavioral Health Cooperative (IBHC) reappointed members of the IGT which included three parents, one former Class Member, two family/youth advocacy representatives, and two providers. The Family Engagement subcommittee is working to recruit youth and young adults to both the subcommittee and to the IGT. This recruitment strategy began by introducing youth to the YES Foundations training content to provide them with an initial basis of understanding.

The IGT has 17 members. Members representing various departments have identified proxies to provide representation when appointed members are unable to attend. The Divisions of Behavioral Health and Medicaid have designated staff to provide technical assistance for the IGT.

Additional progress of the Interagency Governance Team includes the following:

- Adopted a revised charter.
- Adopted IGT Request Form; the purpose of this form is for the IGT to submit official requests for information and receive a response back from the YES Project Team.
- Appointed a new Chair and Co-chair.
- Adopted Family Engagement subcommittee statement of purpose.
- Operational Guidelines were approved in March of 2018.
- The Clinical and Training Subcommittee was established in April of 2018.

The state is also leveraging the value of youth voice in this work and has actively engaged with existing youth organizations, such as Idaho Youth M.O.V.E. and the Idaho Foster Youth Advisory Board (IFYAB) to identify youth who may be interested in participating on or working with the IGT. There is currently one youth member of the IGT and an additional youth representative on the Family Engagement Subcommittee.

Challenges

1. The scope of oversight and decision-making authority was a challenge for the IGT over the past year, as members had differing perceptions on its role and purpose.

2. The IGT membership initially struggled with the purpose of the mandatory Clinical and Training subcommittees. Due to the ambiguity, members of the IGT were reluctant to volunteer to lead these subcommittees. A decision was made to combine the subcommittees initially, but two distinct statements of purpose were created. In April of 2018 the subcommittee convened and identified leadership.

3. The Interagency Governance Team meeting times often conflict with schedules of parents and former Class Members. This resulted in the departure of a former Class Member, and has made recruitment a challenge.

Next Steps:

- Continue to develop the Training and Clinical subcommittee/s.
- Continue to identify the data, reports and other information that the IGT needs to conduct its work.
- Through the Family Engagement Subcommittee develop a recruitment strategy to enhance stakeholder membership representation.

Interagency Governance Team: Parent Perspective

"It has been a struggle to make sure that all the right players are at the table for the IGT. Decision makers are overbooked and putting their time in to the Implementation Workgroup rather than governance. IDJC has consistently sent a qualified representative to IGT who has coordinated closely with decision makers at that agency. SDE struggled to have a consistent representative available at first, but in May 2017 identified a new representative who has provided coordination and follow up with that agency. Medicaid had a similar struggle and identified a representative around the same time frame, though that representative has not been completely consistent in attendance. Medicaid has been sending additional people to answer questions and take on action items which has been helpful. Sometimes it feels that the extra people are making the meeting too crowded and therefore less efficient, though it is nice when the right person is able to answer a question.

The Settlement Agreement states that the governance partnership will be led by the Administrator of the Division of Behavioral Health. It has been difficult for this person to actively participate, especially during the legislative sessions. A representative from the QMIA council does attend consistently. Many other DBH staff attend each meeting. Some provide crucial support with meeting logistics and note taking. Others answer questions and take on action items. Some present information when requested. Some listen silently. Again, the number of people in the room seems to grow with time and make it difficult to keep track of who is truly representing DBH as well as Medicaid. A system of large and small name tags has been devised to keep track of voting members versus support staff.

Returning to the point about the governance partnership being led by the Administrator of DBH, this has been another struggle for the stakeholder representatives. It was decided early on that the Chair of this team should not be an employee of any of the defendant agencies. The balance between the Chair leading the discussions and the Administrator leading the partnership and DBH staff providing support continues to be a challenge. The Chair person is a volunteer and does not have a lot of time to work on preparations outside the meeting times. In order to provide leadership, that person needs extensive support from staff for things like distribution of documents, scheduling, tracking requests and action items. A new request tracking sheet and action item system were developed by the DBH support staff in collaboration with the Chair which we hope will streamline these tasks."

Objective 7: Quality Management, Improvement, and Accountability (QMIA)

The agencies will develop and implement a QMIA plan to establish and maintain a collaborative QMIA system that includes monitoring, measuring, assessing, and reporting on Class Member outcomes, system performance, and progress on implementation and completion of this Agreement. The collaborative QMIA system will increase system-wide capabilities for quality improvement at the clinical, program and system levels associated with increasing effectiveness of services and improving access to services. The parties jointly develop a Quality Review (QR) process to be used to objectively assess and improve clinical practice and program effectiveness system-wide.

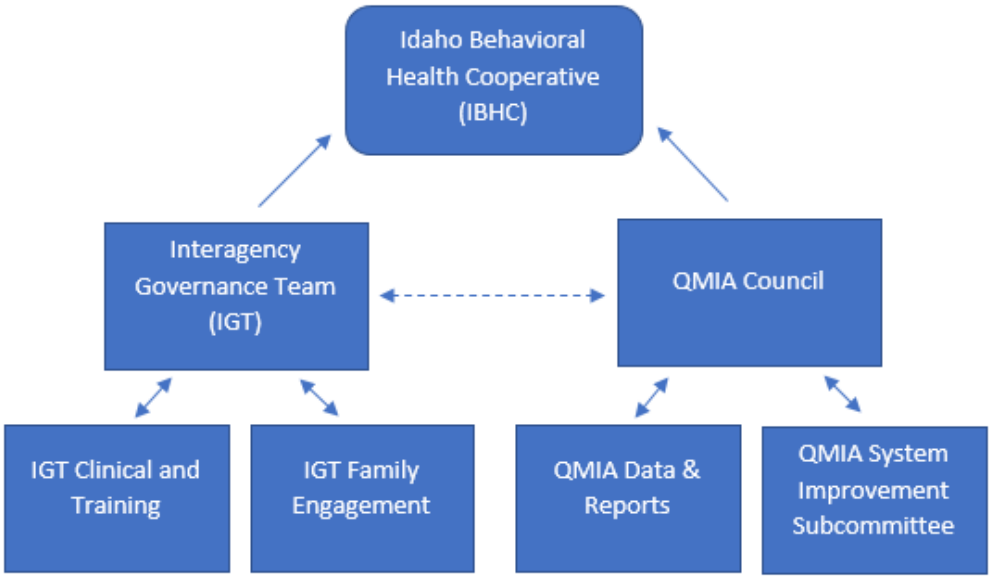
Strategy 7.A

Develop and implement a QMIA plan by March 31, 2016

The QMIA Plan was developed and approved by March 31, 2016. The establishment of the collaborative Quality Management Improvement and Accountability (QMIA) infrastructure noted in the QMIA Plan is in progress.

The QMIA Council, which includes representatives from each of the involved partners has been meeting throughout the past year. Notably the QMIA Council was enhanced through the addition of a family representative in 2017, and a second family representative in 2018.

The QMIA Council has been working collaboratively with the Interagency Governance Team (IGT) on creation of planned QMIA subcommittees. Changes have been made to the original QMIA subcommittee structure based on other groups that have been formed. The revised organizational structure is diagramed below:



The QMIA Council has been working on a Quality Improvement Plan (QIP) Issues that have been experienced by families. Concerns have been logged and desired performance improvement outcomes have been indicated. The QMIA Council is working with the QMIA Data and Reports Subcommittee to identify how data can be collected around problem statements and how improvement could be measured. QIPs will continue to be created by the QMIA Council as needed and delivered to the QMIA System Improvement Subcommittee for facilitation.

In addition, CANS implementation will continue to focus on development of the automated CANS system over the next ten months.

Challenges

1. The original QMIA Plan was written prior to Idaho's recent work with Praed in the development of a TCOM system. QMIA Plan will be reviewed in June and July of 2018 and revised to match with and assure consistency with the Settlement Agreement, Implementation Plan and TCOM.

2. The QMIA Council has experienced some difficulties in membership attendance at meetings due to conflicting priorities.

Next Steps

- Achieve continuous quality structure and improvement through TCOM implementation and training.
- Review a proposal for Quality Review (QR) which will then be reviewed by the IGT and by the Plaintiffs' counsel.
- Establish a QMIA System Improvement subcommittee to facilitate work on Quality Improvement Plans approved by the QMIA Council.

Strategy 7.B

The QMIA Council will adapt and enhance existing quality assurance infrastructure activities.

Each of the YES system partners has existing quality assurance activities in place. The partners use record review, site review, credentialing, complaints, appeals, and review of serious incidents and the mechanisms to assess the current quality issues in each of their programs. The QMIA Council has completed an inventory of each parties' current quality improvement projects which are reported in the QMIA Quarterly Report #5, click here to access the full report.

The following quality improvement activities were noted as "in process" within this report:

- Division of Behavioral Health (DBH)
    - Due Process: Assessment of regional due process procedures and implementation of statewide DBH procedures.

  - Creation of informing materials for families related to the complaints process.
  - Hospital Discharges: Review of state operated hospital discharge policies to make discharge process and post-discharge easier on families.
- Division of Medicaid
  - Pharmacy Quality Improvement Project: The Idaho Medicaid Pharmacy Program has had a major focus on improving the use of psychotropic medications in children since 2011. Many efforts and interventions have been directed toward those children in foster care. Some of the most successful interventions were establishing red flags for when psychotropic medication may be excessive or outside other best practice parameters and doing individual case management with Family and Community Services (FACS) staff, a Medicaid pharmacist, a physician representative from Optum and the foster child's case worker. In 2016 and 2017 there was a focus on the antipsychotic drug class use in children. The goal was to ensure that use of second generation antipsychotics in children younger than 6 years old was appropriate and resulted in positive outcomes. Guidelines were established for antipsychotic use in children younger than 6 years old, which is to be operationalized with a prior authorization form we have created that includes a requirement for informed consent.
  - Psychiatric Residential Treatment Facility Review Process: Medicaid focused on reviewing and improving the process for Psychiatric Residential Treatment Facilities (PRTF) placements in 2017. Application tracking and weekly staffing with management quickly showed areas Medicaid could focus improvement activities. The primary focus was decreasing the time between receipt of the completed application, approval of the request, and completed placement. Medicaid successfully decreased the average turn-around time of 60-90 days in 2016 to 27 days in 2017.
  - Expansion of Cross-Functional Team: Cross-functional team expanded to add additional medical and behavioral health experts.
- Division of Family and Community Services (FACS)
  - Foster Parent Training: Improve foster parent training through the development of Professional Resource Family development plans and specialized, competency-based training curricula.
  - CANS Tool: Continue implementation of Family and Community Services CANS tool.
  - Stakeholder Engagement: Improve stakeholder engagement in Continuous Quality Improvement initiatives with technical assistance from the Capacity Building Center for States
- Department of Juvenile Corrections (IDJC)
  - "Think Trauma": Trauma-informed care training for direct care staff.
  - Funding pass through to Mental Health Program: Approximately 25% of funding passed through to counties and local communities to support effective programming and reintegration. Mental Health Program is one

stream. Last year 245 juveniles were served with a 90% success rate (not being committed to IDJC).
    - Behavioral Health Referral (pilot): Early identification of youth to assist staff in determining most appropriate placement/treatment as early as possible.
    - CANS information for IDJC staff: Information provided re: what the CANS means to IDJC, how to work with it, information for case managers.
- Department of Education (SDE)
    - Idaho Lives Project: School-based suicide prevention initiative involving the Sources of Strength program. Currently, around 47 schools are involved and data is collected on an ongoing basis. Feedback indicates that the schools implementing the program with fidelity and that have local buy-in are seeing improvements in school climate, student support and help-seeking behavior.
    - Safe and Drug Free Schools / ESSA Title IVA: Funding sources with requirements / allow for school districts to budget for crisis response efforts, bullying prevention, violence prevention, substance abuse prevention and general school climate / school safety measures.
    - Idaho Prevention Conference: Annual statewide conference focusing on creating optimal learning conditions with a heavy focus on bullying / harassment prevention, trauma informed instruction / disciplinary policy and diversion.

Challenges

1. The QMIA Council reconsidered the original QMIA structure which included five subcommittees.
    - The first System Improvement Subcommittee will be implemented in June 2018 and will be tasked with working on developing a quality improvement plan to address issues with hospital discharges and transitioning home from residential care. Two issues identified by families involved with IGT, IWG and QMIA-Council.
    - It was determined not to implement the Youth and Family Partnership Subcommittee as there were already other committees and workgroups that had been implemented and the Council felt the need was being met by the other workgroups (the Family Engagement Subcommittee of the IGT and the Parent Network).
        - Note that the work being done with the Youth is being spearheaded by DBH staff and the Boise chapter of Youth MOVE. Youth MOVE is assisting with the development and leadership of the Youth Voice Project initiative. Details regarding youth voice within YES were provided earlier in this report, and can be accessed by clicking here.
    - The Implementation Progress Workgroup was replaced by the various YES workgroups that were doing project management.
    - The Provider Advisory and Clinical Quality Subcommittees were put on hold as well as many providers were also involved in other workgroups

(such as the Clinical Advisory, Workforce Development, Communications, Practice Manual, and IGT).

Next Steps

- Collect data related to hospital discharges and transition home from residential facilities from a survey distributed to families participating in the Family Network.
- Implement the System Improvement Subcommittee by June 30, 2018.

Strategy 7.C

The QMIA Council will monitor, assess, and report system performance using performance metrics.

The previous Annual Implementation Progress Report addressed the progress of Strategy C, indicating that the QMIA Council would continue to use existing data in conjunction with Dr. Israel's consultation and publish quarterly reports.

Idaho's child serving systems have been measuring, assessing and reporting on Idaho's children and youth who need mental health services, YES system performance, and monitoring their progress on implementation of the Settlement Agreement.

The QMIA Council and Data and Reports team is working closely with Dr. Nate Israel of the Praed Foundation to develop the structure needed to use data for management, measuring what needs to be managed, and implementing improvement projects to address issues that are identified. The State has developed the Idaho Transformational Collaborative Outcomes Management (TCOM) Model describing how data will be used to assess the system of care which can be found in Appendix C and has also been referenced earlier within this report; Strategy 2.C.

The QMIA Data and Reports Team established the following methodology for prioritizing data collection:

- Identify and utilize existing reports from each of the parties.
- Utilize data that is easily accessible in published reports and on websites.
- Develop contracts with universities to assist with data collection needed based on QMIA and Workforce Development.
- Identify gaps in collection of data specified in the Settlement Agreement and begin the establishment of systems to collect the data.
- Work collaboratively to define data elements and identify a method for creating a unique identifier for each child to reduce duplication.

The standing report for QMIA, the QMIA Quarterly, has been published on a quarterly basis as required. Input from stakeholders has been solicited to improve the content and usefulness of the report. The QMIA quarterly reports can be accessed by clicking here.

QMIA has also assisted with informing the contract work with Boise State University, for development of reports on Class Membership, projected Intensive Care Coordination

(ICC) utilization and the workforce development provider survey and the provider profiles mentioned previously.

Challenges

The following challenges were noted regarding QMIA data and reports:

1. Data sharing is currently limited between partner agencies due to Health Insurance Portability and Accountability (HIPAA) restrictions which are intended to protect patient's medical records.

2. Data elements tracked by each partner vary based on their federal and state requirements. The Data and Reports team has developed a YES Report Profile and Data Dictionary.

3. Limited CANS data is available as use of the CANS tool has only recently begun. Data will become available on an ongoing basis as more CANS are completed for existing as well as new clients.

4. It's early in the implementation of YES services so there is only limited system performance to measure and evaluate. How well the QMIA works will be tested in the coming months as more services come on line and more children are served.

Next Steps

- As CANS data becomes available the QMIA Quarterly reports will include the number and characteristics of children and youth assessed for YES.
- A beta version of CANS reporting is targeted to be completed Spring of 2018.
- DBH is in the process of creating YES data and outcomes dashboards. A timeline for automated public-facing data dashboards has not yet been confirmed but plans are for data to be available in the Fall of 2018.

Strategy 7.D

Develop a Continuous Quality Improvement culture within the Children's System of Care beginning June 1, 2016.

Considerable system management work has been done through a contract with the Praed Foundation. Praed consultants have been assisting with the implementation of the Transformational Collaborative Outcomes Management (TCOM) approach. TCOM is described as a conceptual and practical framework for managing complex systems. The TCOM approach is based on the concept that the multiple perspectives in a complex service system creates conflicts. The conflicts that arise are best managed by focusing on a common goal, or a shared vision. In the YES system, the shared vision is to improve the lives of children, youth and families. With assistance from the Praed Foundation, the state is working toward creating a continuous quality improvement culture within the YES system where all stakeholders continue to return to this shared vision.

Challenges

1. The QMIA Council and IGT are still developing an understanding of TCOM. An assessment of TCOM implementation indicates that while some system partners have begun to establish a baseline comprehension of the TCOM, most are still just assimilating the basic concepts.
2. To fully develop TCOM each system partner will need to clearly designate individuals as subject matter experts.

Next Steps

- Continue training on TCOM for the QMIA Council and IGT.
- Repeat the TCOM implementation protocol and provide targeted education on each aspect of implementation.
- Continue training on TCOM to further develop subject matter experts in each of YES system partners.
- Individuals clearly designated for each YES system partner to be subject matter experts in TCOM.
- Idaho is working with the Praed Foundation to host a Regional TCOM Conference in May 2019.

Strategy 7.E

Provide accountability by monitoring Idaho's progress toward completion of Outcomes and Exit Criteria required by the Settlement Agreement beginning June 1, 2016.

The QMIA Plan identified the measures and indicators that are being used or will be used to monitor the progress towards completion of the Outcomes and Exit Criteria.

One of the established methods of assuring accountability to the Settlement Agreement is through the monthly IWG meetings with regular status updates provided to the Plaintiffs.

Another method is through the QMIA-Q report and Annual Implementation Progress Report address both the progress made toward implementation and the progress toward completion of Outcomes and Exit Criteria.

In the Annual Implementation Progress Report the focus of the report is on the Implementation Plan, however there is direct relationship between the specific outcomes and exit criteria listed in the Settlement Agreement and the objectives and strategies in the Implementation Plan. This relationship is identified in the tables in the following section of the report.

Next Steps

- The status updates will continue to be improved through input by Plaintiffs so that the level of detail they want to have included is in the reports.

- Complete matrix with each Strategy and Sub strategy from the Implementation Plan.
- Use the matrix as part of QMIA review process to ensure that implementation is on track.
- Identify resources for QMIA of implementation plan.

V. Settlement Agreement Outcomes

This section of the Report provides information on the progress towards achieving the Outcomes defined in the Settlement Agreement which are the expected results of completing the Court approved Implementation Plan. A three-year sustainability period shall begin once the Court has determined substantial compliance with the Outcomes. The Outcomes are listed within the table and there is a link provided to narrative that is associated with the section in the Implementation Plan. The Status column is reflective of the Defendant's perspective on the progress of achieving the outcome and does not imply Plaintiff's agreement nor Court determination as to the achievement of the Outcome. Status clarifications for the following tables are listed below:

- In-Progress: Work has begun toward satisfying this Outcome or Objective, however, the work is not yet considered completed. Details on progress, challenges and next steps can be found within the assigned narrative.
- On-Going: Work is either in-progress or completed, however this is an Outcome or Objective with components that do not come to an end, such as a process, and therefore work will be continuous.
- Completed: Defendants believe all planned work has been completed and the Outcome or Objective is considered satisfied.
- Delayed: Work has begun toward satisfying the Outcome or Objective, however, the target completion date has not been met. Details on progress, challenges and next steps can be found within the assigned narrative.
- Not yet Started: Work on this Outcome or Objective is planned for a future date and therefore has not yet begun. Timelines and Dates are noted for these items.

A. Services Outcomes

Services Outcomes		
Outcome	Status	Link to Details within Report
a. Establish and annually update the range of expected Class Members service utilization, as set forth in paragraph 24;	Completed	Objective 1, Strategy G
b. Develop statewide capacity to timely provide Services and Supports in appropriate scope, intensity	In-Progress Target date for	Objective 1, Strategy J

and duration to Class Members for whom it is medically necessary;	completion June 2019	
c. Provide the full array of Services and Supports, as defined in Appendix C, statewide as needed by and clinically appropriate for Class Members;	In-Progress Target date for completion June 2019	Objective 1, Strategy J
d. Timely provide Class Members with Services and Supports that are appropriate in scope, intensity and duration to meet to their individual strengths and needs, as described in paragraphs 18, 22, 23 and 36; and	In-Progress	Objective 1, Strategy J
e. Provide ICC, as defined in Appendix C, to Class Members with more intensive needs, as set forth in paragraphs 19 through 21.	In-Progress	Objective 1, Strategies A-D

B. Principles of Care and Practice Model Outcomes

Principles of Care and Practice Model Outcomes		
Outcome	Status	Link to Details within Report
a. Develop, adopt, and deliver Services and Supports to Class Members with fidelity to the Practice Model statewide and consistent with the Principles of Care and the Agreement, as set forth in paragraphs 25 through 27; and	In-Progress, On-going	Objective 2, Strategy A, Objective 2, Strategy B
b. Require that contracted mental health providers or mental health managed care contractors deliver services to Class Members consistent with the Principles of Care and Practice Model	In-Progress, On-going	Objective 2, Strategy A

C. Access Outcomes

Access Outcomes		
Outcome	Status	Link to Details within Report
a. Develop, adopt, and consistently use the Access Model statewide to identify, screen, assess, refer, and link Class Members to services and supports, as described in paragraphs 28 through 36 and Appendix A;	In-Progress	Objective 3, Strategy A
b. Implement and use the CANS tool statewide, as described in paragraph 32, to: i. Screen potential Class Members for unmet mental health needs; ii. Assess Class Member's individual and family strengths and needs; iii. Support clinical decision-making and practice; and iv. Measure and communicate client outcomes; and v. Improve service coordination	In-Progress, On-going	Objective 3, Strategy D
c. Develop, adopt, and use statewide a uniform, age-appropriate screen, described in paragraph 33, to identify potential Class Members with unmet mental health needs;	In-Progress, On-going	Objective 3, Strategy C
d. Develop, adopt, and use statewide a standard mental health assessment, described in paragraph 34, to determine class membership status for potential Class Members referred for an assessment;	Completed	Objective 3, Strategy D
e. Establish threshold levels of functional impairment as measured by the CANS tool, in consultation with clinical expert(s) mutually agreed by the Parties, as described in paragraph 35, to be used by Defendants in determining eligibility (i) to become Class Members and (ii) to receive ICC services;	Completed	Objective 3, Strategy C.1
f. Use the threshold levels of functional impairment established pursuant to paragraph 35 when determining eligibility for class membership;	Completed	Objective 3, Strategy C.1
g. Make descriptions or explanations of this Agreement, the Services and Supports, the Principles of Care and Practice Model, and the Access Model easily and publicly accessible to Class Members, their families, and other stakeholders, including but not limited to, posting information on Defendants' websites as described in paragraphs 36 and 37;	In-Progress, On-going	Objective 3, Strategy F
h. Develop and implement a statewide communication plan for outreach and education of the community,	In-Progress, On-going	Objective 3, Strategy F

stakeholders, and families, as described in paragraph 38; and		
i. Require that contracted mental health providers or mental health managed care contractors deliver services to Class Members consistent with the Access Model.	In-Progress	Objective 3, Strategy B

D. Workforce Training and Development Outcomes

Workforce Training and Development Outcomes		
Outcome	Status	Link to Details within Report
a. Develop and implement a workforce development plan, as described in paragraph 39;	Part II of the Workforce Development and Training Plan is in development and is expected to be published in July of 2018	Objective 4, Part I, Strategy B
b. Develop and adopt a Practice Manual, as described in paragraph 40;	Planned for Oct 2018	Objective 4, Part II, Strategy A-B, Objective 4, Part II Strategy C
c. Consistently use a Practice Manual to guide clinical and programmatic activities statewide, as described in paragraph 41;	Planned for Oct 2018	Objective 4, Part II, Strategy C.5
d. Educate and train agency staff, providers, and other community and system partners, as set forth in paragraphs 41 and 42, to use and follow the Access Model, Practice Model, and Practice Manual: i. To identify and refer potential Class Members for screening; and ii. Deliver services and supports to Class Members; and	Foundational Training completed, CANS Training in progress, Clinical and Operational Training on going	Objective 2, Strategy B.2, Objective 3, Strategy C, Objective 4, Part II, Strategy C

e. Educate and train agency staff and providers to use the CANS tool	Piloted with DBH Fall 2017, Implementing Statewide starting July 2018	Objective 3, Strategy D

E. Due Process Outcomes

Due Process Outcomes		
Outcome	Status	Link to Details within Report
a. Develop, adopt, and consistently use a complaint process, as described in paragraph 43, as part of the Practice Model's CFT approach;	In-Progress. Due Oct 1, 2018	Objective 5, Strategy A
b. Provide written notices of action when the circumstances defined in paragraph 44 apply;	In-Progress	Objective 5, Strategy A
c. Provide written notices of action that comply with the criteria defined in paragraph 45;	In-Progress	Objective 5, Strategy A
d. Provide informational materials regarding the circumstances in which Class Members have a right to receive a written notice of action and request a fair hearing on their respective websites;	In-Progress	Objective 5, Strategy A.4
e. Make modifications to contracts necessary to establish the complaint and due process protocols as defined in paragraphs 43 through 46;	In progress	Objective 5, Strategy A.3
f. Develop, adopt, and use a process to monitor and periodically report on compliance with the complaint and due process protocols as defined in paragraphs 43 through 46; and	Not started – Planned for Oct 2018	Objective 5, Strategy B
g. Collect and report data on written notices of action, complaints, and fair hearing requests and outcomes.	Not started – Planned for Oct 2018	Objective 5, Strategy B

F. Governance and Interagency Collaboration Outcomes

Governance and Interagency Collaboration Outcomes		
Outcome	Status	Link to Details within Report
a. Establish and use an Interagency Governance Team, as described in paragraph 49 and Appendix D;	Completed	Objective 6, Strategy A
b. Adopt and use operational guidelines for the Interagency Governance Team, as described in Appendix D; and	In-Progress	Objective 6, Strategy B
c. Include a current or former Class Member representative, a parent or family member of a current or former Class Member representative, and a children's mental health consumer or family advocacy organization representative as part of the Interagency Governance Team.	Completed, On-going	Objective 6, Strategy B

G. Quality Management Improvement and Accountability (QMIA) Outcomes

Quality Management, Improvement and Accountability Outcomes		
Outcome	Status	Link to Details within Report
a. Develop and implement a QMIA plan, as described in paragraph 52;	Completed	Objective 7, Strategy A
b. Develop and operate a QMIA System with capabilities consistent with the criteria defined in paragraph 53;	In-Progress	Objective 7, Strategy B
c. Measure and publicly report QMIA indicators, including, but not limited to, those required in paragraph 55;	In-Progress	Objective 7, Strategy C
d. Jointly develop with Plaintiffs' counsel a QR process, as described in paragraph 56;	Not Started-Planned for Aug 2018	Objective 7, Strategy D.4
e. Conduct QRs, as described in paragraph 57;	Not Started-Planned for July 2019	Objective 7, Strategy D.5
f. Publicly report on the results of the QRs, as described in paragraph 58; and	Not Started-Planned for January 2020	Objective 7, Strategy D.5
g. Achieve improved overall outcomes for Class Members, as measured by improvements in aggregated	Not Started – Planned to	Expected outcome of

CANS domain scores and/or relevant clinical items from the CANS tool, in each Region.	begin July 2018	Implementation Plan

GLOSSARY

Algorithm: A set of instructions for a process that leads to a predictable result; set of rules to be followed in calculations or other problem-solving operations; business flow diagrams.

Class Members: Are Idaho residents with a Serious Emotional Disturbance who are eligible under the Settlement Agreement for services and supports provided or arranged by Defendants and:

a. Are under the age of eighteen (18);
b. Have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosable mental health condition or would have a diagnosable mental health condition if evaluated by a practitioner of the healing arts operating within the scope of his/her practice as defined by Idaho state law; [7] and
c. Have a substantial functional impairment that is measured by and documented using a standardized instrument conducted or supervised by a qualified clinician or would have been measured and documented had an assessment been conducted.

Child and Adolescent Needs and Strengths (CANS): A multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Child and Family Team (CFT): A teaming process that brings together the family and individuals that the Class Member and family believe can help them develop and implement a care plan that will assist them in realizing their treatment goals; the CFT may be small or large.

Commitments: As described in the Settlement Agreement, the commitments are the items or actions that the State will pursue to achieve the intended results of the Settlement Agreement.

Community Based Services: Refers to a continuum of services, from support to intense levels, that operate in targeted population's community that is reflective of the community and meets the community's needs for services; includes hospitals and residential settings. Communities are defined on a continuum from neighborhoods to the whole state.

Completed: Refers to an Objective from the Implementation Plan that has been finished.

---

[7] A substance use disorder, or development disorder alone, does not constitute an eligible diagnosis, although one (1) or more of these conditions may coexist with an eligible mental health diagnosis.

Continuum of care: The array of services and supports as defined in the Settlement Agreement. spanning all levels and intensity of care.

Idaho Behavioral Health Plan (IBHP): Idaho Medicaid's managed care behavioral health plan that is a carved-out program from the overall fee-for-service medical assistance program. Read more about the IBHP on the DHW website.

Intensive Care Coordination (ICC): A case management service that provides a consistent single point of management, coordination and oversight for ensuring that children who need this level of care are provided access to medically necessary services and that such services are coordinated and delivered consistent with the Principles of Care and Practice Model.

In-Progress: Refers to an Objective from the Implementation Plan that is still being developed.

Interagency Governance Team (IGT): A collaborative interagency governance team, including stakeholders, responsible to coordinate and oversee implementation of the Settlement Agreement

On-going: Refers to an Objective from the Implementation Plan that has been developed and is continuing to be implemented.

Parties: Parties in the Jeff D. class action lawsuit: Plaintiffs' counsel, Idaho Department of Health & Welfare, Idaho Department of Juvenile Corrections, State Department of Education.

Partners: YES System Partners to the Jeff D. class action lawsuit: Idaho Department of Health & Welfare, Idaho Department of Juvenile Corrections, State Department of Education.

Person-Centered Planning: A process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the Person-Centered Planning process. The process includes participants freely chosen by the family or individual who can serve as important contributors. The family or participants in the Person-Centered Planning process enable and assist the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes becomes part of the plan of care.

Potential Class Member: Any Idaho resident with unmet mental health needs who has not yet reached their 18th birthday and who IDHW has not yet determined to be a Class Member.

QMIA Council: A quality management, improvement and accountability entity within the YES system structure that is a cross-agency collaborative made up of executive level staff and children's mental health stakeholders with responsibilities specific to meeting the terms of the Settlement Agreement.

Serious emotional disturbance (SED) (Idaho Code, 16-2403 (13)): An emotional or behavioral disorder, or a neuropsychiatric condition which results in a serious disability, and which requires sustained treatment interventions, and causes the child's functioning to be impaired in thought, perception, affect or behavior. A disorder shall be considered to "result in a serious disability" if it causes substantial impairment of functioning in family, school or community. A substance abuse disorder does not, by itself, constitute a serious emotional disturbance, although it may coexist with serious emotional disturbance.

Settlement Agreement or Agreement: The legal document that spells out the terms of the comprehensive agreement reached by the Parties and plaintiffs in the Jeff D. class action lawsuit. The Settlement Agreement includes the requirements necessary to be fulfilled by the State of Idaho for the lawsuit to be dismissed.

Stakeholders: Individuals and organizations that affect or are affected by the changes in the Settlement Agreement. This includes but is not limited to youth with SED, their parents, advocates, providers of youth and children's mental health services, higher education organizations, and defendant agencies.

Status: Refers to the progress towards completion or implementation of an Objective from the Implementation Plan. An Objective may have more than one status.

System of Care (SOC): "A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life" *Stroul, Blau & Friedman, 2010*.

Transformational Collaborative Outcomes Management (TCOM): A set of collaborative processes and information which consistently point people to the shared vision of helping children and families achieve their health and wellness goals, making it is easier to create and manage effective and equitable systems.

Workgroup: A group of representative stakeholders chartered to perform tasks to accomplish objectives in the Implementation Plan. Unless otherwise noted, workgroups include, at a minimum, parents, advocates, providers, and defendant agency staff.

Wraparound: Wraparound is a collaborative, team based, principles driven, planning process. Through the wraparound process teams create one individualized plan of care to meet the needs and improve the lives of multisystem involved youth and their families.

APPENDIX A

History of the Jeff D. Class Action Lawsuit

In August 1980, children who had or could be diagnosed with a serious emotional disturbance (SED), commenced a lawsuit against the Governor of Idaho, the Superintendent of Public Instruction (representing the State Department of Education, SDE), the Director of the Idaho Department of Health and Welfare (IDHW), and the Administrator of State Hospital South. The Director of the Idaho Department of Juvenile Corrections (IDJC) was joined as a Defendant in 2000 after the IDJC became an independent state agency. The Complaint alleged that adequate mental health programs and services, including community based treatment and educational services, were not being provided in violation of the Class Members' rights under the United States Constitution, the Idaho Constitution, and several federal and state statutes. The lawsuit sought to address two primary issues: 1) the intermixing of adults and juveniles in facilities at State Hospital South and 2) the lack of community-based mental health treatment services and programs provided to children and youth with SED.

In 2013, under the direction of the Court, representatives of Parties in the lawsuit and stakeholders began negotiations on a Settlement Agreement that would achieve substantial compliance and fulfill the purposes of the Consent Decrees that had been agreed to and approved by the Court over the past 32 years. The Parties negotiated and the Court approved the *Jeff D.* class action lawsuit Settlement Agreement (Agreement) in 2015. The Agreement required the creation of an implementation plan (now known as the Idaho Implementation Plan) within nine (9) months after approval, a four (4) year implementation period, and a three (3) year sustainability period of successful operations to be completed before a final order will be issued dismissing the lawsuit and ending court monitoring by the issuance of a permanent injunction. The detailed procedural history of the *Jeff D.* case and additional detail about requirements and timelines that must be met is documented in the Settlement Agreement, which can be found at: http://youthempowermentservices.idaho.gov.

As part of constructing the Implementation Plan, the issue of officially naming the project for inclusion in the legal document was considered. In May 2015, the project was recognized as "Children's Mental Health Reform Project" and accepted by the District Court. Later in the summer of 2015, the Youth Empowerment Services (YES) logo and byline were included on Project documents.

Settlement Agreement Timeline:

Jeff D. Class Action Lawsuit: 1980

↓

Formal Mediation: September 2013 - December 2014

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Settlement Agreement: June 2015

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Idaho Implementation Plan: May 2016

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Youth Empowerment Services Project Plan: September 2016

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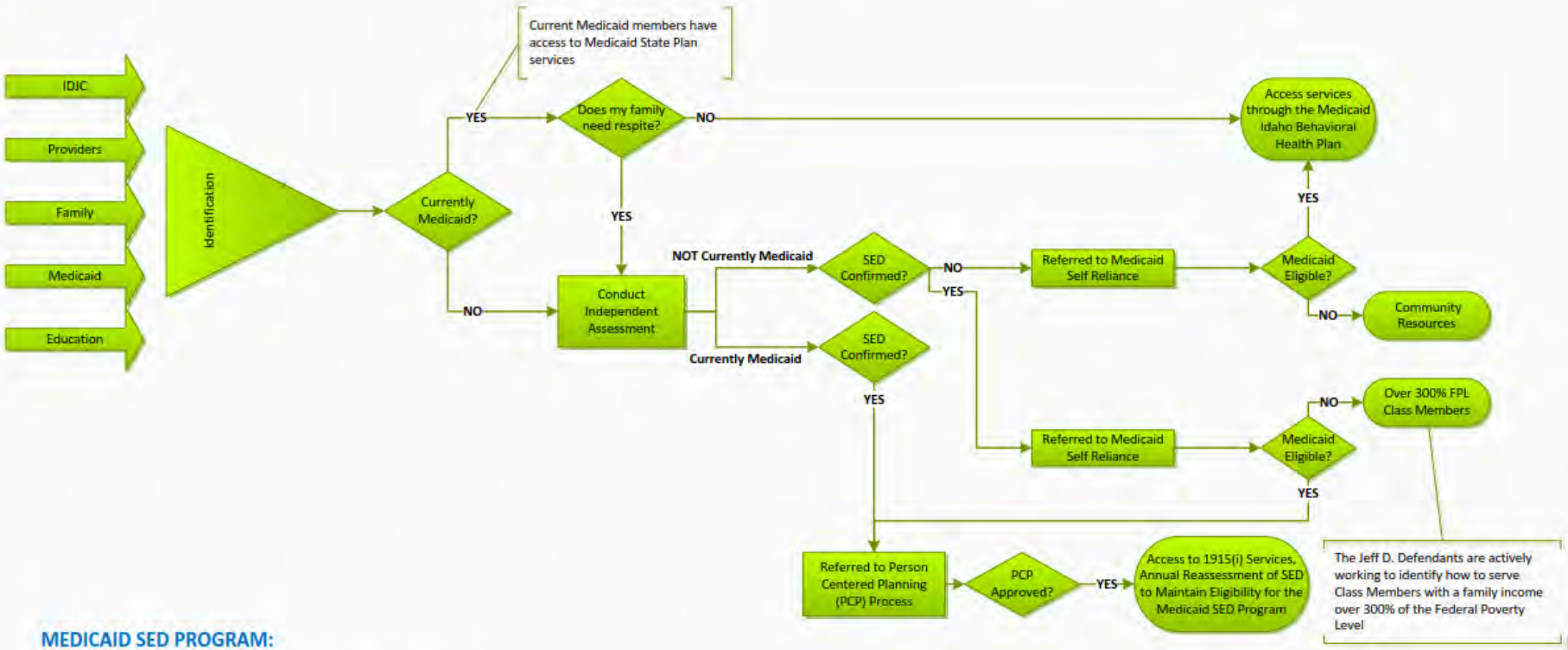
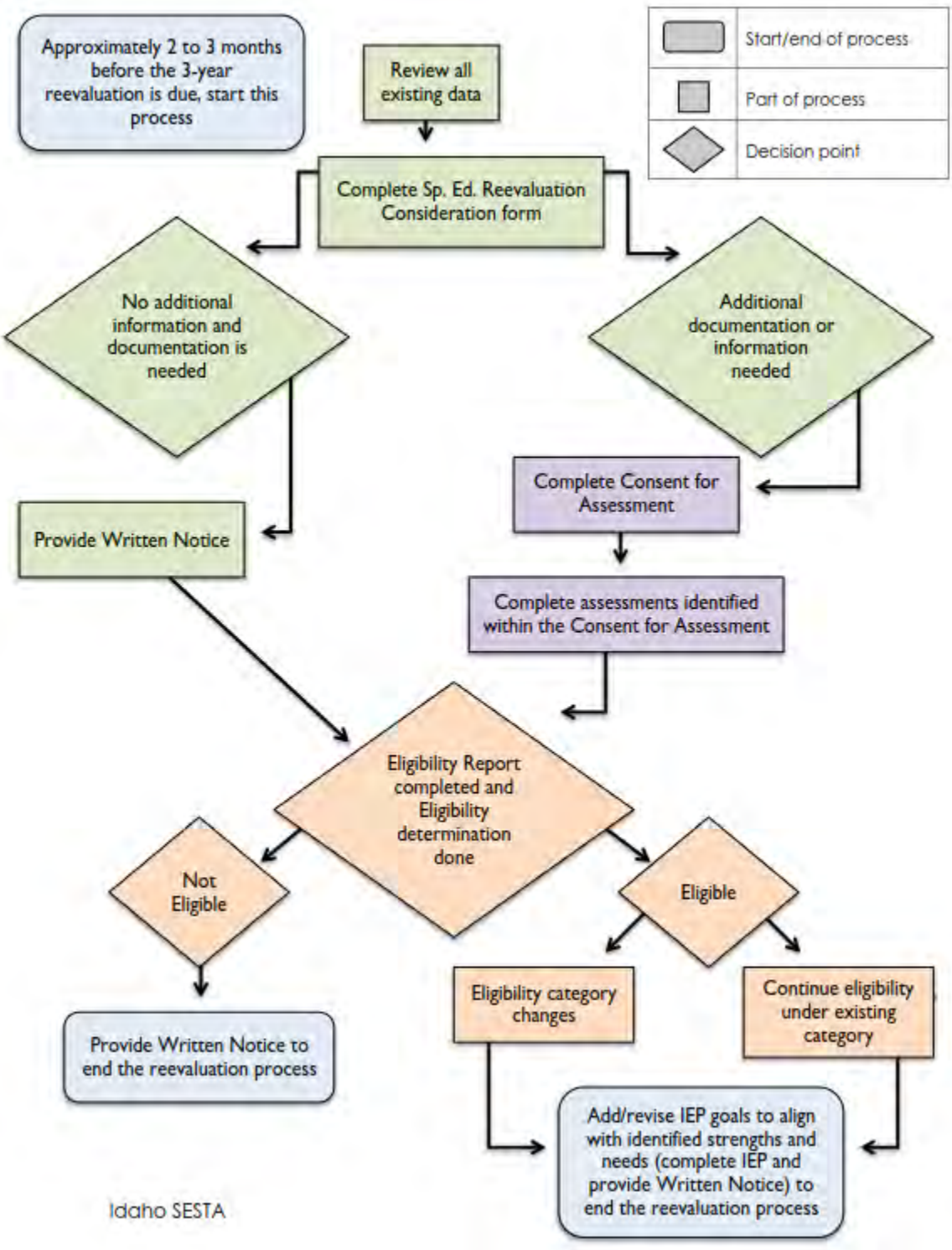
Children's Mental Health System of Care: June 2019 +

APPENDIX B

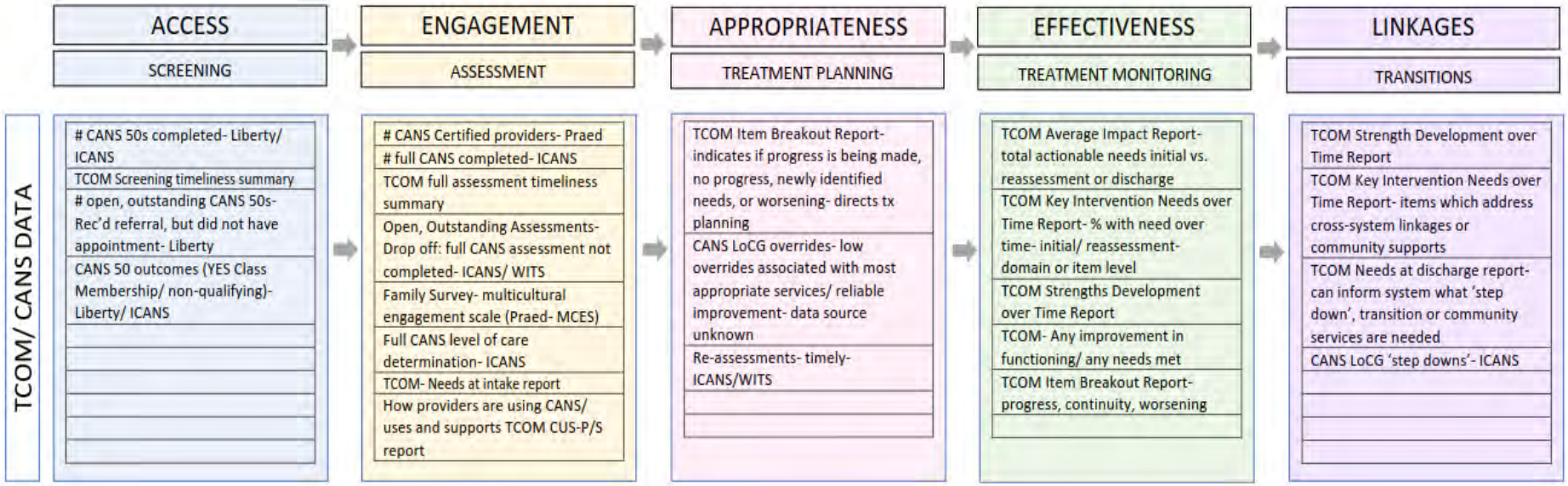

Access to Medicaid Mental Health Services and the Medicaid SED Program
(May 2018)
IDJC
Providers
Family
Medicaid
Education
Identification
Current Medicaid members have access to Medicaid State Plan services
Currently Medicaid?
YES
NO
Does my family need respite?
NO
YES
Access services through the Medicaid Idaho Behavioral Health Plan
Conduct Independent Assessment
NOT Currently Medicaid
Currently Medicaid
SED Confirmed?
NO
YES
Referred to Medicaid Self Reliance
Medicaid Eligible?
YES
NO
Community Resources
SED Confirmed?
YES
Referred to Medicaid Self Reliance
Medicaid Eligible?
NO
Over 300% FPL Class Members
YES
Referred to Person Centered Planning (PCP) Process
PCP Approved?
YES
Access to 1915(i) Services, Annual Reassessment of SED to Maintain Eligibility for the Medicaid SED Program
The Jeff D. Defendants are actively working to identify how to serve Class Members with a family income over 300% of the Federal Poverty Level
MEDICAID SED PROGRAM:
As part of the Youth Empowerment Services System of Care, Medicaid has developed the Medicaid SED Program that allows children with an SED confirmed through Medicaid's independent assessment process access to Medicaid eligibility and 1915(i) services with a family income up to 300% of the Federal Poverty Level.
Services available under the 1915(i) State Plan option are services not traditionally covered by Medicaid dollars. (i.e. Respite)

State Department of Education- Reevaluation Guidance Flow Chart



APPENDIX C

YES TCOM Model



For more information regarding specific TCOM reports, please visit PraedFoundation.org.

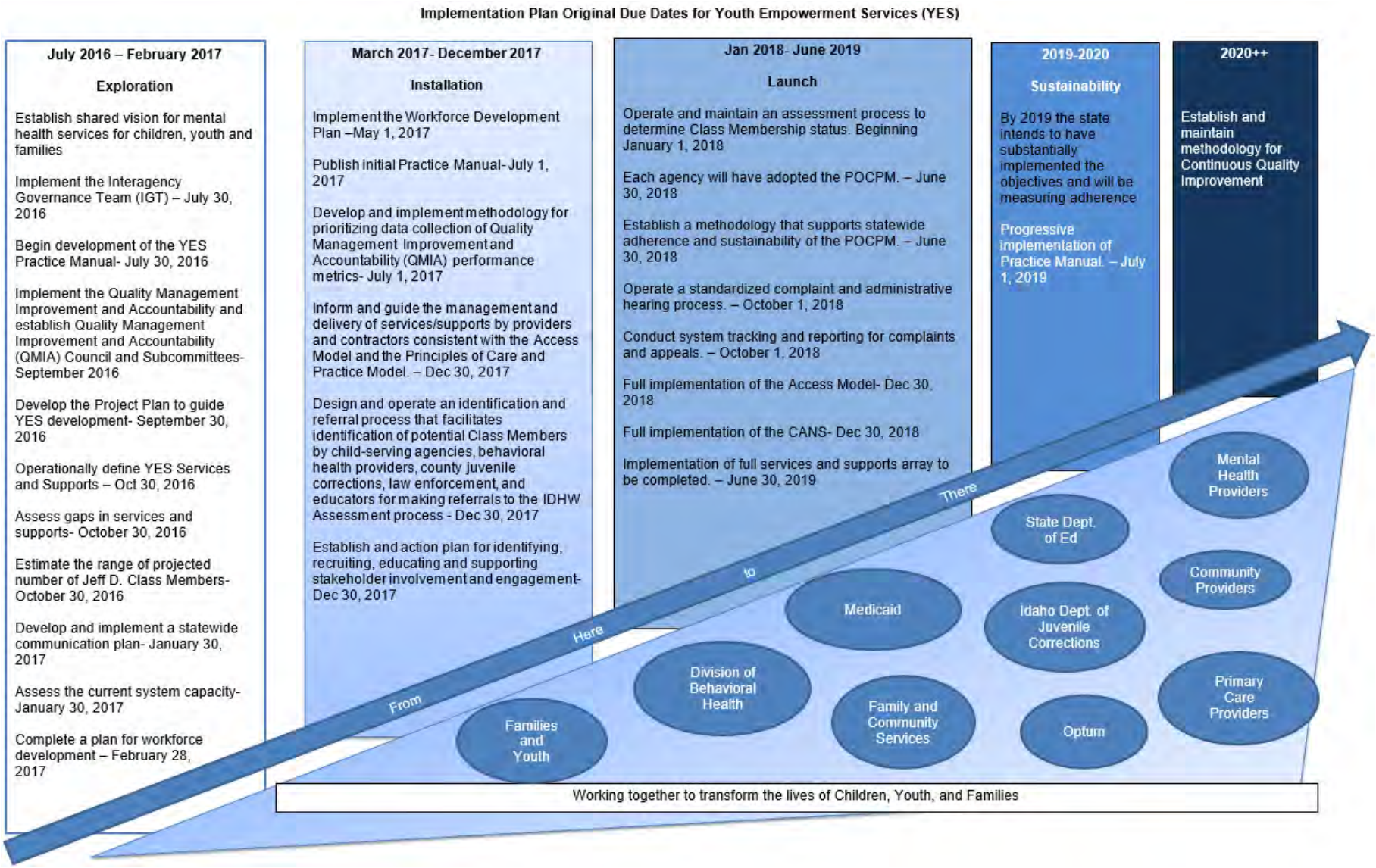
APPENDIX D

Key Elements of ICANS Phases 1-3

ICANS Phase	Key Elements	Additional Information: March 2017-May 2018
Phase 1	ICANS basic platform and assessment functionality for use in the ICANS Pilot 1	Business and technical requirements were completed for the ICANS system for all 3 development phases Phase 1 functionality was released and made available to a limited pilot group of users on 9/11/2017
Phase 2	Enhancements to the ICANS platform that allow the Independent Assessor to complete the CANS 50, a subset to the Children's Mental Health CANS used in the determination of Youth Empowerment Services Class Membership and Medicaid eligibility	Business and technical requirements were completed for the ICANS system for all 3 development phases Phase 2 ICANS functionality (Part 1) released for testing in late November. -Testing completed 12/1/17. -Multiple non-critical issues (no-limited impact to workflow) identified for resolution. -Phase 2 ICANS functionality (Part 2) scheduled for release on 12/15/2017. - Phase 2 functionality was made available statewide as of 1/1/18 to Independent Assessors and Division of Behavioral Health staff.
Phase 3	Additional enhancements to the ICANS that will allow users to consent, transfer, and share ICANS records to other authorized users. Enhancement will also include targeted prompts when high-risk items (i.e. those related to suicidality) are assigned a rating of 2 or 3, enhanced administration modes (i.e. Detailed-mode),.pdf upload capability to facilitate offline administration of the CANS, the addition of the Idaho Department of Health and Welfare Family and Community Services (FACS) CANS tool into the system (CFS-CANS), and the integration of CANS Certification information with the Praed Training site	Business and technical requirements were completed for the ICANS system for all 3 development phases Targeted for completion in 2018, the following enhancements will be made to the ICANS system: 1. Targeted high-risk prompts 2. Detailed administration mode 3. .pdf upload for offline CANS administration 4. Integrated certification management for CANS. 5. Initial steps to establish the technical framework for the inclusion of the CFS-CANS in the ICANS system. 6. Initial release of Phase 3 functionality available for DBH testing 5/7/18. 7. Additional releases to introduce remaining Phase 3 functionality components will occur routinely through November 2018.

APPENDIX E

Visual Representation of Implementation Plan Dates



APPENDIX F

What is YES?

The Idaho Youth Empowerment Services (YES) is a new system of care for Idaho's children and youth who meet criteria for a serious mental health condition.

It will provide a new way for families to find the mental health supports they need for their children and youth. It will be strengths-based and family-centered, and it will incorporate a team approach that focuses on providing individualized care for children.

Through a coordinated and collaborative effort, multiple child-serving agencies will work with the family to build a treatment plan around the unique needs and strengths of each child.

How do I use the Checklist?

This checklist tool can be used by anyone to help determine if a child may benefit from a full mental health assessment.

Families may also request a full mental health assessment without first going through the checklist.

In addition, school problem-solving teams may present this tool to further communicate with parents the importance of seeking additional services outside of the school setting. More information on these services can be found at:

www.yes.idaho.gov

Mental Health Checklist

If you check one or more boxes below, your child may be eligible for a more comprehensive assessment through YES: www.[website pending]

- ☐ My child has shown recent dramatic changes in behavior, mood, or interest level.
- ☐ My child has difficulty making and keeping healthy relationships with others.
- ☐ My child often worries or feels sad.
- ☐ My child often complains about not feeling well which impacts his/her activities (for example, stomachaches, headaches, etc.).
- ☐ My child has difficulty sleeping (too much or too little).
- ☐ My child often challenges, disregards, or defies authority.
- ☐ My child has trouble controlling his/her behavior when upset.
- ☐ My child does or says things that physically/emotionally hurt themselves, others, or animals.
- ☐ My child is often convinced of something that is not really true.
- ☐ My child has difficulty in various community settings such as school, church, clubs, and activities.
- ☐ My child or family experiences frequent, intense arguing and conflict.
- ☐ My family has experienced one or more stressful events that may continue to affect my child today.
- ☐ My family has difficulty understanding and meeting my child's needs.
- ☐ My family may require additional supports to meet my child's needs.

DRAFT

IDAHO DEPARTMENT OF HEALTH & WELFARE

450 W. State Street, Boise, ID 83702

Contact: YES@dhw.idaho.gov

www.yes.idaho.gov

Youth Empowerment Services (YES) is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and, in some cases, religion or political beliefs.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 211.

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 211.

Youth Empowerment Services

Empowering the mental wellness of children, youth and their families

Youth Mental Health Checklist

www.yes.idaho.gov

DRAFT

APPENDIX G

Family and Youth Involvement and Support Contract

To build a program that supports and sustains family and youth involvement at all levels of the Youth Empowerment Services (YES) program, the Department of Health and Welfare's Division of Behavioral Health is developing a *Family Youth Involvement and Support* contract. The Department will be seeking a contractor to assist in establishing family and youth voice as a permanent feature of the YES system of care. The expectation is that the successful contractor identifies, recruits, educates and supports family members and youth for involvement and engagement in system improvements, as well as provide support to families navigating the YES system. A single successful contractor shall provide orientation to family members who participate in the YES system of care process. The contractor shall also provide community awareness activities, a strategic plan for building family and youth involvement into the system, and a website and other materials that educate and support families of children with serious emotional disturbance (SED). This will be a statewide contract in which family and youth involvement methods shall be available to the public for the targeted population in each of the seven (7) regions, which includes rural and frontier areas throughout the State.

The Department hopes to contract with an organization who will provide the following activities to parents/caregivers and to youth utilizing methods that meet their needs and incorporating the YES Principles of Care. Input from Department staff, workgroup participants, parents/caregivers and youth contributed to the development of activities that are being considered for inclusion within the RFP.

Potential areas for inclusion:

- Engagement – identify and recruit family members with lived experience to be a part of the system of care
- Education – orientation of the YES system of care and education about mental health issues, how to access the system, where to find support, and what's needed in transitioning to the adult mental health system
- Involvement – opportunities to be involved in the system from workgroups, advocacy, trainings and community leadership
- Support – provide support to families needing information and resources, as well as support from others who have "been there"
- Advocacy – provide learning opportunities regarding how to advocate for their child (parents/caregivers) or for themselves (youth) on a local, state and federal level

It is expected that the *Family Youth Involvement and Support* contract will be in place by late summer- early fall of 2018.

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Attorney for Plaintiffs

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

JEFF D., et al,	)	Case No. 4:80-CV-04091-BLW
	)	
Plaintiffs,	)	JOINT MOTION AND STIPULATION FOR APPROVAL OF SETTLEMENT AGREEMENT AND PROPOSED ORDERS
	)	
vs.	)	
	)	
CLEMENT LEROY OTTER, et al,	)	
	)	
Defendants.	)	
	)	

COME NOW the Plaintiffs, by and through their attorneys, Howard Belodoff of Belodoff Law Office, PLLC, and Patrick Gardner on behalf of the Young Minds Advocacy Project, on behalf of themselves and the putative class they represent, and Defendants, by and through their attorneys, Michael Gilmore, Nancy Bishop, Mark Withers, and Andrew Snook, Deputy Attorney Generals for the State of Idaho, submit the following joint stipulation and respectfully request

that the Court enter an order granting approval of the parties' stipulated Settlement Agreement as follows:

WHEREAS, Plaintiffs filed suit in August 1980 on behalf of Idaho children suffering from severe emotional disturbances against the Governor of Idaho and other state officials, alleging that Defendants were failing to provide adequate and appropriate treatment and educational programs in the least restrictive environment in violation of their rights under the United States Constitution, the Idaho Constitution, and federal and state statute;

WHEREAS, in April 1983, the parties entered into a settlement agreement, approved and entered by this Court as a consent decree, that offered the injunctive relief the class members sought in their complaint;

WHEREAS, in December 1990 and again in December 1998, the parties entered two additional consent decrees, also approved by this Court, to provide community-based mental health services to class members;

WHEREAS, in November 2007, this Court granted Defendants' Motion to Vacate the consent decrees and dismissed the case, Dkt. 705;

WHEREAS, on May 25, 2011, the Ninth Circuit issued an opinion reversing this Court's vacatur of the consent decrees and remanded to this Court for further proceedings;

WHEREAS, on August 10, 2011, this Court ordered Plaintiffs' counsel to meet and confer with Defendants to address any concerns with the consent decrees, Dkt. 731;

WHEREAS, Plaintiffs and Defendants agreed to use an alternative dispute resolution process designed to help resolve the outstanding compliance issues in this action and the Parties selected a mutually acceptable facilitator to assist in negotiations and consulted with experts;

WHEREAS, Plaintiffs and Defendants, after eighteen months of negotiations, have successfully concluded the mediation of all outstanding compliance issues and reached a stipulated Settlement Agreement that will, if implemented, achieve the purposes of the prior consent decrees;

WHEREAS, it is in the interest of the public, the parties, and judicial economy to resolve the remaining compliance issues without continued litigation;

WHEREFORE, the parties hereby move the Court to approve the Settlement Agreement and enter the proposed orders as stipulated and agreed, by and between Plaintiffs and Defendants, as follows:

1. The parties agree to the terms of the Settlement Agreement incorporated herein, as though fully set forth, and attached as Exhibit A to this stipulation.
2. The parties agree that the Agreement is reasonable and can be implemented if Defendants perform all of their obligations thereunder.
3. The parties agree the Settlement Agreement shall inure to the benefit of and be binding upon the legal representatives and any successors of the parties.
4. The parties agree to the terms of the protective order, attached as Exhibit B to this stipulation, relating to confidential information regarding class members.
5. The parties agree to administratively terminate this civil action in the Court records, without prejudice to the right of the parties to reopen proceedings for good cause shown for the entry of any stipulation or order, or for any other purposes required for implementation of the Settlement Agreement, consistent with the proposed Administrative Termination Order, attached as Exhibit C to this stipulation. Notwithstanding the administrative termination of this action, however, the parties hereby stipulate and respectfully request that the Court retain

jurisdiction to enforce the terms of the Settlement Agreement. *See Kokken v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375 (1994).

DATED this 12th day of June, 2015.

/s/ Mark V. Withers
MARK V. WITHERS
Deputy Attorney General
Attorney for Defendants

DATED this 12th day of June, 2015.

/s/ Michael S. Gilmore
MICHAEL S. GILMORE
Deputy Attorney General
Attorney for Defendants

DATED this 12th day of June, 2015.

/s/ Howard A. Belodoff
HOWARD A. BELODOFF
Next Friend and Attorney for Plaintiffs

IT IS SO ORDERED.

DATED: _____

_____
B. LYNN WINMILL
Chief Judge
United States District Court

Printed: 10/1/2019 1:25 PM - Idaho - OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 12th day of June 2015, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing and a copy of this document to the following persons:

Howard A. Belodoff, ISB No. 2290
BELODOFF LAW OFFICE PLLC

PATRICK GARDNER, CB No. 208199 Pro Hac Vice
WESLEY SHEFFIELD, CB No. 287940 Pro Hac Vice
YOUNG MINDS ADVOCACY PROJECT

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ATTORNEYS FOR DEFENDANTS

/s/ Howard A. Belodoff
HOWARD A. BELODOFF

EXHIBIT A

EXHIBIT A

Jeff D. v C.L. "Butch" Otter, No. 4:80-CV-04091-BLW
Settlement Agreement

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The Parties to this lawsuit, Jeff D., *et al.* (hereinafter "Plaintiffs") by and through their counsel of record; C.L. "Butch" Otter, in his official capacity as Governor of Idaho; Richard Armstrong, in his official capacity as Director of the Idaho Department of Health and Welfare (DHW); Sharon Harrigfeld, in her official capacity as Director of the Idaho Department of Juvenile Corrections (IDJC); Sheri Ybarra, in her official capacity as Superintendent of the State Department of Education (SDE) (hereinafter "Defendants"), make the following Agreement:

I. PURPOSE

1. The purpose of this Agreement is to direct and govern the development and implementation of a sustainable, accessible, comprehensive, and coordinated service delivery system for publicly-funded community-based mental health services to children and youth with serious emotional disturbances ("SED") in Idaho. The specific objective of this Agreement is the development and successful implementation of a service array and practice model that are consistently and sustainably provided to Class Members statewide,[1] in the manner prescribed herein. As a result of this Agreement, Class Members will receive individualized, medically necessary services in their own communities, to the extent possible, and in the least restrictive environment appropriate to their needs.

2. Class Members are Idaho residents with a Serious Emotional Disturbance who are eligible under this Agreement for services and supports provided or arranged by Defendants and:
    a. Are under the age of eighteen (18);
    b. Have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosable mental health condition or would have a diagnosable mental health condition if evaluated by a practitioner of the healing arts operating within the scope of his/her practice as defined by Idaho state law; [2] and
    c. Have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified clinician or would have been measured and documented had an assessment been conducted.

3. Class Members and their families retain the choice whether to accept or reject voluntary services offered by Defendants under this Agreement. However, this Agreement does not apply to services provided to Class Members on an involuntary basis, such as those services provided involuntarily to Class Members in the custody of the state or those services required by court order.

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[1] For the purposes of this Agreement, "statewide" means sufficient in quantity, scope, duration, and geographic distribution to meet the needs of Class Members.
[2] A substance use disorder, or development disorder alone, does not constitute an eligible diagnosis, although one (1) or more of these conditions may coexist with an eligible mental health diagnosis.

4. a. Substantial compliance with this Agreement is intended to satisfy the obligations and fulfill the purposes of the prior consent decrees entered by the District Court in this matter. Upon the District Court's approval of this Agreement, and during the periods of implementation and sustainability, the consent decrees, entered in 1983, 1990, and 1998, and the Implementation Plan, approved in 2001, and the orders related thereto, shall be deemed suspended, and Plaintiffs agree not to seek enforcement of them.
b. Plaintiffs may move the District Court to lift the suspension of the consent decrees, Implementation Plan, and orders related thereto, in the event that Defendants are failing to substantially comply with the duties and obligations under this Agreement, and in the event that this Agreement's dispute resolution process has not successfully resolved the dispute concerning the alleged non-compliance. If such a motion is filed, Defendants shall bear the burden of proving substantial compliance of this Agreement to the District Court. If the District Court finds that Defendants have not substantially complied with this Agreement, the District Court shall lift the suspension and Plaintiffs may seek enforcement of applicable portions of the consent decrees, Implementation Plan, and orders related thereto, subject to Federal Rule of Civil Procedure 60(b)(5). During the pendency of any proceedings initiated under this paragraph, each party shall continue to fulfill its duties and obligations under this Agreement.

5. This Agreement will be completed in three (3) phases, including: (1) development of an Implementation Plan, as described in paragraphs 59 through 63; (2) execution of the Implementation Plan, as described in paragraphs 64 through 68; and (3) sustained performance and compliance with purposes and terms of this Agreement, as described in paragraph 79.
   a. The projected timeline for the Agreement includes approximately nine (9) months to develop the Implementation Plan, commencing once the District Court approves the Agreement, a period of up to four (4) years to complete the Implementation Plan, and a sustained performance and compliance period of three (3) years. The Parties may agree to shorten or lengthen any of the time periods according to the modification procedure defined in paragraph 97. The sustainability period shall commence when the District Court finds that Defendants have substantially complied with the Outcomes set forth in Section VI. Any party may submit a motion to the District Court requesting this finding.
   b. Upon successful implementation of the Agreement, wherein the Defendants are in substantial compliance with the terms of the Agreement, demonstrated through sustained performance of the Agreement as described in paragraph 79, the case shall be dismissed by the District Court. Simultaneous to the dismissal, a permanent injunction will be issued that ensures the Plaintiff Class will continue to be provided the services and supports consistent with the Principles of Care and Practice Model that have been successfully developed through the implementation of this Agreement.

6. This Agreement includes four (4) components: (a) Goals, (b) Commitments, (c) Outcomes, and (d) Exit Criteria.

   a. The Goals are intended (1) to aid in interpreting the meaning and purpose of this Agreement; and (2) to guide planning, implementation, development, and sustainability of Idaho's system of care for children with a serious emotional disturbance. Although the Parties agree that the Goals will be used for the purposes of interpretation and guidance, the Goals are not enforceable as separate requirements. The Goals are not Commitments, Outcomes, or Exit Criteria, and shall not be measured as such.

   b. The Commitments are the items or actions that Defendants will pursue to achieve the intended results of the Agreement. Defendants will substantially and timely comply with all of the Commitments and timelines set forth herein, and as further described in the Implementation Plan, during the pendency of this Agreement.

   c. The Outcomes are the expected achievements or results of Defendants carrying out the Commitments. The Outcomes are the sole objective measures that, when accomplished, determine at the end of the implementation period whether Defendants are in substantial compliance with the requirements for completing implementation of this Agreement.

   d. The Exit Criteria are the expected achievements demonstrating Defendants sustained compliance with the terms of the Agreement. The Exit Criteria shall be the sole objective measures that, when accomplished, determine at the end of the sustained performance and compliance period whether Defendants are in substantial compliance with the Agreement such that the lawsuit will be dismissed.

II. BACKGROUND

7. Original Complaint: In August 1980, the Class Members, a group of indigent children with a serious emotional disturbance, commenced a lawsuit against the Defendants, including the Governor of Idaho, the Superintendent of Public Instruction, the Director of the Idaho Department of Health and Welfare, and the Administrator of State Hospital South and their successors in interest. The Director of the Idaho Department of Juvenile Corrections was joined as a Defendant in 2000. The Complaint claimed that adequate care, treatment and educational services were not being provided in violation of the Class Members' rights under the United States Constitution, the Idaho Constitution, and several federal and state statutes. The Complaint, which sought declaratory and injunctive relief, contained two primary allegations: (1) mixing of juveniles with adults at State Hospital South violated the rights of Class Members; and (2) the Defendants were required to provide

community-based mental health and specialized education services to Class Members.

8. Procedural History: Over the ensuing thirty-four (34) years, the Parties entered several court-approved consent decrees and Plaintiffs' counsel obtained court orders to fulfill the purposes of the consent decrees in the provision of mental health treatment services to the Class Members.

   a. The 1983 Consent Decree addressed separating Class Members from adult mental patients at state institutions, assessing children's mental health programs, and making facilities and programs for mental health treatment and services available in a community-based setting.
   b. The 1990 Consent Decree addressed separating Class Members from adult mental health patients at all state mental health facilities, required the provision of an array of community-based mental health services, programs and professionals, and required Defendants to provide the necessary funding to implement the 1983 and 1990 Consent Decrees.
   c. In 1993, the District Court issued its Report and Recommendation requiring a minimum annualized amount of dedicated funding in each of IDHW's seven (7) regions to begin to deliver the community based mental health services required by the 1990 Consent Decree.
   d. The 1998 Consent Decree set forth an agreed upon screening form as part of the Jeff D. class definition, addressed contracting for and conducting of an independent "Needs Assessment" of children's mental health, required Defendants to request an increase in dedicated funding to implement the Recommendations of the Needs Assessment, and required a request for funding from the state legislature to expand the capacity of community-based services and to maximize Medicaid services to comply with all of the prior consent decrees. The Needs Assessment, issued in June 1999, included 50 Recommendations. The Needs Assessment led to an Implementation Plan, which contained Background Information/Framework for Implementation, Financial Statements, 252 Priority Action Items, and Timelines and a Desired Result sections. The District Court approved the Implementation Plan in June 2001.
   e. In September 2006, the District Court held a two (2) week "final compliance hearing" to determine whether Defendants were in compliance with the terms of the consent decrees. The District Court determined that compliance would be measured by the 252 Priority Action Items in the Implementation Plan and held that Plaintiffs' counsel had the burden of proof to establish non-compliance under the evidentiary standard for civil contempt.
   f. On February 7, 2007, the District Court concluded that Defendants had complied with all but 21 of the Action Items. The District Court further held that "once the Defendants are in compliance with these Action Items, the Defendants may file a motion to vacate the consent decrees." In June 2007, the Defendants filed a motion to vacate the consent decrees.

g. On November 1, 2007, the District Court vacated the consent decrees and Implementation Plan and dismissed the case. Plaintiffs' counsel appealed the order, asserting that it was error for the District Court to measure compliance based solely upon the 252 Priority Action Items, to apply the standard for civil contempt in determining whether to vacate the decrees and to place the burden on Plaintiffs' counsel to prove non-compliance.

9. Ninth Circuit Court of Appeals Decision: On May 25, 2011, the Ninth Circuit Court of Appeals reversed the District Court's order vacating the consent decrees and Implementation Plan. The Ninth Circuit found that the District Court's use of the civil contempt burden and standard of proof was improper for a determination of substantial compliance. The Ninth Circuit further held that the Defendants were required to sustain the burden of establishing that Defendants had substantially complied with the consent decrees or to demonstrate that the facts and the laws have changed so that "it is no longer equitable that the judgment should have prospective application." The Ninth Circuit further held that the Defendants had the burden to establish that if any deviation from literal compliance with the consent decrees occurred, such deviation did not defeat the essential purpose of the consent decrees. The Ninth Circuit also held that the District Court erred in accepting the Action Items as the entire measure of compliance with the consent decrees. Finally, the Ninth Circuit held that it had no way to determine whether the District Court's findings would have been different had the District Court placed the burden of proof on the Defendants to demonstrate they had substantially complied with the Action Items. The Ninth Circuit added that the status of compliance requires overall attention to whether the larger purposes of the consent decrees have been served, not just whether there was substantial compliance with the Action Items.

10. Settlement Efforts: On remand, the District Court instructed the Parties to follow a meet-and-confer process to address concerns regarding Defendants' substantial compliance with the consent decrees and to fulfill the purposes of consent decrees. On October 5, 2013, the Parties began intensive efforts to avoid further litigation and delays by negotiating a settlement agreement that would achieve substantial compliance and fulfill the purposes of the consent decrees. The Parties agreed they would enlist the assistance of a mediator to facilitate the negotiations. Thereafter, the Parties held seventeen (17) in-person mediation sessions and numerous sessions via conference calls from October 2013 through December 2014. Through these efforts, the Parties developed this Agreement. The Parties agree that the best interests of the Class Members will be substantially advanced by resolving any material outstanding issues in this lawsuit through a negotiated settlement based on the Goals and Commitments reflected in this Agreement, rather than through adversarial litigation.

III. JURISDICTION AND AUTHORITY OF THE COURT

11. The District Court will have jurisdiction, in accordance with 28 U.S.C. §§ 1331 and 1343, to enforce this Agreement and the resulting Implementation Plan that will be developed pursuant to paragraphs 59 through 63.

12. Upon execution of this Agreement, the Parties shall submit a joint stipulation to the District Court. The Parties agree to cooperate in good faith to prepare all relevant filings, including, but not limited to, a proposed protective order regarding the handling by the Parties of confidential information and a proposed order addressing the status of this case.

13. Except as otherwise noted, the terms of this Agreement shall not take effect until the District Court issues an order approving this Agreement.

IV. GOALS

14. The Goals are intended to (a) provide structure and guidance for the planning implementation, future development, and sustainability of the service delivery system; and (b) aid in interpreting the meaning and purpose of the Commitments, Outcomes, and Exit Criteria. The Goals are not Commitments, Outcomes, or Exit Criteria, and shall not be measured or enforceable as such.

15. The Goals of this Agreement are to develop, implement, and sustain a family-driven, coordinated, and comprehensive children's mental health service delivery system that:

    a. Identifies and screens potential Class Members and links Class Members to appropriate care according to a consistent statewide procedure, regardless of entry point or referral source;

    b. Provides individualized services to Class Members consistent with the Principles of Care;

    c. Communicates with Class Members and their families about the nature and purposes of services and how to access them;

    d. Delivers a continuum of care that emphasizes high quality community-based services and supports in sufficient intensity and scope in the least restrictive environment appropriate to meet Class Members' individual needs;

    e. Coordinates delivery of mental health services among departments and agencies serving Class Members in order to reduce fragmentation of services for Class Members;

f. Measures and communicates treatment outcomes and system performance in order to improve quality care and increase accountability to Class Members, their families, and stakeholders;

g. Supports engagement and involvement of Class Members and their families throughout the system of care, including treatment planning as well as system improvement and planning efforts;

h. Develops the workforce and infrastructure necessary to meet the need for availability and access to services and supports and provide for education, training, and ongoing coaching of providers, Class Members, their families, and other stakeholders as applied to the system of care and its implementation;

i. Builds on existing strengths of the children's mental health system and uses Defendants' resources efficiently;

j. Fully accessing Medicaid and other federal funds and maximizing opportunities for Class-Member serving agencies to participate in braided funding of common services;

k. Maintains a collaborative governance structure that includes Defendants' agencies, Class Members, their families, and other stakeholders;

l. Affords due process to Class Members; and

m. Leads to improved outcomes for Class Members and their families in order to keep Class Members safe, in their own homes, and in school; to minimize hospitalizations and out-of-home placements; to reduce potential risks to their families; to avoid delinquency and commitment to the juvenile justice system in order to receive mental health services; to correct or ameliorate mental illness, reduce mental disability, and to restore functioning.

V. COMMITMENTS

16. The Defendants agree to timely fulfill the Commitments, using the Goals for the purposes of interpretation and guidance, during the pendency of this Agreement. The Commitments include tasks, actions, processes, achievements, and other concrete deliverables that are required to meet the needs of Class Members.

17. Substantial compliance with the Commitments, including timelines provided herein, is enforceable during the pendency of this Agreement.

A. Services Provided to Class Members

18. Class Members shall be provided all of the services set forth in the Services and Supports document, defined in Appendix C, that are necessary to meet their individualized mental health strengths and needs as recommended by a practitioner of the healing arts.[3]

19. The Parties agree that Class Members with more intensive needs shall be provided Intensive Care Coordination (ICC), as defined in the Services and Supports document. Under this Agreement, Class Members with more intensive needs include any Class Member who either has a qualifying Child and Adolescent Needs and Strengths (CANS) tool score, as developed pursuant to paragraphs 32 and 35, or meets one of the following criteria:
    a. Is at substantial risk of out-of-home placement due to mental health needs;
    b. Has experienced three (3) or more foster care placements within twenty-four (24) months for reasons related to mental health needs;
    c. Is involved with multiple child-serving systems related to his or her mental health needs;
    d. Is under age twelve (12) and has been hospitalized for reasons related to mental health needs within the last six (6) months;
    e. Is under age twelve (12), has been detained within the last six (6) months, and has unmet mental health needs;
    f. Has experienced more than one hospitalization for mental health needs within the last twelve (12) months; or
    g. Is currently in an out-of-home placement due to mental health needs and could be discharged safely to their home or community within up to ninety (90) days if adequate home and community-based supports were provided.

20. Class Members who are provided ICC shall be afforded a formal Child and Family Team ("CFT") in accordance with the Practice Model, attached hereto as Appendix B.

21. Class Members who are provided ICC shall continue receiving ICC until the CFT determines that the ICC Class Member no longer meets medical necessity for ICC and has the CFT has approved a transition plan.

22. Class Members shall have access to services on a voluntary basis whenever informed consent can be obtained. Involuntary treatment or relinquishment of custody to Idaho shall not be a condition for accessing, providing, or paying for services and supports provided under this Agreement.

23. Financial need or income eligibility is not required for access to services for Class Members. Class Members' Families who have the ability to pay for care, after taking

[3] Class Members and their families retain the choice whether to accept or reject services offered under this Agreement by Defendants. This Agreement does not require Defendants to provide services to Class Members on an involuntary basis.

into account their existing financial obligations, may be required to reimburse a reasonable amount of the total actual costs of the services. No Class Member shall be denied services because of the inability to reimburse the cost of services.

24. Defendants shall establish, within six (6) months following approval of this Agreement by the District Court, an initial expected range of Class Members that will utilize the Services and Supports provided pursuant to this Agreement. Defendants shall annually update this expected Class Member service utilization range so that Class Members who need them will be provided Services and Supports under this Agreement. Defendants shall timely provide Services and Supports statewide within the annually established service utilization range.

B. Principles of Care and the Practice Model:

25. Defendants have adopted and shall implement a Practice Model for delivering publicly-funded mental health services and supports to Class Members. The Practice Model, more fully described in Appendix B, provides the framework for providing services and supports to Class Members under this Agreement. The Practice Model describes the expected client experience of care within Idaho's children's mental health system over the course of intake, assessment, treatment and transition.

26. Defendants shall provide services to Class Members in accordance with the Principles of Care and the Practice Model, as set forth in Appendix B. Defendants shall use the Principles of Care and the Practice Model to:
    a. Inform and guide the management and delivery of publicly-funded mental health services and supports;
    b. Describe the treatment and support activities that providers undertake; and
    c. Describe how services and supports are coordinated among child-serving systems and providers.

27. Defendants shall use the CFT approach for engagement, mental health treatment planning, service coordination, and case management for Class Members, as defined and described in the Practice Model.

C. Access to Care:

28. Defendants have adopted an Access Model that describes how Class Members access the full array of services and supports under this Agreement, attached as Appendix A. The Access Model provides an overarching protocol for how Class Members are identified, and how they move into, through, and out of Idaho's children's mental health system of care.

29. Defendants will use the Access Model to describe procedures or processes to:
    a. Inform, identify, and screen potential Class Members in child-serving systems, as well as other discrete groups or populations of children at heightened risk of serious emotional disorders (e.g., homeless youth);

b. Refer and allow self-referral of potential Class Members for screening and assessment;
c. Assess individuals who screen positive for unmet mental health needs and connect Class Members to services;
d. Plan for and provide timely services under this Agreement to Class Members for whom services are medically necessary, based on the assessment;
e. Provide for continuously-coordinated care for Class Members; and
f. Transition Class Members between levels of care to the adult mental health system or to the community.

30. Defendants shall amend the Access Model to include protocols for:
    a. Identifying and referring potential Class Members for screening;
    b. Referring potential Class Members for an assessment, including those potential Class Members identified as having unmet mental health needs as a result of the screening process as well as those potential Class Members for whom screening is optional, as described in paragraph 33;
    c. Offering services to Class Members and firmly linking those who accept services to providers and care planning; and
    d. Transitioning Class Members between levels of care, out of care, and into the adult mental health system, which shall include, but is not limited to:
        i. a process for transitioning out of care those Class Members who no longer meet eligibility requirements pursuant to paragraph 2; and
        ii. an expedited process for former Class Members to transition back into care if they meet eligibility requirements pursuant to paragraph 2.

31. Defendants may further amend or update the Access Model over time, consistent with the purposes and intent of paragraphs 28 through 30, subject to the modification process described in this Agreement, paragraph 97.

32. Defendants shall implement the Child and Adolescent Needs and Strengths (CANS) tool for use in delivering services and supports to Class Members pursuant to this Agreement. The CANS is an assessment strategy and communication tool that Defendants will use to inform: screening, assessment, care planning, level of care decisions, standardization of referrals, clinical practice, measurement of individual outcomes, resource and program management, and improvement of service access and service coordination consistent with Principles of Care and Practice Model.

33. Defendants shall develop, adopt, and administer an age-appropriate screen to children with unmet mental health needs in order to identify potential Class Members. Defendants will refer children who screen positive for an assessment. Defendants shall not require an identifying screen as a prerequisite to receiving an assessment under this Agreement. Children/youth not needing to be screened shall include those who:
    a. Were previously identified as Class Members, but are not presently receiving intensive mental health services;

b. Have had a clinical mental health assessment that was completed within the last six (6) months that indicates the presence of a mental health condition;
c. IDJC or DHW's Division of Family and Community Services (FACS) identifies through assessment processes as Class Members; or
d. Request, through their parents or legal guardians, an assessment.

34. Defendants shall develop, adopt, and administer a clinical mental health assessment for potential Class Members referred for assessment, including those identified using the age-appropriate screen, pursuant to paragraph 33. Defendants will use the assessment to identify mental health diagnosis and functional impairments in order to determine whether a potential Class Member is eligible to become a Class Member. Defendants will also use the assessment to inform individualized treatment planning.

35. Defendants shall use a transparent process to establish the threshold levels of functional impairment used to identify, through use of the CANS tool, potential Class Members who are eligible (a) to become Class Members, pursuant to paragraph 2, and (b) for ICC services, pursuant to paragraph 19, in consultation with clinical expert(s), mutually agreed to by the Parties.

36. The Parties agree that Class Members shall be provided the services set forth in the Services and Supports document that are necessary to meet their individualized mental health strengths and needs as recommended by a practitioner of the healing arts without regard to their eligibility for Medicaid. Defendants agree to use their resources efficiently by fully accessing Medicaid funds when delivering services and supports to Class Members. Defendants will implement and administer Idaho's Medicaid program[4] to provide services to the fullest extent allowed under the Medicaid Act, including (a) services that are currently covered under Idaho's State Medicaid Plan, Idaho's Children's Health Insurance Plan (CHIP), and Idaho's Behavioral Health Plan 1915(b) waiver, and (b) those services that are Medicaid coverable, including all services and supports that are eligible for federal financial participation pursuant to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of the Medicaid Act, 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(10)(A), 1396a(a)(43) and 1396d(a)(4)(B). Defendants shall provide information and conduct outreach activities to educate and encourage Class Members and their families to apply for Medicaid or CHIP.

37. Defendants shall make descriptions or explanations of the Services and Supports, the Principles of Care and the Practice Model, and the Access Model easily and publicly accessible to Class Members, their families, and other stakeholders,

[4] References to Medicaid throughout this Agreement are intended to include those services and supports provided and/or arranged for pursuant to Idaho's State Medicaid Plan, Idaho's Children's Health Insurance Plan (CHIP), Idaho's Behavioral Health Plan 1915(b) waiver, and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of the Medicaid Act, 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(10)(A), 1396a(a)(43) and 1396d(a)(4)(B).

including, but not limited to, conspicuously posting information on Defendants' websites.

38. Defendants shall develop and implement a statewide communication plan for outreach and education of the community, stakeholders, and families about potential Class Members who are eligible to become Class Members, the nature and purposes of services pursuant to this Agreement, and how to access services.

D. Workforce Training and Development

39. Defendants shall develop and implement a workforce development plan (a) to develop and strengthen the workforce in order to deliver Services and Supports pursuant to this Agreement; and (b) to operationalize the Principles of Care and Program Model system wide. The workforce development plan shall include a proposal for how Defendants will address any identified gaps in the workforce capacity necessary to meet the needs of Class Members and deliver services within the utilization range established pursuant to paragraph 24. The workforce development plan shall also include a strategy to develop sustainable regional and statewide education, training, coaching, mentoring, and technical assistance to public and private providers who serve Class Members pursuant to this Agreement.

40. Defendants will develop a Practice Manual to guide and facilitate access to services set forth in the Services and Supports document. The Practice Manual shall be based on the Principles of Care, the Practice Model, and the Access Model. The Practice Manual shall include instructions and guidance for agency staff, providers, and other system and community stakeholders. The Practice Manual topics shall include, but need not be limited to:
    a. Goals of the system of care as described in this Agreement;
    b. Definitions;
    c. Identification, referral, screening, and assessment of Class Members;
    d. The CFT approach;
    e. Collaboration and coordination with other system and community partners;
    f. Roles and responsibilities of providers, CFT members, and agencies;
    g. The services and supports that are available;
    h. Access to services and supports;
    i. Billing and service reporting;
    j. Identification and description of decision points, to include who makes the decision and any criteria to be used in making the decision; and
    k. Procedures for reviewing, reconsidering or disputing decisions and an appeal process consistent with due process requirements.

41. Defendants will direct, through training and contracts, agency staff, providers, and other system and community stakeholders to follow the Practice Manual, developed pursuant to paragraph 40, and the Principles of Care and Practice Model when delivering services and supports to Class Members pursuant to this Agreement.

42. Defendants will educate and train agency staff, providers, and other relevant system and community stakeholders how to:
    a. Identify and refer potential Class Members for screening and assessment using the Access Model;
    b. Implement and use the CANS tool for screening, assessment, care planning, and evaluation of outcomes; and
    c. Provide services and supports consistent with the Practice Manual and the Practice Model.

E. Due Process

43. Defendants shall develop and adopt a centralized and impartial process to address and track complaints as part of the CFT approach, pursuant to paragraph 27, which may run concurrent to the formal appeal process, described in paragraphs 44 through 47. Class members and their families or legal guardians may choose, but are not required, to participate in this complaint process. This provision does not waive or replace Class Members' rights to due process as provided pursuant to this Agreement and under federal and state laws and regulations. The complaint process is intended to address Class Members' and caregivers' concerns related to their dissatisfaction with a process or a provider at the lowest or most appropriate organizational level possible. The process will include documentation of the complaint, a specific time frame to act upon the complaint, and documentation of the outcome.

44. Defendants shall provide written notice of action to a Class Member under the following circumstances:
    a. When Defendants determine that an individual is not a Class Member, following an assessment; or
    b. When Defendants deny or limit a requested service; or
    c. When Defendants reduce, suspend, or terminate a currently authorized service; or
    d. When Defendants deny, in whole or in part, payment for a service.

45. Defendants shall provide written notice that includes:
    a. The action Defendants have taken or intend to take and legal authority for the action;
    b. The rationale for the action including the written documentation consulted and relied upon which supports the action;
    c. The right to file a request for a fair hearing;
    d. The specific timeline and procedure for applying for a fair hearing;
    e. A summary of the fair hearing procedures and the citation to the rules governing fair hearing and the web address link to those procedures;
    f. The right to have assistance with an appeal and contact information for family advocacy organizations;
    g. When an expedited resolution is available and how to request an expedited resolution;

h. The right to have benefits continue, pending resolution of the appeal, how to request benefits continue, and the circumstances under with the Class Member's family may be required to pay for the continued services; and
i. The option to engage in the complaint process as described in paragraph 43.

46. Defendants shall inform Class Members of the circumstances in which they have a right to receive a notice of action and request a fair hearing through written informational materials. Defendants shall provide these informational materials with the decision and on their respective websites.

47. Defendants shall require contracted providers to comply with the notice and informing provisions of this section.

48. As part of the Quality Management, Improvement and Accountability Plan, described in paragraph 52, Defendants shall collect and report data on written notices of action, complaints, and fair hearings requests and outcomes.

F. Governance and Interagency Collaboration

49. Defendants shall establish and use a collaborative interagency Governance structure to coordinate and oversee implementation of this Agreement. The governance structure shall include an Interagency Governance Team (IGT). An initial description of the interagency Governance structure, including the IGT, is set forth in Appendix D.

50. Defendants shall adopt operational guidelines for carrying out the purposes and responsibilities of the IGT, as described in the Governance appendix.

51. Defendants shall encourage engagement and active involvement of Class Members, their families, and other community stakeholders in planning and evaluation activities related to implementation of, and performance under, this Agreement. At a minimum, Defendants shall include a current or former Class Member representative, a parent or family member of a current or former Class Member representative, and a children's mental health consumer or family advocacy organization representative as part of the Interagency Governance Team.

G. Quality Management, Improvement and Accountability

52. Defendants shall develop and implement a Quality Management, Improvement and Accountability (QMIA) plan for monitoring and reporting on Class-Member outcomes, system performance, and progress on implementation of this Agreement, as well as for ensuring continuous quality improvement at the clinical, program and system levels. The QMIA plan shall include goals, objectives, tools, resources, and feedback mechanisms needed to:

a. Measure, assess and report on progress on meeting this Agreement's Commitments, achieving the Outcomes, sustaining performance, and satisfying the Exit Criteria; and
b. Build on existing quality assurance and improvement processes to achieve a collaborative QMIA system for mental health programs and services across Defendants' child-serving systems.

53. The QMIA System shall develop system-wide capabilities to:
a. Consistently, routinely, and accurately monitor progress implementing this Agreement, and document the achievements or satisfaction of Commitments, Outcomes, sustained performance requirements and Exit Criteria;
b. Determine and measurably improve core-system and cross-system program administration and management competencies necessary for successful implementation of the Agreement;
c. Monitor, measure, and evaluate multi-level (e.g., clinical, provider, program, system) information on access, performance, outcomes, service quality, and cross-system collaboration;
d. Regularly communicate the information developed in subsections a-c with managers, decision-makers, supervisors, clinicians, young people and families, the public, and the parties;
e. Improve clinical and program quality by (i) providing feedback of clinical and program experience and data to clinicians, supervisors, and managers; (ii) identifying effective treatment practices and teaching those practices to clinicians, supervisors, and managers;
f. Make CANS data available in real time; and
g. Set goals for improving system accessibility, performance, outcomes, service quality, and cross-system collaboration over time in order to comply with the Agreement's Commitments and sustained performance requirements, and achieve the intended Outcomes and Exit Criteria.

54. Defendants shall complete development of and begin to implement the QMIA plan within nine (9) months after the District Court gives approval of the Agreement. Defendants agree to implement the QMIA plan consistent with its terms.

55. In order to accurately measure and report on progress implementing the Agreement, Defendants shall routinely measure, analyze, and publicly report (not less than quarterly or as determined in the QMIA planning process) on regional and statewide QMIA indicators and data that include, but are not limited to:
a. The number and characteristics of potential Class Members estimated, screened, assessed, and determined eligible for services and supports under this Agreement;
b. The number and characteristics of Class Members that receive any mental health services and supports;
c. The quality, scope, intensity, duration, type, funding source, and program provider of services and supports provided pursuant to this Agreement to Class Members;

d. Service quality, satisfaction, and outcomes for Class Members and their families;
e. Expenditures on each service and support segregated by agency that provides them, by region, and by key demographic data utilizing a reporting format and content uniform across systems; and
f. Number, basis, and outcomes of complaints and appeals;

56. The Parties will jointly develop, and Defendants will initiate on a jointly agreed date, a Quality Review (QR) process to be used to objectively assess and improve clinical practice and program effectiveness system wide. The QR process is an effective tool for identifying program strengths and needs and providing critical information on how to improve practice. The components of the QR process shall include, but are not limited to:
    a. Quality and outcome measures at the clinical and program levels;
    b. A representational sampling of cases, as agreed to by the Parties;
    c. Evaluation of the case sampling by a team of reviewers that will include at least one independent, neutral monitor. The evaluation includes:
        i. Interviews with Class Members and their families that agree to participate in the process, CFT members, and others associated with the Class Members who might have relevant information about the Class Members' experience of care; and
        ii. File reviews.
    d. A QR instrument and rating system to be used by the reviewing team when evaluating the case sampling; and
    e. Use of QR results to help identify best practices and support quality improvement in clinical practice and program performance.

57. Defendants shall conduct QRs on a periodic basis, as agreed upon by the Parties, but not less than annually, beginning after the start of the implementation period on the date specified in paragraph 56 and throughout the sustained performance period.

58. Defendants shall publicly report the QR results on an annual basis. As part of the annual reports, Defendants will identify "lessons learned" from the QRs with recommendations regarding steps to be taken, if any, to improve clinical and program quality.

H. Implementation Plan

59. The Parties agree to establish an implementation work group (IWG) comprised of Plaintiffs' counsel, Defendants' counsel, and children's mental health stakeholders with knowledge relevant to system beneficiaries, services and processes. The IWG is intended to help facilitate successful implementation planning as prescribed by this Agreement. The IWG will convene with sufficient frequency to develop the Implementation Plan. The Implementation Plan will be developed within nine (9) months after the District Court gives approval of the Agreement. The IWG may meet in person or by conference call as necessary.

60. Defendants shall develop an Implementation Plan working collaboratively with the IWG that provides:
    a. Sufficient specific details such that the District Court may determine from the four corners of the plan whether it is reasonably capable of achieving the terms of the Agreement; and
    b. Routine measuring, assessment, and reporting on whether substantial and sufficient progress is being made to assure that when completed, the Commitments and Outcomes are met and the system is sustainable over time.

61. The Implementation Plan shall, at a minimum:
    a. Identify and sequence tasks necessary to fulfill the Commitments and achieve the Outcomes provided in this Agreement;
    b. Develop and use quality assurance and improvement procedures to measure, assess, manage and report on the implementation process;
    c. Set clear and accountable timelines for compliance, including interim progress until compliance is achieved;
    d. Identify responsible agencies and divisions for achieving tasks identified;
    e. Outline processes for the IWG to monitor progress, provide feedback, and resolve problems in meeting Defendants' obligations under this Agreement and carrying out the Implementation Plan;
    f. Identify the staffing and financial resources necessary to fulfill the Commitments and achieve the Outcomes required by this Agreement; and
    g. Describe the communication and outreach activities that Defendants will undertake in order to inform Class Members, their families, stakeholders and the community about services and procedures provided under this Agreement.

62. Defendants shall submit the completed Implementation Plan to the District Court for approval. Prior to submission of the Implementation Plan, Defendants shall review the final proposed Implementation Plan with Plaintiffs' counsel. The Parties shall make reasonable efforts to submit a consensus plan. If the Parties cannot agree on the terms of the Implementation Plan, the disputed issue(s) may be submitted to the District Court for resolution.

63. The District Court shall approve the Implementation Plan if the Court determines the plan is reasonably capable of fulfilling the terms of this Agreement and purposes of the consent decrees and related court orders.

64. Defendants shall timely comply with the Implementation Plan approved by the District Court.

65. The Implementation Plan, including any timelines established therein, may be amended according to the modification procedures outlined in this Agreement. Defendants shall notify Plaintiffs' counsel prior to the expiration of the timeline or

when Defendants determine that a timeline will not be met. An agreement to modify timelines does not alter the substantive intent of the Commitments, but only extends the time by which the Commitments will be accomplished.

66. After approval of the Implementation Plan by the District Court, the IWG will continue to meet at a minimum of twice yearly, but more frequently if needed. During the implementation period, the IWG is intended to foster communication between the Parties by providing a forum to discuss progress on and problem-solve issues related to the Implementation Plan and Defendants' performance under this Agreement.

67. Defendants shall provide an annual report to the District Court and Plaintiffs' counsel on the progress of the Implementation Plan beginning six (6) months after the District Court approves the Implementation Plan or as otherwise agreed by the parties. The report will account for accomplishments made to date and identify potential or actual compliance issues that need attention, including a summary of proposed or actual remedial efforts made to address these compliance issues. The annual reports will use data and information developed pursuant to the QMIA provisions of this Agreement whenever possible.

68. Defendants will provide a draft of the report to Plaintiffs' counsel at least thirty (30) days in advance of filing their annual report with the District Court. Plaintiffs' counsel will provide any feedback within fifteen (15) days of receiving the draft unless the Plaintiffs' counsel request a reasonable an extension of time of up to fifteen (15) days. If the Parties are unable to reach consensus on the final contents of the status report, Defendants may proceed with filing their report, and Plaintiffs' counsel will have the option to prepare a response that will be filed with the District Court and attached as an addendum to a publicly available version of the status report.

VI. OUTCOMES

69. The Outcomes are the results the Parties expect Defendants will achieve in carrying out the Commitments and fulfilling this Agreement. Defendants shall have a period of up to four (4) years to fulfill the Commitments by completing the Implementation Plan. Upon completion of implementation, Defendants shall demonstrate they have substantially complied with the Outcomes set forth in this section. At that time, the Outcomes will be the sole objective measures that, when accomplished, will indicate that Defendants are in substantial compliance with the requirements for completing implementation of this Agreement. Any party may submit a motion to the District Court for a finding of substantial compliance with the requirements for completing implementation as measured by the Outcomes. The sustainability period shall commence when the District Court finds that Defendants have substantially complied with the Outcomes.

70. Six (6) months prior to the end of the Implementation Phase, the Parties will meet to determine whether there is any dispute as to whether Defendants are on track to meet the Outcomes.

A. Services Outcomes

71. Defendants shall:
    a. Establish and annually update the range of expected Class Members service utilization, as set forth in paragraph 24;
    b. Develop statewide capacity to timely provide Services and Supports in appropriate scope, intensity and duration to Class Members for whom it is medically necessary;
    c. Provide the full array of Services and Supports, as defined in Appendix C, statewide as needed by and clinically appropriate for Class Members;
    d. Timely provide Class Members with Services and Supports that are appropriate in scope, intensity and duration to meet to their individual strengths and needs, as described in paragraphs 18, 22, 23 and 36; and
    e. Provide ICC, as defined in Appendix C, to Class Members with more intensive needs, as set forth in paragraphs 19 through 21.

B. Principles of Care and Practice Model Outcomes

72. Defendants shall:
    a. Develop, adopt, and deliver Services and Supports to Class Members with fidelity to the Practice Model statewide and consistent with the Principles of Care and the Agreement, as set forth in paragraphs 25 through 27; and
    b. Require that contracted mental health providers or mental health managed care contractors deliver services to Class Members consistent with the Principles of Care and Practice Model.

C. Access Outcomes

73. Defendants shall:
    a. Develop, adopt, and consistently use the Access Model statewide to identify, screen, assess, refer, and link Class Members to services and supports, as described in paragraphs 28 through 36 and Appendix A;
    b. Implement and use the CANS tool statewide, as described in paragraph 32, to:
        i. Screen potential Class Members for unmet mental health needs;
        ii. Assess Class Member's individual and family strengths and needs;
        iii. Support clinical decision-making and practice; and
        iv. Measure and communicate client outcomes; and.
        v. Improve service coordination.
    c. Develop, adopt, and use statewide a uniform, age-appropriate screen, described in paragraph 33, to identify potential Class Members with unmet mental health needs;

d. Develop, adopt, and use statewide a standard mental health assessment, described in paragraph 34, to determine class membership status for potential Class Members referred for an assessment;
e. Establish threshold levels of functional impairment as measured by the CANS tool, in consultation with clinical expert(s) mutually agreed by the Parties, as described in paragraph 35, to be used by Defendants in determining eligibility (i) to become Class Members and (ii) to receive ICC services;
f. Use the threshold levels of functional impairment established pursuant to paragraph 35 when determining eligibility for class membership;
g. Make descriptions or explanations of this Agreement, the Services and Supports, the Principles of Care and Practice Model, and the Access Model easily and publicly accessible to Class Members, their families, and other stakeholders, including, but not limited to, posting information on Defendants' websites, as described in paragraphs 36 and 37;
h. Develop and implement a statewide communication plan for outreach and education of the community, stakeholders, and families, as described in paragraph 38; and
i. Require that contracted mental health providers or mental health managed care contractors deliver services to Class Members consistent with the Access Model.

D. Workforce Training and Development Outcomes

74. Defendants shall:
    a. Develop and implement a workforce development plan, as described in paragraph 39;
    b. Develop and adopt a Practice Manual, as described in paragraph 40;
    c. Consistently use a Practice Manual to guide clinical and programmatic activities statewide, as described in paragraph 41;
    d. Educate and train agency staff, providers, and other community and system partners, as set forth in paragraphs 41 and 42, to use and follow the Access Model, Practice Model, and Practice Manual:
        i. To identify and refer potential Class Members for screening; and
        ii. Deliver services and supports to Class Members; and
    e. Educate and train agency staff and providers to use the CANS tool.

E. Due Process Outcomes

75. Defendants shall:
    a. Develop, adopt, and consistently use a complaint process, as described in paragraph 43, as part of the Practice Model's CFT approach;
    b. Provide written notices of action when the circumstances defined in paragraph 44 apply;
    c. Provide written notices of action that comply with the criteria defined in paragraph 45;

d. Provide informational materials regarding the circumstances in which Class Members have a right to receive a written notice of action and request a fair hearing on their respective websites;
e. Make modifications to contracts necessary to establish the complaint and due process protocols as defined in paragraphs 43 through 46;
f. Develop, adopt, and use a process to monitor and periodically report on compliance with the complaint and due process protocols as defined in paragraphs 43 through 46; and
g. Collect and report data on written notices of action, complaints, and fair hearing requests and outcomes.

F. Governance and Interagency Collaboration Outcomes

76. Defendants shall:
a. Establish and use an Interagency Governance Team, as described in paragraph 49 and Appendix D;
b. Adopt and use operational guidelines for the Interagency Governance Team, as described in Appendix D; and
c. Include a current or former Class Member representative, a parent or family member of a current or former Class Member representative, and a children's mental health consumer or family advocacy organization representative as part of the Interagency Governance Team.

G. Quality Management, Improvement, and Accountability Outcomes

77. Defendants shall:
a. Develop and implement a QMIA plan, as described in paragraph 52;
b. Develop and operate a QMIA System with capabilities consistent with the criteria defined in paragraph 53;
c. Measure and publicly report QMIA indicators, including, but not limited to, those required in paragraph 55;
d. Jointly develop with Plaintiffs' counsel a QR process, as described in paragraph 56;
e. Conduct QRs, as described in paragraph 57;
f. Publicly report on the results of the QRs, as described in paragraph 58; and
g. Achieve improved overall outcomes for Class Members, as measured by improvements in aggregated CANS domain scores and/or relevant clinical items from the CANS tool, in each Region.

H. Implementation Plan Outcomes

78. Defendants shall:
a. Develop an Implementation Plan for this Agreement, as described in paragraphs 59 through 62;
b. Receive District Court approval of its Implementation Plan, as described in paragraph 63; and

c. Timely execute the Implementation Plan as approved or amended by the District Court.

VII. EXIT PROCESS AND CRITERIA

79. The Exit Criteria are the specific results Defendants will achieve in sustaining performance and compliance with the terms of the Agreement. Defendants shall sustain performance of the Agreement for three (3) years following the District Court's finding that implementation is complete. At the end of the three (3) year sustained performance period, Defendants shall demonstrate they have substantially complied with the following Exit Criteria. At that time, the Exit Criteria set forth in this section will be the sole objective measures that, when accomplished, will indicate that Defendants are in substantial compliance with the terms of this Agreement such that the lawsuit herein may be dismissed.

80. Simultaneous to the dismissal, a permanent injunction will be issued pursuant to Paragraph 5b.

81. Six (6) months prior to the end of the sustained performance and compliance period, the Parties will meet to determine whether there is any dispute as to whether Defendants are on track to meet the Exit Criteria.

A. Access and Capacity

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, as described in paragraph 24;
    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, as defined in Appendix C, 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, as described in paragraphs 18, 22, 23, and 36;
    e. Provide Intensive Care Coordination, as defined in Appendix C, to Class Members with more intensive needs, as set forth in paragraphs 19 through 21;
    f. Deliver Services and Supports to Class Members with fidelity to the Practice Model statewide and consistent with the Principles of Care, and the Agreement, consistent with paragraphs 25 through 27;

g. Consistently use the Access Model statewide to identify, screen, assess, refer, and link Class Members to services and supports, as described in paragraphs 29 through 35 and Appendix A;
h. Use the CANS tool statewide to:
    i. Screen potential Class Members for unmet mental health needs;
    ii. Assess Class Member's individual and family strengths and needs;
    iii. Support clinical decision-making and practice;
    iv. Measure and communicate outcomes; and
    v. Improve service coordination.
i. Use a uniform, age-appropriate screen, described in paragraph 33, statewide to identify potential Class Members with unmet mental health needs;
j. Use a standard mental health assessment, described in paragraph 34, statewide to determine class membership status for potential Class Members referred for an assessment;
k. Use the threshold levels of functional impairment established pursuant to paragraph 35 when determining eligibility for class membership;
l. Make descriptions or explanations of this Agreement, the Services and Supports, the Principles of Care and Practice Model, and the Access Model easily and publicly accessible to Class Members, their families, and other stakeholders, including, but not limited to, posting information on Defendants' websites, as described in paragraphs 36 and 37;
m. Consistently use a Practice Manual to guide clinical and programmatic activities statewide, as described in paragraph 41;
n. Uniformly follow the complaint and due process standards and protocols described in paragraphs 43 through 46;
o. Operate the QMIA System with capabilities consistent with the criteria defined in paragraph 53;
p. Measure and regularly and publicly report QMIA indicators, including, but not limited to, those required in paragraph 55; and
q. Achieve improved overall outcomes for Class Members, as measured by improvements in aggregated CANS domain scores and/or relevant clinical items from the CANS tool within each Region.

B. Quality and Outcomes

83. Throughout the sustained performance period, the Parties expect Defendants will maintain and improve system quality and client outcomes. Consistent with this expectation, Defendants shall monitor performance, quality, accessibility, and outcomes using (a) methods and measures developed or identified in the QMIA planning process, described in paragraph 52, and (b) the QR process, described in paragraph 56, that objectively measures and evaluates the services and outcomes for Class Members and their families. By the end of the sustained performance period, Defendants shall:
    a. Have conducted QRs consistent with the process jointly developed by the Parties, described in paragraph 56, and according to the periodic frequency as agreed to by the Parties, as defined in paragraph 57; and

b. Have publicly reported on the QR results annually, consistent with paragraph 58.

C. Monitoring Role of Plaintiff's Counsel

84. During the sustained performance period, Plaintiffs' counsel will have less formal involvement in system planning efforts. Upon the District Court's finding of substantial compliance with the Agreement's Outcomes at the end of the implementation period, the IWG will conclude its work. Notwithstanding, the Parties shall continue to meet and confer on at least a semi-annual basis as long as the District Court retains jurisdiction.

85. During the sustained performance period and until such time as the District Court grants the Defendants' motion to dismiss the case, Defendants shall provide Plaintiffs' counsel with:
    a. Annual QR reports, as described in paragraph 58;
    b. Periodic reports on regional and statewide QMIA indicators and data, identified in paragraph 55; and
    c. Information available pursuant to Section IX.

VIII. DISPUTE RESOLUTION PROCESS

A. Process

86. Any and all claims, disputes, or other matters in controversy ("dispute") arising out of or related to the implementation of this Agreement, or the breach, implementation or performance thereof, shall be resolved according to the procedure set forth below.

87. The Parties agree to convene, at a mutually agreeable time and place, and use their good-faith, best efforts to discuss and resolve the dispute. This initial meeting will be a direct negotiation between the Parties without the assistance of a mediator or other non-party. Any agreement reached in this forum will be formalized as an addendum to the Parties' Agreement and submitted to the District Court for approval.

88. If the Parties are unable to resolve the dispute within thirty (30) days, or such other time frame upon which the Parties agree, they will engage the services of a mutually-agreeable mediator for the purpose of mediating a resolution to the dispute. The meeting will be at a mutually agreeable time and place, and, with the assistance of the mediator, the Parties will use their good-faith, best efforts to discuss and resolve the dispute. Any agreement reached in this forum will be formalized as an addendum to the Parties' Agreement and submitted to the District Court for approval.

89. If, after negotiating in good faith, no resolution is reached, either Party may file an appropriate motion with the District Court in this matter. The moving Party's counsel shall provide the appropriate notice to the opposing Party's counsel of such action.

90. In the event that Plaintiffs' counsel reasonably believes that there is a systemic risk of imminent harm to a broad group of Class Members as a result of Defendants' material noncompliance with their systemic obligations under this Agreement, Plaintiffs' counsel will make a good-faith effort to consult with Defendants' counsel to discuss the potential harm resulting from an alleged failure to meet their systemic obligations. A "systemic obligation" is one that may affect all of, or a substantial portion of, the Class Members and is not represented or proven by a circumstance or condition affecting an individual Class Member. If the issue or issues are not resolved within a reasonable amount of time given the severity and imminence of harm, Parties may engage in an expedited mediation process, as detailed in the provisions set forth herein. If an appropriately expedited dispute resolution process cannot be scheduled, or the systemic matter is not resolved through mediation, Plaintiffs' counsel may proceed directly to the District Court or may take any other necessary legal action. Plaintiffs' counsel will provide at least one (1) business day's written notice to Defendants' counsel via facsimile transmission or electronic mail and first class mail prior to initiating court action.

IX. PLAINTIFFS' COUNSEL ACCESS TO INFORMATION

91. Defendants shall afford Plaintiffs' counsel the opportunity to monitor Defendants' implementation, compliance, and sustained performance of the terms of this Agreement. Throughout the pendency of this Agreement, Defendants shall:
    a. Upon request, provide Plaintiffs' counsel with funding and staffing requests by Defendants to the Governor's office, significant plans, policies, practice manuals, and agreements that have been developed to implement this Agreement unless the Governor asserts that under the deliberative process privilege and/or mental process privilege the material at issue should remain confidential. Additionally, the Superintendent of Public Instruction is a constitutional officer and reserves all rights and privileges provided to constitutional officers under Idaho law. Defendants shall prepare a privilege log of the kind required by Rule 26(b)(5) (or its successors) for any documents upon which they claim privilege. The Parties will first resort to informal dispute mechanisms if there is a disagreement whether documents are privileged. The party asserting privilege bears the burden of establishing that a document is privileged;
    b. Upon request, provide Plaintiffs' counsel with access to information and documents related to publicly-funded children's mental health services that are obtained, compiled, or generated by Defendants' staff and contractors, including, but not limited to, Defendants' QMIA systems; and

c. Upon request, provide Plaintiffs' counsel access to mental health case records of Class Members that are maintained by Defendants and their agents or contractors, subject to the process set forth in paragraphs 93, 94, and 95.

92. The Parties agree to minimize the number and scope of requests for the data and information not already provided to Plaintiffs' counsel through the annual status report process, described in paragraphs 67 and 68; through the IWG, described in paragraphs 59, 60, and 66, or pursuant to the Commitments set forth in paragraphs 24, 37, 38, 39, 40, 48, 52, 53, 55, 58, and 65 of this Agreement.

93. Should Plaintiffs' counsel seek any data and information not otherwise available as described in the previous paragraph concerning Defendants' progress in implementing this Agreement and the Implementation Plan:

a. Plaintiffs' counsel will make their request for that additional data and information to Defendants through the IWG. Plaintiffs' counsel's request will include:
   i. Specific data and information sought,
   ii. Specific provision(s) of the Agreement to which the data and information are relevant, and
   iii. Specific concerns the data and information are sought to address.
b. Defendants will provide access to relevant data and information that is reasonably relevant to the Agreement and the Implementation Plan, within a reasonable time period. Within five (5) business days of receipt of a request for additional data or information under this paragraph, Defendants will provide a letter that acknowledges such receipt, and give an estimate of the time, of no longer than thirty (30) days, needed to comply with the request.
c. Any disputes with that process regarding the relevance, necessity, availability or timing and thoroughness of production of requested data and information will be resolved through the dispute resolution process provided in this Agreement.
d. Nothing in this Agreement prevents Plaintiffs' counsel from obtaining records pursuant to the Idaho Public Records Act, Idaho Code §§ 9-337 et seq.
e. If the requested data or information directly or indirectly identifies a current or former Class Member, or health information protected by federal or state law, the process set forth in paragraphs 94 and 95 shall apply.

94. In the event Plaintiffs' counsel seek the review of confidential information contained in individual records of a Class Member, the following procedures will apply:

a. Plaintiffs' counsel will obtain a Release from the individual Class Member or his/her parent or legal guardian. Plaintiffs' counsel may use the release to directly obtain the information sought. The Parties agree that, so long as Class Member's name and contact information are known, the Release process is the preferred means to obtain confidential information.

b. If the name and/or contact information of an individual Class Member or his/her parent or legal guardian is not known to Plaintiffs' counsel but is known to Defendants, Defendants shall attempt to obtain written permission from the Class Member and the Class Member's parent or legal guardian to provide the Class Member's name and contact information to Plaintiffs' counsel so that Plaintiffs' counsel may obtain a Release in accordance with paragraph 94a.

95. If Defendants and Plaintiffs' counsel are unsuccessful in obtaining a release from the Class Member and the Class Member's parent or legal guardian, and there is no way to obtain a release, Plaintiffs' counsel may seek a court order from the District Court under a protective order authorizing the release of confidential information contained in the individual records of the Class Member, the Idaho Behavioral Health Plan, and/or the records of a provider of services. Unless substantial reasons exist to prevent disclosure, Defendants, pursuant to Idaho Code § 16-2428 or any other applicable statute, at the request of Plaintiffs' counsel, shall file a stipulation and request a court order from a court of competent jurisdiction authorizing the disclosure of the confidential information, unless the Class Member or Class Member's parent or legal guardian objects.

X. ATTORNEYS' FEES

96. The Parties will make good-faith efforts to negotiate the amount of attorneys' fees, costs, and litigation expenses to be awarded to Plaintiffs' counsel during the course of this litigation. Plaintiffs' counsel may submit their attorney fees, costs and litigation expenses to Defendants within thirty (30) days after approval by the District Court of the Agreement. Defendants will have sixty (60) days to notify Plaintiffs' counsel of their objections and for the Parties to negotiate a settlement of the amounts. If the Parties can reach agreement, Defendants will have a reasonable time to pay the negotiated amounts. In the event that the Parties cannot reach an agreement with respect to attorneys' fees, costs, and expenses, they will submit the matter for mediation to a mutually agreeable mediator. If attempts to mediate are not successful, Plaintiffs' counsel may file the appropriate motion with the District Court.

XI. OTHER PROVISIONS

A. Modifications

97. This Agreement may be amended by mutual agreement of the Parties and approval of the District Court. In order to be binding, such amendments must be in writing, signed by persons authorized to bind each of the Parties, and approved by the District Court. The Parties further agree to work in good faith to obtain District Court approval of necessary amendments and modifications. In the event that an

agreement cannot be reached under this paragraph, the Parties may pursue their options under the Dispute Resolution Process.

98. By mutual agreement, the Parties may make non-substantive changes, including grammatical or formatting modifications that have no effect on the Agreement's content or meaning, without notice to the IWG or the District Court.

B. Miscellaneous

99. The Parties agree those materials contained in the several appendices to this Agreement, as they are referenced in the main body of the Agreement, are included and fully incorporated into this Agreement as if fully set forth herein.

100. This Agreement contains all the terms and conditions agreed upon by the Parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or bind any of the parties hereto.

101. The Parties have participated and had an equal opportunity to participate in the drafting and approval of this Agreement. No ambiguity shall be construed against any Party based upon a claim that the Party drafted the ambiguous language.

102. Defendants or their designated signors of this Agreement and Plaintiffs' counsel represent and warrant they have full legal power and authority to enter into this Agreement and to carry out all actions required of them. Each of the signors warrants that he or she has fully read and agrees to all the terms and conditions contained herein.

103. This Agreement is a reasonable and workable compromise that can be implemented by Defendants within the stated time frames.

104. The Parties recognize and acknowledge that this Agreement must be approved by the District Court. The parties agree to cooperate in good faith in the creation of all papers submitted to the District Court to secure such approval. In the event that the District Court does not approve this Agreement or the order approving this Agreement is reversed on appeal, the Parties shall make good faith efforts to modify the Agreement so as to gain judicial approval.

105. This Agreement, once approved by the District Court, shall inure to the benefit of and be binding upon the legal representatives and any successors of the Parties.

106. If Defendants are unable to accomplish any of their obligations or to meet timelines under this Agreement due to events beyond their reasonable control (such as natural disasters, labor disputes, war, acts of God, or governmental action beyond Defendants' control), Defendants shall notify Plaintiffs' counsel within thirty (30) business days of the date upon which Defendants become aware of the impact of said event and describe the event and its effect on performance. If performance is

expected to be delayed or the event frustrates the purpose of the Agreement, the Parties shall negotiate in good faith to amend the Agreement and seek approval of the District Court for such amendment.

107. The provisions of this Agreement are severable. If any court holds any provision of this Agreement, including any provision of any document incorporated by reference, invalid, that invalidity shall not affect the other provisions of this Agreement.

108. This Agreement may be executed in counterparts, each of which will be deemed to be an original and all of which taken together shall constitute a single instrument. This Agreement may be executed by signature via facsimile transmission or electronic mail, which shall be deemed the same as an original signature.

COUNSEL FOR PLAINTIFF CLASS:

By: _____ Date: 5-26-15
HOWARD BELODOFF
Next Friend
Belodoff Law Office PLLC
ISB No. 2290

By: _____ Date: 5-24-15
PATRICK GARDNER
Young Minds Advocacy Project
CB No. 208110

By: _____ Date: 5/21/15
WESLEY SHEFFIELD
Young Minds Advocacy Project
CB No. 287940

FOR THE STATE OF IDAHO:

By: _____ Date: 6-09-15
DEFENDANT
C.L. "BUTCH" OTTER
Governor

By: _____ Date: 5-15-2015
DEFENDANT
RICHARD M. ARMSTRONG
Director
Idaho Department of Health and Welfare

By: _____ Date: 5/14/2015
DEFENDANT
SHARON HARRIGFELD
Director
Idaho Department of Juvenile Corrections

By: _____ Date: 05/12/15
DEFENDANT
SHERI YBARRA
Superintendent
Idaho Department of Education

APPENDIX A Access Model

The Access Model describes the process by which Defendants will interact with Class Members and thereby afford them access to the full array of services and supports provided under this Agreement. Thus, the Access Model provides the system protocols for how Class Members can expect to move into, through, and out of Idaho's children's mental health system. Defendants will use the Access Model for the following purposes:

1. Inform, identify, and screen potential Class Members for mental health needs;
2. Allow children and/or their families[1] to self-refer for mental health needs screening;
3. Refer children who screen positive for mental health needs for assessment;
4. Plan for and provide timely services and supports under this Agreement to Class Members for whom services are medically necessary, based on an individualized treatment plan;
5. Provide for continuously coordinated care for Class Members; and
6. Transition Class Members to the community or other services pursuant to the individualized treatment plan.

The Access Model is guided by the Principles of Care and Practice Model.[2] The Services and Supports document[3] sets forth the services that will be available to Class Members when medically necessary and as provided in their individualized treatment plan.

A. Identification & Referral

Defendants will identify children who are current or potential Class Members based on evident substantial functional impairment and/or other characteristics indicating a need for services provided under this Agreement, and Defendants will refer those youth for an age-appropriate mental-health screening to identified screening entities.

Schools will have a checklist based upon the age-appropriate screening tool that may be used as part of a classroom management system to provide information to parents on potential mental health needs.

Children and their families may self refer by requesting a screen from agencies designated by the Defendants. All requests for screening will be honored, regardless of referral source.

B. Screening

Children's Mental Health (IDHW), the Idaho Department of Juvenile Corrections (IDJC), the Division of Family and Community Services (FACS), Medicaid network providers, and primary care providers will use an age-appropriate screening tool to identify children with unmet mental health needs who may be Class Members.

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[1] The term "family" is intended to mean birth-parents, adoptive parents, guardians, extended family, family of choice, members of the family's support system, and current care givers.
[2] The Principles of Care and Practice Model are defined in Appendix B.
[3] The Services and Supports are defined in Appendix C.

Defendants will develop and administer screening tools consistent with the program needs of each agency or provider, incorporating the Child and Adolescent Needs and Strengths (CANS) tool to the fullest extent possible. Unless otherwise prohibited by law or regulation, an agency or provider will communicate the results of the screening to the child or his family, as appropriate, both verbally and in writing.

The agency or provider will timely refer children who screen positive for a full assessment, as described below. Each agency or provider shall develop and maintain written standards or guidance on what constitutes a positive screen.

Families and emancipated children may request and will be provided a full assessment even if the screening tool does not indicate mental health issues.

Any child who has previously been identified as a Class Member or has had a clinical mental health assessment within the last six months that indicates he or she is a Class Member may not require an additional screen and can be directly referred for assessment or treatment planning as appropriate.

C. Assessment & Class Member Determination

Defendants will conduct or arrange for a clinical mental health assessment to identify mental health diagnoses and functional impairments for all current and potential Class Members referred for an assessment and to identify Class Members. An assessment tool, such as the Child & Adolescent Needs & Strengths (CANS) tool, will be part of the mental health assessment that will be used to identify the functional impairments, strengths, and needs of the potential Class Member.

Potential Class Members who are Medicaid eligible will receive the clinical mental health assessment from a Medicaid mental health network provider. Potential Class Members who are not Medicaid eligible will receive the clinical mental health assessment through the Children's Mental Health Program. IDJC will conduct a clinical mental health assessment as part of the observation and assessment process for all potential Class Members committed to IDJC custody.

Defendants will identify Class Members using the assessment process. Class Members are Idaho residents with a Serious Emotional Disturbance who are eligible under this Agreement for services and supports provided or arranged by Defendants and:

a. Are under the age of eighteen (18);
b. Have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosable mental health condition or would have a diagnosable mental health condition if evaluated by a practitioner of the healing arts operating within the scope of his/her practice as defined by Idaho state law; [4] and

[4] A substance use disorder, or development disorder alone, does not constitute an eligible diagnosis, although one (1) or more of these conditions may coexist with an eligible mental health diagnosis.

c. Have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified clinician, or would have been measured and documented had an assessment been conducted.

The results and clinical recommendations from the assessment will be provided to the person assessed and his or her family, unless such disclosure is prohibited by law or regulation. The agency or provider will also provide the results of Defendants' determination of class membership.

Class Members and families have a choice whether to accept services offered pursuant to this Agreement. Those choosing not to participate will be referred and connected with other community services.

Children who are determined not to be Class Members will be referred and connected to appropriate mental health and community services and supports.

Class members who are identified using the assessment process will be linked by the agency doing the assessment to a service provider who will affirmatively engage the Class Member and his or her family in care planning, as described below.

D. Care Planning, Intensive Care Coordination, and Case Management

Care planning for all Class Members will occur through a Child and Family Team (CFT) approach, as described in the Principles of Care and Practice Model. CFT is responsible for the initial development, subsequent reviews, and modifications of the Class Member's individualized treatment plan. The CFT will agree upon what services are needed and specified in a written individualized treatment plan. Members of the CFT, including the Class Member and his or her family, will be empowered to present their service recommendations and preferences for the individualized treatment plan.

Class Members with more intensive needs are eligible for Intensive Care Coordination (ICC), a level of care utilizing a facilitated CFT process for care planning and coordination through a single consistent care coordinator, as described in the Services and Supports document. Class Members eligible for ICC include any Class Member who either has a qualifying CANS score or meets one of the following criteria:

a. Is at substantial risk of out-of-home placement due to mental health needs;
b. Has experienced three (3) or more foster care placements within twenty-four (24) months for reasons related to mental health needs;
c. Is involved with multiple child-serving systems related to his or her mental health needs;
d. Is under age twelve (12) and has been hospitalized or detained for reasons related to mental health needs within the last six (6) months;
e. Has experienced more than one hospitalization for mental health needs within the last twelve (12) months; or

f. Who is currently in an out-of-home placement due to mental health needs and could be discharged safely to their home or community within up to ninety (90) days if adequate home and community-based supports were provided.

As with other services provided under this Agreement, Class Members and families have a choice whether to participate in intensive care coordination. Those choosing not to participate will be encouraged to access case management services, as described in the Services and Supports document.

Medicaid mental health network providers will provide case management and ICC when clinically indicated to Medicaid-eligible Class Members.

IDHW's Children's Mental Health program will provide or arrange for case management and ICC services when clinically indicated for Class Members who are not Medicaid eligible.

If IDHW's Division of Family and Community Services (FACS) or IDJC have legal custody of a Class Member, they are responsible to provide or arrange for case management and ICC services when clinically indicated.

E. Service Delivery

Services and Supports as described in Appendix C of the Agreement will be provided consistent with the Class Member's individualized treatment plan and the Principles and Practice Model as described in Appendix B of the Agreement. Care-planning decisions will continue to be directed by the Class Member's CFT, as informed by the functional assessment tool, clinical evaluation, medical necessity, and individual need. To the fullest extent allowed by law or regulation, a CFT will have the authority to approve services provided by agencies represented on the CFT that are recommended in the Treatment Plan. If a service is included in the treatment plan that must be authorized by an agency that is not represented on the CFT, the agency shall have up to 14 days to make an authorization determination. CFTs and non-participating agencies will be trained on what is a covered service under this Agreement to minimize denials of recommended services.

The CFT will periodically review the effectiveness of services and make changes to the individualized treatment plan at specified intervals or sooner in response to situational changes of the Class Member and family. The CFT will use an assessment tool, such as the CANS, to assess progress and the effectiveness of services and for modifications of the individualized treatment plan. Class Members and their families may move between ICC and Case Management as their needs and circumstances change.

F. Transitions

Class Members and their families will transition between levels of care and out of care based upon changing needs, changing circumstances, and effectiveness of services. Defendants shall provide discharge and transition planning to ensure coordinated care

through transitions in level of care, between providers, across child-serving agencies, into the adult mental health system, and out of care. Transition out of care shall occur when a determination is made that the Class Member no longer meets the eligibility requirements to remain a Class Member, pursuant to this Agreement, based upon mental health or functional assessment improvements.

The CFT shall assist in making referrals and linkages to other mental health and community resources, both informal and formal.

APPENDIX B Principles of Care and Practice Model

The Principles of Care are intended to guide child-serving agencies in the delivery and management of mental health services and supports for Class Members. These principles are consistent with the Legislative Intent language of the Children's Mental Health Services Act (Idaho Code 16-2402) and System of Care Values and Principles.

The Practice Model describes the expected experience of care in the six practice components provided to Class Members served by Idaho's children's mental health system. The Practice Model will be utilized by all agencies or individuals in the public sector who serve Class Members and their families.[1]

Class Members and their families retain the choice whether to accept or reject voluntary services. However, these Principles of Care and Practice Model do not apply to services provided to Class Members on an involuntary basis, such as those services provided involuntarily to Class Members in the custody of the state or those services required by court order.

A. Principles of Care

The delivery of public-sector children's mental health services in Idaho is guided by the following Principles of Care:

Family-Centered
A defining characteristic of family-centered care is family engagement. Family engagement emphasizes family strengths and maximizes family resources. Family experience, expertise, and perspective are welcomed. Families are active participants in solution and outcome-focused planning and decision-making. Families of birth, foster, and adoptive parents, and families of choice are respected and valued.

Family and Youth Voice and Choice
Family and Class Members' voice, choice, and preferences are intentionally elicited and prioritized during all phases of the treatment process, including care planning, delivery, transition, and evaluation of services. Service is founded on the principle of communicating openly and honestly with families in a way that supports disclosure of culture, family dynamics, and personal experiences in order to meet the individual needs of the family and Class Member.

[1] In the following Principles of Care and Practice Model sections, the term "family" is intended to mean children, youth, birth-parents, adoptive parents, guardians, extended family, family of choice, members of the family's support system, and current care givers.

Strengths Based
Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the Class Member and family, their community, and other team members.

Individualized Care
Services, strategies, and supports are individualized to the unique strengths and needs of each Class Member and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.

Team Based
A team-based approach in partnership with the family and Class Member to bring together natural supports, professionals, and others to develop a family-driven, strengths-based, and solution-focused individualized treatment plan. The team is committed to work with the Class Member and family regardless of the Class Member's behavior, and to continue to work towards the goals of the individualized treatment plan.

Community Based Service Array
An array of community-based interventions will be available and provided according to the individualized treatment plan and in the least restrictive setting to meet the Class Member's needs.

Collaboration
System partners, including local and state agencies and departments, families, and Class Members, work together to meet the behavioral health needs of Class Members involved in multiple systems. This collaboration occurs at the individual treatment planning level as well as the governance structure.

Unconditional
The team working in partnership with the family and Class Member are committed to achieving the goals of the individualized treatment plan regardless of the Class Member's behavior, placement setting, family circumstances, or availability of services in the community until the family indicates the formal process is no longer necessary.

Cultural Competency
Services are provided in a manner that is understandable and relatable to the family and Class Member. Services are provided in a manner that is considerate of family and Class Member's unique cultural needs and preferences. Services also respect the individuality of each individual.

Early Identification and Intervention
Opportunities are available to screen or assess potential Class Members and provide appropriate interventions when mental health issues are first identified.

Outcome Based
Individualized Treatment Plans contain observable, measurable indicators of success that are monitored and revised to achieve the intended goals or outcomes. State agencies and departments develop meaningful, measureable methods to monitor system improvements and outcomes.

B. Practice Model

In order to benefit from the full array of services, at whatever level appropriate and necessary to meet their needs, Class Members are best served through six key practice components that make up an overarching Practice Model. Over the course of treatment and transition, the six practice components are organized and delivered in the context of an overall Child and Family Team (CFT) approach. Many of these practice components will occur throughout a Class Member's experience in care and several will overlap or take place concurrently with other practice components. Consistent with the principle of individualized care, a Class Member's experience of care should be guided by the Practice Model and tailored according to his or her individual needs and strengths.

1) Engagement
Engagement is the process of partnering with Class Members and their families to empower them to take an active role in the change process, and to motivate them to recognize their own strengths, needs, and resources. Engaging families is the foundation to building trust and mutually-beneficial relationships between family members, CFT members, and service providers. Engagement guidelines include:

a. Families and Class Members are welcomed and provided with respect, honesty, and openness;
b. Providers demonstrate hope and an expectation that the family is capable of succeeding;
c. Family's language is used and jargon is avoided; and
d. Cultural diversity is valued and respected.

2) Assessment
Assessment is the practice of gathering and evaluating information about the potential Class Member and his or her family in order to assess strengths and needs. This discovery process may include a screening, which serves as a brief assessment for identifying children who may have needs for mental health services, as well as a more comprehensive assessment done by a mental health professional that provides an in-depth evaluation of underlying needs, available strengths, mental health concerns, and psychosocial risk factors. Assessment guidelines include:

a. Families are acknowledged as experts on their children;
b. Families are listened to, heard and valued; and
c. Strengths identification of all family members and supports is central to getting to know the family.

3) Care Planning & Implementation

Care planning is the practice of tailoring services and supports unique to each Class Member and family to address unmet needs. The care planning process engages the family, the Class Member, and others in CFT meetings to develop a written Individualized Treatment Plan designed to help the Class Member achieve a better level of functioning and reduce the impact of mental illness. The Individualized Treatment Plan will describe the Class Member's strengths and needs, short and long term goals, and will address crisis, safety, and transitions. The Individualized Treatment Plan should also specify the roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the Class Member and family. Care planning and implementation guidelines include:

a. Families and Class Members are provided written information about choices and limitations on choices;
b. Services and supports, both formal and informal, will be provided in the most appropriate and least restrictive settings within the community, with family voice and choice being the primary factor in making decisions in intervention strategies;
c. Services focus on strengths and competencies of families, not on deficiencies and problems;
d. Planned services are available and accessible to the family and are provided in a manner that causes the least amount of additional strain to the family and Class Member; and
e. Goals and tasks with measurable outcomes are established to assess change not compliance.

4) Teaming

Teaming is a process that brings together the family and individuals agreed upon by the family who are committed to the Class Member through informal, formal, and community support and service relationships. These caring and invested individuals work with and support the Class Member and the family through a CFT approach. By integrating the varying perspectives of CFT members, teaming promotes better informed and more collaborative decision-making throughout the Class Member's experience in care. A Class Member who needs Intensive Care Coordination (ICC) will have a formal CFT that includes a dedicated CFT team facilitator. Teaming guidelines include:

a. Families shall have input regarding who is on the CFT;
b. Families are full and active partners and colleagues in the process; and
c. The decision-making process is a joint process with the family and Class Member rather than a "majority rule" which decides for the family.

5) Monitoring and Adapting

Monitoring and adapting is the practice of continually evaluating the effectiveness of the Individualized Treatment Plan, assessing circumstances and resources, and reworking the Plan as needed. The CFT is responsible for reassessing the Class Member and family's needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner. Monitoring and adapting guidelines include:

a. Services are provided regardless of the Class Member's behavior, placement setting, family circumstances or availability of services;

b. Never giving up on Class Members and families while keeping them safe;
c. Understanding that setbacks may reflect the changing needs of family members, not resistance; and
d. Skills and knowledge of the family and Class Members are essential to the change process.

6) Transition

Transition is the process of moving from formal behavioral health supports and services to informal supports. The successful transition away from formal supports occurs when informal supports are in place, and the support and activities needed to ensure long-term stability are being provided. Transition guidelines include:

a. Families are key in identifying resources and supports which may be utilized for solutions; and
b. The community is recognized and respected as a key resource and support.

C. Child and Family Team Approach

All Class Members will receive care planning and service coordination through a Child and Family Team (CFT) approach. The CFT approach is a teaming process that brings together the family and individuals that the Class Member and his or her family believe can help them develop and implement a care plan that will assist them in realizing their treatment goals. These individuals may include informal community supports, such as extended family, neighbors, friends, coaches, faith-based connections, and tribal members. CFT members may also include formal supports, such as providers, Class Member and family peer support specialists, educational professionals, and representatives from other agencies providing services to the Class Member and family.

The CFT may be small or large. At a minimum, the CFT includes the mental health provider, the Class Member, and the Class Member's parent or legal guardian. The CFT may include additional participants if the Class Member and family are involved in other child-serving systems, have complex needs, have an extensive natural or informal support system, or have multiple service providers.

The size, scope, and intensity of the involvement of CFT members is driven by the needs and desires of the Class Member and family. Members of the CFT may be added or removed as the needs and strengths of the Class Member and family change over time.

Class Members eligible for Intensive Care Coordination (ICC) will have a dedicated CFT team facilitator with training in the wraparound process for care planning.

The role of the CFT includes:

a. Collaboratively developing an Individualized Care Plan that addresses the strengths and needs of the Class Member and family and identifies the roles of all the parties involved;

b. Identifying, recommending, and arranging for all medically necessary services and supports needed by the Class Member and family;
c. Facilitating coordination of service delivery for Class Members involved with more than one child-serving system and/or multiple providers;
d. Working together to resolve differences regarding service recommendations, with particular attention to the preferences of the Class Member and family;
e. Having a process to resolve disputes and arrive at mutually agreed upon approach for moving forward with services; and
f. Reconvening to monitor and consider the outcomes in relation to the services that have been provided to meet treatment goals and to make needed adaptations over time.

D. Services

Class Members are eligible to receive all services set forth in the Service and Supports, defined in Appendix C, that are necessary to meet their individualized mental health strengths and needs.

APPENDIX C Services and Supports

The Services and Supports described herein shall be provided to Class Members based on their individual strengths and needs. Not every service will be needed or clinically appropriate for every Class Member. However, all of these services and supports must be available and accessible to every Class Member as needed or clinically appropriate on a statewide basis and shall be provided in accordance with the Principles of Care and the Practice Model described in Appendix B of the Agreement.

A. Assessment & Treatment Planning

1. Initial Assessment

Initial assessments are strengths-based evaluations of a child/youth's mental health and functioning to determine whether the child/youth is eligible for Jeff D. Services and Supports. Assessment activities include face-to-face contact for the purpose of assessing the child/youth's strengths and needs; an evaluation of the child/youth's current mental health, living situation, relationship, and family functioning; contacts, as necessary, with significant others such as family and teachers; and a review of information regarding the child/youth's clinical, educational, social, behavioral health, and juvenile/criminal justice history. The assessments should be strength based, culturally competent, and conducted in the family home whenever possible.

2. Evaluation & Testing

Specific assessments or testing including, but not limited to, psychological, behavioral, neurological, or psychiatric, to assist in the development of a treatment plan. Providers will most likely be medical professionals who are Ph.D. or Master's level providers with associated expertise. In school settings, the evaluators will be appropriately certified, credentialed, or licensed.

3. Treatment Planning

Treatment planning consists of engagement of the Class Member and family; review and discussion of the assessment; team formation; treatment plan development and modification; crisis planning; and transition planning.

a. Class Member and family team formation: A Case Manager or Intensive Care Coordinator engages the Class Member and family to elicit participation in treatment planning through a team approach that is family centered, strength based, culturally competent, and outcome focused. The Case Manager or Intensive Care Coordinator organizes the initial meeting with the Class Member and family. During the initial meeting, the Case Manager or Intensive Care Coordinator engages the Class Member and family by explaining the Child and Family Team (CFT) approach, discussing the participation of appropriate people as part of the CFT (e.g., extended family, teachers, social workers, etc.), and determining if additional assistance is required to support the family's engagement in the process. The Case Manager or Intensive Care Coordinator contacts potential CFT members identified during engagement and coordinates the schedules of the CFT meetings in a location which is preferred by the family. Engagement of the Class Member and family by the Case Manager or Intensive Care Coordinator and of CFT members continues throughout the provision of services.

b. Treatment plan development, implementation, and modification: The CFT works to develop and adopt a strength-based and individualized treatment plan. The treatment plan describes the Class Member's strengths and needs; long-range and short-term goals for the Class Member; and the services that will best help the Class Member meet the plan's goals, as well as maximize the reduction in his/her mental disability and restore him/her to his/her best possible functional level. Services included in the treatment plan are individualized and will vary from Class Member to Class Member based upon his or her strengths and needs. The services that are provided may include those listed in this document. CFT meetings are facilitated by the Case Manager or Intensive Care Coordinator. During these meetings, the Case Manager or Intensive Care Coordinator facilitates the assignment of tasks to CFT members. The Case Manager or Intensive Care Coordinator tracks completion of team assignments. The Case Manager or Intensive Care Coordinator works with the CFT to modify the individualized treatment plan when appropriate. To the fullest extent allowed by law or regulation, a CFT will have the authority to approve services provided by agencies represented on the CFT that are recommended in the Treatment Plan. If a service is included in the treatment plan that must be authorized by an agency that is not represented on the CFT, the agency shall have up to 14 days to make an authorization determination. CFTs and non-participating agencies will be trained on what is a covered service under this Agreement to minimize denials of recommended services.

c. Crisis planning: Crisis planning is conducted by the CFT and is designed to address safety concerns, predict potential areas of crises, and to identify ways to resolve a crisis should one occur. The CFT creates the crisis plan that (a) anticipates the types of crises that may occur, (b) identifies potential precipitants and ways to reduce or eliminate crises, and (c) establishes responsive strategies by caregivers and members of the Class Member's CFT involving additional community resources as appropriate, to minimize crisis and ensure safety.

d. Transition planning: Transition planning is conducted by the CFT, informed by the assessment process, and designed to ensure that Class Members are appropriately transitioned from services, either when the Class Member leaves the children's mental health system for the adult mental health system, or when the Class Member no longer needs formal supports. Transition planning includes a clear pathway and priority for connecting caregivers and Class Members, at service re-entry, to persons with whom they have worked previously. The CFT creates the transition plan and modifies it when appropriate.

B. Case Management and Intensive Care Coordination

1. Case Management

Case management refers to outcome-focused, strength-based activities that assist families and Class Members by locating, accessing, coordinating and monitoring mental health, physical health, social services, educational, and other services and supports. Case management includes both informal and formal assessment of service needs and service planning. It includes assessing, reassessing, monitoring, facilitating, linking, and advocating for needed services for Class members and their families. Case Managers shall use a CFT approach as described in the Principles of Care and Practice Model.

Case management includes face-to-face activities or collateral contacts that directly benefit the Class Member and the Class Member's family.

Case Managers shall maintain reasonable caseloads, consistent with accepted industry standards for children's mental health systems of care based on intensity of their client's acuity, needs, and strengths.

2. Intensive Care Coordination

Intensive Care Coordination (ICC) is a case management service that provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered consistent with the Principles of Care and Practice Model. ICC includes both assessment of service needs and service planning utilizing a facilitated CFT process. It includes assessing, reassessing, monitoring, facilitating, linking, and advocating for needed services for Class Members and their families.

ICC is delivered through a single consistent Intensive Care Coordinator. The Intensive Care Coordinator is responsible for coordinating multiple services that are delivered in a therapeutic manner, allowing the Class Member to receive services in accordance with his or her changing needs and strengths. The Intensive Care Coordinator is also responsible for promoting integrated services, with links between child-serving agencies and programs.

ICC also includes a treatment planning process that utilizes a formal CFT approach, as described in the Principles of Care and Practice Model. The Intensive Care Coordinator is responsible for facilitating CFT meetings for the purpose of developing outcome-focused, strength-based activities that assist Class Members and their families. The Intensive Care Coordinator is specifically trained in the wraparound process for treatment planning.

Intensive Care Coordinators shall maintain reasonable caseloads consistent with accepted industry standards for children's mental health systems of care based on intensity of their client's acuity, needs, and strengths.

Specific responsibilities of the Intensive Care Coordinator, in conjunction with the Class Member and family, are:

a. engaging the Class Member and family to elicit participation in treatment planning and services;
b. assembling the CFTs and facilitating team meetings on a regular basis;
c. collecting, organizing, and distributing to CFT members assessments and other information about the Class Member and family;
d. coordinating CFT meetings and documenting recommendations of the CFT;
e. developing and distributing the individualized treatment plan;
f. facilitating consensus from all CFT members and assisting in resolving disputes when necessary and appropriate;
g. reviewing the individualized treatment plan on a regular basis and facilitating the CFT in making modifications as needed and appropriate;

h. identifying, arranging, and monitoring services, including informal services in the community;
i. facilitating collaborative communication and decision-making across child welfare, juvenile justice, mental health, and educational systems; and
j. assisting in emergency or crisis situations, which may include responding to a call 24/7, meeting the family where the emergency is occurring, or taking the lead role in de-escalating the situation.

IDJC, which is responsible for the well-being of the children in its custody, provides intensive care coordination under a model unique to its mission.

C. Treatment Services & Support Services (Direct Services)

Treatment & Support Services (hereinafter called "Direct Services") are individualized, preferably evidence supported, strength-based interventions designed to correct or ameliorate mental health conditions and improve a Class Member's functioning. Interventions are aimed at helping the Class Member build skills necessary for successful functioning in the home, school, and community and improving the ability of the family to help him/her to successfully function in the home, school, and community. The types and intensity of interventions are based upon an Individualized Treatment Plan, and will vary over time based upon effectiveness, reassessment of needs, and modifications to the Individualized Treatment Plan.

Direct Services are delivered according to an Individualized Treatment Plan developed as described above, and consistent with the Practice Model. The Individualized Treatment Plan will have specific goals, objectives, and interventions that are the treatment and support services designed to improve the Class Member's functioning.

Direct Services include:

1. Treatment Services

a. Medication Management

Medication management services include a clinical assessment of a Class Member, the prescription of medication and follow-up reviews as part of the Individualized Treatment Plan for the purpose of evaluating the effectiveness and side effects of the medication by medical personnel. A prescriber should be involved with the CFT.

b.Psychotherapy

Individual, family, or group therapy involves outcome-based and strength-based therapeutic interventions. Services may be provided in the home, community, or an office setting. Priority is given to evidence-based therapies, such as, Cognitive Behavioral Therapy, Parent-child Interaction Therapy, and Functional Family Therapy.

c. Skills Building

Behavioral, social, communication, rehabilitation, and/or basic living skills training designed to build a Class Member's competency and confidence while increasing functioning and decreasing mental health and/or behavioral symptoms. Training is related

to goals identified in the individualized treatment plan. Examples of areas that may be addressed include self-care, behavior, social decorum, avoidance of exploitation, anger management, budgeting, development of social support networks, and use of community resources.

d. Behavioral/ Therapeutic Aide Services (including mentoring)

Behavioral/therapeutic aide services focus on social and behavioral skill development, building a Class Member's competencies and confidence. These services are individualized and are related to goals identified in the Class Member's treatment plan. Services that a behavioral/therapeutic aide or mentor may provide include crisis intervention, implementation of a behavioral management plan, and rehabilitation services, such as teaching the Class Member appropriate problem-solving skills, anger management, and other social skills. Behavioral/therapeutic aides or mentors may provide assistance at any time and in any setting appropriate to meet the Class Member's needs, including home, school, and community.

e. Day Treatment

Psychotherapy and/or skills building provided in a structured group environment that includes individual or group activities, therapies, social, communication, and behavior and basic living skills training. Treatment is individualized and related to goals identified in the Class Member's individualized treatment plan. Day treatment services may be provided at any time including during the day in the Class Member's school or other community settings.

f. Intensive Home and Community-Based Services

Intensive in-home services are intensive services provided to Class Members in their home or in the community. Services are individualized, strength based, family centered, and culturally competent. All services focus on the Class Member's emotional/ behavioral needs. Services may include behavior management, therapy, crisis intervention, and parent education and training. Intensive services should be provided to, among others, Class Members at risk of out-of-home placement, including a residential program or psychiatric hospital, Class Members transitioning from an out-of-home placement back to their families or other community setting, and Class Members with significant behavioral health needs.

g. Therapeutic after-school and summer programs

Therapeutic after-school and summer programs encompass individual and related therapies and counseling in a therapeutic setting with an emphasis on social, communication, behavior and basic living skills training, psychosocial skills, and relationship problem-solving. After-school programs can be located on school grounds or other community settings.

h. Integrated substance use disorder (SUD) services for individuals with co-occurring disorders

Integrated SUD services are provided in an individual or group setting that are integrated with the Class Member's mental health treatment. Services may include residential services, intensive outpatient SUD services, education and coping skills training for the mental and SUDs and their interactive effects, and training on handling stress and relapse prevention. SUD and mental health services are integrated as described in the individualized service plan.

2. Residential-Based Treatment Services

a. Treatment Foster Care

A service that provides clinical intervention for a Class Member within the private homes of clinically trained and licensed foster families for the length of time necessary to meet the individual treatment needs of the Class Member. ICC will be provided when a Class Member is placed in treatment foster care and the CFT members will include the treatment foster parents. Treatment foster care includes services provided by a foster parent/family in order to implement the Class Member's individualized treatment plan. Treatment foster parents assist in developing an individualized treatment plan for the Class Member and support the Class Member in achieving his/her service plan goals and objectives. Treatment foster parents perform a therapeutic function in addition to supervision services. Treatment foster care services include supervision, behavioral interventions, psychosocial rehabilitation, skills training and development, participation in treatment and discharge planning, and transition services when a Class Member returns to his/her family. Transition services involving the treatment foster parents may include, among other things, facilitating visits, coaching the permanency caregivers, providing limited respite care, etc. Class Members in treatment foster care may also receive other services listed in this document that are not provided by their treatment foster parents.

b. Residential Care

A service provided by a licensed children's residential care facility that provides treatment and care in a highly-structured setting for a Class Member needing intensive treatment and supervision for the length of time necessary to meet the individual treatment needs of the Class Member. ICC will be provided when a Class Member is placed in residential care and the CFT members will include the residential care provider. The Individualized Treatment Plan will address the transition out of residential care and family involvement while the Class Member is in the residential care facility.

3. Support Services

a. Respite

Respite services are short-term, temporary direct care and supervision for a Class Member intended to relieve a stressful situation, de-escalate a potential crisis situation, or provide a therapeutic outlet for a Class Member's emotional problems. The goal is to prevent disruption of a Class Member's placement by providing rest and relief to caregivers and Class Members while helping the Class Member to function as independently as possible. Respite services are generally limited to a few hours, overnight, a weekend, or other relatively short period of time. Services can be furnished on a regular basis. Respite services can be furnished in the Class Member's home, another home, a therapeutic foster home, or other community location.

b. Transportation

Transportation services involve the transporting of a Class Member and/or his/her family/caregiver from one place to another to facilitate the receipt of services in the individualized treatment plan. The service may also include the transportation of the Class Member's family/caregiver with or without the presence of the Class Member, if provided for the purposes of carrying out the Class Member's service plan (e.g., counseling, meetings).

c. Psychoeducation & Training
Psychoeducation and training educate the family and Class Member about the Class Member's mental health needs and strengths and train the family and Class Member in managing them. The goal of these services is to foster community integration and/or avoid an out-of-home placement by teaching the family how to help the Class Member function within the family, school, and community, including by developing and implementing a behavioral plan. Services are strength based, outcome focused, culturally competent and individualized. Services may be provided individually, in the home, or through group trainings.
d. Family Support
Services provided by other parents who have lived experience and specialized training to assist and support the family in gaining access to services, and to help the family become informed consumers of services and self-advocates. Family support such as, but not limited to, mentoring, advocating, and educating may be provided one on one to the family or through family support groups.
e. Youth Support
Services provided by other youth or young adults to assist and support Class Members in understanding their role in accessing services, and in becoming informed consumers of services and self-advocates. Youth support such as, but not limited to, mentoring, advocating, and educating may be provided through youth support groups and activities.
f. Case Consultation
Case consultation is an in-person or telephonic meeting to develop, monitor, or modify a comprehensive assessment or individualized treatment plan, or to review services and progress towards objectives in the treatment plan between two or more of the following: the case manager, treating providers, physician, and other professionals or paraprofessionals involved in the Class Member's care. Case consultation includes attendance at CFT meetings or educational case conferences.
g. Flexible Funds
Funding available to meet the unique needs not otherwise paid for in an Individualized Treatment Plan. Examples of flex funding include, but are not limited to, family supports such as limited rental payments, utilities, automobile repair, and individual supports such as therapeutic behavioral incentives.

Settings: Direct Services may be provided in any setting where the Class Member is naturally located, including the home (biological, foster, relative, or adoptive), schools, recreational settings, childcare centers, and other community settings. Some of these services may also be provided via telehealth technology.

Availability: Direct Services are available as needed, including in evenings and on weekends.

Providers: Non-clinical Direct Services are typically provided by paraprofessionals under clinical supervision. Peers, including parent and youth partners, and may provide Direct Services. Clinical services are provided by a mental health professional rather than a paraprofessional.

D. Crisis Response Services

Crisis services are available 24-hours a day, seven days a week in response to sudden or unexpected behavior in a Class Member that indicates the presence of acute psychiatric symptoms and the need for an immediate response. The purposes of crisis services are to identify, assess, and stabilize the situation.

a. Crisis Respite
Short term, temporary care of a Class Member by a caregiver different from the usual caregiver to stabilize a crisis situation.
b. Crisis Response Services
Services that are available 24-hours a day, seven days a week through telephonic contact with a mental health professional to determine the most appropriate response to a crisis situation.
c. Crisis Intervention Services
Face-to-face services include safely identifying and assessing immediate strengths and needs to ensure that appropriate services are provided to de-escalate the current crisis and prevent future crises. Services shall be provided consistent with an existing crisis plan using formal and informal supports, in partnership with the family. Services are available 24-hours a day, seven days a week by trained clinical staff.
d. Inpatient
Mental health and medical services provided to a Class Member admitted to a psychiatric hospital when there is an imminent risk of danger to self or others.

Settings: Crisis services are typically provided at the location where the crisis occurs, including the home (biological, foster, relative, or adoptive) or any other settings where the Class Member is naturally located, including schools, recreational settings, child care centers, and other community settings.

Availability: Crisis services are available 24 hours a day, 7 days a week, 365 days a year.

Providers: Crisis services are provided by a trained and experienced crisis professional or team, preferably drawn from members of the CFT.

APPENDIX D Governance

The Behavioral Health Division within the Idaho Department of Health and Welfare, the Department of Juvenile Corrections, and the Idaho State Department of Education have responsibility to serve the multiple needs of youth and families and are committed to partnering with each other and families and will participate on a supervisory team through an interagency governance structure. 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. 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 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.

Purpose

The purpose of the Interagency Governance Team (IGT) is to collaboratively coordinate and oversee the implementation of the court approved Agreement in the Jeff D. class action lawsuit. The (IGT) shall advise the parties to the Agreement on implementation and serve as a vehicle for communication among parties, to identify and remove barriers to implementation, and monitor implementation of the Agreement.

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.

Articles of the Governance Agreement

a. The Interagency Governance Team will support and promote the Principles established in the Principles of Care and Practice Model as defined in Appendix B of the Agreement.
b. The Interagency Governance Team will be collaborative in nature and provide oversight on direction taken related to meeting the systemic needs of youth within its purview. The IGT will provide leadership to influence the establishment and sustainability of the Principles of Care and Practice Model statewide. The recommendations of the IGT will be timely acted on by decision-makers using their discretion and operating within their statutory authority and mission.
c. The Interagency Governance Team will, at minimum, maintain three subcommittees: 1) Family Engagement, 2) Clinical, and 3) Training. The IGT may organize additional subcommittees as necessary to carry out the purposes of the Agreement and Implementation Plan.
d. The Interagency Governance Team will meet as frequently as necessary to fulfill its purpose but at a minimum quarterly. Meetings will be open to the public and meeting notes will be distributed to each member after each meeting and posted on the appropriate website after approval by the IGT membership.
e. The Interagency Governance Team will elect a chair and vice-chair from within its membership.
f. The Interagency Governance Team will adopt operational guidelines for carrying out the above stated purposes and responsibilities.

EXHIBIT B

EXHIBIT B

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

JEFF D. et al., Plaintiffs, v. CLEMENT LEROY OTTER, et al., Defendants.	Case No. 4:80-CV-4091-BLW **PROTECTIVE ORDER**

Before the Court is the parties' Settlement Agreement, filed on the ____ day of _____, 2015 (Docket No. _____), which includes a process in paragraphs 94 and 95 regarding the Defendants' releasing to Plaintiffs' counsel of confidential information regarding Class Members protected from disclosure by federal or state law.

IT IS HEREBY ORDERED that any documents containing confidential information regarding Class Members that Defendants release to Plaintiffs' counsel in accordance with the process set forth in the Settlement Agreement shall retain those rights of privacy and protection from disclosure to which said documents are entitled by law, including the Health Insurance Privacy and Accountability Act (HIPAA) of 1996, and that the same shall remain confidential and not be used by or disclosed to any third party, entity, or person, exclusive of the members of Plaintiffs' counsels' firms and agents hired by Plaintiffs' counsel with respect to the compliance with the Settlement Agreement.

IT IS FURTHER ORDERED that all such documents or information shall only be used for the purposes set forth in the Settlement Agreement, and the production of such documents shall not constitute a waiver of any right of privacy or protection from disclosure or other claim or right of withholding or right of confidentiality to which those persons identified in the

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documents may have.

IT IS FURTHER ORDERED that by complying with this Order and the relevant provisions of the Settlement Agreement, Defendants and Plaintiffs' counsel shall be deemed in compliance with all state and federal laws pertaining to the use and disclosure of confidential information and therefore are discharged from any and all liability, demands, or claims stemming from said compliance.

IT IS SO ORDERED.

DATED: _____

_____
B. LYNN WINMILL
Chief Judge
United States District Court

EXHIBIT C

EXHIBIT C

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

JEFF D. et al., Plaintiffs, v. CLEMENT LEROY OTTER, et al., Defendants.	Case No. 4:80-CV-4091-BLW ORDER ADMINISTRATIVELY TERMINATING CASE

The parties have successfully concluded the mediation of all outstanding compliance issues and the parties have negotiated a stipulated settlement agreement which has been approved by the Court.

Pursuant to the terms of the parties' settlement agreement, the parties shall resolve any and all claims, disputes, or other matters in controversy arising out of or related to the settlement agreement, or the breach, implementation, or performance thereof, according to the process set forth in the settlement agreement. If, after negotiating in good faith, no resolution is reached, either party may file an appropriate motion with the Court in this matter.

Pursuant to the terms of the parties' settlement agreement, the consent decrees, entered in 1983, 1990, and 1998, and the Implementation Plan, approved in 2001, and the orders related thereto, shall be suspended upon the Court's approval of the settlement agreement. Plaintiffs may move the Court to lift the suspension in the event Defendants fail to substantially comply with the duties and obligations under the settlement agreement, and in the event the settlement agreement's dispute resolution process has not successfully resolved the dispute concerning the alleged non-compliance. If such a motion is filed, Defendants shall bear the burden of proving substantial compliance with the settlement agreement. If the Court finds that Defendants have

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not substantially complied with the settlement agreement, the Court will lift the suspension and Plaintiffs will then be able to seek enforcement of applicable portions of the consent decrees, the Implementation Plan, approved in 2001, and orders related thereto, subject to the availability of Federal Rule of Civil Procedure 60(b)(5) relief.

Pursuant to the terms of the parties' settlement agreement, substantial compliance with Defendants' commitments is enforceable during the pendency of the settlement agreement. In the event that Defendants are failing to substantially comply with the duties and obligations under the settlement agreement, and in the event that the settlement agreement's dispute resolution process has not successfully resolved the alleged non-compliance, Plaintiffs may file an appropriate motion with the Court according to the terms of the proposed settlement agreement.

Pursuant to the terms of the parties' settlement agreement, an implementation plan will be prepared and submitted to the Court for approval. The parties shall make reasonable efforts to submit a consensus plan. If the parties cannot agree on the terms of the implementation plan, the disputed issue(s) may be submitted to the Court for resolution. The Court may approve the implementation plan if the Court determines the plan is reasonably capable of fulfilling the terms of the settlement agreement and the purposes of the consent decrees and related orders. Following the Court's approval of the implementation plan, Defendants shall provide annual reports to the Court and Plaintiffs' counsel on the progress of the implementation plan.

Pursuant to the terms of the parties' settlement agreement, Defendants shall complete the implementation plan within four years following the Court's approval of this plan. Upon completion of the implementation plan, any party may submit a motion to the Court for a finding of substantial compliance with requirements for completing implementation of the settlement agreement as measured by objective criteria identified in the settlement agreement.

Pursuant to the terms of the parties' settlement agreement, Defendants shall sustain performance of the settlement agreement for three years following completion of implementation. At the end of this time period, Defendants may submit a motion to the Court for a finding of substantial compliance with the requirements for sustaining performance as measured by objective criteria identified in the settlement agreement. Upon the Court making such a finding, the lawsuit may be dismissed. Simultaneous to the dismissal, the parties shall make a joint motion to the Court to issue a stipulated permanent injunction protecting the interests of the Plaintiff Class.

Pursuant to the terms of the parties' settlement agreement, this Court may issue a protective order to protect confidential information contained in individual records of Class Members. To the extent the parties are unsuccessful in obtaining a release from a Class Member and the Class Member's parent or legal guardian, and there is no way to obtain such a release, Plaintiffs' counsel may seek a court order from this Court authorizing the release of confidential information. Unless substantial reasons exist to prevent disclosure, Defendants, at the request of Plaintiffs' counsel, shall file a stipulation and request a court order from a court of competent jurisdiction authorizing the disclosure of the confidential information, unless the Class Member or Class Member's parent or legal guardian objects.

IT IS HEREBY ORDERED that, based upon the stipulated settlement agreement, the Clerk of Court shall administratively terminate the above-entitled action in the Court records, without prejudice to the right of the parties to reopen the proceedings for good cause shown for the entry of any stipulation or order, or for any other purpose required regarding implementation. Therefore, the case is hereby ordered terminated, subject to the Court retaining jurisdiction to enforce the terms of the stipulated settlement agreement. *See Kokken v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375 (1994).

DATED: _____

_____
B. LYNN WINMILL
Chief Judge
United States District Court

Environmental Factors and Plan

19. Suicide Prevention - Required for 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 M/SUD 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 using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD 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.

This past year we have updated our statewide suicide prevention plan aligning it with the NSSP. In addition, over the course of this next year we will be building out a robust statewide Master Trainer network to increase trainings happening locally. Our hope with this effort is to increase the conversations around suicide happening locally, provide Idaho citizens with the tools to be aware of suicide and to ask friends and family about suicide intent, as well as to provide them with resources, like the suicide hotline when someone does identify with suicidal ideation.

Another effort is focused on youth suicide prevention. We are working with the State Department of Education to develop suicide safer school model policies and assist selected schools to implement those policies. As a part of this effort, evidence-based youth and adult training curriculums will be introduced to selected across the state focusing on training adults in knowing the signs of suicide and referring for a risk assessment in addition to providing youth with resiliency skills and the knowledge of how to ask for help when it is needed.

Finally, we are implementing Zero Suicide in one Public Health District catchment area and will be working with the health facilities in that area to develop a plan for continued care beyond assessment, planning, and follow up.

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 2018-FFY 2019 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

We are building a statewide training system that will provide training for all Idaho citizens.

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

No technical assistance is requested at this time.

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for 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 M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

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?

As indicated in the last application and plan, The Idaho Department of Health and Welfare, the State Department of Education, and the Idaho Department of Juvenile Corrections continue to use a collaborative interagency governance structure (IGT). The purpose of the IGT is to collaboratively coordinate and oversee the implementation of the court approved Settlement Agreement in the Jeff D. class action lawsuit, which is the basis of the new System of Care for Children's Mental Health in Idaho.

As mentioned earlier in this application and plan, Idaho is in the beginning stages of Medicaid Expansion and as this transition unfolds over the next several years, what is identified below as Idaho's service system could begin to look different as the updates are completed through the phase of the grant. In the attachments, the most recent Division of Behavioral Health Medicaid Expansion Project Plan is included. It is estimated that a large portion of the Idahoans who have used Division of Behavioral Health Mental Health and Substance Use Disorders (SUD) services will be Medicaid eligible under expansion, and therefore will have a health plan that will cover their behavioral health services. The Division is working with its state agency partners and providers to prepare for Medicaid enrollment and coverage. Enrollment is planned to begin Nov. 1, 2019, with Medicaid expansion coverage beginning Jan. 1, 2020.

As a result of the expanded services for Idahoans under Medicaid Expansion, the Division of Behavioral Health may be taking a more active role in the Idaho Behavioral Health Cooperative (Idaho Code 39-3124): IDAHO BEHAVIORAL HEALTH COOPERATIVE. 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.

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.

Community-based and Support of State Partners Recovery Support Services

Behavioral Health Crisis Centers
Idaho currently has six crisis centers, and services available in hospitals in one of Idaho's rural region as part of an innovative collaboration to meet rural needs. The Behavioral Health Community Crisis Centers continue to meet the needs of thousands of Idahoans who suffer from behavioral health crises. These Crisis Centers have been effective in reducing unnecessary hospitalization and incarcerations and have quickly become an important part of the community's continuum of care and services for people suffering from a behavioral health crisis.

Homes with Adult Residential Treatment (HART)
Homes with Adult Residential Treatment (HART) was initiated to pilot an intensive, treatment-oriented, residential living program for individuals with as serious and persistent mental illness. The Division of Behavioral Health contracts with four HART facilities across the state to provide a safe and therapeutic homelike environment, including meals, living space, assistance with daily living, and clinical treatment services.

Each HART provider is required to be an Optum Idaho-approved Idaho Behavioral Health Plan provider and be able to deliver an array of treatment services including assessment, treatment planning, psychotherapy, community /peer supports, Community Based Rehabilitation Services (CBRS), group therapy, case management, and medication services. The hope of the HART model is to allow clinical treatment interventions better address behavioral health related issues that not been able to be addressed without evicting the resident or escalating the resident to a crisis or emergency facility.

Recovery Community Centers
The Division of Behavioral Health has a contract with Recovery Idaho to provide social support services for individuals with Opioid Use Disorder through Idaho's nine Recovery Community Centers located throughout the state. Services provided under this contract include support groups, recreational activities, and recovery coaching.

The Recovery centers also meet individuals in the hospital emergency departments who have overdosed on opioids to help them access treatment and recovery support services. They also make similar type of connections with individuals who have been discharged from a local jail.

Substance Use Disorder Recovery Support Services
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.

Partnerships with Public Health Districts
The Division of Behavioral Health continues to contract with the seven public health districts for administrative assistance and support for the regionally based Behavioral Health Boards (BHBs). These partnerships have created a venue in which local boards identify community strengths and needs and work collaboratively to capitalize on the strengths while addressing the needs of the local communities.

This collaborative approach has resulted in the funding and support of a variety of activities, including community events that promote behavioral health awareness, scholarships for conferences, and training, transitional housing needs for individuals with co-occurring disorders, as well as providing recovery coaching services.

The State Behavioral Health 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 BHBs as well as monitoring the capacity of the BHBs 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. The BHBs 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.

In addition to working collaboratively with the BHBs and the State Behavioral Health Planning Council, the Division of Behavioral Health and the Division of Public Health have partnered in the area of "prescriber education" in light of the opioid epidemic. Through a contract with the Department of Health and Welfare, the health districts are educating prescribers on best and safest practices for opioid prescriptions; improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse or

overdose.

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

The CMH Division of Behavioral Health program works closely with the Department of Health and Welfare's, Division of Family and Community Services (FACS), and with the Department of Education. A memorandum between CMH and FACS describe how services will be coordinated for shared clients. These include clients in child protection, adoption, foster care, and screening and early intervention for infants and toddlers.

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 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. Resource and Service Navigation identifies and develops resources to support struggling families, so they can achieve long term stability using customized service plans focused on family strengths and community supports. The Bannock Youth Foundation (Pocatello) and Hays Shelter Home (Boise) provide federal grant funded crisis and emergency shelter to run away and homeless youth; these programs coordinate mental health care needs with CMH.

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. 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 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 other federal and SAMHSA grants such as, The Projects for Assistance in Transition from Homelessness (PATH) grant which allows for outreach to adults with serious mental illness who are homeless. The Division's Treatment and Transitions grant (SAMHSA's Treatment for Individuals Experiencing Homelessness program) allows Idaho to support the development and/or expansion of infrastructure that integrates behavioral health treatment and recovery support services for Idahoans affected by homelessness or at risk of homelessness. The funding will serve individuals who are transitioning out of one of our two psychiatric hospitals, and when vacancies are available, individuals referred by Regional Adult Mental Health staff. Idaho also received a $150,000 Transformation Transfer Initiative grant from the National Association of State Mental Health Program Directors (NASMHPD) that will fund the development of a psychiatric bed registry portal that identifies bed capacity across both publicly and privately funded hospitals. The grant will provide individuals who require inpatient care with a single centralized resource to know where to go to receive that care

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 and 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.

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

No Technical Assistance requested at this time.

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and 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 an Advisory/Planning Council (PC).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 PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

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 M/SUD 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.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

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 grant 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.

In 2014, 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 requests 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, underserved 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 application.

The draft block grant documents are made available to the Planning Council members and the public by being posted on

the Substance Use Disorders, Mental Health and Planning Council web pages. The Planning Council receives notice when new block grant documents have been posted on their website and are available for comment and input. 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 the Office of Drug Policy and the State Epidemiological Outcomes Workgroup, as well as to Regional DBH staff through a Behavioral Health newsletter article.
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 can review and comment on the block grant documents.

Additionally, this year, Block Grant writers and met with the Planning Council's Executive Committee to review the Block Grant draft Application and Plan on July 30, before it was finalized, to answer questions and address any concerns. The agenda for the meeting is attached to this application. The Chair of the Planning Council will be providing more information about this meeting in the council's letter that will be attached to this application. The letter is attached as 20-21 Block Grant Planning Council Letter.pdf. The "by-law" changes referenced in the Chair's letter can be referenced in the July 30 meeting minutes located at this address: http://healthandwelfare.idaho.gov/Portals/0/Medical/Mental%20Health/BHPC/Executive%20Committee%20Idaho%20BHPC%20Notes%207.29-7.30.2019.pdf.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ( ) Yes (●) No

3. Please describe 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 (Title 39 Health and Safety: Chapter 31 Regional Behavioral Health Services). 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 focuses its advocacy efforts at the state level, while the Regional Behavioral Health Boards focus is on the local and regional levels.

With the Planning Council's support, Idaho continues to re-build the state 's children 's mental health program, now known as the Youth Empowerment Services Project (YES).

The Planning Council' s advocacy also successful y supported an ongoing project to test a new intensive residential living program called Homes with Adult Residential Treatment (HART).

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

No technical assistance is requested at this time.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[70]

[70]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.

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Footnotes:

July 2019 Executive Committee Agenda

July 29, 2019

9:00 am – 9:15 am: Welcome and Greetings

9:15 am – 11:00 am: By-law modifications (Review, Discussion, and Vote)

11:00 am – 11:15 pm: Break

11:15 am – 1:00 pm: Potential Members Discussion (Review, Discussion, and Vote)

1:00 pm – 1:15 pm: Break

1:15 pm – 3:30 pm: Block Grant

3:30 pm – 4:00 pm: Review day and adjourn

July 30, 2019

9:00 am – 9:15 am: Welcome and Greetings

9:15 am – 10:00 am: Discussion on next in-person meeting, including date.

10:00 am – 11:00 am: Go over Jon's suggestions for Gaps and Needs Analysis and decide what to use.

11:00 am – 11:15 am: Break

11:15 am – 12:30 pm: Review/Finish Block Grant Application and questions

12:30 pm – 1:30 pm: Block Grant with DBH BG Writers

1:30 pm – 1:45 pm: Break

1:45 pm – 3:30 pm: Block Grant with DBH BG Writers continued

3:30 pm – 4:00 pm: Review of meeting, finalizing details, adjourn

Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Rm. 17E20
Rockville, MD 20857

August 27, 2019

Dear Grants Management Officer,

The Idaho Behavioral Health Planning Council (PC) did not review, discuss, nor had an opportunity to provide comment to the proposed Combined Substance Abuse Prevention and Treatment and Community Mental Health Block Grant Application for State Fiscal Year (SFY) 2020-2021 at any of our in-person meetings. The PC's Executive Committee (EC) did receive an opportunity to review, discuss, and provide comment on the proposed Combined Substance Abuse Prevention and Treatment and Community Mental Health Block Grant Application for State Fiscal Year (SFY) 2020-2021 at our EC meeting on July 30, 2019. Since then, I have personally had 28 days review and interpret the proposed Combined Substance Abuse Prevention and Treatment and Community Mental Health Block Grant Application for State Fiscal Year (SFY) 2020-2021 so that I might submit my letter with my recommendations/comments.

The federal block grant remains a critical resource for providing substance use disorder services, prevention and mental health within the state of Idaho. Reflective in the grant application are several examples of our State's intentions to move towards improving our behavioral health system with the implementation of Medicaid Expansion. Taking the forward momentum of Medicaid Expansion into consideration, I am submitting the following recommendations/comments:

- The Combined Substance Abuse Prevention and Treatment and Community Mental Health Block Grant and the Mini-Application are difficult to read and understand and therefore, should not be posted on the website as a stand-alone resource for review and comment. A notification stating the Block Grant Application is available online for review and comment is insufficient.
  Recommendation: There either needs to be an opportunity for the public to receive a "How to interpret the Block Grant 101 course" or a "guide on how to read, follow, and interpret the Block Grant" that is accompanied with the Block Grant Application.
- There is and continues to be an inadequate representation from Parent(s) of a youth with Serious Emotional Disturbance (SED) and from consumers (adult or youth) with Serious Mental Illness (SMI) on the PC. There is also an inadequate representation of voice from the population up to 138-150 % FPL within all groups (IGT, PC, BHB, etc.). It is difficult enough for a parent/consumer to take time off from work or care-taking duties to volunteer but, it is even more difficult when that parent/consumer has to spend the money to volunteer and wait 4-6 weeks for reimbursement on the costs incurred. This does not include daycare. In order for a

Parent(s) with child(ren) with SED or consumers with child(ren) to volunteer, they pay for daycare costs with no reimbursement.
Recommendation: The State needs to look at the rules and regulations and come up with some creative/outside the box ideas for expanding representative voices from the stakeholders utilizing (for themselves or their children) the behavioral health system. Perhaps have the Adult Support Organization (Empower Idaho) and the Youth and Family Support Organization (N/A) assist with finding, recruiting, and financially assisting with this.

- There is a section on Family and Youth Support contract on page 810 and in Appendix G that states a contract will be in place by early fall of 2018. There have been multiple RFP's out for this contract and few inquiries. It is imperative for families and youth to have support and education on behavioral health, navigating the system, and understanding resources available. As of August 27, 2019, there is not a contract in place, leaving families without that support and education piece as the State attempts to launch a new System of Care. The adult behavioral health currently has this contractor with Empower Idaho under Jannus Inc.
  Recommendation: Create a RFP that is built around the needs of Idaho families and youth. Perhaps receive input from families and youth on what they would expect from a contractor in this position. Work towards to have new Family and Youth Support contract in place by the end of next State Fiscal Quarter to ensure families do not suffer a lengthy period of time without support and education.
- There continues to be a gap in Crisis Intervention Training (CIT) within Regions. It has been mentioned that some police forces/county sheriff's offices are unable to send their officers to the CIT training due to lengthy class time and money. This is important for all Idaho citizens to maintain structure, consistency, and integrity as our adults with SMI and our children with SED are in need of behavioral health assistance.
  Recommendation: Create an incentive program or a grant/scholarship for a certain percentage of each police force/sheriff's office to successfully complete this training.
- The PC has been struggling with the communication and appointments from the Governor's office. This is affecting our ability to maintain and recruit new and/or interested candidates. It is also affecting our ability to meet membership requirements set forth from SAMHSA.
  Recommendation: The EC has met and developed a plan. Please see the "by-law" changes voted and passed on July 30, 2019. The limitation to the by-law change is, the Governor's office conducts a background check on all members. The EC needs to be allowed to give an exception to a person's background. For "Adult SUD consumer" and "Adult MH Consumer" positions to be filled with meaningful experience, there is a risk of the candidate having a criminal background. The determination of acceptance to the PC needs to be at the discretion of the Planning Council seeing as the Governor will not be meeting, speaking, or working with these candidate(s).

The Idaho Behavioral Health Planning Council is committed to educating the Governor, our Legislature, and other community-elected officials regarding the need for quality behavioral health care in our state. We also support the Department of Health and Welfare

and the Regional Behavioral Health Boards as they seek to improve services and promote recovery for children, adults, and families struggling with behavioral health challenges.

With the consideration of the above comments, recommendations and Medicaid Expansion, the Council is in support of the Division's block grant application for SFY 2020-2021.

Sincerely,

Kimberly Hokanson, Chair

Idaho Behavioral Health Planning Council

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Marianne King	State Employees	Office of Drug Policy		Marianne.King@odp.idaho.gov
Rosie Andueza	State Employees	Idaho Department of Health and Welfare		rosie.andueza@dhw.idaho.gov
Sister Sheila Cigich	Others (Advocates who are not State employees or providers)			sistersheilasdg@gmail.com
Debi Dockens	Others (Advocates who are not State employees or providers)	Community Coalitions		communitycoalitionsofidaho@gmail.com
Brady Ellis	Others (Advocates who are not State employees or providers)	Idaho Housing and Finance Administration		bradye@ihfa.org
Melanie Fowers	Providers	Idaho Army National Guard		melaniefowers@gmail.com
Judy Gabert	State Employees	Idaho Lives Project		jgabert@idaholives.org
Kimberly Hokanson	Parents of children with SED/SUD			gkhokanson@gmail.com
Rick Huber	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			Rick2727272000@yahoo.com
Penny Jones	Others (Advocates who are not State employees or providers)			pennyjones1952@gmail.com
Tiffany Kinzler	State Employees	Medicaid		Tiffany.Kinzler@dhw.idaho.gov
Greg Lewis	State Employees	Idaho Department of Correction		glewis@idoc.idaho.gov
Chelsea Lincoln	Others (Advocates who are not State employees or providers)			cgaonalincoln@gmail.com
Angenie McCleary	State Employees	Idaho Association of Counties		AMcCleary@co.blaine.id.us
Renee Miner	State Employees	Idaho State Department of Education		reneeminer@boisestate.edu
Judge Gene Petty	State Employees	3rd District Court		jdggap@canyonco.org

Jim Rehder	Persons in recovery from or providing treatment for or advocating for SUD services			jsrehder@gmail.com
Tammy Rubino	Persons in recovery from or providing treatment for or advocating for SUD services			tammylr@yahoo.com
Dr. James (Ryan) Shackleford	Others (Advocates who are not State employees or providers)			
Mark Sorenson	State Employees	Idaho Division of Vocational Rehabilitation		Max.Sorenson@vr.idaho.gov
Jason Stone	State Employees	Idaho Department of Juvenile Corrections		jason.stone@idjc.idaho.gov
Dahlia Strainer	Others (Advocates who are not State employees or providers)			
Jenny Teigen	Providers	Riverside Recovery		jteigen59@gmail.com

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**27**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	1	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	3	
Others (Advocates who are not State employees or providers)	7	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**14**	**51.85%**
State Employees	10	
Providers	2	
Vacancies	1	
Total State Employees & Providers	**13**	**48.15%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**2**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Environmental Factors and Plan

22. 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

If yes, provide URL:

The Behavioral Health Planning Council chairperson and Regional Behavioral Health Boards, as well as the SSA's tribal liaison, State Epidemiological Outcomes Workgroup, and partner government agencies receive an email notifying them the application/plan is posted and available for comment on the Planning Council's website. The url for the Planning Council's website is: http://healthandwelfare.idaho.gov/Medical/MentalHealth/BehavioralHealthPlanningCouncil/tabid/320/Default.aspx A quarterly Behavioral Health newsletter also announced the upcoming availability of the Block Grant Application and Plan for comment when it was published July 23. That newsletter is publicly available at this URL: https://healthandwelfare.idaho.gov/Portals/0/Medical/SUD/BHNewsletterJuly2019.pdf. The newsletter is distributed to more than 1,000 subscribers. On the Planning Council's website, information is provided on the location of the document and persons to contact if they have questions about the document, difficulty accessing it or want to submit a comment. Articles were also included in e-mailed communications to all of the SSA's staff announcing the availability of the grant for public review and comment.

c) Other (e.g. public service announcements, print media) ◉ Yes ○ No

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Footnotes:

A list of the public comments received by Idaho is attached as Idaho Public Comments Received.

2020/2021 Idaho SABG and MH Block Grant Application and Plan

Public Comment Feedback

Date Received	Question/Comment	Response	Date of Response
8/8/19	It has been the case in past years that a certain percentage of the block grant, 5% or 10%, must be used for comprehensive treatment of individuals suffering from a first psychotic episode. Is this still the case? The application is long and complicated, and I don't know how to find whether this requirement still exists, and whether the Department is planning to use the require portion of the block grant funds for this purpose. John Tanner, Idaho Falls	I completely understand that the application is long and complicated. The pages below specifically talk about the FEP set aside and the services the state of Idaho has, is and will provide. If you click on the link, then hit the magnify glass to search and type "FEP" it will direct you to specific pages with the information you requested below, without having to go through all the pages and attachments. I hope this helps, please let me know if you need anything else. Pg 512 Pg 544 Pg 582 Pg 588 Pg 592 Thank you, Kim Nealey, NCC, LCPC, ACADC	8/9/19
8/20/19	Are there any significant changes in this request compared to years prior that would directly affect what providers are currently doing? I'm cutting to the chase! I can say I looked at it briefly, but didn't read all 898 pages! Joy Husmann Community Liaison Intermountain Hospital Vice Chair, R3 BHB	The narrative has of course been updated this year to reflect any differences in how we provide services now since the 2018-2019 Combined Block Grant Application and Plan. A good portion of the early narrative focuses on the current strengths and organizational capacity of our current system (this narrative begins about page 238), and then identifying the gaps and needs of the system and how to address them. We of course mention upcoming Medicaid Expansion (also about page 238) and we do anticipate that once that takes effect it will significantly change our planning and reporting. But, most of those specifics and the changes involved will need to be addressed in upcoming applications and reports once Medicaid Expansion is implemented. The plan also reflects the recent progress of our YES	8/20/19

		program (on about page 242 and elsewhere in the application) Here below is a section of the narrative from page 238 referring to Medicaid Expansion to give you an idea of how we discussed it. I felt it was a good example.: At the writing of this application, Idaho is in the beginning stages of Medicaid Expansion and as this transition unfolds over the next several years, what is identified below as Idaho's service system could begin to look different as the updates are completed through the phase of the grant. In the attachments, the most recent Division of Behavioral Health Medicaid Expansion Project Plan is included. It is estimated that a large portion of the Idahoans who have used Division of Behavioral Health Mental Health and Substance Use Disorders (SUD) services will be Medicaid eligible under expansion, and therefore will have a health plan that will cover their behavioral health services. The Division is working with its state agency partners and providers to prepare for Medicaid enrollment and coverage. Enrollment is planned to begin Nov. 1, 2019, with Medicaid expansion coverage beginning Jan. 1, 2020. In the attachments, you can find a copy of the Medicaid Expansion Project Plan on page 27 if you want more specifics there. So, we do address coming changes with Medicaid Expansion and projects that have been a part of our YES Project. But I would say those are the most significant changes, outside of changes to reflect the past two years since our last combined application, that are included in this plan compared to 2018/2019. Also, please excuse me if my page numbers are slightly off. Because of the cover pages, the numbers reflected on the PDF are slightly different that if you just try to jump to a page using Adobe Reader or similar. Jon Meyer	